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Introduction

John-Paul Vader
EUPHA president 06/07

EUPHA 2006 is history. From 16 to 18 November, 1'300 public health professionals from 62 countries gathered in Montreux for the 14th Annual EUPHA Conference. It is a pleasure for me in my role as Chair of the Conference organising committee to introduce this mosaic of highlights of the conference.

Reactions indicate that this year's meeting, organised jointly by the Swiss Society of Public Health and the University of Lausanne Institute of Social and Preventive Medicine (IUMSP), was a landmark in the long line of successful conferences. It crowned a landmark year under the presidency of Prof. Horst Noack.

Vital to this success was no doubt the tremendous rallying of so many key players in the Swiss public health scene: federal and cantonal governments; the health promotion foundation; the associations of physicians, nurses, chemists and hospitals; the school of public health; the development agency, the league against cancer, the institute for the prevention of substance abuse, the health observatory.

All meeting rooms at the conference centre were renamed for the occasion to pay tribute to a selection of pioneers in various aspects of the struggle for the public's health and human rights: Mann, Snow, Jebb, Blackwell, Delachaux, Donabedian, Bojan, Nightingale, Pasteur, Dunant, Cochrane, Semmelweiss. It was a fitting reminder to us that whatever victories we have won or will win in the field -- and the potential for progress is tremendous -- we are but adding a marginal gain to the work of our forerunners.

The conference benefited from the interventions of distinguished regional, national, European and international public health officials. But the main actors were the participants: public health practitioners from the field and from different professions, policymakers, and researchers and teachers from academia. In the plenary sessions, workshops, through the poster sessions (250 posters!) and in the 66 parallel sessions, the pre-conference and satellite events, and especially through networking, all sought ways and means to help make policy, practice, training and research converge to serve the public's health. It was indeed the participants who added shape, form, colour and diversity to the warp and woof created by the Organising Committees, the National Advisory Board, the EUPHA sections and the International Scientific Committee.

Behind the exemplary organisation were: Markus Kaufmann, Nicole Baltisberger and Martina Westreicher of the Swiss Society; Dineke Zeegers from the EUPHA office; Valérie Pittet from the IUMSP; and Andreas Lampart and his team of « Organizers ». How exalting it was to witness the flowing together of the work of these teams, in perfect harmony, with extraordinary commitment and marvellous efficiency. Our gratitude goes to all of them!



Introduction

Horst Noack
 EUPHA president 05/06

The 14th Conference of the European Public Health Association (EUPHA), held from 16 to 18 November 2006 in Montreux, Switzerland, was another landmark in the history of European public health. It attracted more than 1 300 public health experts from over 60 countries – an absolute EUPHA record. With 66 oral sessions, over 250 poster presentations and more pre-conference activities than in previous conferences it was the most extensive EUPHA conference ever.

[this first paragraph is a repetition of what John-Paul has put and could be either shortened or deleted]

The Montreux conference provided a very pleasant environment and a unique opportunity to meet friends and colleagues, share experiences and discuss the development of European public health. On behalf of the European Public Health Association I would like to express my deep appreciation and gratitude to the Swiss Society of Public Health, the University of Lausanne Institute of Social and Preventive Medicine and especially to the Chairman of the Local Organising Committee and 2007 EUPHA President, my former colleague Professor John-Paul Vader. In my view EUPHA conferences have reached an excellent scientific standard, a high level of organisational quality and a strong sense of professional commitment.

The organisers of the Montreux conference posed a timely question:

“... to what extent can the pertinence of our experience as public health practitioners, the relevance of our results as public health researchers and the ardour of our commitment as concerned citizens be brought to bear on health politics and health policies in a way that will tip the balance in favour of ‘and the public’s health rather than ‘or the public’s health’ “.¹

According to my own observations and interpretation this question has guided the speakers, discussants and chairs in the plenaries and the oral sessions, in workshops as well as in informal discourse. I would guess that most of them favoured the ‘and’ metaphor.

A large part of the public health community participating in EUPHA conferences seems to agree that public health policies and health politics should no longer be considered distinct fields. Health politics should actively foster and implement public health policies addressing the major determinants of health in order to achieve sustained population-wide health improvement. This was clearly shown in a study analysing the content of a large sample of presentations and about 70 interviews with participants at the 2005 EUPHA conference in Graz. It was concluded that many European countries lack the organisational infrastructure and the professional workforce to develop and implement determinant-oriented health policies.²

As shown by the 2006 conference in Montreux as well by most of the previous EUPHA conferences the public health sciences have established a rapidly growing knowledge base which is overwhelming in terms of content, diversity and magnitude. There exists, however, a serious gap between the public health knowledge at our disposal and the

¹ Prof. John-Paul Vader: Introduction, European Journal of Public Health, Volume 16 Supplement 1, 2006, 1.

