The Development of a European Health Promotion Monitoring System (The EUHPID Project)

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EUHPID Secretariat
John Kenneth Davies, Project Manager
Caroline Hall, Research Officer
Eleanor Linwood, Administrative Assistant
on behalf of the EUHPID Consortium

University of Brighton

International Health Development Research Centre
Faculty of Health
University of Brighton
Falmer, Brighton, BN1 9PH
United Kingdom

Previous members of the Secretariat

Belen Sanchez, Research Officer (from 5 June 2002 – 31 October 2002)
Chloe Hill, Research Officer (from 5 January 2003 - 17 October 2003)
Xanthippe Tzimoula, Research Assistant (from 27 May 2002 – 30 January 2004)
Sue Ginn, Senior Administrative Officer (from 22 May 2002 – 30 May 2003)
Antje Stowesandt, Administrative Assistant (from 29 September 2003 – 30 January 2004)

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Executive Summary

This Report presents recommendations for the development of a European Health Promotion Monitoring System based on sets of common health promotion indicators. It is the result of the work of the EUHPID Project financed by the European Commission DG SANCO under the Health Monitoring Programme. The EUHPID Consortium, which carried out this work, consisted of experts from the Member States of the EU, together with colleagues from Norway and Switzerland, as well as from the principal international professional association – the International Union for Health Promotion and Education.

The EUHPID Project focussed its work on contributing to, and improving, the European Community Health Indicators (ECHI) framework. In particular, it sought to strengthen the framework by making it more holistic and comprehensive through the inclusion of more salutogenic perspectives, based on health capacities and health opportunities at individual and environmental levels. The Project emphasised the complexity of health promotion as a major intervention tool that not only works at individual level but also at group, community and societal levels. It established a health development model to set the context, not only for health promotion as an intervention tool, but also for interventions based on health services and related forms of delivery. This health development perspective, adopted as a context for the Community Health Monitoring System, strengthens the ECHI indicator framework as a flexible and effective tool, not just for monitoring, but also for planning effective interventions at both Community and Member State levels.

The health development model which underlies the EUHPID Health Promotion Model and Monitoring System is offered as a major contribution to the public health field, and to the ECHI framework in particular, as a policy relevant focus for public health development at both Community and Member State levels. It enables the EC Health Information and Advisory System to form an active monitoring and planning tool for intervening in health development.

It is recommended that Class 4 of the ECHI framework is changed to form 'Health Interventions: Health Services' (to include health care and disease prevention), and a new Class 5 is created, entitled 'Health Interventions: Health Promotion'. The new Class 5 will initially be comprised of the following core indicator sets:

- 'Integrated Settings' and
- 'Health Promotion Policy & Practice'

These indicator sets are currently included in the recommended ECHI-2 short list of core indicators.

Demonstration examples of the integrated settings indicators are provided in the Report in relation specifically to the following key settings – work place, school and hospital. It is important that operational data is collected for these integrated settings by further strengthening EUHPID's established links with European networks active in these settings. In particular with the European Network of Health Promoting Schools, the European Network of Workplace Health Promotion and the European Network of Health Promoting Hospitals. (The latter forming an important development interface between the proposed Class 4 and Class 5).

Examples of areas related to health promotion policy and practice indicator sets are included in the Report, with a clear recommendation that data for these indicators be collected at Member State level in conjunction with the HP Source tool and database.

It has been clear from the inception of this work, that this is a development area and further work is recommended on the development of Class 5 (to include, in due course, indicators related to 'Health Protection') and on the further development of a Health Promotion User Window. The latter will enable the broader concept of health promotion to be integrated across the whole ECHI framework of indicators to enable active planning and monitoring of its impact on the determinants and priority areas of public health.

The complexity of the task begun by the EUHPID Project is detailed in the Report, which in no way represents a final stage. From a policy point of view it is essential that EUHPID should continue this process of developing the health promotion monitoring system linked into a comprehensive European Community Indicator System based on the health development model. It is recommended that this can be best achieved by EUHPID combining with ECHI, HP Source and other interested colleagues to make a corporate proposal to DG SANCO to further streamline and fine tune the ECHI system over the next two years. This will enable it to form the engine for the European Health Information and Advisory System, and relate it also to the needs of all the Member States, including the Accession and Candidate Countries.

Introduction

The European Union (EU) gained competency for the first time in the area of public health through Article 129 of the Maastricht Treaty in 1993. This competency was expanded by Article 152 of the Amsterdam Treaty. In 1995 a Health Monitoring Programme was proposed for the first time as part of the EU Public Health strategy. This Programme came into operation in 1998 with a budget of 13.8m euros and had three main pillars:

- A system of community-wide health indicators
- A community-wide network for sharing and transferring health data between Member States
- An emphasis on methods and tools for analysing health status, trends, and determinants to inform policy

The EC Health Monitoring Programme had the goal of establishing a European health information and knowledge system as a policy tool to be used at European Community, national and regional levels. One of its main functions was to contribute to the information and knowledge base necessary to support the new EC Public Health Programme during the period from 2003-2008. This Programme has three strands:

- Improving health information and knowledge
    - By comprehensive health information systems

- Responding rapidly to health threats
  - Such as communicable diseases
- Addressing health determinants – across all policies & activities
  - Through best practice in effective health promotion & disease prevention measures

Strand 1 of this Programme is underpinned by a series of key principles:

- To act as a policy tool at Community, national & regional levels
- To contribute directly to the information & knowledge base of Strands 2 and 3
- To ensure information and knowledge for comparative international comparisons through continuous improvement of data
- To form a comprehensive single system for use in the EU area, including the applicant countries
- To emphasise European Community-added value.

Therefore Strand 1 has the goal of developing and operating a sustainable health monitoring system for the collection, analysis and dissemination of relevant information on health at Community and Member State levels. It includes information on health status, health determinants and health policies. The latter information is particularly important in developing criteria and methods for monitoring and

evaluating health policy developments in public health and in other Community policies.

It is intended by the EC that the various projects funded under the Health Monitoring Programme, and the indicators they recommend, must be brought together to form a single system for use in the European Community, including Member States and Accession Countries. Therefore the European Community Indicator (ECHI) framework was established to propose such a common framework to provide a comprehensive approach to indicator classification.

During the period from 1998 – 2001 the Health Monitoring programme funded 37 Pan-European projects covering a wide range of health issues. One of the last projects to be funded under the 2001 annual work plan was a project to establish a European Health Promotion Monitoring System, which has become known under the acronym of the EUHPID Project (see Appendix 1).

Aims & Objectives

The overall aim of the EUHPID Project is to improve the promotion of health through the development of a common data set of European health promotion indicators. It seeks to benefit from the value-added aspects of a Pan-European perspective to ensure identification of best practice to ensure more effective and efficient application of health promotion policies and programmes. Indirectly the EUHPID programme will seek to develop and reinforce the European conceptualisation and operationalisation of health promotion.

The specific objectives are:

To establish a European Health Promotion Monitoring System, including a set of common health promotion indicators

- Review and analysis of current systems and indicators used in all Member States for health promotion
- Review and analysis of current international work in the area of health promotion indicator selection and definition
- Recommend a common system of health promotion indicators that meet specific criteria related to quality, comparability, language, timeliness, and comprehensiveness, with particular regard to European added-value

To recommend suitable methodology and systems to collect the above data on health promotion indicators and activate the monitoring system

- Review and analysis of current methodological and data gathering systems regarding health promotion in member states and results of international collaborative work in this area
- Exploration of commonalities in data collection, examples of good practice and development needs

To recommend dissemination strategies to policy makers and practitioners at Community level and within Member States

- To establish links to Community Health Monitoring System
- To consider the need for flexibility regarding the continuous development of indicators and changing priorities at policy level
- To explore options for piloting the system of indicators in practice to obtain feedback

EUHPID Infrastructure & Working Practices

A group of health promotion experts from the European Union and Norway was constituted to form the EUHPID Consortium. These health promotion experts are from the following countries – Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, Sweden, and the United Kingdom, together with a representative from the International Union for Health Promotion & Education; and colleagues from Switzerland (under their own funding). The Consortium members are listed in Appendix 2. The inaugural meeting of the EUHPID Consortium took place in Brighton in February 2002 (see Appendix 3a), with subsequent meetings held in London (see Appendix 3b), in Lisbon (see Appendix 3c), Perugia (Appendix 3d) and Brighton in January 2004 (Appendix 3e). Where members were unable to attend due to other commitments, representatives participated on their behalf (see Appendix 4 – for details of dates and participants of EUHPID Consortium meetings).

In addition to the above Consortium meetings, a series a smaller technical working group meetings were held in Copenhagen and Vienna, and in Bern and Zurich (the latter supporting the attendance of 3 and 2 EUHPID representatives respectively, in each case with approval from EC).

The work of the Consortium was assisted by inviting external specialists on occasion to attend Consortium meetings (Dr Noll in Lisbon) and by the University of Brighton initiating 2 consultancy contracts with Professor Goepel (Germany) and with Dr Bauer (Germany).

The Project has been managed and administered by a small part-time Secretariat based in the Faculty of Health at the University of Brighton. This Secretariat consisted of a Project Manager, a Research Officer, a Research Assistant and an Administrative Assistant (the latter linking with a Senior Administrative Assistant both posts funded across the EUHPID Project and the EUMAHP Project – which is also managed and administered by a Secretariat based at the University of Brighton). The inevitable delays in getting the Project established and up to full speed (ie appointing appropriate staff, arranging accommodation, establishing Consortium and related working practices) are reflected in the Project timescale. The support research and administrative staff did not formally take up their posts until May - July 2002 and as a result two amendments to the EUHPID Contract were approved formally by the EC. These extended the Project by 9 months, allowing costs against the EUHPID Budget to be incurred until 31 January 2004 with final report submission deadline of 1st May 2004.

EUHPID Communication Network

Outside Consortium meetings effective on-going communication is maintained between Consortium members and the Secretariat in Brighton by means of email and the establishment of a members' only list serve, which has been built into the EUHPID web-site.

1. **To establish a European Health Promotion Monitoring System, including a set of common health promotion indicators.**

Health Promotion Indicator Review

A questionnaire was designed and despatched to all EUHPID colleagues in order to ascertain relevant indicator work in Member States, at European level and, where appropriate, being carried out at global level. It was also circulated to colleagues in the former European Network of Health Promotion Agencies, which represented many national agencies active in health promotion practice. The findings, together with a more substantive review of the literature specifically related to health promotion indicators, has been documented in a major international review of health promotion indicators (see Appendix 7). This review also included an analysis of health promotion indicator work related to the international social indicator movement, the World Health Organisation (WHO) Health Promotion movement, health promotion performance indicators, related Canadian and international projects, health promotion settings (Healthy Cities /Communities, Healthy Schools, Healthy Worksites, for example), and contemporary European work.

The results of this review identified firstly the dearth of agreement on a common definition of health promotion indicators and secondly, the lack of availability of regularly collected data on health promotion indicators at Community or Member State levels.

European Public Health Policy Context

As EUHPID is clearly linked to policy development to facilitate effective health promotion interventions, an analysis of the context of contemporary European public health policy was carried out and documented in a EUHPID working paper (see Appendix 8). This established the need for a Pan-European health promotion strategy to ensure maximum added-value from the wide range of health promotion networks active in Europe. It highlighted the important role that an effective Pan-European health promotion monitoring system and common set of indicators could play in ensuring effective and efficient health promotion practice.

European Community Health Indicator (ECHI) Framework

EUHPID's work on the development of health promotion indicators needed to fit into the ECHI framework, which was already being established on behalf of the EC as the core indicator framework. The major challenge for EUHPID was to examine, and make decisions on, the location of health promotion within the ECHI framework at that stage of its development. The EUHPID Consortium initially considered that the ECHI framework had three major limitations with regard to EUHPID's work:

1. it did not make evident a clear underlying model for its classification and selection of indicators
2. it focused mainly on the medical/physical domain
3. it had a very narrow conception of health promotion, seeing it as health education and setting it firmly as part of the health service system.

The framework offered by the ECHI Project (Kramers, P 2003) sought to define the areas of data and indicators to be included in the system, following a set of explicit criteria, define generic indicators in these areas and subsets of indicators. The ECHI-1

report (ECHI 2001) defined health as ‘a broad issue’ and wanted the health indicator set to ‘constitute a balanced collection, covering all the major areas within the field of public health’. It divided the main categories of the ECHI indicator set as follows:

- **Demographic & socio-economic factors**
  - **Population**
  - **Socio-economic factors**
- **Health status**
  - **Mortality**
  - **Morbidity disease-specific**
  - **Generic health status**
  - **Composite health status measures**
- **Determinants of health**
  - **Personal & biological factors**
  - **Health behaviours**
  - **Living and working conditions**
- **Health services & health promotion**
  - **Prevention, health protection, health promotion**
  - **Health care resources**
  - **Health care utilisation**
  - **Expenditure & financing**
  - **Health care quality**

According to the final report on the ECHI-1 Project, the designers of the ECHI indicator set based these main categories on considerations of conceptual (logical)

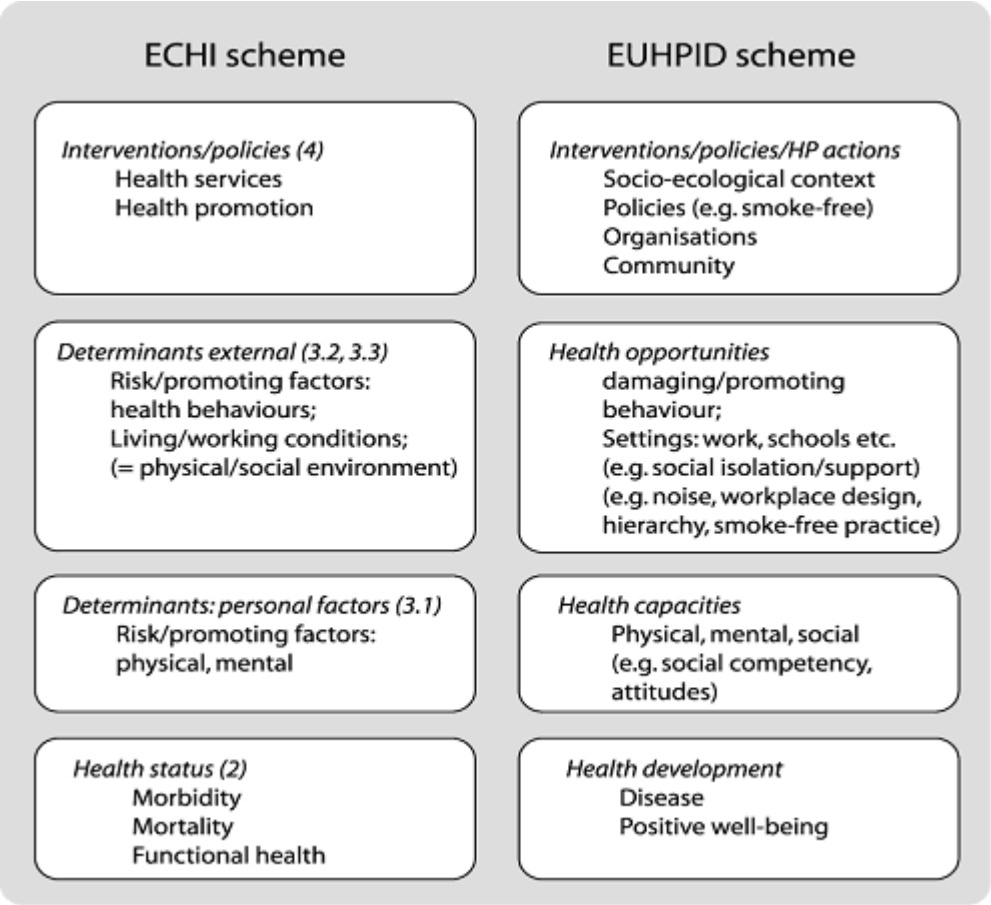
coherence; an optimal consensus among the classifications used by other international organizations; and new developments in public health monitoring.

The challenge therefore faced by the EUHPID Consortium was initially to attempt to establish health promotion indicators within the context proposed by the ECHI framework.

The paradigm underpinning the ECHI framework is the traditional bio-medical/epidemiological/ individual risk factor approach, which has a very narrow conception of health promotion – actually meaning health education. It perceives health promotion as one topic that is part of the health care system and therefore set narrowly within the health services sector as a tool of preventive medicine. The rationale for this construction may relate to uncertainty in the minds of the framework designers as to the scope and purpose of health promotion. It does not reflect internationally accepted best practice in health promotion (WHO 1986) nor that health promotion provides a distinctive perspective on health and a distinctive approach to improving health (Davies & Macdonald 1998; Naidoo & Wills 2000; Nutbeam 2001; Tones & Tilford 2001; Rootman et al 2001; Bunton & Macdonald 2002).

Following detailed dialogue between EUHPID and ECHI colleagues, agreement was reached on the conceptual links between the EUHPID and ECHI frameworks. Table 1 reflects the interrelationship between the two frameworks.

TABLE 1- Relationship between EUHPID & ECHI Frameworks



Two outcomes are recommended regarding EUHPID's position in relation to the ECHI framework:

Firstly, Table 1 reflects the importance and relevance of relating the broad concept of health promotion (or in more practical terms – a EUHPID/Health Promotion User Window) to all the classes of the ECHI framework.

Secondly, taking the dynamic perspective offered by the health development process, Class 4 of the ECHI framework (which was originally referred to as 'Health Systems'), should be entitled 'Health Interventions' (in the health development process). Further this new classification should be divided into 'Health Interventions: Health Services' (Class 4) and 'Health Interventions: Health Promotion' (Class 5).

The above two recommendations are fundamental to setting the EUHPID system and indicators into the enhanced ECHI Framework and this will be revisited in the detailed recommendations on practical indicators, in particular related to the ECHI Core Indicator Short List (Appendix 11).

EUHPID Working Groups

In order to efficiently carry out their complex task, Consortium members were allocated into 3 Working Groups in order to effectively cover the key perspectives in health promotion indicator development. In practice all three approaches have to be combined in order to arrive at measurable, meaningful indicators which are considered in the policy making process. These related to theory-driven; practice-driven and data-driven perspectives respectively, as follows:

- Theory Working Group
    - The theory-driven approach starts from a clear definition of the phenomenon of interest and develops a more detailed theory of it.
    - The conclusions of EUHPID's comprehensive review of health promotion indicators (Appendix 7) highlighted the need for development of a comprehensive working model within the context of a wide perspective of (new) public health

- The theory working group focussed their attention on the development of the EUHPID Health Promotion Model, as a common framework, based on a socio-ecological perspective, from which to develop health promotion indicators. The Working Group sought detailed feedback in order to consolidate the Model, clarify links between concepts and refine the subcategories included in the Model. They then joined in the synthesis process described above to produce demonstration examples of indicators.
- The working group has also focussed its attention on producing two papers for external publication (the first has been published in the *European Journal of Public Health* – see Appendix13; and a second final paper is being developed for publication, for probable submission to *Health Promotion International*)

- Health Promotion Policy & Practice Working Group

  The policy-driven approach develops indicators for those phenomena which are currently on the political agenda and for which data are requested by policy makers. Work focused on the development of indicators that can be used in various settings, building on and linking with the work already identified in the EUHPID Indicator Review. This work utilised existing indicators but also identified gaps and the need for new indicators. The work group incorporated full consideration of the policy context of indicator use in light of the EUHPID Policy Paper (Appendix 8). Their work initially focussed on the identification of examples of indicators for the following settings – schools; workplaces; cities/communities. For each of these 'settings' areas, indicators were chosen and classified using the 3 boxes from the right-hand

side (Figure 2) of the EUHPID model (environment structure & process - health opportunities; system process – salutogenesis, pathogenesis; system structure – health capacities). This is fully discussed in the section entitled 'The EUHPID Health Promotion Model as a Basis for Indicator Classification'. They also explored quantity and quality indicators for use in the field to inform improved practice (Left-hand side of model – see Figure 2). These indicators were then evaluated from the perspectives of experts, society and citizens to form a minimal number of new indicators. Emphasis was given to the policy level related to the Ottawa Charter action areas. These indicators were further synthesised to form a set of common indicators, commonalities were identified and the 3 areas brought together

- Data Working Group
    - In data-driven indicator development the selection of indicators is primarily determined by the availability of data on the desired measurement level (e.g. national data).
    - The initial EUHPID survey/review work was expanded to include a range of social, as well as health surveys, carried out in EU and potentially in the Accession Countries. This formed the beginning of an inventory of inventories (to include inventories provided by EUROSTAT, EUROHIS, DG SANCO). These systems have been reviewed in terms of their relevance to health promotion, the quality of their data collected and its accessibility (Appendix 12).
    - Following the lack of common definitions of health promotion indicators and dearth of identified data regularly collected at European

and Member State levels, the work of a sister SANCO – funded Project – HP Source was identified as a tool having unique potential for data collection to produce potential indicators related to health promotion policy and practice. Based on the HP Source tool an appropriate EUHPID indicator monitoring framework/system could be developed on a local, regional and national level with appropriate criteria, including quality assurance.

The EUHPID Health Promotion Model as Basis for Indicator Classification

The definition of a clear underlying theory is a key factor in indicator development. It should provide a common frame of reference and a basis for agreeing which indicators to develop, particularly in the context of European-wide efforts.

As a result of the dearth of agreement on common health promotion indicators at European and Member State levels, and the position allocated to health promotion in the ECHI framework at that time, the EUHPID Consortium decided to concentrate on developing a convincing model to underpin a European health promotion monitoring and indicator classification system. This model would emphasise the physical/social/mental system structure, social-cultural environmental structure and social/cultural processes. This work would ensure that ECHI (which was in its 2nd phase) provides a more holistic and comprehensive framework for the classification and selection of European indicators as these areas were seen as the blank boxes or white space in the ECHI framework. The EUHPID Consortium felt it was important to support and complement the work carried out by ECHI colleagues and not propose an alternative framework. Yet it also felt that it would be of benefit to colleagues,

trained and practising in more traditional paradigms of epidemiology and public health, to position themselves within a more holistic health development framework. In this way, it was hoped that the socio-ecological model of human life proposed by EUHPID could become a common reference point for the ECHI framework (this point is addressed later in this report), the Health Monitoring Programme and for the public health field. It could demonstrate conceptually and practically how the various public health approaches, including health promotion approaches and approaches based on the medical model are related and complement each other. In practical policy terms, this would mean investing in a set of key indicators. The final vision of the model could thereby influence policy options and reflect the way society looks at itself and its health; to include not only the absence of illness but also more salutogenic entities, such as positive health and health-promoting structures and processes. In order to work towards the above vision, further detailed development of the model has been undertaken to convince relevant stakeholders of its value. Besides linking it to, and complementing, the ECHI framework it needs to be aligned to more popular contemporary models being used in current relevant research. In addition, EUHPID recommends that alliances need to be made with key colleagues to build upon and relate the model to their work. Further development of the model related to the development of a mutually beneficial dialogue which was initiated with the ECHI co-ordinators to take this fundamental issue forward (this point is addressed later in the Report).

Experience from best practice in other indicator development projects (Appendix 7) highlighted 4 key issues that need to be addressed before the actual process of selecting indicators can begin:

- definition of indicators and field of indicator selection
- definition of use and users of indicators
- development of an underlying theoretical framework for indicator selection
- designing a political process of defining the framework and selecting relevant indicators

These four issues were addressed by EUHPID and consideration of them included in a series of internal working papers (including Noack 2002, Bauer 2002). These early papers culminated in the seminal publication '*Advancing a Theoretical Model for Public Health and Health Promotion Indicator Development: Proposal from the EUHPID Consortium'* which appeared in the Supplement on the European Union Health Monitoring Programme in the European Journal of Public Health (see Appendix 13) This paper pays particular attention to the development of an underlying theoretical framework for EUHPID Indicator selection and makes recommendations for taking forward the work in a real world political context.
The following extracts from this paper highlight key issues in relation to understanding the basis of the EUHPID Health Promotion Model for indicator classification:
"Initially, the (theory working group) reviewed and assessed the strengths and weaknesses of health promotion models currently proposed for indicator development. Four general models were compared to identify principles and features relevant to the construction or selection of health promotion indicators and to the development of a health promotion indicator system: a health promotion outcome

model (Nutbeam 2000), a generic logic model for planning and evaluating health promotion (Rootman et al 2001), a framework for mapping health promotion action (Bauer 2002) and a health development model for health promotion (Noack 2002). From this review the following conclusions were drawn regarding properties of a future model - be simple and easy to understand and communicate, to aid effective practice; consist of a limited number of distinct elements to avoid misclassifications and redundancies; use clearly defined concepts and terminology familiar to the fields of public health and health promotion; consider health promotion values and principles; consider pathogenic and salutogenic perspectives; consider interaction between individual, social groups, or other social units, and environment; distinguish between ongoing health development and intentional interventions into this developmental process; consider time as a critical dimension both of health as a dynamic phenomenon and of health development as an ongoing process of human life; and understand health promotion as a complex planned, intentional input into the ongoing process of health development" (p 108-109).

It is important to stress the concept of health development. The health of living beings (living systems) is not a given, but has to be (re-)produced continuously over time, by the living system itself by making use of resources (salutogenesis) and maintaining its identity against risk factors (initiating pathogenesis of the system) of a complex relevant environment. ie people's health develops well or badly throughout their lives – intentional interventions in this development process can come principally from health (and related) services (prevention, treatment, rehabilitation) and/or from health promotion (at various levels from individual to system environment). This analytical division assists in terms of understanding indicator definition but also in terms of allowing for underlying paradigms and principles. The interface of these intervention

areas is in reality not as clear cut ie in terms of health promotion within the health services area (for example Health Promoting Hospitals) and outreach preventive services operating at community level. Nevertheless it is helpful in understanding the interface as well as distinguish differences between the dominant bio-medical/pathogenic and more underdeveloped socio-ecological/salutogenic perspectives of health. The EJPH Paper goes on to detail the socio-ecological model of health development, of public health and of health promotion. (Appendix13).

It is important to stress that EUHPID have provided a model to monitor (observe and measure) health promotion interventions, as well as to plan these interventions. Underlying the EUHPID Model is a systems-based understanding of nature and society, individuals and health, which follows the Quality Model proposed by Donabedian (e.g. 1966, 1982, 1988, 1990). It therefore distinguishes between quality of outcome, which is produced by quality of processes, which is determined by quality of structure. Systems theory describes a system as being made up of interdependent and related parts and therefore must be considered as a whole – it cannot be viewed in isolation from its environment (Checkland 1981).

Health promotion, as far its outcome is concerned, is about maintaining and improving individual and population health. By stressing the multi-dimensionality of health and explicitly naming its physical, mental and social dimensions (Pelikan & Halbmayer 1996) it includes the resource component of health. The EUHPID Model follows the Ottawa Charter (WHO, 1986) action areas of health promotion, which focus on the importance of the ecological, social and cultural environment for creating individual or population health. The Ottawa Charter has a currency and understanding throughout Europe as well as worldwide. It provides the key organising framework for the EUHPID Monitoring System and Indicator Sets. As health

promotion is a dynamic phenomenon and is described in terms of actions or strategies for change – EUHPID Indicators are based on interventions and health promoting processes.

The overall goal of EUHPID Phase 1 is to establish the health promotion perspective within the larger ECHI system by introducing a set of generic health promotion indicators. In this context, the current EUHPID Health Promotion Model has three major objectives:

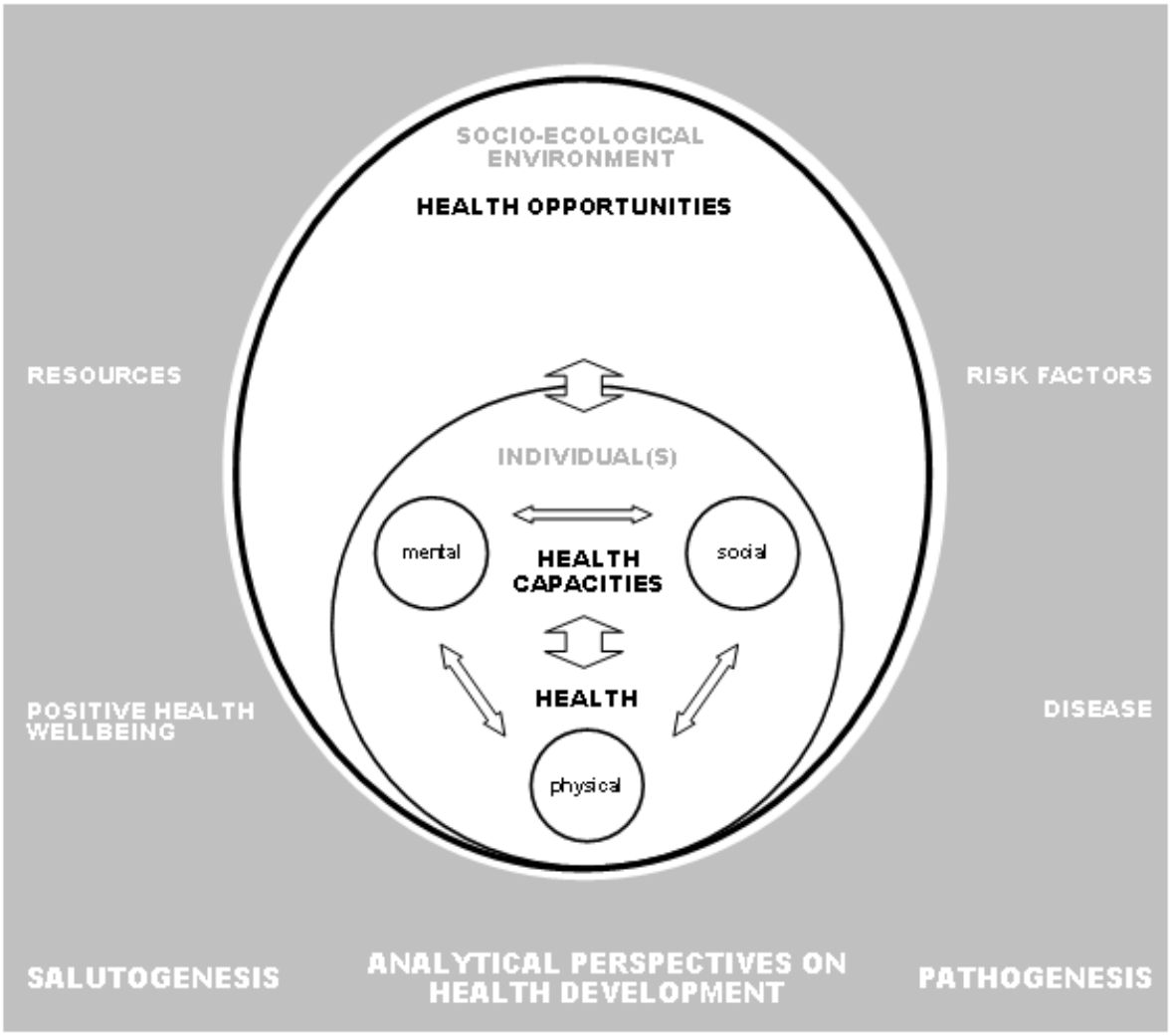
- to provide a clear rational for selecting, organizing and interpreting health promotion indicators (classification system)
- to communicate the unique health promotion approach to the larger public health community (advocacy tool)
- to develop a common frame of reference for the fields of health promotion and public health which shows their interrelation (dialogue tool).

The original version of the EUHPID Model published in EJPH was more generally based on systems theory. But in order to reach the above objectives the Model was further developed to more explicitly include the following issues:

- the WHO definition of health which includes the three dimensions of physical, mental and social health
- health develops from an ongoing interaction between the individual and his/her environment
- continuous health development can be analysed from a salutogenic (health resources and positive health) or pathogenic perspective (risk factors and disease)

- ongoing health development should be distinguished from intentional interventions into this process to improve health
- for health promotion interventions, the Ottawa Charter action areas specify both health promotion actions and health promoting areas to be targeted by these actions

FIGURE 1 – Health Development Model



The EUHPID Health Development Model

The health development model (see Figure 1) distinguishes three dimensions, i.e. physical, mental and social health. The arrows between these dimensions illustrate that they are highly interdependent.

The health of individual(s) depends on their individual health capacity. Health capacities are defined as properties or activities of individuals which contribute to development of their own health. Three closely interrelated dimensions of health capacities are distinguished, the physical (e.g. fitness), mental (e.g. sense of coherence) and social dimension (e.g. social support). The health of individual(s) is not created and lived in isolation but results from an ongoing, close and dynamic interaction with their socio-ecological environment. Those aspects of the environment which are of key importance to the health of people are those which increase or decrease the opportunities for sustainable health development. The term health opportunities highlights that persisting inequities in health in our societies are in large part due to unequal distribution of these opportunities.

Although the EUHPID health development model relates to the health of individuals, the social dimension of health and health capacities, as well as individuals´ interaction with their socio-ecological environment, emphasises that health is created and lived in a wider social context. Health opportunities related to the socio-ecological environment are of key importance when looking at the settings in which people live and work.

The health development model is suggested as common frame of reference to communicate which elements of the health development process are primary targets or leverage points of the respective intervention approaches. Figure 1 shows that in conceptual terms health promotion primarily supports salutogenic health development

whereas health protection, prevention and health care primarily aim at reducing and reversing pathogenic health development. In practice of course there is extensive overlap.

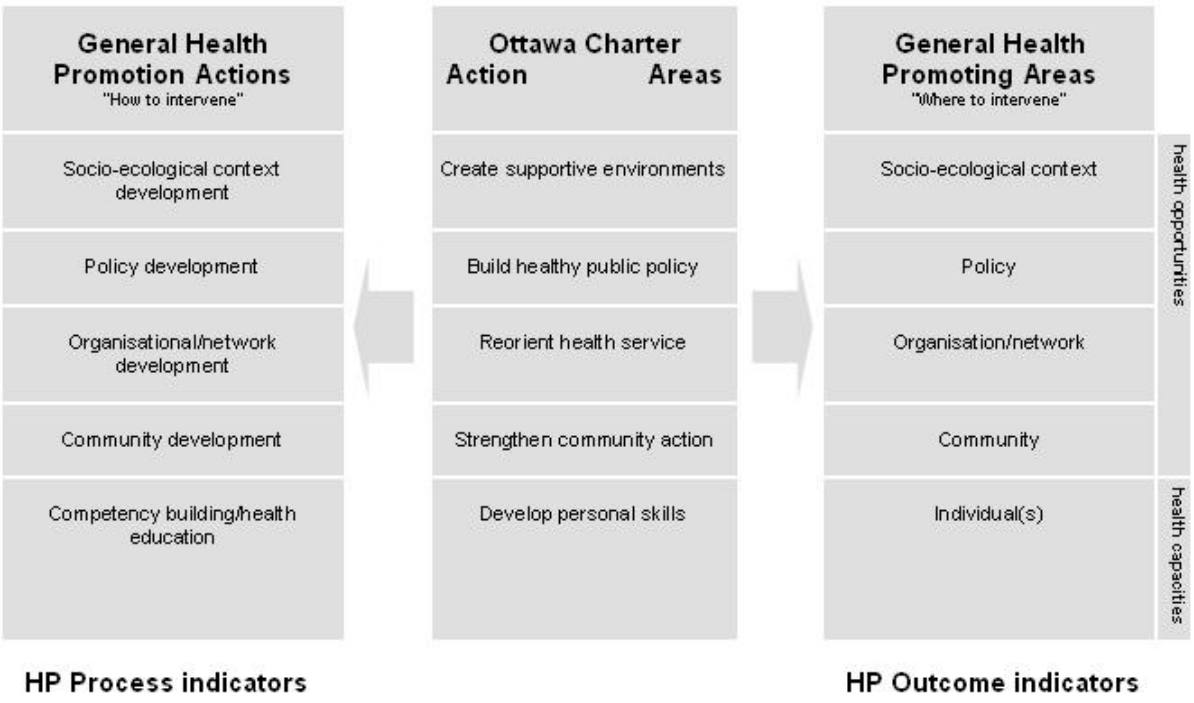
EUHPID Health Promotion Model

The Ottawa Charter for Health Promotion is internationally recognised and accepted as the key framework and reference point for health promotion and health development.

The original Ottawa Charter ”action areas” are compound constructs, which include both an ”action” component which defines “how to intervene” and an “area” component which defines ”where to intervene”. Table 2 separates these two aspects and defines five general health promotion actions and five general health promoting areas to be primarily addressed by these actions.

TABLE 2

Ottawa Charter Action Areas: Reference point for Health Promotion Actions and Health Promoting Areas



The concept of health promoting areas is differentiated from the functional systems implicit in the 5 Ottawa Charter action areas. All 5 general health promotion action areas can be found within relevant functional systems. For example – individuals (employers, employees, clients); community (informal social relationships between employers, employees, clients); organisation/network (eg mission statement, work organisation); policy (eg benefit system, smoking regulations, anti-bullying policy) and socio-ecological context (eg workplace ergonomics, economic pressure). Similar illustrations could be made for other functional systems implied by the Ottawa Charter action areas eg the public policy system and local communities.

The 5 health promoting areas are key dimensions of any functional system, which contributes to health development. The 5 health promoting areas are proposed as standardised categories for assessing how health promoting any functional system can be. In this regard is important to differentiate between health promotion actions and health promotion areas – as various actions (for example individual competency building, community development and organisational networking) can be combined to facilitate the health promoting potential of one area such as the community. This differentiation between health promotion actions and health promotion areas provides the rationale for the EUHPID Health Promotion Model (see Figure 2). The resulting second version of the EUHPID health promotion model presented here keeps the important distinction between health development as an ongoing process of human life and health promotion as one particular intentional intervention aiming at sustainable change in the health development process of individuals and their environments.

FIGURE 2 – EUHPID Health Promotion Model

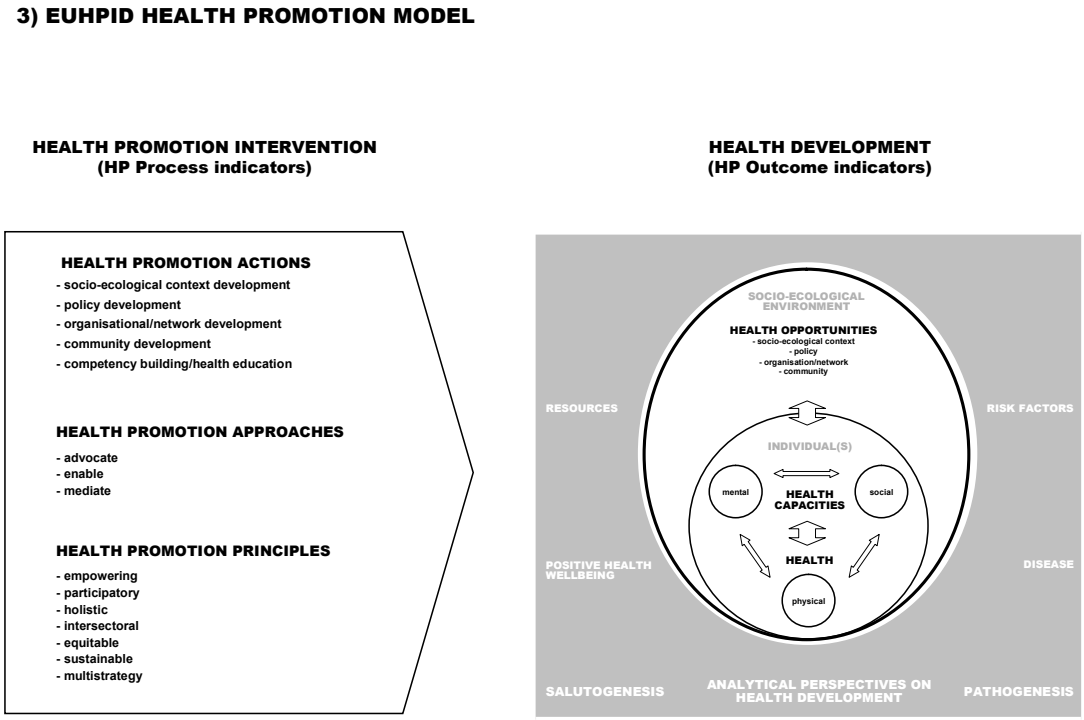


Fig 2 depicts health promotion at the left-hand side as a planned, intentional intervention to support ongoing health development on the right-hand side. The 5 actions areas from the Ottawa Charter are included as sub-elements of health development. Socio-ecological context, policy, organisation/network and community are seen as key health opportunities of the socio-ecological

environment to be enhanced by health promotion. The fifth area – individual/s – lies at the core of the model.

The 5 health promotion actions are included as sub-elements of health promotion and are combined ideally into comprehensive health promotion strategies, tailored to the system which is targeted by health promotion.

It is important to realise that health promotion action builds on and enhances pre-existing health promotion capacities of the professional health promotion system and the system targeted by health promotion. The sub-dimensions of health promotion capacity building cut across the 5 health promotion actions for example health promotion infrastructure, programme sustainability and problem solving (Hawe et al 2000). This issue was introduced and discussed at the EUHPID Consortium meeting in Perugia (Appendix 16) and relates to development work in the next phase of EUHPID.

The EUHPID Health Promotion Model is underpinned by a series of 7 principles (as defined by Rootman 2001) which provide an internationally accepted underlying value basis for health promotion practice.

Application of the EUHPID Health Promotion Model to Health Promotion Practice

The EUHPID Health Promotion Model is formulated to guide health promotion practice and thereby the selection of health promotion indicators informing such practice.

According to the three elements of health development, health promotion can apply three overarching approaches – addressing specific health issues (eg mental health), addressing health and health capacities of particular target groups (eg child health) or addressing specific socio-ecological environments (eg workplace health).

Regarding the socio-ecological environment influencing health development, health promotion can consider various functional systems predominant in our societies,

including education, economy, transportation, health care, neighbourhood or family. Each functional system might be addressed anywhere between the micro and macro level of analysis. For example the influence of the economy on health might be analysed and modified anywhere between the individual worker or workplace, single company, economic sector, and national or global economy - depending on professional interest, skills and responsibility.

Thus, initially health promoters have to decide which functional system(s) and which level(s) of these functional systems are most relevant to health development and can be efficiently modified by health promotion. After this decision, health promotion follows the four steps of the public health action cycle:

- Assessment: initial health, health capacities, health opportunities and health promotion capacity of the selected sub-systems are assessed; key health issues and leverage points for health promotion interventions are identified.
- Planning: health promotion actions appropriate for changing the leverage points are selected and combined into an overarching strategy; health promotion process and outcome indicators appropriate for controlling the impact of the intervention are defined
- Implementation: health promotion strategy is implemented
- Evaluation: changes in initially determined health promotion process and outcome indicators are assessed

In interpreting health promotion outcome indicators it is important to assess which proportion of gains in health, health capacities and health opportunities can be attributed to ongoing health development and which proportion to specific interventions into this process.

Classifying Health Promotion Outcome and Process Indicators based on the EUHPID Health Promotion Model

Within the EUHPID project, the final purpose of the EUHPID Health Promotion Model is to provide a clear rationale for classifying health promotion indicators. Table 3 shows how the three elements of the health development model define three main categories of health promotion outcome indicators: health opportunities indicators, health capacities indicators and health indicators. Applying a causal interpretation, the first two categories can be considered as determinants of the third category ”health outcome”.

For each of these categories, sub-categories of indicators are defined by cross-tabulating the sub-dimensions of the elements of health development with their salutogenic and pathogenic endpoints. The cross-tables results in the following classification of indicators:

- **6 classes of health indicators:**

  disease – social, mental, physical

  positive health/well being – social, mental, physical

TABLE 3 - Categories of Health Promotion Outcome Indicators: Overview

Levels	Elements of health development		Endpoints of elements	Sub-dimensions of elements
Environment	health opportunities	determinants of health	- risk factors - resources	- socio-ecological context - policy - organisation/ network - community
Individual(s)	health capacities			- social - mental - physical
	Health	health outcomes	- disease - positive health/wellbeing	

- **6 classes of health capacities indicators:**

  risk factors – social, mental, physical

  resources – social, mental, physical

- **8 classes of health opportunities indicators:**

  risk factors – socio-ecological, policy, organisation/network, community

  resources – socio-ecological, policy, organisation/network, community

TABLE 4 - Classifying Indicators of Health Promotion Processes

Actions	
Socio-ecological context development	
Policy development	
Organisational/network development	
Community development	
Competency building/ health education	
Health promotion capacities	
Health promotion infrastructure	
Program sustainability	
Problem solving	

Health promotion process indicators are classified according to Table 4 by the 5 health promotion actions and the suggested three dimensions of health promotion capacity - the detailed development of this area will form part of the next phase of EUHPID.

It should be noted that the allocation of outcome indicators to all the categories in Table 3 will depend on their interpretation by users. This will form part of the Health Promotion User Window being developed to interrogate the overall developing ECHI system whose relevance is discussed in more detail in the following section which will be a key part of the next stage of EUHPID. For example, for the fitness industry, physical exercise/fitness may be a core health outcome. But for the medical colleagues, physical fitness may be just one capacity contributing to morbidity and mortality rates.

Health Promotion User Window

The concept of the User Window has been developed by the ECHI Project team, in the anticipation that the system would be employed by users for different purposes. The basic concept is that it selects a subset of indicators from the list of ECHI indicators (in this case the Set of Community Health Indicators – Appendix 11), based on a particular perspective or interest. 'User Windows' are thought to be a flexible and policy relevant approach, and complement the use of the set of ECHI core indicators; which include indicators on health promotion policy and practice related to key areas and related to key integrated settings.

The EUHPID Project therefore recommends the development of a Health Promotion User Window to facilitate the development and use of both the core health promotion indicators ie health promotion policy and practice and the integrated health promotion settings, in particular. ECHI have supported this idea, suggesting a "User windows focusing on different settings for health and associated interventions and health promotion; these user windows may include settings-specific mortality/morbidity determinants and interventions" (ECHI-2 Working Paper, February, 2004). The User Window concept would enable practitioners working in a wide range of settings to use the EUHPID health monitoring framework to gain a holistic perspective on the selection of appropriate indicators for use in their relevant setting.

Application of the Classification System to Practical Health Promotion Indicators

The classification system of health promotion indicators shows the possible range of indicators in this field. In practice, not all of these categories are to be filled by indicators. The categories can be used to analyse the emphasis, and blank areas, of existing indicator systems. Further, the classification system helps to make rational decisions which categories to emphasize in developing new indicator systems.

It should be emphasised that the following lists of indicators do not represent the full potential of the EUHPID classification system. Instead, they give an idea of how, based on the EUHPID Health Promotion model, the concept of the Health Promotion User Window may be operationalised, through the use of the EUHPID classification system. The complexity of this task should be emphasised, in terms of the various levels of analysis, which is dependant upon the user of the EUHPID classification system e.g. analysis may be done at policy level, environmental level, individual level, national, local and/or European level, integrated settings level etc. Examples of an examination of some of these levels of analysis will follow.

In order to exemplify the relevance of the EUHPID Model to practical health promotion indicator development, the following sections demonstrate its application to health promotion:

- following detailed discussion with ECHI, the EUHPID Consortium would fully support the following recommendation being made by the ECHI-2 Project to re-classify health promotion within the ECHI Framework..

The purpose is to discriminate between health interventions occurring within health services, including health care and disease prevention (4.1.1, 4.2-4.5) and interventions outside the health care system (4.1.2, 4.1.3). This would establish a separate class for health promotion indicators on the one hand (Class 5 'Health Interventions: Health Promotion') which would create a new class to include the following core indicators:

Health Promotion Policy and Practice

This is in preference to 'campaigns' which can be one area of health promotion or rather health education practice related to a range of areas including for example tobacco, alcohol, sexual health, illegal drug, skin cancer, physical activity and accident; as well as nutrition.(Although nutrition is separately identified under ECHI-1, it is recommended that this be included under this indicator set). Aspects of health protection related to both legislative and regulatory interventions which support health promotion policy in the above areas (for example restrictions on tobacco smoking, price, marketing and advertising) would be included under the new Health Promotion class.

As suitably adapted from the work of the HP Source Project, the following types of indicators have been identified under Health Promotion Policy & Practice:

Health promotion policies at a national level:

- Existence of national documents published on health promotion related to smoking, nutrition, alcohol, etc.(see ECHI short-list of core indicators).

Health promotion policies at a regional level:

- Existence of regional policy documents in the following areas: smoking, nutrition, alcohol etc.

Health promotion policies at a provincial level:

- Existence of provincial policy documents in the following areas: smoking, nutrition, alcohol etc.

Health promotion policies at a local level:

- Existence of local policy documents in the following areas: smoking, nutrition, alcohol etc.

Health promotion policy formulation:

- Extent to which formulation of health promotion policy is based on regular systematic monitoring of public health.

- Variety of organisations contributing to health promotion policy formulation.

- Extent to which social determinants are taken into account in the monitoring process (e.g. culture, income, rural, urban setting etc).

- Extent to which behaviour, risk factors, protective factors and quality of life is taken into account in the monitoring process.

- Extent to which broader social and economic context (e.g. social and economic inequalities) are taken into account in the monitoring process.

On evaluation of health promotion policy:

- Existence of routine (national) policy evaluation
- Regularity of production of policy evaluation report

On implementation of the health promotion policy:

- Clear guidelines in place which lay out which bodies are responsible for the implementation of national health promotion policy at:- national level, and at provincial, regional and local level (if appropriate).

