HP Source

The Comprehensive Database of Health Promotion Policies Infrastructures and Practices

Annexes to the Final Report
Annexes to the Final Report - HP Source  
(The Comprehensive Database of Health Promotion Policies  
Infrastructures and Practices)

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Contract Variations
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Existing Databases
Existing Web-Sites Research Aids, Libraries and Scientific Databases

A

Academy for International Health Studies
http://www.aihs.com/

Action on Smoking and Health
http://www.ash.org.uk/

Agency for Healthcare Research and Quality
http://www.ahrq.gov/

Alberta Health and Wellness - Health Promotion and Disease Prevention
http://www.health.gov.ab.ca/informat/pubpromo.html

All Health Net.com
http://www.allhealthnet.com/

American Association for World Health
http://www.aawhworldhealth.org/

American Cancer Society
http://www.cancer.org/

American Dietetic Association
http://www.eatright.org/

American Public Health Association
http://www.apha.org/

AskERIC
http://ericir.syr.edu/

Association of Schools of Public Health in the European Region
http://www.ensp.fr/aspher/

Australian Department of Health and Ageing

Australian Health Promotion Association
http://www.healthpromotion.org.au

Australian Institute of Family Studies
Berkshire Health Promotion
http://www.bhps.org.uk/mainframe.htm

Best Practices Learning Centre
http://www.sustainabledevelopment.org/blp/learning/

British Heart Foundation
http://www.bhf.org.uk/

British Safety Council
http://www.britishsafetycouncil.co.uk/

Caledon Institute for Social Policy
http://www.caledoninst.org/

Canadian Mental Health Support Network
http://mdm.ca/cmhsn/

Canadian Public Health Association
http://www.cpha.ca/

Cardiovascular Health Promotion
http://www.jhbmc.jhu.edu/cardiology/partnership/kids/kids.html

US Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/

Center for Drug Evaluation and Research
http://www.fda.gov/cder/

Centre for Health Promotion, University of Toronto
http://www.utoronto.ca/chp/

Centre for Health Promotion Studies, University of Alberta
http://www.chps.ualberta.ca/

Centre for International Cooperation in Health and Development
http://www.ccisd.org/ang/index.htm

Center for World Indigenous Studies
http://www.cwis.org/

Cochrane Health Promotion and Public Health Field
Commission on Macroeconomics and Health  
http://www.cmhealth.org/

The Communication Initiative  
http://www.communit.com/

Community Health Promotion Network Atlantic  
http://www.chebucto.ns.ca/CommunitySupport/CHPNA/CHPNAHome.html

Community of Science  
http://www.cos.com/

Council on Health Promotion - British Columbia Medical Association  

D

Department of Health - United Kingdom  
http://www.doh.gov.uk/

Department of Health and Children - Ireland  
http://www.doh.ie/

Discern  
http://www.discern.org.uk/

Drug Scope  
http://www.drugscope.org.uk/

E

e-Health Ethics Initiative  
http://www.ihealthcoalition.org/community/ethics.html

EPPI-Centre, Social Science Research Unit, Institute of Education  
http://eppi.ioe.ac.uk/index.htm

ETR Associates  
http://www.etr.org/

European Masters in Health Promotion  
http://www.health.bton.ac.uk/sass/eumahp/

European Multilingual Thesaurus on Health Promotion  
http://www.hpmulti.net/

European Training in Effective Adolescent Care and Health  
http://www.euteach.com/
European Who's Who in Health Promotion
http://whoiswho.ensp.fr/

H
Harvard Health Caucus
http://web.med.harvard.edu/healthcaucus/

Health and Safety Executive
http://www.hsedirect.com/

Health at Work - NHS Plus
http://www.nhsplus.nhs.uk/index.html

Health of Wales Information Service
http://www.wales.nhs.uk/index.cfm

Health in Action
http://www.health-in-action.org/

Health Communication Network
http://www.hcn.org.uk/hcn1/exindex.asp

Health Development Agency - United Kingdom
http://had-online.org.uk/

Health Education Board for Scotland
http://www.hebs.scot.nhs.uk/

Health Education Research
http://her.oupjournals.org/

Health First
http://www.healthfirst.org.uk/index.htm

Health Promotion Advocates
http://healthpromotionadvocacy.org/

Health Promotion Agency - United Kingdom
http://www.healthpromotionagency.org.uk/

Health Promotion Department - Fife Primary Care NHS Trust
http://www.fife-hpd.demon.co.uk/

Health Promotion England
http://www.hpe.org.uk/

Health Promotion Glossary - WHO
http://www.who.int/hpr/backgroundhp/glossary/glossaryhp.htm
Health Promotion Hot Links  
http://www.web.net/~stirling/  

Health Promotion International  
http://heapro.oupjournals.org/  

Health Promotion Online  
http://www.hc-sc.gc.ca/hppb/  

Health Promotion Unit, Department of Health - Ireland  
http://www.healthpromotion.ie/  

Health Promotion Unit, Monash University  
http://www.med.monash.edu.au/healthpromotion/  

Health Promotion for Women with Disabilities Website  
http://www.nursing.villanova.edu/WomenWithDisabilities/welcome.htm  

Health Promotion in West Sussex  
http://www.wsussexhealth.org.uk/phweb/HealthPromotion.html  

Health Promotion Strategies for Community Health Services  

Health Resources and Services Administration - US Department of Health and Human Resources  
http://www.hrsa.gov/  

Healthcare without Boundaries  
http://www.health-wa.net/  

Healthfinder  
http://www.healthfinder.gov/  

Healthfinder Kids  
http://www.healthfinder.gov/kids/  

Healthlink Worldwide  
http://www.healthlink.org.uk/  

HealthWrights  
http://www.healthwrights.org/  

Healthy People 2010  
http://www.health.gov/healthypeople/  

Healthy Teeth  
http://www.healthyteeth.org/
HIV InSite
http://hivinsite.ucsf.edu/InSite

ID21 Health
http://www.id21.org/health/

Indian Health Service - USA
http://www.ihs.gov/

Injury Minimization Programme for Schools
http://www.impsweb.co.uk/

Institute of Health Promotion and Education - United Kingdom
http://www.ihpe.org.uk/

Institute of Medicine - Board on Health Promotion and Disease Prevention
http://www4.nationalacademies.org/IOM/IOMHome.nsf/Pages/Health+Promotion+and+Disease+Prevention

Institution of Occupational Safety and Health
http://www.iosh.co.uk/home.cfm

International Alliance of Patients' Organizations
http://www.patientsorganizations.org/

International Institute for Health Promotion
http://www.american.edu/academic.depts/cas/health/iihp/

International Liaison and Medical Research Council
http://www.mrc.ac.za

International Society for Equity in Health
http://www.iseqh.org/

International Union against Cancer
http://www.uicc.org/

International Union for Health Promotion and Education
http://iuhpe.org

Johns Hopkins Center for Adolescent Health Promotion and Disease Prevention
http://www.jhsph.edu/hao/cah/

Johns Hopkins University Center for Communications Programs
http://www.jhuccp.org/
K
Karolinska Institute - Department of Public Health Sciences
http://www.phs.ki.se/whoccse/

Kid's Health
http://www.kidshealth.org/index2.html

M
Massive Effort
http://www.massiveeffort.org/

Mental Health Promotion
http://www.mentality.org.uk/services/promotion.htm

Ministry of Health - Singapore

Minority Health Project
http://www.minority.unc.edu/

N
National Committee on Vital and Health Statistics - USA
http://ncvhs.hhs.gov/

National Health Information Center - USA
http://www.health.gov/nhic/

National Health Information Strategy - Ireland
http://www.doh.ie/hstrat/nhis/index.html

National Institutes of Health
http://www.nih.gov/health/

The National Women's Health Information Center
http://www.4woman.gov/

NSW Health - Health Promotion and Prevention Programs

O
Occupational Health and Safety
http://dmoz.org/Health/Occupational_Health_and_Safety/

Occupational Health Strategy
http://www.ohstrategy.net/
Office of Disease Prevention and Health Promotion
http://odphp.osophs.dhhs.gov/

Office of Health Promotion, Education and Tobacco Use Prevention
http://mdpublichealth.org/ohpetup/

Office of Public Health and Science
http://www.surgeongeneral.gov/ophs/

Office of Women's Health, U.S. Food and Drug Administration
http://www.fda.gov/womens/

Ontario Health Promotion Resource System
http://www.ohprs.ca/

Optimal Health Concepts
http://www.imt.net/~randolfi/

Organisation for Economic Co-operation and Development
http://www.oecd.org/

Ovid Technologies
http://www.ovid.com/

Patient - UK
http://www.patient.co.uk/

The President's Council on Physical Fitness and Sports
http://www.fitness.gov/

Preventive health care and health promotion - Denmark
http://www.sum.dk/health/sider/kap8.htm

Prevline
http://www.health.org/

Public Health Association of Australia

Public Health Association of Japan
http://www.jpha.or.jp/jpha/english/index.html

Public Health Information Exchange
http://www.tu-berlin.de/~ph-doc/engonl.htm

Public Health Institute - Russia
http://views.vcu.edu/views/fap/medsoc/medsoc.htm
Public Health Resources on the Internet

Public Health Services - Queensland Health

Public Health Websites - comprehensive list of public health associations, NGOs, and educational sites

R
Reviews of Health Promotion and Education Online
http://www.rhpeo.org/

Royal Society for the Prevention of Accidents
http://www.rospa.org.uk/CMS/

S
Safe Work
http://safework.ca/

School Health and Youth Health Promotion
http://www.who.int/hpr/gshi/

Scottish Health on the Web
http://www.show.scot.nhs.uk/

Sex Education
http://www.naral.org/issues/issues_sexed.html

Sexual Health Education Programs
http://www.siecus.org/school/sex_ed/sex_ed0004.html

Shape Up America
http://www.shapeup.org/

SHARED
http://www.shared.de/default.asp

Smoking Prevention through Mass Media and School Programs
http://www.uvm.edu/~ohpr/smoke5.html

Society for Nutritional Education
http://www.sne.org/

Society of Occupational Medicine
http://www.som.org.uk/
Sustain
http://www.sustainweb.org/

T
Topics in Reproductive Health
http://www.engenderhealth.org/res/onc/trh-index.html

U
UNAIDS
http://www.unaids.org/

UNESCO
http://www.unesco.org/

US Department of Health and Human Services
http://www.os.dhhs.gov/

United Nations
http://www.un.org

V
VicHealth

W
The Wellcome Trust - Online Resources
http://library.wellcome.ac.uk/

WHO Information Resources

Wired for health
http://www.wiredforhealth.gov.uk/

Women's Health Promotion Unit
http://www-med.stanford.edu/school/whpu/

Worldsafety.com
http://www.worldsafety.com/

Y
Your health is your business
http://www.siu.edu/departments/bushea/
Youthhealth.com
http://www.youthealth.com/home/default.asp

**Research Aids, Libraries and Scientific Databases**

British Medical Association Library
http://www.bma.org.uk/ap.nsf/Content/__Hub+library

The Combined Health Information Database
http://chid.nih.gov/index.html

Directory of Electronic Health Science Journals
http://www.med.monash.edu.au/shcnlib/dehsj/

Health Promotion Index - United Kingdom
http://www.healthcentre.org.uk/hc/pages/hp.htm

Health Promotion Researchers Internet Network
http://www.phs.ki.se/hprin/

Information Waystations & Staging Posts
http://www.iwsp.org/

International Bibliographic Information on Dietary Supplements - Database

International Network for the Availability of Scientific Publications
http://www.inasp.org.uk/

ISI - Thompson Scientific
http://www.isinet.com/isi/

Link
http://link.springer.de/

Medline Plus
http://www.nlm.nih.gov/medlineplus/

MedWeb Plus
http://medwebplus.com/

National Center for Health Statistics - CDC, USA
http://www.cdc.gov/nchs/

National Electronic Library for Health - NHS, UK
http://www.nelh.nhs.uk/

Netlinks - a database of Internet resources for public health
http://www.jhuccp.org/netlinks/index.stm
Annex III
Literature Review
Elisabeth Fosse, 25.08.03

ABSTRACT OF HP SOURCE LITERATURE REVIEW

As a part of the HP Source project a literature review was undertaken and the following guidelines were set for the literature search:
- The scope of the search was limited to literature published in the English language.
- International literature was included where appropriate.
- The focus was on documented research including theory-based analyses of policies and programmes, documentation of evaluations and reports of case-studies.

Published literature was identified using systematic searches in the subject indexes of computerised and online databases, for example Web of Science. We also had access to a library of Health promotion literature and access to a literature search project.

We have chosen to present the review as a commentary on selected research themes in the arena, rather than an account of each contribution. The overall aim was to focus on vital conditions for successful implementation of health promotion policies and to give an account for the most comprehensive evaluations that have been conducted in the field.

On the basis of the literature search, two main categories emerged:

General healthy public policy issues
Literature on healthy public policy and health promotion policy is discussed from a theory-based policy analysis perspective. This literature was used as a framework for the discussion of the various strategies in the second category.

Policy making will not be a technical process where the main issue is to find the right solution to a policy problem. There will always be a process of negotiation between parties with different agendas. Policy development consists of several phases which are a continuum rather than separate phases: initiation, adoption, implementation, evaluation and reformulation. This is seen as a continuous but not necessarily a linear process. Policy formation and implementation must thus be viewed as connected phases and the processes that lead to a policy decision, or output, will influence the implementation of the policy.

Strategies for achieving Healthy Public Policy
The strategies emerging from the literature search may be grouped in four categories:
1. Audits (Investment for health- IFH)
2. Policy tool (Health Impact Assessment-HIA)
3. Planning (Healthy Cities Initiative- HC)
4. Programmes (Canadian Heart Health Initiative- CHHI)

The strategies focused on various aspects and phases of the policy process and they each have their strengths and weaknesses. All of the strategies contributed to agenda-setting and policy-formulation. In the HC and the CHHI initiatives actors at all levels...
were involved, both decision-makers and lay people. These organisational arrangements seemed to contribute to increased commitment. It was only the CHHI that had explicit strategies for the implementation of the programme and the participatory approach also influenced the implementation process. The lack of explicit strategies for implementation may accordingly be viewed as a weakness in the three other strategies.

The overall impression from this literature review is that the obstacles, in terms of political and administrative structures, are difficult to overcome. However, there are promising examples that illustrate the way in which some of these obstacles might be overcome by long term work on the development of the structures necessary for building healthy public policy, for example intersectional co-operation, integrated interventions and participation from communities and decision-makers.
Elisabeth Fosse

REVIEW OF SELECTED LITERATURE ON HEALTH PROMOTION
INFRASTRUCTURE, POLICY AND PRACTICE

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Introduction

This review is a commentary on selected themes in the field of Health Promotion infrastructure, policies and practice. The way in which these three terms are defined is discussed in more detail later in the paper. The nature of these definitions limits the type of literature that has been collected and reviewed:

- **Infrastructure:** Institutions for health promotion
- **Policy:** The complete policy making process
- **Practice:** Policy outcomes

Search Strategy

Published literature as identified using systematic searches in the subject indexes of computerised and online databases, for example Web of Science. We also had access to a library of Health Promotion literature\(^1\) and access to a literature search project, conducted by the International Union of Health Promotion and Education (IUHPE).\(^2\)

Searches were conducted using key words and phrases. These included “healthy public policy” and “health promotion policy”.

Inclusion and Exclusion criteria:

- Language: all literature published in English the scope of the search was limited to literature published in the English language.
- Location: Even though the HP-Source project is a European project, international literature was also included.
- Nature of literature: primarily documented research to include theory-based analyses of policies and programmes, documentation of evaluations and reports of case-studies.

On the basis of these criteria, the following themes emerged through the literature search:

- Healthy Public Policy/ Health Promotion Policy: General issues
- Infrastructures/ Investment for Health
- Health Impact Assessment

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1. The Research Centre for Health Promotion at the University of Bergen, Norway, keeps a comprehensive library of Health Promotion literature.
- Evaluations of Healthy Cities Initiative
- Evaluation of Canadian Heart Health Initiative

We focus on some evaluations in greater detail than others. This review is therefore a commentary on selected research themes in the area, rather than an account of each contribution. The overall aim is to focus on vital conditions for successful implementation of health promotion policies and to give an account for the most comprehensive evaluations that have been conducted in the field. The themes are closely linked together and in this review the literature chosen for discussion focuses on policy development and change, particularly how to develop healthy public policy/health promotion policy.

**The HP Source project**

The aim of the HP Source project is to create a database and communications strategy for *health promotion infrastructures, policy and practice* in Europe. This information can then be accessed by institutions at European and National levels as well as by policy makers, international public health organisations and researchers.

The concept of infrastructure means having a fundament, foundation, basis for something. Usually the term is used to describe the permanent services and equipment, e.g. the roads, railways, bridges, factories and schools, needed for a country or system to be able to function properly. Within the field of Health Promotion the concept must be understood in a broader context.

Moodie et al. (2000:3) define infrastructures for health promotion in the following way:

"…infrastructure refers to institutions, organisations, and associations; the human resources and competencies associated with them; and the finances needed to develop and support them. In addition to this we also talk about the ideas, the social movements and the individuals, champions and leaders that catalyse change and build infrastructures that promote our physical, mental and social well-being"

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2 Thanks to Catherine Jones of the IUHPE who was very helpful in providing us with data
This definition is very broad and includes most aspects of health promotion. The following definition is more limited to the structural conditions and gives a better opportunity to target our focus (Wise and Signal 2000:240):

"Infrastructure refers to the system for policy development, priority setting, monitoring and surveillance, research and evaluation, workforce development, and program delivery that direct and support action to promote, protect and maintain the health of the population."

The main focus in this literature review will be in line with the latter definition and will be mainly on institutions for health promotion at different levels. These institutions may be political/administrative institutions at national, regional or local levels but also universities and even institutions outside the public sector, such as NGOs.

**Concepts of Healthy Public Policy**

There are several definitions of public policy but one that can be useful in the present context is the following (O'Neill and Pederson, 1992:26):

"Public policy is the broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem"

Central to this definition is the notion that public policy is more than simply the programmes of a government but extends beyond the decisions a government chooses to make. Thus, public policy is a guiding principle as much as an outcome.

The concept of healthy public policy is found in the Ottawa-charter, a document produced as a result of the WHO conference in Ottawa in 1986, where it is listed as the first of the five strategies for action. In the Charter it is described in the following way:
"Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well."

The theme of The Second International Conference on Health Promotion, held in Adelaide, Australia in 1988, was Healthy Public Policy. In the proceedings from the conference the following are viewed as elements of the concept of Healthy Public Policy (HPP):

- Interrelationship between environment, economic status, personal choice and health
- Holistic and ecological
- Encourages politicians and policy-makers at all levels to become aware of the effects of their decisions
- Public awareness of health as an essential goal
- Health also depends on economic conditions
- Calls for intersectoral styles of planning and more open minded approaches to problem-solving
- Calls for efforts from many sectors, including industry, education and media
- Community involvement is crucial to the concept of healthy public policy.

The two statements above, as with most statements from international conferences, are quite vague and difficult to use as tools for action. Some authors in the field have been trying to operationalise the concept and tie it in with existing literature and traditions in the field of public policy research. DeLeeuw and Polman (1995)
describe healthy public policy as a major prerequisite for health promotion. They define it as making health a legitimate part of policies in all sectors. Health promotion and healthy public policy ideas are summarised by three concepts (ibid: 332):
1. Intersectoral cooperation
2. Integrated intervention mixes
3. Participation of the community.

Milio (1987) outlines what she calls an ‘ecological’ framework for policy-making. She is pointing to the fact that policy is made in a context within a set of broadly shared and implicit expectations derived from historical, socio-political and organisational experience. Policy making will not be a technical process where the main issue is to find the right solution to a policy problem. There will always be a process of negotiation between parties with different agendas. Milio views policy development as a continuum rather than consisting of separate phases: initiation, adoption, implementation, evaluation and reformulation. This is therefore seen as a continuous but not necessarily linear process.

In line with Milio’s description, **Health Promotion policy will be defined in terms of the whole policy process.** This means both what are usually described as the policy formulation phase and the implementation phases. In recent literature on policy processes it is argued that even if there is a conceptual distinction between the phase of policy formation and that of implementation, this distinction is not always relevant in practice (Hill 1981, Barrett and Fudge 1981, Barrett 1981). The point is that policy formulation and implementation must be viewed as connected phases and the processes that lead to a policy decision, or output, will influence the implementation of the policy. The literature review focuses on policy outputs at the national level but also at implementation arrangements such as the agencies responsible for implementation of policies.

As stated above, policy has been defined as policy decision, i.e. outputs. The results for the relevant population target groups are usually referred to as the outcomes of a policy. In other words, **Health Promotion Practice will be identical to policy outcomes.** In this context these may be programmes or other practical initiatives.
General themes of Healthy Public Policy

DeLeeuw (1993) is focusing on the relationship between epidemiology and policy-making. Epidemiologists have often witnessed how their research findings have not been translated into effective policies. Traditional models of policy-making do not explain why research findings are rarely used in policy-making procedures. In the article it is suggested that this phenomenon is related to three determinants of policy-making:

- A bias stemming from sets of causal, final and normative assumptions and presuppositions
- Interest webs of groups in different domains
- The power of organisations to monitor and communicate activities.