² Noack, H.: Towards a healthier future, In Noack, H., Kahr-Gottlieb, D. (eds.), Promoting the Public’s Health, Health Promotion Publications/Verlag für Gesundheitsförderung, Gamburg, 2006, 249-256.



knowledge which is translated into public policy. The public health community is challenged to reduce this gap.

EUPHA's 10 Statements on the Future of Public Health in Europe can serve as a suitable guide to meet this challenge, as the following selected statements may illustrate:

1. *Future public health can only be achieved if the whole society invests in it: building partnerships is essential here.*
3. *Public health should form an integral of the political agenda in all sectors.*
6. *Research should focus on the needs of policy and practice.*
7. *Researchers should learn how to interact with politicians and practitioners.*

These statements emphasise the need to build closer links between public health research, public health policies and health politics. The Swedish health reform of 2003 and the Health in All Policies implemented in Finland are interesting European cases of evidence-based and determinant-oriented health policies.^{3,4}

Effective capacity building for sustained public health policies and effective health politics will continue to be one of the core functions of the European public health community in the 21st century. Reducing health inequalities within the framework of a comprehensive Health in All Policy remains to be one of the major challenges.

³ Stahl T., Wismar M., Ollila E. et al. (eds.): Health in All Policies, Ministry of Social Affairs and Health Finland, 2006.

⁴ Hogstedt C., Lundgren H., Moberg H. et al.: The Swedish Public Health Policy and the National Institute of Public Health. Scandinavian Journal of Public Health, December 2004, Supplement 64.



Introduction

Ignazio Cassis, president Swiss Society of Public Health

Markus Kaufmann, secretary general Swiss Society for Public Health

The local organising committee (LOC) gathered for the first time in May 2004 and worked for almost two and a half year to prepare the EUPHA conference in Montreux. The key for the success of the conference was the involvement of all important Public Health Players in Switzerland. The Health promotion foundation, the Swiss Federal Office for Public Health and the Swiss Institute for the Prevention of Alcohol and Drug Problems have sent their delegates to the LOC. Other partners of the conference were the Swiss Agency for Development and cooperation, the Swiss School of Public Health, the canton of Vaud, the Swiss Health Observatory, the Swiss Hospital organisation, the Swiss cancer league, the Medical Association, the Swiss Pharmaceutical Society, the Swiss Nursing Association and the Swiss Commission of Unesco. These organisations supported the conference not only financially (39 % of the total cost of 890'000 Euros). They participated largely to the content of the conference with abstracts and workshops. The fact that 476 out of the 1300 participants came from Switzerland was also the due to the strong support of the partners.

A very important part of the conference was the pre-conferences activities on Wednesday and Thursday. Almost 150 persons visited the WHO headquarter in Geneva. Another group went to the Nestlé Research Centre in Lausanne. The themes of the pre-conference meeting covered a wide range: Sickness absence, migrant health, adolescent health, health literacy, health services research, new vaccines, nutrition at school, collaboration between Public Health departments and Universities, Training of future Public Health professionals, prevention of infections, allergies and asthma and "Electronic child records". The pre-conference meetings are a very important opportunity for the EUPHA sections to gather and discuss specific themes. Five activities were organised in collaboration with the industrial sponsors: Nestlé, Astra Zeneca, Sanofi Aventis, Wyeth, Sanofi Pasteur MSD and MSD. The sponsorships covered 16 % of the total costs and were realised according the rules set by the EUPHA executive Council.

The 1300 participants came from 57 countries – the largest delegations after Switzerland (476) came from the Netherlands (125), United Kingdom (83), Sweden (60) and Germany (55). The delegations from Italy, Denmark, Spain, Finland, Belgium, France, Austria, Lithuania and Norway counted more than 20 participants. The participants' fees covered 46% of the total cost of 707 Euros per person.

On behalf of the local organising committee we thank all who have contributed to the success of the conference: keynote speakers and abstract authors, partner organisations and sponsors, members of the governing council, the sections, the scientific committee and finally all the participants.

Key notes lectures

A HISTORY OF HEALTH: HOW AND WHY?