On health promotion campaigns:

- Body(ies) with responsibility for funding/planning/delivery/evaluation of campaigns (official and other national bodies, regional bodies).
- Body(ies) with responsibility for funding/planning/delivery/evaluation of health promotion projects.

On professional workforce:

- Level at which learning and qualification in health promotion is available, at at least one institution of higher education (i.e. BA/BSc, MA/MPhil, PhD, Dr. PH)
- Existence of academic and /or non-academic post-graduate non-degree courses/symposia on the topic of health promotion.
- Existence of associations for professionals involved in: health promotion research, practice, policy-making.

Health promotion funding mechanisms:

- Availability and source/s of funding for health promotion at national, regional, provincial and local levels.
- Existence of guidelines which determine equitable distribution of funding for health promotion, based on structured needs assessment at national, regional, provincial and local levels.

Although the above are related primarily to national, local etc context, indicators related to the settings approach could be added and linked to the following indicator areas on integrated health promotion settings.

Integrated Health Promotion Settings Indicators

It became apparent throughout EUHPID's work that although there are many other colleagues and networks working in the field of health promotion indicators, they do not have a framework giving an overall understanding of the complexity of health promotion to draw on. This is now offered by the EUHPID model (Figure 2). To complement and exemplify the practical usage of the EUHPID health promotion model, in addition to the indicator area related to Health Promotion Policy & Practice, the integrated settings approach has been used to develop practical examples of indicators. The 'expert' nature of the EUHPID Consortium group ensured success in linking into a wide variety of appropriate national and European networks, as will be discussed below.

Three main settings have been emphasised and explored in relation to practical usage of the EUHPID Health Promotion Model:

- Workplace Settings Indicators
- Schools Settings Indicators
- Hospitals Settings Indicators

Workplace Settings Indicators

There are currently no standardised sets of health promotion indicators published for the field of workplace health promotion. However, there are a number of initiatives underway, into which EUHPID has linked, and which could inform the future development of workplace health promotion indicators. Each of the indicator systems were reviewed (Bauer, 2004) and the conclusion was that there is no agreed-upon common frame of reference accepted by policy makers at the EU or Member State level. There is therefore an opportunity for EUHPID to initiate further collaborative working

with the relevant European Workplace Networks such as the European Network for Worksite Health Promotion (ENHWP), Work Health, and the European Foundation for the Improvement of Living and Working Conditions.

Attempts have been made throughout the duration of the project to further these links, for example, a meeting was held with coordinators of the Work Health Project, to exchange 'expert' knowledge, to discuss commonalities and potential future collaborative efforts.

Work Health Project

Workhealth is a project, which like EUHPID, is funded under the EC Health Monitoring Programme (HMP). The objective of the project is to establish indicators for work-related health monitoring from a public health perspective and to deliver a contribution to a community-wide network for sharing health data (Boedeker & Kreis, 2003). A first working paper provides a detailed synopsis of work-related indicator sets in Europe "to facilitate the development of a model of work-related health monitoring…". A policy cycle is suggested in the paper, starting from policies in the wider political environment, which have "a substantial impact on the setting of the workplace". Within the workplace, the following stages are described: policy domains, activities, outputs and outcomes. The policy domains include a long list of overlapping categories, which partly could be considered as determinants of health, and in addition, the outcomes contain heterogenous categories that are not organised within a recognised framework (Bauer, 2004). The project will develop concrete indicators in its next phase, for which the EUHPID model and related indicator categories could provide a rational framework of organisation. The two projects have agreed to continue to work together in a mutually beneficial and way, with an emphasis on developing strategic links between the projects, including data and knowledge exchange.

Additional Workplace Health Indicator work reviewed includes:

Work Place Health in the Public Health Perspective. This paper was published by WHO Europe and includes policy requirements and performance indicators for good practice in health, environment, safety and management in enterprises (GP HESSME). It aims to empower employers and employees to take control over their own and their family's health, considering environmental, lifestyle, occupation and social health determinants. However, the indicators suggested only partly address the determinants of health in the everyday work environment.

Work and Health Country Profiles. WHO Europe initiated development of work and health country profiles, although gaps from a health promotion perspective become apparent (Bauer, 2004), when assigning indicators of such a profile (Rantanen et al. 2000) to the EUHPID indicator classification system, especially in the area of health capacities for working conditions.

Indicators of Quality of Working Life. The Work Health project report (Kreis & Boedecker 2003) reviews two publication, which suggest indicator schemes for quality of work and employment (European Commission 2001; European Foundation for the Improvement of Living and Working Conditions 2001). Both of these schemes mainly build on existing European data and could provide a valuable source for selecting worksite health promotion outcome indicators.

Quality Criteria of the European Network for Worksite Health Promotion (ENWHP)(1999a) has published quality criteria for WHP activities, covering six sectors: WHP and corporate policy, human resources and work organisation; planning of WHP, social responsibility, implementation of WHP, results of WHP. For measuring these criteria ENWHP (1999b) published a standardized questionnaire as a self-assessment tool. Thus, companies can monitor progress along these criteria. In the future this instrument might be used to collect data from a representative sample of companies

across Europe. Further, a simplified version is available for small and medium sized companies (ENWHP 2001).

Indicators of Working Conditions in the European Union. This is a report by the European Foundation for the Improvement of Living and Working Conditions (Dhondt & Houtman, 1997), a project which is based primarily on the European survey on the working environment. This provides longitudinal, comparable data for all EU countries. Examples of appropriate health promotion indicators which can be drawn from their lists, in relation to the EUHPID framework, are shown in the tables below.

Using some of the indicators developed by the above projects, the EUHPID health monitoring framework can be used to demonstrate its practical nature – see Tables 5, 6 and 7. The examples were elaborated upon in Consortium discussions. This was necessary because it is apparent from an examination of current projects, that there is still a dearth of health promotion indicators, and in particular, a logical framework into which indicators can be classified and organized. This is now offered by the EUHPID Monitoring System.

TABLE 5 - Classifying Indicators of Health (Level: Individual(s))

	Endpoints of health	
	Disease	***positive health/wellbeing***
Sub-dimensions		
Social	• Social isolation • Discrimination	• Social support • Participation in community action/ development
Mental	• Depression	• Sense of coherence • Optimism • Work satisfaction
physical	• Immobility • Morbidity	• Fitness of staff

TABLE 6 - Classifying indicators of health capacities (level: individual(s))

	Endpoints of health capacities	
	Riskfactors	***resources***
Sub-dimensions		
Social	• Social withdrawal	• Social networks • Social competency • Social content of job
Mental	• % of stress related sickness • Resignation	• Perceived (mental) work ability • Job autonomy •
physical	• (Fatal) Accidents at work • Health damaging behaviour • Precarious work	• Perceived (physical) work ability

TABLE 7 - Indicators of health opportunities (level: environment)

	Endpoints of health opportunities	
	Riskfactors	***resources***
Sub-dimensions		
socio-ecological context	• Noise level • Handling dangerous substance • Pesticide consumption • Asbestos consumption	• Tailored workplace design
policy	• Hire and fire	• Equal opportunities policy • Smoke-free policy • Sex equality • Maternity/paternity leave
organisation/ network	• Heavy loads • Working with heavy loads • Working over 50 hours per week • Precarious work • Irregular working hours • Strenuous work	• Participative decision making • Continuing professional development programme • Control over working times • Control over working content
community	• Discriminatory work practice • Violence at work	• Social support amongst colleagues • Working climate

Schools Settings Indicators

There has been a substantial amount of health promotion research and intervention work using schools as a setting. EUHPID has attempted to link into some of these projects, to assess the level of

health promotion indicator development, and to demonstrate the use of the EUHPID health monitoring framework for intervention work in schools.

ENHPS and the EVA Project

Health Promotion in schools has developed rapidly as a result of and through the European Network of Health Promoting Schools (ENHPS, 1995), actively and jointly supported by the Commission of European Communities, the World Health Organisation (Regional Office for Europe), and the Council of Europe. ENHPS concentrates on conditions in the school, instead of health damaging behaviour. This is in recognition that health promotion in schools structures schools' approaches to health, and provides a framework in which schools can address a range of health-related subjects. This ensures that they adopt programmes recognised as necessary, rather than ones based on random marketing exercises. In addition, health promotion supports academic success, with absenteeism less likely if the pupils perceive the school as supportive of their needs.

A health promoting school is a place where all members of the school community work together to provide students with integrated and positive experiences and structures, which promote and protect their health. 'Components' and 'checkpoints' are developed in six areas, which reflect the major elements of health promoting schools. These are: school health policies, the school physical and social environment, community relationships, personal health skills and health services. These 'components' and 'checkpoints' act as guidelines for schools aiming at increasing emphasis on the health promoting approach.

Despite attempts to define consensus around the concept of evaluation of health promotion in schools and an examination of the education authorities at all levels to set up conditions conducive to the improvement of health and well being in schools, by tackling individual, social and environmental determinants (EVA 2, ENHPS, 1994), there has been no clearly defined

methodological health monitoring framework to use for this. EUHPID has capitalised on the opportunity to fill the gap', and to complement such work as the ENHPS. Indeed, recommendations from the final report of the EVA 2 Project included: to increase and develop its work with other organisations, increasing the collaboration between different teams, and promoting progress from policy to implementation, a process, potentially operationalised by EUHPID's health monitoring framework (see examples below).

Child Health Indicators of Life and Development Project (CHILD)

This work is closely related to the work of the ENHPS, ECHI and EUHPID. It is a third wave project in the European Union Community Health Monitoring Programme and is the first project to cover a particular population group. The CHILD Project was established in October, 2000 and ran until September, 2002. All fifteen members of the EU member states were involved in the project, as were Iceland and Norway. The CHILD Project looked not only at producing a recommended set of indicators, but also seeks to stimulate understanding of and commitment to their positive use by child professional and the child health community in each member state across Europe (again linked to the ECHI concept of user windows). The concept of child health is seen as having enhanced value as it represented the needs of a sector of the population unable to express their own interests and concerns, and ensures a representation across the entire child age-range from infancy to adolescence. In terms of indicators, like the EUHPID Project, the CHILD Project is based on the belief that health status measures alone are not sufficient to describe the whole range of phenomena of health and development, that health process measures have their own value and that measures of determinants are extremely valuable, as they offer the chance to reduce or protect against risk and thus damage to health. Additionally, the two projects share the socio ecological approach to health, are both based on the ECHI framework, and both exist within an area of low political and economic interest. For example, European children are considered 'healthy', yet there are few mechanisms for their social

and community participation; the health promotion approach can be seen as a threat for some 'unhealthy' policies/policy makers; both children and health promotion investments have an impact in terms of health gains, but are both barely visible in the short term.

Other work in the area of health promoting schools includes:

- Models of Health Promoting Schools in Europe (edited by Bjarne Jensen and Venka Simovska)
- The ENHPS indicators for a health promoting school (by WHO/EU/CE, which has indicators at international, national and local levels)
- There are also several self-evaluation tools created by each country or county or school. At local level there should be a combination of objectives and respective indicators and since HPS is a process of change or maintenance it has to be defined locally, considering to which level the objective must be set and which indictor is the most appropriate to evaluate the achievement.

The EUHPID health monitoring project is able to provide a framework for a holistic approach to health monitoring and evaluation within schools. Practical examples of appropriate indicators are demonstrated in tables 8, 9 and 10. These examples draw on some of the schools/child health promotion work to date, as examined above. It has been noted that the following indicators should be evaluated throughout the process of monitoring and evaluation, in order that the process of change may be understood. This may mean looking at sensitive indicators in order to identify the changes (Loureiro & Piette, 2004).

TABLE 8 - Classifying Indicators of Health (Level: Individual(s))

	Endpoints of health	
	Disease	***positive health/wellbeing***
Sub-dimensions		
social	• Victim of a crime during the last year	• Interpersonal trust and norms of mutual aid and reciprocity • Connectedness • Quality and quantity of social relationships • Perceptions of social connectedness, reciprocity, sharing, trust and co-operation • Per capita membership of voluntary groups • School/Community activities during the last weeks • Victim of a crime during the last year
mental	• Depression • generalised anxiety disorder • suicide attempt • Cognitive limitations in memory, learning, literacy, attention	• self-reported health • self-reported sexual health • psychological well-being • Happiness
physical	• diabetes primary & other causes • HIV/AIDS • STD, specific. Chlamydia • Tuberculosis • Measles • Menigitis • Hepatitis B • Vaccination scheme diseases • Neoplasms • Childhood cancers • Diabetes type 1 incidence in children • migraine/frequent headache • childhood asthma • decayed etc. teeth: mean DMF-12 index • prevalence of any chronic illness or condition • limitations in seeing, hearing, mobility, speaking, biting, agility (disability-free life expectancy) • Temporary limitations by health problem, past 2 weeks • Psychological distress. • Role limitations by emotional problem.	• Body mass index • Opportunities in school, work, leisure, social activities

Table 9 Classifying Indicators of Health Capacities (Level: Individual(s))

	Endpoints of health capacities	
	Riskfactors	***Resources***
Sub-dimensions		
social	• % of Children in single-parent household	• Health promotion school team Assessing, planning, / project development • Training (together) • Curriculum integration • Parents involvement • % teachers sense of belonging to the school • % teachers with a good sense of coherence • % teachers with high self-esteem • % teachers general positive feeling of self-efficacy • % teachers liking school. • parental support for children
mental	• Mental health (psychological well-being, distress, mental health problems and appropriate approach)	• % pupils declaring sense of belonging to the school • % pupils with a good sense of coherence • % pupils with high self-esteem • %pupils general positive feeling of self-efficacy • % pupils liking school • % pupils feeling the class is oK • % pupils declaring receiving help for school work if needed • Mental health (psychological well-being, and appropriate approach)
physical	• Prevention (vaccination, oral health) • Chronic diseases (integration in school) • Functional limitations (seeing, hearing, mobility, speaking, cognitive limitations) • Acute infectious diseases (appropriate measures) • Regular smokers • Drinking in children • Use of illicit drugs (incl.children)	• Sexual behaviour (partners, frequency) • contraceptive use (type, general, 1st intercourse) • Screening preventive examinations • Functional potential, i.e., adequate facilities for children's needs

Table 10 Indicators of Health Opportunities (Level: Environment)

	Endpoints of health opportunities	
	Risk factors	***Resources***
Sub-dimensions		
socio-ecological context	• Economical crisis • % school drop outs • students/teachers school absenteeism • Household situation of pupils • % children seeking asylum within school community • population by 4 ISCED classes: elementary, lower sec., upper sec., tertiary • Literacy rate: including Health Literacy • early school leavers • number of fatal accidents in school • Total energy uptake/person • % energy from fat • air pollutants • noise exposure in classroom • social isolation/participation in school • children social care • experience of violence at home • experience of sexual abuse and violence at home • physical punishment of children	• Social networks • Sanitarian conditions in the School+ hygienic conditions at the canteen and buffets • Way healthy eating products are displayed • Transportation, housing • Safe physical environment • Perception of school (tobacco, nutrition, etc.) policies by pupils/teachers • perceived tobacco environment by pupils (CAS) • Household situation of pupils • pre-primary education (ages 3-5) • Literacy rate: including Health Literacy • Teachers qualifications • Total energy uptake/person • intake of fruit excluding juice • environmental determinants of physical activity: e.g. chances for walking, cycling; • access to public transport • social support in school • access to computers
policy	• school dinners • ineffective interventions	• Tobacco and nutrition policies • regulations on seat belts, helmets • regulations on air/water quality • Protecting policies • Formal agreement between international agencies for School Health Promotion • % schools with consensus on tobacco policy (CAS) • national law on School Health Promotion (so that every school can be a HPS) (EVA 3) • law on compulsory school health education (EVA3) • law on health education or promotion in initial teachers training (EVA3) • national programmes on smoking

		prevention etc. • law about health education or promotion in • Initial teachers training national programmes (on smoking prevention etc) • %secondary schools with total tobacco ban • % secondary schools with enforced smoking policy • Campaigns on smoking, alcohol, diet, safe sex, drug use, sunlight exposure, physical activity, injury prevention • policies on healthy nutrition • regulations on food safety and quality • policies on health nutrition, e.g. food/drink fortification • anti-bullying policies in schools • regulations on noise
organisation/ network	• road traffic injuries • occupational injuries • burns, in children • poisoning, in children • long-bone fractures, in children	• % of primary and secondary schools with link to secondary or primary schools • % of pupils declaring receiving help if needed • % of schools institutional self-efficacy • social empowerment • % of schools premises offered to community activities • HP team coordinator • School health programme implementation (e.g., curriculum). • % of schools with a global health approach (Ottawa, ENHPS etc) • % of health promoting primary schools • % of HP secondary schools • quality assurance system for SHP • Health promotion training for school health teams • HP training for school health teams • International network of HPS
community	• school social capital / social empowerment • % of schools with premises offered to community activities • % of schools with consensus on tobacco, nutrition, etc) policies about (HP) policy changes; to ensure social debate about (HP) policy changes; to ensure social debate about relevant issues.	• % of schools with action in or with the community • % of schools institutional self-efficacy

There needs to be further discussion on how indicators can be integrated and their correlations considered. Many of the current indicators, some of which are illustrated above, and are based on current work on schools and health promotion, are static in that they reflect outcomes. EUHPID is interested to help to develop the current dearth of indicators that reflect processes, recognising the complexity of health development in children, and within the schools setting amongst others.

Hospitals Settings Indicators

The EUHPID project has succeeded in making formal links with the European Network of Health Promoting Hospitals, and has presented current developments within the EUHPID Project at the WHO 4th Workshop on Standards for Health Promotion in Hospitals Workshop (Barcelona, October, 2003) and at the International Health Promoting Hospitals Conference in Florence. (May 2003). Since the EUHPID project aims to develop health promotion indicators in various settings domains, a close collaboration and exchange of knowledge between the EUHPID and the WHO Health Promoting Hospitals and Indicators programme is important.

The WHO European Office for Integrated Healthcare Services established a working group to develop standards for health promotion in hospitals in 2001. Draft standards have been developed, pilot tested for their relevance and applicability, improved accordingly and are now approaching their final form (although future revision is expected as and when new evidence emerges). The aims of the 4th Workshop were to develop a self assessment tool to assess compliance with standards including measurable elements and indicators and to plan the pilot test of the self assessment tool.

Five standards have been developed which address the following issues:

- Standard 1: Management Policy
- Standard 2: Patient Assessment
- Standard 3:Patient Information and Intervention
- Standard 4: Promoting a Healthy Workplace
- Standard 5: Continuity and Cooperation

Each standard has a set of sub-standards, and each sub-standard has one or more measurable elements. Demonstrable evidence is required to show compliance with each standard. Complementary indicators have begun to be developed for each of the sub-standards, however, there is currently no framework for the further development of appropriate indicators. This could be offered by the EUHPID Project, to assist in the development of a truly holistic set of health promotion indicators.

The EUHPID health monitoring system can be demonstrated using the following examples of indicators, partially developed from the 5 substandards above (particular for resources/positive health well/being) (See Tables 10, 11 and 12).

TABLE 11 - Classifying Indicators of Health (Level: Individual(s))

	Endpoints of health	
	Disease	***positive health/wellbeing***
Sub-dimensions		
social	• social isolation amongst staff	• Information is available on patient organisations and those related to his/her condition.
mental	• % of staff smoking • Suicide attempts (staff and patients)	• Patient and staff need for health promotion intervention are assessed.
physical	• % of patients educated about risk factor modification and disease treatment options in the management of their condition. • % of work related injuries • % of short term absence	• % of patients educated about specific actions in the self-management of their condition. • % of discharge letters sent to GP within 2 weeks.

TABLE 12 - Classifying Indicators of Health Capacities (Level: Individual(s))

	Endpoints of health capacities	
	Risk factors	***Resources***
Sub-dimensions		
social	• Social withdrawal	• Opportunities and resources for leisure allocated to staff and patients
mental	• Resignation rates	• staff awareness of content and location of health promotion policies.
physical	• Morbidity rates • Immobility rates	• % of patients assessed for disease specific risk factors according to guidelines • % of patients assessed for generic risk factors

TABLE 13 - Indicators of Health Opportunities (Level: Environment)

	Endpoints of health opportunities	
	Risk factors	***Resources***
Sub-dimensions		
socio-ecological context	• Number of snack machines for staff and patients.	• Non-smoking environment for staff and patients. • Environmental determinants of physical activity e.g. opportunities for exercise (staff and patients)
policy	• Hire and fire culture.	• % staff aware of health promotion policy • Access to healthy food (canteen/snack bars) • Existence of and adherence to an equal opportunity policy.
organisation/ network	• Multi-level hierarchy of staff.	• % budget dedicated to staff health promotion activities • The hospitals stated aims and missions, quality and business plans include and emphasise a health promoting approach. • Resources allocated to the processes of implementation, evaluation and regular review of health promotion policy. • Extent of continuing professional development programme for staff.
community	• Regularity of strike action by work force.	• social support amongst colleagues

Many of the examples above do not relate solely to hospitals, but can also be related to the workplace as a setting for health promotion intervention. This reflects the flexible nature of the EUHPID classification system, the search for commonalities among health promotion settings based indicators and their benefit to the development of the Health Promotion User Window in the ECHI Framework.

All of the settings based networks discussed above (and potentially those related to other settings – such as universities, prisons, etc), together with the EUHPID Monitoring System share an understanding of the principles and approaches stemming from the Ottawa Charter (WHO, 1986). It therefore remains of high importance to continue working together to ensure that a holistic view of health ensures that the ECHI system is robust enough to meet the challenges of tackling determinants of health across Europe.

Additional 'Expert' Discussions

One of the objectives of the EUHPID Project is to establish a classification system for health promotion professionals to use in integrated settings. To further achieve this aim and to test the usability of the EUHPID Health Promotion model, several members of the EUHPID Consortium led a workshop at the 11th Annual Conference of the European Public Health Association (EUPHA) in Rome. This event was used both as a dissemination exercise and as an opportunity to consult with a range of public health and health promotion 'experts', from a range of integrated settings. A primary aim was to discuss the use of the EUHPID health promotion model within the context of the workplace setting. Participants were asked to complete a practical exercise, which entailed using the EUHPID Health Promotion model to come up with examples of practical indicators. The emphasis of the session was on workplace

health promotion indicators, although reference was made to the relevance of the discussions to other settings including schools and hospitals.

The discussions centred upon the project as a growth area, and suggested that there is European-wide interest and support for addressing the dearth of health promotion indicators within practical settings. Participants called for greater EC investment in the area of European Health Promotion indicator development projects, and lent support for a second phase of EUHPID.

Development of Indicators at the individual level

The International Classification of Functioning (ICF) was investigated as to its value to the EUHPID task. The following areas were identified as relevant to individual indicator development for health promotion:

- Individual's physical/mental capacity to perform the specified activity (could relate this to specific settings)
- Individual's level of performance (i.e. capacity) at the specified activity (could relate to settings environment).
- Environmental determinants that affect the individuals (level of) performance: physical, social and cultural. (adapted from the ICF Project).

This work would form part of both the Health Promotion User Window development and explored in relation to further detailed development of the indicator set on Integrated Settings, both being part of the 2nd phase of EUHPID.

Dissemination of EUHPID

The progress of EUHPID has been actively disseminated through various conferences, meetings and publications (see Appendix 5).

Initial contact has been made with colleagues from each of the Accession Countries, who have expressed a formal interest in joining the EUHPID Consortium, and an initial list of experts drawn up (Appendix 10). The involvement of the Accession Countries is seen as essential in a 'truly' European EUHPID Phase 2.

Conclusions and Recommendations

Shifting Paradigms of Health

It is important in the first instance to emphasise the complexity of the task undertaken by the EUHPID Project in attempting to establish a European Monitoring System for Health Promotion based on a set of common health promotion indicators. This complexity relates to both our knowledge regarding health and our understanding of the need to develop comprehensive and effective approaches to health development.

This complex task has highlighted the limitations of our knowledge about the epistemology (how knowledge is acquired) and ontological (our understanding of what exists) dimensions of health and emphasised the need for further investment in knowledge creation and knowledge development regarding the holistic nature of health and its conceptual frameworks. This relates to the need to expand beyond pathogenic perspectives of health based on disease and risk factors (primarily physical) into more salutogenic perspectives based on improving health capacities and health opportunities at both individual and environmental levels. This necessary expansion is seen as part of a wider paradigm shift not only in knowledge creation but

also in the methodology and indicators needed to measure it. The majority of projects funded under the Health Monitoring Programme of the European Commission (EC) take a well established approach to indicator development based on traditional disease and risk factor measurement. The EUHPID Project recommendations reflect the need to build upon and complement these more tried and tested approaches by developing a more holistic perspective. They largely reflect need to fill the gaps in our knowledge which is essential if Europe is to operate a comprehensive public health information and knowledge advisory system to facilitate effective action and synergy at both Community and Member State levels.

Health Promotion

Health promotion is an area of practice that is subject to diverse interpretations. A majority of people perceive it as a form of health education – providing information and advise to bring about individual lifestyle change in behaviours affecting smoking, drinking alcohol, eating and taking physical exercise. But the EUHPID Project emphasises the complexity of health promotion as a major potential intervention tool that works at individual, group, community and societal levels; offering a continuum of approaches that include policy development and creation of supportive environments. This is reflected in the Ottawa Charter (WHO 1986) which forms the foundation for the EUHPID Model of Health Promotion, and the classification framework for the recommended European Health Promotion Monitoring System.

Recommendations to incorporate Health Promotion and improve ECHI

The impact of the EUHPID recommendations related to the above 2 complex areas has had a major practical impact on the core ECHI system for European health

indicators. The health development model which underlies the EUHPID Health Promotion Model and Monitoring System, is offered as a major contribution to the public health field, and to the ECHI Framework in particular, as a policy relevant focus for public health development at both European and Member State levels. The important distinction to grasp lies conceptually between health development as an ongoing process of human life and health interventions (such as health promotion and health services treatment, prevention and rehabilitation) as particular intentional and planned approaches aiming at sustainable change in the health development process of individuals and their environments. The health development model is suggested as common frame of reference to communicate which elements of the health development process are primary targets or leverage points of the respective intervention approaches.

The EUHPID Health Development Model therefore offers the ECHI framework, and thereby the EC Health Information and Advisory System, a more applied and policy relevant function by moving it from a rather static context to form a monitoring and planning tool for intervening in health development. It is recommended that this can be achieved by changing Class 4 of the ECHI system to form 'Health Interventions: Health Services' (which would include health care and disease prevention) and creating a new Class 5 'Health Interventions: Health Promotion'.

The recommended Class 5 will initially be comprised of the indicator sets related to Integrated Settings and Health Promotion Policy and Practice. It is also recommended that they include a range of indicators related to Health Protection – such as various healthy public policy regulations, for example, on smoking in public places/workplace, tobacco marketing/advertising, tobacco price/tax, drinking and

driving, seat belts and cycle helmets, food safety/labelling, etc. (Although the latter is not included in the current ECHI 2 core list).

In addition, the creation of a EUHPID Health Promotion User Window will reflect international best practice by taking a broader concept of health promotion. This tool will now enable active planning and monitoring of the priority areas in the EC Public Health Programme, in particular the interventions funded to tackle determinants of health. In so doing this will link directly to the public health priority areas based on various health interventions including health promotion policy and practice and those based on settings (schools, workplaces, for example); and will thereby establish dynamic strategic and operational synergy between the key pathways of the EC Public Health Programme and to those of the Member States.

EUHPID's current active involvement in the Working Party on Health Systems and proposal to join Working Party 7 on Indicators will help to facilitate this process.

The Establishment of a European Health Promotion Monitoring System including a set of Common Health Promotion Indicators

With regard to meeting specific objectives, the EUHPID Project has recommended a health monitoring system based on the EUHPID Health Promotion Model and classification system. This includes a common set of health promotion indicators which have been accepted into the ECHI-2 List of Recommended '1st Phase Core Indicators (shortlist)':

- Integrated Settings
- Health Promotion Policy & Practice

In addition the development of a Health Promotion User Window is recommended for further development.

The recommended health promotion indicators have resulted from a comprehensive review and analysis of health promotion indicators systems and comparative international work on health promotion indicator development. The 3 elements of the health development model define 3 main categories of health promotion outcome indicators – health opportunities indicators, health capacities indicators and health indicators. The first two categories can be considered as determinants of the third category – 'health outcome'. For each of these categories, sub-categories of indicators are defined by cross-tabulating sub-dimensions of the elements of health development with their salutogenic and pathogenic endpoints. This results in the following classification of indicators:

6 classes of health indicators;

disease – social, mental, physical

positive health/well-being – social, mental, physical

6 classes of health capacities indicators:

risk factors – social, mental, physical

resources – social, mental, physical

8 classes of health opportunities indicators:

risk factors – socio-ecological, policy, organisation/network, community

resources – socio-ecological, policy, organisational/network, community

Health Promotion Indicators related to Integrated Policies and Programmes in Settings

It became evident in carrying out the work of EUHPID that many networks of health promotion policy makers, practitioners and researchers are working in the field of

health promotion indicator development. It also became evident that they lack a common framework to provide them with an understanding of the complexity of health promotion processes and outcomes. In addition these networks are often focussed around settings such as the work place, school and hospital, for example. Therefore the EUHPID Consortium, building upon the above classification of indicators, has used the integrated settings approach to develop examples of practical indicators in the 3 settings related to workplaces, schools and hospitals. These indicators which are detailed in the text seek to demonstrate the value of the EUHPID Health Promotion Model in practice.

Health Promotion Indicators related to Health Promotion Policy & Practice

It is recommended that health promotion process indicators are classified by the 5 health promotion actions (adapted from the Ottawa Charter action areas) and 3 suggested dimensions of health promotion capacity – health promotion infrastructure, programme sustainability and problem-solving (Hawe et al 2000).

In order to develop this important area of health promotion indicator development, it is recommended that a set of indicators on health promotion policy and practice be adopted (it is recommended that this set supersede the existing 'Policies and campaigns on smoking, alcohol, diet, safe sex, drug use, sunlight exposure, physical activity, injury and suicide prevention' in the ECHI Core List and also incorporate the existing 'policies on healthy nutrition'). These indicators incorporate but expand well beyond 'campaigns on lifestyles' to include all aspects of health promotion policy at national, regional and local level, including indicators on policy formulation, implementation, infrastructure development, campaigns and programmes and their evaluation, and funding and workforce development. These indicator sets need to be

further elaborated in practice (building on the initial work of the HP Source Project) and extended to relate to the following indicator sets on integrated health promotion settings).

Health Promotion User Window

In addition of key importance is the recommendation for the development of a Health Promotion User Window, which reflects the breadth of health promotion and its relevance to users across the entire EHCI Community health indicators framework. An example is highlighted in the text in relation to health promotion indicators at the individual level related to the International Classification of Functioning (ICF). Further work is required into the development of a Health Promotion User Window, building upon the above indicators sets and relating them to the overall ECHI framework.

Recommendations on Suitable Methodology and Systems

Following a review and analysis of specific data gathering systems and collaborative work, it became obvious that health promotion indicator data is not regularly collected and collated at European nor Member State levels in any common or organised way. EUHPID therefore sought to analyse commonalities in possible data collection, reviewed examples of good practice, explored gaps and established development needs. It focussed on 2 aspects of current data collection that offered an opportunity to collect data on its recommended health promotion indicators. These related specifically to:

1) Data on Integrated Settings – which mean establishing strong working links with networks working in health promotion settings – principally work place, school and hospital; with the potential to expand to link with other settings networks – for example, universities, prisons, cities/communities. Clear

working links have been established between EUHPID and for example WHO Health Promoting Hospitals Network, the Work Health Project and the European Network for Health Promoting Schools.

2) Data on Health Promotion Policy & Practice – the HP Source Project had devised a questionnaire and had begun to collect data on a range of issues related to health promotion policy and infrastructures. Joint membership existing between the EUHPID and HP Source Consortia enabled good working links to be established.

Further development of these data collection sources is required in Phase 2.

Dissemination

The progress of EUHPID has been actively disseminated through various conferences, meetings and publications (see Appendix 5). Active links have been established with colleagues in all the Accession Countries who have expressed their interest and commitment to be involved directly in EUHPID's work (See Appendix 10). Strong working links have been established also with HP Source, the ISARE Project, WHO Health Promoting Hospitals Network, European Health Promoting Schools Network and EUPHA, IUHPE, and in the areas of Health Promotion Capacities (See Appendix 16) and Health Inequalities.

EUHPID has actively participated in regular meetings of the HMP Co-ordinators in Luxembourg, meetings with ECHI, and recently meetings of the DG SANCO Working Parties – particularly on Health Systems. It has also been proposed that EUHPID join also Working Group 7 on Community Health Indicators, which would enable the results of EUHPID Phase 1 to be incorporated fully into the future

development of the ECHI system and gain maximum benefit to the Public Health Programme.

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APPENDIX 1 – EUHPID Contract

GRANT AGREEMENT
SI2.324916 (2001CVG3-504)

Between

the European Community ("the Community"), represented by the Commission of the European Communities (**"the Commission"**), itself represented by Mr. Robert Coleman, Director-General of the Health and Consumer Protection Directorate-General,

of the one part,

and

University of Brighton with its registered office at **Miothras House, Lewes Road, BN2 4AT Brighton, United Kingdom**

("the beneficiary"), represented by **Professor Stuart Laing, Director of Academic Affairs**

of the other part,

have agreed as follows:

Article 1 – Subject matter

1.1 The Commission has decided to award a grant on the terms set out in this agreement and its annexes, which the beneficiary hereby declares it has taken note of and accepts, for the project entitled: "**European Health Promotion Indicators Development (EUHPID)**" ("the project").

1.2 The beneficiary accepts the grant and undertakes to carry out the project under its own responsibility.

A detailed description of the project is given in Annex I, which is an integral part of this agreement.

1.3 The beneficiary agrees to use the grant exclusively for the purpose of the project.

1.4 Person responsible for performing: **Mr John Davies**

1.5 The operation shall be carried out (principally) at: **Brighton, UK**

1

Article 2 – Duration

2.1 The project shall last for **18** months (from **01/11/2001** to **01/05/2003**) Expenditures corresponding to the operation shall be effected by the Beneficiary within this agreed period of performance. Only expenditures incurred during this period may be considered as eligible and taken into account in order to determine the total amounts due to the Beneficiary in relation to the present Agreement.

2.2 The agreement shall end on the date of the final payment due from the Commission.

Article 3 – Financing the project

3.1 The total cost of the project is estimated at EUR(€) 285.315,00. The detailed budget of the project is set out in Annex I, which is an integral part of this agreement.

The total cost of the project comprises only costs eligible for Community funding, as defined in Annex II. A fixed percentage of 7 % (maximum) of the total amount of eligible direct costs shall be eligible as indirect costs, in accordance with the conditions set out in Article 11.3 of Annex II.

3.2 The Commission shall provide a maximum amount of EUR(€) **192.255,00**, equivalent to **67.38** % of the estimated total cost specified in paragraph 1.

3.3 Should the real costs on completion of the project turn out to be lower than the estimated total cost specified in paragraph 1, the Commission's contribution will be limited to the amount calculated by applying the above percentage to real costs. The beneficiary undertakes to pay to the Commission any sums already paid in excess of this amount.

3.4 The beneficiary agrees that the grant may in no circumstances give rise to profits and that it must be restricted to the amount required to balance revenue and expenditure for the project.

3.5 The beneficiary accepts that the grant does not constitute a claim on the Commission and may not therefore be assigned to another body or transferred to a third party without the Commission's prior written consent.

Article 4 – Payment arrangements

4.1 The **Commission** shall pay the grant to the **beneficiary** as follows:

- EUR 57.676,50 maximum 30 % of the amount specified in Article 3.2) by way of an advance within 60 days of receipt of the payment request.

- EUR 76.902,00 maximum (40 % of the amount specified in the Article 3.2) within 60 days of receipt and acceptance of an interim activity report and of an interim financial statement of the **project** and a request for payment, under the condition that the costs incurred as

shown in the interim financial statement, have reached 30 - % of the total costs envisaged.

- the balance within 60 days of receipt and approval of the activity report and of a final financial statement of the project and a request for final payment.

4.2 Payment due from the Commission shall be made to the following bank account of the beneficiary :

bank account : **63329211**

bank address : **BARCLAYS BANK PLC**
South London & Sussex Corporate Banking Centre
PO Box 112
Horsham
West Sussex RH12 1YQ
United Kingdom

account held by : **University of Brighton**

4.3 The Commission shall make payments in euro. Accepted costs shall be converted into euro at the rate published in the C series of the Official Journal for the first day of the month following the end of the action.

Exchange losses are not covered by this agreement and shall be borne by the beneficiary.

4.4 The Commission may require the beneficiary to supply a bank guarantee in case of a large advance payment.

Article 5 – Reports and other documents

The following reports and other documents shall be supplied by the beneficiary -

5.1 1 interim report(s), 3 copies, including an interim financial report- and an interim report on the execution of the activities, at the following stage: **01/08/2002**

5.2 a final report by **01/08/2003** including:

- a detailed report (activity report) in 3 copies, on the execution of the activities as indicated in the technical description of the project proposal;

- where applicable, the materials produced and/or proof of services rendered as indicated in the technical description of the project proposal, including full details of the distribution of such materials and/or on the performance of such services, in 3 copies;

- a financial statement, in 3 copies, certified by the person in charge of the organisation receiving the contribution, accompanied by duly certified supporting documents and indicating the amount and type of expenditure incurred, together with the corresponding receipts (including the amount of the Commission subsidy);

- where applicable, the most recently dated auditor's report;
- the beneficiary agrees to keep specific detailed accounts for the project in question;

5.3 - the interim and final financial statements of revenue and expenditure must be presented in the same format as the annexed provisional budget, in order to facilitate the financial comparison and follow up; another presentation may render them unacceptable to the Commission.

Article 6 – General provisions

Any information supplied in connection with this agreement shall be in writing and shall be sent to the following addresses:

For the **Commission**:

Administrative questions:

European Commission
Directorate-General Health and Consumer Protection
Unit G3 – Mr Guiseppe Ostinelli
Euroforum building
10 Rue Stumper – Office EUFO 3186
L-2557 LUXEMBOURG

Or by e-mail: giuseppe.ostinelli@cec.eu.int

Or by fax: +352.4301.32059

Technical questions:

European Commission
Directorate-General Health and Consumer Protection
Unit G3 – Dr Henriette CHAMOUILLET
Euroforum building
10 Rue Stumper – Office EUFO 3191
L-2557 LUXEMBOURG

Or by e-mail: henriette.chamouillet@cec.eu.int

Or by fax: +352.4301.32059

For the **beneficiary**:

University of Brighton
To the attention of Mr John Davies
Miothras House,
Lewes Road,
BN2 4AT Brighton,
United Kingdom

Or by e-mail : J.K.Davies@bton.ac.uk
Or by fax : +44 1273 643473

Article 7 – Taxation

The beneficiary is subject to VAT.
The beneficiary's VAT No is 620 658 352.

Article 8 – Final provisions

8.1 The following documents are annexed to this agreement and are an integral part of it:

Annex I: Description of the project (budget included)

Annex II: General terms and conditions applicable to grant agreements of the Health and Consumer Protection Directorate-General

8.2 Should the provisions of the annexes and those of the agreement differ, the provisions of the agreement shall apply.

8.3 Article 9 "Amendment of the Agreement" of the General Conditions is completed as follows :
The beneficiary's request(s) for amendment(s) concerning extensions and budget modifications, will be considered only if the Commission receives them in writing at the latest two calendar months before the end of the period of performance set in Article 2.1 of the present Agreement. The beneficiary's request(s) for amendment(s) other than amendments for extensions and budget modifications, will be considered only if the Commission receives them in writing at the latest before the end of the period of performance.

Done at Luxembourg, in duplicate, in English.

(Please write "read and approved")

For the beneficiary Read & approved

S.I.L.

Professor Stuart Laing,
Director of Academic Affairs
1st November 2001

The University of Brighton

For the Commission

Robert J. Coleman

Mr. Robert COLEMAN
Director-General

12/11/01

APPENDIX 2 – EUHPID Consortium Members

Austria

Horst Noack
Institute for Social Medicine & Epidemiology
University of Graz
AU-8010 Graz, AUSTRIA
E-mail: horst.noack@kfunigraz
Tel no: +43 316 380 4398

Juergen Pelikan
Ludwig Boltzmann Institute for the Sociology of Health
and Medicine
University of Vienna
A-1090 Vienna, Rooseveltplatz 2, Vienna.
Email: juergen.pelican@univie.ac.at
Tel no: +43 1 4277 48230

Germany

Eberhard Goepel
Fachbereich Sozial-und Gesundheitswesen
Hochschule Magdeburg-Stendal
Breitscheidstr. 2
D-39114 Magdeburg, GERMANY
E-mail eberhard.goepel@sgw.hs-magdeburg.de
Tel no: +49 391 8864304

Belgium

Danielle Piette
School of Public Health
Universite Libre de Bruxelles
Route de Lennick 808 – CP569
B-1070 Brussels, BELGIUM
E-mail: Danielle.piette@ulb.ac.be
Tel no: +32 2 555 40 81

Stephan van den Broucke
Flemish Institute for Health Promotion
Gustave Schildkneckstraat 9
B-1020 Brussels, BELGIUM
E-mail: stephan.vandenbroucke@vig.be
Tel no: +32 2 422 4949

Greece

Yannis Tountas
Institute of Social and Preventive Medicine
32 Skouja Str.
GR-10673
Athens, GREECE.
E-mail: ispm@compulink.gr
Tel no: +30 17482015

Panos Th. Dimakakos
University College London
1-19 Torrington Place
London, UK
E-mail p.dimakakos@public-health.ucl.ac.uk
Tel no: +(0)207 679 1702

Denmark

Evelyne de Leeuw
Institute for Public Health
University of Southern Denmark
Winslowparken 19
DK-500 Odense C
Email: edeleeuw@health.sdu.dk
Tel no: +45 6550 3083/4157/4115

Neils Kr. Rasmussen
National Institute of Health
Svanemollevej 25, DK 2100 Copenhagen O,
DENMARK
E-mail: nkr@niph.dk
Tel no: +45 3920 77 77

Ireland

Margaret Barry
Department of Health Promotion
National University of Ireland
Galway
Clinical Science Institute
Galway, IRELAND
E-mail Margaret.Barry@nuigalway.ie
Tel no: +353 91 75 04 63

Finland

Lasse Kannas
Department of Health Sciences
University of Jyvaskyla
PO Box 35
40014 University of Jyvaskyla, FINLAND
E-mail kannas@pallo.jyu.fi
Tel no: +358 14 60 2154

Italy

Giancarlo Pocetta
Experimental Centre for Health Education, Dept of Hygiene
University of Perugia
Cp 45 PG3, I-06100 Perugia, ITALY
E-mail: gipocet@tin.it
Tel no: +39 075 585 7301

France

Vincent Bonniol
Department of Education Sciences, University of Aix-
Marseille 1,1 Avenue de Verdun, 13410 Lambesc, FRANCE
E-mail v.bonniol@educaix.com
Tel no: +33 44 257 1717

Norway

Maurice Mittelmark (*Until August 2003)*
Dept of Psychosocial Sciences and Research Centre for
Health Promotion, University of Bergen,
School of Psychology
Christies Gate 13 5015 Bergen, NORWAY
E-mail: maurice.mittlemark@psych.uib.no
Tel no: +47 55 58 32 51
Elisabeth Fosse (From August 2003)
Dept of Psychosocial Sciences and Research Centre for
Health Promotion, University of Bergen,
School of Psychology
Christies Gate 13 5015 Bergen, NORWAY
E-mail: elisabeth.fosse@psyhp.uib.no
Telephone: +47 55 58 27 58

Portugal

Isabel Loureiro
Rede Nacional de Escolas Promotoras de Saude (RNEPS)
Av. Infante Santo, 2-6
Lisboa Cedex, PORTUGAL
E-mail: isalou@ensp.unl.pt
Tel no: +351 21 3912200

The Netherlands

Nanne de Vries
Department of Health Education
Faculty of Health Sciences
University of Maastricht
PO Box 616, Maastricht 6200 MD
THE NETHERLANDS
E-mail: n.devries@gvo.unimaas.nl
Tel no: +31 43 388 2423

United Kingdom

John Kenneth Davies
International Health Development Research Centre
Faculty of Health
University of Brighton
Mayfield House
Falmer
Brighton BN1 9PH, UK
E-mail: J.K.Davies@brighton.ac.uk
Tel no: +44 (0) 1273-643476

Spain

Concha Colomer
Health Promotion Unit
Escuela Valenciana de Estudios para la Salud (EVES), Juan de Garay 21
E-46017 Valencia, SPAIN
E-mail: colomer_con@gva.es
Tel no: +34 96 386 93 66

IUHPE

Catherine Jones
IUHPE / UIPES
2 rue Auguste Comte
92170 Vanves, FRANCE
E-mail cjones@iuhpe.org
Tel no: +33-1 46 45 00 59

Sweden

Bengt Lindstrom
Nordic School of Public Health
Box 12133, S-402 42 – Goteborg, SWEDEN
E-mail: bengt@nhv.se
Tel no: +46 31 69 39

European Commission

John Ryan
Head of Health Monitoring
SANCO, European Commission
Luxembourg

Switzerland

Georg Bauer
Department of Health & Intervention Research
Institute of Social and Preventative Medicine
University of Zurich, Sumatrastr, 30
CH-8006 Zurich, SWITERLAND
E-mail: gfbauer@ifspm.unizh.ch
Tel no: +41 1 6344638

Ursel Broesskamp-Stone
Health Promotion Switzerland
(Gesundheitsforderung Schwiez)
Dufourstrasse 30, Postfach 311
CH 3000 Bern 6, SWITZERLAND
E-mail: ursel.broesskamp@promotionsante.ch
Tel no: +41 31 350 04 25

Secretariat

Based at:
International Health Development Research Centre
Faculty of Health, University of Brighton
Mayfield House, Falmer
Brighton BN1 9PH, UK

Belen Sanchez *(Until October 2002)*
E-mail: B.Sanchez@brighton.ac.uk
Tel no: +44 (0) 1273-644168

Chloe Hill (Jan 2003 - *October 2003)*
E-mail: C.Hill@brighton.ac.uk
Tel no: +44 (0) 1273-644168

Caroline Hall (*from October 2003)*
E-mail: Caroline.Hall@brighton.ac.uk
Tel no: +44 (0) 1273-644168

Xanthippe Tzimoula
E-mail: X.Tzimoula@brighton.ac.uk
Tel no: +44 (0) 1273-644538

Sue Ginn *(Until June 2003)*
E-mail: S.Ginn@brighton.ac.uk
Tel no: +44 (0) 1273-644169

Eleanor Linwood
E-mail: E.Linwood@brighton.ac.uk
Tel no: +44 (0) 1273-644169

Antje Stoewesandt *(Sept 2003 – January 2004)*
E-mail: A.Stoewesandt@brighton.ac.uk
Tel no: +44 (0) 1273-644536

APPENDIX 3a – EUHPID First Brighton Meeting

EUHPID Project

Notes from the Inaugural Meeting of the EUHPID Consortium

Held at the Russell Room, Royal Albion Hotel, Brighton, UK

23 to 24 February 2002

Present:	Richard Horst Noack (Austria) Evelyne de Leeuw (Denmark) Lasse Kannas (Finland) Eberhard Goepel (Germany) Panagiotis Th. Dimakakos (representing Yannis Tountas, Greece) Margaret Barry (Ireland) Giuseppe Masanotti (representing Giancarlo Pocetta, Italy) Bérénice Staedel (representing Anne Bunde-Birouste, IUHPE) Isabel Loureiro (Portugal) Concha Colomer (Spain) Bengt Lindstrom (Sweden) Georg Bauer (Switzerland) Nanne de Vries (The Netherlands) John Kenneth Davies (United Kingdom) Michael Whiting (University of Brighton) - part Sue Ginn (Secretariat)
Apologies:	Danielle Piette (Belgium) Maurice Mittelmark (Norway) Henriette Chamouillet (European Commission)

John Kenneth Davies welcomed colleagues to Brighton and to the first meeting of the EUHPID Project. He introduced Professor Michael Whiting, Dean of the Faculty of Health, University of Brighton and asked all colleagues to introduce themselves. Following this he invited him to formally open both the EUHPID and EUMAHP meetings. Professor Whiting thanked colleagues for attending the first meeting of the EUHPID Consortium, and those remaining in Brighton for the first meeting of phase 2 of the EUHPID Consortium. With regard to the latter he congratulated EUMAHP Consortium members for their contribution to the successful completion of Phase 1. He indicated his full support to JKD on behalf of the Faculty of Health and the University of Brighton in continuing to co-ordinate phase 2 of the EUMAHP Project and the new EUHPID Project. He expressed his own personal commitment to the importance of this work, in both academic and practical terms, in contributing to the improvement of health among all European citizens. Professor Whiting concluded by wishing all colleagues a successful and productive series of meetings.
Professor Whiting then departed due to other commitments
JKD acted as Chair on this occasion and updated participants on financial and administrative matters. He indicated that Sue Ginn would be responsible for the administration of reimbursement of expenses and colleagues should direct any queries to her during and after the meeting.

