



Health
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Promoting Health



World of health

The role of international collaboration in promoting public health

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The role of the EU in health promotion • Collaboration the cornerstone of CINDI activities
Equity in health at the heart of all we do • Saving lives and sharing learning • The world of Nicare
The role of the World Bank in promoting public health • Investment for health and development

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Promoting health involves people and organisations interacting through many programmes and initiatives. Health promotion initiatives with individuals, families and communities are the most important - helping to give people control over their own health and helping them participate in changing those factors that determine our health. But such initiatives need to be planned and based on evidence of what works. It is vital that we learn from local programmes and projects but there is also a great deal of benefit to be gained from looking further afield and learning from what others have tried and have implemented. This issue of *Promoting Health* looks at the widest canvas for such learning - the role of international collaboration in promoting public health.

It is gratifying to see that Northern Ireland is not only represented in many of the international collaborative programmes outlined in this issue, but also playing a leading role in many of them. Such cooperation will ensure that we can both learn from our colleagues elsewhere and share the many examples of effective health promotion practice being implemented in Northern Ireland.

We have a major opportunity to discuss and debate many of these programmes when the International Healthy Cities Conference takes place in Belfast on 19-22 October. The conference celebrates 15 years of Healthy Cities action by demonstrating the power of local action. It will provide a meeting point and platform for cities, networks, agencies and institutions that are concerned with health, sustainability, equity, urban development and community empowerment.

The event marks the successful conclusion of Phase III of the WHO European Healthy Cities Network and the launch of Phase IV. We congratulate Belfast Healthy Cities on achievements and the recognition they will receive by being chosen to host this important event and we look forward to working with them in their future initiatives.

The WHO Healthy Cities movement is stronger and more relevant than ever. There is now ample recognition of the importance to health and sustainable development of the local dimension and the key role of local governments and civil society. The implementation of several of the health-related Millennium Development Goals (MDGs) requires strong local action. Healthy Cities has 15 years' experience of innovative action developed through times of major social and political change in Europe and worldwide.

This collection of articles underlines the collaborative nature of public health promotion, at a global and local level. It also shows how we can learn from a range of influences and how we can be proud of many of the effective areas of health promotion which we in Northern Ireland have to share with others.

A handwritten signature in black ink that reads "Brian Gaffney". The signature is written in a cursive, flowing style.

Dr Brian Gaffney
Chief Executive

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Healthy Cities

- engaging

cities, towns

and

communities

Andrew Hassard and Joan Devlin elaborate on the Healthy Cities concept, showing how the sharing of experience within an international network has benefited health development in many cities.

Introduction

October 2003 sees the World Health Organization (WHO) bringing its International Healthy Cities Conference 'The Power of Local Action' to Belfast. This is a major international conference which is held only every five years and which attracts speakers and delegates from the WHO's five global regions.

Belfast Healthy Cities was successful in bringing this conference to the city despite strong competition from cities in the European Network - Liverpool, Gothenburg and Turku. The conference, which is being held at the end of Phase III of the European Healthy Cities Project, is an opportunity to celebrate 15 years of Healthy Cities, but more importantly to share the learning from the work of cities and networks in the last phase as well as from WHO collaborating centres and academic institutions together with experience from other towns, cities and

communities around the world that have embraced the Healthy Cities way of working.

It also provides an opportunity to showcase some of the good work that is happening in Belfast and in Northern Ireland generally. It would not have been possible to be successful in our bid for this conference without the significant support and commitment of all the Belfast Healthy Cities partners.

Healthy Cities

So what is Healthy Cities and what is it about the approach that has engaged so many cities, towns and communities? Worldwide, there are now over 4,500 active Healthy Cities initiatives. The WHO's Healthy Cities Project is a long term international development initiative which aims to place public health high on the agenda of decision makers in

Europe and to promote comprehensive strategies for health and sustainable development, based on the principles of Health For All in the 21st Century and Local Agenda 21. Ultimately, the Healthy Cities approach seeks to enhance the physical, mental, social and environmental wellbeing of people who live and work in cities.

The European Network of designated cities can be seen as the testing ground for healthy cities approaches which can then be adapted and used by others throughout the world.

The WHO Healthy Cities project was launched in 1988 with just 11 cities to demonstrate that new approaches to public health grounded in Health For All could work in practice. Today, the project has developed into a major global public health movement at local level.¹

Intersectoral partnerships

Successful implementation of the approach requires explicit political commitment, leadership and institutional change, intersectoral partnerships, innovative actions addressing all aspects of health and living conditions, as well as extensive networking between cities across Europe and beyond.²

Healthy Cities is increasingly being regarded as a valuable source of experience and legitimacy for national and regional programmes. Within the United Kingdom this approach, which is based on intersectoral action to meet community needs that was first advocated by the Urban Centre for Health in the European Healthy Cities Project, is now mainstreamed in government policy and forms the backbone of many initiatives such as the Health Action Zone project. At a regional level, in Northern Ireland the Department of Health, Social Services and Public Safety acknowledged the influence that the Healthy Cities initiative had when it was developing the *Investing for Health* strategy.³

The ongoing evaluation of the European initiative has shown that participating cities have developed and influenced a wide range of programmes based on intersectoral cooperation, community development and addressing the needs of vulnerable groups, lifestyles and environmental health.

European network

The European Healthy Cities project is run in five year phases with cities being designated to the European Network based on an assessment of a city's application against specific criteria and requirements laid down by WHO. The WHO also determines what the end of phase success looks like in terms of products, processes and outcomes within designated cities. For a city to be considered for redesignation to any subsequent phase, WHO has to be satisfied that the set requirements have been achieved.

Phase 1 of the initiative commenced in 1998 with WHO placing the accent on creating new structures to act as change agents and to introduce new ways of working for health in cities. Phase II, to which 39 cities were designated, was more action oriented with a strong emphasis on healthy public policy and comprehensive city health planning. The last International Conference was held in Athens in June 1998 to mark the end of the second phase and to pave the way for the third phase. Cities confirmed their commitment to the Healthy Cities Vision and to the aspirations of Phase III by signing the Athens Declaration. Phase III, which is now coming to a conclusion, has 51 designated cities. The overarching goals of this phase have been equity, sustainable development and social development with a focus on strategic integrated planning for health development.

Healthy Cities is increasingly being regarded as a valuable source of experience and legitimacy for national and regional programmes.

Belfast Healthy Cities

Belfast was the 11th city to be designated to the WHO European Healthy Cities Network in 1988 and has been working consistently over the three phases of the Healthy Cities initiative to place health and wellbeing on the policy agenda of all sectors within the city, to promote understanding and action to address inequity in health and to promote awareness of the interdependence of sectors and organisations and the need for stronger linkages for the improvement of health and quality of life.

The strategic and operational content of each phase within Belfast was developed within the WHO requirements for designated healthy cities and adjusted in consultation with public, voluntary and community organisations to meet the needs of the city.

Belfast Healthy Cities strategic priorities in Phase III have been to:

- place health at the centre of all public policy development;
- support communities to participate in decisions that affect their health and wellbeing;
- build capacity to promote action to tackle inequalities in health;
- promote information and stimulate debate on public health issues within the city.

Belfast has been an active contributor to a number of multi city action plans and thematic groups.

Strategic approach

In line with WHO requirements for Phase III, Belfast Healthy Cities has moved from an operational approach to a more strategic approach focusing on the city health development process, which had the primary role of providing a means to:

- build and mainstream strategic partnerships for health;
- develop a platform to encourage all sectors to focus their work on health and quality of life;
- test the concept of strategic integrated planning for health development within the city.

The process, which involved a major consultation exercise with communities across Belfast and the engagement of all sectors, took three years and resulted in the publication of *Planning for a Healthy City*, which outlines the intersectoral plans and actions for health development that were agreed by the organisations that make up Belfast Healthy Cities.⁴

After one year of the implementation phase, work is well underway to fulfil the objectives and actions of the plan. Examples of completed actions include the development and publication of a *Quality of Life Matrix* for use in assessing plans and the completion of the Belfast Seniorlinks website, together with the publication of a contacts directory

for older people. Full details of the work to date can be found in the *Planning for a Healthy City - One Year On* publication.⁵

Independent qualitative research into the planning process indicated that the process resulted in many positive outcomes, particularly in relation to the influence that it had within organisations. However, it is also clear from the research that integrated planning for health development remains an ambitious challenge within the current administrative and political infrastructure in Belfast.⁶ Belfast Healthy Cities is a WHO initiative, as opposed to a city or government initiative, which entails particular challenges to gain and maintain the commitment from statutory and other bodies.

Tackling inequalities

Another key priority area of work during this phase has been the capacity building programme, Equity and Health - Tackling Inequalities. The aim of this programme has been to develop key individuals from within the public, voluntary and community sector to promote action from within organisations to tackle inequalities in health. This programme was given additional support by the Eastern Health and Social Services Board, which allowed it to be offered to participants from within the Board's Investing for Health Partnership area. This programme also benefited significantly from the input of a number of cities from within the Healthy Cities European Network.

Many other activities have characterised the work of this phase, from ongoing work to develop a community health impact assessment tool to policy days, which allowed organisations from across the sectors to debate and formulate comments to help inform a number of consultation processes on policy development.

International networking

One of the key elements in the success of the Healthy Cities approach is the added benefits that cities can attain from being able to network with other cities internationally. The coming together of different perspectives and approaches on common themes can significantly enhance initiatives for health improvement and can often help reinforce confidence in an approach being adopted within a city.

Throughout the 15 years of Healthy Cities to date, Belfast has been an active contributor to a number of multi city action plans and thematic groups with a variety of individuals and organisations being involved. Examples include women's health, tobacco, Local Agenda 21, active living and healthy urban planning, all of which have had significant positive impacts on the development of policy and practice in the city.

One of the specific requirements for designation to Phase III was that successful cities

We have only scratched the surface of what still needs to be achieved to make the kind of improvements that we all want to see to people's health and quality of life.

should mentor a developing Healthy Cities project within the European Region. As a result, Belfast has been mentoring the development of a Healthy Cities approach in Bosnia. This work has also been supported by the Croatian and Hungarian Healthy City Networks and in September 2001 saw the launch of the Bosnian Healthy City Network by Dr Agis Tsouros from WHO. Work to support the development of Healthy Cities approaches in Bosnia continues with a number of Belfast Healthy Cities partners committed to assisting colleagues in Sarajevo move towards designated city status in Phase IV.

Conclusion

So why has the Healthy Cities approach engaged so many cities and towns globally? It is based on a sound method of intersectoral working based on community needs to achieve better health and quality of life outcomes. It is an approach that can be adapted to local circumstances and, because of the commitment to the European Network, there are many tools, case studies, etc. to support the development of projects. The sharing of experience within an international network, the development of approaches based on that international experience and the evaluation of outcomes on a European basis have underlined the credibility of a process that has shown real benefits for health development in many cities.

In Belfast, the Healthy Cities initiative has come a long way since the city was first designated in 1988. It was probably the first partnership for health in the city and its longevity owes much to the ongoing commitment, both from politicians and from the highest levels within partner organisations. However, despite its undoubted success to date, we have only scratched the surface of what still needs to be achieved to make the kind of improvements that we all want to see to people's health and quality of life.

Commitment from chief executives, Permanent Secretaries and politicians remains strong for the city to apply for redesignation to Phase IV of the initiative. The challenge for us as a partnership will be to take the requirements for Phase IV and to use the structured approach of the initiative to allow us within the city to develop our thinking, to add value to other initiatives and to develop and test new methods which have the potential to make the necessary improvements to health and quality of life.

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Joan Devlin has been Director of Belfast Healthy Cities since 1996 and has had responsibility for the operational development of the Healthy Cities approach and for promoting intersectoral working within the city.

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The WHO

and how of devising a global strategy

Community-based national programmes and regional networks underpin the efforts of the WHO in combating noncommunicable diseases. Global collaboration also is a tool being applied to the Global Strategy on Diet, Physical Activity and Health.

Introduction

The global role of the World Health Organization (WHO) in promoting public health is demonstrated by its development and establishment of a Global Strategy on Diet, Physical Activity and Health. The overall goal of the strategy is to improve public health through healthy eating and physical activity. It is being formulated through a consultation process within the framework of the renewed WHO strategy for the prevention and control of noncommunicable diseases (NCDs).

That strategy was adopted by the 53rd World Health Assembly (WHA) in May 2000 and highlights the WHO role of stimulating regional and international networking and strengthening community-based activities for the integrated prevention of the major NCDs, particularly in developing countries. The multidisciplinary and multisectoral approach as a governing idea of this global strategy is reflected also in the process for a Global Strategy on Diet, Physical Activity and Health.

Background

The World Health Organization, the United Nations specialised agency for health, was established on 7 April 1948. Its objective, as set out in its constitution, is the attainment by all peoples of the highest possible level of health - health being defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.¹

WHO is governed by 192 member states through the WHA, which charts the global course for

the organisation and its member states in dealing with major public health issues. WHO's Secretariat is headed by Director General Dr Gro Harlem Brundtland and is staffed by health professionals, other experts and support staff working at headquarters in Geneva, in the six regional offices and in individual countries. There are regional offices for Europe, Africa, Southeast Asia, the Americas, the Eastern Mediterranean and the Western Pacific. On taking up her position, Dr Brundtland set out the following four strategic directions for WHO's contribution to efforts to advance health at global and country level:

- reducing excess mortality, morbidity and disability, especially in poor and marginalised populations;
- promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes;
- developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair;
- framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.²

Global Strategy on Diet, Physical Activity and Health

Chronic diseases dominate the burden of disease in developed countries and now increasingly affect low- and middle-income countries. Concern about these trends led the 53rd WHA to adopt a resolution

endorsing Dr Brundtland's global strategy for prevention and control of NCDs. The strategy emphasised integrated prevention by targeting three main risk factors: tobacco, unhealthy diet and physical inactivity. Integrated NCD prevention and control is advanced through regional networks - CINDI (European region), CARMEN (American region), NANDI (African region), EMAN (Eastern Mediterranean region) and MOANA (Western Pacific region).