Patrice Bourdelais

Professor, Ecole des hautes études en Sciences sociales, paris

If the historical approaches have been for two millennium one of the basis of the reflection on the societies, and a way to better understand the present - even to imagine a future-, the quick changes occurred for some decades, especially in the scientific and technical domains, seem to have made useless any reference and knowledge to the past. The commemorations or memories are more present on the media than history and some persons can even say that the only important thing is to control the building of the memory of the past. The scientific historical approaches are very often in rupture with the phenomenon of memory building, because the later is based on emotion and immediate political goals and the former on a more sophisticated knowledge process trying to verify the value of the materials mobilized to work: the data, the documents, the testimonies.

Today it is obvious that specialized answers from economics, management or Public Health are not totally relevant because they don't take into account of lot of other dimension of the social life and have difficulties to integrate a dynamic perspective from the past to the future. A new health campaign for instance has to integrate a lot of cultural characteristics to have chances to succeed. The questions addressed to the past are numerous: on the control of epidemics and the fall in the mortality, on the reasons of this fall, on the building of our welfare system and its values... The interest of the historical approaches is to include economic, social, cultural, medical dimensions and try to weave them together to propose the most complete possible explanation about the evolutions identified. The key note has been organized in three parts:

- The past as a laboratory of experiences;
- The history as a process
- The weight of the representation of the past in the mind of our contemporaries

I. The past as a laboratory of experiences:

A. To understand the epidemiological specificities of a new disease

Historical epidemics have been used to better analyse the characteristics, to understand how they disseminate (vector, circumstances, environment ...).

Many evidences have been given about the complex links between scientific knowledge and measures taken to protect the population (efficient measures without knowledge – plague case- but also the opposite, inefficient measures in spite of correct bacteriological knowledge-cholera in Hamburg 1894).

It just points out that a lot of factors interferes between scientific knowledge, political decision and population behaviour for instance.

-B. The arrival of a new epidemic:

How it was announced, what happened on the authorities side, on the population side. With what consequences? On the mortality side, on the economic, social or cultural ones.

-C. A sanitary crisis : the urban penalty :

Why and how to solve it: with the urbanization and industrialization a lot of European cities have known around the middle of the 19th century, a huge mortality increase. Thirty years were necessary to compensate the new penalty and the measures taken indicate that there were no magic bullets but a wide range of specific measures.

II. The history as a process :

A. In our field of Public Health the ways in which the **Great Plague** has been managed probably offer us a good starting point.

But to analyse the arrival and the extension of the plague, we also need to take into account the increase of the population, and especially of the cities, during the 13th century, which lead to an increase of the cereals commerce from the Eastern of Mediterranean, we have to had the war between the Mongols and Italian cities in the Crimea, and the pressure of financial interest for cities and merchants to explain that the plague finally arrived in the harbours of the western Mediterranean.

The Italian cities were already some sort of local states, with specialized functions, bodies of servants, and implemented a concerted and articulated policy. They try to organize a protection of the land from outside by controls, quarantines, lazarettos, sanitary passports.

B. The building of the Early Modern Central Royal State

Since the 15th and 16th, several European countries knew an evolution in their power structure and organization which had as results to centralized the decision, the initiatives and the power on one side, and to consider that the population was the first factor for the wealth and of the power of the Kingdom.

The population is observed, managed, organized and protected. The States organized protection against plagues, wider and wider, the sanitary cordons which isolated a contaminated region from a still healthy one were enlarged during the beginning of the 17th to whole regions, the whole Catalonia for instance or the whole Parisian region (from Rouen to Rheims). This scale of intervention and the permanence of the control until the end of the danger finally lead to the eradication of the Plague after the last epidemic in French Provence at the beginning of the 18th century.

During this period, the medical doctor began to emerge as a profession, regulated, organized and officially patented by the kings.

C. A new era

The mid 18th century saw another major changes: economic improve, plague disappearing, generalized body care among the elites, new demand for medications, and medicine. The smallpox vaccination leads to an important victory against a very serious epidemic which made millions of deaths each year in Europe. The States encouraged, and sometimes organized the first vaccinations. The new demand for body care and health lead to the increase of the social place of medical doctor and to claims also from them.

As the Enlightenment movement emphasized also on the fact that the knowledge would mean progress and social progress too, with a future which will be totally different from the past, this created a big rupture in the ways in which the health and welfare systems were organized.

During the 19th century, the implementation of sanitary movement thesis was more and more present, the welfare systems more and more obvious and complete. Our present social security systems in Europe have been built at the end of the 19th century and after the II World war, offering a minimum net to people and families to survive even confronted to illnesses or unemployment moments.

The health became little by little a market place also where the medical doctors and the pharmacists were eager to defend their monopole, their revenues, their social importance...