John Kenneth Davies

JKD then presented an overview of the EC Health Monitoring Programme and the background to the EUHPID Project (See Appendix 1). He indicated that further details were available to colleagues in a series of documents and through relevant EC

and project websites. In particular he highlighted the ECHI Project, already funded by the EC to provide a framework for a range of European health indicators being produced by numerous projects under the Health Monitoring Programme. One of the pressures on EUHPID would be to propose a series of European health promotion indicators to fill the gaps in the ECHI system. He then went on to introduce the EUHPID project itself, including its objectives. (See Appendix 2). Data would need to be perceived from the perspective of each Member State as well as at Community level. Our work would need to review and synthesize existing knowledge and build upon best practice, as well as producing new and innovative indicators.
JKD indicated that the Project had requested a 6 month extension, due to the inevitable delays due to start up and practical preparation – i.e. although officially the Project had a start date of 1 November 2001, it was planned that commencement would begin in practice from1 May 2002, when by that time we will have support from a part-time research officer, research assistant and administrative assistant.
In order to initiate and stimulate discussion, with regard to both content and methodology, JKD introduced the following issues:

- Canadian model for population health promotion
- Taxonomy of indicators
- Nutbeam Process model

JKD invited all colleagues to make some introductory remarks concerning health promotion indicators from their own experience and from the perspective of their country.

Lasse Kannas

- we have existing models and frameworks to help us - including Don Nutbeam's work.
- The scope is very wide - are we intending to cover everything or perhaps a specific level or dimension? Focussing perhaps on health promotion actions related to input indicators, rather than outcome. There is little evidence-based data on actions. Real health promotion indicators are related to processes - what really happens.
- Situation in Finland is very similar to other countries. Very little concerning actions/process indicators, which are poorly developed.

Eberhard Goepel

- ***National goals for health policy are established on the federal level.***
- Only a few groups in Germany working in this field - Bielefeld most prominent
- Need to relate our work to the action plan on environment and health - based on the human ecology approach and local environmental action plans – ecology related to social policy. The challenge is to conceptualise this approach – using perhaps a systematic social constructionist view.

- Multi level
- More emphasis on community view
- Many indicators on the inter/individual level
- Processes which relate to social capital.

Nanne de Vries

- Need to be practical – health promotion is an activity (promotion as a process and not just a health outcome). At each level – macro, meso, micro – need to consider education also.

Health Promotion

an activity	education is integral	we should be able to communicate	As a process
something going on		global, international, national, local	the way things are developed

- In Holland - apart from health monitoring work, there is an initiative related to QUI - quality of interventions. (See National Institute of Environmental Health and Municipal Health Services). We need to be activity oriented and get people to use the data base – Dutch Association for Health Promotion and Intervention (Hans Krosse) – get them to report what they do – exchange best practices – build respectability and credibility.
- This is a time to assemble information on all health promotion activities (in Holland) together in a data bank. This has only recently been started but could be a model for our indicator work.
- For the next meeting we could all read a book and get some ideas from say WHO Book on Health Promotion Evaluation as we will need to agree a common understanding, a common denominator. We need to breakdown then integrate - moving from health indicators to health promotion indicators.

Evelyne de Leeuw

- Endorsed splitting indicators up into manageable parts and then reintegrating them.
- We should be flexible.
- Introduced work accomplished on healthy cities indicators – highlighting 3 important reference books.
- Rebus - a GIS (Geographical Information System) - based health monitoring system which allows the user to compile data from different neighbourhoods in the city:

Basic indicators used in Rebus:

Health Safety Quality of environment Demography Social economic data Lifestyle	- See how we change and due to which factors - Can compare different neighbourhoods. - Graph is more like an index. - Compare neighbourhoods - Change over time within neighbourhood - health profiles (must be the result of all this indicator work) ❖ also infrastructure ❖ policy and management ❖ sometimes programmes ❖ recommendations ❖ sometimes 'coffee table books' (eg Padua)

- Suggested inviting Nils Rasmussen to the next meeting (urban health).
- Establish an Evaluation Advisory Committee – we have to deal with evaluation.
- Healthy Cities = more appropriate process indicators – at any organisational level. Indicators - published in 1996 and 2001. Explosion of indicators – from 17 to 83. Attempt at consolidation/reduction. Community participation indicators. Hard to collect and interpret. Problem system diversity - so enormous - sometimes have trouble collecting right data and information. If cities don't regard as reliable they won't report on it - some cities made indicators up - some were honest: one of the biggest problems. Process indicators = MARI assessment – (3rd level Healthy Cities grid) can be some work done in parallel with what we do here = 400 indicators? – September 2002. Only internal documents so far - book to be published next year. Will there be a fourth phase of healthy cities?
- grid - should be able to define priorities within grid - elements focussing on policy, vision, output.

Bengt Lindstrom

- salutogenic model referring to the Ottawa Charter, social capital and (adult) good quality of life. Interested in the salutogenic model (open concepts) and resilience research (fixed concepts). Both could be interesting in a discussion about indicators.
- find indicators that work both in practice and are evidence based.
- Competitive/comparison indicators - cannot be manipulated (invented) - good impact on person's life. For example - Perinatal mortality - ultra scans resulted in terminations therefore malformed child was not born. This affects indicators. Open ideas can be transformed. Child health - social care.
- Work with essences - what is important (find indicators in context in a qualitative way).
- Rootman et al WHO Health Promotion Evaluation book - useful.

Panos Dimakakos

- Need to focus on health promotion as a process
- Participation = key (bottom-up/top down)
- Contextual vs individual indicators
- Concept of need is important
- Careful use of existing models

Maurice Mittelmark (reported by JKD)

Priority should be given to:

- reviewing what is going on already in the field of health promotion indicators – for example - Health Canada work on mental health promotion indicators = determinants of good mental health, self efficacy, positive mental health at individual and population levels as determinants of global health
- WHO International Classification of Functioning (ICF) – environment (social) and personal competencies
- Community level and systems level

Concha Colomer

- must define Health Promotion Indicators and move health promotion forward from just considering health risk behaviours.

- provided these backgound issues to help create ideas - Spain in 1986 produced a Government: Health for all Strategy but little done; 2000 Spanish Society for Public Health – Health for All indicators – but more related to preventative medicine (immunisation, screening) and risk factor prevention of behaviours such as tobacco and nutrition (nothing on more structured macro or meso policy indicators)

- Research Project - rapid appraisal approach as a regional strategy for Valencia

- In summary – in Spain has been focus on micro level – education and information campaigns based on KAP model; nothing on meso or macro levels – no evaluation, no tools developed

- Social and gender equity important for evaluation and planning activities

- Important to include implementation and dissemination phases with regard to indicators and evidence-base – found IUHPE Effectiveness Book hard work and professionals can't understand it. (Would their 2nd phase address this?)

Berenice Staedel

- BS indicated that she was new to IUHPE Paris HQ and representing Anne Bunde- Birouste (Programme Director). She indicated that IUHPE's work in this area focussed on the Effectiveness Study, funded by the EC. The first phase of this resulted in the 2 volume book which has been widely disseminated; and currently they have an application with the EC for a dissemination phase within named countries of Europe. The Effectiveness work of IUHPE is a global project, of which the European work has formed a core part. BS indicated further details can be provided through AB-B.

Guiseppe Masanotti

- In Italy have 38 Health for All target monitoring – but regional local level focus and not national – difficult to obtain national data

- Established health promotion observatory – linked to regional responsibilities (for economic as well as health issues). Called together a number of experts who produced a list of 280 indicators (using less than 100 in pilot work) in 5 Italian Regions – Umbria, Piemonte, Veneto, Emilia Romagna and Lombardia. (Being co-ordinated by Lamberto Briziarelli and Giancarlo Pocetta).

Georg Bauer

- In Switzerland – 26 cantons, 4 languages, many cultural differences, 20% migrants, differences between cantons and Federal levels

- National Observatory established in 2002 – produced 160 health indicators – pragmatic, making data more accessible, using existing data from health care services, psychological indicators, health of the elderly

- About half of the cantons have health promotion delegates (biggest department has 10 people)

- Swiss Foundation for Health Promotion – established in 1993, but since 1998 new health care insurance (1.5 euros from each inhabitant into Foundation) – youth health, exercise, nutrition, etc.

- Health promotion indicators – used Nutbeam outcome indicators model; measures to quantify and measure health promotion for applied use – underlying theory for communication and framing agenda; health outcomes = highest value (based on positivistic, experimental paradigm); need to consider alternatives in the causal chain – social construction of indicator development – most successful using stakeholders/users. Attempts in Switzerland in the past haven't worked.

- Need to consider community health (sustainability movement/social constructionist movement) = healthy community – local community based indicators; health promotion as a process; how are healthy cities more sustainable – environment better focus than health? What determines health?

- Consumerism and health – tourism, hotels, wellness centres, health farms – growth of health technology – ethics of health promotion = new kind of discourse – important dimension of indicators.

<u>Horst Noack</u>

- Issues in the field of health promotion indicators
  - Indicator projects in Switzerland/Austria
  - Complexity/dynamics
  - Frameworks/paradigms
- Need to break out of public health medical model – to come from another direction

- Carried out numerous health measurement surveys - including computer-based telephone interviewing – 5k household survey of family care for the elderly for care givers; planning a studies of elderly/middle aged people in communities and primary school children

- What does health mean? Theory (frameworks) Values (ethical, political), Knowledge/information (evidence).

- Epistemology – nothing more practical than good theory. We need models at individual and social levels. Knowledge technology – indicators, indicies, profiles, stories = social constructionist. Levels = micro, meso and macro. Macro, meso and micro levels - to have comparable data on health promotion eg healthy cities indicators, health behaviour of school children/cultural meaning - to refine indicators adapted to each situation

- Scientific or policy model? Biased towards latter = knowledge for health policy purpose – what are aims and objectives of doing this? Preference is for a theoretically sound (agreed) policy framework.

- Need theoretically sound and agreed models for policy frameworks – aims, goals, perspectives, ideas about means and strategies – health promoting actions in a community-setting – 'empowering'

- Principles of health promotion

    - Empowerment – community/local/individual- to listen (feelings, competences); feel able to self-evaluate, accountability)

    - Participation – mobilisation of capacity (internal/external); self-evaluation – construct their own indicators.

    - Sustainability – policy measures, professional's enthusiasm, local impact, ownership

    - Intersectorality – common training, common planning, financial sharing

    - Equity

Measuring change process and dynamics difficult to capture by indicators. (sensible, reliable, tangible, valid). How to measure effectiveness?
Indicators have to be meaningful for the purpose of what we are trying to evaluate.

<u>Margaret Barry</u>

- Good timing for this Project – chance of good link in Ireland – Government discussing health promotion indicators – health promotion unit in Dublin establishing dialogue with regional/local health promotion managers – therefore significant nationally to health promotion accountability and success

- 2000-2005 Irish Health Promotion strategy – move towards topics, population groups and settings

- National Health and Lifestyle Survey (from University of Galway); Health Promotion in Schools Survey, National Unit for Health Inequalities – a lot of data around in Ireland – now looking at data on All Ireland basis (whole island) – and keen to harmonise at European level, especially mental health promotion.

- Need to consider dynamics of processes in action related to positive health indicators and protective rather than risk factors

- Need to interface with evidence debate. What should be the unique indicators we should use?

Isabel Loureiro

- Do we share the salutogenic paradigm?

- What does success mean for us - what are we trying to achieve?

- This is an opportunity to share experiences/best practice

- paradigms

- methodologies

- what is relevant/makes sense

Working Methods - JKD

Timescale

The Project will run for 18 months in the first instance (taking account of the requested 6 month extension) – this means that we will be able to incur costs against the project budget until 1 November 2003 when our final report needs to be completed in practice). An interim report on the Project work and budget needs to be submitted to EC by 1 November 2002.

Staff support

We were in the process of appointing 3 half-time support staff - research officer, research assistant and administrative assistant.

Website

A EUHPID Project Website would be established on an interactive basis – allowing authorised users to both upload and download documentation. The details of health monitoring database and website would be included to allow others to upload to site.

Budget

In the Project budget there is financial support for consultancy and buying in expert time. 4 full EUHPID Consortium meetings have been built provisionally into the contract budget and if all these are felt not necessary, resources could be used for some smaller group work – perhaps in the form of a contractual arrangement with the University of Brighton as the fund holders. We have this flexibility to achieve the Project objectives, as long as we remain in budget.

Chair

JKD proposed the desirability of rotating the Chair at future meetings of the Consortium.

EC Public Health Programme

We needed to be clear about the context that we are working in – that we are part of the EC Health Monitoring Programme, and need to fit into the existing and planned network of Programme Projects. Having said that if we feel that our conceptual/epistemological/theoretical is somewhat different than the majority of other health monitoring projects we will need to convince EC and others (ECHI) of this. We need to see this as an initial phase, and consider its sustainability in the longer term – especially if we see the desirability of a second phase.
JKD reminded colleagues that in the new European Public Health Programme – pathway 1 would relate to health monitoring and pathway 3 to tackling determinants of health through health promotion and public health. We needed to consider linkages therefore between these key pathways of the new programme.

Working Groups

MB said she is in favour of working groups rather than core groups as she felt everyone needs to be involved in making decisions. JKD said he would be happy with working groups as people will be sharing the workload. JKD made the point that we need a real commitment from people who want to contribute practically. We need active participants. He added that it was sad for France that they are not participating in this group as no one willing to take part had be identified. NdV agreed to approach French colleagues following the meeting in an attempt to secure a Consortium member from France – he would inform the Secretariat as appropriate.
CC proposed that the full plenary Consortium should meet every six months in order to take difficult decisions together, with all countries taking part. Other decisions that should be taken together are organisation, budget, meetings – to share all responsibilities and decisions.
A copy of the proposed ECHI template indicator would be circulated to Consortium members for consideration as a working tool.

Conferences

Preparing for conferences is one way of raising awareness of the project, focussing our efforts and obtaining feedback from other colleagues (they can also act as convenient milestones in the development of the Project – see later section.). JKD highlighted the IUHPE European Conference on Effectiveness – Royal College of Physicians, London, 11/13 June 2002, and informed colleagues that he had provisionally submitted an abstract for a workshop-type session on the EUMAHP Project. Those Project members interested in contributing practically and participating should inform JKD – they would present on behalf of the EUHPID Consortium. JKD indicated the desirability of the Project Consortium developing a position paper/EUHPID rationale/concept paper for June conference. There will be an opportunity there to debate as people will be interested.
IL asked whether attendees were aware of the September conference on Health Promoting Schools. There is a big interest in getting researchers involved through perhaps special workshops. IL will send information to Secretariat.
JKD stressed that if anyone knows about any relevant future conferences or similar events they should let the Secretariat know.

Research Work

Framework 6 on Research offers opportunities to network with other programmes. We need to put this on our agenda as it is part of our job to link with appropriate European work.

JKD indicated that there are opportunities for individual contracts to carry out specific work, which should fit within the policy environment of EC or it probably won't get extra/further support/funding.

Publications

BL asked could we decide fairly soon what papers we want to produce. BL said that it would only take him a week to write a paper.

Proposed EUPHID Organisational Framework

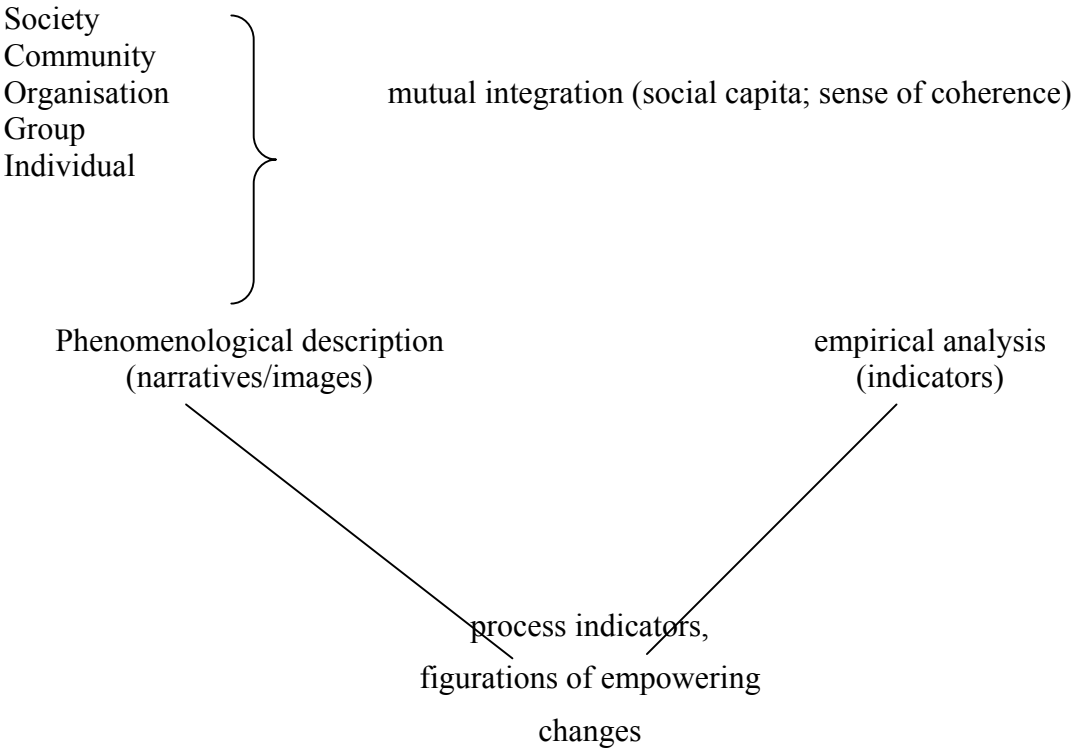
An organisational framework was proposed, which consisted of 4 dimensions:

- EUHPID in Practice (implementation; tools) - NdV
- EUHPID in Theory (methodological considerations) – GB, EdL
- EUHPID in Comparative Context of other projects (documentation scanning) - JKD
- EUHPID In European and National Policy Contexts (in relation and action towards policies of EU and Member States) - JKD

There was agreement that we favour the conception of health promotion action based on the Ottawa Charter. We could use the above as a working framework.
MB advised to take it step by step and review the framework.
EG wanted to avoid making decisions on models at this stage.
EdL said that she would send lists of indicators to JKD over the next few weeks.
MB said we need to be more systematic and review what is there first.

Proposed EUHPID Conceptual Framework

We need to reconceptualise different elements of health promotion:



Health Promotion = advocating, enabling, mediating

EUHPID Working Groups/Tasks

It was decided that EUHPID work groups should be defined on the basis of the personal preferences/interests/own disciplines of Consortium members. The working groups in terms of their work content and named membership (in some cases) are not mutually exclusive. All EUHPID Consortium members are encouraged to participate actively to ensure an equitable division of labour and expertise.

1. Concept Paper for EUHPID Conceptual Framework

To construct an evidence-based salutogenic process indicator for health promotion. BL offered to write first draft of this concept paper. This work will contribute to development of a conceptual framework for EUHPID.

2. Rationale Paper for EUHPID Policy Framework

This work will contribute to the development a policy framework for EUHPID. HN/EdL agreed to produce this rationale paper by 8 June and create recommendations.

Work will include –

- Definition of rationale
- why health promotion indicators are needed
- review available frameworks and recommend more sophisticated framework for EUHPID

- propose timescale and programme of work

This will be achieved through the following process:
All Consortium members to review existing frameworks and send initial comments to HN by 19 April. HN will then share with EdL.
Examples of types we know include:
- review/taxonomy/classification (GB)
- Nutbeam outcome model
- WHO Evaluation book = McQueen & Anderson chapter
- Healthy cities – EdL
- Health Promoting schools – IL
- Complex community initiatives – MB
- IUHPE Effectiveness – ABB
- Worksite Euro Health Network (GB)
- MARI (EdL)
- etc

HN will produce initial draft rationale by 26 April – then EdL, ABB (BS), GB, MB, IL (allow 2 days for each)
Responses to HN by 13 May - then telephone conference of above working group around 15 May to discuss and agree recommendations
Final draft mailed to all Consortium members by 20 May
Final comments to HN by 30 May
HN produces final draft for agreement at EUHPID meeting on 8-9 June
Presentation and discussion at London Conference on 11-13 June.

3. Review Paper on Health Promotion Indicators

This will feed into the EUHPID comparative context framework.

We need to review the current state of relevant work on health promotion indicators such as the recommendations of the WHO Working Group on Evaluation, IUHPE Project on Effectiveness, Swedish work on quality indicators, work programmes of the British public health observatories, work on indicators related to the European health promoting schools network and healthy cities movement, and so on. We need to be up to speed on all these and other relevant work. This would be co-ordinated by EUHPID Secretariat once research staff appointed. Each EUHPID Consortium member (or their representative) would be called on to contribute their knowledge, experience and contacts to this process. Therefore each member had responsibility from now on to keep themselves up to date on all relevant indicators work in their relevant country and field of special interest/expertise. No-one else can do this from the same cultural/contextual perspective – the true European added-value. We needed to achieve agreement that we are all on the same 'wavelength' with regard to both policy framework and analytical framework.

4. EUHPID in Practice Working Group

(to be led by NdV)

To consider goals, processes, and outcomes – also evidence-directed.
Anyone in the Consortium can from their experience pick health promotion activities or events and report to the whole group the types of indicators used; what was missing; levels – micro, meso, macro; whether evidence-based; quantitative and/or qualitative indicators; etc – then report back to the centre, then disseminate – share papers through virtual discussion
Work from theory and models – explore WHO evaluation work – indicators related to models.

5. Theoretical Basis for EUHPID Working Group

To consider methodological issues

To be led by EdL.

6. EUHPID within the Comparative Context of Other Related Projects Working Group

This will link into the review work in 3. above, and be led by the EUHPID Secretariat.

7. EUHPID European and National Policy Contexts Working Group

This will be led by the Secretariat. Some of the relevant external links are:
EC Health Monitoring Programme (EUHPID funding to November 2003)
EU Public Health Programme 2003-2006 - 3 pathway/strands – health monitoring, rapid reaction to threats, tackling health determinants through health promotion and disease prevention (EUHPID phase 2? Also consideration of theoretical and analytical framework linking pathways 1 and 3 in particular?)
EU Framework 6 Research programme 2002-2006 – networks of excellence (EUHPID network proposal?)
IUHPE HQ Effectiveness Project – (connection to EUPHID work especially in Europe?)
IUHPE European Region – conferences in London (June 2002) and Perugia (June 2003)
WHO Health for All Monitoring – (connection to EUHPID?)
European Network of Health Promotion Agencies – potential link to national agencies and to ENHPA work – re Research Directors Proposal?
European Public Health Association – conferences in Dresden (Nov 2002) and Oslo (Nov 2003)
European Public Health Alliance - ?
ASPHER - ?
EC European Health Promotion Networks – schools, workplaces, hospitals, healthy cities/megapoles, etc? Links to work on theoretical and analytical framework for future EC Public Health Programme?)
Developments in Member States – must be clear links
Developments in new accession states – exploration of potential links

National Policy Contexts of Member States – directly and through Consortium members.

Next Meeting of the EUHPID Consortium

This was planned for the weekend before the IUHPE European Effectiveness Conference and therefore would be held on 7-9 June in London. (Ibis Hotel near Euston Station).
CC thanked JKD on behalf of the Consortium for taking the initiative for EUHPID, putting together the successful proposal to the EC and organising this first meeting of the Project. .
Expression of interest formally made by Professor Thomas Abel, University of Bern, Switzerland who wants to collaborate with EUHPID (His contact details are as follows: +41-31-6313428; +41-31-6313512; abel@ispm.unibe.ch).

ACTION POINTS & TIMETABLE**EUHPID Rationale Paper**

Notes from Brighton meeting & revised timescales to all members - 8 April
Circulation of various documents to all members - 12 April
Reflection & comments from all members on issues discussed at Brighton meeting on health promotion indicators to HN - 19 April
HN produces initial draft rationale paper - 26 April
HN circulates to work group members (EdL,ABB/BS,GB,MB,IL) who each have 2 days each to circulate draft and return to HN - 13 May
Telephone conference as necessary -c 15 May
HN sends draft to all Consortium members for comments - 20 May
Final comments from all members to HN - 30 May
HN prepares final draft for presentation at EUHPID London meeting - 8 June
Presentation by Consortium members present at London Conf - 11/13 June

EUHPID Concept Paper

BL to produce initial draft of Concepts paper & circulates

to all members for comments - 19 April
Responses back to BL - 13 May
BL circulates 2 draft prior to next EUHPID meeting - 24 May
Discussion of final draft at EUHPID London meeting - 8 June

EUHPID in Practice Working Group

Comments back to NdV in preparation of paper/work plan for circulation prior to EUHPID London meeting - 24 May

Discussion at next meeting - 8 June

EUHPID Theory & Methodology Working Group

Comments to EdL on theory and methodology in preparation

of paper/work plan for circulation prior to EUHPID London meeting - 24 May
Discussion at next meeting - 8 June

EUHPID in Context of Other Projects Working Group

Comments to JKD in preparation for paper/work plan for

Circulation prior to EUHPID London meeting - 24 May
Discussion at meeting - 8 June

EUHPID Working Group on European & National Policy Contexts

Comments to JKD in preparation for paper/work plan for

Circulation prior to EUHPID London meeting - 24 May
Discussion at meeting - 8 June

APPENDIX 1

1st Meeting of EUHPID Consortium,

Brighton 23-24 February 2002Contribution by

John Kenneth Davies

An Introduction & Background Review

EU Public Health

- **Introduced 1 November 1993**
- **Article 129 of Maastricht Treaty**
- **Programmes adopted in co-decision**
- **Article 152 of Amsterdam Treaty**
- ***Budget = 50m ecus (1998)***
- **= 0.6% EC budget**

Public Health Programmes

- **1987 Cancer = 64m euros**
- **1991 HIV/AIDS + other com diseases = 49.6m euros**
- **1991 Drugs = 27m euros**
- **1996 Health Promotion = 35m euros**
- **1997 Health monitoring = 13.8m euros**
- **1999 Accidents + self inflicted injuries = 14m euros**
- **1999 Rare diseases = 6.5m euros**
- **1999 Pollution-related diseases = 3.9m euros**

Health Monitoring Programme

- **5 year Health Monitoring Programme (proposed 1995) but started 1998**
- **3 pillars:**
  - **System of Community Health Indicators**
  - **Community-wide network for sharing and transferring health data between member states**

- **Methods and tools for analysing health status, trends, determinants (to inform policy)**

Programme of Community Action in Public Health 2001-2006

- **Improving health information and knowledge**
  - **By comprehensive health information systems**
- **Responding rapidly to health threats**
  - **Such as communicable diseases**
- **Addressing health determinants**
  - **Through best practice in effective health promotion and disease prevention measures**

New Action Programme

- **The European Health Forum**
- **European Health Monitoring Centre?**
- **Integration with other policy areas**
- **Budget - 300m euros over 6 year programme**
- **Too much domination by Brussels?**
- **A change in structure rather than in content and scope of EU health policy?**

European Community Health Indicators (ECHI)

- **Measure health status, its determinants and trends throughout the European Community**
- **Facilitating planning, monitoring and evaluation of Community Programmes**
- **Provide Member States with appropriate health information to make comparisons and support national policies**

ECHI - comprehensiveness:
main categories of indicators

- Demographic and Socio-economic factors
  - population
  - socio-economic factors

•Health status

–mortality

–morbidity disease-specific

–generic health status

–composite health status measures

•Determinants of health

–personal and biological factors

–health behaviours

–living and working conditions

•Health services and health promotion

–prevention, health protection, health promotion

–health care resources

–health care utilisation

–expenditures/financing

–health care quality

Flexible use of indicator list: User-windows

•Specific areas of policy interest

–Cockpit information

–Health in other policies

•Thematic entries

–Health inequalities

–Health of mother and child

•Disease-related entries

–Cancers and their determinants/policy actions

•Priority list

–Current EU focus areas (determinants, health promotion, health in other policies, etc.); to be used for priorities in data development

Proposed objectives for ECHI-2

–An improved and more precisely defined indicator list, based on other HMP projects and other relevant sources;

–A more explicit link with EU and MS policy priorities;

–Working out the user-windows concept as a tool for flexibility;

–Making an updated inventory of international indicators, after the ICHI example issued in 1999 by WHO/EU;

–Use of ECHI frame in policy and in prioritising harmonised data collection; role in the new EU Public Health Action Programme?

ECHI-2 activities; link with policy priorities

- **Seek feedback on the ECHI-1 report and its use by MS policy makers.**
- **Produce a short inventory of uses of ECHI in the Commission and Member States.**
- **Promote the awareness and use of ECHI (and via ECHI also results from other HMP projects) in MS.**
- **Update the current health policy priorities in each MS (or autonomous region).**
- **Seek advice from the High-Level Committee on Health.**
- **From this, define user-window list of current hot items for which the development of comparable data collection in Europe should receive the highest priority.**

ECHI-2 activities; parties involved

- **ECHI-participants:**

–initiating, approving and directing activities;

–taking part in subgroups to implement groups of indicators;

–feedback with Member State policy representatives.

- **HMP project co-ordinators:**

–exchanging input during and between project co-ordinators meetings;

–taking part in subgroups to implement groups of indicators;

- **Project co-ordination and support:**

–other communication, overall management; updating the international indicator list (update of ICHI), with partners.

ECHI-2 activities; proposed subgroups for areas of indicators

- **Disease-specific morbidity;**
- **Other health status;**
- **Demography and determinants;**
- **Health systems.**

Projects 1998

- ***Alcohol consumption***
- ***Health surveys***
- ***Health status -> health expectancies***
- ***Causes of death statistics***
- ***Monitoring of sentinel practice***
- ***Socio-economic differences in health indicators***
- ***Eucomp - health care systems***
- ***Mental health***
- ***State of health in EU in 2000***

Projects 1999

- ***Food availability from Household Budget Surveys***
- ***Indicators in EU regions***
- ***Disease-specific morbidity data***
- ***Highlights on health in accession countries***
- ***Rasch Conversion of disability data***
- ***European health risk monitoring***
- ***Use of routine medical data***

- ***European physical activity surveillance system***
- ***Assessment of health interventions***
- ***European food consumption survey method***

Projects 2000

- ***Musculo-skeletal conditions***
- ***Public health nutrition***
- ***Evaluation of public health reports***
- ***Human resources in health systems***
- ***Perinatal health***
- ***Child health***
- ***hospital data***
- ***Cardiovascular indicators***
- ***Indicators on diabetes***

Projects 2001

- ***Indicators for monitoring cancer***
- ***Comprehensive cancer monitoring***
- ***Indicators for COPD and asthma***
- ***European reproductive health indicators***
- ***Health information systems in Europe***
- ***Policy health impact assessment for EU***
- ***Pharmaceutical products***
- ***Benchmarking health monitoring programmes***
- ***European health promotion indicators***

EUHPID Project Aims

- **To establish a European Health Promotion Monitoring System, including a set of common health promotion indicators**

- **To recommend suitable methodology and systems to collect the above data on health promotion indicators and activate the monitoring system**

- **To recommend dissemination strategies to policy makers and practitioners at Community level and within Member States**

APPENDIX 2.

1st Meeting of EUHPID Consortium,

Brighton 23-24 February 2002Contribution by ohn Kenneth DaviesHealth Promotion Indicators

EUHPID Project Timetable

- **Start date 1 November 2002**
- **18 month project**
- **6 month extension requested**
- **Can incur costs to 1 November 2003**
- **Final report by 1 February 2004 latest**

EUHPID Project Tasks

•Stage 1

–Production of set of health promotion indicators (May 2002 - June 2003)

•Stage 2

–Production of suitable methodology and systems to collect data (November 2002 - April 2003)

•Stage 3

–Establishment of European dissemination strategies (March 2003 - October 2003)

–Final report by 1 November 2003

An Health Indicator

- **A measure that reflects, directly or indirectly, the occurrence of a health-related phenomenon, some aspect of a health-related**

phenomenon or a process that could influence the occurrence of a health-related phenomenon

Health Promotion

- **"the process of enabling people to exert control over, and to improve, their health" (WHO 1986)**
- **Tackling determinants at levels of individual health behaviours and social, economic and environmental conditions**
- **Health promotion matrix**
  - **Setting; health issue/disease/risk factor; population group**

Health Promotion Objectives

- **"health promotion programmes and interventions need to be assessed in relation to the social and structural influences that determine health. They therefore need to adopt an approach that implicitly acknowledges the need for outcome data but explicitly concentrates on process or illuminative data that helps us understand the nature of that relationship"**

•Macdonald & Davies (1998)

Need for Mixture of Process and Outcome Information (WHO 2001)

- **Widening outcome to processes and outcomes in Ottawa Charter**
- **Design practical outcome measures**
- **Use indicators at various levels**
- **Proximal and distal outcomes**
- **Indicators clarifying links between healthy public policy and health status**

Planning, Implementation & Evaluation of Health Promotion

- **Problem definition**
- **Solution generation**
- **Capacity building**

- **Implementation**
- **Process, impact & outcome evaluation**

–Nutbeam 2001

APPENDIX 3

Proposed Forward Planning Milestones

First EUHPID Consortium meeting	- February 2002
EUHPID Website	- April 2002
2nd meeting, IUHPE London Conference, flier, position paper	- June 2002
Interim Report, 'country reports'	- October 2002
EUPHA/Dresden Conference, EUHPID brochure	- November 2002
3rd meeting	- April 2003
IUHPE Conference/Perugia	- June 2003
4th meeting, final report	- September 2003

APPENDIX 3b – EUHPID London Meeting

EUHPID Project

Notes from the Second Meeting of the EUHPID Consortium
Held at IBIS Euston Hotel, London, UK
8 to 9 June 2002

LIST OF PARTICIPANTS

Richard Horst Noack
Institute for Social Medicine & Epidemiology
University of Graz
AU-8010 Graz
AUSTRIA
E-mail horst.noack@kfunigraz
Telephone +43 316 380 4398

Juergen Pelikan
Ludwig Boltzmann Institute for the Sociology of Health and Medicine
University of Vienna
A-1090 Vienna
AUSTRIA
E-mail juergen.pelican@univie.ac
Telephone +43 1 42 77 48230

Giancarlo Pocetta
Experimental Centre for Health Education, Dept of Hygiene
University of Perugia
Cp 45 PG3
I-06100 Perugia
ITALY
E-mail gipocet@tin.it
Telephone +39 075 585 7301

Danielle Piette
School of Public Health
Universite Libre de Bruxelles
Route de Lennick 808 – CP569
B-1070 Brussels
BELGIUM
E-mail dpiette@ulb.ac.be
Telephone +32 2 555 40 81

Bengt Lindstrom
Nordic School of Public Health
Box 12133
S-402 42 – Goteborg
SWEDEN
E-mail bengt@nhv.se
Telephone +46 31 69 39

Maurice Mittelmark
Dept of Psychosocial Sciences and Research Centre for Health Promotion
University of Bergen
School of Psychology
Christies Gate 13 5015 Bergen
NORWAY
E-mail maurice.mittlemark@psych.uib.n
Telephone +47 55 58 32 51

Stephan Van den Broucke
Flemish Institute for Health Promotion
Gustave Schildkneckstraat 9
B-1020 Brussels
BELGIUM
E-mail stephan.vandenbroucke@vig.be
Telephone +32 2 422 4949

Isabel Loureiro
Rede Nacional de Escolas Promotoras de Saude (RNEPS)
Av. Infante Santo, 2-6
Lisboa Cedex
PORTUGAL
E-mail Isabel.loureiro@ppes.min-edu.pt
Telephone +351 21 3912200

Evelyn de Leeuw
Institute for Public Health
University of Southern Denmark
Winslowparken 19
DK-5000 Odense C
DENMARK
E-mail edeleeuw@health.sdu.dk
Telephone +45 6550 3083

John Kenneth Davies
Faculty of Health
University of Brighton
Falmer
Brighton BN1 9PH
UK
E-mail J.K.Davies@brighton.ac.uk
Telephone +44 (0)1273-643476

Vincent Bonniol
Department of Education Sciences
University of Aix-Marseille 1
Hotel Dieu
1 Avenue de Verdun
13410 Lambesc
FRANCE
E-mail v.bonniol@educaix.com
Telephone +33 44 257 1717

Georg Bauer
Department of Health & Intervention Research
Institute of Social and Preventative Medicine
University of Zurich
Sumatrastr, 30
CH-8006 Zurich
SWITERLAND
E-mail gfbauer@ifspm.unizh.ch
Telephone +41 1 6344638

Eberhard Goepel
Fachbereich Sozial-und Gesundheitswesen
Hochschule Magdeburg-Stendal
Breitscheidstr. 2
D-39114 Magdeburg
GERMANY
E-mail eberhard.goepel@sgw.hs-magdeburg.de
Telephone +49 391 8864304

Ursel Broesskamp-Stone
Health Promotion Switzerland
(Gesundheitsforderung Schwiez)
Dufourstrasse 30
Postfach 311
CH 3000 Bern 6
SWITZERLAND
E-mail
ursel.broesskamp@promotionsante.ch
Telephone +41 31 350 04 25

Nanne de Vries
Department of Health Education
Faculty of Health Sciences
University of Maastricht
PO Box 616, Maastricht 6200 MD
THE NETHERLANDS
E-Mail n.devries@gvo.unimaas.nl
Telephone +31 43 388 2423

APOLOGIES

Margaret Barry
Department of Health Promotion
National University of Ireland
Galway
Clinical Science Institute
Galway
IRELAND
E-mail Margaret.Barry@nuigalway.ie
Telephone +353 91 75 04 63

Concha Colomer
Health Promotion Unit
Escuela Valenciana de Estudios para la Salud (EVES)
Juan de Garay 21
E-46017 Valencia
SPAIN
E-mail colomer_con@gva.es
Telephone +34 96 386 93 66

Lasse Kannas
Department of Health Sciences
University of Jyvaskyla
PO Box 35
40014 University of Jyvaskyla
FINLAND
E-Mail kannas@pallo.jyu.fi
Telephone +358 14 60 2154

John F Ryan
SANCO
Euroforum Building
Office 3283
10 Rue Robert Stunper
ZI cloche D'or
L – 2557
LUXEMBOURG (Gasperich)
E-Mail john-f.ryan@cec.eu.int
Telephone +352 4301 34658

John Kenneth Davies

Review of the "Programme of Community Action on Public Health" of the EC for 2003-2008

Three main action strands:

1. Improving Health Information and Knowledge

2. Responding Rapidly to Health Threats

3. Addressing Health Determinants across all Policies and Activities.

The most relevant strands for the EUHPID are one and three. John stated the importance of linking both strands to the EUHPID project.

- Main aspects highlighted in John's presentation:
- "Health information and Knowledge" as a policy tool at community, national and regional levels.
- The added value of the European Perspective.
- The problem of Health Promotion being linked to the Health Care System (within the EC European Community Health Indicators (ECHI) framework).

For further information on EU Public Health Policies, see John's presentation (Appendix 1)

Other topics

The majority of the EC funding health monitoring projects are based on the epidemiological research paradigm.

John Ryan and Horst Kloppenburg are two people who are currently leading the HP Programme in EC but this might change during the next year.

The European Parliament decided to support the new Public Health Programme with 312 Million Euros after the conciliation process.

Update on EUHPID

The Project Timetable

- 18 Month project
- Original start date 1st November; finish date 1st of May 2003
- Extension 6 month: finish date 1st November 2003
- Final Report: 1st November 2003

EUHPID Project Tasks

Stage 1: Production of set of health promotion indicators (May 2002-June 2003)

To achieve the objective of that first stage we agreed in Brighton a series of task and working groups to work on:

- A Conceptual Framework – Concept Paper (Bengt Lindstrom)
- A Policy Framework – Rational Paper (Richard Horst)
- A Comparative Context – Review Paper
- A Practice Working Group
- A Theory and Methodology Working Group
- A European and National Policy Context Paper

These six tasks have to be progressed for the next meeting in November, 2002.

Key Importance of EUHPID Framework

Purpose

Needs of users eg new EC health information system; development of health promotion at regional level; one set for Europe; generic indicators linked to many fields.

The Art of Indicator Building

Numbers, sentences, pictures or a combination of all?

Levels

Individual, meso and macro

Modelling Health Development

Changes in epistemology of health to include saluto-genesis, losses/gains in health and operationalising the Ottawa Charter.

Modelling Health Promotion Action

Processes involved.

Outcomes

Final Report

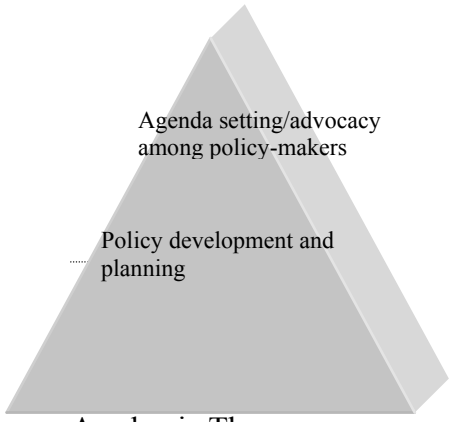
We must be clear on the terminology we are using in EUHPID – therefore it was suggested that we need a glossary as appendix to the final report.

Nanne de Vries

- Highlighted ongoing work in Rotterdam (Willy de Haes project) and being carried out by the Dutch Society of Workers in Health Promotion (registration & professionalisation).
- He also presented copies of a book from a relevant doctoral thesis.

Health Promotion Triad / Pyramid

- He proposed a set of indicators as a pyramid – key indicators at the top of the pyramid for agenda setting/advocacy among policy-makers, then policy development, planning – the bottom of the pyramid based on solid, academic theory – technical properties close to evaluation of interventions. To include key area of monitoring and evaluation; also local level needs of practitioners re good practice. Indicators as a tool for management.



- Framework to generate indicators = system for indicators. An open or closed system?
- Importance of benchmarking data – having general information for cross-country comparisons and agenda setting across the European Community.
- Knowledge – determinants of health and for intervention processes.
- Need for visionary indicators – but not to be too ambitious.

Evelyne de Leeuw

Making IT work for Us

- She presented two websites:

- http://www.nationaalkompas.nl - This website can be accessed horizontally or vertically by topic area.
- http://www.zorgatlas.nl - This site offers information about the geographical and demographic health differences between regions of Holland.

What is the Atlas?

"The National Atlas of Public Health in the Netherlands is literally putting public health and health care on the map. It displays the geographic distribution of all kinds of issues related to people's health, determinants

of health, health care services and prevention. The Atlas truly is an atlas. The focus of attention is on maps. Text, figures and graphs are only intended to help interpret the map. The atlas answers WHERE-questions such as:

- Where are high mortality areas?

- Where are the highest levels of noise nuisance?

- Where are hospitals located?

- What is the degree of vaccination of the population?

On these and many other questions you will find the answers in this Atlas"

(From: http://www.zorgatlas.nl)

- Evelyne suggested that it would be useful to make an analysis of existing websites. (structures, colours, organisation, etc)

- The EUHPID website will be linked to the EC Europa server and thereby into the e-Health Programme.

How are we going to decide the indicators?

Taking existing indicators and adding more? We have to make a review of literature and HP Practice and the State of Art of Health Promotion Indicators.

The Consortium decides to design a Questionnaire on what's happening in Health Promotion Indicator Development. The agreed deadline to reply to the Questionnaire is by 19th of July.

Horst Noack

- Horst introduced his working paper on "A Rationale for the Development of Health Promotion Indicators". It attempted to outline a rationale and several methodological samples. (See Appendix 2)

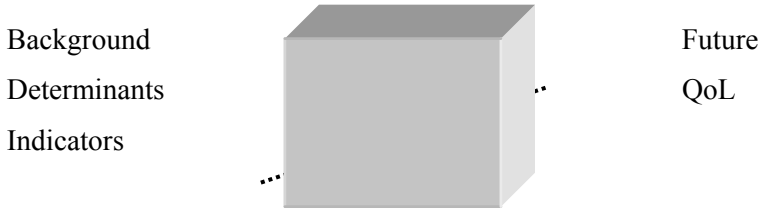
Georg Bauer

- Georg presented an introduction to developing Health Promotion Indicators from the literature. He proposed that we develop a macro/micro framework for mapping health promotion. (See appendix 3)

Bengt Linstrom

- Bengt's presentation focused on Quality of Life (QoL) and Salutogenesis.

- The indicators in salutogenesis should contribute to people's life and we shouldn't manipulate them. Salutogenesis is about people and about their life. The future lies in creating a good life for people.



- In the 1930s only the developed industrialised and Northern Countries could think about the concept of the Welfare Society. Now in the 2002, 70 years later, we should think about changes in respect to QoL and its meaning. He proposed that a literature review must be carried out on QoL and Salutogenesis.

- The United Nations indicators: complex indicators to measure the level of QoL of cCountries. Also, Infant Mortality Rate / Life Expectancy / Literacy Rate / Literacy Rate of Women (mothers).

Stephan van den Broucke

- Stephan stated that it would be very useful to create indicators to evaluate implemented activities in Health Promotion.

- Provided an overview of an EC funded project on monitoring socio-economic inequalities in health and EC member States. (See Appendix 4).

- He highlighted a number of organisations collecting data:

  - Statistics Bureaux
  - Ministries of Health
  - Health Promotion Agencies
  - Public Health Agencies.
  - http://www.eurohealth.com

Jurgen Pelikan

- Jurgen introduced the role of indicators in the area of workplace health promotion and the Health Promoting Hospital setting. (See Appendix 5)

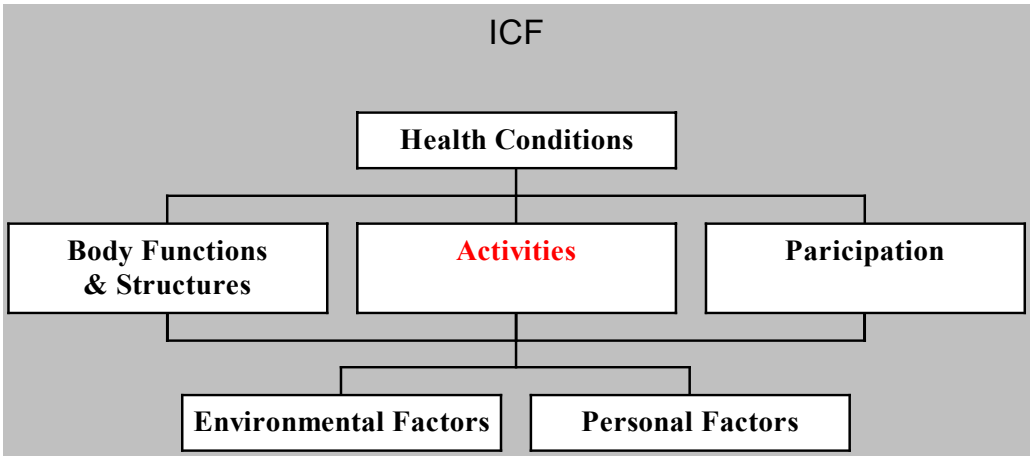
Maurice Mittelmark

ICF Project

- Maurice gave a presentation on the International Classification of Functioning, Disability and Health (ICF). (See appendix 6). ICF is a

common international framework for describing and measuring health and 191 countries have accepted it as the international standard to describe and measure health and disability.

- While traditional health indicators are based on mortality rates of populations, the ICF shifts focus to "life", i.e., how people live with their health conditions and how these can be improved to achieve a productive, fulfilling life.
- The ICF Programme understands indicators in a double dimension: Capacity and Performance.
- Activities are the core of QoL:
  - Having the physical and mental capacity to perform activities.
  - Having a good performance of those activities.
- The ICF Programme has developed indicators related to that duality: capacity to perform the activities and the possibility to produce a good performance. They used the model below:



- Environmental Factors: (Social, Physical and Cultural.) the importance of the role of environmental factors in either facilitating functioning or creating barriers for people with disabilities. Environmental factors interact with a health condition to create a disability or restore functioning, depending on whether the environmental factor is a facilitator or barrier.

Environmental Factors Levels
- 1st Level: Individual
- 2nd Level: Societal

- The ICF doesn't include: Medical Indicators, Macro Socio-economic Indicators, "Spiritual" Indicators. The key are personal contextual factors – environmental/cultural factors and personal factors need to be developed

- The problem is to change the focus of the concept of health used traditionally in ICF from health condition, disability or disease to a positive construct of health. The positive side of health has not been developed. In this regard the need to facilitate health supporting activities needs to be developed.

- The role of ICF will be included in EUHPID review paper.

- In our work, a suitable value system needs to be included

- The possibility to associate with the ICF was discussed.

- The ICF is available in six languages (English, French, Spanish, Arabic, Chinese and Russian)

- More information is available on: http://www3.who.int/icf/icftemplate.cfm and http://www.who.int/icidh

- Maurice mentioned an EC-funded project for Mapping Health Promotion Infrastructures in Europe ("HPSource") (leader: Spencer Hagard)

Conclusions

The following were agreed:

- Maurice agreed to take forward this work on ICF and to identify indicators we can use.

- The key to our work is to select a suitable framework or reference set related to health, health promotion, determinants of health.

- Importance of a mapping framework and a classification of indicators was highlighted.

- We must be realistic with regard to what we can produce in 18 months.

In practice our final report on EUHPID Phase One will probably consist of an inter-related set of working papers. We need to decide on:

- A basic model/framework (Need simple model – perhaps taking our 2 diagrams + Nutbeam model adapted);

- A classification system/tree;

- A review and feasibility, common set; suitable methodology, dissemination strategy.

- A gross National Health Promotion Indicator.

(See 'the Possible Scot' = 'the Possible European'?

http://www.scottishpolicynet.org as a possible idea in this direction)

EUHPID Phase 2 = will build in raising the profile and consider the possible European Observatory on Health Promotion

(Panos agreed to produce and present a working paper on Social Capital for the next EUHPID meeting.)