In May 2002 the 55th WHA recognised the importance of the framework for action on diet and physical activity within the integrated networking approach to prevention and control of NCDs. It requested the Director General to develop a Global Strategy on Diet, Physical Activity and Health in consultation with member states and the United Nations system. Dr Brundtland put the seriousness of the public health problem in context:

"Cardiovascular disease, cancers, diabetes, respiratory disease, obesity and other noncommunicable conditions now account for 59% of the 56.5 million global deaths annually, and almost half, or 45.9%, of the global burden of disease. The majority of chronic disease problems now occur in developing countries. Unhealthy diet, physical inactivity and tobacco use are among the leading causes.

*"To effect changes in diet and physical activity poses an enormous challenge. In an increasingly globalized and interdependent world, we believe WHO's goals can only be met through broader involvement with diverse stakeholders."*²

Responding to the WHA mandate for action, WHO has embarked on several focused initiatives to address the major risks for chronic diseases. The organisation is engaged in an 18-month process that will involve a broad and inclusive consultation, which will lead to the Global Strategy on Diet, Physical Activity and Health. The overall goal of the strategy will be to guide the development of actions at local, national and international levels that, when taken together, will lead to measurable improvements in risk factor levels with reduced disease and death rates due to chronic diseases related to diet and physical activity in populations.

The guiding principles of this process are:

- stronger evidence for policy: synthesise existing knowledge, science and interventions on the relationship between diet, physical activity and chronic disease;
- advocacy for policy change: inform decision-makers and stakeholders of the problem, determinants, interventions and policy needs;
- stakeholder involvement: agree on the roles of stakeholders in implementing the Global Strategy;
- a strategic framework for action: propose appropriately tailored policies and interventions for countries.³

This extensive, population-wide, prevention-based strategy will be presented to the WHA in 2004 and will become the strategic backbone for WHO and its member states to work together with other stakeholders in promoting global changes towards healthier diets and increased physical activity, to prevent chronic diseases and promote population health. In engaging constructively with all stakeholders in developing its global strategy, WHO believes that governments, health professionals, the food and advertising industries, and wider civil society should all contribute to making the healthy choices, both for diet and physical activity.

The overall goal of the strategy will be to guide the development of actions at local, national and international levels.

Multifaceted process

The causes of NCDs are complex and the response needs to be multifaceted and multi-institutional. The evidence is overwhelming that prevention is possible when sustained actions are directed both at individuals and families, as well as the broader social, economic and cultural determinants of NCDs. The scientific evidence is strong that a change in dietary habits and physical activity can powerfully influence risk factors such as obesity, high blood pressure, high cholesterol in populations.⁴

The benefits of behavioural interventions in reducing the rates of cardiovascular disease, cancers and diabetes in populations have been well-proven in countries such as Finland, Japan and Singapore. Cost-effective behavioural and pharmacological treatments for high blood pressure, diabetes and raised cholesterol have life-saving impacts and should be routinely implemented at the primary health care level. Dietary, physical activity and smoking cessation programmes should be integral to both the prevention and management of chronic diseases. Good health demands a 'life

course' approach to eating and physical activity that begins with pre-pregnancy, includes breast feeding, and extends to old age.

In developing the strategy, the WHO is considering recommendations in the report prepared by the joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases, which assembled and reviewed the latest scientific evidence on diet, physical activity, and prevention of chronic diseases. This specifically discusses obesity, cardiovascular diseases, cancer, diabetes, dental diseases and osteoporosis, and provides recommendations on population nutrient goals.

Consultation with stakeholders

The process of developing the Global Strategy on Diet, Physical Activity and Health through consultation with stakeholders will rely on a well-informed public. Countries and their peoples must be alerted to the health problems caused by unhealthy diets and physical inactivity, of the devastating social and economic outcomes of chronic conditions resulting from these risk factors and to the proven prevention interventions. The involvement of different stakeholders will allow an opportunity to ensure that this information is adequately provided to decision-makers, the public and, above all, the participants of the process. Communication of this information, therefore, will be an essential facet in the process leading to a strategy document. WHO is addressing this need to inform, convince and mobilise stakeholders continuously in the course of the development of the strategy.

The 55th WHA resolution requested that the strategy be developed in consultation with member states, bodies of the UN and professional organisations. It also requested the Director General to strengthen collaboration with other partners including intergovernmental organisations and the private sector. In response to this, the WHO Noncommunicable Diseases and Mental Health Cluster (NMH) has embarked on a consultation process with these stakeholders. The strategic framework for action involves five tracks:

- regional consultations with member states;
- UN agency consultation, eg World Bank, UNICEF, World Trade Organization;
- consultation with civil society organisations with special interest in health, nutrition and physical activity;
- consultation with the private sector, eg food, sport and advertising industries;
- virtual public consultation through the Internet.³

The global nature of the desire for common ground for collaboration is illustrated by track 1. The purpose of the regional consultations with member states is for countries in each region to provide information on the extent of the problem associated with diet, physical activity and chronic disease, and

appropriate prevention strategies for their particular countries. The consultation will focus on the discussion of national, regional and global interventions that will be effective within individual countries and that will take account of national, social, cultural and economic realities. Regional differences, common concerns, or global consensus, will be noted and serve as the basis for the development of the global strategy.

Conclusion

In pursuing its activities, the WHO adopts a global view - demonstrated in the range of global strategies developed and established down the years. One such strategy is the Global Strategy on NCDs, adopted in 2000. Within the framework of this strategy, another is being developed - a Global Strategy on Diet, Physical Activity and Health. The development and implementation of the strategy complements and reinforces work already in progress under WHO leadership in relation to infant and child nutrition, child development, healthy ageing and tobacco control. Integral to the strategies is broadly based international action spanning many health systems and stakeholders. Partnerships and networks within a global context are key to the process.

This article was compiled by the Health Promotion Agency.

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The **role** of the **EU** in **health** promotion

The EU public health strategy aims to achieve a 'Europe of Health' that can be more than the sum of its national parts, as **David Byrne** explains.

Introduction

Europe's citizens expect the European Union (EU) to be good for their health. They expect it to play an active role in protecting them from health threats and, if possible, to contribute to health improvements. At the same time, though, citizens are deeply attached to their national healthcare systems and the values they embody. There is no appetite for creating a centralised European healthcare system run from Brussels - least of all from my part. The EU's public health strategy therefore aims to:

- develop an EU role in health that supports and complements the member states;
- integrate health into all EU policies.

I will give a brief overview of both these facets of EU health policy, as well as the forces that are driving the development of our health strategy. I will then explore the EU's role in health promotion.

Overview of EU health strategy

Three central objectives of the EU's health strategy are to:

- develop EU-level health information and knowledge;
- enhance the EU's capability to respond to health threats;
- address the determinants of ill-health.

These central objectives were spelled out in a strategy document adopted by the European Commission in May 2000.¹ In March this year I launched an Action Programme that will spend €312 million between now and 2008 on achieving these objectives.² In concrete terms, this means we will develop, and help to finance, better and more comparable EU-wide gathering of health data. We will network experts from around the EU so as to

pool their expertise on health threats. And we will be funding EU-level projects and networks, run by civil society and the public sector, to address the causes of ill-health.

Integrating health considerations into all areas of EU policy is, of course, one of the key tools for achieving the objectives of our strategy.

Integrating health into all EU policies

The European Commission, and indeed the European Parliament and Council, are committed to ensuring a high level of health protection in all EU policies. What this means is that in areas such as EU food policy, health protection takes priority over other considerations. In 2000, I launched an overhaul of the EU food safety legislation that has toughened up an already demanding Europe-wide set of rules. This integration of health into agricultural and food policies was taken a stage further in the reform of the Common Agricultural Policy agreed by the EU's Agriculture Council on 26 June this year. In future, the EU's financial support to farmers will be linked more to the quality of food production - in terms of food safety, animal welfare and sustainable agriculture - rather than to the quantity of production.³ The mainstreaming of health priorities can also be seen in the way the EU regulates its internal market, eg there is EU legislation requiring high standards of safety for pharmaceuticals, medical devices and, indeed, consumer goods circulating in the EU's internal market.

Tobacco products in the EU internal market are, I am glad to say, subject to the toughest regulation of all. An EU directive passed in 2001 has tightened up maximum limits for tar, nicotine and carbon monoxide in cigarettes and mandated high

visibility health warnings to cover 30% of the front of packs (these new warnings will be appearing Europe-wide this Autumn). A directive agreed in 2002 will ban tobacco advertising in the print media, on radio and on the Internet by 2005. Tobacco advertising on television was banned under a 1989 EU directive.⁴

What is driving the EU's strategy?

Public health goes global

In September 2000 I spoke about the EU health strategy at the first All Ireland Health Conference. I told my audience in Ballyconnell that:

"Now, more than ever, health policy and the development of healthcare have to be seen in an international context. We are all of course painfully aware that communicable diseases, food-borne infections and the health effects of pollution do not respect national borders. And protecting public health from these hazards therefore requires effective international cooperation".⁵

The pace of this globalisation has accelerated since then. In 2001 we had anthrax attacks in America and, in 2003, the outbreak of the Severe Acute Respiratory Syndrome (SARS) in east Asia. These incidents, as well as others, underline that health threats in our era are increasingly international. SARS, for example, spread from a small village in China to North America, Asia and Europe in a matter of weeks. In a European Union where frontiers have been abolished, and where millions of people daily cross internal borders, a serious infectious disease outbreak in one member state could very quickly become a concern of the whole EU.

SARS has demonstrated the value of Europe's Communicable Disease Network in monitoring the spread of disease outbreaks. The shortcomings of the existing set-up were evident too, though. In particular, there is no EU-level body that can give authoritative scientific advice on new health threats, and the EU has scarcely any legal power to act to contain human disease outbreaks. That is why I want to create a small, but influential, European Centre for Disease Prevention and Control (ECDC) to network the EU's health expertise. The ECDC would be a source of authoritative advice on health threats and could make recommendations for both EU and national control measures. I would like to see it up and running by 2005.

Healthcare cooperation in the EU

Each health system in Europe is unique, and the national values they embody must be respected. That said, though, all face similar challenges, like coping with ageing populations, rising costs and patients unwilling to settle for second-best. As Northern Ireland and the Republic of Ireland have been demonstrating for a number of years, cross-border cooperating between healthcare systems can help member states meet these challenges. We see this, too, in other parts of the EU, eg Denmark has reduced its waiting

lists by taking advantage of empty hospital beds in Germany. We need to work together to develop a shared European vision for health systems that can help us realise the potential benefits of collaboration while respecting the responsibility of member states for their systems. To achieve this, together with my colleague Anna Diamantopoulou, Commissioner for Employment and Social Affairs, I launched an informal process of reflection on patient mobility and healthcare developments. This brings together health ministers plus representatives of health professionals and other stakeholders, and we aim to produce conclusions by the end of 2003.

Health promotion at EU level

The EU's 2003-2008 Public Health Action Programme has some €16 million–€18 million to spend each year funding projects and networks addressing the determinants of ill-health. Similar amounts will be spent each year on the Health Information and Health Threats strands of the programme.⁶ The determinants are grouped under four headings:

- lifestyle (tobacco, alcohol, nutrition and physical activity, drug abuse, mental health);
- socioeconomics (health inequalities);
- environment (health and environment, injury prevention, electromagnetic fields);
- genetics and screening.

Organisations involved in health promotion will be key partners for the Commission in building successful projects to address these determinants. Health promotion professionals will also be needed under the Health Information and Knowledge strand of the new programme. The programme recognises patients and the general public - along with health professionals and policy makers - as one of the audiences that needs to be able to access health information produced at EU level.

We are well aware that expertise we need for successful projects is scattered all around Europe. The value of EU level programmes is to make a virtue of Europe's diversity. Multi-country, multidisciplinary projects can allow us to compare different approaches, exchange ideas and, through this, develop more effective tools. We have received more than 300 project proposals in response to a call for projects that closed in May 2003. The Commission will be making decisions on which of these it will finance towards the end of this year.

The work done under the new programme will build on the achievements of the previous programme. Between March 1996 and the end of 2002 the European Commission spent about €7 million each year funding studies, training activities, innovative projects and identification of best practice in the field of health promotion. Health determinants addressed under the 1996-2002 Health Promotion programme were alcohol, mental health, nutrition and physical activity - as well as cross cutting issues such as health inequalities. It is also worth

recalling that most of the previous programmes - Cancer, AIDS and Communicable Diseases, Injury Prevention, Pollution Related Disease, Rare Diseases, Drug Prevention, Health Monitoring - also addressed health promotion issues in their specific area.