According to DeLeeuw, in epidemiological circles policy-making is still regarded as a more or less rational process where actors decide on the basis of more or less objective information. She states that this view is not in line with what really goes on in the process of policy making. Policy-makers acquire in their career and through the organisational culture of their professional environment a set of implicit assumptions about general policy directions. These assumptions often relate to notions of efficiency (often subjective), acceptability and appropriateness of policy instruments. Together they constitute the policy theory: the cohesive assumptions and presuppositions that are the foundations of a framework in which policy objectives, instruments and time frame are tested and judged for implementation feasibility. These assumptions and presuppositions are rarely made explicit. A fine example can be found in health education; it is a "smooth and easy" intervention type, often too easily employed without any considerations about surplus effectiveness or efficiency of other intervention types such as facilitation or regulation. At the basis of these assumptions are some normative considerations: the standard recipe to choose the "softest" intervention type first before proceeding to more rigorous approaches. Regulatory interventions are generally considered ultimate solutions.
Laumann and Knoke (1987) (in DeLeeuw 1993) found in their extensive research that the degree of power and the capacity to monitor and communicate is highly predictive of the success that organisations will have in predicting the policy process (Ibid:52).

"These mechanisms in policy making have little or nothing to do with the "truth content" of epidemiological work, and everything with the way this work is deployed in the policy-making game."

Several authors give examples that illustrate the problems involved in the implementation and evaluation of Healthy Public Policy and health promotion policy (Fosse 2000, Milio 2001, Rütten 2001, Warren et al 2001). These examples also illustrate designs made to increase implementation outcomes and those made to influence policy processes.

Warren et al. (2001) stresses the complexity of policy processes and the need to take this into account and to build partnerships to win support for the policies. The policy evaluated in this case was the Ontario Tobacco Strategy, a comprehensive, province-wide programme focusing on smoking prevention and cessation and the protection of the public from environmental tobacco smoke. Key components included interministerial coordination; legislation; public information; awareness and education; community programmes; provision of resource centres and research. The implementation of the Strategy has required eight steps:

1. The creation of an independent, arm's-length agency to monitor and to report on programme performance
2. A wide range of stakeholders were involved in establishing the goals, objectives, key components and activity structures for the Strategy. This process produced clear consensus on and broad acceptance of the key aspects of the Strategy
3. Stakeholders took part in establishing accountability standards and procedures for the Strategy as a whole and particularly aspects for which key stakeholder groups have accepted responsibility. As a result, the rate of participation in providing information referable to these standards of accountability has been extremely high.

Researchers and Strategy participants took the next three steps in partnership by:
4. Strengthening participants' capacities for information collection by working with stakeholders to identify core information needs, identifying and rationalising existing collection efforts and to reduce the response burden and strengthening skills.

5. Identifying key information gaps and focusing resources towards filling them

6. Involving users in the collection and interpretation of the information

7. Producing, disseminating and utilising the results. This was achieved in several ways, including integrating the results into strategic planning processes; communicating with policy-makers and communicating through the media with the broader community.

The authors point out that this approach, like all others, has a number of limitations that must be considered. These include: voluntarism, self-report, so-called resistance to negative findings and most important, issues of power and control.

**Investment for Health - a tool for improving infrastructures for Health Promotion**

In 1994 an International Seminar was arranged in Paris by the International Union of Health Promotion and Education (IUHPE) on the theme "National Health Promoting Policies, Strategies and Structures." This seminar may be viewed as the starting point for the development of practical strategies in the field of healthy public policy in a European context (Nutbeam, 1995). The report from the seminar emphasised the need to assemble data in a way that clarifies the relationship between investment in health and subsequent economic and social development. The theme "investing in health" was picked up in several of the reports presented by the participating countries. These pointed to the need to place health promotion efforts in the wider context of a country's social and economic goals.

In 1995 the WHO Regional Office for Europe established a new service to its Member States - appraisal of Investment for Health (IFH) (Ziglio et al. 2000a, Ziglio et al. 2000b, Ziglio et al. 2001). The assessments work both at the national and the sub-national levels:
• It assesses a country's, region's or locality's current efforts, both within and outside the health sector, to promote the health of its population; and
• Advises on the construction of a strategy that strengthens population health through selective investment (both within and outside the health sector) while supporting the country's key economic and social priorities.

The IFH process helps governments (at all levels) take effective action to promote robust population health. IFH starts by asking the following questions (Ziglio et al. 2000a, Ziglio et al. 2000b, Ziglio et al. 2001):

1. Where is health promoted and maintained in a given population?
2. Which investments and strategies produce the largest population health gains?
3. Which investments and strategies help reduce health inequities?
4. Which investments contribute to economic and social development?

In the present connection 'investment' means political will, commitment and action that will contribute to robust health of the population. The kinds of actions that may be appropriate are illustrated here:
• new policies, regulatory changes
• nurturing of non-governmental resources
• strengthening health promotion infrastructure
• improving inter-sector collaboration
• refocusing education
• investing in research relevant to health promotion
• training health promotion professionals
• environmental improvements

Some of the needed actions will take place in the health care (medical) sector, but many will be needed in other policy sectors, including tourism, industry and commerce, food production and distribution, transportation, education, social services, security and defence, culture, the arts, sport and recreation.

People in these diverse policy sectors are not waiting to be reformed or even advised by health promotion experts. Motivation for strengthening the positive health impact
of policies and action in non-health care sectors must be fostered. The potential benefits of policy change to the policy sector must be clearly visible and sufficient to encourage sharing of ideas, experience, and data. Policy changes that promote health must be tailored to fit a sector’s historical, political and cultural context and carry no negative consequence (such as additional costs, loss of jobs, or jurisdictional conflicts).

The IFH process is sensitive to these issues. It is a steady, trust-building approach, one that is consultative, not commanding. IFH proceeds in four steps:

1. examining existing policies across sectors for their impact on health;
2. understanding issues that may enhance or inhibit desired policy changes;
3. developing options that benefit both health and the specific policy sector;
4. planning for and executing the necessary changes (legislative, regulatory, financial, organisational, etc).

In several countries, the first step in the IFH process has been a national IFH appraisal. This has been the case in Hungary, Malta, Romania, Slovenia and Latvia.

The IFH appraisal varies from country to country, but basically follows these steps (Hagard, 1996a, 1996b, 1997, 1999, 2000, Ziglio et al. 2000a, Ziglio et al. 2000b, Ziglio et al. 2001):

1. An official request for the appraisal is received from the Ministry and President of the Parliament.
2. WHO-EURO assembles an international team of around six experts from WHO, academia and national governments other than the country being appraised.
3. Terms of reference for the appraisal are agreed upon
4. The appraisal team is supplied with a wide range of documents on history, geography, Constitution, relevant laws, key economic and fiscal data, demography, social, health and sickness data, and information regarding relevant structures, organisations and institutions
5. The appraisal team makes a country visit, lasting about a week, during which interviews, semi-structured discussions, and a workshop are conducted
6. Based on the above, the team then drafts an Investment for Health Strategy, consisting of three parts, each of which identifies the opportunities to promote health more effectively:
- the overall situation in the country (strengths/weaknesses)
- sector-by-sector analysis (strengths/weaknesses)
- structural, organisational, intersectoral and institutional issues
7. The draft is reviewed by participants from the country that is being appraised
8. A final draft is prepared and submitted to the Parliament

The appraisal is the first step in the IFH process and it takes about a year. It provides a basis and impetus for the rest of the process, which unfolds within the country, calling on WHO resources if needed.

The conclusions that have been drawn from the national appraisals is that if IFH is to be effectively applied, traditional policy-making approaches must change (Ziglio et al. 2000). New commitment and skills of policy analysis and assessment are needed. The national appraisals have shown that the challenges of moving from an understanding of IFH to implementing it should not be underestimated. It is a huge step from believing that the connections between health, economic and social development are real to getting nations to change the ways in which they work. To prepare the ground for IFH, the following developments are essential:
1. There needs to be political priority given to health.
2. There needs to be a clear accountability for health improvement across policy sectors and departments.
3. There needs to be a public understanding of health and how population health can be promoted and sustained.
4. There needs to be a recognition of the trade-offs between health, economic and social development outcomes.
5. At all levels of society, skills need to be developed in working across sectors
6. New incentives have to be developed; sectors must see benefits for their efforts.
7. A clear picture of what an IFH strategy can deliver needs to address not only what is possible at state or civil level but also what individuals and communities can achieve.
8. New infrastructure may be required to support IFH. However, it is far more important to adapt the current infrastructure to sustain IFH.
9. Crucial to all the above is a willingness to make IFH work.

Rütten (2001) outlines and analyses the evaluation of a policy intervention in a region in former Eastern Germany. This was a project initiated by a university in the region to use WHO's thinking about Investment for Health to create an intersectoral strategy for regional development. The project aimed at supporting changes in the policies of public institutions and communities as well as private businesses and NGOs to make them more conducive to the health of the population. This project was used as a WHO demonstration project and showed how the concept of healthy public policy could be implemented. At the local level, cooperative planning groups developed and implemented joint coordinated actions, using multiple approaches to put health investment on the agenda of local policy-making processes. An intersectoral Umbrella Group performed this task in even more comprehensive policy settings. As a general feature, the policy evaluation concept strongly emphasised process and participatory evaluation.

Rütten stresses the following experiences in evaluating impacts of multi-sector policies:

- Local policy environments can build a crucial intervening implementation structure. Important contextual factors at this level include the commitment of top local policy-makers and other stakeholders, the structure of relevant policy arenas, supportive issue networks and advocacy coalitions, and local political culture, history and administrative infrastructures.

- The next level of investigation is related to the receptiveness and sensitivity of the community. Here, further clarifications will be needed on what participation really means and how it can be measured effectively.

- Health outcomes of the implemented policy must be investigated. The investigation could focus on psychosocial indicators, sense of control and a feeling of affiliation with the community all of which are directly related to the health and well-being of the population.
• The need for elaborating policy analysis frameworks has a strategic dimension. Thus, policy evaluators should have in-depth knowledge about the rules of the game, the teams that are playing and their strategies and tactics in order to investigate the role that the evaluation is expected to play.

**Health Impact Assessment**

Health impact assessment (HIA) is a process related to, yet distinct from, the IFH process described above. IFH is much more encompassing and can include HIA at some of its stages. However, HIA can be employed without IFH as is usually the case.

The origins of HIA are generally discerned in the National Environmental Policy Act, passed in the USA in 1969. This mandated Environmental Impact Statements on all Federal legislation and major actions affecting the human environment (Burney 1998). Environmental Impact Assessment (EIA) is a tool to examine the environmental and social implications of proposed development projects.

In 1992 Australia developed the national framework for health impact assessment in environmental impact assessment. The national framework designates policy areas and types of development projects that are subject to health impact assessment. In the Australian model, HIA and EIA are twin elements of a single process. In many cases, consultation with health authorities is mandatory for planned development projects.

The HIA processes parallel the standard EIA process which includes screening for relevance, scoping for range, profiling for baseline data, risk assessment and management, implementation, and monitoring and evaluation. Public participation, workforce training and accreditation are key components of the Australian approach.

In the United Kingdom some aspects of EIA have been part of government policy since 1993 (Burney 1998). The Government White Paper "Saving Lives - Our Healthier Nation", published in 1999 states that Government's intention is to apply HIA to its relevant key policies. Also in other countries, HIA has been developed as policy tool (e.g. New Zealand, Canada and Sweden).
Frankish et. al (2001) define Health Impacts as **health outcomes**. Health impact assessment is defined as (ibid.409)

"Any combination of procedures or methods by which a proposed policy or program may be judged as to the effect(s) it may have on the health of a population"

This definition seems to have gained support and in a consensus seminar arranged by WHO in Gothenburg in 1999, these definitions were developed further. Health impacts were defined as (p.4):

"The overall effects, direct or indirect, of a policy, strategy, programme or project on the health of a population."

Health Impact Assessment was defined as (ibid: 4)

"……a combination of procedures, methods and tools by which a policy, program or projects may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population."

Burney (1998:34) adds that HIA generally refers to assessment of the health effects derived from interventions that are not primarily aimed at affecting health

Several authors stress that HIA is a tool for achieving Healthy Public Policy (Frankish et. al, Scott Samuel 1998, Kemm 2001, Mittelmark 2001). Kemm (2001:80) argues that two conditions have to be satisfied if healthy public policy is to be produced and states that HIA is an approach that could assist with meeting with both these prerequisites:

- The health consequences of different policy options have to be correctly predicted
- The policy process has to be influenced so that health consequences are considered.

Milner (1998) points to the fact that assessment of a policy's impact is not a new area of policy appraisal. The impact of a policy is regularly assessed in terms of economics, political interest, social life and the physical environment. Any attempt to predict the outcome of complex areas of human activity presents theoretical and
practical challenges for those involved. In HIA the outcome under consideration is "production of population health". One of the major difficulties in developing models of HIA is the concept of health itself. Although in a broad sense much is known about the production of health, Milner (ibid) states that as incorporated in a social model of health, it is often difficult to specify the causal relationships in a way which satisfies local policy needs. For many of the interventions of greatest local relevance, such as those to create new employment opportunities, the identification and valuation of forecast outcomes is difficult. This is because it is possible to identify both health "gainers" and health "losers" in the population, and because account must be taken of desired policy outcomes other than health.

Mittelmark (2001) states that HIA is an essential tool for healthy policy-making and practice. There has been international coordination and co-operation in developing HIA and consensus has been reached as to HIA consisting of the following five elements (ibid: 271):

1. HIA examines direct and indirect impacts on health of policies, strategies, programmes or projects.
2. The initial stage is screening using available information to determine if there is confidence that impact is negligible, or if more information is needed.
3. If more information is needed, scoping is necessary in order to determine what level of resources and expertise are required to develop the relevant information (ranging from a rapid appraisal using additional expertise to an in-depth impact analysis or an extensive impact review).
5. Modification of the policy/project if indicated.

Further, two types of HIA can be outlined (Milner 1998, Scott-Samuel 1998):

1. Prospective HIA are carried out prior to the development of the policy, programme or project under consideration to estimate the potential impacts on health. The assessment should contribute to the decision making and planning process.
2. Retrospective HIA are carried out after the developments have taken place (or possibly during the intervention) to assess the actual impacts on health. The
information obtained from such assessments can help to inform future prospective HIAs.

Scott-Samuel (1998) states that key principles of HIA include an explicit focus on social and environmental justice (it is usually the already disadvantaged who suffer most from negative health impacts); a multidisciplinary, participatory approach; both qualitative and quantitative assessment methods; explicit values and politics; and openness to public scrutiny.

Mittelmark (2001) is worried that the trend of ever more technical and complicated methods of impact assessment threatens to exclude average citizens from participation. As the technology becomes more complex, elites may take over and the technology transforms into quasi-science. This has happened to the EIA arena and may be a threat to HIA. User interfaces of the simplest kinds are needed if HIA is to reach where it is most needed. Health promotion should strive to build an approach to HIA that any person or group with average education and intelligence can master with some study and practice.

HIA are by nature speculative (Burney 1998) and there will not be one single tool or method that can be applied to achieve an effective HIA. Milner (1998:54) states that HIA screening is capable of delivering benefits by making policies, programmes and projects more health conscious. Once focus goes beyond this basic expectation, the potential resource intensiveness of the process increases considerably. Even at a high level of resource usage any conclusion reached through the HIA process will always be, in part, subjective and therefore likely to be contested.

Milner (1998) states further that if screening for health impacts is to become a normal part of policy development, it will have to be grounded in the everyday reality of local authority business. It is important to bear in mind the opportunity costs and time scales involved. Local authority business cannot be crippled by this process.

What experiences have been made so far with HIA? The following outlines some examples both at national and local levels.
Canada

The Canadian experience is portrayed as a "case example" of the development of HIA (Frankish et al. 2001). In Canada, the application of HIA is highly variable across provinces. No single process or model exists. Most of the provinces have developed their own unique approach to HIA, with little or no attention paid to initiatives in other provinces. Some provinces link HIA to cabinet submissions and the policy development process; other provinces couple HIA with provincial health goals and several provinces consider HIA within the context of EIA.

There are positive developments at the community level. A particularly stimulating example comes from Eastern Nova Scotia, Canada (Gillis, 1999). The People Assessing their Health (PATH) project was undertaken in a region of Canada that is geographically isolated and faces difficult socio-economic circumstances. Community HIA was used to increase public understanding of the determinants of health and empower citizens to play an active part in decisions influencing their health.

The first stage in the work was the local development of community HIA tools (CHIAT’s) tailored to the specific needs of each of community. All three CHIAT’s were intended to provide answers to the same question: What does it take to make and keep our community healthy? Other objectives were to develop the CHIAT’s in such a way as to:

1. examine a broad range of factors that determine health, rather than only specific interests;
2. identify what community members consider important in building a healthy community;
3. encourage all community members to become involved in decisions about local programmes and policies;
4. reflect community concerns and priorities;
5. provide information useful to community health boards to guide decisions about the organisation of primary health care.

The process used included four steps. Initially public meetings were held to determine who in the community was interested in becoming involved; a local
committee selected a local person to co-ordinate the project; teams were trained in communication and group facilitation techniques and local steering committees were formed.

Next, facilitators conducted citizen meetings, starting from the premise that community people know what it takes to make their community healthy. The process included measures that encouraged community members to consider the broadest possible range of determinants of health and they were not steered (or distracted) by a predetermined list complied by public health ‘experts’.

In the third step, steering committees designed their CHIAT’s based on data collected during the latter stage. Information typically included was a statement of the values and principles that guided the work, a vision statement for a healthy community, a summary of key determinants of health, a list of factors important in building and sustaining a healthy community and priorities for action. Community workshops were used to obtain feedback on drafts and the final CHIAT’s incorporated this feedback.

In the final step, steering committee members worked with local community leaders to ensure that the CHIAT’s were used in decision-making undertaken by community health planning groups and municipal decision-makers.

Outcomes were similar in each community. The most important health determinant identified in all three communities was employment opportunities. Other determinants identified were healthy child development, lifelong learning, lifestyle practices, physical environment, safety and security, social support, stable incomes and good health services. The CHIAT’s also pointed to factors thought to be key in building healthy and sustainable communities. These included: good communication; community involvement; local control; opportunities for leadership development; confidence in one’s community; co-ordination and co-operation in service delivery; ethics, values and spirituality; and respect for one’s culture and history.

The key lessons learned through the PATH experience are very likely applicable to other communities. The highly participatory process helped many people shift their
thinking beyond the illness problems of individuals to consideration of the way in which programmes and policies could support or weaken community health. In all three communities, the process brought to light local socio-economic inequalities and illuminated community capacity and control to improve conditions for a healthier community. Finally, PATH demonstrated the value of developing CHIAT’s as a strategy to support community action on health.

PATH illustrates some core principles for community HIA and these are consistent with community development strategies that have proven value (Mittelmark, 1999; Restrepo, 2000). PATH is a particularly good example of how ordinary citizens can have a place at the very heart of local decision-making, with the CHIAT process as a central element for positive change. PATH is of course not the answer for all communities. Some communities need processes to evaluate specific proposals, for example road-building projects, public safety issues, or educational policies. Community HIA need not take place at the community level, as in PATH, but could be focused in settings such as schools and work places. Inevitably, some communities/settings need impact assessment as a tool to help fight unwelcome change that threatens community wellbeing (new industry located in the wrong place, for example).

**Australia and New Zealand**

In 1991 the Resource Management Act was passed in New Zealand. The act refers to health as one of the considerations in the sustainable management of natural and physical resources and establishes the "resource consent process" which includes a requirement to undertake Impact assessments (IA) as a means of controlling major developments at local and regional levels (Mahoney and Morgan 2001). However, the experience is that the systematic considerations of health impacts have been sidelined. Even though health impacts have not been ignored in the resource consent process, there is rarely an attempt to carry out a systematic appraisal of the health implications of proposals and the emphasis of current practices is on health protection. This health protective view of HIA is still a strong perspective at the project level. At the moment, two trends seem to be developing with the risk/environmental/health protection model at the project level and the policy level interest in HIA linked to social determinants of health.
Australia's story is similar to that of New Zealand, with exception to the last steps into policy-linked HIA. HIA has not been pursued to any extent as part of the EIA processes (Mahoney and Morgan 2001). There is currently little evidence that HIA is being considered as a tool for policy development.

The authors argue that there is a need for an increased awareness and discussion on methods. There seems to be an assumption that the risk/health protection model applied at the project level will also be appropriate at the policy level. However, policy assessment requires different methods and techniques and is often not amenable to the more simplistic dose-response or cause-effect rationale of the risk/health protection model. Mahoney and Morgan (2001) conclude that there is a need to move the discussion on to ways to make HIA more inclusive. This will involve discussing how the technical and social can be balanced and reflecting on contemporary thinking about community-oriented research in order to find answers to the critical questions facing HIA, inclusiveness, legitimacy and method.