5th IUHPE European Conference on Effectiveness and Quality in Health Promotion Action Lab on Health Promotion Indicators

Colleagues who planned to attend the London Conference the week following the meeting had a brief discussion regarding the objectives, included format and content of the Action Lab session.

(Those present at the Action Lab = Georg, Danielle, Ursel, Vincent, John, Margaret, Eberhard and Jurgen).

Next meetings of the EUHPID and EUMAHP consortia

These would be held on 8-11 November in Lisbon. Arrival for lunchtime on the 8th and departing late afternoon of the 11th. Details as follows:

Chairs and Dates EUHPID & EUMAHP	
EUHPID Chair:	Stephan Van den Broucke
EUHPID dates:	8th –9th of November 2002
EUMAHP Chair:	Isabel Loureiro
EUMAHP Dates:	10th-11th of November 2002

EUHPID Working Groups/Tasks

1. **Practice Working Group**

Task 1. Indicators Tree (Deals with task 2 of the Theory Working Group).

To further develop the concept and framework for a EUHPID Classification system. Work on simplifying the models, frameworks and classification systems, which is being led by the theory and methodology group (sub-group led by Georg) would feed into this work.

- Maurice Mittelmark (leader) Evelyne de Leeuw, Georg Bauer

Task 2. Survey and literature review of current practice in Health Promotion Indicators.

Questionnaire on Health Promotion Indicators Development in Europe and internationally.

The secretariat of the EUHPID will forward to all members a Questionnaire regarding general information of HPID in each country. The Questionnaire should be returned to the secretariat by the 19th of July.

- Secretariat, John K. Davies (leader)

Literature review on Health Promotion Indicators

All members of the consortium will contribute to the Survey and literature review on Health Promotion Indicators (HPID). Docking stations/entry points (ICF for example) will be identified as part of the literature review.
Everyone contribute and led by *JKD and Secretariat*

- **Theory and Methodology Working Group**

Task 1. Gross National Health Promotion Indicator
They would be explaining the potential of a single complex National Health Promotion indicator – similar to GDP on the economic side. It would focus on models and frameworks including those proposed and discussed during the meeting.

- Eberhard Goepel (leader), Vincent Bonniol

Task 2. Simplification of Models and Frameworks and classification systems.
They would focus on models and frameworks, including those proposed and discussed during the London Meeting.

- Georg Bauer (leader), Richard Horst, Juergen Pelikan, Vincent Bonniol, Ursel Broesskamp, Margaret Barry.

Task 3. Literature Review and Analysis of Salutogenesis and Empowerment.
Commissioning a review could be explored.

- Bengt Lindstrom (leader), Isabel Loureiro

- **European and National Policy Working Group**

Task 1. Position Paper on the impact of Health Promotion on EU Health Policy.
The position paper of the impact of Health Promotion on the EU Health Policy will be a 5-page report.

It will link with EU strand 1: "Health Information and Knowledge in the Future Action Programme" and the 3rd strand: "Action on the Determinants and Health Policies".

It needs also consider the sister project EUMAHP.

John K. Davies (leader), Stephan van den Broucke, Giancarlo Pocetta, Daniele Piette.

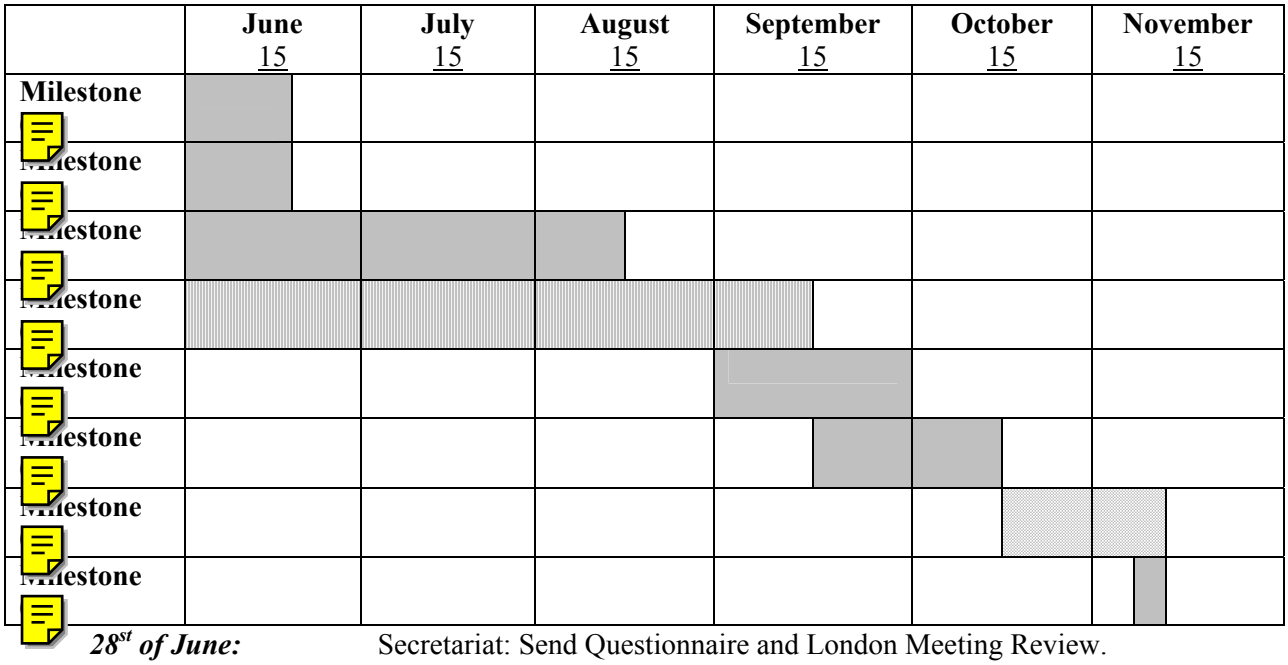
Task 2. Phase 2: Comparative survey linking with the 1st position paper

- John K. Davies (leader)

Tasks Milestones (10-06-2002/ 08-11-2002)

Milestone 01: Produce a brief review of the discussions and conclusions of the London Meeting; Clarify and agree on the tasks and deadlines for all members of the consortium. (Secretariat)
Milestone 02: Design and disseminate a questionnaire. (Secretariat)
Milestone 03: Subgroups working time. Prepare a brief report of the working process to date.
Milestone 04: (Cont.) Sub groups working time. Produce the final paper and forward it to reviewers.
Milestone 05: Time for reviewers to comment.
Milestone 06: Time for author/s to amend
Milestone 07: Distribution of the papers to the members of the consortium.
Milestone 08: Lisbon meeting.

Deadlines



28st of June:	Secretariat: Send Questionnaire and London Meeting Review.
1st of July:	Agree on tasks and deadlines.
19th of July:	Return the Questionnaire to the EUHPID Secretariat.
August:	Send a brief report of the working process to Brighton.
15th September:	Send the final paper to reviewers.
1st October:	Reviewers send back the papers to the authors.
15th October:	Send the final amended document to the secretariat for distribution.
8th-9th November:	EUHPID Lisbon Meeting

Summary of Appendices

Appendix 1	***John Kenneth Davies*** *- Meeting of EUHPID Consortium*
Appendix 2	***Richard Horst Noack*** *–EUHPID Project Working Paper: A Rationale for Development of Health Promotion Indicators*
Appendix 3	***Georg Bauer*** *– Developing Health Promotion Indicators: Key Lessons from the Literature and Practice*
Appendix 4	***Stephan Van den Brocke*** *–Health Promotion Indicators and Health Inequalities*
Appendix 5	***Jurgen Pelikan*** *– The Concept of Health Promoting Hospitals and Possible Indicators*
Appendix 6	***Maurice Mittelmark*** *– International Classification of Functioning Disability and Health (ICF)*

It is intended that this report and these appendices will be displayed on the EUHPID part of the University of Aix-Marseille website. The complete set, or individual appendices, are also available on request from the EUHPID Secretariat.

APPENDIX 3c – EUHPID Lisbon Meeting

Notes from the Third Meeting of the EUHPID Consortium
National School of Public Health
Lisbon, Portugal

8th to 9th November 2002

LIST OF PARTICIPANTS

Margaret Barry
Department of Health Promotion
National University of Ireland
Galway
Clinical Science Institute
Galway, IRELAND
E-mail Margaret.Barry@nuigalway.ie
Telephone +353 91 75 04 63

Georg Bauer
Department of Health & Intervention Research
Institute of Social and Preventative Medicine
University of Zurich
Sumatrastr, 30
CH-8006 Zurich, SWITERLAND
E-mail gfbauer@ifspm.unizh.ch
Telephone +41 1 6344638

Vincent Bonniol
Department of Education Sciences
University of Aix-Marseille 1
Hotel Dieu
1 Avenue de Verdun
13410 Lambesc, FRANCE
E-mail v.bonniol@educaix.com
Telephone +33 44 257 1717

Ursel Broesskamp-Stone
Health Promotion Switzerland
(Gesundheitsforderung Schwiez)
Dufourstrasse 30, Postfach 311
CH 3000 Bern 6, SWITZERLAND
E-mail ursel.broesskamp@promotionsante.ch
Telephone +41 31 350 04 25

Stephan van den Broucke
Flemish Institute for Health Promotion
Gustave Schildkneckstraat 9
B-1020 Brussels, BELGIUM
E-mail stephan.vandenbroucke@vig.be
Telephone +32 2 422 4949

Concha Colomer
Health Promotion Unit
Escuela Valenciana de Estudios para la Salud (EVES)
Juan de Garay 21
E-46017 Valencia, SPAIN
E-mail colomer_con@gva.es
Telephone +34 96 386 93 66

John Kenneth Davies
Faculty of Health
University of Brighton
Falmer, Brighton BN1 9PH, UK
E-mail J.K.Davies@brighton.ac.uk
Telephone +44 (0)1273-643476
Panos Th Dimakakos
University College London

1-19 Torrington Place
London, UK
E-mail p.dimakakos@public-health.ucl.ac.uk
Telephone +(0)207 679 1702

Eberhard Goepel
Fachbereich Sozial-und Gesundheitswesen
Hochschule Magdeburg-Stendal
Breitscheidstr. 2
D-39114 Magdeburg, GERMANY
E-mail eberhard.goepel@sgw.hs-magdeburg.de
Telephone +49 391 8864304

Catherine Jones
IUHPE / UIPES
2 rue Auguste Comte
92170 Vanves, FRANCE
E-mail cjones@iuhpe.org
Telephone +33-1 46 45 00 59

Lasse Kannas
Department of Health Sciences
University of Jyvaskyla
PO Box 35
40014 University of Jyvaskyla
FINLAND
E-Mail kannas@pallo.jyu.fi
Telephone +358 14 60 2154

Bengt Lindstrom
Nordic School of Public Health
Box 12133
S-402 42 – Goteborg, SWEDEN
E-mail bengt@nhv.se
Telephone +46 31 69 39

Isabel Loureiro
Rede Nacional de Escolas Promotoras de Saude (RNEPS)
Av. Infante Santo, 2-6
Lisboa Cedex, PORTUGAL
E-mail isalou@ensp.unl.pt
Telephone +351 21 3912200

Maurice Mittelmark
Dept of Psychosocial Sciences and Research Centre for Health Promotion
University of Bergen
School of Psychology
Christies Gate 13 5015 Bergen, NORWAY
E-mail maurice.mittlemark@psych.uib.no
Telephone +47 55 58 32 51

Horst Noack
Institute for Social Medicine & Epidemiology
University of Graz
AU-8010 Graz, AUSTRIA
E-mail horst.noack@kfunigraz
Telephone +43 316 380 4398

Heinz-Herbert Noll
ZUMA
Postfach 122155
D-68072 Mannheim, GERMANY
E-mail noll@zuma-mannheim.de
Telephone +49-621-1246-241

Danielle Piette
School of Public Health
Universite Libre de Bruxelles
Route de Lennick 808 – CP569
B-1070 Brussels, BELGIUM
E-mail dpiette@ulb.ac.be
Telephone +32 2 555 40 81

Giancarlo Pocetta
Experimental Centre for Health Education, Dept of Hygiene
University of Perugia
Cp 45 PG3
I-06100 Perugia, ITALY
E-mail gipocet@tin.it
Telephone +39 075 585 7301

Niels Rasmussen
National Institute for Public Health
Svanemollerg 25
DK2100
Copenhagen 0
DENMARK
E-mail nkr@si-folkesundhed.dk

Nanne de Vries
Department of Health Education
Faculty of Health Sciences
University of Maastricht
PO Box 616, Maastricht 6200 MD
THE NETHERLANDS
E-Mail n.devries@gvo.unimaas.nl
Telephone +31 43 388 2423

Secretariat

Eleanor Linwood
Faculty of Health
University of Brighton
Falmer
Brighton BN1 9PH, UK
E-mail E.M.Linwood@brighton.ac.uk
Telephone +44 (0)1273-644169

Xanthippe Tzimoula
Faculty of Health
University of Brighton
Falmer
Brighton BN1 9PH, UK
E-mail X.Tzimoula@brighton.ac.uk
Telephone +44 (0)1273-644168

Apologies

Henriette Chamouillet
Evelyne de Leeuw
Yannis Toutas

Welcome & Introductions

Isabel Loureiro opened the meeting and introduced Professor Antonio Correia de Campos, President of the Scientific Committee of the National School of Public Health, who formally welcomed participants on behalf of the National School of Public Health, Lisbon. All participants introduced themselves.

Update

In the delayed absence of Stephan van den Broucke, who had agreed to chair the meeting, John Kenneth Davies took the chair and gave a brief update of developments since the last EUHPID Meeting held in London in June 2002. He reported that a further three-month extension had been requested and approved by the EC. This means that the project can incur costs until 31 January 2004, and a final report will be required by the EC by 1 May 2004. An interim report needs to be sent to the EC by 15 December 2002, together with a financial statement of costs incurred up until that date.

He requested participants to consider what realistically the project could achieve during the remainder of this fourteen-month period. In light of this, he also asked participants to consider what could be the longer-term aims and objectives of a possible Phase 2. He stressed the need during the remainder of Phase 1 for an emphasis on policy relevance rather than a purely academic perspective.

With regard to the Secretariat, Belen Sanchez, Research Officer, left the project on 31 October 2002. Her part-time post has been advertised and a replacement will be appointed as soon as possible. All attendees signed a best wishes card for Sue Ginn, who is recuperating following hospitalisation and will join the Project secretariat again soon.

John reported on the following events since the London meeting:

- Since the last meeting in London, he had presented progress reports on the Project at:
  - The International Union for Health Promotion & Education / Centers for Disease Control (CDC) joint seminar in Atlanta in June,
  - The EC Health Monitoring Co-ordinators Meeting and the Magdeburg Summer School, both held in September.
- EUHPID Website – had now been established, and would be used as an interactive communication platform for Project work
- Action Lab London Conference – several Project members actively participated in an Action Lab Session on the EUHPID Project at the 5th European Confernce on Qaulity and Effectiveness of Health Promotion in London in June. This attracted great interest and a large audience of Conference delegates participated.
- EUPHA Dresden Paper – a paper will be presented at the next European Public Health Conference.
- EndNote Database – this developing database of relevant articles and related documentation has been established at the Secretariat to act as a resource.

- European Journal of Public Health (EJPH) – it was announced that the EC had agreed to support a special edition of EJPH on the work of its Health Monitoring Programme. John raised the possibility of a contribution from the EUHPID Project and would discuss further with EC colleagues.
- Contact by OECD – John reported interest by OECD colleagues working on International Quality Indicators in Health Care Project building in potentially useful mutual links with EUHPID .
- International Health Promotion Indicators Project – John discussed his recent correspondence with Canadian colleagues led by Suzanne Jackson at the University of Toronto concerning this international project - initially developed for WHO/HQ and reported at the Jakarta Conference. Currently they were interested in revitalising this work.

John outlined the format of the EUHPID meeting. Initially there would be a series of plenary presentations updating upon work done by Consortium members since the last meeting; this would be followed by in depth working group discussions and reporting back in plenary sessions.

EUHPID Socio-Ecological Model

Georg described the background to the paper (See Appendix 1) which was initiated at the last meeting in London. He highlighted in particular: (See Appendix 1a)

- The needs of different users.
- The properties we are trying to achieve with our EUHPID model.
- The importance for health promotion action of identifying particular leverage points.
- Key health development strategies to influence the health development cycle.
- European and national perspectives.
- The Health Promotion Action Model.

Margaret stressed the importance of health promotion indicators being used to assess the impact / effectiveness of interventions. (Does health promotion work or not?)

Concha indicated that the concept of natural health promotion was not the best one to adopt as the identification of intervention points had the biggest chance of success. (She requested clarification of the word 'natural' and was uncertain whether there were 'natural' processes affecting health promotion).

Georg acknowledged 'natural' was not perhaps the best term.

Maurice suggested that natural be used to refer to states where there was no organised health promotion.

Horst presented prepared feedback comments on the paper.

He highlighted the need to define terms / indicators – a theoretical framework was essential to outline any scientific approach. He raised in particular two questions:

- The policy related purpose of the model described in the paper (What is a suitable working model?)
- The need to clearly identify the potential users of the model (The importance of their background and values – which were variable)

Horst presented further comments on the paper. (See Appendix 1b)

Health must be considered as a process, focusing on the dynamic relationship between interaction between individuals and their environment.

Indicator models were discussed within a policy perspective, with the intention of stressing within the EUHPID Project the need to emphasise indicators rather than focus only on model building.

EUHPID Review Paper and Policy Paper

In introducing the review paper (See Appendix 2) produced by the Secretariat, John stressed the progress made internationally over the last fifteen years in particularly in defining health, health promotion, and related indicators. He went on to highlight the future work needed, and within our current European context, the lack of a suitable theoretical model for the EC health monitoring programme. The Policy Paper emphasised the political context of our work and possible practical links. (See Appendix 3).

Maurice found all the papers prepared for the meeting very useful. He reflected on the need for further work on developing indicators outside our current specific framework and time mandate. Do we challenge this framework In order to do this we need a more practical/political focus, and need to build links outside academia. Therefore this means to keep our work relatively simple, using existing health promotion terminology and definitions, and – focus on how health promotion technology works. Our users should initially be people involved with European Health Promotion Programme. It was also important politically to maintain and develop existing co-ordination within EC countries.

Nanne stressed the value of investment in health promotion to enable people to demonstrate success in health promotion. Within EUHPID this meant shifting to consider in more detail the left-hand side of the Model, as health promotion indicators should have practical as well as of political importance.

Margaret warned of the risk of being over ambitious. She thought that the Model offered us a sound conceptual map, but needed to be made to work in health promotion terms.

Concha felt it important to have the model first. Now our main aim should focus on the production of national indicators for use by policy makers. This would demonstrate the important for producing European added value.

Georg felt that we cannot develop new indicators but have to select those that are health promotion specific.

Ursel mentioned that focusing on existing indicators only was not good enough and that we need to develop a new toolbox and tools.

Concha mentioned that she had worked on another EC project on child health indicators where they produced an annex of indicators that are not available but need to be developed in the future.

Horst emphasised the need to reflect on European policy indicators with reference to some more specific fields.

Bengt highlighted the importance of exploring the values underpinning the model.

National indicators should be:

- Salutogenic
- Beneficial
- Competitive
- Positive

ICF Update

From his work since the London meeting, Maurice indicated that only a small proportion of ICF indicators were useful to the EUHPID Project, but this small proportion was highly relevant, i.e. allows cross national comparisons. He agreed to maintain oversight of this work on behalf of EUHPID. (See Appendix 4 & 4a).

Stephan van den Broucke joined the meeting and apologised for travel delays beyond his control. He took over as Chair of the meeting.

Danish Health Surveys

John indicated that Niels, who was due to speak on his work involving both Danish and various European surveys, had been unavoidably delayed. He read summerised the main points from a fax that Niels had sent him. This indicated the importance in particular of the Danish survey planned for 2004, and its potential value to EUHPID, as it would include more salutogenic questions.

Neils made his presentation on the next day. (See Appendix 5). (This section is therefore brought forward to aid continuity).

The Danish Survey is available via Internet – but in Danish only.

He expressed a willingness to work with EUHPID in relation to the Danish Health Survey and other related work. He stressed the importance of the work of the EUROSTAT task force and suggested that we make contact with Marlena Schmidt (EC Luxembourg).

Neils foresaw the importance in the future of developing indicators on the determinants of health, which EUHPID could feed into. He highlighted the following projects that might be important to EUHPID's work:

- SILC – Income and Living Conditions Survey
- European Health Interview Survey (EUROHIS).
- European Community Health Indicators (ECHI) Monitoring Programme (40+ European Projects – including EUHPID). Peter Kramers as co-ordinator of ECHI is looking for 'soft' indicators. (Note – John had discussed with Peter the limitations of ECHI for

Projects such as EUHPID. It was therefore important now that EUHPID had developed its conceptual framework/model that further discussions be held with Peter – John undertook to arrange this).

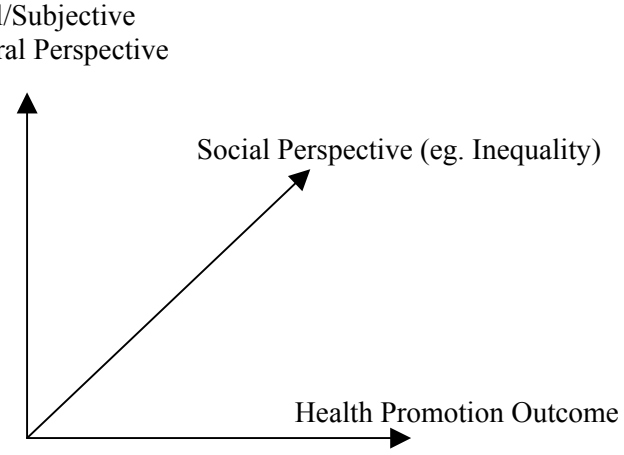
- Nordic Indicators Review – which included sustainable development in health indicators.

There was clearly a need to share and co-ordinate reports and surveys of relevance to EUHPID.

Niels felt that medical as well as social definitions are important. As medical definitions include good and poor health measures.

A core methodological issue remains – how to measure and define social health and well-being (of the individual ?) In studying health we need to include the bio-medical approach and population health from different perspectives. Neils presented the following diagram. (Figure 1)

Fig.1



Following Niels's presentation, Nanne felt there was an obvious need for a shopping list of surveys and related work from each European country involved in EUHPID.

Social Indicators and Social Reporting from a European Prospective

Heinz-Herbert spoke on the history and theory of social indicators over the past thirty-five years. (See Appendix 6). He highlighted the following issues:

1. Data Driven Approaches e.g. EUROSTAT

2. Policy Driven Approaches e.g. safe and sustainable pensions, EU Social Protections Committee.

3. Concept Driven Approaches e.g. European system of social indicators.

He saw the basic requirements for constructing a system of social indicators:

1. Appropriate Conceptual framework (Individual / societal)

2. Appropriate Elements of architecture (e.g. European system of social indicators).

It was important to differentiate between the conceptual framework and the system architecture.

(See ZUMA website – www.gesis.org/zuma – for further details of the work on social indicators and social reporting).

1. Application of this model to Health Promotion?

Little in this field as yet, except health status / health care / health related attitudes.

2. Applicable to European perspective?

Useful as a comparative tool to compare EC and non-EC countries.

Maurice felt we should seriously consider using this model, which needs to be simplified for us to use it.

Horst highlighted the importance of:

- The European prospective
- Producing a tool to compare EU, with other European and non-European countries.
- Existing data availability.
- Life Domains / Data sets available.

What resources are needed to build a system of health promotion indicators?

1. Review of available concepts from sociological and political literature.

2. Policy goal analysis.

What do we want to achieve?

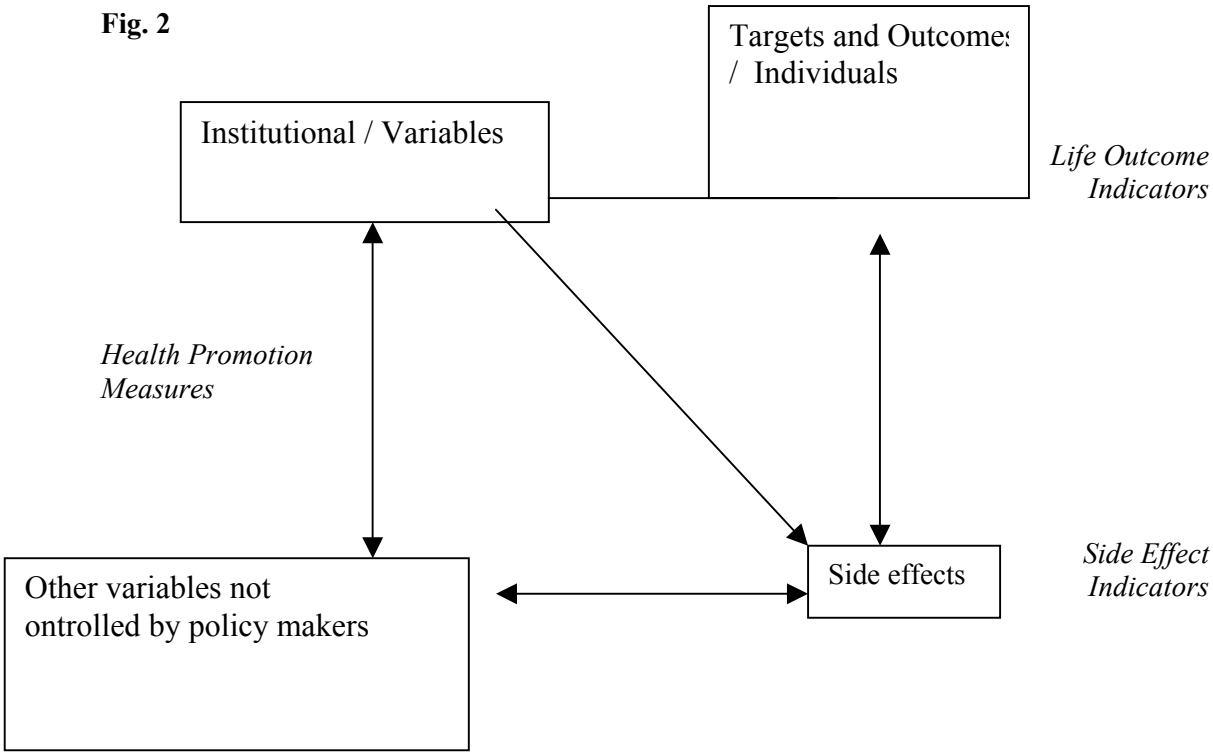
1. To evaluate / assess health promotion programmes / policies.

2. Need to do more than look at outcomes

Panos felt that the weakness of social indicator model was that it does not distinguish between cause and effect.

In reply Heinz-Herbert explained that looking at cause and effect was not an aim of the model. Its emphasis was on monitoring outcomes.

Fig. 2



Gross National Health Promotion Indicators

Eberhard introduced this item and spoke to his paper (See Appendix 7). which had already been circulated. Based on systems theory, a composite indicator can be based on sociological/ecological/technical aspects. In this regard, health promotion is defined as a dynamic process. Eberhard agreed to send further ideas to the Secretariat.

Social Capital

Panos introduced his paper, which had already been circulated in advance of the meeting. (See Appendix 8). In his presentation (See Appendix 8a) He saw social capital as based on Durkheimian approach and explored the following issues:

- What is social capital
- Theoretical Approach
- Key Issues
- Existing approaches to measuring social capital.

Ursel questioned whether the focus on people rather than organisations?

Maurice queried the link between social capital and health promotion.

Niels asked whether social capital a construct?

Ursel felt the approach had the strength of focusing on the social rather than purely technical.

Italian Health Promotion / HIA Indicators

Giancarlo distributed a paper (See Appendix 9) and gave a presentation on the work he has been carrying out in Italy on health promotion indicators linked to health impact assessment (See Appendix 9a)

Project objectives are compatible with Ottawa Charter action areas.

Data was collected from ten different health 'areas' in Italy.

The work was part of an on-going process of shifting from a national to regional system of health in Italy.

A key problem was the homogeneity of the data involved.

Plenary Discussion centred on the following perspectives:

- Health Promotion Policy & Practice Driven
- Concept Driven
- Data Driven

It was decided to establish three work groups based on these perspectives to progress our work based on these three perspectives to progress our work.

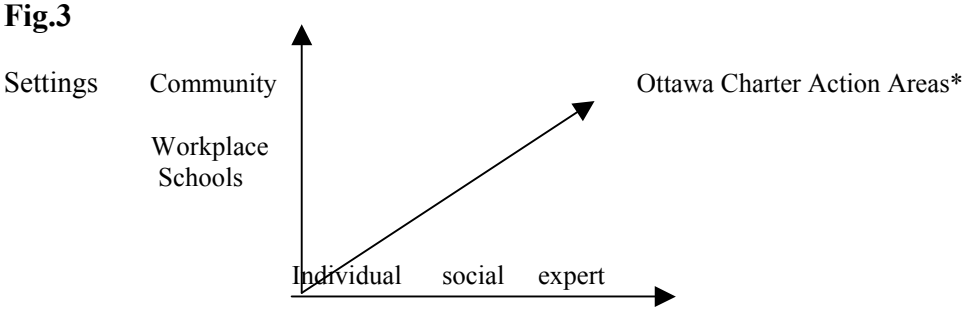
Health Policy & Practice Work Group

*Membership**

Nanne (co-ordinator), Isabel, Lasse, Danielle, Bengt, Concha, Maurice, Panos, Margaret.

Nanne agreed to co-ordinate the work of this group. They agreed to take an Ottawa Charter perspective and settings approach to health promotion with a minimal use of jargon. They would focus their work on the development of indicators that can be used in various settings, and build on the work already identified in the EUHPID Review Paper (See Appendix). This included therefore the utilization of relevant existing indicators and identification of gaps/needs for new indicators. This would incorporate consideration of the political context of indicator-use and particularly consideration of setting their work within the context of the EUHPID Public Health Policy Report (See Appendix). A key focus of their work would be to explore what makes health promotion unique (the 'genetic code' of health promotion in contemporary work).

Fig.3



*Five Ottawa Charter Action Areas (Build Healthy Public Policy, Create

Supportive Environments, Reorient Health Services, Develop Personal Skills,

Strengthen Community Action)

They agreed to focus on examining indicators for three groupings of settings – schools; workplaces/hospitals/prisons; and cities/communities. With particular regard to the schools setting, Isabel, Lasse, and Danielle agreed to provide expert technical advice/input.
Maurice agreed to take responsibility for arranging a special session(s) at the forthcoming IUHPE European Conference on Health Promotion and Education in Perugia (June 2003). By the Conference, the Group would have produced examples of indicators for all three settings. Nanne agreed to facilitate this initially by the end of 2002, after which the work group would divide into sub-groups to discuss each setting. The health promotion indicators for the 15 cells would be produced by 1 may 2003, and a formal presentation of them made at the Perugia Conference.
In operational communication terms, Nanne would discuss with the Secretariat the possibility of establishing 3 internet discussion groups (which would be open to all EUHPID colleagues members) on the three settings.
It was agreed that in addition initial contact would be made with relevant colleagues in Candidate Countries. This would commence at the EUHPA European Public Health Conference in Dresden in late November. Nanne would discuss this with Eberhard, who would be present.
Concept Work Group

Membership*

Georg (co-ordinator – until Model Paper completion), Horst, Ursel, Jurgen, Cath.
The work group were in agreement with the EUHPID Model in principle, but no clear consensus emerged from the work group's deliberations mainly due to differences in theoretical perspectives among group members. They agreed to proceed by refining the sub-categories included in the Model Paper (See Appendix 1) to provide examples of indicators.
They agreed the following steps:

- To obtain feedback from all EUHPID colleagues on the Model Paper (via email within 2 weeks - by 22 November to Georg) – this would then be used to clarify what works and doesn't work in relation to the EUHPID Model
- Input feedback and refine/clarify links between concepts within the Model to develop health promotion indicators
- Emphasise the policy level (Ottawa Charter) in order to refine the underlying model and indicator classification. Establish terminology related to the 5 action areas of the Charter.
- Demonstrate how we can use the model/classification system
- Georg agreed to co-ordinate completion of this stage of model development incorporating feedback from all EUHPID colleagues by the end of November for the EUHPID Interim Report
- A final version of the model paper would be presented at the European Conference in Perugia in June.
- The work of the Concept work group should not progress in the future in isolation but should be closely integrated into the work of the other 2 groups,

particularly with the Health Promotion Policy & Practice group. (With regard to the latter Maurice agreed to propose a mechanism to action this at a practical level).

TABLE 1.

Health Promotion Ideas
Ottawa Charter, etc.
Intervention ↓ Change/Outcome

Socio-Ecological Environment (Health Opportunities)	Indicators	Indicators
Individual Person (Health Capacity)	Indicators	Indicators
Social Interactions/Actions	Indicators	Indicators

Table 13a needed to be filled in and clarification was needed on who and how this would be accomplished.

Data Work Group

Membership*

Niels (co-ordinator), Vincent, Stephen, Giancarlo

Niels agreed to facilitate the work of this Group. Discussion among group members centred on the need to expand our initial EUHPID survey to include broad social and health-related surveys carried out in Europe.

Three reasons were given for focussing on indicators:

- Monitoring & evaluation
- Research
- Comparisons between countries

It was felt EUHPID should concentrate on indicators at EU level and at national level.

The Group agreed it would carry out the following activities:

- Develop an inventory of inventories for each of the above levels to obtain a comprehensive overview of what is going on in Europe. This EUHPID Inventory would include relevant aspects of social policy, including social indicator systems in EU and the Candidate Countries. It would also include a database on conceptual literature, instruments, methods of surveys, etc. This would enable us then to achieve a critical review of those systems in terms of :
  - Relevance to health promotion
  - Quality of data
  - accessibility
- to define our EUHPID Indicator System – which has to provide an on-going monitoring system on a national level (Heinz-Herbert's slides would assist us in defining the detailed criteria for the indicator system – See Appendix 6)
- to explore and review in particular existing inventories provided by:

        - EUROSTAT
        - EUROHIS
        - DGSANCO
    - to develop a framework to be distributed to network members
    - to use criteria for social indicator framework systems
    - to prepare a paper on this work for presentation and discussion at the European Conference in Perugia in June 2003

A number of inevitable challenges were identified:

- Cultural bias in questionnaires
- Regional differences within countries
- The need to consider quality assurance procedures for surveys
- The need to 'market' our product to colleagues in the bio-medical field who don't perceive interest in exploring social issues – focus on key questions they are interested in eg why people smoke?
- The need to satisfy political pressure for immediate practical answers.

*John (or EUHPID Researcher) to be ex-officio member of all work groups to provide input/support and ensure communication / co-ordination in terms of Project goals.

Close of Meeting

The next meeting of EUHPID would be held in June 2003 in Perugia (practical details of dates and venue to be communicated following discussions with the Conference Organisers). Thanks were given to Isabel and her colleagues for the hospitality and work in preparing and hosting and meeting.

APPENDIX 3d

Perugia Meeting 2003

EUHPID Project

Notes from the Fourth Meeting of the EUHPID Consortium

Held at the University of Perugia, Italy 22 June 2003

LIST OF PARTICIPANTS

Georg Bauer
Department of Health & Intervention Research
Institute of Social and Preventative Medicine, University of Zurich,
Sumarastr, 30
CH-8006 Zurich, SWITZERLAND
E-mail: gfbauer@ifspm.unizh.ch
Telephone: +41 6344638

Helen Bourene (representing Vincent Bonniol) Department of Education Sciences
University of Aix-Marseille 1
Hotel Dieu
1 Avenue de Verdun
13410 Lambesc, FRANCE
E-mail: h.bourene@wanadoo
Telephone: +33 44 257 1717

Ursel Broesskamp-Stone
Health Promotion Switzerland (Gesundheitsforderung Schwiez)
Dufourstrasse 30
Postfach 311 CH 3000
Bern 6, SWITZERLAND
Email:
ursel.broesskamp@promotionsante.ch
Telephone: +41 31 350 04 25

Stephan Van den Broucke
Flemish Institute for Health Promotion
Gustave Schildkneckstraat 9
B-1020 Brussels, BELGIUM
Email:
Stephan.vandendroucke@vig.be
Telephone: +32 2 422 4949

Concha Colomer
Health Promotion Unit
Escuela Valenciana de Estudios para la Salud(EVES)
Juan de Garay 21
E-46017 Valencia, SPAIN
E-mail: colomer_con@gva.es
Telephone: +34 96 386 93 66

John Kenneth Davies
Faculty of Health
University of Brighton
Falmer
Brighton BN1 9PH, UK
E-mail: J.K.Davies@brighton.ac.uk
Telephone: +44 (0)1273-643476

Eberhard Goepel
Fachbereich Sozial-und Gesundheitswesen
Hochschule Magdeburg-Stendal
Breitscheidstr. 2
D-39114 Magdeburg
GERMANY
E-mail: eberhard.goepel@sgw.hs-magdeburg.de
Telephone: +49 391 8864304

Catherine Jones
IUHPE/UIPES
2 Rue Auguste comte
92170 Vanves, FRANCE
Email: cjones@iuhpe.org
Telephone: +33 1 46 00 59

Lasse Kannas
Department of Health Sciences
University of Jyvaskyla, PO Box 35
40014 University of Jyvaskyla,
FINLAND
E-Mail: lasse.kannas@SPORT.jyu.fi
Telephone: +358 14 60 2154

Evelyne de Leeuw
University of Southern Denmark
Department of Health Promotion Research
Niels Bohrs Vej 9-10
DENMARK
E-mail: edeleeuw@health.sdu.dk
Telephone: +45 6550 3083 /415 714 115

Bengt Lindstrom
Nordic School of Public Health
Box 12133
S-402 42 - Goteborg, SWEDEN
E-mail: bengt@nhv.se
Telephone: +46 31 69 39

Maurice Mittelmark
Dept of Psychosocial Sciences and Research, Centre for Health Promotion
University of Bergen
School of Psychology
Christies Gate 13, 5015 Bergen
NORWAY
Email:
maurice.mittelmark@psych.uib.no
Telephone: +47 55 58 32 51

Saoirse NicGabhaninn (representing Margaret Barry)
Department of Health Promotion
National University of Ireland
Clinical Science Institute
Galway, IRELAND
E-mail:
saoirse.nicgabhainn@nuigalway.ie

Horst Noack
Institute for Social Medicine & Epidemiology
University of Graz
AU-8010 Graz, AUSTRIA
E-mail: horst.noack@kfunigraz
Telephone: +43 316 380 4398

Jurgen Pelkan
Institute of Sociology
(4th floor, room 406)
Rooseveltplatz 2
A-1090 Vienna
Email: jurgen.pelikan@inivie.ac.at
Telephone: +43 1 42 77 48230

Giancarlo Pocetta
Experimental Centre for Health Education
Department of Hygiene
University of Perugia
Cp 45 PG 3
1-06100 Perugia, ITALY
Email: gipocet@tin.it
Telephone: +39 075 585 7301

Neils Rasmussen
National Institute of Public Health
25, Svanemollevej
DK-2100 Copenhagen, DENMARK
Email: nkr@si-folksundhed.dk
Telephone: +45 3920 7777

Luis Saboga Nunes (representing Isabel Loureiro)
Rede Nacional de Escolas Promotoras de Saude (RNEPS)
Av. Infante Santo, 2-6
Lisboa Cedex, PORTUGAL
E-mail: saboga@ensp.unl.pt
Telephone: +351 91 4747 066

Yannis Tountas
Institute of Social and Preventative Medecine
32 Skouja Str
GR-10673 Athens
GREECE
Email: ispm@compulink.gr
Telephone: +30 17 48 20 15

Nanne de Vries
Department of Health Education
Faculty of Health Sciences
University of Maastricht
PO Box 616, Maastricht 6200 MD
THE NETHERLANDS
E-Mail: n.devries@gvo.unimaas.nl
Telephone: +31 43 388 2423

SECRETARIAT

EUHPID Project
International Health Development
Research Centre
University of Brighton
Falmer
Brighton BN1 9PH, UK

Chloe Hill
E-mail: C.A.Hilll@brighton.ac.uk
Telephone: +44 (0)1273-644169

Eleanor Linwood (Administrator)
E-mail: E.M.Linwood@brighton.ac.uk
Telephone: +44 (0)1273-644169

Xanthippe Tzimoula
Email: X.Tzimoula@brighton.ac.uk
Telephone: +44 (0) 1273 644168

Welcome

Eberhard Goepel(EG) (chairing) welcomed delegates to the meeting and invited them to introduce themselves.

He stated that key objectives of the meeting were:

- to look at indicators focussing on the setting approach
- to decide on the future development of the EUHPID project

Report from Working Groups

Working group co-ordinators reported on progress on the tasks agreed at the Third EUHPID Consortium Meeting in Lisbon in November 2002.

1. Data Work Group

Neils Ramussen (NR) reported on the on-going work of this group in creating an updated inventory of indicator programmes (Appendix 1). During a meeting in Copenhagen the existing ECHI list of indicators has been reviewed. He noted that indicators conducive to health rarely featured, as the emphasis tended to be on negative aspects of health. The group have discussed indicators in a range of settings, for example, schools, hospitals and workplaces. The group intend to develop generic indicators for settings drawing on the work they have already undertaken and identify existing measures and gaps requiring indicators to be produced.

EG commented that the settings approach needs to be applied to other approaches such as thematic approaches.

Action Points

- Give emphasis to programmes related to health promoting schools, hospitals and workplaces. — NR

- Distribute survey of health promotion indicators that have been developed by member states to consortium members. — NR/SvdB

2. Health Policy and Practice Work Group

Nanne de Vries (NdV) apologised for limited work to date. However some work is being fed back into the group:

- Isabel Loureiro (IL) has been undertaking work on health promoting schools (Appendix 2).
- NdV has links with the National Health Promotion Programme in the Netherlands.
- NdV will be making contacts with Austrian colleagues in respect of health promoting hospital indicators.
- John Kenneth Davies (JKD) is liasing with G. Breucker to exchange information on workplace health promotion indicators. NR commented that ECHI indicators are not settings indicators. Concha Colomer (CC) proposed looking at cities as settings. NdV agreed that it would be appropriate to study communities, including cities. He will continue to co-ordinate further developments in this working group.

Action Points

3. Concept Work Group

Georg Bauer (GB) reported on the on-going work of the group in

ECHI, whilst at the same time being distinctive from ECHI and other work in the field. He stated that one of the aims of the group was to introduce more health promotion language into the model. Since the EUHPID meeting in Lisbon the group has:

- produced the following article to be published in The European Journal of Public Health: Advancing a Theoretical Model for Public Health and Health Promotion Indicator Development: Proposal from the EUHPID Consortium.
- held a meeting in Vienna where they worked on the outline of a second paper. (To date they have been concentrating on the theoretical aspect of the model.)

Action Points

• Working group members to attend second ALL meeting to be held on 1st and 2nd July 2003 to work on a second paper which will emphasise the practical application of the model.	ALL
• Chloe Hill (CH) to distribute copy of slides from EUHPID CH Action Lab held at the IUHPE Conference in Perugia.	CH

Links with ECHI

JKD stated that health promotion needs to be integrated into the ECHI 2 lists. He gave a slide presentation concentrating on main areas:

- Environment
- Lifestyle
- Morbidity
- Mental Health
- Health Care System
- Other Setting (work places, schools etc)

JKD considered that data collected by EUROSTAT groups could be linked in. The aim would be to compliment the ECHI system with our work. To further this aim JKD has been liasing with Peter Kramers and using the 'user windows' concept. NR commented that DG SANCO have called for new proposals for projects within public health as part of the Network of Competent Public Health Authorities.

Action Point .

• NR asked consortium members to contact their respective national representatives	ALL

being undertaken within the EUHPID project

Settings Approach

Indicators for Capacity Building in Health Promotion

Stephan Van den Broucke (SvdB) gave a presentation on capacity building in health promotion.

(View presentation in pdf format - then close the window to return here)

He portrayed capacity building - the process of building sustainable skills, resources, commitments - as at the heart of health promotion activities for both individuals and groups. He stressed that capacity building becomes an outcome of health promotion. He commented that capacity building within the EUHPID context has been applied to individual. He asked consortium members to broaden this application to include groups / organisations; thus bringing it more into line with the WHO definition.

The following features of capacity building were emphasised:

- Sustainability
- Infrastructure
- Health promotion work strategies
- Organisational / contextual development
- Strategies of Capacity Building
- Action Areas e.g. organisational development, workforce development, resource allocation
- Context Elements e.g. leadership, partnership

Challenges to building indicators of health promotion capacity building were outlined as follows:

- The need for indicator measures
- Language issues
- Silo effect
- Links between capacity building and health outcomes

NdV asked whether generic indicators at organisational level could be fitted into different settings. SvdB replied that could be applied at programme quality level as well as organisational level.

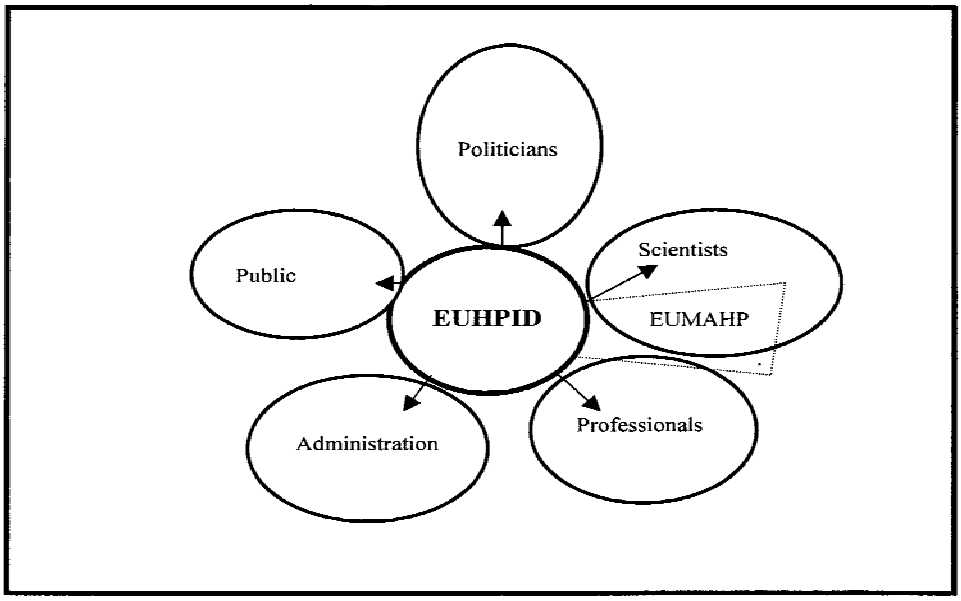
Action Point

- SvdB agreed to circulate his presentation to consortium members. SvdB

Towards a Second Paper

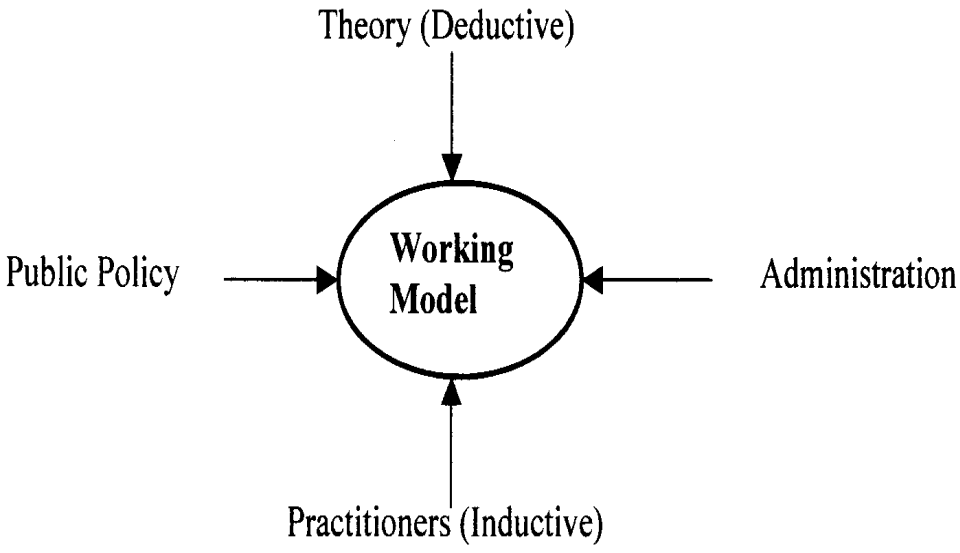
EG stated that the second paper should be used to develop a simple, easy to communicate interconnecting model that condensed collective wisdom.

He illustrated the factors linking influencing the development of the EUHPID indicators as show below. (These can be linked with the action points arising from the Vienna meeting.)



Framework

Additionally EG displayed a cognitive map demonstrating EUHPID core health promotion factors, as shown below.



It was further stated that all consortium members, in addition to those that met in Vienna need the opportunity to discuss the general model. It was proposed that the model most be developed at a practical as well as a theoretical level. This would facilitate the marketability of the EUHPID project.

Health Development Model

GB presented an overview of the EUHPID Health Development Model since the last EUHPID consortium meeting. In view of the concerns expressed he emphasised the practical aspects of the model.

- He covered the following areas:Identification of key messages in health promotion
- Links with the Ottawa Charter
- Three Dimensions of the Model that interact with each other .. Social .. Mental .. Physical
- Health and the environment o Health literacy
- Educational / Health Care systems
- The model as an on-going process.
- Health Capacities

Luis Saboga Nunes (LSN) commented that a fourth dimension – spiritual – could be added to this model. (This is an aspect of health recognised by WHO) and he further noted that pathogenesis and salutogenesis, need to be linked within the model, and not in opposition as in the figure. These were viewed by consortium members as part of the same process rather opposed perspectives.