EU-level networks

The previous programmes produced valuable results. Not least of these was interconnecting Europe's health promotion expertise via the sponsoring of EU-level networks such as:

- European Network for Health Promotion Agencies (ENHPA)
- European Network for Mental Health Promotion (ENMHP)
- European Network of Megapoles (ENMP)
- European Network for Health Promoting Schools (ENHPS)
- European Network for Workplace Health Promotion (ENWHP)
- European Network on Smoking Prevention (ENSP)
- European Network for Young People and Tobacco (ENYPAT)
- European Public Health Alliance (EPHA)
- European Network for a Master in Public Health (ENMPH)

The EU's 'Feel Free to Say No' campaign

'Feel Free to Say No' is a Europe-wide campaign financed by the European Commission that aims to break the link between smoking and glamour. The campaign presents young people with "cool" role models who do not smoke and positions non-smoking as a fashionable lifestyle choice. I launched the campaign on 31 May 2002 at an event co-hosted by the European Football Federation, UEFA. Over the summer of 2002 the EU's 'Feel Free to Say No' campaign ran a series of television advertisements linked to the 2002 World Cup and featuring European football players. In November and December 2002 the campaign ran a second wave of television spots and pre-film cinema advertising, this time featuring stars from the world of pop music. During 2003 the campaign is targeting youth magazines as a medium, and having a campaign truck touring throughout Europe.

Much rides on the performance of the EU's 'Feel Free to Say No' campaign. The EU is faced with rising rates of teenage smoking in all member states: roughly one in three young people in the EU smokes regularly, according to the latest EU-wide opinion poll.^{7,8} Given what we know about smoking in teenage years being the key determinant for smoking in later life, reversing this trend must be one of the key public health challenges for the EU. Beyond this immediate health goal, 'Feel Free to Say No' also provides a potential model for EU cooperation in running other major health promotion activities.

With EU backing, the 'Feel Free to Say No' campaign has been able to develop highly professional materials and "social marketing" concepts that partner organisations around the

member states can then access and adapt. European-level campaigning partnerships with UEFA, the Europe-wide television channels MTV and Eurosport as well as with footballers and pop stars have also benefited partners in the member states. In other words, a coordinated campaign with EU-level backing can be bigger and have a higher profile than a series of individual national campaigns.

Conclusion

Health promotion, like healthcare, remains primarily a member state responsibility. I do not see this changing. What is changing, though, both in the worlds of healthcare and health promotion is the growing realisation of the benefits of cooperation across national borders. The European Commission has been supporting this cooperation since the 1990s and will continue to support it under its 2003-2008 Health Action Programme. By working together, pooling our expertise and sharing our experiences, the 'Europe of Health' can be more than the sum of its national parts.

David Byrne was appointed in September 1999 as the European Commissioner for Health and Consumer Protection, with particular responsibility for Food Safety, Public Health and Consumer Protection.

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Collaboration

the cornerstone of

CINDI activities

CINDI works towards reducing noncommunicable diseases by integrating and coordinating health initiatives of member countries.

Introduction

Established in the early 1980s, CINDI (Countrywide Integrated Noncommunicable Diseases Intervention) is a programme of the World Health Organization's (WHO) Regional Office for Europe. Through the establishment of collaborative mechanisms and methodologies, CINDI seeks to integrate and coordinate health initiatives of member countries to prevent and control noncommunicable diseases (NCDs), focusing especially on cardiovascular disease and cancer. The rationale behind this programme is that by avoiding the duplication of efforts in different countries, resources will be used more efficiently. CINDI also provides a bridge between public health systems throughout Europe, including those in eastern and central Europe which are experiencing social and economic change.

CINDI works to improve health and the quality of life in communities by reducing premature death, disease and disability from major NCDs. Its objectives are to enable member states:

- to develop measures for integrated disease prevention and health promotion as part of their primary healthcare systems in order to reduce morbidity by reducing common risk factors;
- to establish effective collaborative mechanisms and methodologies to implement these measures.

Northern Ireland and CINDI

Northern Ireland has been a member of CINDI since 1989 and intends to renew its formal attachment to the programme in October 2004. The Health Promotion Agency (HPA) has been the main point of contact with CINDI and its member countries, not just for Northern Ireland but for the UK. Currently, the Chief Executive of the HPA is a member of the overall management committee and has contributed

to a number of policy and programme documents. Within Northern Ireland the HPA would see its contributions to a wide range of public health programmes and initiatives as being linked to CINDI's development. The surveys of health and health behaviours are comparable with CINDI data.

The CINDI Programme

NCDs are a set of chronic diseases of major public health importance, including cardiovascular disease, cancer, chronic respiratory diseases, accidents, mental disorders and diabetes. The aim of the CINDI Programme is to reduce modifiable risk factors, eg smoking, high blood pressure, raised blood cholesterol level and obesity, which are associated with NCDs. Two out of three adults including those in Northern Ireland have at least one such risk factor.

These risk factors and unhealthy behaviours are more prevalent in poor and disadvantaged populations and therefore are responsible for widening the gap in life expectancy, mortality and quality of life among and within countries in the European region. WHO recognises NCD prevention and control as a major health issue that needs to be comprehensively addressed.

CINDI provides participating countries with an integrated approach to activities to prevent and control risk factors and to address their social and environmental determinants. The concept of an integrated approach towards the prevention and control of NCDs implies recognition that a number of risk factors are common to major noncommunicable disease and are related to lifestyle. The implementation of the concept combines community-based strategy directed towards a healthy lifestyle with high risk strategy aimed at improving risk profile through preventive measures at individual level.

Pre-1990, a new outlook on the delivery and structure of health care known as the "new public health approach" emerged. It emphasised a balance between individually-based prevention activities and community-based health promotion efforts. This required cooperation between the health and non-health sectors so that the many societal issues which contribute to the development of NCDs could be addressed comprehensively. Adopting this approach presented challenges to the CINDI network which had member countries with varying political, economic, and cultural structures.

Twenty eight countries are now members of the CINDI Programme: Austria, Belarus, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Estonia, Finland, Germany, Hungary, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Malta, Republic of Moldova (became a CINDI participating country in 2002), Poland, Portugal, Romania, Russian Federation, Slovakia, Slovenia, Spain (Catalonia), Turkmenistan, Ukraine and the United Kingdom (Northern Ireland). Azerbaijan, Bosnia and Herzegovina and Georgia are in the process of joining the network.

CINDI countries work towards reducing NCDs by:

- combining efforts to promote health and prevent disease;
- promoting collaboration between the different sectors;
- encouraging community involvement;
- enhancing the role of health professionals;
- making the best use of existing resources;
- implementing evidence-based preventive practice;
- epidemiological monitoring;
- evaluating of programmes;
- continuing established health policies.

CINDI demonstration areas

CINDI puts existing knowledge in participating countries to use - first in demonstration projects in small areas and then countrywide. In addition, its member countries form a network in which they can share their experience in developing their national programmes. Indeed, CINDI has been adopted by WHO as the model for new networks in other regions such as South America and the Far East.

The programmes implemented in demonstration areas are linked to relevant national health policies, such as legislation on smoking or practice guidelines for preventive medicine. In these areas, intervention measures are monitored and health trends regularly evaluated.

Community involvement at all levels of this process is encouraged and promoted. The programme works closely with individuals, health professionals, statutory and voluntary organisations, education, industry, agriculture and other sectors and

policy makers. Such collaboration is vital to the work of the programme because it is only through multisectoral action that the best health policies can be developed and implemented. Experience gained in several national demonstration projects such as the North Karelia project in Finland or the Veliko Turnovo project in Bulgaria, shows that such work can be a powerful tool for the development of national policy.



Programme management

The CINDI Programme is managed by the Chronic Disease Prevention Programme in the WHO Regional Office for Europe (www.euro.who.int), the Council of Programme Directors, and the Programme Management Committee. The WHO Euro office acts as the coordinating centre and provides the technical coordination of the core programme. The Council of

Programme Directors is the highest policy and decision-making body for the programme and meets annually. The Programme Management Committee assists WHO in the management and administration of the programme, and institutes and monitors measures for quality and control of programme data.

CINDI has a standardised methodology and comprehensive system for monitoring and evaluating the programme, at both national and demonstration-area levels. The CINDI protocol and guidelines specify the core indicators and the methods to be used for measuring them for international collaboration. Monitoring and evaluation are carried out at regular intervals using agreed indicators and applying an agreed methodology for epidemiological surveys.

CINDI seeks to integrate and coordinate health initiatives of member countries to prevent and control NCDs through the establishment of collaborative mechanisms and methodologies.

Research and information

The CINDI Health Monitor is a new tool to record and analyse health behaviour and lifestyle-related risk factors in CINDI demonstration areas, regional or national level. Its development is supported by the National Public Health Institute (KTL), Finland, and the Centers for Disease Control and Prevention (CDC), USA. The methodology of the survey is based on the experience of the Finbalt Health Monitor project.

In 1999-2002, 32 surveys were conducted in 26 CINDI-participating countries. Data was collected by using a postal questionnaire or by a telephone or personal interview. Information covered smoking, food habits, physical activity, alcohol intake and personal

assessment of health of people aged 25-64. Preliminary analysis of the pilot phase of the project indicates that it is feasible to implement such a survey across CINDI-participating countries, and international comparison of information on health behaviour is possible.

Capacity building

A CINDI training course in Chronic Disease Prevention took place in Schruns, Austria, in October 2002 with participation from 30 countries. This seminar was a joint effort of the WHO CINDI Programme; CDC; St Louis University, School of Public Health, St Louis, USA; School of Public Health, USA; CINDI-Austria; CINDI-Finland; and CINDI-Lithuania. The course provided theoretical knowledge and improved practical skills on evidence-based NCD prevention and health promotion and gave a fresh impetus, cohesion and motivation to the further implementation and development of CINDI in participating countries.

A training seminar on community-based health promotion and chronic diseases prevention was hosted by the National Public Health Institute, Finland, in February 2002. The CINDI Winter School was the fifth training course at which CINDI experience on the implementation of an integrated approach to NCD prevention and control was presented. The WHO global strategy for NCD prevention and control was introduced and practical guidance on national NCD control programmes provided.

Various programmes were carried out at country level:

- in Canada, the G8 Promoting Heart Health telematics project allows access, through the Internet, to practical knowledge and experience on the implementation of heart health interventions among selected G8 countries (www.med.mun.ca/chhdbc);
- a Healthy Nutrition Action Plan 2002-2007 was developed in Latvia;
- under the umbrella of the joint CINDI/EuroPharm Forum project on hypertension management at pharmacies, a pilot project to enhance collaboration between GPs and pharmacists on the primary prevention of NCD was launched in Germany;
- the Quit & Win smoking cessation campaigns, coordinated by the KTL in Finland since 1994, continued in participating countries.

Conclusion

CINDI seeks to integrate and coordinate health initiatives of member countries to prevent and control NCDs through the establishment of collaborative mechanisms and methodologies. This concept of an integrated approach towards the prevention and control of NCDs illustrates the role of international collaboration in promoting public health.

This article was compiled by the Health Promotion Agency.

Spaghetti on the menu

EU health policy networking is more like a bowl of spaghetti than a streamlined model of participation and cooperation, argues Clive Needle.

Introduction

An increasing feature of my work in Brussels is to organise study visits by groups of NHS professionals. Nursing leaders, trust directors, regional bodies and primary care managers have been the most prominent students, and the King's Fund of London the most active organisers. As part of the briefings I usually draw them an organigram of European Union (EU) networks: a bowl of spaghetti! For, while there are some splendid initiatives that I shall describe, the general experience has been haphazard and competitive rather than cooperative.

Undoubtedly, the potential EU role in public health policy development is more overlooked than it deserves. After 30 years of common market growth and only staccato recognition of public health relevance, the first legal basis for a funded programme came after the Maastricht Treaty during the 1990s. The small, barely visible programmes that resulted eventually included health promotion and monitoring, HIV/AIDS and cancers, accidents, rare and pollution-related diseases.

Hotchpotch of ministries

In each case, the European Commission (EC), which

is charged with administering the programmes, sought to identify what it called "networks", mostly by contacting national governments and facilitating a hotchpotch of ministries, academics and nongovernmental organisations (NGOs). While some other EC Directorates, such as those responsible for environment or overseas development, used standard models of networking, the new health officials perhaps had to be more pragmatic and funded a disparate range of groupings. That inevitably has resulted in some very uneven outputs and outcomes. It also means that few people at the sharp end of health policy implementation know much about the work that has been done.

When it became time to introduce a new programme, widespread consultation showed a demand for sharing of transferable lessons and national implementation. There was also considerable consternation about "unhealthy" EU policies, from road building to tobacco production subsidies to economic perpetuation of inequalities, which rather undermined credible activities in the field.

Although much delayed and hugely under-funded - about €50 million per year for public health against €950 million for tobacco growers -

the new six year integrated programme promises much in the field of information, addressing health threats and determinants: lifestyles, environmental, demographic and genetic. But will networking and delivery be improved?

Obese Europe

The diplomatically negotiated texts suggest it should. Already in the field of health information, indicators and data collection, national observatories are being more engaged than hitherto. A new initiative on alcohol will try to bridge the gap between Scandinavian abolitionists and Mediterranean aficionados, and a new approach to nutrition and physical activity will try to take some flesh off the bones of the increasingly obese Europe, for example.

Tackling those Common Agricultural Policy (CAP) fats and sugar subsidies is perhaps more likely than before, but health promoters will not underestimate the powers of multinational food industries despite the combined clout of the EU. Surely the way forward is by coordinated evidence-based policy and advocacy, not more complex discussion groups?