Between the two world wars, the pharmaceutical industry developed on the new chemical synthesis, in a decade of large progress of medications (a number of vaccines and sulphonamides for instance, and just after the second world war the antibiotics), a huge industry is emerging then and this recent history is still really present today as you know.



III. The weight of the representation of the past in the mind of our contemporaries

The history is present in the mind of the population today, a lot of representations of the past with some very precise points on our field.

A. The increase of the life expectancy

Deeply assimilated by people today, the fact that we have known a broad progress since the Second World war, with important consequences : an improvement of Health which gives a longer adult age and a postponement of the elderly period with a redefinition of the rhythm of the generation successions.

The population has associated that progress to the normal evolution of our societies.

B. The infection diseases as diseases from the past

For the European population today, the epidemics and infectious diseases are characteristics of the past or of the poor countries.

Which explain the worry about the possibility of a new epidemic as SARS or Chicken Flue. The government will be responsible for each sanitary problem of this type with eventually very serious consequences, which explain that they try to organize even now the defence against the epidemic propagation

C. The welfare system identity

As the modern welfare system has been built little by little since the end of the 19th century to be totally organized after the Second world war, managing maternity, illnesses, retirements... the whole system is seen by the population as a base of the today society, as a characteristic of the place of the country on a scale of social progress. It is the reason why one part of the population in a lot of European countries votes regularly against Europe integration process, because they think that their own welfare system will be impoverished by Brussels and the dominant liberal policy. It is of course a big issue, clearly historically rooted.

Conclusion:

The history of Public Health is today very important because of the place of body cares in our societies. The European populations have still in mind the historical horizon of eradication of infectious diseases and the historical horizon of an boundless progress in social condition and level.

The history of this field helps also to have a more critical view about the policies proposed and the ways in which they are applied. The main governmentally is not the public health but the liberal economy which means that the health priorities can never arise at the first rank but only, in the best case at the second. It also allows to test some big issues as the role of a welfare policy in the economic development and not the opposite.

The history of Health has also shown that the ideal of Progress has been one major lever to solve finally the obstacles to a diminution of the mortality or to the build a better access to cares, even if the consequences of social inequalities are still very important.

Key notes lectures

SLEEP AND HEALTH: GENDER, SOCIO-ECONOMIC CIRCUMSTANCES AND INEQUALITIES IN SLEEP

Sara Arber

Professor, Centre for Research on Ageing and Gender (CRAG), Department of Sociology, University of Surrey.

Sleep is fundamental to health and well-being, with lack of sleep increasingly shown to impact on cardiovascular risk factors and diabetes, as well as work and traffic accidents. Yet sleep has been the subject of little epidemiological or public health research, and is largely invisible in health promotion literatures. Inequalities in health research are not matched (yet) by parallel research on the extent and nature of inequalities in sleep among representative population samples.

The presentation addresses two distinct areas. First, sleep provides a rich site for understanding aspects of gender inequalities within the family. The quality and timing of sleep is influenced by the social context in which it takes place, and by the individual's roles in the private and public sphere. The majority of adults share their sleeping space with a partner; each partner's actions influence the quality of the other partner's sleep, but in gender differentiated ways. Our qualitative data (focus groups, couple interviews, individual interviews, audio sleep diaries) illustrated how studying sleep can be used as a window to examine the dynamics of gendered relationships.

Second, the presentation analysed a representative sample from the UK *Psychiatric Morbidity Survey, 2000*, which asked questions about the quality of sleep and sleep problems. A sample of over 8000 men and women, aged 16 to 74 will be analysed, focusing on reported sleep problems. Nested logistic regression models show how the extent of sleep problems varies with age, gender, marital status, responsibilities for children, socio-economic circumstances and health status. There are strong links between socio-economic circumstances and poor sleep quality, particularly low income, Authority housing, non-employment and low educational qualifications. Although reported worries, smoking, health status and psychological health are closely linked to sleep problems, these variables do not explain the identified associations of disadvantaged material circumstances with poor sleep.