NdV suggested separating supportive environments to simply physical conditions. He emphasised the need to look at other elements, i.e. economics, social. It was agreed that construction of a health public policy entails not only intervention on a policy level, but at the level of individuals' thinking and behaviour.

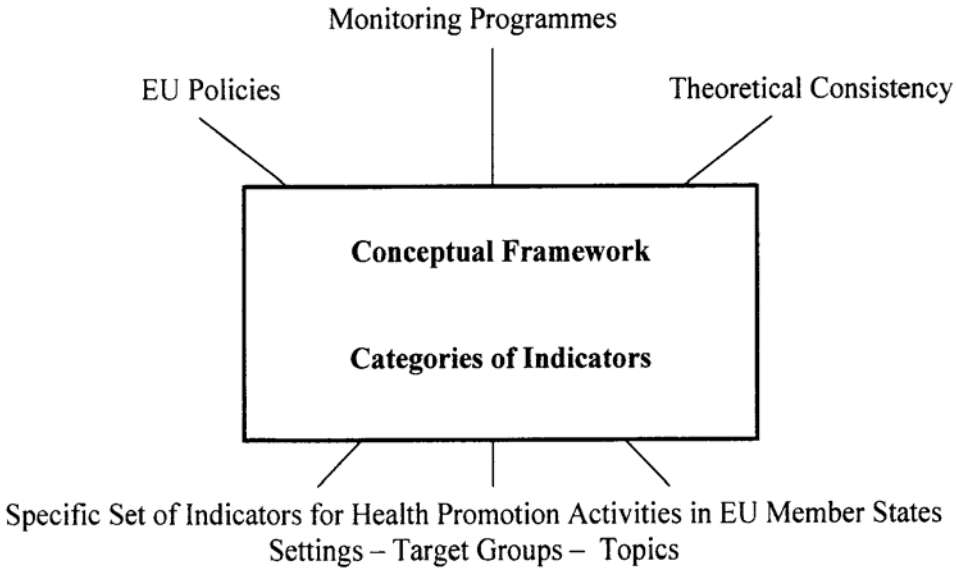
Ursel Broesskamp-Stone (UBS) proposed referring to societies rather than communities within the model, with an emphasis on inter-organisational relations.

It was considered that some of the terminology used would need to be redefined and gaps in the module addressed, for example the classification of behaviour of both organisations and individuals.

The linear nature of the model was commented upon. However, it was recognised that different levels could be examined within the linear structure, for example school settings.

There was concern as to whether the five quality criteria could be used for all system areas. However, it was agreed that all five levels are accessed in relation to each other and they have the ability to intervene at different levels. Thus the model is a dynamic model.

EG depicted key aspects of the model as shown below.



Towards Common Aims

It was agreed that EUHPID consortium members work towards establishing a common set of core health promotion indicators for the EU within a methodological framework by concentrating on the following:

- Specific pan-European indicators that cannot be developed at a national level.
- Political issues, i.e. an awareness of and an ability to respond to key health promotion issues within the EU
- A pragmatic approach, i.e. practical issues as well as policy
- The relevance of the model as a classification system that can be further developed
- Establishing a dialogue with specialists working on relevant projects in the area of health promotion at workplace, school, communities.

In order to further to progress the work of the project along these lines, it was agreed to establish five working groups. These groups will concentrate on the production of indicators in different settings or target groups.

The working groups established were as follows:

1. Child Health Promotion Indicators Workgroup

Membership:
CC (Co-ordinator), Bengt Lindstrom (BL) , LSN , JKD.

2. Workplace Health Promotion Workgroup

Membership:

Maurice Mittelmark (MM)

3. Physical Activity Indicators Workgroup

Membership:
NdV(Co-ordinator), Lasse Kannas (LK) , MM, EG

4. Socio-Economically Disadvantaged Indicators Workgroup

Membership:
SvdB (Co-ordinator), Margaret Barry (MB), UBS

5. Healthy Communities Indicators Workgroup

Membership:

Evelyne de Leeuw (EdL) (Co-ordinator), EG, Giancarlo Pocetta (GP),Helene Bournene (HB), MM

The main task of these workgroups is to produce indicators that can be tested against the theoretical model. Thus facilitating the further development of the model.

Action Points

- Production of a marketing tool to be presented at the European Public Health Association Conference to be held in Rome in November 2003.

- Production of a marketing package to raise the profile of the project to be aimed at ECHI and EU members. For example a poster to be presented at the Melbourne Conference on Health Promotion and Health Education, as well as a smaller document as a marketing tool.

- CH to use the model to apply the reduced list of health indictors identified by ECHI — CH

• Initial feedback from working groups, to include the identification of relevant indicators from the ECHI existing list of indicators, to be sent to the secretariat by 25th July 2003 .	All
• Secretariat to produce overview based on feedback received and distribute it to consortium members by 1 September 2003	Secretariat
• Consortium members to submit feedback on the overview and progress of working groups to date by the 20th November 2003	All
• Meeting of working group co-ordinators prior to Rome Conference, subject to this been agreed as a viable use of EUHPID resources in terms of time / budget.	W.G. Co-ordinators

End of Meeting

EG invited delegates to give their view of the days meeting. Some delegates stressed the importance of fully utilising the skills of all EUHPID consortium members in the project. It was generally agreed that the meeting was productive with a good level of agreement and were enthusiastic about undertaking further work on the project.

Next Meeting

It was proposed that if a fourth EUHPID Consortium meeting is required it should be held on the 10th October 2003 in Brussels.

APPENDIX 3e - EUHPID Second Brighton Meeting

EUHPID Project

Notes from the Fifth Meeting of the EUHPID Consortium

9 January 2004

Mayfield House, University of Brighton

United Kingdom

List of Participants

Georg Bauer
Department of Health Intervention
Research
Institute of Social and Preventative Medicine
University of Zurich
Sumarastr 30
CH-8006 Zurich, SWITZERLAND
E-mail gfbauer@ifspm.unizh.ch
Telephone +41 6344638

Helene Bourene
(Representing Vincent Bonniol)
Department of Educational Sciences
University of Aix-Marseille
1 Hotel Dieu
1 Avenue de Verdun
1310 Lambesc, FRANCE
E-mail h.bourene@wanadoo.fr
Telephone +33 44 257 1717

Ursel Broesskamp-Stone
Head, International Affairs

Health Promotion Switzerland
Dusourstr. 30
PO Box 311
CH-3000 Berne 6, SWITZERLAND
E-mail
Ursel.broesskamp@promotionsante.ch
Telephone +41 31 350 04 25

Concha Colomer
Health Promotion Unit
Escuela Valenciana de Estudios para la Salud Juan de Garay 21
E-46017 Valencia, SPAIN
E-mail colomer_con@gva.es
Telephone +34 96 386 93 66

John Kenneth Davies
International Health Development Research Centre, Faculty of Health
University of Brighton
Falmer, Brighton BN1 9PH
United Kingdom
E-mail J.K.Davies@brighton.ac.uk
Telephone +44 (0)1273-643476

Elisabeth Fosse
Dept of Psychosocial Sciences and Research Centre for Health Promotion
University of Bergen,
School of Psychology
Christies Gate 13 5015 Bergen, NORWAY
E-mail elisabeth.fosse@psych.uib.no
Telephone +47 55 58 27 58

Eberhard Goepel
Fachbereich Sozial-und Gesundheitswesen
Hochschule Magdeburg-Stendal
Breitscheidstr. 2
D-39114 Magdeburg, GERMANY
E-mail eberhard.goepel@sgw.hs-magdeburg.de
Telephone +49 391 8864304

Lasse Kannas
Department of Health Sciences
University of Jyvaskyla
PO Box 35
40014 University of Jyvaskyla
FINLAND
E-Mail lasse.kannas@sport.jyu.fi
Telephone +358 14 60 2154

Bengt Lindstrom
Nordic School of Public Health
Box 12133
S-402 42 – Gotenborg, SWEDEN

E-mail bengt@nhv.se
Telephone +46 31 69 39

Isabel Loureiro
Escola Nacional de Saude Publica
Av. Padre Cruz
1700 Lisboa Cedex, PORTUGAL
E-mail isalou@ensp.unl.pt
Telephone +351 21 1 797 45 41

Juergen Pelikan
(Representing Horst Noack)
Ludwig Boltzmann Institute for Sociology of Health Medicine
University of Vienna
Rooseveltplatz 2
1090 Vienna, AUSTRIA
E-mail juergen.pelikan@univie.ac.at
Telephone +43 1 42 77 48230

Neils Rassmussen
National Institute of Public Health
25, Svanemollevej
DK-2100 Copenhagen
DENMARK
E-mail nkr@si-folkesundhed.dk
Telephone +45 3920 7777

Nanne de Vries
Faculty of Health Sciences
Department of Health Education
University of Maastricht
PO Box 616
6200 MD Maastricht
THE NETHERLANDS
E-mail n.devries@gvo.unimaas.nl
Telephone +31 43 3882423

EUMAHP SECRETARIAT

Based at:

International Health Development Research Centre
Faculty of Health
University of Brighton
Falmer,
Brighton BN1 9PH
United Kingdom

Caroline Hall (Research Officer)
E-mail Caroline.Hall@brighton.ac.uk

Telephone +44 (0)1273-644168

Xanthippe Tzimoula (Research Assistant)
E-mail X.Tzimoula@brighton.ac.uk
Telephone +44 (0)1273-644535

Eleanor Linwood (Senior Administrator)
E-mail E.M.Linwood@brighton.ac.uk
Telephone +44 (0)1273-644169

Antje Stoewesandt *(*Administrator)
E-mail A.Stoewesandt@brighton.ac.uk
Telephone +44 (0)1273-644536

APOLOGIES

Margaret Barry

Wolfgang Boedecker

Stephan van den Broucke

Oliver Grone

Ole Henrikson

Catherine Jones

Pieter Kramers

Julia Kreis

Danielle Piette

Giancarlo Pocetta

Yannis Tountas

Opening of the Meeting

JKD welcomed delegates to this EUHPID consortium meeting.
JKD reported that this is the final meeting as the period of funding finishes on 31 January 2004, with a further three months to prepare the final report.

Structure and Objectives of the Meeting

JKD outlined the structure of the meeting. He identified key objectives as achieving agreement in the following areas:

- Completing the second EUHPID model and classification framework for the second EUHPID publication.
- Discussing practical examples of health promotion indicators derived from the model in use.
- Agreeing recommendations for a second phase of EUHPID.
- Agreeing the content of the final report.

In relation to the second EUHPID paper, JKD further stated that he had prepared a short framework paper that linked it to the agenda of the meeting (see Appendix 1). He proposed that the consortium draw on it and develop it further when achieving the objectives of the meeting.

It was agreed that detailed discussion on practical examples of indicators was needed as part of this meeting. UB-S, had agreed to chair the meeting, and she proposed that time was allocated to the core issues as follows:

- Second Paper (One hour)
- Indicators (Three hours)
- Final Report (Thirty minutes)

EUHPID Update

Reference was made to the EUHPID update paper (appendix 2), prepared, prior to the meeting by the secretariat, which summarised recent EUHPID developments.

JKD elaborated on this update, during which those present added their comments.

The following developments were highlighted:

- ***Restructuring of Working Parties and responsibilities within DG SANCO*** This has included the creation and establishment of seven working parties to further develop the European public health knowledge and information system. (EUHPID is currently classified under the Health System Working Party). The meeting agreed that it was important to consider whether this was an appropriate 'home' for EUHPID. It was considered whether EUHPID should be included under:
  - The 7th generic/ECHI working party on overall issues.
  - A proposed new working party on integrated settings
  - To be considered following further attempts to 'merge' the EUHPID model and conceptual base with that of the Dutch public health model, which underpinned the ECHI framework.

- ***EUHPID Meeting with Pieter Kramers*** This was held on 31 October 2003 to discuss EUHPID links with ECHI. Discussion centred on the suggestion of restructuring the ECHI-2 list, with class 4 to be renamed 'Health Interventions: health services', and an additional class to be created and to be named as 'Health Interventions; health promotion. Class 5 would include 3 lower categories: health promotion, health education and health protection. These discussions are on-going. It was commented by consortium members that ECHI has tended to concentrate on outcome rather than process indicators, and that addressing these gaps is part of the challenge for EUHPID.

- ***4th Workshop on Standards for Health Promotion in Hospitals, Barcelona, 24-25 Oct, 2003.*** JKD reported that he had attended this meeting in, which had the objectives of developing and establishing quality standards for health promotion in hospitals across Europe and related indicators for health promoting hospitals. A presentation on this theme would be submitted by EUHPID to the 12th International Conference on Health Promoting Hospitals to be held in Moscow in May, 2004.

- ***Development of Practical Indicators*** This was agreed as a EUHPID action point at the previous Consortium meeting. There had been some opportunities to raise this at the EUPHA conference in Rome in November 2003.

- ***BKK Institute in Essen*** XT attended a meeting at the institute in December 2003 as a representative of the EUHPID Secretariat. Up to date work of the WORKPLACE health Project includes the production of a preliminary list of generic indicators. (See appendix 3)

- ***Candidate Countries*** Contact has been made with Candidate Countries in order to identify and confirm appropriate colleagues who would be interested to participate in the 2nd phase of EUHPID.

- ***Meeting of Competent Authorities Group*** This had been discussed in Perugia as part of a process of forging links with colleagues at a national level such as representatives on Member States..

  NdV offered to make contact with the National Institute for Health Promotion and Disease Prevention in the Netherlands to further this objective as part of the next steps for EUHPID.

  JKD, at the request of UB-S, agreed to produce a handout for Consortium members summarising current developments within DG SANCO . This is to include where EUHPID is currently placed in relation to the seven newly-appointed working parties.

Core Discussion Points

Second Paper and related work undertaken

JKD drew Consortium members attention to the draft outline of the second EUHPID paper, '*Monitoring Health Promotion in the European Union: the EUHPID Project and its Applications'* (Appendix 1)

GB, JP and CC were invited to give presentations to the meeting on work they had produced for the EUHPID Project, which would form part of the final report (Appendices 4, 5 and 6 respectively)

SvDB, who was not present at the meeting, had contributed a paper entitled *Indicators on Social Health Inequalities in Health and Health Promotion,* (Appendix 7), to be considered for the second paper, was distributed to delegates.

Additionally, IL distributed a handout on Health Promoting Schools (Appendix 8).

1. ***Presentation – GB***

GB introduced the work undertaken on behalf of the model group since the Perugia meeting (June, 2003). (See *Health Promotion Indicators: Underlying Model and Classification System*, appendix 4)

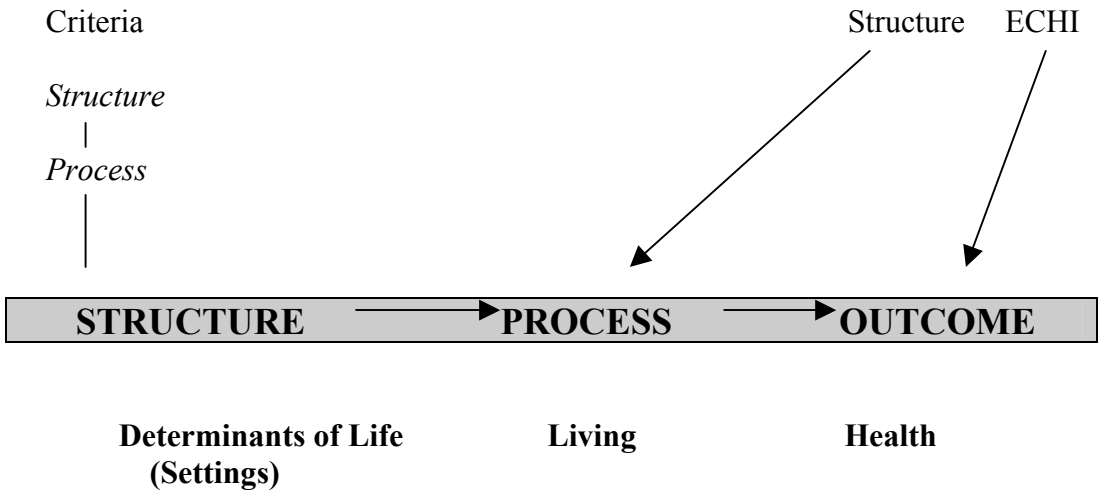
He proposed a slight change to the left-hand side of the EUHPID Health Promotion model, however, due to time shortages during the meeting, it was decided that the model group would meet separately, that evening to further discuss the proposal. It was noted however that due to the impending closure to phase 1 of EUHPID, it was unlikely that alterations would be made during this phase of the project.

2. Presentation – JP

JP presented his work on the elements of the model portraying the interconnectedness of:

- Structure
- Process
- Outcome

He represented this in the form of a diagram:



3. Presentation – CC

CC gave a presentation on work undertaken to date by the DG0-sANCO-funded Child Health Indicators of Life and Development (CHILD) Project. See Appendix 6

She reported that this project:

- has looked at the quality and pragmatic effectiveness of indicators.
- used the ECHI system to develop the classification of indicators.
- was developing indicators not currently used in many countries.

Further work on classification of indicators is still needed and the work of this project is on-going.

It was noted that CC's links to the CHILD project have allowed for the testing of the EUHPID model in concrete areas for example the application of health promotion indicators into a structure that supports children at risk of bullying or children exposed to smoking at home.

(Work undertaken on workplace indicators by GB in particular (appendix 4) can also be tested against the model).

Practical Indicators

The presentations and contributions submitted stimulated discussion on practical indicators and data collection. Issues considered were as follows:

- how to measure data which is meaningful at a national level.
- the practicality of becoming actively involved in obtaining / collecting data.
- the need to understand how to influence Member States in the type of data collected, for example, through the health Information survey (HIS).
- the need for further individual expert input from Consortium members.
- the need to concentrate on settings and draw on indicators that have already been developed in detail, e.g. health promoting hospital standards indicators.
- the level of focus within specific settings, for example in workplace settings should the emphasis be solely on staff, or should a broader ecological model be adopted.
- the need to consider data at all levels, for example, in considering smoking policies in the workplace draw on – national government policies on smoking, the percentage of companies with smoking policies, staff awareness of anti-smoking policies.
- the need to consider the target audience.
- the need to consider the effect of the perception of policy and its implementation, in developing specific and related-indicators.
- the possibility of linking to work on Mental Health/Promotion Indicators within Europe. (See *Establishing a Set of Mental Health Indicators for Europe,* Scandinavian Journal of Public Health 2003; 31: pp 451-459)
- the need to draw on ECHI in producing some prepared examples relating indicators related to specific settings, whilst moving beyond ECHI's focus on predominantly negative factors. Strategically, it remains important to link in

to ECHI, and in doing this, to highlight gaps in the framework, especially in relation to resources-related process indicators.

The Workplace Setting

It was agreed that the meeting would concentrate on indicators within the workplace setting. Comments were invited from those present. In summary it was agreed to consider the following in the course of the discussions:

- using GB's proposals and developing them from the theoretical to practical indicators.
- examples at a policy level, e.g. policy on smoking in the workplace in terms of national laws., how the law is implemented and how this is affected by the potentially varying perceptions of the law.
- Structures in place that support 'health' policy e.g. career development, human resources management.
- when looking at policy we also need to consider:
  - functions
  - resources
  - monitoring
  - interventions which have been identified as necessary
  - individuals / communities – their evolvement / dynamics and empowerment
  - level and understanding of politicians
- the integration of companies into the community
- work-life balance
- the impact of unemployment, for example on the mobility of individuals in respect of job availability
- quality of education / training in the workplace
- family friendly companies
- WHO health promotion settings
- social capital
- company certification – how do organisations become a learning organisation
- financing mechanisms for the implementation of best practice policies, and links to relevant organisations/networks.
- The explicitness and operationalisation of policies, which raise the quality of life in the workplace. This was discussed as relating to Antonovsky's concept of sense of coherence.

It was proposed that the meeting divide into four groups to discuss the workplace setting in specific contexts as follows:

1) **Social / Ecological**

Group Members

IL, BL, EF, NR, CH, AS.

2) **Policy**

Group Members

JKD, CC, LK

3) **Organisational Network**

Group Members

UB-S, GB, JP, XT.

4) **Community**

Group Members

EG, NdV, EL.

Reports back from these groups were as follows:

1) **Social / Ecological**

The group decided that there was a need firstly to define the socio-ecological context. This was defined as being integrally linked to the concept of the environment in the Ottawa Charter (WHO, 1986), and could be broken down into physical and social dimensions, as discussed earlier in this phase of the EUHPID project. The group focused on examples of indicators, relating to the socio-ecological environment, within the context of the workplace. However, further discussion led to the realisation that many of the examples below could be related/adapted to other settings.

Physical Dimension

In relation to the physical dimension, areas for possible indicator development were discussed as follows:

- Basic conditions in the workplace e.g. warmth, access to water.
- Safety in and around the workplace e.g. policies that concern assuring safety.
- Sanitation standards
- Policies that define the quality of the environment
- Workplace ergonomics: e.g. quality of office furniture
- The relationship between people and nature.

Social Dimension

Areas for possible indicator development were discussed as follows:

- Social capital e.g. social coherence, social networks, social opportunities.
- Distance to travel from home to workplace, and access to/availability of commuting facilities.

- How integrated work life is with home life e.g. crèche facilities.
- Issues of democracy: whether there are centralised decision-making mechanisms.

In addition to the above, three cross-cutting themes were identified: inequalities, culture and gender.

Inequalities (exclusion from the labour market)

- Extent to which individuals have equal and democratic access to positions of privilege within the organisation e.g. through policies which support this.
- Extent of protective policies in place e.g. for marginal immigrants.
- Extent to which there are measures in place to address inequalities in the workplace, with the aim of creating a more harmonising environment for all.

Culture

- Extent to which the organisation is accepting of and accommodating towards different cultural orientations e.g. language courses on offer, provision of language interpreters, availability of information in different languages.

Gender

- Extent of support given to young mothers.
- Availability of resources that are supportive of both sexes.

Examples were given by individuals to illustrate some of the above suggestions.

2) Policy
(Workplace Indicators)

Policy was perceived as having a broad definition – from a wide spread of national laws and regulations (work/life related) which could directly or indirectly affect health through to releasing material resources to create opportunities and space to facilitate health opportunities. This would include family-friendly policies/companies – legislation for maternity leave, flexible working hours for fathers as well as mothers, child care facilities, employment rights, ergonomics, for example.

Policies can also be regarded on three levels: 1) written/agreed policies and appropriate documentation 2) actual implementation and 3) policy perception (shared and open/transparent decisions/dialogue.

Key issue = empowerment in the workplace – enabling workers to learn from cultural resources and health (eg theatre, music, arts, etc). Health promoting social innovation policies – example given of the 'Health Card' – a form of 'credit' card given to employees to 'buy' fitness and cultural services. Staff development policies – education and training opportunities about health promotion in the work place – built into general company law. NB - crucial to health that worker has power and choice over his/her work.

Leadership styles important in relation to health and well being, even within a hierarchical structure. Trust related to social capital important – sharing and empowering/transparency in governance. Joint ownership – health promotion principles and values.

3) Organisational Network

It was considered important to define the organisational level. It was agreed that two level should be examined: national and company / organisation.

Structure on a Company / Organisational Level

The group referred to the indicator system developed in the European Foundation of the Improvement of Living and Working Conditions Survey on Quality of Working Life, but added further ideas on job organisations such as opportunities for personal growth.

It was agreed that the company level would include:

- Learning organisations
- Participating Organisations
- Control over work time (e.g. flexible working hours) with a system or place that allows this.
- Control over work content – regulations / rules that allow control can be identified.
- Formal / informal culture of organisation
- Job organisation e.g. job variety, rotation, opportunities for personal growth
- Vocational training

Linking to the community dimension:

- Social content
- Management style
- Provisions for staff well-being, e.g. canteens, child-care.

Structure on a national level

It was agreed that a national structure which supports health promotion would incorporate:

- National Organisations for the workplace and or Public Health, which addresses competencies.
- Concerted communications, e.g. websites, reporting systems
- National laws for work place health promotion
- National resources for workplace health promotion, including budgets of national government, NGO's and the private sector.
- Stakeholders - NGOs, networks, professional associations and training organisations.

- Tools – guidelines, standards, certifications, systematic implementation process (targets – evaluation)
- National platform, inter-sector co-operation, cross level evaluation.

4) Community

The group found it important to clarify the term 'community' more clearly in the specific sense of meaning as a social system of organisation level, compared to the meaning of 'community' in a political-geographical entity. We referred to GB's paper where he described 'community' carrying the characteristics of shared, informal goals, rules, practices and social cohesion.
This can be conceptualised as 'working climate' in a metaphorical sense and linked to concepts of 'social capital'.
Signs of a good 'working climate' can be mutual empathy among the members of the organisation, involvement in decision-making and commitment for the goals and a shared vision of the organisation.
Examples of operationalisation of indicators:

- If you experience problems in your work, can you discuss it with your colleagues and receive support?
- If you experience problems in your private life, can you discuss it with your colleagues and receive support?

Useful instruments can be found in 'Human Resources Development' or 'Total Quality Management'.

NdV referred to the work of Hofstede, who developed a survey in order to compare different cultures of decision making, focusing on hierarchical vs. participatory styles of decision-making. His instruments are used for trans-national comparisons and might be considered for the routines of data gathering at the national level with regard to styles of work organisation and their impact on health development.

Final Report

John Kenneth Davies highlighted that the final report would need an Executive Summary together with a detailed Final report text, together with a series of appendices, such as reports produced and minutes of Consortium meetings. The Secretariat would compile this information.

Based on the above, this meeting should consider conclusions on what had been achieved to date with regard to the Project Contract objectives to be included in the Final Report / together with recommendations and steps forward for phase 2.

What has been achieved to date?

It was agreed that discussions with representatives of ECHI have helped develop an integrated settings approach. This represents an advance from the perception of

health promotion as primarily concerned with health promotion/ education campaigns e.g. health promotion campaigns. It was considered that the EUHPID model fits along side ECHI whilst also adding to it by providing a multi-dimensional classification system, which is not covered within ECHI.

It was further commented that the EUHPID theoretical model forms the basis for the rest of the work of the EUHPID project e.g. applying the theoretical model to concrete settings. It was noted that whilst there are many others working in the field of health promotion indicators, they do not have a framework giving an overall understanding of the complexity of health promotion to draw on, such as the EUHPID model, and as illustrated by the examples discussed during the meeting. EUHPID offers colleagues working on practical settings a comprehensive framework for health promotion monitoring.

The report should emphasise the strength of the EUHPID as an 'expert group', and the extent of the networks in to which the project has linked.

In addition, credit should be given in the final report to the production of learning materials and to the development of academic thought i.e. development of a conceptual model, achieved during this phase of the EUHPID.

Where next?

It was agreed that a case should be made for a 2nd phase of EUHPID. A 2nd phase could build on the achievement of producing the theoretical model and focus on further developing practical indicators related to the settings approach within the framework of the model. It could begin to achieve this by:

- forging links with national agencies
- drawing on data that has previously been gathered, for example within EUROSTAT.
- Possibly developing a pilot data-gathering role.
- developing its role in bridging fragmented aspects of health promotion
- from an early stage focus on a qualitative product, e.g. the workplace
- involve policy makers, practitioners, data gatherers and analysers, academics and users.
- work across themes .e.g. across medically orientated systems
- draw on the 'user-windows' system developed in the first phase of ECHI. (The health promotion window could cut across all indicators).

Close of the Meeting

JKD thanked delegates for attending this meeting and actively participating in the EUHPID Project.

APPENDIX 4 – Dates and Participants: EUHPID Consortium Meeting

EUHPID CONSORTIUM MEETINGS
23-24 February 2002 – Brighton
8-9 June 2002 – London
8-9 November 2002 – Lisbon
22 June 2003 – Perugia
9 January 2004 – Brighton

Participants
Margaret Barry (Ireland)
Georg Bauer (Switzerland)
Helene Bourene (France)
Ursel Brossekamp-Stone (Switzerland)
Stephan van den Broucke (Belgium)
Concha Colomer (Spain)
John Kenneth Davies (United Kingdom)
Panos Dimakakos (Greece)
Elisabeth Fosse (Norway)
Eberhard Goepel (Germany)
Catherine Jones (France)
Lasse Kannas (Finland)
Evelyne de Leeuw (Denmark)
Bengt Lindstrom (Sweden)
Isabel Loureiro (Portugal)
Giuseppe Masanotti (Italy)
Maurice Mittelmark (Norway)
Horst Noack (Austria)
Heinz-Herbert Noll (Germany)
Jurgen Pelikan (Austria)
Danielle Piette (Belgium)
Giancarlo Pocetta (Italy)
Niels Rasmussen (Denmark)
Luis Saboga Nunes (Portugal)
Berenice Staedel (France)
Yannis Tountas (Greece)
Nanne de Vries (Netherlands)

Secretariat
Sue Ginn (Senior Administrative Assistant EUHPID / EUMAHP)
Eleanor Linwood (Senior Administrative Assistant / Administrative Assistant EUHPID / EUMAHP)
Antje Stowesandt (Administrative Assistant)
Belen Sanchez (Research Officer EUHPID / EUMAHP)
Chloe Hill (Research Officer)
Caroline Hall (Research Officer EUHPID / EUMAHP)
Xanthippe Tzimoula (Research Assistant)

APPENDIX 5 – Dissemination of EUHPID Project

On behalf of the EUHPID Consortium:

Health Promotion Indicators: an Action Lab, 5th IUHPE European Conference on the Quality & Effectiveness of Health Promotion and Education, London, June 2002

Health Promotion Indicators: the EUHPID Project, Joint Centers for Disease Control(CDC)/IUHPE Seminar, Atlanta, June 2002 (other funding)

EUHPID Progress Update, EC Health Monitoring Project Coordinators Meeting, Luxembourg, September 2002

European Health Promotion Indicators Project, Summer School, Magdeburg, September 2002 (other funding)

Goepel, E (2002) The EUHPID Project: from Theory to Practice. European Public Health Conference, Dresden, November 2002 (other funding)

Meeting Of Health Monitoring Programme Co-ordinators, Luxembourg, March, 2003

11th International Conference on Health Promoting Hospitals, Florence, Italy, May, 2003

6th European Conference on Health Promotion and Health Education, Perugia, Italy, June, 2003

Expert Discussion with Colleagues from the Health Promotion Theory Book Group and Guests from the EC-Project, EUHPID, Bern, Switzerland, July, 2003.

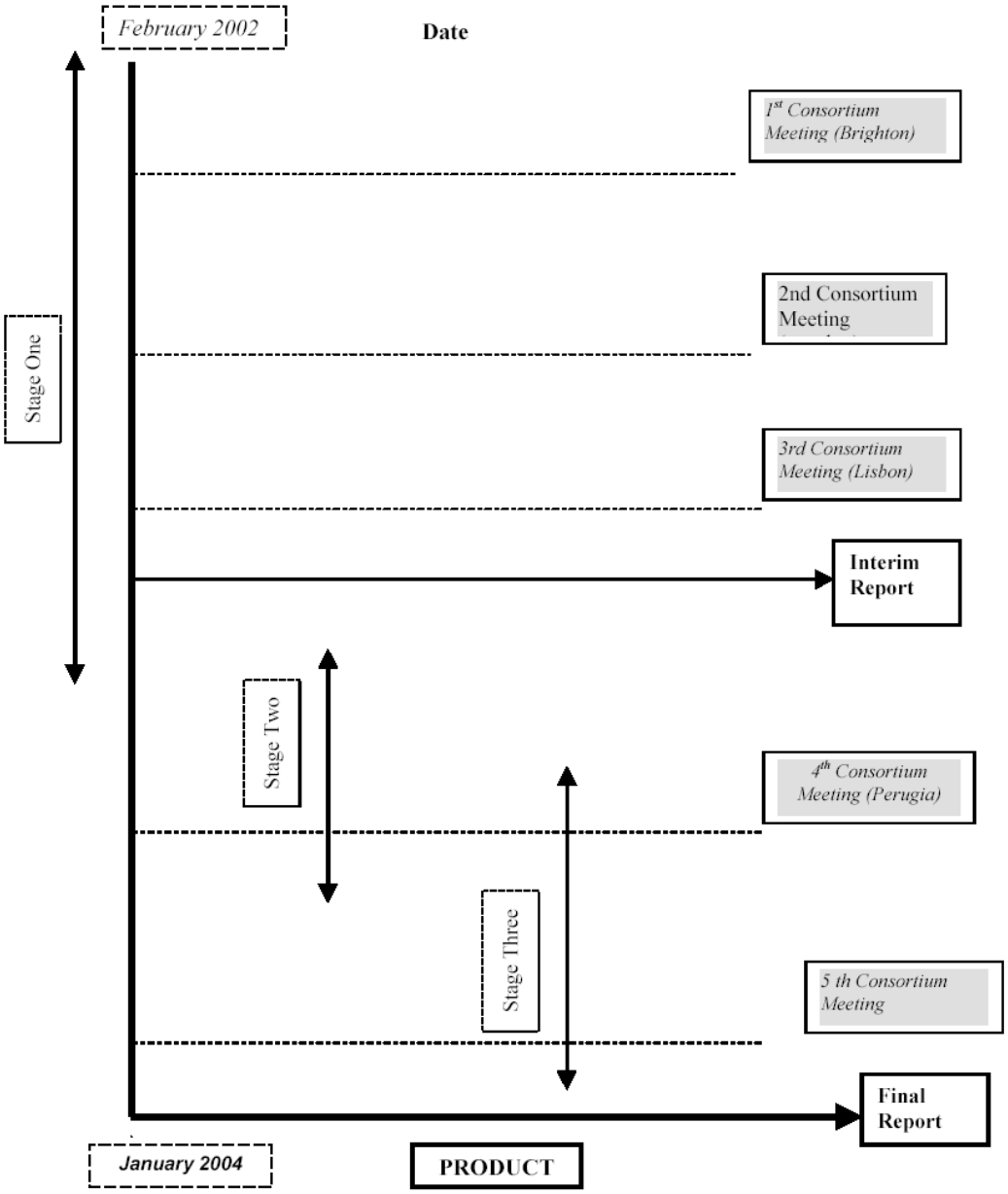
WHO 4th Workshop for Standards for Health Promotion in Hospitals, Barcelona, Spain, October 2003.

11th Annual Conference of the European Public Health Association (EUPHA), Rome, Italy, November, 2003.

5th ECHI meeting, Luxembourg, February, 2004

Meeting Of Health Monitoring Programme Co-ordinators, Luxembourg, March 2004

APPENDIX 6 – Draft Timetable



Appendix 7

A Review of Health Promotion Indicators

A Review of Health Promotion Indicators
A EUHPID Working Paper
Lisbon, November 2002

John Kenneth Davies, Belen Sanchez & Xanthippe Tzimoula
EUHPID Secretariat
Faculty of Health
University of Brighton

CONTENTS

TABLES AND FIGURES:

1. INTRODUCTION

This paper begins a process of continuous identification and recording of relevant work on health promotion indicator development to underpin the EUHPID Project.

It seeks to cover historical and contemporary examples of work on indicator development that have specific relevance to health promotion.

The paper reflects work in progress and at this stage is meant to be a stimulus to discussion and analysis rather than presenting a totally comprehensive review.

It has attempted to document relevant progress in the development of health promotion indicators since the establishment of the WHO Health Promotion Programme in the 1980s, its rapid growth in practical terms during the late 1980s and 1990s and current state of play. An initial expert-led foray attempted to establish a more dedicated research foundation for health promotion during the 1980s (culminating in the Berne Workshop on health promotion indicators). The undeveloped state of health promotion practice and experience at that time prevented further progress. It was during the 1990s that the operationalisation of the Ottawa Charter conceptual framework, principally through the practitioner-led, settings approach started to become evident. This is reflected in the exemplar focus on healthy cities and health promoting school indicators in the paper.

There are gaps in the paper to be filled – for example more details from the field of workplace health promotion indicators, health promoting hospital indicators, for example.

At the same time as health promotion was growing and becoming more widespread internationally, largely as a result of the succession of WHO Conferences and Declarations, other areas of indicator development were progressing. Of direct relevance to EUHPID has been the growth of interest in more salutogenic measures, linked to the holistic concept of health, such as quality of life, sustainability and attempts to define and measure social capital. Many of these other approaches to indicator definition and measurement share health promotion's principles and values – tackling inequity, encouraging more participative approaches to empower citizens and building sustainability.

The following sections of the report are not presented in chronological order but they somewhat reflect the rather eclectic nature of indicator development linked to health and health promotion.

2. THE SOCIAL INDICATOR MOVEMENT

The social indicator movement relates to the goal of presenting quantitative information that is valuable for social policy and social planning. It began in the early 1960's when it was first realised that economic indicators alone had limited value in social and public policy. Data was needed for different purposes (Mootz 1988). In terms of explanation, social indicators were seen as components in a social system model – for example, to understand the causes of health and illness (Land & Spilerman 1975). Mootz (1988) highlighted three specific goals to be met by social, and particularly health, indicators:

- Determination of policy goals and priorities
- Development of methods to change undesirable phenomena
- Determination of resource allocation to programmes.

In basic terms social indicators could be used to monitor and evaluate specific programmes (Bauer 1966).

In other words it was realised that social indicators were required to fulfil a vast range of different purposes. This was further complicated by the realisation that health was a multi-dimensional phenomenon. Mootz (1988) felt that, within the European Region, WHO had solved some of these problems by creating its Health for All strategy and targets and initiating its Health Promotion Programme. With regard to the latter, he specifically pointed to the priority the WHO Health Promotion Programme had given to discussion on how to enhance health. Research he stressed should formulate indicators for the subject areas of health promotion (WHO 1984).

McQueen & Noack (1988), discussing specifically health promotion indicators, distinguish between two broad types of indicators – social indicators and research/scientific indicators. They define social indicators as measures that relate to social policy and decision-making. In research terms, concepts are not things that are directly measurable so an indicator or marker is developed.

Writing in 1998, Bauer reflected that 'the social indicators movement was mostly expert driven and lacked policy relevance'(p54).

The role of social indicator reporting activities in relation to living conditions and quality of life has been given new impetus recently by the process of European integration. As Noll (in press) points out –

> "The improvement of living conditions and the quality of life in the member states are among the main goals of the European Union……..to create the 'Social Europe' of the 21st century" p 2.

His paper explores and discusses a range of 'concepts of welfare' – and reflects the change over time regarding welfare of European citizens - from economic materialism (economic growth as the principle indicator of social progress) to a more recent concern with quality of life and well-being. The latter phenomena, which are of most recent interest in the social indicator movement, but perhaps not yet fully accepted, include concepts such as social cohesion, social capital, social exclusion, human development, sustainability, etc.(**Appendix 2 gives an overview of the concept of quality of life**). Noll's paper (in press) goes on to discuss in depth the following related issues in relation to quality of life:

Scandinavia level of living approach
American quality of life approach
Objective living conditions
Subjective well-being

He concludes that quality of life implicitly or explicitly relates to individual characteristics. Societal characteristics and qualities, such as equity, freedom, social justice, are largely neglected in attempts at empirical measurement. This also applies to the definition and measurement of social relations in society. Noll goes on to discuss:

Liveability and the quality of nations
Social cohesion, social exclusion, social capital
Sustainability
Human development
Social quality

Fig 1 shows the conceptual framework of the European System of Social Indicators with its 2 perspectives and 2 measurement levels (Noll in press p 19).

Fig. 1: The Conceptual Framework – Levels, Perspectives and Dimensions

	Welfare Measurement	Monitoring Social Change
Individual Level	Quality of Life - living conditions - well being	Values and Attitudes - postmaterialism - gender roles - party preferences etc.

Societal Level	Quality of Society *Sustainability* -preservation of natural and human capital Social Cohesion - reduction of disparities, inequalities, exclusion - strengthening of ties	Social Structure - demographic - social class - employment etc.

The Conceptual Framework of the European System of Social Indicators (Noll in press)

Within the elements of the architecture of the European system of social indicators are 14 life domains or modules:

Population
Household and family
Housing
Transport
Leisure, media and culture
Social and political participation and integration
Education and vocational training
Labour market and working conditions
Income, standard of living, consumption patterns
Health
Environment
Social security
Public safety and crime
Total life situation

Noll suggests for each life domain there are the following goal dimensions:
Improvement of objective living conditions
Enhancement of subjective well-being
Reduction of disparities, inequalities and social exclusion, promotion of equal opportunities
Strengthening social connections and ties – social capital
Preservation of human capital

Preservation of natural capital

He provides the example of the labour market and working conditions domain - Fig 2 details the goal dimensions and measurement dimensions involved.

Fig. 2: Goal Dimensions and Measurement Dimensions for the Life Domain: Labour Market and Working Conditions (Noll in press)

Life Domain: Labour Market and Working Conditions	
Goal Dimensions	Measurement Dimensions
Improvement of Objective Living Conditions	- labour market: opportunities and risks - employment level - working conditions - mobility unemployment
Enhancement of Subjective Well-Being	-evaluations of personal employment situation
Reduction of Disparities/ Inequalities	-regional disparities of employment opportunities -gender inequality of employment opportunities -inequality of employment opportunities for disabled people -social exclusion: long-term unemployment
Strengthening Connections / Social Ties – Social Capital	-participation of employees in decision making -trade-unions and professional organisations -European-specific concerns -exchange of workers across countries
Preservation of Human Capital	-working accidents and occupational diseases -measures of further training
Preservation of Natural Capital	-Consumption of natural resources by economy -Environmental pollution by economy
Social Structure Socio-Economic Structure Values and Attitudes	-employment status -occupational structure -sectoral structure - work orientation

Within this same domain, Fig 3 provides the measurement dimensions and sub-dimensions related to the goal dimension – 'Improvement of Objective Living Conditions'.

Fig 3: Measurement Dimensions and Subdimensions related to the Goal Dimension "Improvement of Objective Living Conditions" within the Life Domain "Labour Market and Working Conditions" (Noll in press)

Measurement Dimensions	Subdimensions
Labour Market: Opportunities and Risks	Employment Opportunities
	Unemployment Risk
Employment: Potential and Level	Labour Force Potential
	Labour Force Participation
	Employment Level
Working Conditions	Working Hours
	Earnings
	Work Environment and Job Content
Mobility	Horizontal Occupational Mobility
	Promotion Chances
	Job-related Geographic Mobility
Unemployment and Underemployment	Level of Unemployment
	Duration of Unemployment
	Subsistence of Unemployed Persons
	Level of Underemployment

3. WHO HEALTH PROMOTION PROGRAMME

3.1 WHO Health For All

More than 100 indicators were proposed for monitoring the WHO Health for All targets (WHO 1985). But none of these indicators show how health can be promoted and most of the indicators proposed for the 38 targets are not comparable.

Mootz 1988 feels that there has been too much energy devoted to the development of indicators of health status.

Indicators for public health are mainly limited to an individual and population health status and don't take into account socio-ecological context.

3.2. History Of WHO Health Promotion Programme

Concern with the dynamic nature of health, followed the Declaration of Alma-Ata in 1978 (WHO 1978), gave rise to the new public health movement and its principal driving force – health promotion. The development and establishment by WHO of a Health Promotion Programme within its European Regional Office in the early 1980's reflected the new thinking. This included aspects of health related to multiple causation, an epistemological focus on a salutogenic model of health ie processes affecting health rather than factors determining disease, a focus on social and structural influences on health, a concern with the concept of lifestyles, a reflection on effective policy and programme intervention (Dean 1988). (See Appendix 1 for an overview of the salutogenic model of health). These and related issues are key concerns for the development of health promotion indicators. Therefore the growth of interest in health promotion in the 1980's sparked off a corresponding need for indicators to monitor its progress, especially from the World Health Organization.

3.3 What Is Health Promotion?

It is a broad unifying concept which is directed towards the multiple forces that affect health. It is not confined to disease prevention and health services (NB this presents a challenge for EUHPID in relation to the current European Community Health Indicators (ECHI) framework, which underpins the EC Health Monitoring Programme.

The Ottawa Charter defines health promotion as "the process of enabling people to take control over, and improve, their health" (WHO 1986).

The end product of health promotion is strengthening health potential rather than preventing specific diseases.(Noack 1987). It is therefore concerned with the means to improve health - the strategies and processes to improve health. Positive health or well-being is the goal towards which the means are directed (Dean 1988). These are key issues conceptual issues in the development of health promotion indicators.

Following the seminal definition of health promotion's concepts and principles (WHO 1984), a series of expert workshops and symposia were held in an attempt to discuss and recommend a solid research foundation on which to base its development. These meetings included:

Working Group on Research In Health Promotion, WHO/Scottish Health Education Group (SHEG) (WHO Collaborating Centre for Health Promotion Research), Edinburgh 1985

Symposium on Health Behaviour Research, WHO/SHEG/UK Economic and Social Research Council (ESRC), Pitlochry 1986 – this symposium began the process of identifying health promotion indicators. Key papers from the Symposium were revisited, edited and published. (Anderson, R et al 1988).

Workshop on Measuring Health Behaviour And Health: Towards New Health Promotion Indicators, Berne 1986 – Seminal meeting where most of the key issues and problems related to health promotion indicators became manifest. They re-emerged at each stage of this intensive process in the late 1980's. (See Table 1 for issues and problems in health promotion indicators – McQueen & Noack 1988).

Table 1: Issues and problems in health promotion indictors (McQueen & Noack 1988)

Purpose and applications	Concepts and theories	Methodologies
Research	**Defining the field**	**Measurement**
Testing of theory	Universality versus specificity	Data source
Prediction of change	Meanings of health promotion indictors	Qualitative versus quantitative data
Explanation or understanding	Subjective versus objective indicators	Reliability and validity of data
Development of new techniques	Static versus dynamic indicators	Data collection
Policy	**Defining the theory**	**Data analysis**
Baseline information	Micro- versus macro-level	Simple versus composite
Monitoring and change	Process versus imput, output models	Statistical versus mathematical
Evaluation of interventions		Presentation

Workshop held on Indicators And Measurement Of Health at 1st International Conference On Health Promotion, Ottawa 1986 (WHO 1986a) – a special session was held on health promotion indicators where the Berne Workshop report was presented (WHO 1986b)

Meeting on Health for All (HFA) (1985) Regional Lifestyle Indicators, Edinburgh 1987 – discussed health promotion indicators.

International Conference On Inter-Cantonal Indicators Study, Lausanne 1987– addressing the health information needs of policy makers included further discussion of health promotion indicators.

New Public Health: Implications For Research, Edinburgh1987 - theoretical and methodological issues of indicator development were discussed.

Changing The Public Health Conference, Heriot-Watt, Edinburgh1987 (Martin & McQueen 1989) – papers and discussion of relevance to indicators.

WHO Regional Office for Europe reviewed the state of knowledge of indicators and measures of health promotion (Abelin, T et al 1987). Included in Abelin et al's edited text was a chapter on 'Indicators of Behaviour Conducive to Good Health' by Kar and Berkanovic (1987), who identified gaps in indicators to measure personal and social behaviours conducive to good health. They highlighted that the vast majority of empirically sound indicators occurred in area of individual action related to physical health/specific behaviours and quantiof lifestyles, quality of life and health indicators (Bergner 1985, Carley 1981, Hansluwka 1985, Mootz 1986, Read et al 1987). Hansluwka (1985) provides an historical overview of the health indicator movement, defines indicators and indexes, and gives details of several health guidelines for the selection of health promotion indicators:

- Valid and functional
- Meaningful
- Feasible
- Contextual and mutable
- Having cross-cultural utility
- Having collective consensus
- have cross-cultural utility
- have collective consensus

For a detailed analysis of the survey methodology and indicators identified see Kar et al (1988) – see in Table 2 the ranking of indicators in the matrix of health-promoting behaviour.

Table 2: Ranking of Indicators (Second Survey) in the Matrix of Health-Promoting Behaviour (Kar et al 1988)

Level	Physical Health	Mental Health	Social Health
Individual	Recommended personal promotion actions (77%) Timely use of services (68%) Correct knowledge / attitude (55%) Practise proper skills (52% Seek information/knowledge (51%) Participate in community health promotion programme (51%) Recommended clinic visits (40%) Use recommended products (39%) Planned parenthood (30%) Use contraception (30%) Participate in social/political action for health (16%) Compliance with law / policy (11%) Provide resources to meet basic physical needs (77%) Provide health education/information network (73%) Make services available (71%)	Practise recommended actions for personal mental health and stress control (88%) Correct knowledge and attitudes (76%) Timely use of services (66%) Seeking information / knowledge (67%) Engage in socially supportive relationship (64%) Participate in community mental health activities (58%) Use of services as recommended (49%)	Engage in socially supportive relationship (75%) Correct knowledge / attitude on social issues (74%) Participation in community health promotion activities (73%) Participate in community development / organisation activities (69%) Seek information / education (61%) Family size (50%) Seek / keep appropriate employment (44%) Comply with social norms (25%) Provide educational opportunities (85%) Provide adequate employment (73%)

Social	Provide environmental health protection measure (68%) Make services accessible/ acceptable (56%) Provide adequate training of health care providers (51%) Provide community health action (38%) Appropriate legislation (36%) Adequate resources for health promotion (28%) Provide incentives for health promotion behaviour (21%) Safety of health products (20%) Provide recreational facilities (15%)	Provide mental health education (81%) Provide funds for mental health promotion programme (74%) Provide promotion of adequate services (70%) Accessible, equitable, and acceptable services (68%) Adequate training of health care providers in mental health (66%) Provide adequate counseling services / network (64%) Provide recreational facilities (49%) Appropriate legislation (29%)	Provide community facilities for social health promotion (71%) Provide adequate school health promotion services (68%) Provide adequate resources for social health (64%) Develop/sustain social support networks (56%) Adequate social /recreational facilities (43%) Adequate crime prevention / law enforcement (39%)

The WHO initiated work culminated in the Berne Workshop on health promotion indicators, the main papers and outcomes of which were published in a Special Edition of Health Promotion: an International Journal in 1988. This edition covered intensive work on indicators during the period 1986-1988.