**Tasmania, Australia**

In Tasmania, Australia, members of the neighbouring rural townships of Launceston and Upper Tamar Valley (referred to hereafter as the community) expressed concern over increased respiratory illnesses during the winter months (Mittelmark et al., 2003). An investigation into air pollution, environmental health and respiratory diseases, commenced in 1991, concluded that the main cause of the pollution was the use of wood-fired heating in winter, exacerbated by unfavourable topographical and meteorological conditions. Other factors were forest fires, poor waste incineration practices in the timber industry and rural and domestic outdoor burning. There was an increase in the use of domestic wood heaters following the surge of world oil prices during the 1970s. The improper use of wood heaters played a significant role in the high level of air pollution.

The community and government agencies worked hand-in-hand to identify the causes of pollution and develop strategies to reduce pollution levels. A community action group stimulated involvement of the media and school and academic leaders in order
to publicise the issue and educate the community about the effect of wood burning on the atmosphere and of the need to improve techniques of fuel combustion.

Technical reports were prepared that advised more stringent emission stipulations for new wood heaters, subsidies for upgrading of heaters, quality controls on firewood, continuing community education and encouragement of homeowners to properly insulate their houses. The local government worked in partnership with the Australian Solid Fuel Heating Association Inc., in a proactive manner to educate the community by offering a free advisory service to any domestic consumer who had a problem with smoke from a wood heater. The Local Council improved a local law that controlled the construction and use of incinerators, restricted the operation of domestic incinerators to two days a month and banned on-the-ground burning.

This case study illustrates the feasibility of changing local government policy and ordinances in respond to community advocacy about a health issue raised by citizens. Critically, the advocacy initiative was armed with evidence from an impact assessment that identified the determinants of the health problem. The community demonstrated its willingness and ability to tackle a complex problem in partnership with government and industry. The three-year process undoubtedly strengthened the community’s confidence and ability to take concerted action on a wide range of issues that might arise in the future. Thus, while the impetus for action was a problem with respiratory illnesses, the process for problem solving was community development supported by the use of HIA-CD.

**Programs: exemplars of Healthy Public Policy**

**Healthy Cities**

The Healthy Cities movement focuses on changing municipal policies to create health-enhancing environments. The original idea came from a model developed in the 1980s by Hancock and Perkins which emphasised interrelationships in what they called the ‘mandala’ of health (Curtice et al., 2001). Following this, Labonté developed a model that characterises a healthy city as one that balances health, the environment and the economy in a viable, equitable and sustainable way; this recalls the objectives of local Agenda 21 (ibid).
This makes it necessary with involvement both from the community and other non-
health sectors in the decision-making process, particularly local government, who 
play a vital role in creating health through their decisions on resource allocation, 
education, housing, water, air pollution and poverty. Healthy Cities was thus intended 
to be a practical experiment in healthy public policy.

The International Healthy Cities initiative started as a small project of the WHO 
Regional Office for Europe to encourage the implementation of the WHO Health for 
All strategy at the local level and to support the development and learning by creating 
a European network of participating cities. The project has had a major influence on 
developing the settings approach to health policy and health programmes and has 
taken root worldwide as a social movement in a variety of forms (Curtice et al., 2001).

A healthy city is defined in terms of both process and outcome: a healthy city is 
conscious of health and striving to improve, not one that has achieved a particular 
level of health. A city's participation in the movement depends on its commitment to 
health and having a structure and process to achieve it, not current health status.

The literature search showed that particularly projects in England and The 
Netherlands seem to have been submitted to research-based evaluation. In the 
following, three evaluations will be presented; two focus on the process of developing 
a City Health Plan in Liverpool, the third compares ten case studies; five in the United 
Kingdom and five in the Netherlands.

The City Health Plan (TIP) is a broad and extensive plan for improving health which 
cities committed themselves to produce during the second phase of the Healthy Cities 
Project. City Health Plans focus on intersectional collaboration, first and foremost 
joint working (Costongs and Springett 1997). In the formulating and implementation 
phases of the Liverpool TIP, joint working was considered a vital instrument for 
change. The evaluation showed that it is important to recognise that simply 
establishing formal joint structures is not enough to secure successful cooperation. 
More attention needs to be paid to “arenas for dialogue” and the process of joint 
working. The findings from the evaluation offers suggestions to how to achieve joint 
working. (Costongs and Springett 1997). Through informal joint working, arenas for
dialogues are created and the people who work together get to know one another. The research findings showed that producing a City Health Plan revolved round the way people work together. The extent to which joint working developed depended on the combination of:

- The participant’s backgrounds (from the community, the statutory, voluntary, or private sector)
- The commitment of their organisation
- Their personalities and skills
- The facilitation skills of the chair.

These characteristics determined the degree of power the participants had, how they were perceived by other group members and their functioning in the group. Accordingly, these characteristics had an impact on the process of joint working and therefore on the success of intersectoral collaboration. In addition the research findings emphasised the importance of the Healthy City Unit. This unit was a neutral body and it had an important “glue” function as it played a major co-ordinating, motivating and facilitating role and was an important element in the joint working process.

Storable and Bruce (2000) have been evaluating participation and consultation in the process of making the TIP in Liverpool. The draft TIP set out a 5-year strategy and action plan with long and short term targets, which had been prepared by inter-agency task groups an agreed by the executive level of the Joint Public Health Team in the city. The strategy was based on a very broad view of health and its determinants - among the aspects were housing, poverty and unemployment, the environment and young people.

Apart from an extensive publicity campaign, the main method employed in the consultation was the use of trained facilitators to hold meetings in communities as well as statutory sector groups in order to make consultations more interactive and accessible. Facilitators provided background to the TIP in order to encourage discussions and ideas for the final version of the plan. A total of 58 group meetings were run during the consultation period of five months, involving an estimate of 680
people. In addition, feedback on the draft plan was encouraged from other individuals, organisations and non-facilitated groups. All comments were sent to the Healthy City office, which co-ordinated the modification of the draft and published the final document.

The results from the evaluation indicated that face to face meetings appeared to be a welcome and appropriate means for discussing a proposed plan but a participative consultation of this complexity could be more effective if run as a two-phase process involving more extensive two-way communication. Differences in expectations regarding the type and extent of participation, as well as its outcomes, need to be accounted for. They need to be handled carefully to avoid disillusionment and withdrawal of participants from the process. A clear aim combined with communication during the process should minimise confusion and unrealistic expectations on all sides. The researchers conclude that a structured process is needed to help translate individual and group concerns into a coherent strategic plan and to try to avoid the feeling among contributors that their ideas are at best being unreasonable and at worst ignored without explanation.

Goumans and Springett (1997) have been studying the process from projects to policy and asked the question as to whether the Healthy Cities initiatives have been a mechanism for policy change. The second phase of the official WHO/EURO project had the following aims (Goumans and Springett 1997:12):

- To bring together a network of European cities to assist and support the implementation of local HFA efforts
- To move health high up on the political agenda
- To move health on to the public agenda and integrate the health aspect into economy, culture and city life
- To develop city health policies
- To foster the development of supportive environments (physical and social)
- To create action for health
- To facilitate the development of networks and communication skills
- To exchange knowledge and expertise.
The Chief principles should therefore be:

- Intersectoral collaboration
- Community participation
- Equity.

The point of departure for Goumans and Springett is the view that the Healthy Cities projects should be a tool for change and that the change should be a development from project to policy. They focus on two elements of policy change, first and second order change. First-order changes consist of minor adjustments that do not change the core of an organisation, while second-order changes are multidimensional, multilevel, qualitative radical changes involving a paradigmatic change.

In the ten case-studies that were a part of the project, the key informants were asked whether Healthy Cities had actually made a difference. In terms of content of activities, it was felt that little difference had been made. Old activities quite often continued under a new label. However, Healthy Cities was perceived as having added value. This was most often defined in terms of facilitation. Involvement in Healthy Cities provided a meaningful framework which drew people together around health issues. But developing linkages between people, coordinators and their associated units established an engine role for Healthy Cities and for health. Through the efforts of core participants the process contributed to learning and to understanding where and how health was created and what can be done by each individual and organisation to promote health in an urban setting. In that sense Healthy Cities functioned as a key to innovation.

What did the Healthy Cities imply about the nature of change in the context of healthy public policy? All of the cities referred to have achieved some level of “first order” change; i.e. minor adjustments that have not changed the core of organisations in municipalities. A few cities of the sample of ten cities were struggling towards “second-order” change. Local health strategies in the form of a health plan were becoming the focus of Healthy Cities work. The authors argue, however, that writing a policy document is not by itself sufficient. Top down strategies cannot succeed unless bottom-up action takes place and small-scale projects cannot have an impact
without a strategic framework that moves the resources that support the change. It will therefore be an open question whether this move towards second-order change is sustainable, or whether Healthy Cities projects and ideas will become a short-term enthusiasm of like-minded people or remain a label attached to a few small-scale projects.

Even if projects do not automatically result in policy they can facilitate the policy-making process. What influences political decision-making is not the practical outcomes of a project but quite often the cumulative process of participating in and seeing the consequences of a series of projects. This is particularly true if policy-making is considered as a system of innovation and learning amongst a web of linked actors continuously exchanging information and skills.

The authors conclude that moving forward is most likely to be accomplished by a pragmatic approach rather than one focusing too much on the word “health”. If second-order change is going to occur at an organisational level, health promotion would automatically be a part of the domain of public policy at the local level. However, they conclude that movement towards this broader goal of healthy public policy is still tentative and its prospects fragile.

Acknowledging this must also have implications for the evaluation methods used in complex settings as with Healthy Cities. Springett (1997) argues that there needs to be a move away from reliance on rigid "top down" evaluation methods based on a natural science paradigm towards more "bottom up" interpretative, process-oriented methods with an emphasis on learning from experience. This shift of evaluation methods is particularly relevant when studying complex policy processes involving many actors.

Curtice, Springett and Kennedy, (2001) suggest that it is important to acknowledge the interdependence of the city with wider political, social and economic forces and the policies that seek to address them. In particular, identifying the qualities that cities must possess to promote equity and a sustainable quality of life may help to focus on the values, conditions and processes needed to make cities active agents in a democratic and inclusive society.
The Canadian Heart Health Initiative

The Canadian Heart Health Initiative (CHHI) has been described as a systematic translation of public health policy into community action to prevent cardiovascular disease (CVD). The initiative was organised to strengthen the capacity of the public health system to develop and deliver heart health interventions at the community level. A five year demonstration phase laid out the basic infrastructure including the creation of teams in all of Canada's ten provinces, establishment of evaluation systems and development of coalitions at national, provincial and community levels.

The Canadian approach followed a public health or population health model and it was built into the existing health system. In this sense, the design of the initiative differs from demonstration projects for CVD prevention implemented in other countries (Stachenko 2001). The initiative systematically implemented a multilevel (national, provincial and community) strategy to build capacity to prevent CVD. It was conceived in five phases, from policy development to dissemination and deployment, over a period of 15 years. The initiative is co-funded by Health Canada, through the National Health Research Development Program, and by the ten provincial departments of health. The Heart and Stroke Foundation of Canada and its provincial affiliates are key partners. The initiative aims to exploit the synergies between the health promotion and disease prevention approaches that are most useful in reducing CVD risk and its determinants (Stachenko 2001).

The federal-provincial partnerships enabled the implementation of standardised provincial heart health surveys, leading to the Canadian database on CVD risk factors. The first survey was carried out in 1985. The key consistent finding from each province was that about two thirds of the adults had one or more risk factors for CVD. This provided the scientific rationale for a public health approach based on health promotion principles. Obviously, an issue affecting most of the population could not be addressed through a clinical preventive approach alone hence the strong community orientation for the provincial demonstration programmes for heart health that followed (Stachenko 2001).
The provincial heart health demonstration programmes, co-funded by the federal and provincial departments of health were the key instruments for translating policy into practice. The demonstration phase took place between 1989-1997, and provinces joined at different times. The federal and provincial departments established the following conditions for funding the provincial programmes:

- A focus on a public health approach
- The establishment of provincial intersectoral coalitions to support programme development and implementation
- An evaluation of the process of intervention as an essential component
- A review of the intervention and evaluation protocols by a scientific team in site visits arranged by the National Health Research and Development.

According to Stachenko (ibid.) the financing of the programme seems to have been instrumental in ensuring the implementation of the programme. It was based on limited but concrete financial resources and served as a catalyst for provincial action. In addition, the provinces' freedom to join the initiative when it was appropriate for them was significant for the quality of the partnerships that were built. The co-funding arrangements and flexibility in the definition of the project intervention mix of the provincial programmes contributed to the good functioning of the national coalitions. Typical components of the various provincial heart health programmes have been documented and include strategies for public education, community mobilisation, healthy public policy and prevention services.

The conditions for funding had two important implications for implementation. First, they created focal points with clear responsibility for the continued development and implementation of the heart health policy: the provincial department of health. Second, they encouraged the process of partnership development from the beginning. While the terms and the conditions for the provincial coalitions varied, the partnership approach became the modus operandi of heart health programmes in the provincial and the community demonstration areas.

The principal investigators of the provincial programmes jointly adopted process guidelines for evaluation with some co-ordination from the national level and
technical consultation of academic experts as was needed. The evaluation of the program could be described as a "two-tier system". A key tenet was to keep the evaluation practical and affordable: no more than 3-6 indicators for each project were envisaged to be tackled. While this was to be the norm for most projects, the guidelines recognised that the provincial programmes might wish to conduct evaluation research on certain projects. This provided for in-depth evaluation of some projects and a simpler tracking system for the majority.

In addition to the core process indicators, the principal investigators were asked to reflect on various aspects of the implementation. In consultation with their teams they prepared written responses on the following topics:

- Contextual influence, such as political climate, economy and health care reform
- Resources, including volunteers, staff and resource mobilisation
- Organisation and management, including leadership and functioning of coalitions
- Processes, including the selection of demonstration communities, integration of strategies, linkages with other health issues, strategic and operational planning, and partnership development
- Evaluation, including experience with process evaluation in provinces and communities
- Technical support
- Perception of success and barriers to implementation and reference to the most and least successful projects
- The legacy of demonstration projects.

Stachenko outlines some of the conclusions from the programme evaluation. Projects set goals for both behaviour and systems; the latter included the establishment of coalitions, implementation, organisational capacity, infrastructure, sustainability and the dissemination and institutionalisation of interventions. The vast majority of projects involved action on more than one risk factor and had more than two partners, attesting to the integrated approach that heart health is supposed to bring to risk reduction and to the intersectoral and partnership model for implementation.
There is evidence that the linkage of the provincial heart health to the provincial public health systems supports the sustainability and institutionalisation of interventions (ibid). The maintenance of the co-funding arrangements by the provincial departments of health reflects the value that the departments place on the initiative as an instrument to enhance capacity in health promotion.

The explanation why the initiative was considered a success has got much to with the political climate in Canada at the time it was launched. A broad consensus on health policy was developing in 1986 when consultation on the CVD policy started. The Ottawa charter and the framework for achieving health for all in Canada were published at the same time and set the agenda for the nature of intersectoral approaches needed to implement the CVD population strategy.

Eventually, Canada took the reputation as a leader in health promotion. For example, in collaboration with the European Regional Office of the WHO, Canada helped to accelerate the evolution of behaviourally oriented health education toward a more global, political and environmentally sensitive health promotion (O'Neill et. al 2000).

Canada has continued to support major elements of a welfare state. However, during the 1990s these programs have been eroded somewhat, under the influence of American policies, the North American Free trade agreement and the tide of neo-conservatism that has swept the world (O'Neill et. al 2000). To reduce budget deficits, massive cuts have been made in the health sector.

In 1994 O'Neill et al. concluded that the primary health promotion actor in Canada, The Health Promotion Directorate of Health Canada, had begun to abandon its leadership of the field under a variety of pressures. Since then, under the restructuring pressures of a "downsizing" federal government, this tendency has accelerated (O'Neill et al 2000).

This situation has also affected the Dissemination project of the Canadian Heart Health Initiative (CHHI). Nine out of ten Canadian provinces have taken part in the Dissemination phase of the CHHI (O'Loughlin et al. 2001). Although all nine projects focused on the study of dissemination, the projects were quite different in
focus and approach. The diversity reflects the commitment of each project to do work relevant to their local (provincial) context and to examine dissemination issues of specific and immediate concern. One common thread that emerged across projects was a focus on the importance of building capacity to support dissemination; this was reflected in the projects’ descriptions (O’Loughlin et al. 2001).

Provincial health system reforms and the ensuing instability in the health systems have been important challenges to both capacity building and the research processes more generally. Other broad contextual barriers include lack of resources (both financial and human) and a mixed appreciation for understanding of health promotion and disease prevention by decision-makers, policy leaders and the general public. Difficulty recruiting and retaining volunteers additionally hampers community capacity building (O’Loughlin et al. 2001).

Aside from these difficulties, important learning processes have taken place and through the projects several insights have been made (O’Loughlin et al. 2001). First and foremost there is a strong broad-based provincial commitment to contribute to the store of practical knowledge about how to achieve effective sustainable heart health promotion. Second, despite the profound diversities regarding time and contexts, there is an emerging consensus across the country on the nature of organisational and community-based capacities required to support dissemination of CVD prevention interventions that will be institutionalised within the public health system and have a population level impact.

**Summary and conclusions**

In this review we have focused on health promotion infrastructure, policies and practice. The three themes are closely linked and the literature chosen for discussion focuses on policy development and change, particularly on how to develop healthy public policy/health promotion policy. In the following, we summarise and discuss each of the themes and draw some overall conclusions.

The Investment for Health (IFH) Initiative is aiming at strengthening *health promotion infrastructures* at national and local levels. The majority of IFH appraisals have so far been conducted at the national level. The experiences with the
appraisals indicate that even though it may be necessary to develop new infrastructures to reach the objectives, it is important to build on the institutional arrangements that already exist in a country. A further conclusion is that if IFH is to be effectively applied, traditional policy-making approaches must change. New commitment and skills of policy analysis and assessment will all be needed. The challenges of moving from an understanding of IFH to implementing it should not be underestimated. There is a huge step from believing that the connections between health, economic and social development are real to getting nations to change ways of working.

This issue of problematic implementation is also raised in literature discussing healthy public policy in general. One point that is made by several authors is that people outside the policy research community often view the policy process as a rational and technical process where actors decide on the basis of more or less objective information. This is, however, not in line with what really occurs in the process of policy making. Through their career and the organisational culture of their professional environment, policy-makers acquire a set of implicit assumptions about general policy directions. These assumptions often relate to subjective notions of efficiency, acceptability and appropriateness of policy instruments. These assumptions and presuppositions are rarely made explicit. At the basis of these assumptions are some normative considerations: the standard recipe to choose the "softest" intervention type first before proceeding to more rigorous approaches. Regulatory interventions are generally considered ultimate solutions. This implies that it is not enough to have a list of recommendations and "correct" approaches to change policy-making.

This is also shown in evaluations in the field of health promotion practice and especially in the development from projects to policy as is illustrated by several projects within the Healthy Cities initiative. Two elements of policy change were focused, first and second order change. First-order changes consist of minor adjustments that do not change the core of an organisation, while second-order changes are multidimensional, multilevel, qualitative radical changes involving a paradigmatic change. All of the cities referred to had achieved some level of “first order” change; i.e. minor adjustments that have not changed the core of organisations.
in municipalities. A few cities of the sample of ten cities were struggling towards “second-order” change.

Even if projects do not automatically result in policy, they can facilitate the policy-making process. What influences political decision-making is not the practical outcomes of a project but quite often the cumulative process of participating in and seeing the consequences of a series of projects. This is particularly true if policy-making is considered as a system of innovation and learning amongst a web of linked actors continuously exchanging information and skills.

Moving forward is most likely to be accomplished by a pragmatic approach rather than one focusing too much on the word “health”. If second-order change is going to take place at an organisational level, health promotion would automatically be a part of the domain of public policy at the local level. However, that movement towards this broader goal of healthy public policy is still tentative and its prospects fragile.

Participation seems to be a critical point in changing policy and practice at all administrative levels. The concept of participation is at the core of health promotion ideology but it is important to specify who the participants should be. In the community tradition, emphasis is placed on participation from target groups in the local communities. To achieve policy change it is also vital that policy-makers and other groups of decision-makers participate. They set the agenda and often have control over budgets and thus have the power to decide the future of health promotion policy initiatives.

Changing administrative cultures will be a process that also is strongly influenced by the general political climate. The political climate in the Western world has for the last decade been strongly influenced by a neo-conservative trend, where an overall aim is to down-size the public sector. An example of this can be found in the Dissemination project of the Canadian Heart Health Initiative. Provincial health system reforms and the ensuing instability in the health systems have been important challenges to both capacity building and the research processes more generally. Other broad contextual barriers include lack of resources, both financial and human, and a
mixed appreciation for understanding of health promotion and disease prevention by decision-makers, policy leaders and the general public.