Selected Publications on Sleep

- J Hislop and **S.Arber** (2003) 'Sleepers wake! The gendered nature of sleep disruption among mid-life women' *Sociology*, 37 (4): 695-711.
- J Hislop & **S Arber** (2003) 'Sleep as a social act: A Window on gender roles and relationships' in **S.Arber**, K. Davidson & J. Ginn (eds) *Gender and Ageing*, Maidenhead: Open University Press.
- J Hislop and **S Arber** (2003) 'Understanding Women's sleep management: beyond medicalisation-healthisation?', *Sociology of Health & Illness*, 25(7): 815-837.
- J Hislop and **S Arber** (2004) 'Understanding Women's sleep management: A response to Simon Williams', *Sociology of Health and Illness*, 26 (4): 460-463.
- A Dzaja, **S. Arber**, J Hislop, M Kerkhofs, C Kopp, T. Pollmacher, P Polo-Kantola, D Skene, P Stenuit, I Tobler and T Porkka-Heiskanen (2005) 'Women's sleep in health and disease', *Journal of Psychiatric Research*, 39: 55-76.
- R Meadows, S. Venn, J. Hislop, N. Stanley and **S Arber** (2005) 'Investigating couples' sleep: an evaluation of actigraphic analysis techniques', *Journal of Sleep Research*, 14 (4): 377-386.
- J. Hislop, **S. Arber**, R. Meadows and S. Venn (2005) 'Narratives of the Night: The Use of Audio Diaries in Researching Sleep', *Sociological Research Online*, 10(4): <<http://www.socresolnline.org.uk/10/4/hislop.html>>.
- J Hislop and **S Arber** (2006) 'Sleep, gender and ageing: Temporal perspectives in the mid-to-later life transition'. In T Calasanti and K Slevin (eds) *Age Matters: Realigning Feminist Thinking*, London: Routledge
- Website: <http://www.sociologyofsleep.surrey.ac.uk/>

Key notes lectures

ADOLESCENT HEALTH IN EUROPE: WHAT WE KNOW AND WHAT WE STILL DON'T KNOW

Pierre-André Michaud

Professor, Multidisciplinary Unit for Adolescent Health, University Hospital, Lausanne, Switzerland

In many European countries, the health and quality of life of adolescents has declined over the last two decennia's or - at best - has remained stable. The improvement of adolescent health thus constitutes a major public health challenge which can be addressed in several areas.

Area of epidemiological data

Although epidemiological data are currently available in several if not most European countries (mortality/morbidity rates, self-assessed status of health and health determinants), their utilization in the field of public health and policy making is limited by three factors:

- 1) the absence of a real consensus on how to measure health indicators and how to disaggregate the age span of adolescence;
- 2) the lack of measures of these indicators over time (trends);
- 3) a deficient dissemination and valorisation of the data among politicians and decision-makers.

Area of health care settings and health care delivery

The second area of concern is the one of health care settings and health care delivery: we have some evidence on the effectiveness of implementing youth-friendly health services in meeting the specific needs of adolescents, but we still lack strong evidence that the implementation of such services has a long-term impact on their health status. Although we have some evidence that training health care professionals improves their skills in the screening of behavioural/mental problems, we have little evidence that the comprehensive approach advocated by adolescent physicians (such as applying the "HEEADSSS" acronym) is effective in reducing short-term and long-term health burdens and problems. Preventive and health promotion strategies therefore represent one of the most promising ways to improve adolescent health in developing and developed countries. The school health setting has been the most studied area for interventions. In several fields such as nutrition, physical activity, substance use, mental health, sexual & reproductive health and unintentional violence, both life skills approaches and the modification of the environment have proved to be the more effective.

The lack of clear evidence in many areas as outlined in this presentation should not deter anyone in keeping adolescent care and health promotion on the agenda. On the contrary, it is a very good reason to encourage all stakeholders to put more resources in improving the health of this segment of the population and to improve the quality of the research. The presentation concluded on future areas of research and on the importance of involving young people in the development of health enhancing interventions.



Key notes lectures

THE PREVENTION OF DISEASE AND PROMOTION OF HEALTH THE NEED FOR A NEW APPROACH

S. Leonard Syme

Professor of Epidemiology and Community Health (Emeritus), School of Public Health University of California, Berkeley, U.S.A.

Effective disease prevention and health promotion programs depend on the identification of disease risk factors. The objective of this search is to share with people information about some of these risk factors in the hope that they will change behavior to lower their risk. There are three major problems with this model that require our serious attention. First, after decades of epidemiologic research, it has proven very difficult to identify disease risk factors. Second, even when we do identify risk factors, it has been very difficult for people to change behavior to lower their risk. Third, even if everyone did change their behavior, new people will continue to enter the risk population because we rarely take account of the fundamental determinants of health at the population level that cause the problem in the first place. These three issues are a major challenge to our current public health model and, to address them, we will need a different approach. The new approach will require a new way of classifying disease, one that does not depend on the currently- used clinical model of disease. It will also require that we focus (1) more on life problems that are of concern to people in the community and (2) less on problems of concern to us in Public Health. To accomplish this transformation, we will need to develop new ways of funding both research and training programs in population and public health. This, in turn, will require governmental policies very different from those now in place. That may be the biggest, and most difficult, challenge of all.