3.4 State Of Play Of Health Indicators Field In 1988

Work produced by Dean, in relation to the development of Health Promotion Indicators, placed emphasis on the multidimensional concept of health that includes physical, mental and social well- being. The importance of issues of multiple causation and the *processes* that affect health rather than the factors that determine disease as well as social factors and structural influences on health, lifestyle, effective policy and intervention was put forward (Dean, K, 1988). According to Dean (1988) –

> "The development of indicators of health promotion … has only just begun. We are searching for indicators of the process of translating health resources into health, as distinct from indicators of health itself ……The end – health – and the means – health promotion – must be kept distinct ….theoretical deficits inhibit the development of meaningful indicators" (p16).

Dean also notes the excessive focus on individual personal behaviour over the need for focussing effort on socio-structural and cultural influences on health.

There was a 'wide array', according to Dean (1988), of often ad hoc measures sometimes focussing on health or functioning, sometimes on conditions or behaviours that correlate with

health, sometimes measuring something else. Dean (1988) goes on to review mortality, disability days, bed days or restricted activity days – none of which measure health.
Since 1940's there has been an exclusive reliance on mortality supplemented by wide series of measures of **morbidity**, **perceived health** and **functional status** (Goldsmith 1972; Hunt et al 1981; Moriyama 1968).
Many indicators have separate measures for **mental health**, **physical health** and **social health** (Bergner et al 1981; Chambers et al 1982).
Composite health indicators or aggregated indices are attempts to combine morbidity and mortality (Chiang 1965).

A key factor is the need to integrate health promotion research and policy development ie a need for reliable and meaningful information on health promotion.

In 1988, indicator development in health promotion was seen a new field prior to Berne Workshop, where 17 papers were presented.
During the Workshop, working groups were set up to suggest future developments in health promotion indicators in relation to:

- health status and dimensions of health
- health behaviour and health resources
- and important cross-cutting themes.

12 papers were eventually published in the 1988 special edition following rewriting after the Workshop. They included:

- **Conceptual, strategic and methodological issues in the development of health promotion indicators** (Noack paper – policy context and general theoretical and methodological framework, Dean paper – differences between concepts of health and health promotion and the particular conceptual and methodological problems encountered in measurement of health promotion, Mootz paper – taking the lessons from the social indicators movements of the 1960's and 1970's – strengths and critical issues in contemporary approaches to indicator development)
- **Health status measurement** (Hunt paper – conceptual, technical, methodological and practical problems of measuring subjective indicators of positive health- eg Nottingham Health Profile, Kaplan paper– using mortality and morbidity data into composite measures of health, Groothoff paper – changing relationship and meaning of mortality and disability measures over time)

- **Conceptual and methodological problems related to development and validation of indicators of health promotion processes** (Kar et al paper – methods and some results of cross-cultural project, using modified Delphi technique to identify a set of indicators of individual and societal actions related to physical, mental and social health, Bucher & Gutzwiller paper – a composite indicator of preventive health behaviours and evidence to support its validity, Rootman paper – the design, development and use of a national system of health promotion indicators in Canada)
- **State of the art of health and health promotion indicators** (Spuhler paper – summary of the Berne Workshop discussions, Thuriaux paper – the contemporary status of HFA indicators in the WHO European Region specifically related to health promotion and lifestyle targets, Muller paper – provides a critical review of both the concept of health promotion and the demand for health promotion indicators (to improve social policy or increase social control?), McQueen & Noack paper – tries to summarise Berne Workshop and subsequent work – including suggested practical steps towards the development of suitable indicators within a comprehensive programme of health promotion policy and health research and the contemporary status and theoretical and methodological issues and problems in the specification and use of health promotion indicators).

Noack, H (1988) Measuring Health Behaviour and Health: towards New Health Promotion Indicators Health Promotion Vol 3 No 1 pp 5-11

Feels there are too many traditional indicators related for example to mortality. Therefore there is a need to identify new indicators – in the fields of lifestyles, quality of life and health indicators (Bergner 1985, Carley 1981, Hansluwka 1985, Mootz 1986, Read et al 1987). Hansluwka (1985) provides an historical overview of the health indicator movement, defines indicators and indexes, and gives details of several health indicator classification systems.

But the challenge according to Noack is to develop indicators that are sensitive to changes in positive health in specific groups and population eg in
bio-psycho-social wellbeing, physical and psychological health indicators. He summarises macro-level and global indicators of social and economic development, health care provision, health status, coverage by primary health care + mortality, morbidity and well-being.
WHO (1985) lists the essential and optional indicators for monitoring and evaluating progress in relation to national and European Regional targets.
Research on health indicators – meetings in UK of researchers and others from several European countries in early 1980's discussed health indicators (Culyer 1983).

In USA in early 1980's conference discussed ways of measuring health status and various dimensions of health (Bergner 1985).

In 1987 a conference held in Portugal discussed measuring health status and health-related quality of life (Katz 1987).

3.5 Health-Related Quality Of Life And Health Status

There have been significant advances in research on quality of life and on valid and reliable measures of health status in its various dimensions - Noack suggests that health status or health-related quality of life maybe (if measured properly) a crucial criterion of health promotion.

But if we are referring to the processes and conditions that maintain or improve health then health promotion as a concept has a different meaning!

"TO ASSESS OR MEASURE HEALTH PROMOTION PER SE REQUIRES DIFFERENT MEASURES OR INDICATORS" (Noack p 6).

This was stressed by Kar et al (1988) who saw it as imperative to identify indicators of the impact of programmes separate from the traditional measures of health status; and these indicators should include indicators of societal as well as personal action,

Kar and his colleagues reported on a WHO-sponsored Delphi survey of 151 specialists from 43 countries, to develop a set of indicators of both societal and individual processes involved in the promotion of health.

The Berne Workshop choose a framework that identified 5 groups of potential measurements or indicators:

1. healthy public policy and health promotion programmes
2. societal and community health resources
3. group and personal health resources
4. health-related social processes
5. dimensions of health

1)HEALTHY PUBLIC POLICY

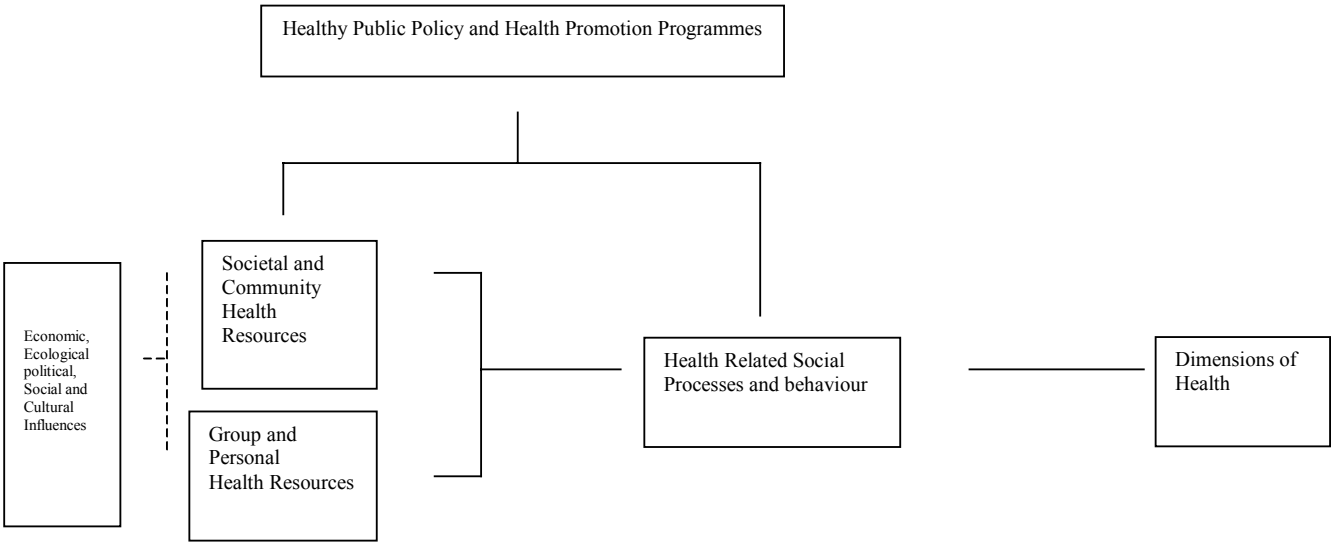
Noack reported that there were a number of indicators proposed to assess and compare policies for health and health promotion programmes at both national and international levels

(Abelin et al 1987; Hunt et al 1986; McDowell & Newell 1987; WHO 1985). Examples included:

- existence of laws and regulations on safety and labelling of goods/products
- time allocated to health information programmes on TV
- public participation in health activities at community or at regional level
- coordination and integration of health promotion activities in government or in the community

See Fig 4 for a conceptual framework of health-related conditions and processes and of dimensions of health (Noack 1988).

Fig. 4: Conceptual Framework of Health-Related Conditions and Processes and of Dimensions of Health (Noack 1988)



According to this conceptual framework - "healthy public policy and health promotion programmes are assumed to influence the health resources of societies and communities and of groups and individuals as well as health-related social processes and behaviours" (p8).
HEALTH RESOURCES = to include static elements (shared health knowledge, cultural values and practices) and dynamic elements (health education campaigns, use of preventive medical services).

2)SOCIETAL AND COMMUNITY HEALTH RESOURCES

Include

- o environmental conditions (housing, clean air & water, access to healthful goods/products)
- o economic factors (work, income, social security)
- o social conditions (social contact and support, caring, social inclusion)
- o cultural conditions (shared health values, health knowledge, health enhancing practices)

Government and voluntary institutions – health promotion programmes, educational input disseminating health information, teaching-related health skills, primary care and other services, self help, etc

- numerous indicators are available or can be defined (Abelin et al 1987).

3)GROUP AND PERSONAL RESOURCES

Include

- health-related norms, rules or customs shared by families and other social groups
- social relationships
- physical characteristics
- psychological characteristics

Examples of indicators = stable and supportive social networks; positive health values and attitudes in families; adequate personal health knowledge and skills.

4)HEALTH-RELATED SOCIAL PROCESSES AND BEHAVIOUR

Noack sees as distinct yet closely related to health resources eg all forms of interaction between a person and their environment that have a direct or indirect bearing on health. Includes positive health enhancing behaviour – eating healthy diet, coping with pressures, regular physical exercise, using preventive services, etc. Also health damaging behaviours – smoking, alcohol abuse, dangerous driving violent social behaviour, etc.

Social processes – such as social and emotional support and caring.

Examples of indicators = proportion of people with or without regular social contact; average daily intake of calories and nutrients; average alcohol consumption per capita; etc.

BUT NOACK MAKES PLEA FOR MORE RESEARCH ON HEALTH-ENHANCING AND COPING BEHAVIOUR + HEALTH-RELATED SOCIAL INTERACTION.

5)DIMENSIONS OF HEALTH

Seen by Noack as interrelated closely with health-related social processes and behaviour and sometimes subsumed under health status – better to conceptualise health in terms of dynamic concepts such as HEALTH BALANCE and HEALTH POTENTIAL (Noack 1987).
Health balance = biopsychosocial well-being or functioning; or perhaps a distinction between physical/mental/social well-being or functioning.
Health potential = capacity of a person or group to maintain balance and re-establish it if lost.

Traditional indicators mainly reflect aspects of negative health = disturbances of physical, mental or social functioning (morbidity, disability) or death (mortality).

There are measurements of wide range of positive and negative health indicators (Bergner 1985, Carley 1981, Hansluwka 1985, Mootz 1986, Read et al 1987).

But the challenge according to Noack is to develop indicators that are senstive to changes in positive health in specific groups and populations eg in biopsychosocial wellbeing, physical and psycho social functioning (or changes in perceived symptoms and disability, and to assess the health potential of groups and individuals = eg capacity for self-help, coping competence, etc.

Noack proposes 2 types of models – input-output & process models.

Input-output = independent variable (health promotion programme) seen as input to system and changes in health behaviour/group health dimension = output. Assumes
social and behavioural processes = black box. Emphases quantitative predictions /changes in outcome variables. Weakness = it cannot explain why changes do or don't occur.

Process models are different in focus. Don't predict outcomes. They attempt to describe, understand and explain the contextual, behavioural and biological processes involved in health behaviour, health balance or health potential. Process models are research models rather than elaborated theories.

Which model will depend on purpose of project and questions to be answered.
"The purpose of a given project will further determine the kind of health and health promotion indicators needed".

Noack recommends that any well planned project for indicator development should follow these steps:

- specify the purpose of the project
- identify and describe the health-related phenomena to be assessed
- define and select the most appropriate indicators or measurements
- analyse the validity, reliability, sensitivity and cost of the selected indicators, using all available research results and experience
- choose an ongoing study or plan a new one to test out the validity of the indicators and other key properties. This should use national projects (and European) to monitor health promotion programmes for example based in the workplace.

KEY SEEMS TO BE TO DISTINGUISH BETWEEN MEASURES OF HEALTH OR FUNCTIONING VS MEASURES OF THE ENHANCEMENT OF HEALTH OR FUNCTIONING!

In her review of the state of health promotion indicators in the late 1980's, Dean (1988) concluded that there was a need to move from

> "an excessive focus on indicators of personal behaviour to the identification of indicators of cultural, structural and situational processes that influence health" (p20).

In their review of the state of the art of health promotion indicators in the late 1980's Noack & McQueen (1988) concluded that health promotion indicators needed to be discussed "in the wider context of the health information system that a society is willing to build and maintain" (p74). At that time, they felt there was little new to be gained by experts meeting to define indicators, until emerging concepts and principles of health promotion became fully integrated into a more solid health promotion research framework. Likewise the pressure from end users ie policy makers for simple and immediately available indicators was unrealistic at that time due not only to the state of knowledge but also to limited resources and time available to researchers. They also called for a continuous dialogue between health researchers and health decision-makers in order to achieve consensus.

In his summary and analysis of the Berne Workshop, Spuhler (1988) highlighted a standard process for developing indicators of health promotion:

- levels at which indicators to be used – international, regional, national,
- users – policy-makers, researchers,

- purpose of the indicators – policy/decision making, increase knowledge, evaluation of programmes,
- time frames – weeks, years,
- their objectives or goals,
- type of action to be measured – individual, legislative, educational,
- qualities of the measurement – meaningful, valid, reliable,
- methods of data collection – single or multiple, primary or secondary data,
- procedures for dissemination of results – suitable for different audiences.

From the Berne Workshop participants also highlighted –

- potential conflict between expectations of policy-makers wanting immediate, feasible, simple, meaningful indicators and researchers wanting to develop indicators based on concepts of health promotion
- need for validation and reliability tests as essential requirements
- need for standardised methods of data collection and measurement
- although valid and reliable indicators based on standard methods meant cross-national comparability – would not guarantee cross-national relevance due to cultural and language differences
- age-related methodological difficulties – most measures of health developed among young and middle-aged adults – what about children and the elderly
- timing of measurements – related to outcomes

In summary from the Berne Workshop – at the time the concepts and operationalisation of health promotion for research and evaluation were not clear therefore expectations of their development and use, particularly by policy-makers, should not be to high. Participants saw the following types of areas as possibilities for indicator development:

- health status indicators – readily available but not specifically relevant to health promotion
- morality and morbidity – should be used selectively
- health promotion indicators, indicators of health resources and health-related social processes – major gaps in our knowledge

Relevant Recommendations of Berne Workshop (from Spuhler 1988):

1. small, targeted working groups (4-5 members) should be created to develop health promotion indicators in areas such as **health resources and health-related social processes**; **health-related behaviour**; **dimensions of subjective health and health status**.
2. networks be established of researchers and policy-makers to translate policy issues into research problems and research results into policy
3. health promotion indicators to be produced for specific contexts of groups such as students, workers, community, different age ranges, etc.
4. attention needed to methodological and technical aspects – sampling, data collection and analysis.

In their paper after the Berne Workshop, McQueen & Noack (1988) reported that data sources for health promotion indicators that incorporated contextual effects had not been considered eg measures of social support networks, socio-cultural environment and its effects on health-related behaviour; changes in the physical environment, etc. They also highlight the lack of an underlying theory of health promotion –

> "An exact theory of health promotion has not yet been made" (McQueen & Noack 1988 p 122).

They saw the need for defining a new conceptual field as the applicability of available health indicators proved of little use –

> "…Much work has to be done to find indicators appropriate to an emerging conceptual area" (McQueen & Noack 1988 p 122).

They define health promotion using the Ottawa Charter and its action areas – all of which are concerned with change – therefore they see health promotion indicators as capable of detecting movement. In this regard they propose three key theoretical issues in the development of health promotion indicators:

- the role of the macro (broad social and environmental) perspective as opposed to the micro (individual) perspective
- the notion of process as a key property of health promotion
- the role of models and model building in theory development.

Hayes & Willms (1990) reviewed and followed up the Berne Workshop, indicating that it produced more questions than answers. The main problem they highlighted – researchers need valid and reliable indicators, but policy-makers need simple and meaningful indicators that can be understood by the general public.

4 PERFORMANCE INDICATORS IN HEALTH PROMOTION

4.1 Introduction

During the 1980's and early 1990's, there was a development of interest in performance indicators to monitor performance and value for money in public services. The National Health Service in the UK developed a set of performance indicators in 1983, later renamed health service indicators. A national set of performance indicators for health promotion proved more difficult to develop (Whelan et al 1993). The UK Society of Health Education and Health Promotion Specialists (SHEPS) tried to create a standardised set of performance indicators in the mid-1980's for all health districts.(Beales & Blanks 1987). They could not obtain agreement and each district was left to develop their own indicators. In Wales a standardised set of performance indicators has been developed which are mainly numerical relating to inputs and number of activities undertaken ie quantity as opposed to quality. This does not therefore allow any measures of effectiveness or efficiency to be calculated.

In 1992 SHEPS published a manual outlining the need for performance indicators for health promotion and put forward a range of possible indicators (SHEPS 1992). The indicators they proposed were mainly quantitative in relation to impact and outcome for seven types of health promotion programmes. It was not possible to use these indicators to measure quality, they were too general, it was not possible to attribute them to the programme activities undertaken and they focussed on outcome to the detriment of process indicators (Whelan et al 1993).

> "The disparate nature of much health promotion work makes it very difficult to develop a comprehensive system of performance indicators". (Whelan et al 1993).

This is due to, according to Whelan et al 1993, each health promotion programme's lack of clearly specified objectives, inherent problems in measuring its effectiveness and its number of potential audiences. They therefore proposed a performance indicators model (input-process-output-outcome with feedback loop). See Fig 5 on detailed process indicators suggested by Whelan et al.

Fig. 5: Process Indicators

TYPE OF INDICATOR	DESCRIPTION
I DEVELOPMENT a) Planning Indicators b) Liaison and Field Development Indicators	- a needs assessment survey - develop a strategy, aims and objectives for the initiative - the kind of partnerships - the number and extent of contacts - the method of communication - the number of contact receiving information and or/advice
II DELIVERY a) Health Promotion Projects or Events indicators b) Target Population Indicators	- the nature and duration of the initiative(s) - the potential population - the population reached - the kind of participation reached - editorial activities (designing and publishing leaflets) - purchasing activities (number of materials purchased, stockholding levels) - distribution activities (who are the key partners/ clients, how many publications do they receive) - promotional activities (maintaining and developing resources) - the number and type of health promotion activities aimed at the mass media - the nature and number of training events and conferences (including their aim, target population and participant evaluation)
III) EVALUATION a) Evaluation Strategy Indicators b) Data Collection Indicators c) Fieldwork Indicators	- the design of the evaluation strategy - the method(s) of data collection (such as postal questionnaires or interviews - the nature of fieldwork undertaken

Work produced by the Australian Centre for Health Promotion, for capacity building resulted in a rather specific, narrower list of indicators (Hawe, P. K. L, Noort, M., Jordens, C., Lloyd, B., 2000). Indicators proposed favour the problem-solving dimension of capacity building. Checklists accessing three levels of capacity-building were given. At community level indicators refer to commitment, predisposing awareness of each part of community's identity and contribution, caring collective efficacy, enabling factors and reinforcing factors (Hawe, P. K. L., et al, 2000).

4.2. Health Promotion Indicator Development In The 1990's.

In a journal editorial of 1999, Lawrence St Leger remarks that –

> "The notion of indicators in health promotion is certainly in good currency"
> (St Leger 1999 p 193).

He went on to observe –

> "…..those involved in health promotion theory and practice in many countries have been energetic in developing a large number and range of indicators in the last decade" p 193.

He assigns this growth in indicators to increased accountability of health promotion interventions in terms of resource use and outcomes from funding bodies.
Labonte et al (1997) highlighted the plethora of indicators in use in health promotion, and stressed the lack of involvement by target audiences in their production.

In the period from 1988 Berne Workshop to St Leger's editorial a decade later, our knowledge and experience of health promotion strategies and programmes has grown exponentially. Evidence from the health promotion literature has reflected the delineation and classification of indicator types (eg Whelan et al 1993; Raphael, D et al 1996; Raphael, D et al 1999; Kolbe, L et al 1997; Macdonald, G 1997; Nutbeam, D 1997)). Within this literature, health promotion indicators can be observed in the following areas:

Individual knowledge
Attitudes
Personal behaviour
Skills
Biology
Physical & man-made environment
Social/cultural relationships
Partnerships
Policy development
Policy implementation

There is an established history of indicator development in areas such as individual knowledge and biological measures – eg health knowledge and health status – these are well developed, numerous and accepted.

But key need is to shift beyond a narrow to a holistic concept of health setting individuals within their physical and social settings. Settings are major social structures providing channels of influence for reaching defined populations (Goldstein, G 1997). In this latter context there is not a well established history nor acceptability in the health development field compared with the more traditional and accepted biomedical paradigm (St Leger 1999).
St Leger refers to this wider context as "the big picture" – combining biological, social, political, economic, with marketing, education, psychology, sociology, anthropology, etc. – ie the multidisciplinary, intersectoral and more eclectic approach of health promotion and the Ottawa Charter (WHO 1986). St Leger regards most health promotion practice as being "the little picture".

St Leger (1999) notes a shift from emphasising personal indicators to setting the individual in context facilitated by the move in interest towards the settings approach in health promotion development. In this regard both the Healthy Cities and Health Promoting Schools movements are both areas of development that have in particular facilitated a more sophisticated approach to health promotion indicator meaning, definition and classification. But the problem is that these initiatives have been practitioner driven with no clear delineated theory underpinning them.
(Davies & Kelly 1993). In addition indicators are poorly linked to policy making.
Therefore there is a need to clearly define use(s) of indicators. Nutbeam's model (1998) offers a framework through which to set health promotion indicators – he suggests 4 distinct layers of indicators– from distal (mortality and morbidity) to proximal (health promotion outcomes – healthy public policies, health literacy) – together with 3 different types of health promotion interventions (health education, facilitation and advocacy). The latter providing 3 different (health promotion) outcome indicators.

The challenge is to move towards the most proximal indicators eg health literacy and structural determinants.

4.3. Jakarta Conference 1997 – 4th International Conference On Health Promotion – New Players For A New Era: Leading Health Promotion Into The 21st Century

This conference, the 4th in WHO's series of international conferences on health promotion, was the first conscious attempt to reflect true global participation. There were many interesting papers presented but two in particular are useful in our EUHPID endeavour:

4.3.1. 'Research for Health Promotion: a Challenge for the 21st Century'

Noack, H (1997) presented a final draft paper prepared for the Advisory Committee on Health Research (ACHR) of the World Health Organisation on the theme of **'Research for Health Promotion: a Challenge for the 21st Century'**. Noack reinforces his view that the majority of concepts and indicators of individual health status are relatively static, and that we need to capture the dynamic aspects of health by creating constructs and thereby indicators that see health as an ability or potential. (He gives examples as Antonovsky's Sense of Coherence and Bandura's Self-Efficacy). Noack's ideas are updated and reinforced within recent EUHPID conceptual framework and its working papers.

4.3.2 Who Global Health Promotion Indicators Project

A group of colleagues from the Centre for Health Promotion at the University of Toronto prepared a progress report for the Jakarta Conference on a WHO Global Project on Health Promotion Indicators. This was supplemented and updated in 1999 (Jackson, S et al 1999b).

In the first draft report of the project, a set of thirty-three indicators was presented. However, emphasis was placed on policies in the form of global or international treaties, national policies or legislation, national programmes or projects and mechanisms for participation and monitoring (Jackson, S.F.E.R., Goodstadt, M., Rootman, I., 1998). Health promotion indicators were seen as process based and intervention orientated. They were based on the Ottawa Charter framework and indicators were grouped into five categories: health promotion action, build healthy public policy, create supportive environments, strengthen community action and develop personal skills. Further, for each category four types of indicators were identified: indicators representing a country's participation in global or international treaties, indicators exhibited in national government policies or legislation, indicators which are national programmes or projects and indicators which represent policy mechanisms for public participation or monitoring (Jackson, S. et al, 1998). The earlier Jakarta paper emphasised a set of policies in relation to global or international treaties, policies or legislation, national programmes or projects and mechanisms for monitoring and participation. Each of the 5 Ottawa Charter action areas is explored through indicators based on:

- Global/international treaties
- National policies/legislation or programmes and projects
- They propose a process that every country could use at both national and regional level to develop a set of health promotion policy/action indicators to reflect their progress towards health promotion.

Moreover, the paper addresses the question of how policy is implemented with respect to those who are more vulnerable in the population (Jackson, S.F.E.R., Goodstadt, M., Rootman, I., 1999). Problems that can be encountered in the development of health promotion (policy)

indicators as a result of diversity in cultural and socio-economic circumstances and principles of policies for health equity identified by Whitehead were mentioned (Jackson, S., et al., 1999). Health promotion indicators were seen as a tool for countries to evaluate their health promotion policies relate to the Ottawa Charter. A questionnaire was further refined for countries to assess their health promotion policies was based on the five action areas of the Ottawa Charter (Jackson, J., et al., 1999). The 1999 paper extends these policy indicators by proposing a set of complementary indicators related to the distribution and coverage of these policies. Within their approach is the core principle of equity and thereby emphasising to what extent policies are applied to most vulnerable sectors of society. Depending on a country's level of sophistication regarding data collection, the indicators can be extended to a third level of outcome and process indicators.

Their approach is firmly based on the Ottawa Charter concept of health promotion and its 5 action areas. In each action area:

- building healthy public policy
- creating supportive environments
- developing personal skills
- strengthening community action
- reorienting health services.

They present a series of indicators linked to the current theories and constructs which underpin actions proposed by existing international bodies eg UNESCO, WHO, World Bank, UN, etc.

Indicators in all actions areas are to be represented and all considered together to form a pattern. They feel that outcomes are important and encourage countries to begin a process of collecting this data but they are so variable, it is difficult to suggest suitable standard mechanisms across multiple countries. Therefore they stress the use of an action checklist of indicators rather then outcomes; this means focussing on implementation and coverage of the indicator areas. The tools they produce are to be used by an independent 'assessor' (from an international governmental or non-governmental organisation, for example). Each user would determine the response to the data from their own perspective. (Policy analyst, community activist for example).

They recommend keeping out of the 'quagmire of outcome indicators':

> "Outcome indicators are very useful for evaluating the impact and extent to which health promotion policies and programmes are effective. However there are on-going

disputes about appropriate positive health outcome indicators, difficulties of attributing health outcomes to health promotion activities, variations in data collection capabilities and resources from one country to another, and varying levels of understanding about health promotion". (p4).

They therefore have developed their approach to indicators on the premise that positive health outcomes are more likely to occur if the policy conditions and basic infrastructures are in place.

Examples

BUILDING HEALTHY PUBLIC POLICY

Available Measures/policy processes

- stated health goals and objectives

Available Measures/policy content/substance

- public expenditure on health, education & social services
- national education system
- access to safe water
- access to health care
- immunisation
- income inequality

CREATING SUPPORTIVE ENVIRONMENTS

Available Measures

- healthy communities initiatives
- work environment initiatives eg worker discretion, stress/control ratio

STRENGTHENING COMMUNITY ACTION

Available measures

- social insurance
- daily newspapers
- expenditure on social security
- social security coverage

DEVELOPING PERSONAL SKILLS

Available measures

- primary school enrolment ratio
- female primary school enrolment ratio
- secondary school enrolment
- teaching staff

REORIENTING HEALTH SERVICES

Available measures

- supply of health personnel by demographic region
- health infrastructure & services
- population per physician.

In correspondence with Suzanne Jackson – they are trying to get WHO HQ interested in resurrecting and progressing this project.

5. WORK ON COMMUNITY HEALTH INDICATORS

Community health indicators are a set of quantitative, longitudinal measures which reflect the status and changes in the health of the community on the individual, collective and environmental levels. Systems theory proposes that changes in one part of the system will result in readjustments to other parts of the system. Bauer (1998) suggests that this means we can identify and measure a limited set of key indicators to assess and monitor the health of the community = CHI System.

6. HEALTHY CITY INDICATORS DEVELOPMENT

The World Health Organization (WHO) Healthy Cities Project is a long-term international development initiative which aims to place health high on the agenda of decision-makers in Europe and to promote comprehensive local strategies for health and sustainable development based on the principles and objectives of the strategy Health for All in the twenty-first century (HFA 21) and Local Agenda 21. It has produced guidelines for indicator development.

The Project has developed through a number of phases:

Phase I (1987-1992) involved 35 cities in the network of WHO project cities. The accent was on creating new structures to act as change agents and to introduce new ways of working for health in cities. In the 1st phase a set of 53 indicators was produced by a working group to assist cities to gather data information about their cities health levels. The indicators included: health indicators (traditional), health services indicators, environmental indicators and socio-economic indicators. See http://www.who.dk/document/hcp/ehcpquest.pdf

Between 1992-1994 data was collected from 47 cities on the 53 indicators. This data was analysed by a multidisciplinary group of experts. The available data and the validity of the information brought the possibility of making international comparison (WHO 1996a). This

document includes an explanation of the methodology to gather the data and indicators validity (including a set of criteria which define the validity of each indicator). , a survey conducted in 47 European cities applying to join the third phase of the World Health Organisation Healthy Cities Project. Although it was suggested that the set of indicators produced attempted to capture the wider dimensions that relate to health and broad health-promoting processes, the instrument that was produced it provided a list of items that fall within four categories of indicators, health status indicators, health service indicators, environmental indicators and socio-economic indicators (Doyle, Y. G., Tsouros, A. D., Cryer, P.C., Hedley, S. and Russell-Hodgson, C., 1999).The Healthy Cities Indicators' Report also includes a discussion and interpretation of each indicator and these four different clusters. A survey, that was conducted in 47 European countries and tested the feasibility of recording baseline information on health promoting processes and activities in the cities, was reported in summary in Doyle et al (1999). Their article includes also details of the means of verification, learnt lessons and recommendations.

Phase II (1993-1997) had 39 cities in the network, including 13 that had not participated in such a network in Phase I. This phase was more action-oriented with a strong emphasis on healthy public policy and comprehensive city health planning. In 1995, WHO HQ published a "Practitioners Guide" for building healthy cities, which suggests a set of indicators for the evaluation of the Healthy Cities projects (WHO 1995a). A part from the traditional indicators, it did include some differences from the list of baseline indicators produced during phase I. In this guide are suggested new indicators such as:

- Indicators of community participation in health and environmental services and municipal planning and management.
- Healthy Public Policies by municipal and national governments.
- Values, eg importance of health goals for various sectors
- Indicators for the reorientation of health services from a curative approach to a preventive approach.
- Re-orientation of non-health urban services and agencies to incorporate health goals and assist improved health.
- Public education for health (in schools, workplaces, mass media, etc.)
- Concern for "sustainable", ecologically sound urban development.

During the 90s there was also a strong interest on how to access information on the described indicators, research tools, means of validation, interpreting data, etc. In 1995, WHO – Europe published a manual of tools for healthy cities (WHO 1995). The manual gathers information

about 19 different tools developed by regional leaders of the Healthy Cities Programme. Each of the tools are designed to measure different issues from community level to youth behaviour, etc. Especially interesting tools are: "The CITYNET Manual", "The Focus Group" and "Empowerment Education" given that they are designed to measure health promotion.

In 1997, the World Health Organization published another manual on "How to Report on Health on your City" (WHO 1997). In this manual, apart from including a basic traditional description of the population (number, age structure) and vital statistics (birth and death information), it considered the need to include data information on the following aspects:

5 Health Status (including: vital statistics, measures of morbidity, etc)
6 Lifestyle (including smoking, alcohol, misuse of drugs, exercise and diet)
7 Living Conditions (including number of homeless people in the cities, physical characteristics of housing, density of occupation, etc)
8 Socio-economic conditions (including education, employment, income, crime and violence, cultural participation, etc.)
9 Physical Environment (including air and water quality, noise pollution, radiation, open spaces, food quality, etc)
10 Inequalities (here should be identified the inequalities on health and the determinants of health according to population characteristics. It should be also illustrated the gradients across groups)
11 Physical and Social Infrastructure (it may include information about transport, communications, city renewal and planning. Regarding social infrastructures, it might include information about training opportunities, description of community development evidence on social isolation, etc)
12 Public Health Policies and Services (including information on policies and services aimed at disease prevention, education policies and services and environmental policies and services)

By the end of this phase, in1998, the final list of baseline indicators was produced. Some of the original 53 indicators were excluded, as the information they provided was not reliable or appropriated. The result was a more concise list of 32 indicators (**See Appendix 3**). The new questionnaire was sent out for re-testing later on in 1998.The Athens Conference marked the end of Phase II and beginning of Phase III.

Phase III (1998-2002) At the Athens International Conference on Healthy Cities (June 1998), national networks met and agreed to an overall strategy document for national networks (WHO 1998). Priority themes for the III Phase are: equity and social exclusion, social determinant of health**,** indicators, healthy setting and integrated city health and environmental

planning. Hence, phase III re-established importance of indicators and the baseline list should be included on all healthy cities plans (WHO 1997).

The Valencian Community Healthy Cities Network conducted an evaluation. (Boonekamp et al 1999). The aim was to find out the concepts and opinions of the project co-ordinators concerning the opportunities and problems for healthy municipal policies, and to analyse the municipal organizations with a view to detecting structural opportunities for interdepartmental work. Interviews were conducted with the people responsible for the project in 13 cities and the relevant documents analysed. When discussing their health concept and actions for health, few of the co-ordinators mentioned the ideas contained in the Ottawa Charter. The established health programmes were rather based on personal/ individual changes and topic approach than setting-based strategies. Even though the article does not refer directly to indicators, the article is very useful as it does present qualitative techniques to gather information data.

In 2001, the questionnaire including the 32 indicators formulated during phase I and corrected on the phase II, was tested again aiming to gather information from 44 cities out of 51 member cities that belong to the Healthy Cities European Network (WHO 2001). The final questionnaire includes definitions of each indicators as well as the method of calculation and section for the value of the indicators. Most of the 32 indicators request information data in a quantitative format but the qualitative indicators included on the questionnaire provide valuable information for a wider dimension of health within the cities.

One of the latest approaches to evaluation of community-based programmes, such as Healthy Cities, has been produced by Judd (2001). In her paper she stresses the necessity to create standards for evaluation and those standards should be set from an inclusive, salutogenic orientation. She argues that in the health promotion context, standards of acceptability serve to identify the desired level of outcome and allow all parties to agree on how much change should be achieved.

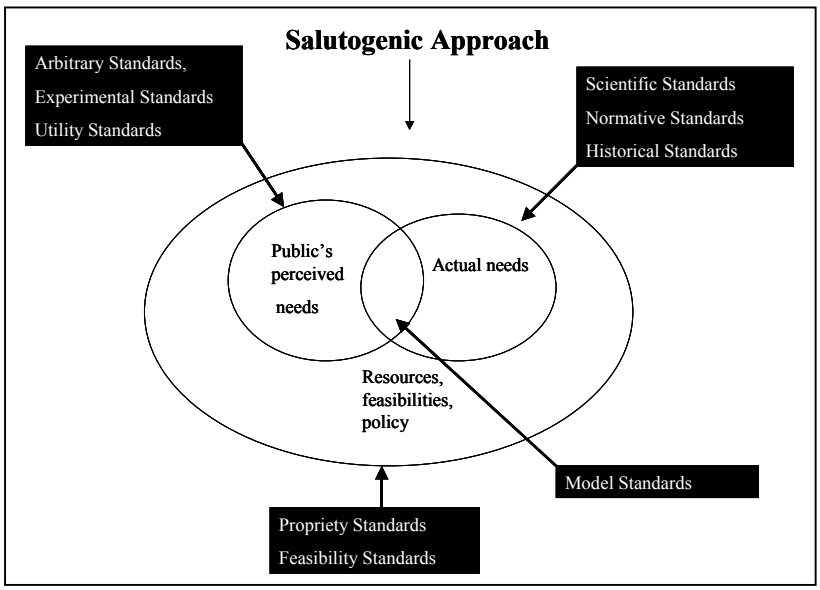


Fig.1: Setting Standards for evaluation . Adapted from Green and Kreuter, 1999

7. RELEVANT CANADIAN WORK ON INDICATORS

During the last quarter of the twentieth century, Canada has been in the forefront in health promotion and related areas, and has been most prolific in the development of indicators related to health, health promotion and population health. For example:

7.1 Local Community Indicators Development

Canadian Health Indicator Workbook (BC Ministry of Health 1995) is aimed at the public and uses the analogy of a garden to describe process of gathering information about the health of the community. It includes categories of indicators related to production, consumption, physical environment, etc).

Community Capacity Indicators (Centre for Health Promotion Toronto 1999a) describes a participatory action research project that developed a model and qualitative indicators of community capacity.

Pathway to Healthy Communities (Ontario Healthy Communities Coalition 1998) this 'indicators and evaluation tool-kit' draws on examples from across North America.

State of Our City Report A citizen-led review of 24 indicators of sustainability is produced by Sustainable Calgary (1998) and forms the State of Our City Report. It includes indicators covering the following areas – economy, resources use, natural environment, community and health & education (latter includes childhood asthma hospitalisation rates, self-rated health, level three adult literacy, grade 3 achievement scores and healthy birth weight babies.

7.2 Measuring Social Well-being & Quality of Life

The **Index for Social Health**, first developed in the USA, was applied to Canada to provide an overview of social performance(Brink & Zeesman 1997). Each indicator of the Index relates to a sector affecting quality of life – health, employment, education, psychological well-being, income, etc. The strength of social institutions such as the family and school are reflected on each indicator.

Raphael et al (1996) consider quality of life and health from a variety of approaches, and perceive quality of life as an outcome variable and as part of social diagnosis in health promotion. Raphael and colleagues developed a Quality of Life approach to Healthy Cities in Canada. This article describes a method to measure the Quality of Life of communities. The **Quality of Life Profile** (QOLP) provides a measure of individual quality of life and includes both determinants and components of health and well-being (Raphael et al 1998). The Profile consists of 54 items – 6 in each of 9 sub-domains = physical being, psychological being, spiritual being, social belonging, community belonging , physical belonging, etc). The approach draws upon developments in social indicators and urban quality areas. The model

operates within the qualitative inquiry paradigm and strives to be community based. The Quality of Life model is defined as a degree to which a person enjoys the important possibilities of his or her life in three main areas: Being (reflects on "who one is" - Physical, psychological and spiritual components); Belonging (the fit between a person and his or her physical, social and community environment); and Becoming (refers to the activities that a person carries out to achieve their personal goals, hopes and aspirations). The article also includes a table that describe the 9 domains of quality of life and the questionnaire used for the Quality of Life in the Healthy Cities project. Conclusions are summarised in Raphael et al (1999).

The **Quality of Life Index** (QLI) is a composite index that includes 12 indicators, 3 from each of the following sectors: health, social, economic and environmental (Shookner 1999). Quality of life is defined as:

> ' the product of the interplay among social, health, economic and environmental conditions which affect human health and development'.

Employment and working conditions in the context of determinants of health has been used to develop a set of population-level indicators (Lavis et al 1998). They explored 4 constructs – unemployment, job insecurity, low job position and job characteristics.

Genuine Progress Index (GPI) is an attempt to integrate social, environmental and economic fields to demonstrate their interdependence (Coleman 1998). 20 indicators are used in the Index, which focuses on Nova Scotia and Atlantic Canada. Based on shared values (including security – containing health, livelihood security) also equity, environmental quality, freedom, caring society, for example.

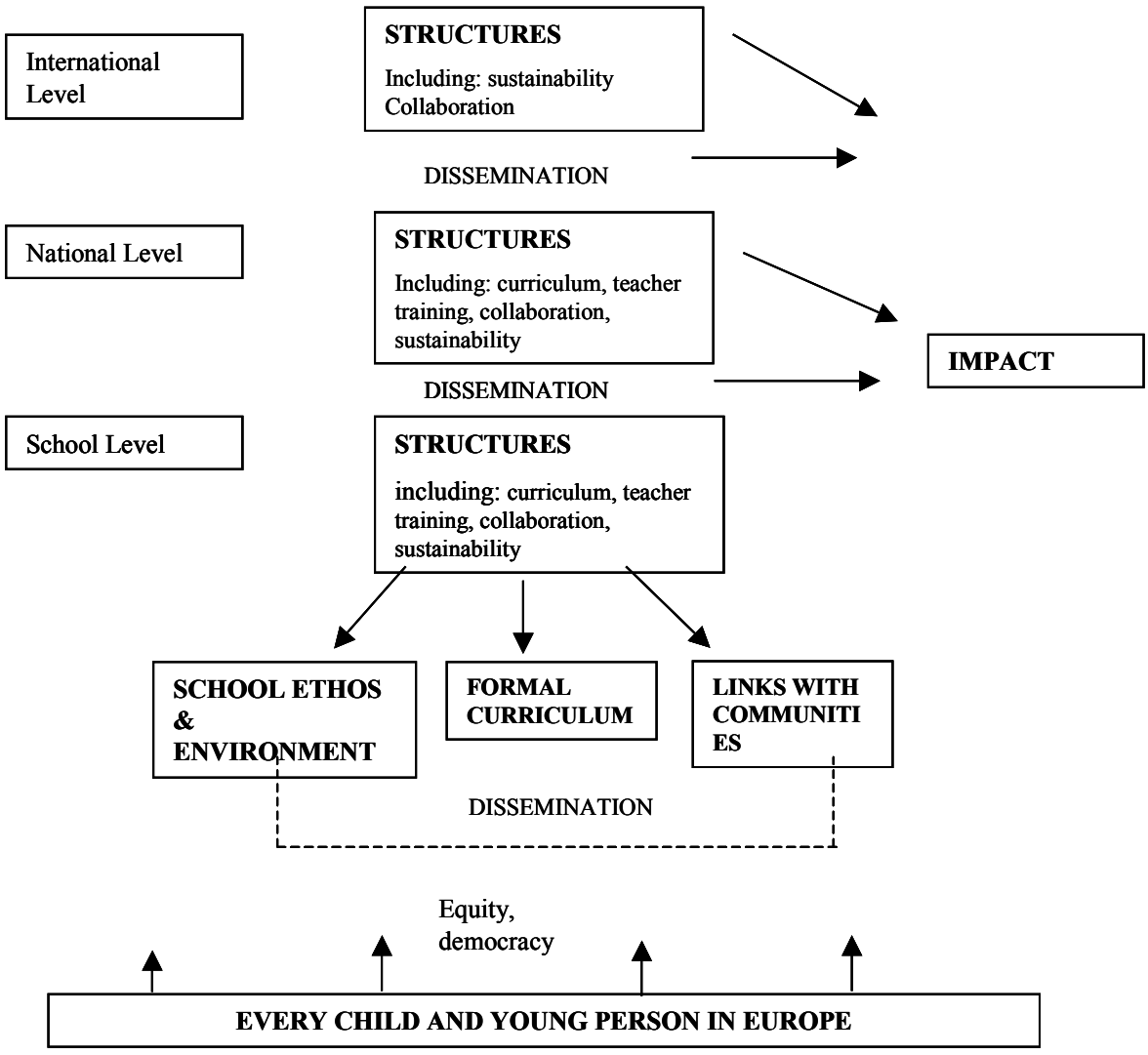
8. HEALTH PROMOTING SCHOOLS INDICATOR DEVELOPMENT

The WHO Expert Committee on Comprehensive School Education and Promotion (1996) identified 5 types of indicators, which reflect integration between the priorities of the health and education sectors:

- Children's health status (eg calorie intake, height, etc)
- Learning ability, attendance & learning achievement (eg numeracy, literacy, basic learning competences, etc)
- Behaviours affecting health (eg physical activity, tobacco, drugs, etc)
- Quality of the physical and psycho-social health environment (eg water and sanitation quality, policies and practices in schools, etc)
- School health programme implementation (eg curriculum, links with local school community, etc).

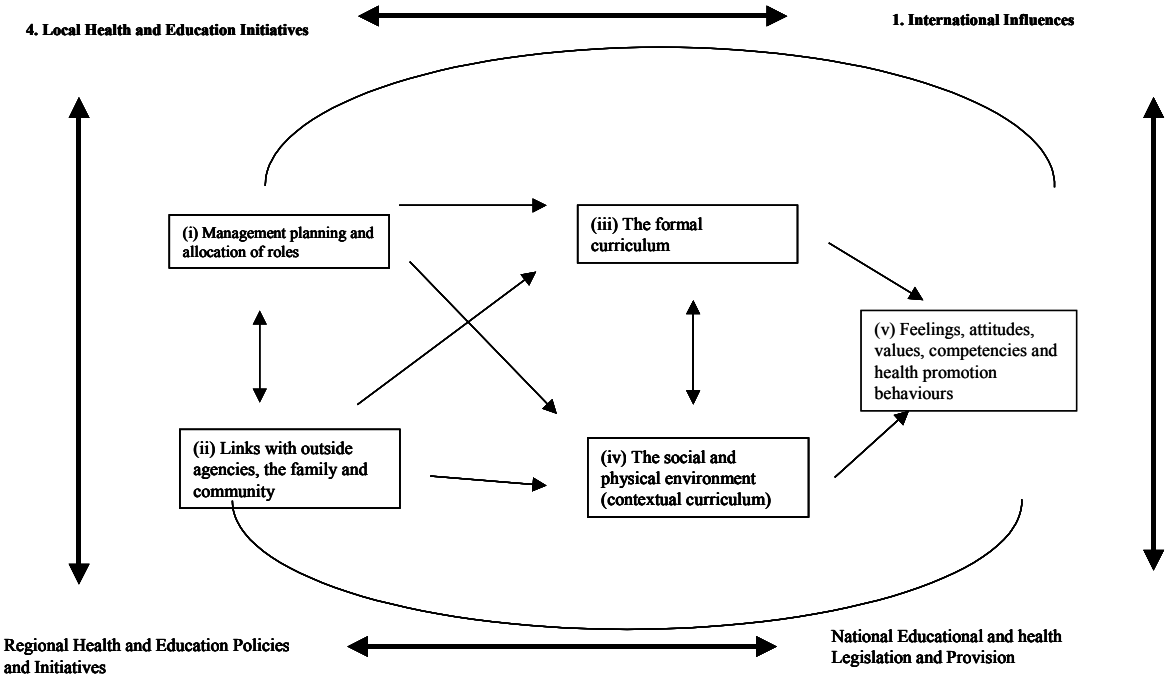
The European Network of Health Promoting Schools (ENHPS) is a collaborative initiative supported by the WHO, Council of Europe and European Commission. It began in 1991-1992 as a pilot project of 4 countries in central and eastern Europe and has expanded to over 500 pilot schools in 38 countries. The Network has produced a report that proposes a framework for the development of indicators for a health-promoting school (ENHPS 1999?). This report seeks to provide a framework for measuring the progress of the ENHPS as a concept across Europe and also to provide help to countries at both national and local level in assessing and monitoring the development of health promoting schools. The ENHPS indicators proposed are underpinned by ten principles for action from the ENHPS Resolution developed in 1997 at the 1st Conference of the European Network of Health Promoting Schools = democracy, equity, empowerment and action competence, school environment, curriculum, teacher training, measuring success, collaboration, communities and sustainability (see Fig 6 – ENHPS flowchart to demonstrate HPS indicators link to the 10 Conference resolutions);

Fig. 6: Flowchart showing how Indicators link to the Ten Conference Resolutions (ENHPS 1999)



and the factors of the eco-holistic model of the health promoting school (see Fig 7 – Parsons, Stears & Thomas 1996).