There seem to be serious barriers in the development of healthy public policy/health promotion policy. Even though there are promising case studies, the overall impression from this literature review is that the obstacles, in terms of political and administrative structures are difficult to overcome. On the other hand, there are promising examples that illustrate that some of these obstacles might be overcome by working long term on developing the structures that are necessary for building healthy public policy, including intersectoral co-operation, integrated interventions and participation from communities and decision-makers.
Bibliography


WHO Regional Office for Europe.


Muntaner, C., Lynch, J., & Smith, G. (2001). Social capital, disorganized communities, and the third way: Understanding the retreat from...


Annex IV
Minutes of the first
User Advisory Group Meeting
HP Source First User Advisory Group Meeting, 28 February - 1 March

At the London School of Hygiene and Tropical Medicine
Present: Elisabeth Fosse (EF), Norway, Pierre Arwidson (PA), France, Giuseppe Masanotti (GM), Italy, Dimitra Tryantafyllou (DT), Greece, Maggie Davies (MD), UK, Thara Raj (TR), UK, Spencer Hagard (HP Source) and Jackie Robinson (HP Source)

Thursday 28 February
SH welcomed everybody and gave a brief introduction to the project.

JR said that by the end of the meeting we wanted to:
- Gain an understanding of participants' (as representatives of end users) expectations of the database.
- Get some clear definitions of the terms we are using so that we can all talk in a common language.
- Define the questions we need to ask people in order to obtain the information we need and design an instrument for data collection.
- Consider other methods of obtaining information/data.

SH introduced a table which would serve as a basis for our discussion and give us some broad headings under which to formulate questions for data collection.

EF said that it was important to set a time limit on what we are looking at, as otherwise data collection would never be finished. Things are changing rapidly in the health promotion field.

SH said that we had a strategy to deal with this, but at the same time we need to know what is happening now. There needs to be flexibility within the database for these elements. It is important to capture the dynamic but also not to capture the not too dynamic!

PA commented that there is often a gulf between the concept and the practice. The proposed new name for his institute in France was "The National Institute of Prevention and Health Promotion", but the senate took out "promotion" and replaced it with "education."

SH said that this raised the question of how to find who is doing the health promotion, to put some boundaries around it and describe it.

PA said that a problem was that elected representatives feel that they are naturally the health promoters, even though they may have no expertise in the field.

SH commented that the politicians do have a major role, but they are not the health promoters.

PA pointed out that health promotion has been seen as a natural activity of elected people / parties / governments and though a natural part of democratic process rather than a specific professional / political activity.
GM said that in Italy health promotion is becoming more regionalised, and the same seemed to be happening in Germany, Belgium and Spain. He wondered if this meant that high level policy committees etc. would be difficult, less, or more important? He said that for him the questions we ask will have to be translated so that he can take them to colleagues and the regions.

PA suggested that we have a "bottom-up" design, where the bottom would be infrastructure and the top policy. He suggested a structure where there would be the 12 concepts (in SH's document) in columns, and the rows would be Institutions, Projects, Texts, and Links. He suggested that perhaps questions like "Do you have an institutional arrangement for formulating national health promotion policy?" needed to be broken down more e.g. going into more detail about the institutions.

MD said she was not happy with the word “institutional” as it might be misconstrued.

SH replied that there has to be an institutional responsibility; perhaps we need to define "institution".

MD thought the question could be more open ended, such as "Who is responsible for HP policy in your country?"

SH suggested that we could give options and then an open option.

PA suggested that we could have a survey – not a database to see if the different countries meet those requirements. We need to find the relevant elements in each country and see how they contribute to the goal for the database.

MD said that we need to concentrate on who is going to use the database and what for.

SH agreed and said that he thought it best if the information provided was factual. People will not be able to express opinions – unless they are specifically stated as such

MD reminded us that this is meant as a guide for researchers. It is not just a general questionnaire to be sent out, so we can afford to be more complex.

SH agreed; in principle, researchers should not be daunted by quite a detailed questionnaire. The first stage is that they answer the questionnaire and then we follow up. Going to a further level of depth is for a follow-on project. In some countries we could go into more depth as in Finland.

MD pointed out that ENHPA is updating its database and using a questionnaire with questions about infrastructure etc. There will be some kind of overlap.

A general discussion followed about why a database would be useful and the following points were highlighted:

- Currently there is nothing enabling people to find easy information and compare and contrast on these issues
- What are the EU Member States doing as regards Health Promotion?
What have they got (e.g. Institutions/Policies)?
Advocacy
How do different Member States organise the HP/HE structure - when thinking about re. organising own structure, or for policy advocacy?
We need accessible information in a standardised format
We need examples of good practice to look into further
It would be useful to have signposts to other information.

GM made the point that the Health Promotion field needs this and we need to be highly visible – if we don’t do this well then we can forget any kind of sustainable EU support for the field.

**Friday 1 March**
The morning was spent refining the headings and then developing the questions for the instrument for data collection. (See separate document for draft questionnaire)
The following main subject headings were agreed:

**Subject Headings**

1. a) High Level Formulation of HP policy (including parliamentary scrutiny of HP implementation)
   b) Evaluation of the implementation of HP policy
2. H.P. systems design and management
3. a) Regular systematic monitoring of the state of public health
   b) Regular reports on the state of public health
4. Survey and research capacity & knowledge development for health promotion.
5. National and local implementation
6. Professional workforce
7. Professional learning and apprenticeship (evaluation& training)
8. Professional Associations
9. Funding (including policy formulation)

Cross cutting issue – social legitimation and public involvement

(PA made the point that there is expenditure on HP issues that is under other budgets, maybe in wording we should be more open and not have an HP concept that is too closed and too elitist)

**Literature review**
Elisabeth Fosse will undertake a literature review to support the data gathering process.

*Sources for the literature review:*
1. Policy documentation on the European level directly related to our data.
2. We also need to know about policy institutions. Project needs access to policy documents. National researchers need to help Elisabeth with this information.
3. We need to make explicit the theoretical basis (research based knowledge). Theory based policy research within the field of health promotion. Empirical research. We need to be pragmatic. (WHO Mexico, IUHPE 1994, WHO 1999)

SH added that this documentation will support the sustainability of the database in the long term.
PA commented that there are many books comparing health systems, but talking about health promotion is like talking about the entire system.

EF said that this is why she was asking for the help of the group!

TR suggested that we should share papers that will be useful to the project.

EF said that she wants to gather to get all literature on policy and infrastructure. It will be her responsibility to do this, but she needs all our help.

SH commented that we need to be pragmatic and to work on English Language documents. We can use UAG (and country researchers) to list what the other (non English) documents are, and we will have some kind of check list for indicating what is in documents. Part of process is listing documents that are available and not available and making recommendations for translation etc.

EF said that she envisaged that when the database was completed it would be possible to click on policy documentation for a country, links, and also international literature.

PA commented that most of what we are looking for is not written yet! It may be useful to interview people from Australia, Canada, and Sweden and find out what exists. We should look at dynamics and what has changed since the concept of health promotion was introduced.

EF suggested it would be useful to look at what has been published in more advanced countries and look at the way we can classify documents.

SH said again, we must be pragmatic, it may be difficult to get documentation and information on the professional Health Promotion workforce in UK but in Netherlands it would be very easy. The data-base will grow over time, and hopefully these omissions will be useful advocacy tools.

EF said that we need to work out a simple classification system, in broader categories like infrastructure, policy and practice.

SH added that we should enable researchers to classify documents in a country’s own language so that they can be referred to and linked to.

JR and SH thanked everybody for their participation and the group agreed to provide their comments and suggestions on the draft instrument for data collection.

Close
Annex V
Questionnaire for Data Collection
Welcome to the "downloadable" data collection instrument for HP Source. In early December you will be able to in-put your data on-line at the www.HP-Source.net website. However it is useful to be able to have all the questions in a hard copy, so you can prepare your data before in-putting and get a view of your progress.

**Points to Consider**

1. For the sake of simplicity we use the term "health promotion" throughout to cover health promotion, health education and aspects of public health practice emanating from the Ottawa Charter\(^3\)

2. If you have any problems regarding content please contact Spencer Hagard at spencer.hagard@lshtm.ac.uk or Jackie.Robinson@dunelm.org.uk

3. Where you see the insertion [Document Reference(s)] you will be prompted to give the following information for each document:

   a) Document title:
   b) Author(s):
   c) Date of issue:
   d) Place of issue:
   e) Issue authority:
   f) Address where available:
   g) URL (web-site address) where available
   h) Abstract (300 words):
   i) Key words (5-10)]

10. Where you see the insertion [Organisation Reference(s)] you will be prompted to give the following information for each organisation:

   a) Organisation title:
   b) Contact Job Title
   c) Contact Name:
   d) Address:
   e) E-mail address:
   f) Website:

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\(^3\) *Ottawa Charter*, WHO, 1986, see [www.HP-source.net](http://www.HP-source.net) web-site
Please provide information as follows:

1. **Description**

Provide a short description of the overall system of health promotion in your country at national and sub-national levels (100 words max.)

2. **Formulation of health promotion policy/policies**

**National level**

2.1 Have national policy documents on health promotion been published? Yes ☐ No ☐

If no go to 2.1.10

If yes, are any of these documents inspired by the action areas of the Ottawa Charter? If no, go to 2.1.10

If yes which action areas do they refer to? (tick boxes)
- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills;
- reorienting health services?

2.1.2 If yes, for each document please provide:
[Document Reference(s)]

2.1.3 What is the status of the documents?
- a) governmental committee proposal
- b) governmental green paper
- c) government white paper
- d) a bill decided by the parliament?
- e) other status - what? [max words: 50]

2.1.4 List of key references that each document uses to establish its health promotion credentials.

2.1.5 List of key policy recommendations/statements through which each document exhibits its health promotion credentials (and references) [max words: 50]

2.1.6 List of practice recommendations/statements through which each document exhibits its health promotion credentials (and references) [max words: 50]

2.1.7 At what levels are actions proposed (e.g. local, regional, national, international)?

2.1.8 In which sectors are actions proposed? [Max words: 50]

2.1.9 a) Does the document contain any goals (i.e. general statements of aim or purpose, e.g. to reduce alcohol-related health problems)? Yes ☐ No ☐

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*From Ottawa Charter. WHO. 1986*
If yes, how many goals does it contain?
b) Does the document propose specific objectives or targets (i.e. quantifications of goals, e.g. to reduce smoking related mortality by 10%)?  Yes ☐
No ☐

If yes, how many specific objectives/targets are proposed?

Go to 2.1.12

2.1.10 Are there specific plans to publish such a policy document in future:
2.1.11 If yes, by which body, when? Please state subject area.
2.1.12 Which body/bodies is/are responsible for formulating the document(s)

Regional/provincial and local levels

2.2 Does health promotion policy-making take place at sub-national levels?

Yes ☐
No ☐

If no go to 3

If yes at what levels: (tick boxes)

Regional ☐
Provincial ☐
Local ☐

Regional Level

2.3 Have regional policy documents on health promotion been published?

Yes ☐ No ☐

If no go to 2.4

2.3.1. If yes, are any of these documents inspired by (i.e. do they express or represent) action areas of the Ottawa Charter?
If no go to 2.5
If yes which action areas do they refer to? (tick boxes)

building healthy public policy; ☐
creating supportive environments; ☐
strengthening community action; ☐
developing personal skills; ☐
reorienting health services? 5 ☐

5 From Ottawa Charter: WHO. 1986
2.3.2. Please provide a maximum of 3 examples
[Document Reference(s)]

2.4 If no, are there plans to publish such documents? (If no, go to 2.5)
2.4.1 If yes, by which bodies, when?
2.4.2 Which body/bodies is/are generally responsible for formulating the regional documents? [Max words: 50]

**Provincial Level**

2.5 Have **provincial** policy documents on health promotion been published?
If no go to 2.6

2.5.1. If yes, are any of these documents inspired by action areas of the Ottawa Charter?
If no go to 2.6
If yes which action areas do they refer to? (Tick boxes)
- building healthy public policy;  □
- creating supportive environments;  □
- strengthening community action;  □
- developing personal skills;  □
- reorienting health services?  □

Please provide a maximum of 3 examples
[Document Reference(s)]

2.6 If no
Are there plans to publish such documents at provincial level? (If no, go to 2.7 )
2.6.1 If yes, by which bodies, when?
2.6.2 Which body/bodies is/are generally responsible for formulating documents at provincial level? [Max words: 50]

**Local Level**

2.7 Have **local policy documents** on health promotion been published which refer to one or more of the following areas:
- building healthy public policy;  Yes  □  No  □
- creating supportive environments;  Yes  □  No  □
- strengthening community action;  Yes  □  No  □
- developing personal skills;  Yes  □  No  □
- reorienting health services?  Yes  □  No  □

If yes, please provide URLs (web-site addresses) for relevant PUBLISHERS of local documents

If no

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6 From Ottawa Charter. WHO. 1986 - see the Charter at [www.HP-Source.net](http://www.HP-Source.net) website

7 From Ottawa Charter. WHO. 1986
2.7.1 Are there plans to publish such documents?
If **no** go to 2.8
2.7.2 If **yes**, by which bodies, when?

2.8 Describe any involvement _not already mentioned above_ of the following bodies in the approval process of health promotion policy/frameworks: [max words:100]
- Other national or regional/provincial ministries
- Cabinets of ministers
- Ad hoc standing committees or commissions of parliaments
- Parliaments as a whole
- Other bodies

### 3. High level evaluation of health promotion policy

3.1 Are **National** health promotion **policies** evaluated:
   a) routinely?
   b) ad hoc?
   c) rarely or never?
   [if **never**, go to 3.4]

3.2 When were the most recent policy evaluation reports published?
When are the next due?
Please provide the following information about them:
3.2.1. [**Document Reference(s)**]
3.2.2. Whether internal (by bodies themselves) or external (by researchers, consultants etc.) or both.

3.3 If available provide (an) example(s) [max 3 examples] of changes that have been made as a result of evaluations  [Max 100 words]

3.4 -Are **National** health promotion **programmes/projects evaluated**?
If **no** go to 4

If **yes** when were the most recent evaluation reports published?
When are the next due?
Please provide the following information about the most recent reports [Max 5]:
3.4.1. [**Document Reference(s)**]
3.4.2. Whether internal (by bodies themselves) or external (by external researchers, consultants etc.) or both.

3.5 If available, provide (an) example(s) [Maximum 5] of changes that have been made as a result of evaluations?
   3.5.1. Example [Max 100 words]
   [**Document Reference(s)**]

3.6 Are any evaluations of National health promotion programmes/projects planed?
If **yes** give details [max 50 words]
4. Monitoring and Reporting

4.1 Is the formulation of health promotion policy based on regular systematic monitoring of public health? Yes □  No □

If no, what material or facts is health promotion policy formulation based on?
If yes, what other material or facts is health promotion policy formulation based on? [Max words: 50]

4.2 At what levels are data disaggregated: [tick box(es)]
   a) regional/provincial □
   b) local □
   c) other, please state □

4.3 Which organisations participate in this?
[Organisation References]

4.4 When was the last report? Who is responsible for producing it?
When is the next due?
[Document Reference(s)]

4.5 For the above:
   Who provides the data? [Max words: 50]
   What data sources are used? [Max words: 50]
   Who decides the data sources to be used? [Max words: 50]
   Who funds the process? [Max words: 50]

4.6 Does any of the monitoring take into account: [tick box(es)]
   a) Behaviour? □
   b) Risk factors? □
   c) Protective factors? □
   d) Quality of life? □

4.7 Does any of the monitoring take into account the following social determinants: (tick boxes)
   a) culture? □
   b) income? □
   c) urban/rural setting? □
   d) others? Please list. [Max words: 50]

4.8 Does any of the monitoring take into account the broader social and economic context (e.g. social and economic inequalities)?
Please provide a brief description. [Max words: 50]

4.9 If necessary, to cover any points that have not been covered above, please provide a brief description of the approach to monitoring the health of population[Max words: 50]
5. Survey and research capacity & knowledge development for health promotion

5.1 Please provide [Organisational Reference(s)] - of the principal bodies (e.g. consultancies, academic bodies, public health laboratories) that are involved in the development of:
   a) Health promotion theory and research (max 12)
   c) Design of health promotion programmes (max 12)
   e) The evaluation of health promotion programmes (max 12)

6. National and Local Implementation

6.1 Which bodies are responsible for the implementation of National health promotion policy?
   a) at Central (National) level?
   b) Provincial level (if applicable)?
   c) Regional level (if applicable)?
   d) Local level (municipalities) (if applicable)?
   e) Other? [Max words – 100]

6.2 Name the bodies with the following health promotion responsibilities at national, regional and provincial levels

6.2.1 Body(ies) with responsibility for facilitating better health promotion practices:
   a) official national body [Organisational Reference(s)]
   How would you categorise this body/these bodies?
      Health Sector
      Other Public Sector
      NGO
      University
      Research Centre
      Resource Centre
      Other: Describe [max 20 words]
   
   b) other national body(ies) [Organisational Reference(s)]
   How would you categorise this body/these bodies?
      Health Sector
      Other Public Sector
      NGO
      University
      Research Centre
      Resource Centre
      Other: Describe [max 20 words]

   c) regional body(ies) [Organisational Reference(s)]
   How would you categorise this body/these bodies?
      Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

d) provincial body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

6.2.2 Body(ies) with responsibility for creating health promotion materials

a) official national body  [Organisational Reference(s)]
How would you categorise this body/these bodies?
Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

b) other national body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

c) regional body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]
d) **provincial body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

6.2.3 Body(ies) with responsibility for **networking**:
a) **official national body [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

b) **other national body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

c) **regional body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

d) **provincial body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
6.2.4 Body(ies) with responsibility for planning and running programmes:

a) official national body [Organisational Reference(s)]
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

b) other national body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

c) regional body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

d) provincial body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

6.2.5 Body(ies) with responsibility for planning and running campaigns

a) official national body [Organisational Reference(s)]
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
b) **other national body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?

Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

6.2.6 Body(ies) with responsibility for **evaluating health promotion interventions(policies, programmes, campaigns, projects):**

a) **official national body  [Organisational Reference(s)]**
How would you categorise this body/these bodies?

Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

b) **other national body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
6.2.7 Body(ies) with responsibility for funding programmes campaigns and projects:

a) official national body [Organisational Reference(s)]
How would you categorise this body/these bodies?
Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

b) other national body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?
Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]
c) **regional body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

d) **provincial body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

6.2.8 Body(ies) with responsibility for **other actions, (state what)**

a) **official national body [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

b) **other national body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]

c) **regional body(ies) [Organisational Reference(s)]**
How would you categorise this body/these bodies?
- Health Sector
- Other Public Sector
- NGO
- University
- Research Centre
- Resource Centre
- Other: Describe [max 20 words]
d) provincial body(ies) [Organisational Reference(s)]
How would you categorise this body/these bodies?

Health Sector
Other Public Sector
NGO
University
Research Centre
Resource Centre
Other: Describe [max 20 words]

6.3 (formerly 6.8) At local level, is there a system of public sector bodies responsible for any of the following functions? (yes/no)

a) Establishing and disseminating methodological expertise and techniques in health promotion practice? (optional: provide up to 3 names, contact details and URLs)

b) Providing technical materials to others? (optional: provide up to 3 names, contact details and URLs)

c) Networking (optional: provide up to 3 names, contact details and URLs)

d) Planning and running programmes? (optional: provide up to 3 names, contact details and URLs)

e) Planning and running campaigns?. (optional: provide up to 3 names, contact details and URLs)

f) Evaluating health promotion interventions (policies, programmes, campaigns, projects) (optional: provide up to 3 names, contact details and URLs)

g) Funding programmes, campaigns and projects (optional: provide up to 3 names, contact details and URLs)

h) Other actions. (optional: provide up to 3 names, contact details and URLs)

6.4 [Optional Question] Choose a maximum of 10 local level projects exemplifying good practice (it is understood that the choice is subjective)

Name of project/programme
[Organisational Reference(s)]

Does the project/programme cover any of the functions detailed below? tick box(es)

a) facilitating better health promotion practices (establishing methodological expertise) □

b) creating health promotion materials □

c) networking □

d) planning and running programmes □

e) planning and running campaigns □

f) evaluating health promotion interventions(policies, programmes, campaigns, projects) □

g) funding programmes campaigns and projects □

h) other actions, state what [max 50 words]

6.5 At local level, when implementing national policy, where, on a scale of one to ten where would you place the level of freedom of local bodies in setting priorities (where 0 is complete freedom (decentralisation) and 1 is total direction from National level)?
7. Professional Workforce

7.1 Is learning and qualification in health promotion at Bachelor (e.g. Bachelor of Arts / Bachelor of Science) level available at at least one institution of higher education?
   If no go to 7.2
   If yes
   7.1.1 Provide name(s) of institution(s) and URLs (web-site addresses)

7.2 Is learning and qualification in health promotion at M.A./M.Phil level available at least one institution of higher education.
   If no go to 7.3
   If yes
   7.2.1 Provide name(s) of institution(s) and URLs (web-site addresses)

7.3 Is learning and qualification in health promotion at Ph.D level available at least one institution of higher education?
   If no go to 7.4
   If yes
   7.3.1 Provide name(s) of institution(s) and URLs (web-site addresses)

7.4 Is learning and qualification in health promotion at Dr. PH level available at at least one institution of higher education?
   If no go to 7.5
   If yes
   7.4.1 Provide name(s) of institution(s) and URLs (web-site addresses)

7.5 Are academic post-graduate non-degree courses/symposia or similar offered on topics of health promotion?
   If no go to 7.6
   If yes
   7.5.1 Provide name(s) of institution(s) and URLs (web-site addresses)

7.6 Are non-academic courses offered on topics of health promotion?
   If no go to 8
   If yes
   7.6.1 Provide name(s) of institution(s) and URLs (web-site addresses)

8. Professional Associations

8.1 Do you have any associations for professionals involved in:
   a) health promotion research? Yes □ No □
   b) health promotion practice? Yes □ No □
   c) health promotion policy-making? Yes □ No □
   d) Other (please state) [Max words: 50]

8.2 Please describe each as follows:
   [Organisational Reference(s)]
Is it a voluntary association? Yes ☐ No ☐
Is it only for health professionals? Yes ☐ No ☐
If yes which health professionals are eligible to join [max: 50 words]
If no, who is eligible to join: [Max words: 50]
Is there anything else you wish to add about this association? [Max 100 words]

9. Funding

9.1 Please describe in no more than 100 words how health promotion is funded in your country, indicating:
a) the trend of HP funding (up or down over time the past 2-3 years)
b) the year-on-year predictability of funding over 2-3 years ahead
c) the predictability/rationality/stability of the funding mechanism(s)
d) the transparency and criteria for the allocation of funds.