The really interesting straws in the winds from Europe come from reactionary changes rather than positive developments. As anthrax scares hit America in the wake of terrorist attacks, the legal requirement for the EU to ensure a high level of human health protection kicked in. The first EU Health and Consumer Protection Commissioner, David Byrne from Ireland, has linked strongly with the WHO and USA to toughen up continental regulations and networks of public health experts on communicable diseases.

Executive agency

His bio-terrorism task force and a programme unit overseeing such actions are expected to be upgraded to a full agency on FDA lines as soon as practicable. It will be joined by an executive agency, run by the EC but with clear national inputs, to pull together the threads of general health data collection, despite predictable reservations by certain countries less than keen that citizens might compare health status and systems information.

Meanwhile, senior health ministers, many previously uninterested in EU issues, have been energised by increasing streams of patients crossing borders for treatments, products and services, backed by court decisions that when a single market was set up in the 1980s it gave them individual rights that in some cases outweigh the collective rights of governments to alone organise national systems. Sensitive issues such as clinical governance, professional and patient mobility, centres of excellence and demographic pressures are high on coming EU agendas.

Many of those patients are forming groups that network to increasing effect across Europe, and the EC recently recognised that by funding a

'Patients' Forum' to seek a collective input to policy making. That is not without controversy, given the previous interest of the pharmaceutical sector in the lobbying activities of some groups, eg on clinical trials, patenting and research funding policies.

Belfast to Budapest

A discussion paper is keenly anticipated from Commissioner Byrne on where all this will take the EU strategically, at a time when the current 15 EU states are enlarging to 25, from Baltic to Aegean and Belfast to Budapest, with massive new public health challenges. But where will that leave those trail-blazing few who advocated for a European approach to public health and health promotion in the last quarter of the previous century and who have developed their varying networks to keep that vision alive?

Frankly, the future looks fragile without some real commitment from public bodies in the field, unless you believe in fairy godmothers or generous philanthropists and, given the relative prosperity of western Europe where a cow gets more subsidy per day than most people earn in a month in Africa, that is unlikely. But there are some good examples worth sustaining.

The foremost global network in the field of health promotion, the International Union for Health Promotion and Education (IUHPE), played a key role in setting up the European Network of Health Promotion Agencies (ENHPA) in 1996, with seed corn funding from the EC. This grew to include all EU member state national agencies plus as many from other states. It included the Health Promotion Agency for Northern Ireland (HPA), where Dr Brian Gaffney and his colleagues have made valuable contributions to its work on inequalities and the establishment of constructive links at organisational level that complement initiatives under the IUHPE umbrella.

EuroHealthNet

But the reliance on EC funding had drawbacks and, with the introduction of the new EU health action programme at the beginning of 2003, it was decided to begin a new independent organisation. Already the network had set up an innovative website, www.eurohealthnet.org, operated from its Brussels offices, which aimed not only to showcase its own work but to highlight relevant activities of others and disseminate both national and EU health promotion policies generally. This site provided a new name for the network: EuroHealthNet.

The network will include all previous ENHPA members, but now allow participation by other national and regional public bodies responsible for health promotion and disease prevention. At its inaugural General Assembly it was agreed to prioritise work on five broad policy areas:

- equity (including health inequalities and social exclusion);
- evidence and effectiveness;

- older people;
- young children;
- CAP reform.

Project proposals are being submitted to EC Directorates in each field, but crucially the participating agencies are undertaking joint work irrespective of EC support. In addition, the network will continue to support initiatives by the EC and WHO to develop health impact assessment implementation, and has just helped the National Assembly for Wales to publish a useful summary of the situation.

Networks

All networks claim they fulfil functions such as advocacy and dissemination, and EuroHealthNet is no exception. But while it is a good example of an organisational model welcomed within the EU, it is not the only vehicle for everyone seeking involvement at EU levels. There are several unofficial categories of network that may be identified:

Professional

The European Public Health Association (EUPHA) is the independent scientific and professional voice for public health for over 9,000 experts, and can be contacted via www.eupha.org

The European Health Management Association (EHMA) links academics and practising managers in health services from its Dublin office. Its authoritative input into systems and services policies can be accessed via www.ehma.org

Most specialist professions and national associations are represented in Brussels, eg by the Standing Committee of Nurses (PCN Europe) or their equivalent for doctors. Public service trades unions are also well organised and influential.

Nongovernmental

The European Public Health Alliance (EPHA) has just celebrated its 10th anniversary of networking national NGOs and European groups campaigning for public health improvements. Its magazine *Update* is a critical source of information on EU public health policy, as is its website www.ephah.org

Specialist

There are numerous networks acting on specific determinants, settings or conditions, some of whom coordinate lobbying and activities with EPHA. Among those who have worked in partnership with EuroHealthNet are:

- anti tobacco - ENSP (www.ensp.org) which links national coalitions and European networks on tobacco control, smoking prevention etc which have formed the most significant part of EU health-related legislation in recent years;
- cardiovascular - European Heart Network (www.ehnheart.org) working on a cross-sectoral basis on determinants;

- mental health - Mental Health Europe links organisations on the basis that "there is no health without mental health", a policy area largely disregarded by the EU until Commissioner Byrne's arrival coincided with strong advocacy from Finland;
- workplace - the European Workplace Health Promotion Network operates from Germany from a strong EU legal basis of health and safety (www.enwhp.org);
- schools - the European Health Promoting Schools network, stretching far beyond EU boundaries from its base at WHO Copenhagen, but significantly funded by EC programmes.

Research framework

That gives just a flavour of the plethora of opportunities for participation. I have not mentioned almost 400 project applications received for the new EC Health Action Programme, or the 15,000 expressions of interest submitted for the new Research Framework which includes public health, but that gives an indication of the growth of interest.

Most practical information on EC public health programmes, policies and personnel can be found within the public health section of the vast official site www.europa.eu.int, although do not expect critical analysis. The discussions of the newly created EC Health Policy Forum, a facilitated consultative body of 50 leading NGOs, can also be accessed via that source.

The next phase of EU health policy networking should be about expansion, transferable learning and implementation, using the advanced communications tools that have become available in the past decade. After that it looks increasingly likely that, although no one is suggesting a European Health Service, the scale of common problems will naturally demand comparisons and interventions across borders. With that inevitably will come regulation and executive agencies to bolster the voluntary cooperation that is the current norm.

Conclusion

Perhaps if I am still drawing my organigram to students by the end of this decade, I will be presenting a streamlined model of participation and cooperation, but somehow I suspect spaghetti will still be on the menu!

Clive Needle is Director of EuroHealthNet at its Brussels office. He is also an independent public policy adviser working from the east of England, a region he represented in the European Parliament 1994-99.

Equity in health at the heart of all we do

The approach of the International Union for Health Promotion and Education to international collaboration emphasises project work in addition to knowledge and capacity building, networking and advocacy.

Introduction

The International Union for Health Promotion and Education (IUHPE) is a global, independent, professional organisation of about 2,000 members from 90 countries. The IUHPE, which celebrated its 50th birthday in 2001, has the mission to improve the quality and effectiveness of health promotion, and to strive for the achievement of equity in health between and within countries.

The IUHPE draws its strength and authority from the quality and commitment of its diverse membership, including government agencies, universities, nongovernmental organisations, and individuals. The IUHPE decentralises its activity through regional offices on every continent. It works in close cooperation with major intergovernmental and nongovernmental organisations to influence and facilitate the development of health promotion strategies and projects.

Coordinated from its headquarters in Paris, the IUHPE undertakes and publishes health promotion effectiveness reviews. It supports a family of three print journals and one online journal. It conducts global and regional health promotion conferences. It mounts and conducts advocacy campaigns. It conducts short courses, seminars and symposiums for workforce development. It undertakes applied research and education projects in partnership with organisations such as the US Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO).

Collaboration projects

To illustrate the IUHPE's approach to developing international collaboration, a brief review of selected major IUHPE international collaboration projects is presented below.

The Health Promotion Journals Equity Project (HPJEP) initiated in July 2001 at a joint meeting between members of the editorial boards of the IUHPE "family of journals" during the 17th World Conference on Health Promotion and Health Education in Paris. Coordinated by the Editor in Chief of *Promotion & Education*, HPJEP currently involves *Promotion & Education* along with *Reviews of Health Promotion &*

Education Online, *Health Education Research* and *Health Promotion International*, and is most recently joined by the *International Journal of Mental Health Promotion*. The overall aim of the project is to address equity in relation to access to journals and their content, and publication.

The second strand arose from concern about the dominance of articles in English in the literature generally and within systematic reviews and the difficulty of non-English speaking authors getting their work published in Anglophone journals. The project has addressed various issues related to accessing the journals' content including establishing more equitable subscription rates for readers from developing countries and increasing the availability of free access to the journals' contents via the Internet.

The Global Programme on Health Promotion Effectiveness is coordinated by the IUHPE, in collaboration with WHO, and supported by the African Medical and Research Foundation; the Australian International Health Institute; Health Canada; the Health Development Agency, England; Health Promotion Switzerland; the Netherlands Institute for Health Promotion and Disease Prevention; the US Centers for Disease Control and Prevention (an agency of the Department of Health and Human Services); and the Voluntary Health Association of India, among other partners.

In 1999, the IUHPE published a unique set of books, *The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe*, with funding and support from the European Commission and the US CDC. The project assembled experts from the IUHPE's global, professional network, together with high-level politicians and media and communications experts, to review evidence of health promotion effectiveness, concentrating on its practical outcomes. The active participation of politicians helped the academicians understand how to better communicate effectively to a non-scientific audience. The books address not only health impacts of effective health promotion, but also economic, social and political impacts. They have become the most sought-after references in the field and have mobilised interest in similar reviews around the globe.

Sustainable approach

The IUHPE has decided, therefore, to launch a well coordinated, three year global project in collaboration with the WHO, the US CDC and other partners, that will undertake ongoing review and dissemination of evidence, include evidence from the non-English literature, and ongoing specific activities which address agreed priorities.

The principal challenge in the continuation of the project is to develop a sustainable approach with adaptations suitable to different regional needs and maintain the high quality for which the initial work is recognised. Thus, in each of the IUHPE regions, plans are in place to develop a review-and-analysis process of needs and existing resources wherein a selected group of high level professionals is collaborating on the design of an appropriate programme for the region in question.

The Francophone Africa Seminar on Media and Tobacco is a multi-partner initiative involving many International Organisations [WHO/Headquarters and AFRO, IUHPE, Francophone International Network of Health Promotion (REFIPS), International Union Against Cancer (IACC), the Observatory of Tobacco in Francophone Africa (OTAF), the European Network for Smoking Prevention (ENSP)], national organisations (CDC's Office on Smoking and Health, Canadian Association of Public Health, French League Against Cancer, Quebec Coalition Against Tobacco), influential experts, and an international press agency (Syfia International) and international radio (Radio France International), that cover all Francophone African countries. It is led and coordinated by the IUHPE headquarters.

The intention is to create a long term force of collaboration between media and health promotion professionals, as a force of resistance against the tobacco industry strategies and tactics. This involves research of data and facts; mobilisation and catalysis of media and health promotion professionals as well as of a broad range of African and international partners through meetings, seminars, conferences and publications; and capacity-building activities to improve African media and health professionals' ability to play their role in the fight against tobacco, and develop policy measures and public health regulations which can blunt the tobacco industry's efforts.

Broadly-based partnerships

World Conference on Health Promotion and Health Education

The 18th World Conference on Health Promotion and Health Education of the IUHPE (Melbourne, Australia, 26-30 April 2004) is organised in conjunction with the Australian Health Promotion Association, the Public Health Association of Australia and the Health Promoting Schools Association of Australia. The conference title 'Valuing diversity, reshaping power: exploring pathways for health and wellbeing', highlights the need for broadly-based partnership in health development if the global changes and

challenges are to be addressed through health promotion.

The conference aims to bring together the diverse international membership of IUHPE with familiar and new partners for health promotion, recognising that the mobilisation of leadership and action among policymakers, field practitioners and researchers is essential to drive and sustain the type and scale of advocacy and action needed to achieve priority health issues such as those identified in the Global Burden of Disease Study, the UN Millennium Development Goals and in the WHO 2002 Report.

This conference will provide state-of-the-art information across a range of health areas, health promotion, methodologies, population groups and settings and will provide an excellent opportunity for organisations to showcase their programmes and projects before a global audience. It will be attended by some 2,000 participants who will have the chance to engage with highly qualified presenters, to build new knowledge and skills and to network and socialise with international and local practitioners, researchers, educators, government representatives and ministers from a variety of portfolios and countries. The site of the conference www.health2004.com.au is the best resource for everything one needs to know about the event, such as programme details.

HP Source

The Comprehensive Database of Health Promotion Infrastructures, Policy, and Practice (known as HP Source) has worked in partnership with academic institutions and government bodies to unite, for the first time in a web-based database, comprehensive data on Health Promotion Infrastructures, Policies and Practices across the European Region. This database contains systematically organised details of health promotion policy, infrastructure and practices. It became available online (<http://www.caint.com/HP-source.net/frontend/>) in July and, like any website, it is accessible to all of us who have access to a computer, but is primarily aimed at national level public health institutions, international public health organisations and policy makers. The IUHPE is a major partner in HP Source, with responsibility to assist the partnership expand from its present European confines to all parts of the world.

Conclusion

The projects described above do not represent the entire project portfolio of the IUHPE. However, this limited presentation does help illustrate the IUHPE approach to international collaboration, which emphasises project work in addition to knowledge and capacity-building, networking and advocacy, with the goal of equity in health at the heart of all we do.