Fig. 7 An Eco-Holistic Model of the Health Promoting School

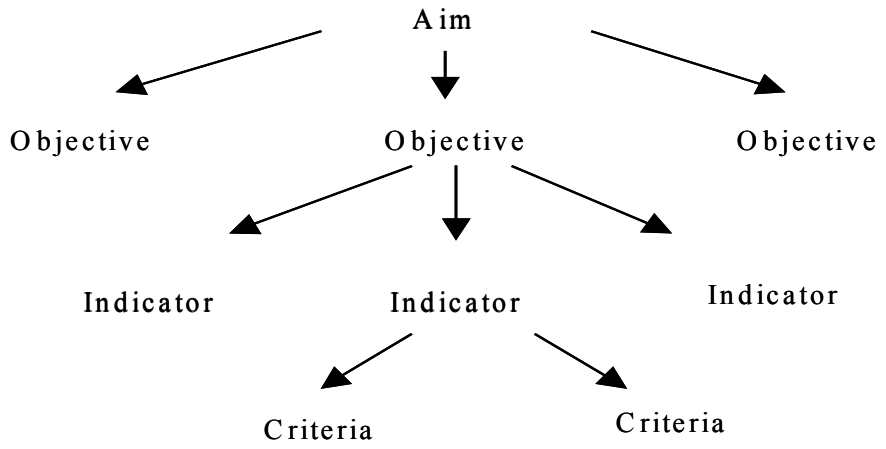


(Parson, Stears & Thomas, 1996)

The indicators, it is stressed, will be very different and change over the course of development of health promoting schools – early on the emphasis is on establishing structures and creating conditions for health promoting schools to survive and flourish, later emphasis will move to processes of dissemination and sustainability.

Indicators for HPS are grouped at three levels – international, national and school levels. At each of these levels – key areas reflect key stages of development – Dissemination, Structures and Impact. Each area provides objectives which reflect specific indicators and examples are proposed with criteria to measure success. (See Fig 8 – relationship between aims, objectives, indicators and criteria – ENHPS).

Fig. 8: The Relationship between Aims, Objectives, Indicators and Criteria



(ENHPS 1999)

Overall the ENHPS Indicators Report provides a framework on which to build content linked to the curriculum and psycho-social context of the school.

The EHHPS indicators are designed to take account of national variations and the cultural context of each country. Individual countries and schools are invited by ENHPS to adapt these indicators or develop their own using the framework proposed.

See Fig 9 for representation of Grid of Indicators for Schools.

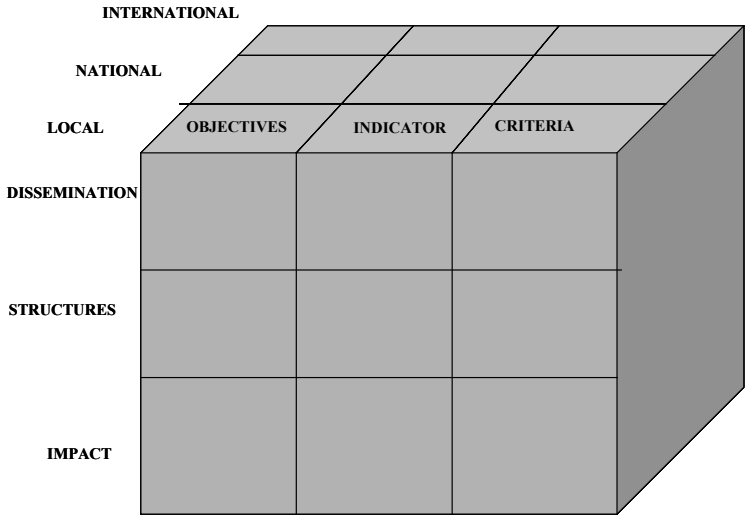
Fig 9: Grid of Indicators for Schools

Aim of ENHPS/HPS Initiative	**More Specific Objectives/Goals**	**Indicators**	**Criteria for Success**	**Information Source /Method of Collection**
Needs to be made more specific	Need to be operationalized	Needs to be measured Quantitatively or Qualitatively: How many/ How well	Need to be set at a realistic level	Pupil/teacher questionnaires, interview, records of meetings, documents
To promote the well-being of pupils	To enhance the self-esteem of pupils	Proportion of pupils who report that they like themselves	Increase in proportion of pupils who report that they like themselves	Survey based on questionnaire
To improve training for teachers about the HPS concept	To include the HPS concept in initial teacher training	Proportion of teacher training courses including the HPS concept	All initial teacher training courses to include the HPS concept	Review of course content

(ENHPS 1999)

Fig 10 provides an overview of the relationship between categories.

Fig. 10: The Selection of Indicators



Seeing them as starting points for further development, ENHPS see the following examples of both indicators and criteria broken down by their key areas of dissemination, structures and impact :

Table 3 at international level

Table 3: Indicators of Success: ENHPS at International Level

Objective	Indicators	Criteria for Success
Key area: Dissemination		
1.1 To raise awareness of the ENHPS & HPS concept throughout Europe	• HPS on the agenda of supra-national organisations	• Evidence of reference to HPS in key documents/ publications
1.2 To recruit new countries to the ENHPS	• Number of new countries tin the network each year	• A continued increase year on year in the number of countries participating in ENHPS
1.3 To support the further development of the HPS concept within countries	• Number of countries moving from pilot to policy as a proportion of the total number possible	• Increase in number of countries moving from pilot to policy
1.4 Technical Secretariat to act as advocates for the HPS internationally and nationally	• Number of representations made by the Technical secretariat on behalf of National coordinators to their ministries • Perceived level of support from Technical Secretariat by National Coordinators	• Reported success of these representations • Confirmation of the value of this support
1.5 To disseminate good quality	• Dissemination strategy in	• Yes / no

information throughout the ENHPS	place • Monitoring records e.g. number of publications, resource packs, conferences, users of web sites, people attending training	• Number of people reached • Perceived quality • Meeting perceived needs
1.6 To mobilise expertise	• Record of expert meetings convened and output	• Perceived usefulness of product/s

(ENHPS 1999)

Table 4 at national level

Table 4: Indicators of Success: National Level

Objective	Indicators	Criteria for Success
Key area: Dissemination		
2.1 To increase annually the numbers of schools working within the HPS concept	• Percentage of schools working within the HPS concept • Representation of all ages of pupils and level of education • Schools involved are spread equally across the country and social groups	• Increase in percentage involved • Meeting identified targets • Equal involvement of all areas of the country and social groups
2.2 Commitment and collaboration between Ministries of Health, Education & other key sectors and organisations	• Statements in official documents • Financial commitment • The HPS is integrated into strategic planning	• Consistently supportive statements made • Assured and increasing funding (if appropriate) • Evidence of reference to the HPS concept in Strategic plans
2.3 Regular, useful meetings between coordinators and ministers	• Records of regular meetings and contacts	• Regularity, frequency and usefulness of meetings per year
2.4 National support teams to distribute good quality information to schools	• Number of guidance documents, resources, newsletters distributed • Proportion of school coordinators reporting that documented received were useful.	• Adequacy and range of material received • Very high proportions of school coordinators judging material useful
2.5 Support teams organise national and / or regional conferences	• Increase in the number of conferences arranged which include the HPS concept • Proportion of school sending participants	• Meeting identified targets • High proportion of delegates agree that attendance has increased their capacity to fulfil their role in relation to the HPS concept • Increase in numbers reached
2.6 Support teams to promote relevance, quality and impact of programmes	• Dissemination of methods of good practise, as reported by school coordinators • Proportion of school coordinators reporting support of National Coordinators in the evaluation process	• Increase in dissemination • High proportion reporting effective support
• *Key area: Structure*		
2.7 Establish forum for dialogue between National Coordinator and Depts. Of Health and Education about HE/HP in the national curriculum	• Regular (at least annual) logged and minuted meetings	• Dialogue perceived as productive by all parties

(ENHPS 1999)

ENHPS are clear that their long-term goal maybe to effect quality of life, health status and well-being, but in shorter term they need other indicators of effectiveness related to dissemination, structures and impact. They provide numerous examples of structures related to policies, impact related to physical and psycho-social environment, for example. They also provide indicators at school level and emphasise the issues of processes and provision.

Work in Australia has attempted to develop a framework for categorizing school health promotion indicators (St Leger 2000). It goes on to suggest a matrix which maps the levels of influence different stakeholders have in the categories of indicators. 5 guidelines are presented which enable stakeholders to choose a manageable set of indicators that:

- Give useful data and add value
- Are within the boundaries of influence of the programme
- Add to knowledge and understanding about how the programme is implemented
- Involve key stakeholders in the development
- Represent the 5 WHO fields (mentioned earlier in this paper)

9. OTHER CURRENT RELEVANT WORK

Finbalt Health Monitor

9.1 WHO Schoolchildren's Health Behaviour Survey

This well established survey has collected data on numerous health indicators from 10-15 year olds from a number of countries over many years; it has provided comparable, longitudinal data on young peoples' health behaviours (Wold et al 1994).

9.2 Work on Health Promoting Workplace (European Network for Health Promotion in the Workplace)

Proposed indicators:

- Health of staff, absenteeism, health knowledge (KAP), social cognition model (amount of control), social support, perceptions of the job (Antonovsky's Sense of Coherence), perception of rewards, self esteem
- Environmental structures = laws and legislation relating to work, allows team work, hierarchical structure (flat/steep), organisational structure, health

promoting infrastructure, staff development/programmes/policies, minimum wage, child care support

- Open communication, inter-professional communication & collaboration, joint decision making procedures
- Individual staff active participation in decision-making, all staff involved/all levels, staff participation in development and training, work styles, work/life balance

9.3 Recent Health Education Research Special Edition - On Behaviour Change Consortium Work In Usa (Her 2002).

The US National Institutes for Health Office of Behavioural and Social Sciences Research has recently commissioned two reports from the US Institute of Medicine/National Academy of Sciences. The first report updated research findings on the relationship between biological, psychosocial and behavioural factors and health (IOM 2001). In a recent paper, it was noted that this IOM report highlighted the need for

> "interventions to recognise that people live in social, political and economic systems that shape behaviours and access to the resources they need to maintain good health". (Solomon & Kington 2002 p498)

The second report (Singer & Ryff 2001) noted the need for

> "interventions targeted at multiple levels (eg individual, family, organizational and population) and pertinent to large segments of the population, not just high-risk groups. (with an emphasis on) …work-site and school-based programs in community-level intervention packages" (Solomon & Kington 2001 p 498)

These reports signal a new way of thinking about socio-ecological and environmental approaches to the maintenance and promotion of health. They emphasis the need for interventions to be multi-level.

The Behavior Change Consortium (BCC) is an American collective of 15 National Institutes of Health-funded behaviour change projects, established to evaluate the efficacy and effectiveness of innovative interventions to change various health-related behaviours. In a review of the BCC initiative, the different projects have been classified according to their 'predominant mediator variables' (Ory, Jordan & Bazzarre 2002). Ory et al define a mediator as 'any variable that can be said to account for the relation between the predictor and the outcome (ie mediators explain how external events take on internal psychological significance)". Ory et al p 508.

They then go on to list the most common mediators found across the BCC projects:

- Decision balance (for & against)
- Goal-setting
- Outcome expectations
- Self-determination/autonomy
- (Self-) efficacy
- Social support
- Stress

The vast majority of interventions discussed by Ory et al (2002) are still at the individual or interpersonal level. Although they acknowledge the growth of interest in social and environmental barriers or facilitators.

10. RESULTS OF EUHPID SURVEY OF CONSORTIUM MEMBERS (2002)

10 countries responded and 7 countries did.

The questionnaire was also sent to ENHPA members afterwards (but only via Health Development Agency colleagues) – it did elicit a couple of useful responses.

The results are summarised as follows against country of respondent:

Belgium

SIS Health Information System (in French only)

School Health Promotion Guidelines & Indicators (in English)

Health Promotion Monitoring System – Flanders (in Dutch)

Policy Initiatives for Health Behaviour – Flanders (in Dutch)

Targets/Indicators of Health Behaviour (Flanders, Wales, Netherlands) (in Dutch)

Empowerment Questionaire (in Dutch)

Monitoring Socio-economic Inequalities in Europe (in English)

Austria

Health & Health Promotion Surveys (Austria, Italy, Slovenia) (in German; also English)

Health & Health Promotion in Schools (German; also in English)

Netherlands

Quality of Interventions (QUI) (in Dutch)

Public Health Forum (in Dutch)

Dissemination of Evidence-base in Health Promotion (in Dutch)

Intervention Mapping: detailed Protocol for health promotion development and evaluation (in English)

National Kompas Website (in Dutch)

Atlas Website (in Dutch)

Ireland

Strengthening Evidence base Paper by D. McQueen (in English)

Tones & Tilford chapter including indicators (in English)

US Book on New Approaches to evaluating Community Initiatives (in English)

Mental Health Promotion Paper by Barry (in English)

National Development of Health Promotion Indicators in Ireland (in English)

Greece

Media Advocacy Evaluation Paper by Stead et al (in English)

Health Technology Assessment in Health promotion & Disease Prevention by Swedish Council on Technology (in English)

QA of Health Promotion Projects by Swedish Federation of County Councils (in Swedish; also in English)

National Health Promotion Indicators by Toronto Group (in English)

Capacity-Building in Health Promotion by New South Wales Group (in English)

France

Nil return

Health Barometers in France 1995/99: Key Findings (in French ; but summary book in English published by CFES)

Italy

Health & Environment Project (in Italian)

Italian National Observatory on Health Promotion (in Italian)

Inequalities in Health – determinants and policies (in Italian)

Health of Modena, Bari, Arezzo, Berletta, (in Italian)

103 Cities Quality of life (in Italian)

Some Evaluation Projects by Italian Network of Health Promoting Hospitals (in Italian)

England (UK)

Health in England Surveys – HEA (in English)

Numerous Regular Government Health Surveys – eg General Household Survey (in English)
Health Development Agency Evidence Base (in English)
NHS Dissemination Reviews – York (in English)
Work of Regional Public health Observatories (in English)
+ numerous references in text of paper

Switzerland

Quality of Life Switzerland (in German) (possible translation into English?)
Use of Nutbeam Model to improve Quality (in German)

11. HEALTH CANADA 2001 POPULATION HEALTH TEMPLATE

This contains the usual health status measures but emphasises the need to develop 'aggregate health indicators' (combining mortality with loss of function and quality of life) together with indicators for determinants of health – mixing biological, behavioural, environmental, and socio-economic factors. Latter includes following:

Social support – friends and families
Education – sense of control, literacy, job security
Employment and working conditions
Physical environment
Healthy child development
Personal health practices
Individual capacity and coping skills
Biological and genetic influences
Health services

With gender as cross-cutting theme.

They clearly see health promotion as intervention (as opposed to health protection and disease prevention).

12. RECENT EUROPEAN WORK

12.1 Megapoles Project

- data on public health in capital cities in Europe (Bardsley 1999)
- city/regional level indicators

- aiming for set of key public health indicators in analysing major urban data bases linked to European comparative data base/s.

12.2 OECD Health Data

- OECD Health Care Quality Indicator Project – quality indicators for benchmarking but related to health care (include preventive activity) working with Commonwealth Fund of New York (USA, Australia, Canada, UK, New Zealand) and Nordic Group (Denmark, Finland, Sweden, Iceland, Norway). Recently agreed – Austria, Germany, Ireland, Netherlands, Portugal, Spain, Switzerland) will join = 17 countries in all. They are working on development of a group of key quality indicators for health care (evidence-based, internationally comparable, collected and exchanged given existing national data availability). Have January 2003 meeting in Paris. They have made initial list of domains of quality = vaccination rates (various), breast cancer screening and 5 year survival rates, cervical screening and 5 year survival rates, childhood leukaemia; heart disease, diabetes, stroke, asthma.

  JKD has been contacted by OECD Consultant in Paris to see any mutual links with EUHPID.

12.3 EUROSTAT Regio database for Regional Data on Health.

12.4 Danish National Institute for Public Health produced a questionnaire which was administered as part of a study investigating the health and lifestyle of residents of Copenhagen and in order to analyse their development in health and lifestyle and so to contribute to prioritisation and policy making (Lissau, I. T. H., Paulsen, J., Rasmussen, N., 2000). Areas covered by the questionnaire included social affiliation to neighbourhood, satisfaction with housing, perceived exposure in housing, social networks, health and illness perceived health, feeling well, perception of stress, experience of long-standing illness, work changes due to illness, termination of work due to illness, activity restrictions, allergic reactions and hypersensitivity, mental health problems within the past fourteen days, seek leave due to illness within the past fourteen days, social support in case of illness, contact with health care system and use of medication, contact with own general practitioner/other physician/dentist with the past three months, use of medication, lifestyle (actions on maintaining good health, physical activity, proportion of sedentary work, overweight, alcohol use and smoking habits), working environment (e.g. monotonous work, speed, pressure at work), children's health (e.g. illness within fourteen days, immunisations) and health among the elderly (e.g. use of assistance/aids, receipt of home help). Finally, variations between city

districts and variations between groups with different school education levels were examined (Lissau, I. T. H., Paulsen, J. Rasmussen, N., 2000).

12.5 Health Barometer

The Health Barometer was developed in the Netherlands, in the municipality of Rotterdam. It was based on the REBUS existing programme (Rotterdam Area Health Authority, 1991-1995). Health Barometer is a graphical representation of scores on six different dimension concerning health, directly or indirectly, and the characteristics they are based on. It is a simple graphical representation of gathered information, t make it possible to compare neighbourhoods and their characteristics but, also, to enable to see developments in time. Information is gathered and data is collected via questionnaire administration about infectious diseases, client participation in methadone programmes and data concerning health behaviour (smoking, drinking, health experiences). Other information gathered is demographic, such as number of inhabitants and mortality rates, environmental, such as complaints of stench and noise. Further, reports of burglary, theft, destruction, violence, and moral offences are, also, included. The five clusters of neighbourhood health description, physical environment (which is split into safety and quality of environment), demography, social status and lifestyle were used for the development of the Barometers groupings (Rotterdam Area Health Authority, 1991-1995).

12.6 Quality Indicators For Health Promotion Programmes

Ader et al (2001) produced 14 general indicators for successful health promotion programmes, and produced a template of indicators to test out. Examples of their indicators are:

- Programme structure = goals, target groups, responsibility, resources, organisation, design
- Programme process = network, commitment, exposure, participation
- Programme outcome = behavioural changes, environmental changes, epidemiological changes, maintenance.

12.7 Settings Based Health Promotion

A review paper by Whitelaw et al (2001) produced 5 types of settings with related indicators.

12.8 WHO European Health Report 2002

Provides a broad picture of health status and health determinants for the European region – data on life expectancy, poverty (GDP), etc.

12.9 WHO 'Highlights On Health'

The WHO Regional Office for Europe produced this series, which provides an overview of factors which relate to health of the population of a country. It is a continuous work that is concentrated on Eastern European countries. Although information about socio-political factors in each country are given, which may play a role for health status of the population, indicators provided fall in the categories of health status (life expectancy, main causes of death and morbidity, cardiovascular diseases, cancer and other causes of death, external causes of death and injuries, mental health, infectious diseases, long-term illness and stability, self-assessed health, children and adolescent's health, women's health), lifestyle (tobacco and alcohol consumption, illicit drug use, nutrition, physical activity, overweight), information on environmental factors that can influence health (microbial food borne diseases, quality of air, water quality, waste management and soil pollution, housing, occupational health and safety), information about the health care system (health care reform, organisational structure, health care finance and expenditure, information on primary health care sector, secondary and tertiary care, pharmaceutical industry and supplies, human resources such as number of physicians, dentists, nurses, midwives.

13. CONCLUSIONS

1)Need for Conceptual Framework – what concerns and measurements to be covered – what concept of health promotion to be used – what components and dimensions are to be covered (link also to EUHPID Working Paper on European Policy to set indicators in terms of societal and political goals).

A framework or model is recommended in the literature to set guidelines and a context for the selection of indicators.

2)Need for a Systems Architecture - to define structural elements and procedures of measurement

3)Need for System of Health Promotion Indicators – to ensure comprehensiveness.

Appendix 1:

The Salutogenic Model of Health

During the 1970's the public health care system was criticised for placing emphasis on a mechanistic view of health. As a result of these criticisms and the realisation of the complexity of health, a biopsychosocial approach to health developed. This approach incorporated somatic, psychological and social factors (Bengel, J., Strittmatter, R., Willmann, H., 1999). Around this time a movement towards community psychology, movements towards the formulation of the concept of empowerment and emphasis on social-ecological approaches had an impact on the Ottawa Charter of the WHO in 1986. According to the WHO 'health is a state of optimal physical, mental and social well-being and not merely the absence of disease and infirmity'. This definition of Health, in a more positive view and in 'holistic' approach covering physical, mental and social aspects of life, placed interest on the strengthening of the Salutogenic (*salus* =well-being and *genesis* =origin) theoretical model of health. Although workers in health promotion at times may appear to be more concerned with disease prevention, while emphasising community and individual measures which will assist in the development of lifestyles that will enhance 'well-being', emphasis on risk behaviours inevitably is related to a dichotomous classification of health. As a result health is viewed as one of the extreme poles of the health/disease division. However, the Salutogenic model sees health/disease (or as according to Antonovsky, ease/ dis-ease), as a continuum and places emphasis on the movement towards the health end of the continuum, rather than concentrating on particular risk factors and risk behaviour. Therefore, central in the Salutogenic model is the identification and emphasis of the human complexity (Antonovsky, 1992). Although Antonovsky viewed health as part of the health/dis-ease continuum, he did not attempt to a more specific definition of the concept of health, as he claimed that explaining health as an absolute or an ideal concept does not correspond to the true conditions and that by defining health norms are being established by which individuals may be judged (Bengel, J. et al, 1999). Antonovsky, however, offered a metaphor in order to describe the salutogenesis and the health/dis-ease continuum approach. According to:

'...my fundamental philosophical assumption is that the river is the stream of life. None walks the shore safely. Moreover, it is clear to me that much of the river is polluted, literary and figuratively. There are forks in the river that lead to gentle streams or to dangerous rapids and whirlpools. My work has been devoted to confronting the question: 'Wherever one is in the stream- whose nature is determined by historical, socio-cultural, and physical

environmental conditions- what shapes one's ability to swim?' (Antonovsky, 1987a, p.90 as cited in Bengel, J., et al, 1999)

The metaphor of life as a stream where an individual swims in waters, the danger of which is influenced by environmental conditions (physical or socio-cultural), illustrates Antonovsky's view. However, the important question that salutogenesis model attempts to answer is 'What explains movement toward the health pole of the ease/disease continuum?' In order t answer this question the concept of 'Generalised Resistance Resources' was introduced.(Bengel, J. et al, 1999). This concept is referred to resources which maybe of property of an individual or collective property and which facilitates successful coping, as they assist providing information and so they provide assistance in order to 'make sense' of the world (Antonovsky, 1992). These resources are termed as 'generalised' as they are effective in all kind of situations, and they are characterised as 'resistance' resources as they increase an individual's resistance when confronted with stressful situations (Bengel, J, et al, 1999). So, generalised resistance resources assist in making sense of stressors and it functions as a potential which can be activated when a stressful situation arise. Life experience can have a positive effect on resistance resources or they may result to resistance deficits (Bengel, J. et al., 1999). When resistance resources result to successfully make sense of situational stressors, then they result to positively influencing one's sense of coherence, while experience that are not successfully met situational demands, have a negative effect on an individual's sense of coherence. Although external environmental factors may influence health, even when people are exposed to the similar environmental conditions, their health status is not influenced in a comparable way. As a result, one's cognitive, affective-motivational orientation influences the way resources are being utilised. This cognitive, affective-motivational outlook on life is, one's sense of coherence (SOC) (Bengel, J., et al. 1999). The greater a person's sense of coherence is, the healthier they will stay in the face of environmental stressors. According to Antonovsky, the sense of coherence (SOC) is:

'*The sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges worthy of investment and engagement'* (Antonovsky, 1987a, p.19 as cited in Bengel, J., et al, 1999)

As one's general orientation to life is influenced by life experiences and it influences the kind of life experiences, and this interaction results to a more enduring sense of coherence (Bengel,

J. et al, 1999). According to Antonovsky, depending on the strength of a person's sense of coherence, the world will be perceived as more or less comprehensible, meaningful and manageable, when confronted with a stressor (Antonovsky, 1992). The sense of comprehensibility refers to the extent that environmental stimuli is processes as orders and structured as opposed to random and inconsistent. Therefore, comprehensibility is concerned with one's cognitive processing of stimuli. The sense of manageability refers to a person's belief that difficulties can be solved and so adequate resources are at one's disposal in order to meet environmental demands. The belief that resources are available does not depend on the one's own resources but may include others' resources or belief on a higher power that can assist in successfully dealing with difficulties. According to Antonovsky, manageability is related to one's cognitive emotional processing. Further, the sense of meaningfulness refers to extent that events and environmental stimuli are viewed as challenges that are worth the effort demanded, so that they can be met, rather than appearing to be an additional burden. The meaningfulness component of one's sense of coherence, is the motivational component and it is, according to Antonovsky, the most important component of one's sense of coherence as without the belief that events met can be more of a challenge rather than burden, the sense of coherence will not be high even if the other two components are high (Bengel, J.,et al, 1999). A strong sense of coherence will result to one's more flexible reaction to environmental demands and therefore, better adjustment, whereas, a weak sense of coherence will result to one's rigid reaction to environmental stimuli and in inadequate coping with demands, since one's perceives that they have weak coping resources. However, importance is placed on the combination of the components of one's sense of coherence and the fact that one had the experiences to lead to a strong sense of coherence, rather than what experiences lead to a strong sense of coherence Therefore, the concept of sense of coherence it is not a culture- bound concept (Antonovsky, 1992). The experience influencing the strength of one's sense of coherence fall into three kinds of experiences: consistency, the balance between under load-overload and participation in decision- making that is socially valued (Antonovsky, 1992). As a result, according to the salutogenic approach to health, movement towards the health pole of the health/dis-ease continuum can be facilitated by a strong sense of coherence which influences effective coping with environmental demands.

Appendix 2:

Quality of Life

While a domination of the material development as a measure of welfare took place, in 1960's the concept of quality of life was introduced, which although included wealth as one of its components, it placed emphasis on other factors that influence welfare, such as social and ecological aspects. It has been considered that quality of life includes so subjective as objective factors. Objective factors of quality of life refer to a population's actual living conditions, whereas subjective factors of quality of life refer to the citizen's subjective perceptions and evaluations of the living conditions (Berger-Schmitt, R. & Noll, H.H., 2000). Two approaches to quality of life have been identified, the Scandinavian approach of level of living, which places emphasis on objective conditions of living and the American approach, which stresses the subjective well-being. The Scandinavian approach to living conditions is influenced by the definition of welfare as 'the individual's command over resources through which the individual can control and consciously direct his living conditions' (Erikson, 1993, p. 72-73; as sited in Berger-Schmitt, R & Noll, H., 2000). Although resources, which include income, education, social relations, are important, emphasis is placed on external conditions, which will influence the utilisation of these resources. Therefore, this approach, although does not overlook the subjective indicators of well- being, it concentrates to objective indicators. On the other hand, the American approach to quality of life places importance on the satisfaction of individual needs, and, therefore, development is better defined in terms of subjective satisfaction and happiness rather than objective factors of quality of life (Berger-Schmitt, Noll, 2000). In this approach satisfaction and happiness is viewed as related to life satisfaction, positive affect and absence of distress, or as life satisfaction, pleasant and unpleasant affect, while research in this approach subjective well-being is seen as consisted of positive and negative affective and cognitive aspects. While satisfaction refers to cognitive dimension, happiness relates to affective dimension of subjective well- being (Berger-Schmitt, Noll, 2000). Disagreement on the use of either objective or subjective indicators of quality of life exists (Walter-Busch, E., 1982). Although it has been suggested that the relationship between the objective and the perceptual indicators is weak, other research has indicated that high interdependencies take place between subjective and objective indicators of quality of life (Walter-Busch, E., 1982). Moreover it has been suggested that researchers have relied on objective indicators of well- being as subjective data between communities is limited (Furuseth, O., Walcott, W., A., 1990). However, disagreement over what objective data is used in order to measure well- being takes place. While some research used microeconomic criteria as objective indicators, other research used indicators of true cost of

living index (Furuseth, O., Walcott, W., A., 1990). Although disagreement between objective and subjective indicators of quality of life exists, approaches, which incorporate both objective as well as subjective indicators, have been developed and they are widely used in research (Berger-Schmitt, R., Noll, H., 2000). The 'basic needs approach' is an approach which considers both objective and subjective features of well- being. This approach refers to the three basic needs of human beings: Having, Loving and Being. Having is related to the satisfaction of material needs, while Loving relates to the need of social relations and Being refers to the need of integration to the society and to the relation to the nature. Indicators, so objective as subjective, are considered from each of the three dimensions of need satisfaction (Berger-Schmitt, R., Noll, H., 2000). Moreover, another approach that integrates both objective and subjective indicators of quality of life is the German approach to quality of life. According to this approach, objective living conditions indicators refer to material aspects, working conditions, state of health and social relations, whereas subjective well- being indicators refer to cognitive and affective evaluations of living conditions. Both objective and subjective indicators form a typology of four constellations where good living conditions (objective) and high subjective well- being is seen as well- being, good living conditions (objective) and low subjective well- being is seen as dissonance, while poor living conditions (objective) and high subjective well- being is presented as adaptation and, finally, poor living conditions and low subjective well- being is called deprivation (Berger-Schmitt, R., Noll, H., 2000). However, another approach to quality of life is concerned with the capability of an individual to act and with the enhancement of individual capability and individual choice. In addition, in a work produced by Schmitt, R. and Noll, H. (2000) in order to develop a theoretical framework for the development of European Social Indicators, the relation between the concepts of social cohesion, social exclusion, social capital and quality of life, and sustainability, human development and quality of life. Apart from empirical work that has suggested the relation between social cohesion and quality of life, conceptually it has been argued that a society characterised by cohesion will relate to high quality of life for its members, while a society where quality of life is, in a broad sense, its characteristic, that will be a result of the society's individual members quality of life (Schmitt, Noll, 2000). On the other hand, social exclusion if it is a characteristic of a individual in relation to the society he/she belongs, will have a negative consequence for the individual's quality of life, while social exclusion as a characteristic of a society will relate to it's members low quality of life (Schmitt, Noll, 2000). Further, social capital, like social cohesion, as a property of the relations of the individuals of a society will relate to their quality of life (Schmitt, Noll, 2000). Moreover, the concept of sustainability was examined in relation to quality of life. Sustainability is 'the development that meets the needs of the present without compromising the ability of future generations to meet their own needs' (World Commission on

Environment and Development 1987, p.43; as cited in Schmitt & Noll, 2000). Sustainable development has been seen to involve three dimension: economic, societal and environmental, which they influence each other. Although sustainability has been seen as related to collective qualities (as equality, equity, preservation of the natural environmental, quality of life has been viewed as relevant to individual welfare. And although it could be argued that sustainability may be concerned with a broader view of quality of life, as quality of life for a population, the concept of sustainability extends to future generations and, further, does not include a guideline for well- being (Schmitt, Noll, 2000). However, sustainability has been seen as a dimension of human development. Human freedom, human security, empowerment (as participation in economic, social, political activities and in decision taking) and economic growth are the other dimensions of human development. The human development concept concentrates on the individual and their well- being, while it relates to the capability approach to quality of life, as it places emphasis on enabling the individual to act and participate in decisions affecting them. However, the concept of human is not only concerned with individual well- being as it includes the aspects of equality, equity, solidarity and so expands beyond the individual level (Schmitt, Noll, 2000).

Appendix 3

List of Baseline Indicators: WHO – HC Programme

A Health indicators

A1 Mortality: all causes

A2 Cause of death

A3 Low Birth weight

B Health service indicators

B1 Existence of a city health education programme

B2 Percentage of children fully immunized

B3 Number of inhabitants per practising primary health care practitioner

B4 Number of inhabitants per nurse

B5 Percentage of population covered by health insurance

B6 Availability of primary health care services in foreign languages

B7 Number of health related questions examined by the city council every year

C Environmental indicators

C1 Atmospheric pollution

C2 Water quality

C3 Percentage of water pollutants removed from total sewage produced

C4 Household waste collection quality index

C5 Household waste treatment quality index

C6 Relative surface area of green speces in the city

C7 Public access to green space

C8 Derelict industrial sites

C9 Sport and leisure

C10 Pedestrian streets

C11 Cycling in city

C12 Public transport

C13 Public transport network cover

C14 Living space

D Socio economic indicators

D1 Percentage of population living in substandard accommodation

D2 Estimated number of homeless people

D3 Unemployment rate

D4 Percentage of people earning less than the mean per capita income

D5 Percentage of child care places for pre-school children

D6 Percentage of all live births to mothers > 20; 20-34; 35+

D7 Abortion rate in relation to total number of live births

D8 Percentage of disabled persons employed

Appendix 4:

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Addendum

(Contribution received after initial review report completed).

Portugal

O que e a suade na escola (in Portuguese)
The European Network of Health Promoting Schools 'The ENHPS indicators for a health promoting school (in English)
Tracking down ENHPS successes for sustainable development and dissemination.
The EVA2 project- final report (2000) (in English)
Self-assessment for sustainable development of school health promotion (auto diagnosis) (in English)
Kent Health and Education Partnership. School Evaluation and Development Planner (in English)
Investment opportunities for Health Promotion in School in Wales: a valuation of assets (in English)
Indicator of health promoting kindergarten (in English)
Healthy Schools Assessment Tool. An instrument For monitoring and recording health promotion assets in school. The Welsh Network of Healthy School Schemes (in English)
Towards an evaluation of the European Network of Health Promoting Schools- The EVA project (in English)
The Irish Network of Health Promoting Schools. A training manual for monitoring and recording health promotion assets in schools (in English)

Appendix 8

European Public Health Policy

European Public Health Policy
A EUHPID Working Paper
Lisbon, November 2002

John Kenneth Davies
EUHPID Secretariat
Faculty of Health
University of Brighton

Contents:

EC Public Health Framework

On September 23 2002, the European Parliament and the European Council adopted a programme of Community action in the field of public health. The programme will come into effect on 1 January 2003 and has three strands – improving health information, responding rapidly to health threats and tackling health determinants through health promotion and disease prevention. It has been proposed, but not clarified, that the important strategic and political issue of health in other Community policies should run through each of these 3 strands. Strands 1 and 3 have particular relevance for the work of EUHPID.

It is unclear how the programme links operationally into EC policy and programmes – on the macro level, there is an assumption that will this be through the DG SANCO (which is expecting an internal staff reshuffle of personnel and their responsibilities) and the Public Health Programme only. How will it relate to other DGs and other areas of EC Policy is not clear? (eg alcohol, food, tobacco, CAP, environment, enlargement, trade, research and development, health inequalities, health websites/e-Health, etc). If the focus remains DG SANCO, it is not clear how officials will operationalise the 3 strands and how will they interrelate them in practical terms? It is clear that Health Unit staff within the EC need the effective contribution of experts in the health promotion field in Europe in this key development in order to gain maximum impact. This need is due partially to a lack of dedicated staff resources internally in the EC and also due to the current challenges health promotion faces as a developing force for health improvement.

An additional factor in this process is the establishment of the European Health Forum and clarification of its objectives in practice - whether it is simply a communication conduit to the citizens of EU through various health-related European NGOs or whether it has a proactive role in policy development for health promotion and public health at European level. The rapid growth in information technology and ease of electronic communication with regard to health has resulted, in basic health education/health literacy terms, in a rather naïve (though political attractive) way of giving citizens 'health information' – e-Health, websites, etc.

What are Health Promotion Networks?

Health promotion networks are international consortia made up of policy-makers, academics and practitioners from a wide range of organisations, most of whom are working across all the EU Member States, new accession States and the wider Europe to improve health and tackle

disease through prevention and health promotion interventions. All have come together for mutual benefit in order to more effectively and efficiently achieve their objectives in improving the health of European citizens by encouraging health promotion around a specific health related topic, theme, target group, setting, disease entity or risk factor or for generic health promotion purposes that incorporate all of these concepts. A key factor is that they have all received funding for their work from the current Health Promotion Programme of the EC. This latter point is important to emphasise, as there are of course many other 'networks' working in health promotion across Europe – some of whom receive funding from other EC Programmes eg Cancer, Accidents, HIV/AIDS, etc. and many who do not receive funding from EC – these consist of both governmental networks and NGOs.

The following are examples of EC Health Promotion Networks:

- Megapoles - Public Health Network for Capital Cities/Regions
- Mental Health Policy Network
- European Heart Health Initiative
- European Network of Health Promotion Agencies
- European Public Health Alliance
- European Network for Smoking Prevention
- Mental Health Europe
- European Network for Workplace Health Promotion
- European Network of Health Promoting Schools
- European Workplace Health Information Centre
- European Masters Programme in Health Promotion (EUMAHP)
- Working Group on Alcohol and Health
- European Network on Health-enhancing Physical Activity (HEPA)
- European Nutrition Network

There are also more recent networks funded on a fixed project basis such as HP Source, which is working on health promotion infrastructures.

EUHPID is the only 'health promotion network' funded by the EC Health Monitoring Programme (strand 1). The majority of other projects funded under this Programme are underpinned by a biomedical, illness/health care treatment perspective and positivist, empirical, natural science paradigm. A couple of projects, such as reproductive health, child

health and health impact assessment mention, or attempt to link into, a more holistic and broader concept of health.

European health promotion networks are formed around a range of health-related concepts such as specialist health topics, themes, risk factors, health-related behaviours, diseases, settings, core activities such as education & training or health promotion monitoring and effectiveness, and for generic health promotion purposes. They link with a wide range of stakeholders such as government institutions, universities, NGO's, international organisations, voluntary organisations, etc. Their networking activities include:

- information /intelligence gathering & dissemination
- policy development support
- advocacy & lobbying
- co-ordination and project development
- sharing expertise and resources
- education and training (including competencies and standards)
- organisational development and capacity and capability-building
- research and development (including documenting evidence and increasing effectiveness)
- building upon good practice

These activities relate closely to the core skills of health promotion = advocacy, information and communication, enablement, policy development, education, marketing, monitoring and evaluation.

The Health Promotion Vision

Together we need to build on the gains and experiences made at international level over the last 20 years and set health promotion epistemology, ideology and theory as bases for best and effective practice.

The values which underpin health promotion are firmly based upon the principles of participation, empowerment, sustainability and a desire for equity in health. Best current policy and practice advocates multi-level approaches to programmes and interventions that consist of diverse yet complementary activities such as developing individual resources and skills, creating healthy public policy and strengthening community action. These actions need

to operate synergistically to promote health gain. At a Community level, the Networks, sharing this common vision of health promotion and working together in this synergistic way, are in a unique position to influence future policy and practice at this time and make a unique contribute to health improvement.

Yet we face some challenges and dilemmas both in Member States and at Community level as health is still dominated by the biomedical service-delivery/treatment model. (Experiences at the initial Health Policy Forum meetings in Brussels further endorsed this approach). The inevitable political and commercial interest in health services in Member States and the potential during the next 10 years for Community competency to be agreed in the open market provision of health care services will make this trend difficult to stop. In addition the role of industry as well as a range of professional interests – doctors, nurses, etc will mirror the situation in Member States at Community level. This situation will be further complicated as the EU grows potentially to 25 or more Member States during the next 10 years). Based on a perception of health as absence of disease, this vertical disease-based, risk factor approach is still encouraged even though this was criticised in the initial EC Public Health Programme 1996-2000, consisting of 8 vertical programmes with unlinked topics.

The Need for a Pan-European Health Promotion Strategy

We need at this time in the history of EU competency in public health to advocate for a matrix model of health promotion (which regards settings/diseases/risk factors as complementary sides of the health promotion policy matrix) at Community level in order to create a more sustainable approach to improving health gain and to building capacity and capability across Europe.

It is encouraging that the approach taken by the new Public Health Framework moves away from the vertical programme system and therefore offers the opportunity for more co-ordinated policy making and the chance to build a more sustainable approach through networking. In this regard, the expertise and experience of the European Health Promotion Networks will prove invaluable

It is important therefore that Networks become more strategic as well as being 'project' driven. In this way we can facilitate complementariness by more closely linking the work of the established European Networks to ensure sound investment and sustainability in their contribution to health improvement. These approaches need to be set firmly within the concepts of Europeanisation, of European added-value and the European dimension. In this

regard the health promotion networks provide a unique infra-structure to facilitate the goals of strand 3 of the Public Health Framework.

We need to ensure that the underlying foundations for such a European strategy are in force laterally in order to strengthen the work of all networks. Two key functions to ensure are given priority and fully supported in this regard are:

Pan-European Research, Development & Evidence

- 5th Framework for research
- linking a wide range of related national agencies, associations and networks
- link into EUHPID
- the need for visible measurable outcomes from networks

Pan-European Education & Training

- To support and build sustainability into health promotion approaches
- To establish opportunities meet the needs of health promoters across the various networks
- To build health promotion capacity across the EU (EUMAHP)
- To establish quality standards and benchmarking to improve health promotion policy and practice across Europe

Networking the Networks

As indicated earlier in this paper, there are a wide variety of networks existing within Europe. As well as the EC Networks listed earlier in this paper, there are other types of networks which have different goals, but a direct or indirect involvement in health promotion. For example, health care practitioners – looking to wards the EC for European standards, training, transferability between Member States; researchers – in order to achieve successful research funding need effective Pan-European networking; Regional & Local Authorities – through the Committee of the Regions in Brussels, and also through WHO Regional Health Network; other Networks - such as IUHPE/Euro, EUPHA, WHO Collaborating Centres in health promotion, etc.

It seems logical that the EC Health Promotion Networks should have a more pro-active and facilitating role, along with EC colleagues, in contributing to the objectives of the EC Public Health Framework. They could also act as a networking core that links to other health promotion networks (some examples of which are given above) in their relevant fields and specialist interests of health promotion and disease prevention. By developing such a core, the health promotion actions of the EC and of Member States can clearly be influenced and the benefits of European added value optimised in terms of both policy development and programme/project work.

Therefore perhaps the lead offered by the EC Health Policy Forum, and their devised system of interlinked networks, could be adapted to produce a European Health Promotion Network (EHPN). It is suggested that the criteria for the different network levels should be made transparent, as follows:

It seems sensible that such a networking system could be complementary or become a specialist link to the EC Public Health Forum, in order to gain maximum efficiency and effectiveness from both infrastructures.

The important factor would be to ensure that the above networking system operates in both directions – from bottom up as well as top down. Guidance could come strategically from both the EC Public Health Framework and from the European Health Policy Forum, as indicated above. It would enable other European networking organisations, at inter-governmental level, such as WHO/Euro, and non-governmental level, such as

Potential Key Role of EUHPID in this Context

There is a need to establish various cross-cutting themes to strengthen the move towards effective practice in health improvement and health development across Europe.
In the core functions of policy development, resource prioritisation and effective and efficient programme delivery, EUHPID could play a unique role.

Therefore in discussion on the way forward, it is important to consider the important place a Pan-European system of health promotion indicators could play in relation to the work of the numerous health promotion networks, and the need to consider the best way to achieve mutually beneficial working links.

Commission of the European Communities (2000) *Interim Report from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the Implementation of the Programme of Community Action on Health Promotion, Education, Information and Training (1996-2000)* Brussels. COM (2000)165 final.

References:

World Health Organisation (1986*) The Ottawa Charter for Health Promotion*. Copenhagen. World Health Organisation, Health & Welfare Canada & the Canadian Public Health Association.

APPENDIX 9 – The EUHPID Health Promotion Model

3) EUHPID HEALTH PROMOTION MODEL

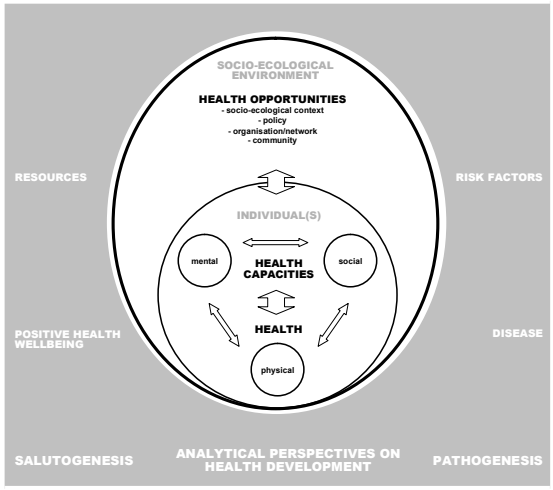
HEALTH PROMOTION INTERVENTION
(HP Process indicators)

HEALTH PROMOTION ACTIONS
- socio-ecological context development
- policy development
- organisational/network development
- community development
- competency building/health education

HEALTH PROMOTION APPROACHES
- advocate
- enable
- mediate

HEALTH PROMOTION PRINCIPLES
- empowering
- participatory
- holistic
- intersectoral
- equitable
- sustainable
- multistrategy

HEALTH DEVELOPMENT
(HP Outcome indicators)



APPENDIX 10 – List of Identified 'Experts' from Candidate Countries

Candidate Country Representatives for EUHPID 2

Cyprus	Dr. Pavlos Pavlou IT Coordinator Ministry of Health Markou Drakou 10 Pallouriotissa 1448 Nicosia e-mail: pavlospavlou@cytanet.com.cy
Czech Republic	***Dr. Zuzanna Kamberska*** Institute of Health Information and Statistics of the Czech Republic Palackeho nam 4, PO Box 60 CZ – 128 01 Prague 2, Czech Republic. e-mail: kamberska@uzis.cz
Estonia	**Anu Kasmel** Institute for Health Promotion Research University of Southern Denmark Niels Bohs vej 9-10 DK-6700 Esbjerg Denmark Phone 372 51 05 621 Fax 45 6550 4283 E-mail: akasmel@health.sdu.dk Estonian Union for Health Promotion Mustamae tee 4, 10621 Tallinn Estonia Phone 372 51 05 621 E-mail: akasmel@health.sdu.dk
Hungary	Maria Kopp Director Institute of Behavioural Sciences Semmelweis University of Medicine Nagyvarad t. 4 H- 1089 Budapest e-mail: komar@net.sota.hu
Latvia	***Ineta Pirktina*** Director Health Promotion Centre Skolas iela 3 Riga LV-1010 e-mail: vvc@park.iv

Lithuania	Prof. Zilvinas Padagais Vice-Rector for Studies Kaunas University of Medicine A.Mickeviciaus str. 9 LT-3000 Kaunas e-mail: padaiga@kmu.lt
Malta	Marianna Massa Principal Health Promotion Officer, Health Division Malta, Health Promotion Department, 1 Crucifix Hill, Floriana, Malta. Email: maryanne.massa@gov.mt
Poland	Pawel Gorynski Head of Department National Institute of Hygiene Department of Medical Statistics 24 Chocimska Street 00-791 Warsaw e-mail: pawel@medstat.waw.pl
Slovak Republic	**Daniela Marcinkova** (PhD) University of Trnava Faculty of Health Care and Social Work Department of Hygiene and Epidemiology Univerzitne namestie 1 91700 Trnava e-mail: dmarcinkova@yahoo.com Gabriel Gulis University of Southern Denmark Unit of Health Promotion Research Niels Bohrsvej 9-10 6700 Esbjerg e-mail: ggulis@health@sdu.dk
Slovenia	(Potential representative) **Viktorija Rehar (President)** Slovenian Union for Health Promotion and Education Zalec SUHPE Hmelijarske 3 3310 Zalec, Slovenia fax +386 371 00089

APPENDIX 11 – Core List of ECHI Indicators

ECHI-2-35

ECHI-2 list of recommended 'First Phase Core Indicators' (shortlist)

Draft version of Februari 10, for discussion in the ECHI team Februari 19-20, 2004

Changes since December 2003 version:

- *Format changed: column for 'justification' included;*
- *Many suggestions incorporated more definitively;*
- *Recent comments included;*
- *Update of availability and data sources.*

Preamble

History of the shortlist

- The projects ECHI-1 and ECHI-2 (European Community Health Indicators, projects under the HMP, Health Monitoring Programme) have developed a comprehensive list of indicators, in close co-operation with many of the other projects run under the HMP.
- By March 2003, the list included approximately 400 items/indicators. There was a strong wish from the Commission to extract a shortlist, in order to prioritize the work for harmonisation of EU member State's data collection. ECHI-2 undertook the work to select the indicators for the shortlist. This would be a first phase in a process of expanding comparable data collection in EU countries.
- This selection procedure of the shortlist from the long ECHI list has been performed as follows:
- 19 public health generalists (mostly the ECHI team) individually selected 50 first and 50 second choice priorities from the total of approx. 400 items in the long ECHI list; explicit criteria were: size of public health problem and possibilities to improve on these.
- Ranking the items according to number of 'votes', taking an arbitrary cut-off point, produced a list of approx. 50 items (or 80, with another cut-off point, for a larger list).
- Discussion of the result in the ECHI team meeting of June 2003 led to some changes, mostly additions, to have the list less old-fashioned and more balanced. The health systems area was felt not well-done.
- The results were presenting in the Network of Competent Authorities (NCA) meeting of July 10, 2003. During and after this meeting several comments were received. The area of health systems received most of the comments.
- The status quo was reported in the period November 2003-February 2004 in the Working Parties (WP's) on Health Systems, on Mental Health, on Injury Prevention, on Mortality/Morbidity, and on Lifestyles, and also in the Working Group on Public Health Statistics of Eurostat. These groups provided useful comments and suggestions for changes.