9.2.1. Are funds dedicated to health promotion clearly identifiable in the national budget? Answer yes or no.

If yes

9.2.2. At national level, is it possible to give the amounts dedicated to health promotion from various funding sources?" Answer yes or no.

If yes, complete a table as follows

(Note: All amounts must be in Euros. For exchange rates go to www.oanda.com. Use the exchange rate for the end of the year in question.)

<table>
<thead>
<tr>
<th>National Level</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>General taxation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from gambling (e.g. slot machines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please name)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>And add rows where necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.3.1. Are funds dedicated to health promotion clearly identifiable in sub-national budgets? Answers are yes or no.

If yes

9.3.2. At sub-national level, is it possible to give the amounts dedicated to health promotion from various funding sources?"
(Note: All amounts must be in Euros. For exchange rates go to www.oanda.com. Use the exchange rate for the end of the year in question.)

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Level (provincial, regional or local)</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>General taxation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from gambling (e.g. slot machines)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Alcohol tax</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please name)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>And add rows where necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.4.1 Are funds dedicated to health promotion campaigns and/or other population-scale activities (like anti-tobacco, pro-healthy eating etc)? (Note: these might not necessarily be labelled "health promotion" but nevertheless function as health promotion.)

Answers are yes or no.

If yes

9.4.2. Is it possible to identify the sources of funds for these activities, campaigns etc? (Note: the funds may be 'hidden' within a Ministry of Health budget line which funds all of the Ministry's communications issues, from hospital closures to SARS, or be provided by another Ministry under a non-health heading, e.g. road traffic management.)

Answers yes or no.

If Yes

9.4.3. What are the the **funding sources** and **amounts** for these actions, campaigns etc.?  
If data not available state "data unavailable"

(Note: All amounts must be in Euros. For exchange rates go to www.oanda.com. Use the exchange rate for the end of the year in question.)
<table>
<thead>
<tr>
<th>Level (National, provincial, regional or local)</th>
<th>Name of Campaign or Programme</th>
<th>Funding Source</th>
<th>Year (2000 - 2003)</th>
<th>Amount</th>
</tr>
</thead>
</table>

*Contact Details for any queries or issues arising regarding data gathering for the HP Source Project:*

Maurice Mittelmark  
maurice.mittelmark@psych.uib.no  
+ 47 55 58 32 51

Spencer Hagard:  
Spencer.Hagard@lshtm.ac.uk  
Tel: + 44 20 7612 7895

Jackie Robinson:  
jackie.robinson@wanadoo.fr  
Tel: + 33 4 94 99 71 15
Annex VI
Feedback from HDA / IUHPE
Conference Workshop Session
Feedback from HDA / IUHPE Conference Workshop Session  
11 June 2002

- We should build in the possibility of including data from other countries such as Australia and Canada, and certainly build in links to appropriate web-sites in these countries.

- Look at the role of Health Promotion in Public Health Policies – update the information from the IUHPE seminar on HP policies, infrastructures and practices.

- We need to link up with ENHPA’s needs assessment and Eurohealth.net.

- We need to think about the link between policies, structures and strategies and the links between the three (why do we always tend to lump them together?)

- It would be interesting to do an exercise for “the perfect country” to see if analysis of the web-site would support this.

- We need to think carefully about accession countries and what information would be appropriate and relevant to them.

- We should use and link to the glossary and thesaurus of HP terms.

- We need to think about our definition of Health Promotion and what it encompasses. What are we going to include and exclude? How do we capture programmes that are not labelled Health Promotion – what are our indicators of Health Promotion? (Link with John Davies’ indicators project.)

- We need to make it simple and clear.

- We need to have a better understanding of the needs of the end user in order to assess where to put our boundaries and build in manageability.

- In terms of policy, are we looking at health policy, health promotion policy or healthy public policy? All three are implicated in health promotion in different countries.
Annex VII
Second User Advisory Group Meeting
Present: Amanda Killoran (AK) (England), Angela Clements (AC) (Wales), Chris Roberts (CR) (Wales), Catherine Jones (CJ) (IUHPE), Bernt Lundgren (BL) (Sweden), Margaret Barry (MB) (Ireland), Andrea Lins (AL) (Austria), Pierre Arwidson (PA) (France), Rosana Peiro (RP) (Spain), Joana Godinho (JG) (World Bank), Spencer Hagard (SH) (HP Source), Jackie Robinson (JR) (HP Source), Dawn Davis (DD) (HP Source), Maurice Mittelmark (MM) (HP Source), Maggie Davies (MD) (HP Source), Richard Lunn (RL) (HP Source database developer), Phil Ahern (PAH) (HP Source database developer.)

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice and Support for Elisabeth Fosse in the development of the literature review</td>
<td>All</td>
<td>20 July 2002</td>
</tr>
<tr>
<td>Circulate references for literature review so group can add to it</td>
<td>Elisabeth Fosse</td>
<td>25 June 2002</td>
</tr>
<tr>
<td>Review minutes, send comments / amendments to JR</td>
<td>All</td>
<td>28 June 2002</td>
</tr>
<tr>
<td>Send SH annotated feedback on draft instrument</td>
<td>All</td>
<td>28 June 2002</td>
</tr>
<tr>
<td>Circulate amended minutes</td>
<td>Jackie Robinson</td>
<td>4 July 2002</td>
</tr>
<tr>
<td>3rd Draft of instrument for data collection (addressing all issues raised) to be circulated</td>
<td>Spencer Hagard, Jackie Robinson, Richard Lunn, Phil Ahern</td>
<td>26 July 2002</td>
</tr>
<tr>
<td>Comments on 3rd draft back to SH</td>
<td>All</td>
<td>3 September 2002</td>
</tr>
<tr>
<td>Instrument for data collection goes out to participating countries</td>
<td>Spencer Hagard, Jackie Robinson, Richard Lunn, Phil Ahern</td>
<td>10 September 2002</td>
</tr>
</tbody>
</table>

Minutes of the Meeting

After brief introductions Spencer Hagard and Jackie Robinson gave a brief history and overview of the project.

Elisabeth Fosse then updated us on her progress in the literature review which will provide the foundations for focusing and contextualising the project. Elisabeth requested the help of group as she continues this process in the coming weeks.

EF said that in order to be able to collect the right data and for the database to make sense we need the definition of the concepts – infrastructures, policies and practice.
For example infrastructures will be defined as institutions at national regional and local levels, along with Universities and NGOs. The institutions will vary from country to country and, for example, maybe the civil sector will be more important in Scandinavian countries.
The objective of the database is to get information about European countries, but in the literature we want to look outside Europe. We want exemplars of the experiences in different countries and references to important policy documents.

We will focus on policy that has been published. The literature review can’t bring in all the information available from all the different sources. It will be a focused article but still bring in important information. We will look at policy documents at different levels, for example WHO documents, European Union documents and other national policy documents. They will be limited to those published in English but there will be references to documents published in national languages.

PA asked if we are looking at policies on tobacco, safety issues etc.

EF said that to an extent this would be defined by the policy outcomes. In political science language the output is the policy decision. Are strategies put into practice? If we use a very narrow scope we will have too many examples, but so far there does not seem to be too many to cope with.

MD said that she was worried that there is just too much going on to fit into the review and database.

EF said that this was why it was so important to define and contextualise, to draw boundaries about what will be addressed.

SH said that what helps to limit the fields is the relationship between policy, infrastructure etc. so we are looking at policies to do with infrastructures, infrastructures to do with policy and so on.

AK suggested that we make explicit a systems approach to policy as basis for dimensions of data. Using the model of process of national policy development, implementation and evaluation.

EF pointed out that we are at an early stage in the process. We have to think again and develop it further. There are some initiatives that are clearly useful, for example, healthy public policy documents. The concept of policy is vague so we have to refine our definition.

We need to look at the issues of equity and equality, identify documents at national level, and discuss theory from the point of view of both the medical and the sociological approaches to these issues.

BL said that he thought we should be careful to differentiate between inequalities in health and social inequalities. From a health promotion perspective we need to focus on social inequalities.

MD stressed that we need to make explicit the model and the framework. The core function of HDA is to do web-based evidence base, so there is potential to benefit from each other.

AK pointed out that the evidence base is largely to do with process evaluation implementation. There is very little around policy implementation. In terms of public health implementation it is quite difficult to establish a sound evidence base. Are we convinced that we are implementing public health policies?

EF said that in her view it is more important to have a discussion about our experiences.

AK added that we need to acknowledge the uncertainty and make it explicit.
EF said that it was in some ways HIA (Health Impact Assessment) in its broadest sense. She needs to fill in the gaps in the literature and asked for the help of the group in completing this task.

PA asked for EF’s reference list so that we can add to it, and EF agreed that she would circulate it.

Richard Lunn and Phil Ahern, the database developers for this project, then gave a brief presentation regarding the technical capabilities of the database when it is built, and some of the technical issues surrounding the collection of the data. They stressed that it is important that wherever possible we give people multiple choice type options so that the information stored is standardised and it is possible to make comparisons between the different countries. It will not be possible to have large fields full of free text, but we will be able to make links to pages of free text either on our own site or others where appropriate.

JR thanked Richard and Phil for their input and said that it would help to focus the group's mind on the next exercise.

The group split into small working groups of three or four people and worked on potential user scenarios. The objective was for each group to consider what kind of information would be required from the database with regard to its chosen scenario and how the information might be presented.

As a reference point the group was given the questionnaire that was developed at the first User Advisory Group and since updated, plus the feedback from the workshop at the IUHPE/HDA Conference earlier in the week.
Scenario 1

"You are a senior advisor to WHO/World Bank/UNICEF and have been asked at 48 hours notice to advise the government of a former Soviet Republic on developing Health Promotion, more or less from scratch. What do you want from the database? Provide some mock pages."

Joana Godinho and Spencer Hagard worked on this scenario.

<table>
<thead>
<tr>
<th>The Database Should Contain:</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tracer problems</td>
<td>JG said that if we can show what happened as a result of some intervention or policy then we can show how health promotion works. In this scenario it would be useful if we could look at the relationships between inputs, outputs, determinants, risk factors etc. and advise on short and long term strategies.</td>
</tr>
<tr>
<td>Links to WHO quantitative data on (for example) CVDs</td>
<td>Lung Cancer AIDS</td>
</tr>
<tr>
<td>2. Key determinants</td>
<td>-</td>
</tr>
<tr>
<td>Links to quantitative data on (for example)</td>
<td>Poverty Education Employment Alcohol</td>
</tr>
<tr>
<td>3. Risk Practices</td>
<td>Smoking Diet Exercise</td>
</tr>
<tr>
<td>Links to Quantative data on (for example)</td>
<td></td>
</tr>
<tr>
<td>4. Key Outputs</td>
<td>HP Policies</td>
</tr>
<tr>
<td>Equity Effectiveness Efficiency</td>
<td>Programmes Campaigns Communication</td>
</tr>
<tr>
<td>5 a) Key Policies</td>
<td>Price / Tax</td>
</tr>
<tr>
<td>Sectoral activities</td>
<td>Smoking bans</td>
</tr>
<tr>
<td>Political decision making</td>
<td>Fat content</td>
</tr>
<tr>
<td>5b) Key Public Campaigns</td>
<td></td>
</tr>
<tr>
<td>Stop smoking</td>
<td></td>
</tr>
<tr>
<td>Drink driving</td>
<td></td>
</tr>
<tr>
<td>Destigmatising AIDS</td>
<td></td>
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<tr>
<td>Balanced Diet</td>
<td></td>
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<tr>
<td>5 c) Key Community Activities</td>
<td></td>
</tr>
<tr>
<td>Community participation</td>
<td></td>
</tr>
<tr>
<td>Demand driven?</td>
<td></td>
</tr>
<tr>
<td>Harm reduction</td>
<td></td>
</tr>
<tr>
<td>CINDI?</td>
<td></td>
</tr>
<tr>
<td>6. Key Inputs</td>
<td></td>
</tr>
<tr>
<td>Funding - Sources and amounts</td>
<td></td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
</tr>
<tr>
<td>Human Capital</td>
<td></td>
</tr>
<tr>
<td>Technology</td>
<td></td>
</tr>
</tbody>
</table>
Scenario 2

You are preparing a paper for a meeting of top officials of local government and health authority (or equivalent) wanting to influence the resources devoted to joint action for Health Promotion. What information would you want to find on the database? Provide some mock pages.

Pierre Arwidson, Andrea Lins and Rosana Peiro worked on this scenario

<table>
<thead>
<tr>
<th>The Database Should Contain:</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information on the legal definition of Health Promotion</td>
<td>For a question such as &quot;Is health promotion a legally defined term in your country?&quot; there would not be a straight &quot;yes&quot; or &quot;no&quot; answer for countries such as France and Spain (and probably others.) We would therefore need a text field for an explanation.</td>
</tr>
<tr>
<td>2. Health Promotion Policies in other countries or regions</td>
<td>There are potentially an enormous number of responses for questions about health promotion infrastructures and this should be taken into account in the design of the database. It would be useful to have contact details of key people in each country and also links to regional tables.</td>
</tr>
<tr>
<td>Country A</td>
<td></td>
</tr>
<tr>
<td>Country B</td>
<td></td>
</tr>
<tr>
<td>Country C</td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td></td>
</tr>
<tr>
<td>e-mail</td>
<td></td>
</tr>
<tr>
<td>websites</td>
<td></td>
</tr>
<tr>
<td>Principles in a few lines</td>
<td></td>
</tr>
<tr>
<td>Infrastructures</td>
<td></td>
</tr>
<tr>
<td>Involved: Multiple response possible</td>
<td></td>
</tr>
<tr>
<td>Reports/ web-sites</td>
<td></td>
</tr>
<tr>
<td>3. Help to move - Health Education → Health Promotion Framework</td>
<td>This could be a stated principle in an introductory page.</td>
</tr>
<tr>
<td>4. When no HP Policies</td>
<td>In some countries there may well be healthy policies but not explicit health promotion policy, so we need to be able to highlight these.</td>
</tr>
</tbody>
</table>
5. Find the Healthy Settings Movement
Contacts / Short Explanation / Achievements

<table>
<thead>
<tr>
<th>6. Social inequality indicators?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social organisation description?</td>
</tr>
</tbody>
</table>

We need to be able to look at health promotion benefits in terms of reduction in inequalities. This would be a very useful advocacy tool.

It should be possible to analyse data from the "top down" and the "bottom up".

It was also stressed by this group that in the 21 countries involved in the project there are latecomers to health promotion and we should not diminish what they are doing by the way the database is structured.

AK added to this that a Health Promotion policy per se is not necessarily better than healthy public policy integrated into other sectors. So we should be careful not to make the format judgemental. For example we could ask questions like:
"To what extent within economic policy is account taken of health"
Having a health promotion policy is not necessarily a proof of having good health promotion policy or practice.

**Scenario 3**

You are a researcher doing comparative research on the relationship between Health Promotion policies and action in Europe. What kind of information do you want from the database? Provide some mock pages.

Margaret Barry, Elisabeth Fosse and Bernt Lundgren worked on this scenario

<table>
<thead>
<tr>
<th>The Database Should Contain:</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policies</strong></td>
<td></td>
</tr>
<tr>
<td>- Is there a national health promotion policy framework</td>
<td></td>
</tr>
<tr>
<td>- e.g. alcohol transport</td>
<td></td>
</tr>
<tr>
<td>- Summary of characteristics, goals, objectives, strategies and approaches - e.g. intersectoral, up-stream</td>
<td></td>
</tr>
<tr>
<td>An expansion of the existing question 1.3</td>
<td></td>
</tr>
<tr>
<td>There should be a drop down menu of possible policy areas.</td>
<td></td>
</tr>
</tbody>
</table>

| **Infrastructures**         |            |
| - Funding |
| - Funding sources and arrangements |
| - Amounts % allocations, budgets |
| - Workforce and knowledge |
| - Agencies / bodies etc. |

| **Action**                  |            |
| - Need to know about implementation structures and action plans at different levels |
| - Evaluation |
| Revise 1 B and section 5 of existing questionnaire. |

EF said that we need also to address the debate about whether health promotion is part of public health or public health is part of health promotion.
AK added that this was also linked to the issue of the difference between the implementation of health promotion systems and the role of health promotion as a function.

**Scenario 4**

*What useful information could the database provide for the IUHPE?*

*Provide some mock pages*

Maurice Mittelmark and Catherine Jones worked on this scenario

<table>
<thead>
<tr>
<th>The Database Should Contain:</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Front Page</strong></td>
<td>The database should have:</td>
</tr>
<tr>
<td></td>
<td>- full text search capacity</td>
</tr>
<tr>
<td></td>
<td>- lots of hyperlinks (www and e-mail)</td>
</tr>
<tr>
<td></td>
<td>- users to return/contribute data</td>
</tr>
<tr>
<td></td>
<td>- user assistance by category</td>
</tr>
<tr>
<td></td>
<td>- topical search capacity</td>
</tr>
<tr>
<td></td>
<td>appropriate link to the literature review</td>
</tr>
<tr>
<td><strong>Contents</strong></td>
<td>The database can also be a learning tool - using for example, Frequently Asked Questions.</td>
</tr>
<tr>
<td><strong>Logo</strong></td>
<td><strong>IUHPE Needs and Interests</strong></td>
</tr>
<tr>
<td><strong>Branding</strong></td>
<td>- membership development</td>
</tr>
<tr>
<td><strong>Who? What? Why?</strong></td>
<td>- partnership building mapping networks</td>
</tr>
<tr>
<td><strong>Site Map</strong></td>
<td>- advocacy</td>
</tr>
<tr>
<td><strong>Topic</strong></td>
<td>- HP events</td>
</tr>
<tr>
<td><strong>FAQs</strong></td>
<td>- finding venue</td>
</tr>
<tr>
<td><strong>Partners</strong></td>
<td>- fundraising/resource tracking</td>
</tr>
<tr>
<td><strong>Links</strong></td>
<td>- case studies/success stories</td>
</tr>
<tr>
<td><strong>Register to search</strong></td>
<td>- communications improvement</td>
</tr>
<tr>
<td><strong>Search by</strong></td>
<td><em>IUHPE Contribution - global professional network and expertise</em></td>
</tr>
<tr>
<td><strong>Country etc.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Global HP Directory</strong></td>
<td></td>
</tr>
</tbody>
</table>

JG Commented that it was a good idea that users should be able to give feedback.

**Scenario 5**
The Finance Minister asks for a brief for a Council of Minister’s agenda item on the role of health promotion in reducing social and economic inequalities in European Countries. What do you want the database to tell you and to link you to? Provide some mock pages.

Amanda Killoran, Chris Roberts and Amanda Clements worked on this scenario. They specified that the Finance Minister was interested in the cost effectiveness of investment relating to inequalities.

<table>
<thead>
<tr>
<th>The Database Should Contain:</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern of investment versus level of problem</td>
<td>Need to draw attention to effectiveness data</td>
</tr>
<tr>
<td>Health and economic development</td>
<td></td>
</tr>
<tr>
<td>Health (functions) social &amp; economic development implicit/ explicit</td>
<td>What would be good indicators of resource investment?</td>
</tr>
<tr>
<td>Mapping inequalities - i.e. context info.</td>
<td>Health needs to be linked to wider social and economic aspects.</td>
</tr>
<tr>
<td>Priorities - deprived areas/groups</td>
<td>Mapping of social inequalities across the EU - you do need a minimum of contextual information.</td>
</tr>
<tr>
<td>&quot;Tracer&quot; programmes e.g. childhood poverty</td>
<td>What are sensitive indicators? Key indicators response?</td>
</tr>
<tr>
<td>Good links to other &quot;basic&quot; information sources including EC profiles.</td>
<td>The database can only partially answer questions of this type.</td>
</tr>
</tbody>
</table>

PA pointed out that inequality is a political issue and we should ensure that the database is non-judgemental and readable to right and left wing politicians.