Key notes lectures

**POLITICIZING HEALTH STATISTICS:
THE DANGER OF THE NUMBER GAME
FERANC BOJAN MEMORIAL LECTURE**

Nina Schwalbe

Director of Policy, TB Alliance, New York

It is a great honor to be giving the Feranc Bojan Memorial Lecture. I never had the opportunity to meet Professor Bojan, but heard a great deal about him from my mentor, colleague and friend, Martin McKee.

From 1998 until 2005, Martin and I worked on a project to invest in and strengthen schools of public health and public health education in Central and Eastern Europe. The conceptual framework for this program was based on Prof. Bojan's work in establishing a new school of public health in Debrecen, Hungary. The Debrecen School, now 10 years old, has received international acclaim for its excellence and under the strong leadership of Rosa Adany, serves as a training hub for the region.

In Dr. Bojan's honor, I have been asked to speak today about an issue related to the countries of the former Soviet Union. In keeping with the theme of the conference, "Policies, Politics and/or the Public's Health," my focus will be on the role statistics have played in health policy decision making.

I began thinking about statistics and politics in graduate school in 1991. My thesis was on infant mortality in Central Asia. In order to get the data for the report, I received special access to a library in Washington, D.C. at the U.S. Bureau of the Census. This library held international population statistics. The chief statistician there took me through multiple passage ways to a locked room and brought out a copy of a document with black pen marks on the top of each page.

The document was a 1986 compendium of basic population health statistics from the Soviet Union, including demographic information and morbidity and mortality, by oblast. It had been smuggled out. The marks on the top of each page hid a printed number. That number identified the copy and the person to whom it had been assigned.

When I tried to access a similar set of statistics in Russia in 1998, I learned that the practice of assigning numbered copies had not changed. One Friday night that year a senior official at Moscow Medical Academy gave me his version to photo copy – but only on the condition that it was back in his office by Monday morning. I still keep this copy on my desk as a reminder of the deeply political role that statistics can play.

Statistics were not only hard to access; they were also commonly misunderstood and thus misused. For example, absolute figures were often used instead of rates to make year to year comparisons. When working in Sverdlosk in the mid-90s, I had a discussion with the chief obstetrician/gynecologist of the region. He was excited that the absolute number of abortions in his region had dropped the previous year. But when we looked at the figures together with numbers of births, as a rate, in fact he saw that the situation was worsening, not improving. What we were seeing was the result of a dramatic fall in overall births. Such confusions between absolute numbers and rates were also very common in the media.



As this audience clearly understands, appropriate statistical information is critical for making evidence based policy decisions. Much of the time, however, appropriate data do not exist. And even where they do, data are often misused and numbers and information “spun” to reflect a particular political bias.

Before going further, I need to admit my own bias, as a TB advocate. As the policy director at the Global Alliance for TB Drug Development, I lobby against an 8000 year old bug, which now kills a projected 1.7M people per year. This disease, largely controlled in most high income countries, has become a leading infectious cause of death in many low income countries, particularly those with a high prevalence of HIV.

The goal of our policy work is to get people to care about TB and convince them that a key reason TB is such a problem is that there have been no new drugs for its treatment developed for over 40 years. There have been no new drugs, because TB is a disease of the poor, with very little market value or profit to be made by pharmaceutical companies.

As an advocate, I recognize how we manipulate statistics and make different diseases seem relatively more important by choosing how we will measure them. This leads me to the subject of today’s talk.

In my experience, there are three ways statistics are most commonly misused. The first is to *understate* the problem, failing to disaggregate data so that a high rate in a particular vulnerable group is lost in the overall population rate. For example, according to a report by UNDP, in 1989 in Bulgaria, the national infant mortality rate was 40 per 1000 live births, however among the Roma population it was 240. Thus, knowing only the national rate hides the problem among Roma⁵.

Another example comes from the US in 1990. At that time, life expectancy for males was close to 72. However, a study in the New England Journal of Medicine showed that for black men in Harlem, New York, it was 8 years younger (and that these men were less likely to reach the age of 65 than men in Bangladesh). Thus the national rate masked a serious health problem among a particular subpopulation⁶.

The second most common way to misuse data is to *overstate* the problem, often through use of modeling and other statistical techniques. One example is claiming that 30 percent of world is infected by TB, but failing to explain that their infection is latent. Another example relates to discussing mortality. If we look at overall mortality in high income countries, cardiovascular disease is the most significant contributor. If we revise our parameters to look at “years of life lost under 75” cancer has greater prominence than cardiovascular disease. If we look at “years of life lost under 60,” then injuries become most important. By also factoring in “disability,” we can make a strong case for action on mental health.