This article was compiled by Catherine Jones, Marie-Claude Lamarre and Maurice B Mittelmark from the International Union for Health Promotion and Education, Vanves, France. To learn more about the IUHPE, visit www.iuhpe.org

Saving lives and sharing learning

Health, as much as disease, crosses and is created across many geographic and political boundaries. **Chris Brookes** outlines the role of the HDA in developing international collaboration.

Introduction

In the following article I would like to articulate why, and how, the Health Development Agency (HDA) has been involved in three different kinds of international collaboration - collaboration in relation to the European Union (EU) institutions, technical assistance in accession countries, and sharing international learning.

The HDA was set up under the auspices of 'Saving lives: Our healthier nation', as the national public health agency for England. Its function is to develop the evidence base for effective public health, to develop the capacity of the wider public health

workforce, and is currently focusing on the process of getting evidence into practice, particularly to contribute to tackling inequalities in health.

So why does a national agency concern itself with international collaboration? 'Saving lives' itself recognised the importance of the international context to modern approaches to public health, and the benefits of sharing learning, stating: *'(Our goals) are consistent with the World Health Organization's (Europe's) new Programme for the 21st Century and the European Community's developing Strategy for Public Health'.¹*

Collaboration on EU policies

As a national agency in an EU member state, we have a pivotal role in providing information to the wider public health workforce in England on developing policy and legislation at the EU level and in finding ways for the workforce to input to discussions and developments. John Ashton, Regional Director of Public Health for north-west England, recently acknowledged the importance of the EU perspective, arguing: "As providers of public health services we cannot ignore legislation and policy development at the European level which will have likely future impacts on our practice in England". Indeed, Don Nutbeam, Public Health chief at the Department of Health, has stated, "European policy is increasingly seen as an extension of domestic policy."

At the end of last year the European Parliament and the council adopted a new community action programme for public health, which broadly breaks down into three strands:

- health information;
- health threats;
- health determinants.

The aim of community action in the field of health determinants is 'to encourage and support the development of actions and networks for gathering, providing and exchanging information in order to assess and develop policies, strategies and measures, with the purpose of establishing effective interventions aimed at tackling the determinants of health'.²

More broadly, Article 152 of the Amsterdam Treaty, which refers to the public health competence of the EU, not only provides the legal basis which allows for the development of the above 'community action', but also requires 'a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'.³ While currently perhaps more honoured in the breach, the Commission is working with public health experts to try to develop a better understanding of how the impacts of EU policies can be determined.

Current areas of interest for the public health workforce range from the framework convention on tobacco control, to environmental legislation, to reform of the Common Agricultural Policy (CAP), to food safety, to social exclusion, to structural funds. All can play a significant, if complex, part in promoting or harming population health.

Central partner

Given the range of these, and many other, potential areas impacting on population health, the HDA has been a central partner in supporting the development of the European Network of Health Promotion Agencies and its successor nongovernmental organisation (NGO), EuroHealthNet, 'to build and maintain relationships and communication links to and between the national health promotion agencies and with the EU institutions'.⁴ By different agencies taking

a lead in different areas, a much broader range of EU policy areas can be reviewed from the perspective of public health, than could be individually achieved.

It is my belief that while the budget for the latest public health programme looks substantial at €312 million over six years, developing an effective mechanism for disseminating and responding to EU policies and legislation across a broad range of areas will ultimately bring the biggest health benefits.⁵ To be effective will continue to demand collaboration with other agencies, to develop a common understanding and a common position.



Over the past few years, much emphasis and discussion has been given to the effects of globalisation on health.

We are also monitoring the European Convention, which is seeking to consolidate all the EU treaties.⁶ Despite numerous calls from the NGO community, health is not stated as a fundamental policy objective of the EU, though 'common safety concerns in public health matters' and remains a shared competence between the EU and member states. There is also some suggestion that the currently proposed amendment to Article 152 (renumbered Article 174) will give wider scope for legislative action in the field of public health. Work on the constitution is now being continued by member state representatives at the Intergovernmental Conference, from October 2003 to March 2004.

Globalisation

More broadly, over the past few years, much emphasis and discussion has been given to the effects of globalisation on health. The rapid spread, and the effective tracking of the SARS epidemic, showed us in thoroughly understandable terms how the physical movement of people today spreads disease faster than it did even 50 years ago. Many people would argue, however, that the real effects of globalisation exist far more at the deterministic level, impacting on jobs,

governance, human migration patterns, in a way that is too complex to ultimately predict whether the product will be health promoting or health damaging overall.

There is a growing public health awareness of the impact of organisations like the World Trade Organisation (WTO) on population health through both the liberalisation of trade including attempts to open up service sector contracts to private competition, and protection of intellectual property rights.

It is to be hoped that international collaboration can be fostered with national public health bodies.

While it is difficult for a national agency like the HDA to play a concerted role in considering the impact of WTO agreements and rulings, it is probably in this area where many of the most significant decisions which impact on population health will be played out. It is to be hoped that international collaboration can be fostered with national public health bodies to analyse and consider the public health implications more thoughtfully in the future.

However, if we recognise that at least through trade and communications, we are more connected than we have ever been, then we can also recognise as members of the public health community the potential for working together for a range of purposes:

- share the knowledge we have built up with countries who are seeking to establish health promotion and multi-disciplinary health systems;
- learn from the experiences of other countries ourselves;
- work together on common problem identification and solution;
- collaborate on international programmes.

Sharing knowledge

After the dramatic collapse of the former Soviet Union and consequent re-emergence of independent states in central and eastern Europe, the UK Department of Health signed a memorandum of agreement with the World Health Organization (WHO) 'to provide technical assistance for the whole country development of health promotion in countries in transition'. The predecessor of the HDA, the HEA, was delegated as the operational partner - a role taken on by the HDA at its inception in April 2000.

There have been a number of notable features of the work. Not least is that it has offered peer-to-peer support for developing health promotion capacity, keeping the partners at the centre of the development process in all aspects from needs assessment, to training, to evaluation.

It is significant that Estonia, one of the countries where we started the programme in 1993, helping first to develop the capacity of the national centre, and then supporting the development at regional level, is now perceived, and more importantly perceives itself, as an equal partner in Europe-wide work of health promotion agencies.

Case study Estonia

1993 - special Memorandum of Agreement signed between Health Education Authority and Estonian Ministry of Social Affairs;

1994-1996 - training of national centre in range of health promotion measures;

1996-1998 - joint funding from EU Phare programme allows for the development of training capacity at the national level, and the development of regional (county level) capacity;

1998-1999 - support given to 'community development approaches to health promotion development programme';

2003 - 10 years of health promotion in Estonia celebrated.

Comments about the programme have been positive:

- *"The programme set a standard for collaboration and the sustainable development of health from which others might learn both inside and outside the health sector"* (Erio Ziglio, Director of WHO Investment for Health);
- *"This is an excellent project which is well conceived and implemented. The contribution of the project is out of all proportion to the relatively small budget"* (A European Union Phare programme evaluation);
- *"The supportive and stimulating collaboration has had its special value during the transition years"* (Anu Kasmel, Director of the Estonian Health Promotion Centre).

Public health problems

Since 1996 most of the activities in support countries in transition have been carried out with funding from bilateral (UK Department for International Development) or multilateral (World Bank, WHO) funding or contracts. It is recognised that this not only provides valuable input to countries in transition, but also provided a useful exercise for professional development and broadening our understanding of how public health problems can be framed and addressed.

The programme has drawn predominantly on the public health workforce within the NHS and has enabled several managers to develop their thinking

and expertise as well as raising their profile nationally and internationally. While this work of know-how transfer is drawing to a close, as many countries in transition are soon to become equal members of the European Union, the HDA continues to maintain a network with accession countries in support of the Department of Health's priorities.

The HDA is also continuing to offer a service to public health specialists who wish to work internationally, by providing an online database on which potential consultants can register. If you are interested in registering, please go to <http://internationalconsultants.hda-online.org.uk>

International lesson learning

Implicitly we have always learned from what other countries are doing in terms of public health and health promotion, whether it be through movements such as the WHO Health Promoting Schools Programme, promoting a whole school approach to improving health, to the strongly Canadian-influenced Healthy Cities movement, to disease-specific exemplars such as the coronary heart disease project in North Karelia, Finland.

Such public health movements will of course continue to develop. Indeed, the HDA is working closely with the WHO Investment for Health and Development Centre, in exploring ways to work inter-sectorally and politically for health, and particularly exploring the key characteristics of features in a community that can help protect population health. The work will seek to identify how these community assets can be supported or increased, echoing the work of Robert Putnam on social capital and John McKnight on supporting communities.^{7,8}

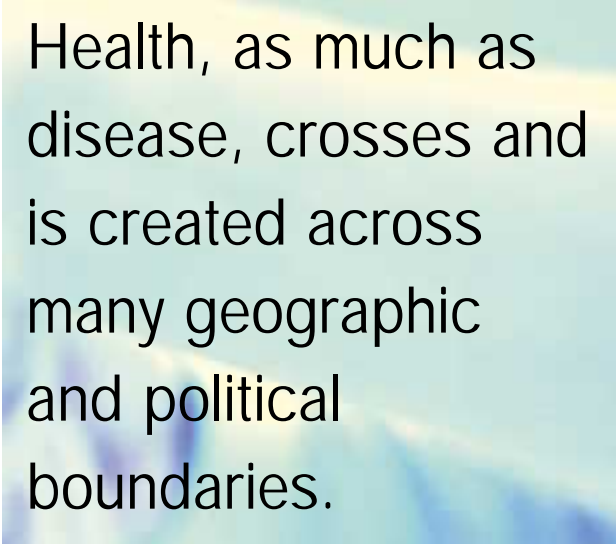
However, there is also an increasing acknowledgement that in the drive towards evidence-based public health, there is considerable merit in pooling research resources, or at the very least in developing commonly agreed protocols for conducting systematic reviews of evidence, so that at one level evidence can be transferable. At another every country's legislative framework, public health infrastructure, and culture are different requiring thoughtful translation of the evidence into 'practicable practice'. This, however, holds true no less at regional and local level.

Evidence base

The HDA has played its part in this area, by helping to bring together a European wide research directors network that will be seeking sufficient agreement on evidence protocols to increase the acceptability of evidence transfer, and will begin to explore how to incorporate grey literature into the evidence base. A proposal is currently with the European Commission submitted by NIGZ, the Dutch health promotion centre, on behalf of a range of European agencies looking at establishing standards in developing the public health evidence base.

We are also working with the International

Union for Health Promotion and Education (IUHPE) on a revision to their publication *The Evidence of Health Promotion Effectiveness*, and looking at the thorniest of all issues - developing the evidence for what works in getting evidence into practice - how do you bring together research knowledge with practical experience and support institutional change.



Health, as much as disease, crosses and is created across many geographic and political boundaries.

Conclusion

Health, as much as disease, crosses and is created across many geographic and political boundaries. The health of Europe and the models of economic and social development that we pursue will impact on our population's health. Agencies like the HDA and the Health Promotion Agency need to collaborate actively with a range of international partners if we are to successfully analyse and begin to address some of these broader issues.

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The world of Nicare

Through its international linkages with other health systems, Nicare has found areas of commonality and areas of difference, as **Colin Sullivan** explains.

Introduction

The WHO International Healthy Cities Conference (Belfast, 19-22 October 2003) is creating many opportunities for linkages between Northern Ireland's health sector and those from all over the world. Such events provide a basis for the sharing of experiences, having discussions around solutions to common problems and transferring of knowledge. It was with a view to building upon international linkages with other health systems that Nicare was established as the international division of Northern Ireland's public sector Health and Social Services in 1990. Over the intervening period, we have worked with colleagues in around 50 countries on a wide range of health and social sector projects.

Our cooperation has mainly involved working with health sector colleagues in the developing world and those countries (located mainly in central and eastern Europe) with transitional economies following the end of communism. Most of our cooperative activities have been supported by the major development agencies such as the European Union, the World Bank and the UK Department for International Development. Whilst each experience is unique, it is interesting to note the cross-over which exists between the different countries. Thus the questions arise: what areas do we have in common with other health sectors and what areas are very different and do not have a direct linkage?

Common themes

Looking at the *Priorities for Action* (2003/04) document for Northern Ireland's Health and Social Services reveals 20 priority themes (see Table 1).¹ Most if not all of these are to be encountered in other

settings in the developed world. However, how many of these themes can also be found in transitional economies and how many in developing countries? Table 1 indicates which of the 20 Northern Ireland priority themes might also be considered major priorities in these other locations. This is my own interpretation based upon recurring themes I have found in a diverse range of settings. This is open to debate and it is important to acknowledge that there may be great diversity within these broad headings. Furthermore, if we were going into this topic in great detail we would need to develop universally accepted definitions for each of the themes. Nevertheless, with those caveats in place, it is interesting to note the level of cross-over that exists.

The health development theme within the 20 Northern Ireland priorities includes reference to *Investing for Health*, which is a new approach for Northern Ireland and entails working across the whole of Government (not just the Health Ministry) and with other agencies. This concept is not new to those working on health issues in the developing world where the terminology "sector wide approach" might be used to describe a concept which recognises the limitations of a series of isolated initiatives and is constructed on an overarching basis.