JG suggested creating links to European Commission definitions and information on inequalities.

AK said that we must have population size and a minimum contextual section.

MM then gave a brief presentation about the EUPHID project (European Union Public Health Indicators)

This 18 month project is funded by the European Commission and directed by John Davies at the University of Brighton. The aim is to work on three existing frameworks prepared by members of the team and develop a single unified framework to develop indicators for health promotion.
To support the task they will be referring to the ICF (International Classification of Function) and ICD (International Classification of Diseases).

They will be looking for indicators at all levels - individual, community, regional and for systems. ICF has a category on the body but also on activities and performance capabilities. They will then classify across the range of indicators. They are not taking the ICF as the indicator model but will use what is appropriate.

There is evidently some overlap between our two projects and we share several members, so we should share our minutes and keep each other informed of our progress.

AK said that, referring back to a framework of the evidence base and experience, maybe the evidence base can only take us so far and then we need consensus.

SH said it would be interesting to compare the evidence base with the data that comes up from the participating countries.

JG suggested that we update the existing questionnaire.

SH suggested that members of the group annotated their questionnaires and send their comments back to us then we could make a new draft based on these.

PA pointed out that people had asked for example of specific projects. Do we choose one example or a number of examples?

AK suggested that perhaps we would find it helpful to have one summary page of all the different sections and headings and how it fits together. We need to look at what the questions represent in terms of infrastructures and make this more explicit.

BL As it stands the questionnaire starts with discussion about one policy. It will actually be relevant to Sweden but in other countries this overarching question may seem irrelevant.

AK agreed that the question should really be about a policy framework, which would be more sensitive to reality.

EF said that we also need to think about the short basic information which will create the context.

CJ suggested a map for each page showing country demographics - male / female etc. the GNP and 5-10 points that would contextualise the data.

The group agreed the following:

Next Steps
1. SH to circulate existing draft of questionnaire by e-mail by 20 June.
2. Annotated feedback to be sent to SH by 28 June.
3. All the input from this week (conference workshop) and User Advisory Group Meeting will be amalgamated into draft 3, with a diagrammatic first page.
4. We will give some thought to key topic areas
5. We will address the abruptness with which the current draft starts with a single dimension.
6. We will try to address the issue of capturing country policy reality both overarching policy and policy areas.
7. We will examine what should be provided in terms of country contextual information.

AK suggested that the group should forward what they think are the key questions. What are the questions designed to address, and who are going to be the users?

SH said that the questions were designed to address policy development and research into the effectiveness of infrastructures.

Users will be:
- Policy makers (especially at national levels)
- Researchers
- Advocates for Health Promotion
- NGOs

PA said that perhaps we could choose key topic areas e.g. smoking as an example, or each country should choose an example of best practice.

AK said that we should see it as a matrix of functions and problems - Country, functions, and topics. The process of putting together the database and the database itself could have a big impact.

CR said that from his point of view the Welsh Assembly would be very happy to have this tool and would be very happy to participate in piloting if this is built into the process.

CJ added that taking into account all the different perspectives and issues could only strengthen our communication.

BL said that it was an important job and an interesting job, and we should see it in terms of public health policy reporting, as in our aim to report to the national government.

RL said that from the point of view of the database designers the day had been very useful and that an image of the database was starting to take shape.

PA added that we should not be overambitious and keep it within the realms of the feasible. If we have hundreds of links they will all need to be updated regularly. The database will need an administrator and constant resources.

RP said that for her the day had been very interesting and she now understood more clearly what we are proposing to do. Health promotion is not well developed in Spain so it will be a useful advocacy too.

JG said that we should bear in mind that one important group of users will be developing countries and we should be sure to make it possible for them to see the lessons we have learnt. She added that we clearly had a vision and we now have to work to make it a reality. JG is happy to continue working with the group to make this happen.
SH and JR thanked everybody for their commitment and energy and participation and said that they were looking forward to continue working with this team.

*Close*
The following points and ideas were raised at the above meeting regarding the development of the database, all of which are perfectly viable. As they relate largely to the front-end of the application no action is necessary at present.

- The addition of forums and discussion boards to allow debate
- The need for user assistance in the shape of case studies and 'Frequently Asked Questions'
- A user feedback form
- A user registration option
- The ability to store hyperlinks and email links
- The need for access with low specification browsers
- The need to offer an alternative to yes/no input of data in certain circumstances
- A topical or full text search
- Data gathered may need to be manipulated within the database to provide more meaningful interpretation.

Richard Lunn
Senior Developer
Caint.com
HP Source

Minutes of the 3rd User Advisory Group Meeting held at LSHTM on 23rd and 24th January 2003

Those Present:  Phil Ahern (Caint.com)
Andrea Bertola (WHO)
Spencer Hagard (LSHTM)
Catherine Jones (IUHPE)
Amanda Killoran (HDA)
Richard Lunn (Caint.Com)
Maurice Mittlemark (University of Bergen)
Rosemary Phillips (HP Source)
Jackie Robinson (HP Source)

Thursday 23 January 2003

HDR CD Review
The HDR CD was reviewed. All agreed it was a very simple and straightforward way of searching and showing records.

PA said that the most important aspect of the database design was designing the search tool. It was agreed the ‘search terms/words’ would need to be decided. This raised the issue of tagging utility which PA said could become complicated. One possibility would be just to list all the words in the database, but if free text fields were large this would be an enormous job.

It was agreed that as user researchers need to know if information on the site is likely to change that the date of the annual update should be posted on the site, together with dates for quarterly introduction of new countries. PA said it would also be possible to email those who had recently hit the site, as they have these records.

The minimum specification to access database was raised. PA said they would recommend a certain resolution, but would make it accessible to as many as possible.

It was agreed hyperlinks would be used in the database to link to other information sources.

HP Source Review
(copy of slides available on request)
JR gave a brief review of HP Source to date. Denmark and Scotland being the two countries outstanding. MM suggested Evelyn de Leeuw. It was agreed JR would give Kristin one final chance, as she represented an official body, but would then approach Evelyn.

JR reported that not all, in fact relatively few countries would have their data inputted by 5 February. SH suggested that the first country to complete their data should be made available on the site to encourage the others, but with a caveat along the lines that ‘this is the first completed data, still to be edited and not a guide to definitions’.

ACTION

ALL

PA / RL
MM raised the issue of pedigree: It was agreed that each year quality control would be made on the objective evidence that the documents listed related to Health Promotion.

JR stated the next stage would be analysing the data with the three exemplar countries.

MM suggested a training session for all inputting data. JR stated it was hoped that a number of researchers would all be at the Perugia conference 18-21 June. CJ confirmed one session had been reserved for this. It was agreed 2 sessions should be requested and that researchers should be told as soon as possible that this would be taking place. JR to get Horst's agreement to use existing travel and subsistence budgets for this.

SH reported on the feedback from the different users as documented.

MM suggested that a Links sub-working group may be necessary. JR suggested that AB could take that on in the next phase if WHO agreed to go ahead with the project. AB said there was to be a meeting in Copenhagen next week where he could raise the idea of HP Source.

Scenario 4 raised the issue of language. It was agreed this should be kept as simple as possible. MM stated that the networking of researchers would play a key role in this.

Standard Query Tool
PA explained that the Standard Query Tool worked on a three layer model, but that the purpose of some of the questions was not clear. For example question 9.

MM said that now it (Q. 9) was a map, but for example, if he saw that a country funded its health promotion through an alcohol tax, he would like to click on that and find out more about it. SH stated it was being built so that it could potentially be developed at a later date.

MM questioned whether the researchers were willing to be the contact in each country. SH reported that this would be an issue to be raised at the June workshop and for the second stage of funding.

CJ questioned whether there could be a site map to indicate where questions lead. PA explained this difficult as there were no clear key words or phrases at this point.

It was agreed that a line had to be drawn now on the development of the Questionnaire. However, additional data collection would be in the next phase, and could help add strength to the proposal.

SH suggested there be an index of the 9 sections. PA said the full text and index searching could only be developed once the material had been input. RL stated that the site had been designed as a database to bring up tables as a comparative list by country rather than as a text based database.

AK raised the issue of guidelines in interpretation and understanding of terminology. It was agreed that national level was not an issue. However, regarding local level questions it was down to individual researcher's interpretations and this should be discussed at the workshop in June. It was agreed that this was a discovery
tool to set people on the right path rather than give comprehensive data, that it was to facilitate networking rather than research. It was agreed that Stage 2 should include a budget to make it a key component to include all local level (county/municipality) organisations. At this point, however, just association/union of local governments should be listed.

It was agreed that on the site map, something should direct people to the initial 100 word introduction. It was agreed that before (or at) Perugia JR should work with researchers to get this into a comparative format for each country.

**Query and Display Solutions**

It was agreed the there should be a facility to read countries in groups. It was agreed the Overview box should include key differentiating factors in regard to each country, possibly a nine sentence summary covering each point. At every point, there should be a facility to click on the country and see the Overview.

It was suggested that Stage 2 should include a budget to do country profiles, although at this point there could be a link to WHO profiles.

CJ suggested a map with a simple country profile. It was also suggested that Stage 2 should develop the Additional Information in Q10.

It was agreed that the priorities were to be:
1. Country
2. Level within the country
3. 5 categories of the Ottawa Charter

An undated Word version of the Questionnaire text was requested for everyone. JR said that as this would be made available.

It was agreed a new users' guide would be developed by JR and AK quickly so that those inputting data now could benefit from it.

It was suggested the site map should include the country, the 9 questions, and a list of documents and organisations.

**Suggested Modules (for future development):**

- Health Impact Assessment
- Inequalities
- Conferences - mapping - infrastructures
- Mapping of publications in health promotion
- Inaccessible literature
- Language and discourse - policy and forming agendas
- Infrastructure for capacity building - professional standards
- Regional/Local level infrastructures

24 January 2003

**Review of Yesterday's Conclusions**

PA said that he and RL were now clear in about how the data should be presented. Most questions will be presented with the standard query tool, going down to different levels. Options will be to have a comparable list and then go down to a more detailed description of data, and then you can either leave the database, or
return and do another search. We have looked at all questions and agreed that
Question 1 will link from the map our country list.

We also decided that we are going to create action buttons for each country which
will give general details of the country and a list of organisations and documents
available on the database. Additional information is either going to link to that or to
something else, depending on what the additional information section turns out to
contain.

We also said that we might do a case model as well. E.g. "Someone looking for this
kind of information has done this kind of search". On the basis of how this is used,
six months into use we could tailor typical questions and put them in as a guide.

AK said that we had coined the phrase *discovery tool*. In an initial phase can we
gather the types of enquires – perhaps people could post what they have actually
done. She suggested that we could perhaps design a questionnaire as a feedback
form. We could have an evaluation panel across the countries and part of their role
would be to demonstrate their use in the first phase. It would be tremendously
helpful as an exchange. She wondered if it would be possible to keep a users
utilisation log.

MM suggested that perhaps we could monitor people’s enquiries for a certain
period.

AK said that this assumes that people have particular search strategies – but they
may just be exploring. An evaluation could analyse what people wanted and if they
got it, and what else they might have had. There has to be a protocol of evaluation
which will be a cross section of different types of users. What type of impact is it
having? We should be wanting to clarify impact outcomes on different levels.

SH wondered if there was any way that referencing in publications would give us
indications of the use, and MM suggested that we ask them to put HP-Source in a
key word list.

CJ commented that if people find their way to publications they would cite the
papers as their reference, not HP Source.

PA said it would be possible to put in a facility so that if you click on a link it would
flash up a reminder that “you came here from HP-Source.”

AK Reminded us that we had discussed that there is a need for some form of
guidance for users in terms of interpretation in certain areas – just some guide to
finding their way through data base as in the map idea.

CJ Asked who might potentially be the contact if you are having problems with this
site in terms of one's research.

JR said that there were no resources to deal with people's research problems, so we
must first direct them to Frequently Asked Questions and, including technical or
research questions and then perhaps we could have a message board to answer
research problems. All agreed that this was a good idea.

MM suggested that it would be a good indicator of how well it was working if we
asked if the user is happy or not.
Design Issues
Participants suggested examples of web-sites they particularly liked in order to give RL and PA a good idea of what is required in terms of design. All agreed that they wanted something uncluttered, clear, with some artistic flair but still professional.

Pilots ("Experimental" Countries)
SH said that we have an open field in what we do with the "experimental" countries or pilots. We must recognise that the database has limitations; it is about things and not functions of those things. It is weak on interconnections; about how a system hangs together. We hope to have an array of pilots from a relatively sophisticated country, Wales and a not so sophisticated country, Latvia.

MM asked, if he was in one of these countries doing a pilot study, how would HP Source help him?

SH said that it would be as case of finding out that through experimenting with the data. We would find out what it is good for and what not. Wales and Latvia would be on same level (i.e. as countries) and the NW of England would look at how useful at how useful it is at next layer down (i.e. at regional level).

MM asked if we were talking about data testers, would we not be better perhaps going to particular researchers in giving them an assignment requiring use of the database and give them a thorough debriefing?

AK asked where these ideas fitted in as we had been talking about a new phase that deals with evaluation.

JR clarified that this was written into the contract for this phase. It is supposed to be shared learning and something that is useful for countries and regions carrying out the work, as well as for HP Source. As part of our contract we have to make these studies available on the web-site.

MM suggested that we should do that, but also identify four or five colleagues and engage them in a data test and then have a phone conversation evaluating their use of the database.

CJ suggested that IUHPE could also bring in people from beyond Europe for testing.

All agreed that in Latvia, Wales and North-West England we would be doing a mutually beneficial demonstration, and at the same time we could carry out some data testing.

Dissemination Events
CJ said that the Strasbourg event at the European Parliament would take place on the 23rd or 24th September. It is being sponsored by John Bowis MEP. CJ has established good contact with Stuart his parliamentary assistant and they have arranged a conference call in two weeks to discuss finer details. JR and CJ have made a list of critical VIPs who need to be invited from the Commission. We expect about 30 MEPs to be attending, and past experience shows us that for this we need to send out hundreds of invitations.

It will be strictly a dinner event, so we will try to negotiate three PCs and a big screen so that people can try out the database. 13 project people have funding to go to the meeting so they can have briefing the night before and we can compile lists of
questions and discussion subjects. Hopefully will have a clear idea of whether there will be a Phase II by then and we can consult on that. We need to leave room for John Bowis to say a few words, as well as Commissioner Byrne or Matti Rajala.

From the HP Source team MM will give his brief talk about what health promotion is from the global perspective, and then Spencer will come in on where HP Source comes in as a discovery tool. We are not only trying to make them aware but also make them clear that they can use the tool for their decisions. We should be able to take some concrete issues and use that to enforce utility of the tool. We are putting up the data for the 15 countries of European Union and there should be some interesting things we can point out on the European level. We need to all note any key committees we want to target and it could be useful to ask all the HP Source contacts if there are any particular members of the European parliament that they would like to be there. We will be inviting members of the key committees environment and health, the intergroup on ageing and the intergroup on health.

As for Perugia, JR has asked Lamberto Briziarelli and Giuseppe Masanotti for a double session, and there will be a demo running on an exhibition stand. Perugia should not be seen as a launch but a last chance consultation.

In terms of the Italian Presidency event, JR and SH have passed a one page document to Errio Ziglio of WHO in Venice and are now awaiting feedback. JR pointed out that we need to be pragmatic about what the event will be. Given the priorities of the Italian Presidency we are unlikely to get a mainstream event so need to look at the sideshow option on some larger event. She clarified that this event was not contingent on WHO Venice taking on the database.
The Literature Review
MM pointed out that the Literature Review will be too long to be published in a peer review form. It can be used as a training tool, available on the web-site. We need to find a place for it in the database and then we can do searches on it using right search terms and key words.

Finally MM put forward his ideas for the long term future of HP Source. He pointed out that WHO Europe only covers Europe but IUHPE is global. There may be CDC funding to take this on.

Close
Annex IX
Notes from the Mutual Learning Exercise in the North-West of England
Introduction

Spencer Hagard (SH), HP Source project director and Jackie Robinson (JR), HP Source Project Manager met with Dominic Harrison (DH) representing the Health Development Agency in the North-West of England and Lancaster University. The aim of the meeting was to carry out a mutual learning exercise using the prototype of the HP Source database. Specifically we intended to assess the current usefulness of the database, and to take note of features which could be developed in the long –term, particularly as regards supporting strategy and research on a regional basis.

Notes of the Meeting

In the first instance DH pointed out that in many ways, at least as far as the North-West of England was concerned, regions and countries in the European Union shared similar features and problems. The North-West of England has a population of 7 million, which is bigger than five of the current EU member states. It is clear that some programmes are only viable beyond a certain population level. In terms of the functions of the regional Public Health and Health Promotion bodies some are appropriate Nationally and others regionally. This is because the relative levels of autonomy in policy making and resource allocation vary according to issue/ function as well as to governance level and population.

Generally, across Europe, 43% of the GDP is public spending so, by concentrating on an investment for health approach we have the potential to harness almost 50% of the economy. This can be done through a dynamic planning and target-setting process with other sectors e.g. transport, town planning, environment. DH gave the example of the links with the Food Policy Group at John Moores’ University. He added that one of the difficulties for HP Source, and for the Health Promotion field in general, was to how capture the issues, e.g. how alcohol affects mortality rates.

[Implication for long term development of HP Source – How to capture the policies and infrastructures which support Health Promotion across the different sectors?]

Health Promotion Skills

One of the major Public Health responsibilities at regional level is to pull levers in other sectors. The power for action often lies with strategic health authorities and with Primary Care Trusts (PCTs) working with local authorities. On average one PCT covers approximately 250,000 - 500,000 people. In England there has been a massive shift in Health Promotion and its functions are now discharged in different ways in different PCTs. In the North-West, they are integrated into the Public Health teams and they are negotiating and advising on other sector’s activities, e.g. Sure Start.

SH asked if in DH’s opinion, in the sense that there were not people with “Health Promotion” in their job title, this left a deficit.

DH said that in his opinion it did not. Health promotion is an activity, not a profession, and it may be more effective to carry it out across different sectors. Public Health has become a social objective, not a branch of medicine as many once conceived it, and health has been integrated into area based activities. We need to look at how our resources can be used in other sectors and build political support for salutogenesis or investment for health.

SH raised the question of Health Promotion Skills. It was not a problem to integrate the current workforce into other sectors as they have the skills which they have learnt through health promotion training and experience, but he wondered how the skills of the current workforce would be ensured as people were replaced.
DH shared his concern about this: it is by no means clear. He said that it was the responsibility of the Strategic Health Authorities and workforce development federations, but they hadn't addressed it yet. There is also now a Master’s degree in applied Public Health at John Moore’s University.

The skills (referred to in the Ottawa Charter) of enabling, mediating and advocating are built incrementally through experience. At the local level people can build up skills in negotiating health outcomes.

Public Health Medicine Networks have existed historically and are now applied to the broader Public Health workforce. For example, the Greater Manchester Public Health Network has about 130 members. The members are made up of PCTs, full-time Public Health professionals and people in other sectors with Public Health roles. Public Health Networks are there to share skills e.g. commissioning services for learning difficulties, and to share training initiatives. They have academic capacity coupled with resources from the workforce development federations. In the latest review of the Chief Medical Officer it was stated that there were 3 levels of Public Health
1. Public Health Specialists (100s)
2. Practitioner Level (e.g. health promotion specialists) (2000-3000)
3. Deliverers of Public Health in the health services and in many other sectors. (100,000+)

Training and Accreditation

SH asked about accreditation of the Public Health workforce at the National level. DH said that workforce planning has historically given normative numbers for roles in the delivery of Public Health. Now it is more about looking at what is required for particular populations.

DH said that the database question on workforce training was not particularly useful. The possible ossification caused by professionalisation of Health Promotion is a matter for debate and it would be useful to address this.

[Implication for long term development of HP Source – How to capture the debate about the professionalisation of Health Promotion causing stagnation in the field whilst at the same time recognising that specific skills and competencies are needed. We need to frame a new question about professional standards or accreditation of practice, professional associations and networking]

Looking at some of the data for England DH said that question 1 was a fair summary of Health Promotion in England but there was not much room for the discussion of functions. There is a high level of complexity in the delivery of health promotion objectives. People in other sectors are delivering health promotion, and the health sector is also capable of delivering the targets of other sectors. Neither at national or regional level does the instrument capture how the public health function is discharged. It would also be helpful if the completed version for England referenced the White paper on Regional Government and the role of the RDPH in Reg. Govt.