Finally, statistics are often misused, just by being *ignored*. In other words, no matter how horrifying the information, it doesn’t make a difference. Instead, decisions are made to achieve political gain.

With regard to TB and HIV in the former countries of the Soviet Union both *understatement*, *overstatement* and *ignorance* have been used to further particular political agendas.

⁵ ROMA Human Development Challenges and Opportunities. <http://roma.undp.sk/>

⁶ McCord C (1990). Excess mortality in Harlem. *New England Journal of Medicine* 322:173-177

In terms of TB, as of 1992, reported rates began to increase in all parts of the FSU and rose for over a decade⁷. Although now beginning to drop again, rates remain high, with 10 out of the 15 countries of the region currently classified by WHO as “high incidence” (more than 70 cases per 100,000 population). Although still low, as compared to countries in Africa and Asia, the statistics become alarming when broken down by sub-populations. For example, in Russia in 2002, the general population rate of TB was 90/100,000. However, among the sub-population of prisoners, the rates reached over 4000/100,000 in some regions of the country⁸ and mortality for the prison population was 40 times higher than the civilian population.⁹

Without providing policy makers with disaggregated statistics such as these that explain the differences between the general population and subpopulations like prisoners there is no way to understand the nature of the problem or how to allocate the appropriate resources to deal with them. In this case, by looking only at the overall rate, one might focus on the civilian sector, rather than investing in TB control in prisons.

While use of rates has understated the problem among prisoners, use of absolute numbers has overstated the problem in Russia, as compared with the rest of the region. Let me explain.

WHO has ranked the countries with the greatest number of TB cases as “high burden”. Russia’s rate, or *cases per 100,000*, is significantly less than that of Kyrgyzstan, Kazakhstan or Moldova but because of the size of its overall population, it is among the top 22, classified as a “high burden country,” and thus eligible for donor resources and technical assistance¹⁰. China and India illustrate the same issue – lower rates than other countries but because of their enormous populations, they are among the 22 “high burden countries.” In theory, addressing TB in these 22 most populous countries will eliminate TB as a global public health threat. However, in practice, countries with higher rates of disease are left out of the “high burden club” because of their small populations. Is this emphasis on “quantity” really what we mean when we teach “new public health”? Is this really in line with our so called commitment to “health for all”?

In TB, targets are also problematic. The World Health Assembly goal for TB is “reaching 70 percent of smear positive cases and curing 85 percent of them.” However, only about 50 percent of people with active TB are actually “smear positive.” Children and people with HIV, for example, are often smear negative. So what about these special populations? Do they not matter to the TB public health community because they are less infectious and thus less likely to spread disease?

And why is the target only 70 percent? What about the other 30 per 100 people? Further, is a cure rate of 85 percent aspirational enough? Does it mean we are willing to state that we have achieved success if 15 percent of patients under treatment die? One wonders the extent to which the politicians who endorsed the target, really understand that it is about reaching less than 50 percent of cases in only 22 countries.

To return to TB and the region, the rates of drug resistance are truly alarming. In Eastern Europe, almost 10 percent of all cases are drug resistant.¹¹ In Latvia close to

⁷ HFA Database, www.euro.who.int/hfadb

⁸ Bobrik A, et al (2005). Prison Health in Russia: The Larger Picture. *Journal of Public Health Policy* 26:30-59

⁹ Bobrik A, et al (2005). Prison Health in Russia: The Larger Picture. *Journal of Public Health Policy* 26:30-59

¹⁰ Zignol, et al (2006). Global Incidence of Multidrug-Resistant Tuberculosis. *Journal of Infectious Diseases* 194:479-485

¹¹ Zignol, et al (2006). Global Incidence of Multidrug-Resistant Tuberculosis. *Journal of Infectious Diseases* 194:479-485



20 percent of drug resistant cases have XDR¹². XDR is multi-drug resistant TB with additional resistance to at least three classes of 2nd line drugs.¹³ Further, XDR has now been identified in all FSU countries.