Inequalities in health is an important theme amongst the Northern Ireland *Priorities for Action* and it is certainly applicable in other settings worldwide. Interestingly, Wagstaff (2002) notes that some of the greatest inequalities can be found within some of the most developed of economies.² This is perhaps in contrast to what many expect as developed countries have established social assistance schemes for vulnerable citizens. The difficulty is that some people fall through these safety nets!

Table 1

	Northern Ireland *	Transitional economy countries	Developing countries
Health development			
Making services more responsive to need			
Primary care			
Workforce			
Acute hospital services			
Child health			
Ambulance service			
Community care			
Care of older people			
Mental health			
Learning disability			
Physical and sensory disability			
Family and child care			
Better governance and performance improvement			
Capital investment and estate			
Information and communications technology			
Equality			
New targeting social need (TSN) +			
Human rights			
Cross border cooperation and joint working +			

Very relevant	Relevant	Somewhat relevant	Not relevant
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* All marked as 'very relevant' given they are established priorities in Northern Ireland even if the importance attached to some areas is greater than others.

+ Specific initiatives relating to Northern Ireland only but these themes are appropriate in other settings.

Human resources is another interesting area. In Northern Ireland, we have shortages of staff in certain professional groups. We aim to ensure sufficient staff are trained, and in the interim we have "borrowed" staff from elsewhere to help meet our shortfall. Many developing countries also encounter great disparities in practitioner coverage with the healthcare practitioners often tending to gravitate towards the large centres of population where opportunities are greater (and if they are privately funded, where incomes are often higher). Another related linkage is the recruitment domino effect, ie if we recruit South African doctors to the UK we have seen these replaced by doctors from other African countries, creating a knowledge gradient.

Cooperative working

Focusing upon a number of these common themes,

Nicare has been able to work cooperatively with colleagues in other settings. For example:

- In Bangladesh (funded by the Department for International Development - DFID) we have been working with local colleagues on an imaginative new way of improving healthcare access to rural areas.
- In the Gaza Strip (funded by the European Union - EU) we commissioned the European Gaza Hospital, a new-build 250 bed hospital with a range of medical and surgical specialities.
- In Romania (funded by DFID) we have been undertaking community development activity designed to improve health status in two remote and relatively impoverished areas (Calaras and Brailia) located in the Danube delta.
- In Bosnia and Herzegovina (funded by EU) we worked on public health and health promotion issues with both entities [the Bosnian Federation and the

Republika Srpska (Serb Republic)] to develop a health promotion strategy.

- In St Helena (funded by DFID) we have been working with the local community health department and the island's population to try to reduce the prevalence of chronic diseases such as diabetes and hypertension.

The ongoing reform of primary health care is a theme common across the world in developed and developing countries alike.

These experiences have provided us with exposure to new ways of looking at common problems. In Nicare's early days, we concentrated on linking staff and institutions in our health service with counterparts in other health systems. This remains an important part of our work. However, we have found that, increasingly, we respond to project work with team members drawn from a wide variety of settings. This permits effective cross-fertilisation of ideas between team members who may be drawn from across the EU or beyond. We also place increasing emphasis upon involving specialists from the country or region in which we are working. These south/south inputs have both helped to better orientate our teams and have built local capacity within the focal region. (South/south cooperation: One developing country or region learning or gaining insight from another developing country or region (perhaps a close neighbour) that has faced or is facing similar issues.)

Development areas

From the above analysis it would appear many of us engaged in our national health service are working on themes common to colleagues in the transitional economies and the developing world and this has been borne out when we have engaged colleagues to work internationally on projects tackling many of the issues listed above. However, this commonality needs to be qualified with context. There are, of course, issues which are major priorities in other parts of the

world, but are not significant issues for us in Northern Ireland (the UK has the fourth largest Gross Domestic Product - GDP) or other parts of the developed world.

HIV/Aids would be the major theme encountered in many parts of the world, not least eastern and southern Africa, where large percentages of the population are affected. Fortunately, it is a topic of much reduced significance in Northern Ireland. We are also fortunate to not suffer from the tropical diseases, such as malaria, found in many developing countries. Likewise, providing a range of basic primary health care (PHC) services is a priority to many in developing countries. While this is important in some developed countries for those who have fallen through the safety net, it is not a major concern in the UK (outside of some inner cities where staff shortages have created problems) with all services free at the point of delivery to those in greatest need. That said, the ongoing reform of PHC is a theme common across the world in developed and developing countries alike.

Development agencies see the reduction in poverty as their overarching goal. The two-way connection (Claeson et al, 2000) between poverty and health, found in developing as well as developed countries, suggests that poverty leads to poor health and that adverse health outcomes contribute to income poverty.³ The United Nations (UN) goal is to halve world poverty by 2015. The UN and other international agencies are placing greater emphasis upon health status improvements as it is now recognised as not only being a means of improving intrinsic wellbeing, but also a means of attaining the overarching economic goal of reducing world poverty. Of course, when dealing with such agencies we are not normally considering recurrent resources. National health systems have been established primarily to meet clinical need, and not to reduce poverty as such.

We can get an idea of the differing contexts when we look at structural policy issues for health services or related areas. An overview of the types of health and related reform policies being pursued across many of the world's countries was provided in the *World Development Report - Investing in Health* prepared by the World Bank (1993).⁴ This policy document sought to highlight the agenda for change in low- and middle-income countries and the transitional economies. Whilst it did not receive universal support, it was nonetheless a useful indication of many of the types of issues facing these countries and has been an important guiding document for international health sector development. Table 2 presents a summary of the main themes of *Investing in Health*. By way of comparison, I have scored the policies currently being pursued in some or all of the countries of the UK.

The table indicates, in general, there is limited cross-over on the "common" policies as defined by the

Table 2

Foster an enabling environment for households to improve health	Low-income countries	Middle-income countries	Friendly socialist countries	Northern Ireland
Pursue economic growth policies that benefit the poor				
Expand investment in education, particularly for females				
Promote the rights and status of woman through political and economic empowerment and legal protection against abuse				
Improve government investments in health				
Reduce government expenditures for tertiary care facilities, specialist training, and discretionary services				
Finance and ensure delivery of a public health package, including AIDS prevention				
Finance and ensure delivery of essential clinical services, at least to the poor				
Improve the management of public health services				
Facilitate involvement by the private sector				
Encourage private sector finance and provision of insurance (with incentives to contain costs) for all discretionary clinical services				*
Encourage private sector delivery of clinical services, including those that are publicly financed				
Provide information on performance and cost				

Very relevant

Relevant

Somewhat relevant

Not relevant

* The Health and Social Services in Northern Ireland are financed from general taxation and not through user subscription to independent health insurance schemes.

World Bank's development report. This suggests that, when working at a strategic policy level, we need to be very careful to not make too many comparisons between the developed and developing countries. In response, we in Nicare have been very conscious, when working with colleagues in other locations, not to arrive with preconceived ideas or pre-set models of how to tackle specific issues.

Conclusion

Whilst the extent of specific themes may vary greatly between settings (often but by no means always worse in the developing country), there are many health issues which are common to countries with very different levels of economic development.

However, in order to effectively work with colleagues in the developing world, we need to bring two types of experience to bear: our health professional backgrounds and a knowledge of the context in which we are engaged. Armed with these two types of knowledge we can learn much from international exchanges which benefit our colleagues and our own setting.

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The role of the World Bank in promoting public health

We can all work together to accelerate progress on the health-related Millennium Development Goals. Achievement of the goals involves working together more dynamically at the country level, building on existing mechanisms and linking up with existing global health initiatives.

Introduction

The World Bank's commitment to achieving good health, nutrition and population outcomes, including its commitment to the Millennium Development Goals (MDGs) and the adoption of a Poverty Reduction Strategy (PRS) framework, underscores the importance of embracing principles and practices of public health. Effective public health interventions are directly related to achieving the MDGs. Public health knowledge, advisory services, and capacity-building are key instruments for development effectiveness.¹

For bank operational purposes, major public health functions can be grouped into five categories:

- policy development;
- creating and disseminating evidence for health policies, strategies and actions;
- prevention and control of disease;
- multi-sectoral action for better health;
- human resource development and capacity building.

The roles of the public health cluster in the bank are to: manage and disseminate knowledge on public health and public health functions; conduct analytic work related to public health functions; engage in global health initiatives that will help countries make measurable progress towards their health, nutrition and population (HNP) goals; build capacity for poverty reduction; and improve bank and

client performance.

In 2000, roughly 11 million children died before their fifth birthday, almost all of them in the developing world. An estimated 140 million children under the age of five were underweight, almost half of them living in south Asia. In 1995, 515,000 women died during pregnancy or childbirth, only 1,000 of whom died in the industrialised world. Tuberculosis claimed another two million lives.

Death and illness

As these numbers might well suggest, death and illness act as a brake on economic growth, and contribute to income poverty: health and demographic variables account for as much as half of the difference in growth rates between Africa and the rest of the world over the period 1965-1990.

Nearly half of the MDGs concern, directly or indirectly, HNP issues. But based on present trends, relatively few low-income countries will achieve these goals. Only 17% of countries are on target for the under-five mortality goal (a two-thirds reduction between 1990 and 2015).

Also, on present trends, sub-Saharan Africa as a whole will take 100 years to achieve the under-five mortality MDG. In all regions other than the Europe and Central Asia region, the under-five mortality rate declined faster during the 1980s than it

did during the 1990s. The slowdown was particularly pronounced in Africa and the Middle East. In many countries, improvements in child mortality and malnutrition have been smallest among the poor.

The challenge

The challenge, while serious, is not universally insurmountable. Effective interventions for most of the health MDGs are available. Some countries have managed to deliver these on a scale that has resulted in major advances. Globally, the tuberculosis case detection rate increased steadily through the late 1990s under the directly observed treatment short course programme. Sustained reductions in HIV infection have been achieved in Thailand through government efforts to promote safe sex.

Free treatment and insecticide-treated nets have reduced malaria deaths, and oral rehydration therapy for childhood diarrhoea has had documented impact on childhood deaths on a national scale in several countries. A number of countries that are currently off-track for the child health MDG did manage to achieve the required annual percentage reduction in under-five mortality during the 1980s.

Current issues

Countries making little or no progress are typically being held back by a combination of weak household demand for effective interventions and an inadequate health service delivery system. Households - especially poor ones - often do not know about health services which could make a difference in their lives, or where to find them. On top of that, the costs for households to use such services - in terms of both money and time - can be prohibitive. Women often lack control over household resources and often lack the power to make decisions about matters that affect their health and that of their children.

Health clinics and other facilities are often inaccessible because they are too far away or the roads are in poor condition, and especially in rural areas the clinics are often poorly stocked with drugs and understaffed. Providers are often poorly trained and lack motivation, sometimes because they are not paid enough. Well-trained staff often find more lucrative employment abroad in industrialised countries. Facilities and health systems overall are often poorly managed, lack effective oversight, and suffer from the weak governance structures evident elsewhere in public institutions.

Common framework for action

The World Bank's health, nutrition and population team is working with a wide range of partners in both developing and developed countries to create a common framework for action, to accelerate progress towards the HNP MDGs. The framework that is being developed focuses on removing the

The World Bank's health, nutrition and population team is working with a wide range of partners in both developing and developed countries to create a common framework for action.

roadblocks to more effective health systems by, for example, improving the quality of healthcare staffing, ensuring a safe and predictable supply of drugs, and managing stronger management and effective public-private interactions.

It is also an attempt at working together more dynamically at the country level, building on existing mechanisms (poverty reduction strategies and sector-wide approaches), and linking up with existing global health initiatives, rather than trying to create a new global initiative. It will be important to harmonising donor efforts and working closely with nongovernmental organisations at country and sub-national level, to adopt a strong multi-sectoral framework and to strengthen monitoring and accountability. This means adopting a results-based approach to achieving the HNP MDGs.

In order to achieve the MDGs, the key constraints at household and health systems levels have to be analysed and effectively addressed. Within the bank, activities are underway to change from business as usual, to business for results, eg better aligning the current advice and lending to spur improved child and maternal mortality MDGs outcomes in countries where these are priority problems; conducting economic and sector work to underpin efforts to accelerate progress towards MDGs; building health systems capacity through a new training programme; and working cross sectors on the major contributors to health such as water, sanitation and hygiene, indoor air pollution and roads.

Targeted efforts to reach poor

Widening equity and reducing poverty are central to achieving the MDGs. This can only be done by targeted efforts to reach the poor, and by measuring progress in different income groups - not by reporting on overall national MDG progress, eg in reducing the numbers of child deaths, the vision is to strengthen global, national and local leadership, mobilise and sustain targeted resources, and build effective health systems, in order to prevent the deaths of millions of children under the age of five every year.

The aim is to close the inequity gaps between poor and rich and between girls and boys. Applying an equity lens to the MDG for child survival shows how the increasing gap between rich and poor in some areas of the world is due to inequalities in exposure and susceptibility to diseases as well as to different levels of coverage of preventive and curative services, between and within countries. Equity considerations have to be an integral part of policy making and monitoring of the MDGs.

To ensure that the MDGs are translated into useful, relevant and action oriented indicators that can be measured regularly, and be representative, simple, easy to understand and likely to be available at country level, the bank convened a consultation back in November 2001 with experts on reproductive and child health, communicable diseases, nutrition and poverty. The indicators are available in the World Bank document *Health, Nutrition and Population Development Goals: Measuring progress* using the poverty reduction strategy paper (PRSP) framework.²

The World Bank and partners are gearing up for a "compact" between individual countries and donors to accelerate progress built on: a credible strategy and implementation plan; commitment to improving governance and policies; donor buy-in and coherence; incremental financing and lower transaction costs; leveraging existing initiatives, processes and funding; working cross sectors within the PRSP context and commitment to monitoring and evaluation for results. We know it can be done, and must be done - if there is a will. Denying women and children the access to quality healthcare deprives new generations of a better future. And that is not only unconscionable. It is also profoundly unacceptable.