Status by February 5, 2003

The version of the shortlist below includes the complete list by February 5 (column 1). It also indicates (column 2) whether the indicators were originally selected in the panel procedure, or added afterwards by the ECHI meeting of June 2003, following suggestions of the NCA or members of WP's. Column 3 provides a short indication of the public health importance of the indicator, as requested by the NCA meeting of December 2003. Column 4 gives indications of availability of data, or on the specification of the indicator definition. Otherwise, the following has to be taken into account:

- Where appropriate, data should be stratified by gender, age, SES, region. Basically, the inequality issue should be covered in this way.
- Several comments address the issue of children. This can be taken on board in some cases by appropriate selection of age

groups, but data collection does not always cover young ages, e.g. 5-14. This needs further attention.

- Quite some indicators are still mentioned as items rather than operationalised indicator definitions. These indicator definitions will be derived from Eurostat activities (Core Groups) and from the recommendations of EU-HMP projects.
- The remarks under 'availability' are (1) based on an assessment by the Eurostat of February 9, 2004, and (2) on information from HMP project reports. For the Eurostat part, items are marked as follows:
  - *A = available;*
  - *AA = annually available*

  See the remarks below the tables for the Eurostat (Estat)

  abbreviations and for detailed information on the various

  survey modules.
- Under 'availability', it has also been indicated whether the item is included in indicator lists of WHO-HFA and OECD health data.
- In some cases the selected items refer to a comprehensive database which is larger, e.g. the total of mortality data or hospital discharge data.
- The project ISARE (health indicators for subnational regions) has also formulated a shortlist (15 items) and an additional 'longlist' (19 items). The ones covered by the ECHI shortlist (21 out of 34) are indicated in column 2.
- At the bottom, a summary table is presented giving the 'availability' in three groups (tentatively): readily available, partly or non-uniform available, non-available ('wish list').
- All further details on selection procedures etc. are available on request from pgn.kramers@rivm.nl.

CLASS 1, DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS

Population

Indicator	Origin	Justification	Notes on data availability
• Population by age • Birth rate • Fertility rate • Population projections	Originally selected; decided by ECHI meeting not to include formally since these background indicators would be available anyway; mentioned her for completeness. *Population by age, births, deaths in shortlist ISARE*	Basic demographic data population	Generally available in routine statistics; AA Estat, WHO-HFA; OECD
• Teenage pregnancies	Suggested by NCA and Reprostat project	Important indicator of sexual behaviour in young people	AA Estat; WHO-HFA; recommendations Reprostat project

Socio-economic factors

Indicator	Origin	Justification	Notes on data availability
• Population by 4 ISCED education classes	Originally selected; *also in longlist ISARE*	Important indicator for socio-economic differences in health	AA Estat: theme3/lfs/pophouse/pgaed; WHO-HFA; OECD
• Population by occupational class, by ISCO groups	Addition by NCA	Important indicator for socio-economic differences in health	AA Estat: theme3/lfs/emp/egais (employed)
• Total employment rate 15-64 & total employment	Originally selected; *also in shortlist ISARE*	Important indicator for socio-economic differences in health	AA Estat: theme3/lfs/emprates; WHO-HFA; OECD
• % population with income below 60% national median (Eurostat definition.)	Originally selected; NCA: specifiy for children	Important indicator for socio-economic differences in health	AA ECHP/SILC; Structural indicator for income inequality: income quintile share ratio; theme3/ilc/ilc-li/li06

CLASS 2, HEALTH STATUS

Mortality

Indicator	Origin	Justification	Notes on data availability
• Life expectancy at various ages	Originally selected	Basic indicator for population health	AA Estat; theme3/demo/demor/melexpec - also Laeken indicator (SDI); select age cut-offs; OECD; WHO-HFA
• Infant mortality	Originally selected	Important indicator for population health	AA Estat: theme3/demo/demor/minf(ind) OECD; WHO-HFA
• Perinatal mortality	Suggested by Peristat project; *also in shortlist ISARE*	Important indicator for perinatal health care and preventive care	AA Estat: theme3/demo/demor/minf(ind) -Peristat project: include neonatal, fetal mortality as explicit components; also by gestational age and birthweight; are these subgroups available? WHO-HFA; OECD
• Standardised death rate Eurostat 65 causes, age 0-65)	Originally selected; *in shortlist ISARE*	The 65 causes list contains the most frequent causes of death, including all ICD chapters as a whole.	AA Estat: theme3/health/public/cdeath; WHO-HFA; OECD
• Standardised death rate Eurostat 65 causes, age 65+)	Originally selected; *in shortlist ISARE*	The 65 causes list contains the most frequent causes of death, including all ICD chapters as a whole.	AA Estat: theme3/health/public/cdeath; WHO-HFA; OECD
• Smoking-related deaths	Originally selected	Important group of preventable deaths	WHO-HFA: selected smoking-related causes, includes some cancers, ischemic heart disease, stroke, copd, (i.e., more than smoking-attributable deaths); AA Estat: can be calculated
• Alcohol-related deaths	Originally selected Injury WP: take care that injury deaths are explicitly included	Important group of preventable death	65 causes Estat: alcohol dependence WHO-HFA: selected alcohol-related causes, includes oesophagus/ larynx cancer, alcohol dependence, chronic liver disease, all external causes (i.e., more than alcohol-attributable deaths); AA Estat: can be calculated
• Drug-related deaths	Suggested by EMCDDA	Important group of preventable death	EMCDDA operationalisation; AA Estat: cause 30 (Is this the same??)

Disease-specific morbidity [General comment: make clear whether we want incidence or prevalence or both. If one of both is logically preferable, this has been added]

Indicator	Origin	Justification	Notes on data availability
• HIV/AIDS	Originally selected; *also in shortlist ISARE*	Novel disease with expansion potential and link to prevention	AA Estat (from EuroHIV data): theme3/health/public/hastatus/aids; WHO-HFA; OECD
• Lung cancer	Originally selected	High-burden disease	AA Estat (EUCAN/IARC, coded same as CoD); theme3/health/public/ hastatus/cancer; WHO-HFA; OECD
• Breast cancer	Originally selected; *also in longlist ISARE*	High-burden disease	
• Diabetes	Originally selected; NCA: specify for children	High-burden disease	A Estat (International Diabetes Institute data); EUDIP project: prevalence of all types; HES or primary care sentinel network; choose age groups to account for children; WHO-HFA
• Dementia/Alzheimer	Originally selected	High-burden disease	Special surveys
• Depression	Added by ECHI meeting	High-burden disease; highlights mental health priority	Mental health project: CIDI surveys
• Acute myocardial infarction (AMI)	Originally selected	High-burden disease	Incidence/attack rate; Eurociss project: from hospital discharges, in-hospital mortality; preferable population registers; see hospital data project; WHO-HFA
• Stroke	Originally selected	High-burden disease	Incidence/attack rate; Eurociss project: from hospital discharges, combined with mortality data; see hospital data project; WHO-HFA
• Chronic obstructive pulmonary disease (COPD)	Originally selected	High-burden disease	Prevalence; population surveys, primary care and hospital data; WHO-HFA
• (Low) birth weight	Originally selected	Important indicator for pregnancy conditions; important cause for problems later in life	Peristat project: proportion of births within 500 g intervals, by vital status at birth, gestational age, plurality; available? WHO-HFA; OECD
• Suicide attempt	Added by ECHI meeting	Highlights mental health priority	See below; mental health WP: base on suicide

			item in CIDI survey
• Injuries by intent and sector, to include road traffic, workplace, home/leisure, suicide attempt, other violence	Originally selected: road traffic; Injury WP: add other sources of injuries; *no. of road traffic accidents in shortlist ISARE; work accidents in longlist ISARE*	Highlights all mains sources of injury; high-burden health problem	Injury prevention WP: basically on hospital discharges (i.e. different for suicide attempt); AA Estat for road traffic & work; theme7/road/roaccidt; theme3/health/hs_work; WHO-HFA: road traffic, work, home/leisure; OECD: road traffic

Perceived and functional health; composite Measures of Health Status

Indicator	**Origin**	**Justification**	**Notes on data availability**
• Perceived general health	Originally selected	Widely used measure of general health	AA Estat: 18 items HIS/ECHP/ECHIS-EMHS/SILC; WHO-HFA; OECD
• Prevalence of any chronic illness or condition	Originally selected	Widely used measure of general health	AA Estat: 18 items HIS/ECHP/ECHIS-EMHS/SILC
• General musculoskeletal pain	ECHI meeting wanted musculoskeletal indicator; MSD preferred this one	High-burden health problem	MSD project proposes new instrument used in HIS/HES; prevalence
• Limitations in seeing, hearing, mobility, speaking, biting, agility	Added by ECHI meeting	Physical disabilities are a high-burden health problem	A Estat: 18 items HIS/ECHIS-EMHS; various instruments in use; WHO-HFA
• Limitations of usual activities, past 6 months, health-related	Added by ECHI meeting	Activity limitations due to health problems are widespread	AA Estat: 18 items HIS/ECHP/ECHIS-EMHS/SILC; new concise instrument
• Psychological distress	Added by Mental health WP	Important to have a generalised measure on mental health status	MHI-5 is first choice; await further advice WP mental health; also recommended in EuroHIS; A Estat: 18 items HIS
• Health expectancies based on the above: • Perceived general health • Any chronic illness • Limitations in seeing etc. • Limitations of usual	Added by ECHI meeting, modified by Reves project	Health expectancies are important as composite measures, including both mortality and morbidity elements	Calculated based on life expectancy and prevalences of the above items. Estat: structural and sustainable indicator to be developed; WHO-HFA; OECD.

activities			

CLASS 3 DETERMINANTS OF HEALTH

Indicator	Origin	Justification	Notes on data availability
• Body mass index	Originally selected; NCA: specify for children; *also in shortlist ISARE*	Important determinant of health; amenable to intervention; growing problem;	A Estat: 18 items HIS/ECHP/ECHIS-EHMS; choose age groups to account for children; WHO-HFA; OECD
• Blood pressure/hypertension	Originally selected	Important determinant of health; amenable to intervention	EHRM project: HES; WHO-HFA
• Regular smokers	Originally selected; *also in shortlist ISARE*	Important determinant of health; amenable to intervention	A Estat: 18 items HIS/ECHP/ECHIS, to be included in health determinant module (EHDM); WHO-HFA
• Pregnant women smoking	Added by ECHI meeting	Important determinant of perinatal health; amenable to intervention	HIS?
• Alcohol: % of heavy drinkers, frequency of heavy drinking	Originally selected	Important determinant of health and welfare; amenable to intervention	A Estat: 18 items; medium availability/comparability ECHIS; to be included in EHDM; WHO-HFA
• Total alcohol consumption	Originally selected	Important determinant of health and welfare; amenable to intervention	A Estat: ECHIS, to be included in EHDM (but often calculated from trade data!); WHO-HFA; OECD
• Use of illicit drugs (including children)	Added by ECHI meeting	Important societal problem, especially for children; amenable to intervention	EMCDDA; also A Estat 18 items, but low availability/comparability
• Intake of fruit excluding juice	Added by ECHI meeting	Important health-promoting food item, use declining in many countries; amenable to intervention	Food consumption/household budget surveys; A Estat: ECHIS, to be included in EHDM? WHO-HFA; OECD
• Intake of vegetables excl. potatoes and juice	Added by ECHI meeting	Important health-promoting food item, use declining in many countries; amenable to intervention	Food consumption/household budget surveys; A Estat: ECHIS, to be included in EHDM? WHO-HFA; OECD
• Physical activity (time spent,	Originally selected	Important determinant of health;	A Estat: 18 items HIS low availability/

energy expenditure)		amenable to intervention	comparability; ECHIS, to be included in EHDM; Eupass project recommends IPAQ
• *Contraceptive use*	*Suggested by Reprostat project: include??*		
• Breastfeeding at various ages	Added by ECHI meeting	Important determinant of mother's and child health; public health issue of rising importance	HIS; recommendations Nutrition project; WHO-HFA
• Environmental health indicator	Suggested for addition by NCA; ECHI: select housing conditions	Housing conditions have substantial impact on mental and physical health; other choices may be justifiable	Environment and health project will give further recommendations; housing: also SDI (sustainable development indicator)
• Social and/or workplace indicator	Suggestion for addition by NCA and mental health WP; ECHI: select social support/networks/ isolation/participation indicator	Social and workplace conditions are important for health. These aspects should be covered in a comprehensive public health view	Social networks are measured in ECHP; await further recommendations from WP mental health and Workhealth project; EuroHIS recommends the Oslo 3 item social support scale, for which field trials were done in many MS. Good choice?

CLASS 4 HEALTH SYSTEMS *(see below for some general remarks on this class)*

Prevention, health protection and health promotion

Indicator	**Origin**	**Justification**	**Notes on data availability**
• Vaccination coverage in children	Originally selected; *also in longlist ISARE*	Classical prevention strategy which should be maintained to continue effective protection	WHO-HFA. In OECD A list for quality of care
• Breast cancer screening coverage	Originally selected	Preventive strategy considered as effective on a major disease	Estat: 18 items HIS, medium availability; ECHIS: to be included in health care module (EHCM)? In OECD A list for quality of care
• Cervical cancer screening coverage	Originally selected	Preventive strategy considered as effective on a major disease	

• Policies on healthy nutrition	Added by ECHI meeting	This is an important area of activities in health promotion, indicators to monitoring these should be developed	Operationalisation? WHO-Europe study on nutritional policies in European countries?
• Policies and campaigns on smoking, alcohol, diet, safe sex, drug use, sunlight exposure, physical activity, injury and suicide prevention	Added by ECHI meeting, amended by WP's injuries and mental health	This is an important area of activities in health promotion, indicators to monitoring these should be developed	Operationalisation?Await recommendations EUHPID project
• Integrated programmes in settings: e.g. schools, workplaces	Added by ECHI meeting	This is an important area of activities in health promotion, indicators to monitoring these should be developed	Operationalisation? Await recommendatiuons EUHPID project

Health care resources

Indicator	**Origin**	**Justification**	**Notes on data availability**
• Physicians employed	Originally selected; *also in shortlist ISARE*	Indicator used in assessments of accessibility or efficiency	AA Estat; theme3/health/public/ hcare/hstaff/hpers; WHO-HFA; OECD
• Nurses employed	Originally selected; *also in shortlist ISARE*	Indicator used in assessments of accessibility or efficiency	AA Estat partly available; focus of work in Estat Core group; theme3/health/ public/hcare/hstaff/hpers; WHO-HFA; OECD
• MRI units, CT scans	Suggestion of NCA	Indicates aspects of up-to-date quality of care	OECD
• Mobility of professionals	Suggestion by Sanco	Related to EU policies	Source? Operationalisation? This issue is not in the full ECHI list

Health care utilisation

Indicator	**Origin**	**Justification**	**Notes on data availability**
• Average length of stay, limited diagnoses	NCA suggested beds or beddays, ECHI discuss: better ALOS and discharges? *Also in longlist ISARE*	Indicator used in assessments of quality of care, costs and efficiency	Available OECD, WHO-HFA; Hospital data project standardises a.o.: discharges, beddays, ALOS, daycases, by gender, age group and

• Hospital discharges, limited diagnoses	NCA suggested beds or beddays, ECHI discuss: better ALOS and discharges?	Indicator used in assessments of costs, efficiency; also as best measure for occurrence of some diseases (see Class 2)	diagnosis/external cause/procedure. A shortlist was made of some 130 diagnoses/external causes and 18 procedures. The diagnoses include almost all of the Eurostat 65 causes of death, and most of diseases under morbidity in this shortlist; ICD codes to be checked or made explicit. Limit presentation to these diagnoses.
• *Hospital daycases, limited diagnoses*	*Suggested by PK on basis of Hospital Data Project shortlist*	*Indicator used in assessments of quality of care, costs and efficiency*	
• *Daycase-discharge ratio, limited diagnoses*	*Suggested by PK on basis of Hospital Data Project shortlist; this item is not in ECHI longlist*	*Indicator used in assessments of quality of care, costs and efficiency*	
• General practitioner utilisation	Originally selected	Indicator used in assessment of cost and (equity of) access	Estat AA; 18 items HIS/ECHP; ECHIS: to be included in health care module
• Other outpatient visits	Suggested by NCA	Indicator used in assessment of cost and (equity of) access	Estat A; 18 items ECHP
• Patient mobility	Suggestion by Sanco	Related to EU policies	Source? Operationalisation? This issue is not in the full ECHI list
• Surgeries: PTCA, hip replacement, cataract operation	Suggested by NCA; *cataract and hip operations also in longlist ISARE*	Indicates aspects of accessibility, up-to-date quality of care, and costs	Available OECD; included in the procedures shortlist of the Hospital data project.
• Medicine use, selected items	Suggested by NCA; WP mental health: include antidepressives in primary care	Indicates aspects of accessibility, up-to-date quality of care, and costs	Available OECD; to be further defined with Medicine project

Health expenditures/financing

Indicator	**Origin**	**Justification**	**Notes on data availability**
• Insurance coverage	Suggested by NCA	Important indicator of access to services	OECD
• Total public/private expenditures of health	Originally selected; NCA: can informal payments be included?	Important for a view on total costing and partitioning of it	Mostly OECD; comparable under SHA

Health Care Quality/Performance

Indicator	Origin	Justification	Notes on data availability
• Accessibility, including equity	Suggested by Sanco	An indicator for general access to different health care sectors and for different population and income groups is appropriate;	WHO-HQ responsiveness instrument?
• Waiting lists, for elective surgeries: PTCA, hip replacement, cataract operation	Originally selected	Indicator for the accessibility of health care, with focus on elective interventions	Some data from OECD project waiting times elective surgeries, WHO-HQ;
• Surgical wound infections	NCA suggestion	Indicator for the safety of operative interventions	Helics project? Broader as hospital infections? OECD A list
• Stage at cancer diagnosis	NCA suggestion	Indicator for effectiveness of screening and diagnosis for a high-burden disease group	Check Eurochip project
• Cancer survival rates; breast, cervix	Originally selected	Indicator for effectiveness of screening and treatment of a high-burden disease	IARC; recommended by Eurochip project; in OECD A list for quality of care: breast, cervical, colorectal cancer
• Nephropathy in diabetics: end-stage renal failure	NCA suggested diabetes complications; ECHI: select nephropathy, from OECD list	Indicator for effectiveness of care, in a high-burden disease	Recommendations from Eudip project, OECD A list on quality of care

Abbreviations in the column on availability:

- HIS 18 items (Estat): 2002 data collection for MS and EFTA countries : Detailed tables "Health in Europe - Results from 1997-2000 surveys (PDF)" at: http://europa.eu.int/comm/eurostat/Public/datashop/print-product/EN?catalogue=Eurostat&product=KS-57-03-184-__-N-EN&mode=download; new data collection in 2004 including ACC and CC countries (limitations: walking (preferably 500 metres), seeing newspaper print clearly, seeing clearly the face of someone from 4 meters (across a road), hearing what is said in a conversation with one person, lifting and carrying a shopping bag of 5 kgs).
- ECHP (Estat): European Community Household Panel 1994-2001 available, not continued after 2001.
- ECHIS (Estat): European Core Health Interview Survey, European Module on Health Status, available in : http://forum.europa.eu.int/Members/irc/dsis/health/library?l=/reports/healthsinterviewssurvey&vm=detailed&sb=Title; other modules (health determinants EHDM and health care EHCM) to be developed, implementation of the ECHIS all modules 2006-2007.

- SILC (Estat): Statistics on Income and Living Condition survey, pilots in 2003, full implementation on an annual basis from 2004 (EU15) and 2005 (EU25) onwards.
- SDI (Estat): Sustainable Development Indicators (SDI), see Circa site of at : http://forum.europa.eu.int/Members/irc/dsis/susdevind/home.
- LFS (Estat): Labour Force Survey.

CLASS 4 HEALTH SYSTEMS, general remarks

Around December 2003, most comments were on the chapter of health systems. It appears that, more than for the other chapters, the original selection was not satisfactory. Part of the problem may be that the criteria 'relevance in terms of size of health problem and possibilities for improvement' cannot so easily be applied on the list of items as they are arranged following the ECHI/OECD scheme of 'resources', 'utilisation', and 'expenditures'.

Criteria applying to this class can be taken from the concept of '*performance*' of health systems. In many recent reports, *domains of performance* are named such as:

1. Quality/effectiveness/safety; does the system produce health as we expect it to do? OECD is preparing a series of indicators in this area.
2. Accessibility/equity; is the system readily accessible for everyone?
3. Efficiency and costs; is the system working at reasonable inputs and input/output ratio's?
4. Health promotion and health protection are felt by many as being quite different from all other items in this chapter, as representing all activities *outside* the health care system.

Most of this is highlighting the relevance for public health of the health (care) system rather than the economic and management view.

In the present selection of indicators in Class 4 quite a few of the suggestions from the NCA and others are taken on board, and at the same time it has been attempted to formulate the justification in terms of the elements of performance as mentioned above.

It is foreseen that in this Class 4, some finetuning will be done by the ECHI project, the WP on Health Systems and the Core Group on Health Systems of Eurostat. In the long list of ECHI this will be presented as a separate user-window.

Note: In this area (but also prevention), OECD has developed a first list (A list) for indicators on quality of care. In its meeting of December 8-10, 2003, OECD is discussing further proposals in the areas of mental health, cardiac care, diabetes care, prevention/primary care and patient safety. This work has to be taken into account.

Annex: Summary estimate of availability of all recommended indicators/items

Group	Available Eurostat etc.	Regularly available but not annually, availability and comparability limited	Wish list: not yet uniformly defined
Demographic and Socio-economic factors	• Teenage pregnancies • Population by education (ISCED) • Population by occupation (ISCO) • Total employment rate 15-64/ unemployment • Income inequality		
Mortality	• Life expectancies • Infant mortality • Perinatal mortality • SDR 0-65 • SDR 65+ • Drug-related deaths	• Smoking-related deaths • Alcohol-related deaths	
Morbidity	• HIV/AIDS incidence • Lung cancer incidence • Breast cancer incidence • Injuries by intent and sector	• Diabetes prevalence • Dementia/Alzheimer • Depression prevalence • AMI incidence • Stroke incidence • COPD • (low) birth weight • Suicide attempt	
Perceived and functional health, health expectancies	• Self-reported health • Prevalence of any chronic illness • Limitations of usual activities past 6 months • Health expectations based on these	• Limitations in seeing etc. • General musculoskeletal pain • Psychological distress	
Health determinants		• BMI • Blood pressure • Regular smokers • Pregnant women smoking • Heavy drinking • Total alcohol consumption • Use of illicit drugs • Intake of fruit • Intake of vegetables • Physical activity • Breastfeeding • Housing (or other environm. indicator) • Social support or related	
Health	• Vaccination coverage	• Breast cancer screening	• Policies on nutrition

promotion, Prevention		• Cerv. cancer screening	• Policies/campaigns on lifestyles etc. • Integrated programmes in settings
Health systems: resources, utilisation, expenditures	• Physicians employed • Nurses employed • Technologies (MRI, CT) • ALOS • Hospital discharges • GP visits • Surgeries • Medicine use • Insurance coverage • Expenditures on health	• Other outpatient visits	• Mobility of professionals • Patient mobility
Health care quality	• Cancer survival rates	• Responsiveness • Waiting lists/times elective surgeries • Hospital infections • Stage at cancer diagnosis • Nephropathy in diabetics	

Group	**Available Eurostat etc.**	**HMP etc. recommendation, availability and uniformity limited**	**Wish list: not yet uniformly defined**
Socio-economic factors	5		
Mortality	6	2	
Morbidity	4	8	
Perceived and functional health, health expectancies	4	3	
Health determinants		13	
Health promotion, prevention	1	2	3
Health systems: resources, utlisation, expenditures	10	1	2
Health care quality	1	5	
Total	**31**	**34**	**5**

Work still to be done:

- Options for harmonised age groups, SES groups, regions
- Specific items to be developed, advised, decided:
    - ECHI:
        - Discuss all recent changes
        - Include contraceptive use (Reprostat); additional items from Hospital Data Project?
    - Mental health WP: advise on general indicator of (positive) mental health. Is MHI-5 OK? Also advise on indicator of social support/isolation/cohesion/participation.
    - Environmental health indicator(s): environment project
    - EUHPID project: health promotion indicators
    - Smoking-related deaths and alcohol-related deaths: how to operationalise?
    - Mobility of professionals and patient: what is wanted? operationalisation?
    - Medicine use project on specific medicine groups to include
    - Update with OECD health care quality work
    - WP health systems, Eurostat Core group Health Systems on selection, grouping and justification of indicators
- Assessment of availability of data on many indicators/items.

APPENDIX 12 – Review of Relevant Health and Social Surveys in the EU

Name of initiative	Organization	Geographic scope	Number of indicators	Categories
Baltic 21 Action Programme	Baltic 21 and sector lead parties	Denmark, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, NW Russia & Sweden	7 areas	A safe and healthy life, a cooperative and prosperous economy and society for all, democracy, openness and participation (participation in national and local elections), biological and ecosystem diversity, atmospheric and land/water pollution, renewable resources, and awareness of sustainability
Cities Environment Reports on the Internet programme (CEROI)	UNEP/GRID Arendal	12 cities worldwide	90 (29 core indicators)	DPSIR, external impact, economic sector, physical environmental, social environment (crime, health, housing, income, jobs and monuments), and instruments
Cities21 project	International Council for Local Government Initiatives (ICLEI)	16 cities worldwide	70 indicators	Freshwater resources management, climate change, and governance for sustainable development
EUROHIS project	WHO/Europe	Europe	11 (recommended instruments), 8 (in development)	The recommended instruments include: perceived health, temporary disability, long-term disability, mental conditions, smoking, BMI, breast feeding, socio-economic classification and other recommendations. The indicators in development include: chronic physical conditions, mental disability, alcohol consumption, physical activity, use of curative medical services, use of medicines, use of preventive health care, and health-related quality of life (QOL)
European Common Indicators Initiative/Towards a Local Sustainability Profile	Campaign Interactive/Expert Group on the Urban Environment	90+ cities	10 (5 core indicators and 5 additional indicators)	Sustainability/environment
European Community Health Indicators	National Institute of Public Health and the Environment (RIVM), The Netherlands	EU Member States	14	Demographic and socio-economic factors, health status, determinants of health (substance use, nutrition and other health-related behaviours), health systems
European Environment Agency (EEA) Indicators	European Environment Agency (EEA)	18 EEA countries	96 (13 themes)	Agriculture, air, air quality, climate change, coasts and seas, energy, households, nature, soil, tourism, transport, waste, water
European Environmental Pressure Indices Project /TEPI	Project team representing five European countries	Europe	60 (10 policy areas)	Air pollution, climate change, loss of biodiversity, marine environment & coastal zones, ozone layer depletion, resource depletion, dispersion of toxic substances, urban environment problems, waste, and water pollution
Global Urban Observatory (GUO)	United Nations Centre for Human Settlements	200+ cities worldwide	23 key indicators and 9 qualitative data	Shelter, social development & eradication of poverty, environmental management, economic development, governance, and international cooperation

Green Headline Indicators to Assess Sustainability in Sweden	Swedish Environmental Advisory Council (EAC)	Sweden	12 headline indicators	Use of energy, use of materials, use of chemicals, greenhouse effect, acidification, quality of urban air, eutrophication/water quality and quantity, biological diversity/land use, environmentally sound transport, environmentally sound purchases, recycling of nutrients, environmentally sound work practices
Healthy Cities Indicators	WHO Regional Office for Europe, Centre for Urban Health	ca. 45 cities	32 (4 categories)	Health, health service, environmental , and socio-economic indicators
Healthy throughout life - the targets and strategies for public health policy of the Government of Denmark, 2002-2010	Ministry of Health and the Interior	Denmark	61 indicators (14 'key' indicators)	Life expectancy, lost years of good life, infant mortality, self-perceived health, social difference in mortality, social differences in quality of life, heavy smoking, exceedence of the National Board of Health's alcohol limits, proportion that consumes more than 40% fat, physical activity levels, BMI, accidents, serious work-related accidents, drug use (youth)
Indicators of the State of the Environment in the Nordic Countries	Nordic Council of Ministers	Nordic countries	13	Climate change, ozone layer depletion, eutrophication, acidification, toxic contamination, urban environmental quality, biodiversity, cultural landscapes, waste, water resources, timber resources, fish resources, and agricultural land resources
Making News for Monitoring Progress	Various partners (representing nine cities throughout Europe	10 cities	Specific to cities	Specific to cities
Minimum Health Indicator set for South Eastern Europe	Public Health Collaboration in South Eastern Europe (PH-SEE) Network	All countries of SEE	32	Demography/social/economy, mortality, morbidity & hospital discharges, lifestyle (alcohol consumption, calories from protein), environment, health care resources, health care utilization/cost, maternal and child health
National Public Health Report	Centre for Epidemiology, National Board of Health and Welfare	Sweden	?	Living conditions, lifestyle, work environment, environment, social conditions
National Sustainable Indicators for Finland	Finnish Environment Institute	Finland	83 (20 "issue chapters")	Climate change, ozone layer depletion, acidification, eutrophication, biodiversity, toxic contamination, economic development, environmental policy instruments, natural resources, community structure and transport, productions and consumption, demographic developments, lifestyle and illness (daily smokers, obesity, alcohol & drug-related illnesses, HIV infection, suicide), the workforce, social problems and equality issues (poverty incidence, income level differences, homeless, women's earnings relative to men's, relocated children, violent crime), education, research and participation (education levels, R&D expenditure, young people neither studying nor working, voter turnout), access to information,

				cultural heritage (meadows and pastures, visits to museums, age structure of buildings), ethnic minorities, and development co-operation
Nordic Major City Statistics	NORDSTAT	16 Nordic cities	21 (6 categories)	Population, industry, dwelling & business premises, construction, social services, and other data
Norway's Health Indicator System	National Institute of Public Health	Norway	300+	Population & social factors, environment, tobacco, alcohol, drugs etc., mortality & life expectancy, morbidity, reproductive health, self-reported health, health services, and social security & other financial contributions
OECD Development Indicators	OECD/DAC	Global	20 area-specific indicators (3 goals)	Economic well-being, Social development, Environmental sustainability and regeneration
OECD Health data	OECD	Global	8 areas	Health status, health care resources, health care utilization, health expenditure, financing and remuneration, special protection, pharmaceutical market, and non-medical determinants of health (food consumption, alcohol consumption, and tobacco consumption)
Project Megapoles	European Commission	14 cities	34	General social & economic indicators, general health indicators (smoking, alcohol, obesity), children & young people, and older people
Setting up a Coherent Set of Health Indicators for the EU	Euro-REVES	EU	5 domains	Chronic morbidity, functional limitations, activity restrictions, self-perceived health, mental health
Sustainable Development Indicators for Sweden	Statistics Sweden/Swedish Environmental Protection Agency	Sweden	30 (4 themes)	Efficiency, contribution and equality (women's salaries as a percentage of men's salaries, electoral participation, purchases of eco-labelled products and services), adaptability, values and resources for coming generations
The Finnish Urban Indicators System	Committee for Urban Policy/Ministry of the Interior	38 cities (in Finland)	27	Demographic issues, housing, urban & regional economy, employment & labour market, transport & communication, education, welfare services, culture & leisure, municipal finances, construction, and environment and civic involvement
UK Indicators of Sustainable Development	Department of the Environment, Transport and the Regions (DETR)	United Kingdom	29 (15 core indicators)	Use of resources, protection of environment, health & education, access to services, surroundings, empowerment & participation, and sustainable local economy
United Nations Indicators of Sustainable Development	United Nations	Global	134 (4 categories)	Social, environmental, economic, and institutional indicators
Urban Audit	European Commission	58 cities	107	Socio-economic aspects, participation in civic life, education & training, environment & culture, and leisure
Urban Environment and Environmental Health Indicators	WHO European Centre for Environment and Health (ECEH)	22 cities (in Italian)	53	Air, energy, green areas, noise, transport , waste, water, and demographic data

APPENDIX 13 – EUHPID Seminal Publication

Advancing a theoretical model for public health and health promotion indicator development

Proposal from the EUHPID consortium

Georg Bauer, John Kenneth Davies, Jurgen Pelikan, Horst Noack, Ursel Broesskamp, and Chloe Hill* on behalf of the EUHPID Consortium**

Abstract

This paper discusses the work of the EUHPID Project to develop a European Health Promotion Monitoring System based on a common set of health promotion indicators. The Project has established three working groups to progress this task – health promotion policy and practice-driven, data-driven and theory-driven. The work of the latter group is reviewed in particular. EUHPID has taken a systems theory approach in order to develop a model as a common frame of reference and a rational basis for the selection, organization and interpretation of health promotion indicators. After reviewing the strengths and weaknesses of those health promotion models currently proposed for indicator development, the paper proposes a general systems model of health development, and specific analytical, socio-ecological models related to public health and health promotion. These are described and discussed in detail. Taking the Ottawa Charter as the preferred framework for health promotion, the socio-ecological model for health promotion adopts its five action areas to form five types of systems. The structure and processes for each of these five systems are proposed to form the basis of a classification system for health promotion indicators. The paper goes on to illustrate such a system with reference to indicators in the workplace setting. The EUHPID Consortium suggest that their socio-ecological model could become a common reference point for the public health field generally, and offer an invitation to interested readers to contribute to this development.

APPENDIX 14 – Glossary

A Socio-Ecological Model of Human Life for Health Promotion: EUHPID ENGLISH GLOSSARY

At risk group

A group vulnerable to certain diseases or ill health because of their economic, social and behavioural characteristics in the environment. (See Risk behaviour).

Bio-medical model

(Sociology) Focuses on the causes and treatment of ill health and disease in terms of biological cause and effect. This approach does not refer to the social, psychological, or economic conditions that may have influenced the health of the individual. (See Health equity).

Community Health Indicators

Set of quantitative, longitudinal measures, which reflect the status and changes in the health of the community on the individual, collective and environmental levels.

Control

Both power to change and power to keep factors that influence health (both in regard to individual lifestyles and environmental factors).

ECHI Project
EC-funded HMP (Health Monitoring Programme), which aims to act as a framework, bringing together recommended indicators from the various EC-funded projects, under the health information and knowledge area. It seeks to form a single, comprehensive system for use at Community and member state levels.

Empowering

Action that improves control of a system (i.e., *Physical / body*).
Empowerment *(Ethics)* Situation in which individuals have a high degree of power. Empowerment is important in order to enable individuals and communities to make healthy choices.

Health Actions
Processes that occur in the system (otherwise referred to as health practices**).** Health capacities in use (see below), or intentional or unintentional processes of a system operationalising the potential for controlling determinants of health.

Health Capacities
Stable properties of the system providing the potential for 'gaining control over the determinants of health'.

Properties or activities of individuals, which contribute to the development of their own health.

Health Development

The interaction between (individual or collective) people with their environment.

Health Equity

(Sociology) Implies ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential, if it can be avoided. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest level possible.

Health Opportunities
This includes environmental structure and processes, both considered as health opportunities, which influence the level of health capacities and actions.

Health Outcomes

Attributable to specific interventions, or just to passing of time, outcomes represent differences in valued qualities or structures of processes, observed or measured at least at two different points in time (referred to as base-line and follow-up measurement).

Health Promotion
The process of enabling/empowering individuals and communities to gain control over the factors that influence health and thereby improve (their) health.

Health Promotion Actions
Acting as the interface between ongoing health development and influences of intentional health promotion interventions, the five primary action areas of the Ottawa Charter (see definition) are reflected within the health promotion actions (environment, policy, organization, community, person). As such, they are often combined into health promotion strategy.

Health Promotion Principles

Embodied in the Ottawa Charter, these include participation, empowerment, intersectoral collaboration, equity, multi strategic and sustainability. Together they form the foundation for health promotion actions.

Indicator
Construct to be expressed in quantitative or qualitative terms, reflecting an important unique aspect of an underlying phenomenon.

Indicator system
A limited set of quantitative or qualitative measures, which reflect current status and changes of a complex system and are expected to reduce complexity.

Model

(Theoretical debate) A misused word, sometimes interchanged with the theory, perspective, approach and position. Refers to temporary conceptual constructions used to assist our thinking, more primitive than theories but perhaps embodying propositions, hypothesis, etc.

Ottawa Charter
The first health promotion international conference in Ottawa (1986), concluded with the production of a charter, which outlined five principle areas for health promotion action, as well as three process methodologies (mediation, empowerment, and advocacy), forming a framework for the delivery of health promotion programmes, to this day, through which, people could begin to take control over their own health.

Participation

An essential element of the settings approach (see below), yet it is criticized for the vague interpretation of the term. It concerns the involvement of people concerned in the decision-making process, and in the definition of problems (for them). A distinction is made between collective participation and collective involvement in expert-led measures.

Pathogenesis
The origination and development of disease.

Perspective

(Theoretical debate) A term favoured by theorists to describe the unique qualities of their work. Best thought of as describing their epistemological basis (core assumptions about how their theoretical knowledge is generated).

Positive Health
The concept of positive health is central to the philosophy of health promotion. It means a state of health beyond an asymptomatic state. Concepts of positive health usually concern the quality of life and the potential of the human condition. Notions of positive health may include self-fulfilment, vitality of living and creativity. Positive Health is concerned with thriving rather than merely coping. Considerations of positive health transcend the traditional concerns of medicine with preserving and restoring health.

Processes

Relates to a sequence of events that that may demonstrate observable changes over time.

Quality of Life

Refers to the individual's experience of, and satisfaction with the range of different elements of their life (e.g. family, housing, income, working conditions etc). Measurement bridges various dimensions: physical, psychological, social wellbeing and function relate to the daily task of living.

Resources
Refers to factors, which support the process of health development.

Risk Behaviour

Specific forms of behaviour known to be associated with increased susceptibility to certain diseases or ill health. In health promotion, changes to risk behaviour are a major goal in disease prevention (see At Risk Group).

Risk Factors

In epidemiolology, a risk factor is any variable statistically linked to the occurrence of an event. It is an individual or collective characteristic, causally associated with an increase of the incidence of the disease or with a health problem in a population and thus with an increase of the likelihood of an individual developing the disease or health problems.

Salutogenesis

Derived from the latin term "salus," meaning health and well-being, and coined by Antonovsky in 1979, Salutogenesis, is the opposite of pathogenesis. The salutogenic model focuses on the causes of global well-being rather than the aetiology of specific disease processes.
Salutogenesis examines which resources in human life support health development towards positive health and well-being.

Settings Approach
Settings for health:

The place or social context in which people engage in daily activities and in which environmental, organisational and personal factors interact to affect health and well being.

A setting is also where people actively use or shape the environment and thus create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organisational structure.

Actions to promote health through different settings can take many different forms, often through some forms of organizational development, including change to the physical environment, to the organizational structure, administration and management. Settings can also be used to promote health by reaching people who work in them, or using them to gain access to services, and through the interaction of different settings with the wider community. Examples of settings include schools, worksites, hospitals, villages and cities.

Structures

Are characteristics of a system or environment that are fairly stable over time and thus not usually modifiable by an individual alone.

Sustainability

The development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

System

Refers to a multi-layered micro-to-macro-concept that reaches from the micro (individual living system) to the macro level (global system).

Processes

Relates to observable events over time.

Theories
(Theoretical debate) Organised or integrated sets of propositions, better thought of as a 'theoretical system' in contrast to the above terms. Synonymous with explanatory system. Retains etymology of 'composition' and 'speculation' (same origin as spectator, spectacle, etc., meaning viewpoint or perspective).

User Window
A concept developed from the ECHI project, in anticipation of the ECHI framework being used by different users, for different purposes, therefore requiring specific sub-sets from the totality of indicators. The idea behind the concept is that a 'user-window' is more policy relevant and flexible than a set of core indicators.

Please note: this glossary is a working document. Please feel free to make comments and suggestions.

APPENDIX 15 – Abbreviations Glossary

CC
Candidate Countries

CHI
Community Health Indicators

CHILD Project
The Child Health Indicators of Life and Development project

ECHI Project
European Community Health Indicators Project

EC
European Commission

EFILWC
The European Foundation for the Improvement of Living and Working Conditions.

ESWC
The European Survey on Working Conditions

ENHPA
European Network of Health Promotion Agencies

ENWHP
European Network of Workplace Health Promotion

ENHPH
European Network of Health Promoting Hospitals

ENHPS
European Network of Health Promoting Schools

EU
European Union

EUHPID Project
European health Promotion Indicator Development Project

EUROHIS
European Health Indicator Survey

HDA
Health Development Agency

HMP
Health Monitoring Programme

ISARE
Indicateurs de Sante dans les Regions d'Europe (Regional Health Indicators in Europe Project)

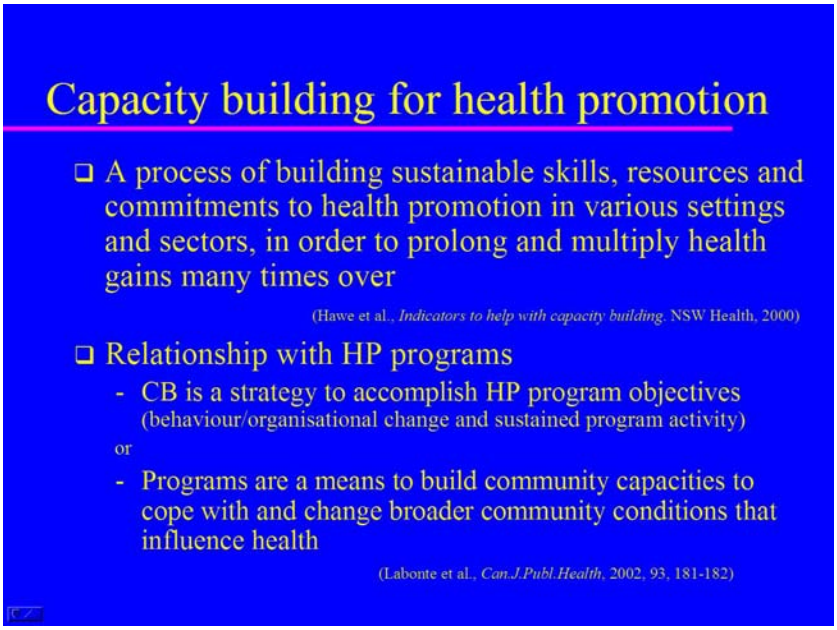
IUHPE
International Union of Health Promotion and Education

NCA
Network of Competent Authorities

PHSF report
Public Health Status and Forecasts Report

WHO
World Health Organisation

APPENDIX 16 – Indicators for Capacity Building in Health Promotion



Whose capacity?

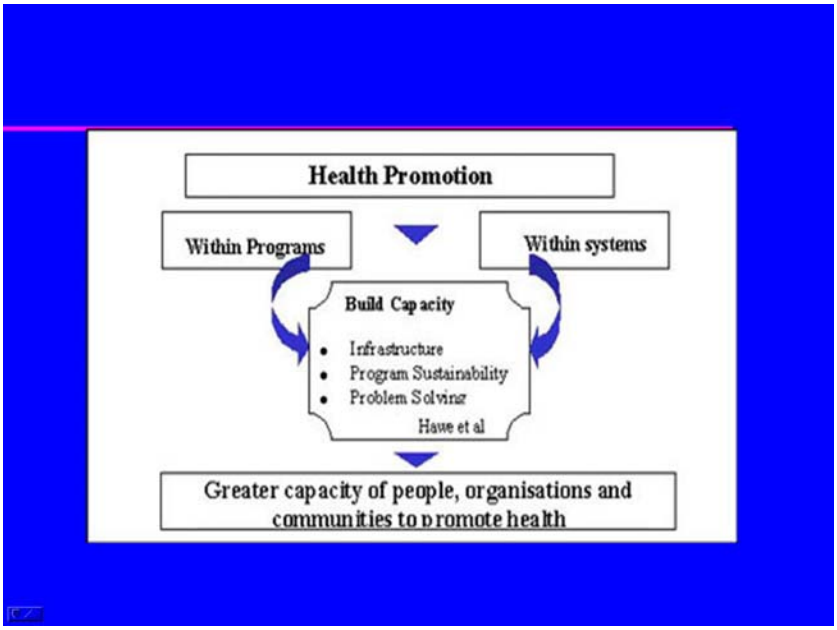
Capacity building can target various levels

- Individuals
- Groups
- Organisations
- Interorganisations/coalitions
- Communities

Dimensions of capacity building

(Hawe et al., 2000)

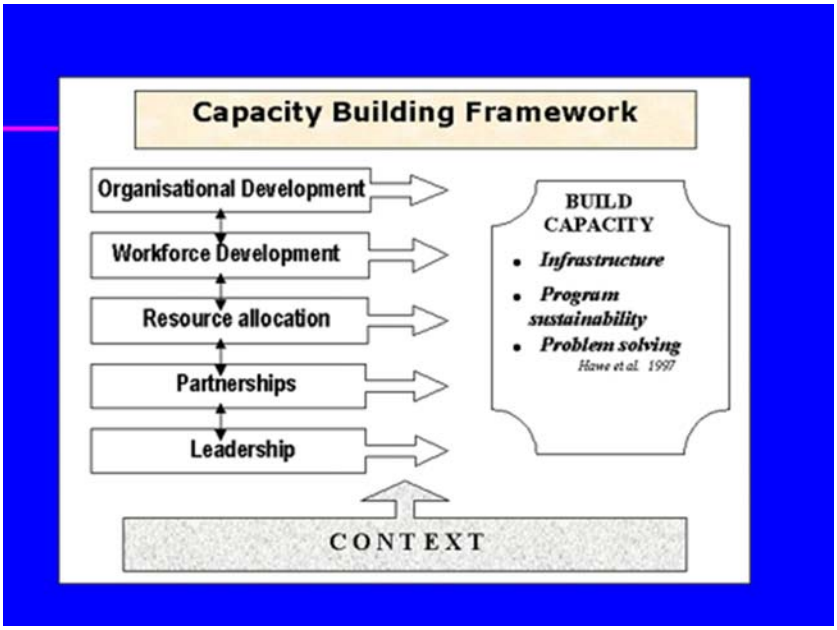
- Infrastructure
  - The capacity to deliver program responses to particular health problems
  - Expressed in terms of minimum requirements in structures, organisatons, skills, and resources
- Program sustainability
  - The capacity to continue to deliver a program through a network of agencies in addition to, or instead of, the program initiatior
- Problem solving
  - The capacity to identify health issues and develop appropriate mechanisms to address them, building on to experience with a particular program, or as an activity in its own right



Strategies of capacity building

(Hawe et al, 2000)

- Action areas
  - Organisational development
    policies, strategies, management, reward systems, information, QA systems
  - Workforce development
    learning, professional development, support, supervision, performance mgt
  - Resource allocation
    financial, human, information, physical
- Context elements
  - Leadership
    interpersonal, organisational and technical skils, visioning, personal qualities
  - Partnerships
    shared goals, relationships, planning, sustained outcomes



Implications of adopting a capacity building framework

- Capacity building becomes an outcome of HP interventions in addition to a process
- HP programmers need to specify how programs contribute to the capacity of people, organisation and communities
- Capacity building outcome measures must be developed and used

Indicators of HP capacity building

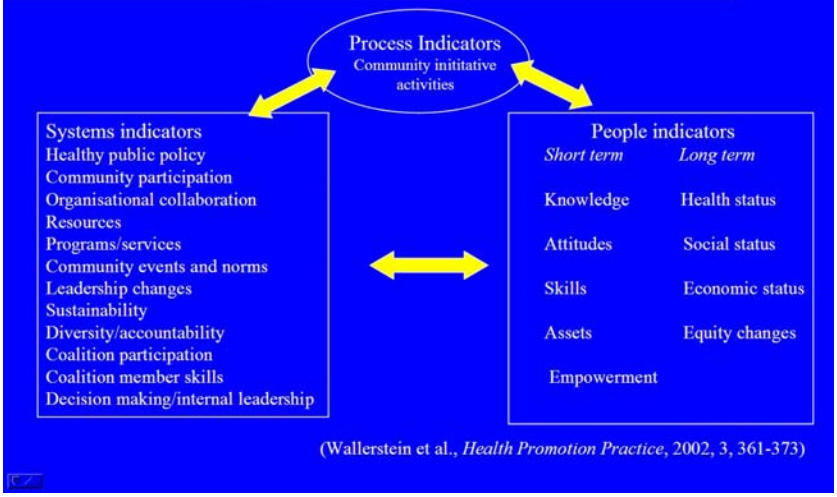
- Need for indicators which
  - map the principal domains of capacity building in organisations, groups and communities
  - capture high quality practice
- Need for measures which operationalize these indicators
- Use indicators to monitor the implementation of capacity building initiatives and programs
  - to make practice more understood, visible, and accountable
  - to make recommendations for improvement

Example of capacity building measures

(Hawe et al., 2000)

- Set of 9 generic indicators of capacity building to monitor and evaluate HPCB initiatives
- Operationalized via 9 checklists:
  - Strenght of a coalition
  - Opportunities to promote incidental learning among health workers
  - Opportunities to promote informal learning among health workers
  - Likelihood of a program to be sustained
  - Learning environment of a team or project group
  - Capacity for organisational learning
  - Capacity of a particluar organisation to tackle a health issue
  - Quality of program planning
  - Community capacity to address community issues

Community initiative evaluation model



(Wallerstein et al., *Health Promotion Practice*, 2002, 3, 361-373)

Challenges to building indicators of HP capacity building

- Language
  - Use of the terminology and concepts of capacity building differs widely
  - Need to develop a shared understanding of definitions and approaches
- Silo effect
  - Organisations working in isolation leads to duplication and reduced impact.
  - Working in partnerships to enhance capacity provides solution
- Links between capacity building and health outcomes
  - More work needs to be done to demonstrate pathways from capacity to health outcomes
  - Links to issues, activities and programs must be pointed out to policy makers