DH said it would be useful to have a keyword search – we need to be able to search by issue and it would also be useful to add a section for a listing of Networks e.g. organisations funded by EU, academic networks, EUPHA etc. JR said that these were outside of the scope of the current contract with the technical sub-contractors but they would be added to the long-term development plan.

[Implication for long term development of HP Source – A key word search urgently needs to be included and in the long term more sophisticated search facilities would be useful. We should also consider adding a section on Public Health / Health Promotion Networks.]
DH recommended that we learn more about rapid knowledge transfer technology where a lot has been learnt from the financial sector and economic development thinking. He recommended that we ask Chris Brown of the WHO about the poverty and health database.

DH said that in the long term development of HP Source we should take into account the fact that the political importance of regions is growing, and from this point of view the exchange of policy level knowledge and advice was extremely useful. We all want to know what works in terms of quality, effectiveness and efficiency.

He said it was important to try to capture some of the information and knowledge that is being drawn together in the HP Source database; National campaigns are still being run, but mass media campaigns are disconnected from practitioners. The knowledge capital of the Health Education authority has been disaggregated and diminished in the process, yet it is known that integrated programmes are required and it is interesting to see how this is being tackled in other countries.

DH also drew attention to the need to develop the database in two other areas:

1) To 'dig down' into common national strategic priorities, such as heart disease and cancers, to enable comparisons about how these are being done in different European countries

2) To collect more detailed information on the development and evaluation of policy in different countries

DH said that generally he thought that the HP source database was a very useful tool and that for him its most useful feature was as a portal to what was happening at the policy level in other countries and regions. Finally he stressed it was It is important for the context of the current Public Health and Health Promotion debates to be captured. [Implication for short-term development of HP Source – The Home-Page needs to capture the context of the current debates in Health Promotion]
Summary of Implications for the Development of HP Source

Short Term Development
1. The Home-Page needs to capture the context of the current debates in Health Promotion

Long Term Development
1. More sophisticated search facilities would be useful. Key Word Search facility should be a priority.
2. We should also consider adding a section on Public Health / Health Promotion Networks (e.g. organisations funded by EU, academic networks, EUPHA etc.)
3. We need to capture the debate about the professionalisation of Health Promotion causing stagnation in the field whilst at the same time recognising that specific skills and competencies are needed; we need to frame a new question about professional standards or accreditation of practice, professional associations and networking.
4. We need to capture the policies and infrastructures which support Health Promotion across the different sectors
5. and 6. - as 1) and 2) just above
Annex X
Action Plan from Mutual Learning Exercise in Latvia
Health Promotion Source Field Research: Latvia, 30 September-3 October 2003

Introduction
Spencer Hagard (SH), HP Source project director and Jackie Robinson (JR), HP Source Project Manager met with Ineta Pirktna (IP) representing the Latvian Health Promotion Centre. The aim of the meeting was to carry out a mutual learning exercise using the prototype of the HP Source database. Specifically we intended to assess the current usefulness of the database, and to take note of features which could be developed in the longer term.

Conduct of the Meeting
The meeting comprised the thorough systematic examination of the complete HP-Source database entries for Latvia, in order to identify:
- ways of improving the current data entry process
- possible data entry improvements in any future phase of HP-Source
- research issues from the field users' perspective

An opportunity was also provided to make a presentation of HP-Source to the Minister of Health.

Main findings
The findings were substantial and are detailed in the Action List on the next page. They can be grouped as follows:

Improving the current data entry process
Actions: 1, 2, 3, 4, 5, 6, 7

Possible data entry improvements in a future phase
Actions: 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29

Research issues
Actions: 15

Comment
As can be seen, most of the findings related to future improvement of data entry. Although specific research-related findings were limited, both IP and the Minister of Health referred to the importance of being able to research in future the comparison between Latvia's situation and that of other EU member states, and in particular to compare the nature and effectiveness of different health promotion infrastructures.
<table>
<thead>
<tr>
<th>ACTION NEEDED</th>
<th>CATEG.</th>
<th>WHO</th>
<th>WHEN</th>
<th>? √</th>
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</thead>
<tbody>
<tr>
<td>1 Data 3.3 &amp; 3.5.1 need to be accessible at front end</td>
<td>Current</td>
<td>Phil</td>
<td>asap</td>
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<td></td>
<td>Techn.</td>
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<tr>
<td>2 Clicking on ‘other status’ at 2.1.3(e) needs to</td>
<td>Current</td>
<td>Phil</td>
<td>asap</td>
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<td>read through to front end, ie the 50 words (max) need to be readable</td>
<td>Techn.</td>
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<td>3 3.5 and 3.5.1 back end need to read through to</td>
<td>Current</td>
<td>Phil</td>
<td>asap</td>
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<td>front end</td>
<td>Techn.</td>
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<td>4 4.5 ‘What data sources are used?’ has been</td>
<td>Current</td>
<td>Phil</td>
<td>asap</td>
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<td>omitted and needs to be included</td>
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<td>5 6.5 data need to come through to the front end</td>
<td>Current</td>
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<tr>
<td>6 8.2 front end is awry after ‘No’ in response to</td>
<td>Current</td>
<td>Phil</td>
<td>Asap</td>
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<tr>
<td>‘Is it only for health professionals, so needs sorting</td>
<td>Techn.</td>
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<td>7 Check the database for category errors,</td>
<td>Current</td>
<td>SH</td>
<td>28/11</td>
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<td>inconsistencies and inappropriate entries, eg at</td>
<td>Support &amp;</td>
<td></td>
<td></td>
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<td>2.1, documents where none of the Ottawa</td>
<td>Future</td>
<td>JR &amp; SH</td>
<td>Final</td>
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<td>Charter categories has been checked and the document titles/contents indicate</td>
<td>Design</td>
<td></td>
<td>Report</td>
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<td>another subject area (such as disease prevention):</td>
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<td>discuss appropriateness with relevant</td>
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<td>researchers</td>
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<td>8 Tell John Ryan that whoever is responsible for the database in future will</td>
<td>Future</td>
<td>SH</td>
<td>29/10</td>
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<td>need to provide:</td>
<td>D’base</td>
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<td>♦ Online help plus Telephone helpdesk</td>
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<td>♦ Capacity to decide (after consulting users and researchers) about the</td>
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<td>kinds of improvement listed in the Action Categories ‘Future Design’, ‘Future</td>
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<td>Support’ and ‘Future Content’, and then to incorporate them in ongoing</td>
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<td>database design improvement and subsequent data</td>
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<td>collection and support</td>
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<td>9 Data entry needs to be simplified – a major</td>
<td>Future</td>
<td>JR &amp; SH</td>
<td>Final</td>
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<td>technical job, which has now become possible by the development of a front</td>
<td>Design</td>
<td></td>
<td>Report</td>
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<td>end to iterate against the back end</td>
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<td>&amp; New</td>
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<td>Advis.</td>
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<td></td>
<td>Cttee</td>
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<td>10 Explore potential for on-screen advice to people as they do data entry,</td>
<td>Future</td>
<td>JR &amp; SH</td>
<td>Final</td>
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<td>eg with an icon to click</td>
<td>Design &amp;</td>
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<td>Report</td>
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<td>Ideally, every single question and sub-question would be illustrated by</td>
<td>Future</td>
<td></td>
<td>&amp; New</td>
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<td>front end examples.</td>
<td>Support</td>
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<td>Advis.</td>
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<td>NB: major task</td>
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<td>Cttee</td>
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<tr>
<td>11 Workshops for researchers to practice data</td>
<td>Future</td>
<td>JR &amp; SH</td>
<td>Final</td>
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<td>entry (and make own notes in own language) to facilitate subsequent</td>
<td>Support</td>
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<td>Report</td>
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<td>full data entry.</td>
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<td>&amp; New</td>
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<td>12</td>
<td>Data validity is a key issue. At data entry, the researcher needs to persist all the way down the hierarchy of each question. Then, needs to ask other people to thoroughly check the front end before confirmation. Another workshop training issue.</td>
<td>Future Support</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
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<tr>
<td>13</td>
<td>Editorial control needs to stay in the hands of the researchers responsible for entering the data, and they need to be able to protect themselves from outside, especially political, interference in data content. Overall, the achievement of high repute by the database would help to create a more open operating environment for individuals, while workshops would enable them to share experience and learning.</td>
<td>Future Support</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
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<tr>
<td>15</td>
<td>For advocacy purposes, researchers may need same formats to be able to compare data from different countries, and need to be able to contact and work with other researchers to define new sub-dimensions, for example school health education syllabuses</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
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<tr>
<td>16</td>
<td>Q.1 template, section 5: + and – answers are not fully consistent - refers to support which could imply external, eg for methodology or materials from a higher level, whereas + implies only that it is being done (so in future external support needs to be asked about)</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
</tr>
<tr>
<td>17</td>
<td>Q.2.1: As it currently stands, researchers may legitimately enter non-policy documents despite the section heading. Should read ‘Have national policy documents on health promotion been published?’</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
</tr>
<tr>
<td>18</td>
<td>Q.2.1.10: At the front end, actually having published a document looks less substantive than simply planning to do so. The question should read: ‘Are there specific plans to publish such documents in future?’ and need to add ‘Please state the subject area(s) of the planned document(s)’</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
</tr>
<tr>
<td>19</td>
<td>Q.3.4 should read ‘If no, go to 3.6’ and Q.3.6 should read ‘Are any evaluation reports expected or planned? If ‘yes’, go to a subset. If ‘no’, go to 4. Probably need the same routine at the end 3.1.</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
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<td></td>
<td>Section 3 only asks about the most recent evaluation reports. In future, need to have (i) the most recent overall report, eg Latvia 1998, and (ii) the (up to) 10 most recent other reports, and (iii) archive</td>
<td>Future</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
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<td>20</td>
<td>Q.4 needs to cover monitoring which is not systematic and/or not regular.</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
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<tr>
<td>21</td>
<td>Q.4.4: need to enter document references</td>
<td>&quot;</td>
<td>&quot;</td>
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<tr>
<td>22</td>
<td>Q.4.5 – see action point (AP)5 above. In future, could envisage a drop down menu with different kinds of data source</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
</tr>
<tr>
<td>23</td>
<td>Section 4 needs restructuring in next phase to enable users to reach references to (and where possible to reach the actual) (i) source documents (eg Latvia FinBalt Survey Report or HBSC Report, Finland physical activity monitoring) and via these to reach other reports in the same categories (eg earlier years, other countries’ reports using the same instruments, international comparison reports [such as WHO HBSC report] (iii) overall monitoring reports (ii) synthesis reports, such as Annual Reports on the National State of Public Health.</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>Final Report &amp; New Advis. Cttee</td>
</tr>
<tr>
<td>24</td>
<td>Need the facility to enter &gt;1 URL for apparently unique documents, eg National PH Strategy may be in more than one national language + English translation</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
</tr>
<tr>
<td>25</td>
<td>Section 7: need to define each level of qualification. Perhaps consult EUMAHP about contents of study for Bachelors, Masters etc..</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
</tr>
<tr>
<td>26</td>
<td>Section 9: would it be possible to link researchers to a source of information showing %GDP spent on publicly and privately funded health care (?WHO)</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
</tr>
<tr>
<td>27</td>
<td>? Add organograms and functional descriptions to show Ministry and Ministers, HP National Body and Regional HP institutions and structures</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
</tr>
<tr>
<td>28</td>
<td>? Show the international HP networks to which national institutions are connected + contact details</td>
<td>Future Design</td>
<td>JR &amp; SH</td>
<td>&quot;</td>
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<tr>
<td>29</td>
<td></td>
<td>Future Design</td>
<td>JR &amp; SH</td>
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Annex XI
Copies of the articles published on HP Source
The field of health promotion in the European region is positioned within a diverse framework of a variety of health promotion visions, models and practices, influenced by a wide range of cultural and health environment perspectives. Until now, there has been no systematically assembled, easily accessible electronic database providing comparative information on health promotion policy, infrastructures and practices in the European Union. HPSource is a new on-line database which provides this information to policy makers, researchers and practitioners working on the development and enhancement of health promotion in the European region and beyond.

The database has been compiled with the participation of 24 countries, who have provided data in the following categories:-

- A national overview of health promotion
- Formulation of policy
- Evaluation of policy
- Monitoring of Public Health
- Survey and Research
- Implementation
- Professional workforce
- Professional associations
- Funding

At the click of a mouse, you can access information at national, regional or local levels, and directly access policy or project documents. The added value of HPSource is its capacity to support individual country's efforts and European Community public action as a whole, by making information available from multi-national sources, which would otherwise be inaccessible, undervalued and not amenable to country-by-country comparison.

On September 23, 2003, the International Union for Health Promotion and Education (IUHPE) organised a dinner event at the European Parliament in Strasbourg in honour of the launch of this comprehensive on-line database. In his address to the attendees which included representatives from the European Commission, WHO officials, Members of Parliament, and representatives from other European NGOs, the IUHPE President Maurice Mittelmark presented the audience with a response as to why health promotion, proven as it is, is under-utilised in Europe.

"... a large part of the answer has to do with a need to strengthen policy, infrastructure and practice in virtually all the countries of Europe. You cannot mount and conduct highly effective health promotion if national policy, and commitment at the highest levels, is not optimal. You cannot disseminate effective health promotion practices, if the workforce is inadequately equipped and trained. You cannot achieve constant quality improvement in health promotion technology, if research is under-funded. You cannot practice effective health promotion on all levels from international to the local, if all elements of infrastructure are not linked properly, within countries and between countries. Thus, we have HP Source -- not an answer to the challenges we face, but a mapping of what we have, from which we can learn how to improve and extend the resources needed."

One of the most important outcomes of the development and implementation of HPSource is the mature and tested approach for the collection, verification and dissemination of this data.
The *HPSource* standard exemplifies the establishment of a pedigree for data collection from existing professional networks in order to provide insight into what constitutes effective health promotion infrastructure, policy and practice and to strengthen research capacity in this under-researched area, which is vital for the effectiveness of future investment in health promotion.

It is recognised that the database as it stands is only a starting point, and that the complexities of the health promotion debate, the nuances of health promotion in other sectors and the delivery of health promotion are far from fully captured at this point. On-going work is being done by the project's participants and partners to meet these challenges. For example, future issues to be taken up include: How can data analysis support strategy development and facilitate identification of effective health promotion infrastructure and policy? How can we enhance the efforts of the wider public health workforce in each country to learn about and build on models of good practice?

See the project website at [www.HP-Source.net](http://www.HP-Source.net)
Annex XII
Report of the HP Source Workshop in Perugia
1. Introduction and discussion of prototype database: PA and RL demonstrated how the database works and how the queries relate to the main headings, and asked for feedback from the group. They explained that the database was still being developed, but the first version should be on-line within the next two to three weeks (but only for the national researchers and HP Source team).

2. Feedback from the HP Source researchers: It was clear that question 9 (relating to funding sources) needs to be re-considered as very few people were able to clearly identify and/or disaggregate this information.

UB noted that in Switzerland they had stuck to the 'narrow' (Ottawa Charter) definition of Health Promotion, as requested in the instructions, but she noticed that some other countries had interpreted Health Promotion very widely and included prevention, which in her view weakened the database. She added that the structure was quite difficult for federal systems.

MM suggested that we could refine the database later, but LS pointed out that to start with a broad definition and then narrow it entailed a lot of work which would be wasted, and most countries just don't have the resources for this. He suggested that we should give more guidance in terms of what kind of information should be included.

SH pointed out that we had always worked within the parameters of the Ottawa Charter definitions and that these should continue to be a strong guide.

VS said that she thought that there should be more opportunity for local projects to put their information onto the database.

LS added that it was clear that the infrastructure even to do this exercise did not exist in Portugal and he was nervous that subjective points of view coloured the information that was entered.

AK reassured him that this was the same for everyone. It is meant to be a starting point for discussion and debate, not a presentation of undisputed facts.

SH agreed and said that we could even point out where the issues where contentious. He said that the Home Page would say who had entered the information and why they had been chosen to do so.

3. Standardisation and Quality Control of data: AK discussed with the group the importance of standardising and ensuring that the data entered were capable of comparisons among countries. She began with her ideas for standardising the information in Question 1 (The overview). This was the start of quality controlling the information which would be an ongoing process. She gave out a
template which could act as a guide for Question 1 (See Annex XIII). Any additional information which was not covered by the template could be shifted into Question 10.

The group assessed the template and agreed that they would attempt to standardise their Question 1’s in this way and then feedback their problems, issues and additional ideas to the group.

UB asked how often the data should be updated.

JR said that this was a question of how the database would be maintained in the future but to begin with it could be as often as people wanted, until they were satisfied with the quality of their information.

EF said that it was important not to be too ambitious and that once everyone was satisfied with their data, we could update the information every year.

UB suggested that the management team now needed to set out very clearly what the next steps should be.

LS agreed and suggested that we build a knowledge base that can be built upon.

AK said that by starting the process of quality control and standardisation of the information we could also start to build the knowledge base. She suggested that the researchers start an e-mail group so that they could discuss issues of interest and any problems that arise.

LS also proposed that FAQs and their answers be provided, and also suggested that they might be able to have live chats by internet as well.

SH suggested being able to click to get an explanation of each question/sub-question + a model answer for each.

CJ proposed that the IUHPE help disseminate the researchers’ discussions in order to maybe spark a debate and encourage exchange on the issues and challenges (specifically in terms of those resulting from the standardisation and quality control of data) they are facing in this on-going process. This can be done through any one or all of the IUHPE communication tools - P&E, HPI, HER, etc. All agreed that this was an excellent idea.

JR and SH said that they very much hoped that the researchers and counterparts in the participating countries would very much take over the development of the resource now. The HP Source Team would facilitate this development as far as their current budget and contract allows.

All agreed that the workshop had been interesting and exciting and had left them with a sense of interesting possibilities as regards the usefulness of HP Source as a resource and its future development.
Action

RL and PA to get the database on line to the national researchers as soon as possible so that people can see and check their data as it appears.

AK and EF to set up an e-mail group of researchers, start FAQs and answer page, and initiate the preparation of explanations and model answers for each question/sub-question.

Researchers to work on their Question 1's using AK's template (see Annex XIII)

AK and EF to start the process of researchers working on quality control and standardisation of other questions.

As soon as the database is on line JR and SH to explain to the researchers and counterparts what the next steps should be.
Annex XIII
Template for the Country Overviews
This template is proposed as a framework for completing question one. The aim of the template is to act as a guide that will help develop a common understanding and approach to what we mean by a health promotion/public health system.

The template consists of seven dimensions of the system. For each of these dimensions different countries will have different approaches or will be at different stages of development (range).

Please describe your country’s system with reference to these seven dimensions. Also for each dimension indicate your overall assessment with reference to possible range.

Please return to amanda.killoran@hda-online.org.uk

What statement best describes the situation in your country?

1. **Policy**

Objectives to improve health are part of all relevant government policies.

Objectives to improve health are part of a number of government department policies.

Objectives to improve health are primarily the concern of the health service policies.

2. **Tackling health inequalities**

Health inequalities are a problem and recognized as a priority, and policies are in place for tackling health inequalities

Health inequalities are a problem and recognized as a priority, and policies to address the problem are being developed

Health inequalities are a problem but not regarded as a priority; and policies are limited.

3. **National/regional/local**

Health promotion policy is developed centrally and implemented through central programmes

Health promotion policy is developed at regional/federal level and implemented through regional programmes

Health promotion is developed at a local level and implemented locally

The health promotion policy process is a combination of the 1,2,3. (specify which)

4. **Governance and accountability**

Structures and partnerships exist at national level that provide leadership and are accountable for improving health and tackling health inequalities

Structures and partnerships exist at regional/federal level that provide leadership and are accountable for improving health and tackling health inequalities

Structures and partnerships exist at local level that provide leadership and are accountable for improving health and tackling health inequalities

Structures and partnerships is a combination of 1,2,3.
5. Local strategies

Arrangements are in place locally for the development and implementation of local multi-sectoral health strategies.

Arrangements are being developed to support the development and implementation of local multi-sectoral health strategies.

There are no clear arrangements to support the development and implementation of local multi-sectoral health strategies.

6. Research and development

Policies and programmes are well informed by evidence of needs and what works.

Policies and programmes are informed by evidence of needs and what works.

Policies and programmes are inadequately informed by evidence of needs and what works.

7. Capacity of health promotion/public health function

The arrangements and funding of training and development of health promotion/public health are well established.

The arrangements and funding of training and development of health promotion/public health professionals are being developed.