This article was compiled by Mariam Claeson and Adam Wagstaff of the World Bank.

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1. For more information about the HNP MDGs, see Health, Nutrition and Population and the Millennium Development Goals on <http://www.worldbank.org/hnp>
2. <http://www1.worldbank.org/hnp/MDG/measureprogress.pdf>

What are the MDGs?

At the UN Millennium Summit in September 2000, the 189 states of the United Nations reaffirmed their commitment to work towards a world in which eliminating poverty and sustaining development would have the highest priority. The Millennium Declaration was signed by 147 heads of state and passed unanimously by the members of the UN General Assembly.

The Millennium Development Goals (MDGs), which grew out of the agreements and resolutions of world conferences organised by the United Nations in the past decade, have been commonly accepted as a framework for measuring development progress. The goals focus the efforts of the world community on achieving significant, measurable improvements in people's lives. They establish yardsticks for measuring results not just for developing countries but for the rich countries that help to fund development programmes and for the multilateral institutions that help countries implement them.¹

Health and the MDGs

The first seven MDGs are directly or indirectly linked with the activities of the health, nutrition, and population sector in the World Bank, either as health and nutrition status indicators or as determinants of health outcomes. There are many synergies among these activities, so that working with other sectors - such as education, water and sanitation, and gender - is likely to be the most effective way of achieving progress.²

Millennium Development Goals

Goal 1: Eradicate extreme poverty and hunger

Target 1

Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Indicators

- proportion of population below \$1 per day;
- poverty gap ratio [incidence x depth of poverty];
- share of poorest quintile in national consumption.

Target 2

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicators

- prevalence of underweight children (under five years of age);
- proportion of population below minimum level of dietary energy consumption.

Goal 2: Achieve universal primary education

Target 3

Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Indicators

- net enrolment ratio in primary education;
- proportion of pupils starting grade 1 who reach grade 5;
- literacy rate of 15-24 year olds.

Goal 3: Promote gender equality and empower women

Target 4

Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.

Indicators

- ratio of girls to boys in primary, secondary and tertiary education;
- ratio of literate females to males of 15-24 year olds;
- share of women in wage employment in the non-agricultural sector;
- proportion of seats held by women in national parliament.

Goal 4: Reduce child mortality

Target 5

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

Indicators

- under-five mortality rate;
- infant mortality rate;
- proportion of 1 year old children immunised against measles.

Goal 5: Improve maternal health

Target 6

Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

Indicators

- maternal mortality ratio
- proportion of births attended by skilled health personnel.

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 7

Have halted by 2015, and begun to reverse, the spread of HIV/AIDS.

Indicators

- HIV prevalence among 15-24 year old pregnant women;
- contraceptive prevalence rate;
- number of children orphaned by HIV/AIDS.

Target 8

Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.

Indicators

- prevalence and death rates associated with malaria;
- proportion of population in malaria risk areas using effective malaria prevention and treatment measures;
- prevalence and death rates associated with tuberculosis;
- proportion of TB cases detected and cured under directly observed treatment short course.

Goal 7: Ensure environmental sustainability

Targets 9-11

Integrate the principles of sustainable development into country policies and program and reverse the loss of environmental resources.

Halve, by 2015, the proportion of people without sustainable access to safe drinking water.

Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers.

Indicators

- change in land area covered by forest ;
- land area protected to maintain biological diversity;
- GDP per unit of energy use;
- carbon dioxide emissions (per capita);
- proportion of population with sustainable access to an improved water source;
- proportion of population with access to improved sanitation;
- proportion of population with access to secure tenure [urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers].

Goal 8: Develop a global partnership for development

Target 12

Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction - both nationally and internationally).

Indicator

- some of the indicators will be monitored separately for the least developed countries, Africa, landlocked countries, and small island developing states.

References

1. <http://www.developmentgoals.org/>
2. <http://www1.worldbank.org/hnp/MDG/mdg.asp>

Investment for health and development

The WHO European Office for Investment for Health and Development seeks the active engagement of member states, their institutions and health organisations.

The World Health Organization (WHO) Venice Office for Investment for Health and Development is the newly established Centre for the European Region of the WHO, working on health promotion and the social and economic factors that determine public health.

Development and health are interdependent, each affecting the other. A healthy country with greater health assets will be able to develop better, both economically and socially, than one with poorer health; a better developed country will be able to provide the environment in which public health can be improved and where health becomes a consideration in all planning and development programmes.

In the Venice office we are working to define and act upon the major social and economic

determinants of the health of the population in European countries. Our main aim is to strengthen the capacity of European countries to promote population health in an equitable and sustainable manner.

Joint initiatives

Collaboration and joint initiatives are a key for effective and sustainable action in this field and we seek the active engagement of member states, their institutions and health organisations. To this aim we provide a range of scientific projects and country services.

It should be noted that within our region, the large differences in health - between countries, within countries and even within cities - are only partly explained by the differences in available healthcare. We provide information that analyses these differences and can help decision-makers to identify health policy measures to complement social and economic actions to address the inequalities.

Many of our current programmes benefit from active partnership and collaboration. An example of this is the Health Behaviour of School Children (HBSC) survey: A WHO Collaborating Survey. This is an international project of cooperative action across 36 countries.

Other examples include: our analysis of initiatives on poverty and health which report on many health initiatives and organisations throughout the region; our Assets for Health programme which aims at identifying the salutogenic factors that protect and promote the health of individuals and communities. (A salutogenic model aims at exploring

Many of our current programmes benefit from active partnership and collaboration.

Studies in developing countries have shown that a 10% increase in income per capita corresponds to a 3.5% fall in child mortality rates.

the origin of health rather than explaining causes of disease.) These and other ongoing programmes benefit from a sustained contact and partnership that can bring the best thinking on investment for health to the widest constituency.

Sustained partnership

Active collaboration also allows us to work efficiently and effectively, ensuring that our products are responsive to the needs of our member states and that they play an active part in future planning and policy-making. Our products include:

- reviews on public policies that affect health, such as employment, housing, environment, education;
- assistance for politicians and policy-makers to understand the health impact of their decisions;
- consultation on using available resources for population health in more productive ways;
- studies and reviews of evidence on health determinants;
- assessment of health promotion;
- evidence on the ways in which health systems can deal better with issues of poverty and health;
- tools to aid investment for health;
- communication initiatives tailored for different groups - public, private, non-profit and civil society organisations, in addition to health ministries;
- communication with advocacy groups that promote the health investment process;
- the development of interactive websites to promote regional discussion and debate.

This article was compiled by Erio Ziglio and Steve Turner of the World Health Organization European Office for Investment for Health and Development.

The interdependency of development and health

The WHO global strategy of achieving health for all is fundamentally directed towards achieving greater equity in health between and within populations, and between countries. In both developed and developing countries, the number of people in poverty is an especially important reason for differences (inequalities in health).

There is now overwhelming evidence that much of contemporary illness and death (and thus the potential for health promotion) is rooted in the prevailing type of economic development in a region and linked to social factors experienced by that region's population. In general, if economic development goes hand in hand with decreasing social inequities, is environmentally friendly and strengthens social capital, it will have positive impact on a wide range of social and health indicators. The higher a country's average income per capita and the more equal its income distribution, the greater the likelihood of longer and healthier lives for its population. Studies in developing countries have shown that a 10% increase in income per capita corresponds to a 3.5% fall in child mortality rates.

In many parts of today's world, rising proportions of people are living in poverty. High economic growth in conjunction with rising unemployment, job insecurity and low-paid jobs lead to widening income gaps and to rising social inequality. Changes in living conditions and a widening range of family structures (single parent families, divorce, commuter families, etc) are an increasing reality in most countries worldwide. A narrowing labour market and fragile social and family support networks result in a higher proportion of children at risk of living in poverty. We know that this will have serious short- and long-term ill-health consequences.

Unless decisive, coordinated, intersectoral policies are explicitly designed to address these phenomena, and effectively implemented, the maintenance of health, let alone its improvement, will be much more difficult to achieve.

Erio Ziglio et al. Principles, methodology and practices of investment for health. Promotion & Education 2000/2; 7: 4-15.

Public **health**, **sustainable** **development** and the **international** **role of cities**

Dimitris Avramopoulos argues that the challenge of the time is to create a healthy living and working environment in harmony with the world's natural ecological systems.

Introduction

The issue of international collaboration in promoting public health and sustainable development is very important for our planet, for the nations, for cities and local authorities, for the citizens of the world. I know how hard it is to fight for this fundamental human right under difficult conditions related to the demands of development.

The challenge of sustainable development is a very crucial one and has been the subject of extensive and thorough discussions everywhere, since it concerns our present and our future. Our planet is seriously threatened and we are all aware that we must unite our forces in order to react and do something while there is still time. As former Mayor of Athens, from 1995-2002, I have personal

experience regarding environmental issues and quality of life.

Urbanisation

The urbanisation process can be characterised as a global phenomenon both in terms of magnitude and intensity. It is a lengthy process, yet it has followed the same course, ie the movement of population from the rural regions to the cities. For the first time in history, the urban population exceeded the rural one. The phenomenon of the urban development of cities to which multinational companies directed their mass investment is worth noting. At a pace of 50 million new habitants in cities every year, the urban population all over the world is expected to reach 52% up to 2020.

This huge increase is not similar to the one that took place in the big cities of the industrialised countries. There is no period for adaptation, which is necessary, nor institutional or financial means. As a result, there is and there will be even more high percentages of poverty, high environmental pollution and low conditions of life and health. Although the necessary actions for adaptation are decisive, they are not always effective. These actions take place mainly at the institutional level, both locally and internationally.

Globalisation

The new international economic environment, which is generally termed globalisation and which is the result of specific financial, technological, communication and political processes, favours urbanisation and is favoured by the phenomenon of big cities. There has been a parallel progress of these two phenomena. The new forms of economy, ie the ones based not so much on the old factors (energy, raw materials, labour force), but on constructed resources, are better organised around administration and control centres, which regulate, control and coordinate the activities of business networks. This shows how important the urban environment is in our post-industrial global society.

Thus, sustainable development means that present generations must use the world's resources in such a wise manner so as not to put at risk the future of generations to come. Applying in practice the principles of sustainable development was the main objective of the Earth Summit held in Rio de Janeiro in 1992.

Challenge of the time

The challenge of the time is to create a healthy living and working environment in harmony with the world's natural ecological systems. However, it is really difficult to imagine how urban centres could be in truce with ecological systems. It seems, indeed, that cities are alienated from any natural system. Nevertheless, we have no choice but to strive

towards cities that will minimise the conflicts between the human endeavour for economic advancement and the safeguard of natural environment. Therefore, cities must be transformed into sustainable units that will secure future existence and will provide a high level of quality of life.

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There is another reason for the creation of sustainable cities: The city has always been identified as an autonomous, self-sufficient and self-reliant unit in economic needs and social forces. Therefore, the city as a social organism represents the miniature, in which the various dimensions of social and ecological sustainability can be applied in practice. In other words, actions and measures aiming at environmental protection and upgrading the urban environment, implemented within the municipal boundaries - on a municipality or city level, are more effective and more likely to achieve their goals.

Sustainable development

According to the concept of the sustainable city, towns and cities must not shift their environmental problems across their boundaries or postpone them for the future, and thus shift the burden to future generations. This is contrary to the concept of sustainable development. The answer is to find solutions to the existing problems or not create problems at all. And solutions must always be geographically defined, ie restricted within local boundaries - problems must be handled on a local level in such a way that local societies can safely absorb them.

The belief that without the local authorities' active participation in planning and protecting urban

Over the last decade, large-scale economic reforms combined with population mobility have restructured the social and economic tissue of many European cities.

environment, all environmental policies are going to fail, is now reflected in all international and European initiatives concerning significant policy and development issues. National states cannot, on their own, centrally manage and control the complex, fast-moving cities and towns of today and tomorrow. Only strong decentralised local governments, in touch with and involving their citizens and working in partnership with national governments, are in a position to do so.

Therefore, regarding the issues of sustainability, the principle of subsidiarity is the best solution to follow. Subsidiarity is now widely appreciated and it is one of the most important principles. (The subsidiarity principle is intended to ensure that decisions are taken as closely as possible to the citizen and that constant checks are made as to whether action at community level is justified in the light of the possibilities available at national, regional or local level.)

Social institutions

Local authorities are efficient when they can create projects, exploit local possibilities - mainly at the human resources level and at the level of socioeconomic factors - as well as the international opportunities for cooperation, the funds from

governmental but mainly from transactional institutions, the possibilities of acquiring funds and more overall benefits by taking advantage of the wider financial circumstances. The purpose is to renew infrastructure, to create a climate of cooperation between the administration and the financial agents and social institutions supporting the weaker citizens and securing the conditions for social peace and cooperation.

Of course, to fulfil all policy obligations, a corresponding commitment from central government is needed as well. We have the recent example of France. The government of Paris presented a new law proposing the inclusion to the French Constitution the 'right to environment' as a fundamental constitutional right, equal to civil, political and economical human rights.

Centres of health

Overall, a national strategy is essential. But on the other hand, local authorities in order to be efficient must have the ability in terms of responsibilities and resources. In our times, cities have the opportunity again to become centres of culture, of creation, of good life and health for their inhabitants. The examples to follow or to avoid are many throughout the centuries and the principles for the administration of a city - as they were expressed by Plato and Aristotle 2,500 years ago - can become valuable counsellors to those who are interested in the supreme good of the citizens, the establishment of a more human and happier society.

Over the last decade, large-scale economic reforms combined with population mobility have restructured the social and economic tissue of many European cities. Thus, economy has had a significant impact on the environment. There is, however, the growing realisation that economic development is liable to the same natural constraints; as any other process on planet Earth it must ultimately act within the natural ecological limits of the environment. By contrast, we must also realise that without business and industry there will be no urban settlements. Therefore, the strategy should not be the outright condemnation of economic activities, but their rational management in harmony with the natural world, the combination between economic growth and sustainable development.

Green Diplomacy

A significant development was the commitment of the Thessaloniki European Council in June 2003 to advance the 'Green Diplomacy', a proposition of the Greek presidency, by integrating the environment into external relations and promoting a European Diplomacy on sustainable development. This development coincides in a harmonious way with 'Glocal and Cities Diplomacy' (Glocal = global/local), another initiative of the city of Athens during my

mayorship, inviting cities to collaborate on a permanent institutional base on issues affecting the life conditions of the citizens, and searching solutions to problems which are local and 'glocal' at the same time.

The Cities' Diplomacy has been officially ratified by the mayors of the world and the United Nations as a new multidimensional parameter of international relations. The World Institute of Glocal and Cities' Diplomacy, which I have the honour to be its first President, is this instrument, the tool, to advance international cooperation among cities in collaboration with the international organisations, the nongovernmental organisations and private institutions and companies.

Local authorities can take a series of immediate actions to achieve sustainability and environmental protection in this field. Reducing traffic and congestion by essentially encouraging a shift from private car use to the means of public transport can regenerate the city centres, relieve the citizens and encourage tourism. We should, however, keep in mind that, even though measures are of major importance as short-term solutions, they are not the means to achieve long-term sustainability.

Role of cities

So far, we have seen different sectors in which local authorities can intervene in order to prevent environmental degradation. The role of cities in the contemporary global reality has changed. The role of local authorities is complementary to the role of central government - they are co-decision makers. Cities are called to protect their citizens, their welfare, their prosperity, their health, their wellbeing, to function in harmony with natural environment, to upgrade quality of life, but also to provide for economic growth and development.

I believe that "an active citizen is a good citizen". The more informed the citizens are, the more educated they are and the more chances they have to participate, the more they will want to participate and contribute to the finding and implementation of solutions to various problems that may be tormenting their urban environment, their own lives and health. Nowadays, that cities have become multinational, multilingual, multicultural centres, it is education, cultural interchange and solid democratic institutions that will help the citizens acquire progressively a common identity, the sense of belonging and the sense of solidarity among them.

Conclusion

We must make the citizen the centre of all policies, of all strategies and of all measures. Otherwise, we risk getting involved in a vicious circle of endless efforts and fruitless attempts, leading to the construction of impersonal and inanimate urban centres and not to the creation of cities similar to ancient polis, where

The role of cities in the contemporary global reality has changed. The role of local authorities is complementary to the role of central government - they are co-decision makers.

the citizens used to fight for their common good and their common future.

Dimitris Avramopoulos, former Mayor of Athens (1995-2002) is the founder and President of the World Institute of Glocal and Cities' Diplomacy and Executive President of the World Union of Olympic Cities.



Healthy Cities - the launch of a new phase

Agis D Tsouros and **Jill Farrington** examine the Healthy Cities movement as an effective vehicle for international cooperation, and focus on the launch of a new phase for 2003 to 2007.

Introduction

As the European Healthy Cities movement has evolved over time, it has responded to new global strategies and priorities, and to changing socio-political, demographic and organisational contexts. The evolutionary process undertaken by the network is mirrored within member cities - as they too adjust to new national and local contexts, policies, structures and population health trends. Healthy Cities therefore needs to be seen as a dynamic concept. Its shape and content are influenced over time by new strategies and priorities; lessons learnt from past experience; advances in the evidence-base relevant to health development interventions and the determinants of health; and changes to political, policy and organisational environments.

It has been necessary to divide this dynamic process into five year 'phases' (1988-1992; 1993-1997; 1998-2002; 2003-2007) for the purposes of action planning and focused delivery. Although each phase has put special emphasis on one or more core themes, and has sought to expand the strategic scope of the project, the principles, methods and vision of Healthy Cities have remained true to four constants, which represent its overarching action elements:

- action to address the determinants of health and the principles of Health for All and Agenda 21;
- action to integrate and promote the World Health Organization's (WHO) European and global priorities;
- action to put health on the social and political agendas of cities;
- action to promote democratic and participative governance and partnership-based planning for health.

The Healthy Cities concept was based on the recognition of the importance of the local and urban dimension in health development and the key role of local governments in health policy and partnership building for health and sustainable development. In strategic terms the most important and powerful attribute of the Healthy Cities project has been its emphasis on networking for innovation and change at international, national and subnational levels.

Networks are organisational forms that provide for collective learning processes and can thus reduce uncertainty in the implementation of innovation. By sharing the experience of innovators, networks can help cities avoid repeating mistakes or having to reinvent the wheel. Thus, networks can provide the basis for competence building, creating complementarity and influencing the evolution/innovation process. Times of rapid social, economic and technological change have highlighted the need to use innovation networks as strategic instruments.

It is worth noting that 15 years' history of Healthy Cities in Europe, 1988 to date, coincides

with historic changes in the political and social scene of eastern and western Europe and at the global level. Cities participating in the WHO Healthy Cities networks did not just share an interest in urban health but were fully committed to implementing the policy goals and deliverables of the project. Without doubt, the major strength of the WHO Healthy Cities networks has been the political legitimacy they have provided to a wide range of policy changes and practices in challenging areas such as health inequalities, action addressing the determinants of health and democratic participative processes.

Healthy Cities is present in 31 European countries and involves more than 1,300 cities. These networks represent a tremendous resource of expertise and solidarity, a platform for public health advocacy and an effective mechanism for inter-city cooperation. WHO works directly with a network (WHO Healthy Cities Network) of designated cities on the basis of requirements specific to every phase and also supports the development and capacity building of national networks. The Phase III (1998-2002/3) WHO network consisted of 55 cities including eight from the UK (Belfast, Camden/London, Glasgow, Liverpool, Manchester, Newcastle upon Tyne, Sheffield and Stoke on Trent).

The Healthy Cities concept was based on the recognition of the importance of the local and urban dimension...

Overall goals of the WHO Healthy Cities Network

There are six strategic goals for the WHO network:

- **To promote policies and action for health and sustainable development** at the local level and across the European region, with an emphasis on the determinants of health, poverty and the needs of vulnerable groups, increasing local capacity and promoting good governance.
- **To increase accessibility of the WHO Healthy Cities Network** to all 52 member states of the European region;

- **To promote solidarity, cooperation and working links** between European cities and networks and with cities and networks participating in the Healthy Cities movement in other WHO regions;
- **To strengthen the national standing of Healthy Cities** in the context of policies for health development, public health and urban regeneration;
- **To play an active health advocacy role at European and global levels** through partnerships with other agencies concerned with urban issues and networks of local authorities;
- **To generate the policy and practice know-how, the good evidence and the case studies** for promoting health to all cities in the region.

Underpinning all of the strategic goals of Phase IV is an aspiration to increase the effectiveness of the network as a whole.

Phase IV concept and core themes

The concept of the Phase IV approach is based on two elements:

1. **An investment in health development**, which is partnership-based and which puts emphasis on equity, tackling the determinants of health, sustainable development and participative and democratic governance. City Health Development Planning will remain at the heart of Healthy Cities work, providing cities with a means to build and maintain strategic partnerships for health and to develop a platform to encourage all sectors to focus their work on health and quality of life. The cities participating in the Phase IV WHO Healthy Cities Network will be developing and implementing an inter-sectoral plan for health development being informed by an up-to-date city health profile (report on the health of the city).
2. **A working partnership with the European Office of WHO** on core developmental themes with the aim of developing knowledge, tools and expertise which will be of benefit to all European member states. The

choice of these themes reflects European public health priority issues and issues that require further development. The WHO Phase IV network work on core themes will be based on specific and commonly agreed deliverables in 18 to 24 month cycles. The WHO network can then add new core themes to work on. During the first two years of Phase IV, cities will be working on the following core developmental themes:

- **Healthy urban planning**: encouraging and supporting urban planners to integrate health considerations in their planning strategies and initiatives with emphasis on equity, wellbeing, sustainable development and community safety;
- **Health Impact Assessment (HIA)**: applying HIA processes within cities to support cross-sectoral action for promoting health and reducing inequalities. Through a combination of procedures, methods and tools, HIA provides a structured framework for mapping the health consequences of a policy, programme or project.

In addition, there will be a complementary focus on healthy ageing whereby the network can directly benefit from work being carried out in WHO and elsewhere with a view to identifying and implementing transferable tools and expertise at the local level:

- **Healthy ageing**: working to address the health, care and quality of life needs of older people with special emphasis on active and independent living, creating supportive environments and ensuring access to sensitive and appropriate services.

Ways of working

Attention will be paid to ensuring that capacity is built across the network, focusing both on strengthening the capacity of member cities individually and on investing in the potential of the network as a whole. Whilst the Healthy Cities movement has always recognised its geographical spread and the political commitment from cities as a strength, the scope of the network with regard to advocacy, public health influence, transferable learning, mutual support and sharing of expertise, has not been realised in full.

Underpinning all of the strategic goals of Phase IV is an aspiration to increase the effectiveness of the network as a whole. In particular, the goals of promoting solidarity and cooperation between cities, and of playing a more active role at European and global levels, require Healthy Cities to operate as a strong and cohesive network. In order to enhance network capacity and effectiveness, attention will be paid throughout Phase IV to issues of:

- **Promoting networking**: both within the network (through sub-networks, mentoring and communications processes) and through strengthening links with other networks (at national,

European and global levels) and to other WHO programmes;

- **Monitoring and evaluation:** monitoring impact, with appropriate indicators and focusing on outcomes; documenting evidence of good and effective practice; encouraging and supporting empirical comparative studies on selected topics involving groups of interested cities (eg on social integration of the elderly, or transport and health);
- **Methodological support:** training and education relevant to the implementation and evaluation of Healthy Cities approaches; development of tools and resources to support practice (eg in relation to healthy urban planning); support for the replication of projects and activities that have been effective in supporting the goals of Healthy Cities;
- **Support for network infrastructure:** from WHO and through the network advisory committee structure; fundraising; investing in translations and a translations fund; interactive web site and newsletter.

A promising future

Healthy Cities is a genuinely diverse and multifaceted movement that is active and visible in every part of the world and supported by all six WHO regions. The Healthy Cities approach is more relevant than ever. Many new global strategies and initiatives on sustainable development, violence and health, diet and physical activity, Local Action 21, healthy environments for children, etc, recognise and stress the relevance of the urban context and the importance of the role of local governments. Increasing numbers of international agencies including the World Bank, the Council of Europe, UNESCO (United Nations Educational, Scientific and Cultural Organization), UNICEF (United Nations Children's Fund - formerly United Nations International Children's Emergency Fund), the OECD (Organisation for Economic Cooperation and Development), UNEP (United Nations Environment Programme) and UN-HABITAT (The United Nations Human Settlements Programme) support programmes and projects on aspects of urban development. The European Union (EU) develops strategies that address the urban environment, urban development, governance and health.

Ten major networks of local authorities including ICLEI (International Council for Local Environmental Initiatives), CEMR (Council of European Municipalities and Regions), Eurocities, Energy Cities and Healthy Cities are working under the umbrella of the EU supported European Sustainable Cities and Towns Campaign promoting implementation of sustainable development policies and plans at the city level.

Healthy Cities is uniquely positioned with its long experience in partnership-based work and its well-established networks. There are great new opportunities to further expand the Healthy Cities

Healthy Cities is a genuinely diverse and multifaceted movement that is active and visible in every part of the world and supported by all six WHO regions.

policy and strategic agenda and to strengthen its standing nationally, regionally and internationally.

Dr Agis D Tsouros is Head of the WHO European Centre for Urban Health and Jill Farrington is Deputy Head.

Useful websites

Agenda 21

<http://www.un.org/esa/sustdev/documents/agenda21/>

CEMR <http://www.ccre.org/docs/index.html>

Council of Europe <http://www.coe.int/DefaultEN.asp>

Council of European Municipalities and Regions

<http://www.ccre.org/docs/index.html>

Eurocities <http://www.eurocities.org/>

European Sustainable Cities and Towns Campaign

<http://www.iclei.org/europe/la21/sustainable-cities.htm>

Health for All <http://www.who.int/archives/hfa/>

Healthy Cities Phase IV package

<http://euro.who.int/healthy-cities>

ICLEI <http://www.iclei.org/>

International Council for Local Environmental Initiatives

<http://www.iclei.org/>

OECD <http://www.oecd.org/home/>

UNEP <http://www.unep.org/>

UNESCO <http://www.unesco.org/>

UN-HABITAT <http://www.unhabitat.org/>

UNICEF <http://www.unicef.org/>

World Bank <http://www.worldbank.org/>

World Energy Cities Partnership <http://www.wecp.org/>



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