There are limited arrangements and funding for the training and development of health promotion/public health professionals.
Annex XIV

Outputs from the Briefing Meeting for Members of the European Parliament in Strasbourg
**Participants**

MEPs who attended the dinner

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Nationality</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>BANOTTI, Mary-Elisabeth</td>
<td>Mrs.</td>
<td>Ireland</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>BERNIE, Jean-Louis</td>
<td>M</td>
<td>France</td>
<td>EDD</td>
</tr>
<tr>
<td>BOWIS, John</td>
<td>Mr.</td>
<td>UK</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>BUSHILL-MATTHEWS, Philip</td>
<td>Mr.</td>
<td>UK</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>CORRIE, John Alexander</td>
<td>Mr.</td>
<td>UK</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>DOVER, Densmore</td>
<td>Mr.</td>
<td>UK</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>FLEMMING, Marialiese</td>
<td>Frau</td>
<td>Austria</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>GOODWILL, Robert</td>
<td>Mr.</td>
<td>UK</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>KUZMICKAS, Kestutis</td>
<td></td>
<td>Lithuania</td>
<td>NS/ELDR</td>
</tr>
<tr>
<td>MALLIORI, Minerva</td>
<td>Ka</td>
<td>Greece</td>
<td>PSE</td>
</tr>
<tr>
<td>NEWTON DUNN, Bill</td>
<td>Mr.</td>
<td>UK</td>
<td>ELDR</td>
</tr>
<tr>
<td>PRITCHARD, Stuart</td>
<td>Mr.</td>
<td>Bowis' office UK</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>READ, Mel</td>
<td>Ms.</td>
<td>UK</td>
<td>PSE</td>
</tr>
<tr>
<td>ROD, Didier</td>
<td>M</td>
<td>France</td>
<td>VERTS</td>
</tr>
<tr>
<td>ROVSING, Christian</td>
<td>Mr.</td>
<td>Denmark</td>
<td>EPP-ED</td>
</tr>
<tr>
<td>SANDBÆK, Ulla</td>
<td>Fru</td>
<td>Development Denmark</td>
<td>EPP-ED</td>
</tr>
</tbody>
</table>

**VIP attendees:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BJORNESTAD, Paal</td>
<td>Mr.</td>
<td>Second Secretary; Mission of Norway to the EU</td>
</tr>
<tr>
<td>BROWN, Chris</td>
<td>Ms.</td>
<td>Tech. Off. for HP WHO/EU</td>
</tr>
<tr>
<td>CASAS, Juan Antonio</td>
<td>Mr.</td>
<td>Sr Ext. Relat. Officer, WHO office at EU</td>
</tr>
<tr>
<td>MIERZEWISKI, Piotr</td>
<td>Dr.</td>
<td>Council of Europe-European Health Committee</td>
</tr>
<tr>
<td>RYAN, John</td>
<td>Mr.</td>
<td>Health and Consumer Protection</td>
</tr>
<tr>
<td>TAMMINIEMI, Kaarina</td>
<td>Ms.</td>
<td>EuroHealthNet</td>
</tr>
</tbody>
</table>

**Project team member attendees:**

- AHERN, Phil
- HAGARD, Spencer
- JONES, Catherine Marie
- KILLORAN, Amanda
- KOK, Henriette
- LINS, Andrea
- LUNDGREN, Bernt
- MITTELMARK, Maurice
- O'DONOGHUE, Shane
- PERRY, Martha Wright
- PHILLIPS, Rosemary Ann
- ROBINSON, Jaqueline
- REEMAN, Helene
Ladies and Gentlemen,

It is with great pleasure that I accepted the invitation to come here this evening. This presentation of the new database on health promotion policies developed by the International Union for health promotion, the London School of Hygiene and Tropical Medicine, the NHS Development Agency and University of Bergin co-funded under the Community public health programme, is an important occasion to recall the significance of health promotion as part of the EU Public health activity.

The Health Promotion Programme of the EU ran from 1996 to 2001 with an annual budget of 7M€, and from 2001 to 2003 with an annual budget of 7.26M€ per annum. The general aim of the programme was to improve the general state of health within the Community by improving knowledge about risk factors, with a view to empowering people to apply healthy choices and lifestyles. The programme also aimed at supporting inter-sectoral approaches, taking account of socio-economic factors and the physical environment.

Priority areas in a issue related approach were alcohol, nutrition, cardiovascular disease, physical activity, mental health, and Osteoporosis. As priority settings were chosen schools, workplaces, metropoles, and health establishments. The approaches of training and technical development using for example modern web based technologies were also included. One of the major outcomes was the support given to the creation and development of the various European health promotion networks, such as those in the field of mental health, on workplace health promotion, on schools, on capital cities, for heart health, and for health policy advocacy.

Even though the Commission services have striven recently to publicise the results of pan European projects, and to provide information on the activities of our networks on the EUROPA web-server, and through publications made available at conference information stands and in other diffusion initiatives, it is clear that the vast majority of the public and of interested persons do not have easy access to European level public health information. That is one of the major challenges in the new EU public health programme, which came in
to place in January 2003 for a six year period. The health information strand of the new programme is already in the implementation phase. It consists of several new approaches which I would like to outline briefly. Firstly, we have reinforced the involvement and commitment of the Member States in the health information field by creating a network of competent authorities which will meet twice yearly to approve the health information initiatives to be taken. Secondly, we have regrouped all existing and future projects into working parties in order to ensure continuity and coherency. These include working parties on injuries, morbidity, rare diseases, mental health and lifestyles. The idea is that these working parties will progress work on developing indicators and facilitating the making available of data and information on the areas under their responsibility. On the other side, the diffusion of information is to be reinforced under the information strand of the new programme through the creation of an EU Public Health Portal, through the launch of a series of regular health status reports, and through other information initiatives such as the co-operation with WHO on their “Health Evidence Network”.

In the third strand of the new programme, dealing with Health determinants, much of the work developed in the health promotion field, but also in other programmes such as those dealing with drug prevention, AIDS, cancer, and pollution related diseases will be taken forward. I am sure that the comprehensive database of health promotion policies, infrastructures and practices which is launched here tonight will be a useful resource for the future, especially in order to help newcomers and especially accession and candidate countries, to find project partners and to consider existing expertise. As soon as the final version is available and has been approved by the Commission at the end of the contractual process, it may be useful to see if the tool can be linked to the Commission Europa server in order to make it available to a wider audience.

Thank you again for your attention, and congratulations on this launch initiative which has given some welcome focus on health promotion in the European Parliament setting.
Setting the Stage for HP Source

Professor Maurice B. Mittelmark, President, IUHPE

In a few moments, Professor Spencer Hagard will brief you on the HP Source project that is the focus of this evening’s gathering. My task is to set the stage for him, and I wish to do that by saying a few words about the key mileposts in the field of public health policy that led to the idea for the HP Source project.

At the Alma Ata Conference in 1978, the WHO launched the global collaboration Health For All in the 21st Century. This was a reaffirmation of commitment to the proclamation in the Constitution of the World Health Organisation, that the highest attainable standard of health is a fundamental human right of every human being.

The field of health promotion was forged as a tool to help us achieve Health For All, by melding two strategies that had previously been underdeveloped and poorly connected:

- Provide the people with knowledge to empower them to take control over their own health situation.
- Develop policies in all sectors of society to create healthy living conditions.

Twenty-two years later, on January 18, 2000, I had the pleasure to participate in a dinner-discussion with Members of Parliament of the European Union, in this marvellous building. The dinner included a number of the Members present this evening, and it was hosted, then as now, by a health promoter named John Bowis.

That evening, we announced the completion of a project in which evidence of health promotion’s effectiveness had been summarized in two books, with foci on the positive health, social, economic and political impacts that can be achieved when the health promotion strategy is applied with rigor and with seriousness.

My talk that evening included a description of the health promotion technologies that had been developed and perfected over the two decades since Health For All was launched. I ended by posing this question: why is health promotion technology, proven as it is, underutilised in Europe?

Already then, it was clear that a large part of the answer had to do with a need to strengthen policy, infrastructure and practice in virtually all the countries of Europe. You cannot mount and conduct highly effective health promotion if national policy, and commitment at the highest levels, is not optimal.

You cannot disseminate effective health promotion practices, if the workforce is inadequately equipped and trained. You cannot achieve constant quality improvement in health promotion technology, if research is underfunded. You cannot practice effective health promotion on all levels from international to the local, if all elements of infrastructure are not linked properly, within countries and between countries.

Thus, we have HP Source -- not an answer to the challenges we face, but a mapping of what we have, from which we can learn how to improve and extend the resources needed to achieve Health for All in the 21st Century.

And my brief history of health promotion ends, not because the story is finished, but because it falls naturally, and it falls best, to Professor Spencer Hagard to tell the rest of the story…
Feedback about the briefing meeting at the European Parliament:

"The opportunity to discuss in-depth the further development of HP Source with key parliamentarians was invaluable, since projects like this must meet the practical needs of decision makers. The insightful comments and advise we received will certainly inform our expansion of HP Source, as we work to include all European countries in this health promotion infrastructure data base."

Maurice Mittelmark
IUHPE President

"At our table we discussed the amount of money that goes to health promotion which is a tiny little bit compared to the amount that goes to health care. So our statement was that Health Promotion should be more on the National and European agenda. HP Source can certainly contribute to this by showing useful information about HP."

Henriette Kok
The Netherlands Institute for Health Promotion and Disease Prevention

"I think it is very important that the data will be updated regularly and that the work in the HP-Source-Project with Spencer Hagard and Jackie Robinson can continue. Then the database can become an important tool for health promoters all over Europe. The dinner in Strasbourg was an excellent event to celebrate one big step of the database-project."

Andrea Lins
Annex XV
Contact List
## National Counterparts, Researchers and Advisors

<table>
<thead>
<tr>
<th>Country</th>
<th>Counterpart</th>
<th>Researcher(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Andrea Lins</td>
<td>Andrea Lins (address as opposite) Dr. Wolfgang Dür Ludwig Boltzmann-Institute for the Sociology of Health and Medicine Rooseveltplatz 3/1 A-1090 Wien E-mail: <a href="mailto:wolfgang.duer@univie.ac.at">wolfgang.duer@univie.ac.at</a></td>
</tr>
<tr>
<td>Belgium - Flemish</td>
<td>Stephan Van den Broucke PhD Head of Research Flemish Institute for Health Promotion Gustave Schildknechtstraat 9 B-1020 Brussels Tel. +32 (0) 2 422 4949 Fax: +32 (0) 2 422 4959 Email: <a href="mailto:stephan.vandenbroucke@vig.be">stephan.vandenbroucke@vig.be</a> Website <a href="http://www.vig.be">http://www.vig.be</a></td>
<td>Veerle Stevens Flemish Institute for Health Promotion Gustave Schildknechtstraat 9 B-1020 Brussels Tel. +32 (0) 2 422 4949 Fax: +32 (0) 2 422 4959 Email: <a href="mailto:veerle.stevens@vig.be">veerle.stevens@vig.be</a></td>
</tr>
<tr>
<td>Belgium - French</td>
<td>Professor Danielle Piette Health Education &amp; Promotion Unit (ULB-PROMES) School of Public Health Free University of Brussels (ULB) Route de Lennik 808 CP596 B.- 1070 Bruxelles BELGIUM Tel: +32 (0) 2 555 40 81 Fax: +32 (0) 2 555 40 49 Email <a href="mailto:dpiette@ulb.ac.be">dpiette@ulb.ac.be</a> Web-site: <a href="http://www.ulb.ac.be/esp">http://www.ulb.ac.be/esp</a> <a href="http://www.ulb.ac.be/esp/promes">http://www.ulb.ac.be/esp/promes</a></td>
<td>Charlotte Lonfils Email: <a href="mailto:sipes.promes@ulb.ac.be">sipes.promes@ulb.ac.be</a></td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Jana.Havelkova <a href="mailto:Jana.Havelkova@izpe.cz">Jana.Havelkova@izpe.cz</a></td>
<td>Jana Havelkova (address as opposite)</td>
</tr>
<tr>
<td>Denmark</td>
<td>Kristin Gudnason <a href="mailto:KGU@SST.DK">KGU@SST.DK</a></td>
<td>Kristin Gudnason</td>
</tr>
<tr>
<td>Finland</td>
<td>Dr. Harri Vertio Director Finish Centre for Health Promotion Karjalankatu 2 C 63 FIN- 00520 Helsinki Finland Tel: +358 9 725 30300</td>
<td>Arja Rimpelä Kansanterveysliitoksen professori Terveysliitoksen laitos FIN-33014 Tampereen yliopisto Tel +358 3 2156802 Fax +358 3 2156057 Mobile +358 50 5698285</td>
</tr>
<tr>
<td>Country</td>
<td>Name</td>
<td>Address</td>
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</tr>
<tr>
<td>France</td>
<td>Pierre Arwidson</td>
<td>2, Rue Auguste Comte 92170 Vanves, France</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Helene Reemann</td>
<td>Bundeszentrale für gesundheitliche Aufklärung (BzgA) Ostmerheimerstr. 220 D – 51109 Köln</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Greece</td>
<td>Yannis Tountas</td>
<td>ISPM Alexandroupoleos 25 115 27 Athens Greece</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iceland</td>
<td>Anna Björg Aradóttir</td>
<td>Email: <a href="mailto:annabara@landlaeknir.is">annabara@landlaeknir.is</a></td>
</tr>
<tr>
<td>Ireland</td>
<td>Margaret Barry</td>
<td>Department of Health Promotion National University of Ireland, Galway Galway Ireland</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>Prof. dr. Lamberto Brizarelli</td>
<td>Italian Committee for Health Education c/o Exp. Center for Health Education</td>
</tr>
<tr>
<td>Country</td>
<td>Name</td>
<td>Contact Details</td>
</tr>
<tr>
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<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td>Latvia</td>
<td>Ineta Pirktna</td>
<td>Director, Health Promotion Centre Skolas Str.3 LV1010 Riga Latvia Tel: +371 724 0446 Mobile: +371 946 0359 Fax: +371 724 0447 e-mail: <a href="mailto:vvc@parks.lv">vvc@parks.lv</a></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Dr. Yolande Wagener</td>
<td>Direction de la Santé Div. de la Medecine Preventive et Sociale Villa Louvigny L-2021 Luxembourg, Luxembourg Tel: +352 4785544 Fax: +352 467527 Email: <a href="mailto:yolande.wagener@ms.etat.lu">yolande.wagener@ms.etat.lu</a></td>
</tr>
<tr>
<td>Netherlands</td>
<td>Gerard Molleman</td>
<td>Director, Netherlands Institute for Health Promotion and Disease Prevention P.O. Box 500 3440 AM Woerden, The Netherlands Tel: +31 348 437600 Fax: +31 348 437666 Email: <a href="mailto:gmolleman@nigz.nl">gmolleman@nigz.nl</a></td>
</tr>
<tr>
<td>Norway</td>
<td>Maurice Mittelmark</td>
<td>Research Centre for Health Promotion University of Bergen Christiegt.13 N-5015 Bergen Norway Tel: +47 55 58 32 51 Fax: +47 55 58 98 87 Email: <a href="mailto:maurice.mittelmark@psych.uib.no">maurice.mittelmark@psych.uib.no</a></td>
</tr>
<tr>
<td>Portugal</td>
<td>Isabel Loureiro</td>
<td>National School of Public Health Tel: +351 217512158 (ENSP) Email: <a href="mailto:isalou@ensp.unl.pt">isalou@ensp.unl.pt</a></td>
</tr>
<tr>
<td>Spain</td>
<td>Begoña Merino Merino</td>
<td>Rosana Peiró Pérez</td>
</tr>
</tbody>
</table>
| Consejera Técnica  
Coordinadora del Área de Promoción de la Salud  
Ministerio de Sanidad y Consumo  
Subdirección General de Promoción de la Salud y Epidemiología  
Paseo del Prado 18-20  
28071 MADRID (España)  
Tel: +34 91 5964194 / 5964276  
Fax: +34 91 5964195  
Email: bmerino@msc.es | Unidad de promoción de Salud  
Centro de salud pública de Alzira  
(Comunidad Valenciana)  
email:peiro_ros@gva.es  
Carmen Fernandez García.  
Coordinadora de la unidad de promoción de salud  
Centro de Salud Pública de Alzira  
(Comunidad Valenciana)  
E-Mail: carmen.fernandez@sanidad.m400.gva.es  
Dr José-Manuel Freire  
Director-Gerente  
Centro Oncológico MD Anderson I. España  
Gómez Hemans, 2 ES-28033 MADRID  
Tel: +34 917680682  
Mobile: +34 696949276  
Email: jmfreire@mdaie.es |
|---|---|
| **Sweden**  
Bosse Pettersson,  
Head  
National Institute of Public Health  
International Relations  
Olof Palmes Gata 17  
S-10352 Stockholm,  
Sweden  
Tel: +46 8 5661 3515  
Fax: +46 8 5661 3601  
Email: bosse.pettersson@fhi.se | **Sweden**  
Bernt Lundgren  
Public Health Planning Manager  
National Institute of Public Health  
International Relations  
Olof Palmes Gata 17  
S-10352 Stockholm,  
Sweden  
Tel: +46 8 5661 35 40  
Fax: +46 8 5661 3601  
Email: bernt.lundgren@fhi.se  
Ewy Thornqvist:  
E-Mail: Ewy.Thornqvist@fhi.se |
| **Switzerland**  
Ursel Broesskamp, MPH  
Head International Affairs  
Health Promotion Switzerland  
Dufourstrasse 30  
P.O. Box 311  
CH-3000 Bern 6  
Tel: +41 31 350 04 04  
Direct: +41 31 350 04 25  
Email: ursel.broesskamp@promotionsante.ch  
Frau Dr.med. Stutz Steiger Therese  
Bundesamt für Gesundheit  
Fachstelle für öffentliche Gesundheit  
Postfach  
3003 Bern  
E-mail: therese.stutz@bag.admin.ch | **Switzerland**  
Henry Wyes  
Juffersland 31  
NL-3956 TS Leersum  
E-Mail: wyes@wxs.nl |
| UK - England | Maggie Davies, Programme manager  
Health Development Agency  
Holborn Gate  
High Holborn  
London  
WC1V 7BA  
Tel: + 44 (0) 20 7061 3012  
Email: Maggie.Davies@hda-online.org.uk | Amanda Killoran  
Health Development Agency  
Holborn Gate  
High Holborn  
London  
WC1V 7BA  
Tel:  
Email: Amanda.Killoran@hda-online.org.uk |
| UK - Scotland | Graham Robertson  
Chief Executive  
Health Scotland  
Woodburn House  
Canaan Lane  
Edinburgh E10 4SG  
Tel: +44 (0) 131 536 5500  
Fax: +44 (0) 131 536 5501  
Email: graham.robertson@hebs.scot.nhs.uk | Jill Muirie  
Public Health Project Manager  
Health Scotland  
Clifton House  
Clifton Place  
Glasgow G3 7LS  
Tel: 0141 300 1023  
Email: jill.muirie@phis.csa.scot.nhs.uk |
| UK- Wales | Peter Farley  
Health Promotion Division  
Welsh Assembly Government  
Cathays Park  
Cardiff CF10 3NQ  
Tel: +44 29 2082 5995  
Email: peter.farley@wales.gsi.gov.uk | Chris Roberts and Angela Clements  
Address as opposite  
Tel: +44 29 82 6543 (CR)  
Tel: +44 29 82 6541 (AC)  
Emails:  
Chris.Roberts@wales.gsi.gov.uk  
Angela.Clements@wales.gsi.gov.uk |
| UK- Northern Ireland | Brian Gaffney  
Health Promotion Agency for Northern Ireland  
18 Ormeau Avenue  
Belfast  
Email: b.gaffney@hpani.org.uk  
DrBG@hpani.org.uk | Brian Gaffney (address as opposite) |

Many thanks to our advisors:

Erio Ziglio/ Chris Brown  
Head of Office  
WHO European Office  
Investment for Health and Development  
6074 Campo Santa Marina  
I-30122 Venice (Castello)  
Italy  
Tel: +45 23 23 49 72  
Email: ezi@ihd.euro.who.int  
chb@ihd.euro.who.int

Joana Godinho  
World Bank  
International Development Association  
1818 H Street N.W  
Washington D.C. 20433  
U.S.A.  
Tel: + 1 202 477-1234  
Email: Jgodinho@worldbank.org

Catherine Jones  
Communications and Development Manager  
International Union of Health Promotion and Education

Caroline Costongs and Clive Needle  
European Network of Health Promotion Agencies
Horst Kloppenburg  
European Commission  
Directorate-General Health and Consumer Protection  
Unit G3  
Euroforum Building  
10 Rue Stumper - Office EUFO 3182  
L-2557 Luxembourg  
E-mail: horst.kloppenburg@cec.eu.int

John Kenneth Davies  
Faculty of Health  
University of Brighton  
Falmer, Brighton, BN1 9PH, United Kingdom  
Tel: +44 (0)1273 643476  
Email: J.K.Davies@brighton.ac.uk

Dominic Harrison  
Health Development Agency, North West Regional Office,  
Public Health Development Unit,  
C Floor, Bowland Tower East,  
Alexandra Square,  
Lancaster University,  
Lancaster, LA1 4YT  
Dominic Harrison  
Home / Office telephone and fax: 01524 812 316  
E-mail: dominic@blueskies.enta.net

Others who have contributed to and participated in the project:  
Constantino Theodor Sakellarides: sak@ensp.unl.pt  
Marie-Claude Lamarre: mclamarre@iuhpe.org  
X. Tzimoula: X.Tzimoula@bton.ac.uk
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