So what has history taught us about how to sell very data-driven arguments to politicians? If we review the global MDR advocacy campaign in late 1990s, we see that the political will garnered had little to do with rates or statistics. The convincing argument was devoid of an evidence base. Some donors, like George Soros, engaged for human rights reasons. MDR was a problem in the prison population. “Why,” he asked, “were prisoners being given a TB death sentence simply because they were serving time for a crime”? Others choose not to engage for so-called “public health reasons.” They argued that MDR was too expensive to treat. And said, “why worry about prisoners? Isn’t the situation ideal? They are already locked up and thus in no way pose an epidemiological threat to the community.” Of course, this argument had many holes, not the least of which was that it failed to acknowledge that prisoners can transmit infection to prison staff, who can then become vectors of transmission for society as a whole. But that is not the point. The point was that in this case, even the statistics were not compelling. What eventually swayed both donor and popular opinion was the “threat to self.” Because people from the region were allowed to travel more freely, there was a chance, albeit small, that the Russian or Uzbek or Tajik sitting next you on an airplane might have MDR and you would get it too.

As an aside, Martin McKee reminded me that the “threat to self” has always been a strong driver of public health policy. That is why the first public health policies related to both infectious diseases and mental health. The idea was to isolate people who might be of harm to you.

Between 1998 and 2000, together with a number of advocacy organizations, George Soros used the “airplane argument” to call together Hillary Clinton (then First Lady) and Gro Bruntland (then Director General of the WHO) to deal with the urgent epidemic of MDR in the Former Soviet Union. The “airplane argument” was supported by articles in the media and MDR and TB in the region were on the map. With this political pressure, treatment of MDR became part of the regular WHO guidelines for treatment of TB. But in the end, statistics had not convinced the policy makers – rather, fear had.

HIV

Advocacy for attention to HIV in the region took a different route than TB. For HIV, the numbers were first used to understate and then, perhaps, overstate the extent of the epidemic.

When I moved to Russia in 1994, HIV was very much suppressed from political discourse. The rationale people gave at that time for why HIV would not be a problem in the Former Soviet Union included – “Russian’s are different – they aren’t susceptible,” “HIV is an African disease” and “only tourists and gays carry HIV.”

The first registered case in the region, in 1986, was a homosexual in the military. Because of homophobia and the potential for scandal, attention to this case was minimized. The disease became more widely reported the following year, with an outbreak in Elista, Russia among children who had received injections and other invasive procedures with improperly sterilized equipment. In response to the Elista situation, the government invested heavily in setting up a system of vertical AIDS centers, one in each

¹² Zignol, et al (2006). Global Incidence of Multidrug-Resistant Tuberculosis. *Journal of Infectious Diseases* 194:479-485

¹³ CDC (2006). Emergence of *Mycobacterium tuberculosis* with Extensive Resistance to Second-Line Drugs – Worldwide, 2000-2004. *Morbidity and Mortality Weekly Report* 55 (11): 301-305



region, or oblast. In each capital city, there were usually two separate AIDS services – one oblast funded and one city funded. They were each big buildings with their own staff structures, separate from other health care services, and dedicated solely to HIV and AIDS.

The Russian government also invested in a system of mass population screening, performing 18-20 million tests per year. The screening methods, however, were problematic. Screening was population based, rather than focused on high risk groups. Those tested included food workers, teachers and other inappropriate categories. High risk groups, such as injecting drug users, were those least likely to be screened¹⁴.

In any case, Russia claimed the low case finding was evidence of the success of their system of AIDS centers and mass screenings. By the end of 1997, according to the Federal AIDS Center, there were still less than 7000 people in Russia who had been infected with HIV and fewer than 500 deaths¹⁵. In 1998, however, things began to change. This was a time in Russian history when oblast authorities enjoyed significant power in the political system and had liberty to voice opinions which differed from the central government. Some of the oblasts started to see dramatic increases in the numbers of cases. And even though nationally the absolute number of people with HIV was still low relative to other parts of the world, the rate of increase of new cases was alarming and growing exponentially with a 200 percent increase between 1999 and 2000 and a 100 percent increase in the following year¹⁶.

Also, in 1998, a number of NGOs initiated the first ever harm reduction programs in the region and through their work began to quantify the extent of the problem of injecting drug use. These groups put pressure on the federal government and external donors to commit increased resources to harm reduction as a key prevention strategy. The initial reaction to the oblast information and NGO lobbying was an aggressive denial by the head of the Russian Federal AIDS services that HIV was really a problem. He continued to cite the success of his AIDS centers and mass screening as evidence of program success. But with donor funds beginning to flow to NGOs and opportunities of significant financing from groups like the World Bank, the head of the AIDS service seemed to recognize an opportunity for additional resources to support a very expensive and bulky system. He then needed to lobby internally and change the official story. Rather than success, or despite success, he needed to prove that the epidemic was growing rapidly.

The World Bank, which was deeply committed to seeing a loan move forward, joined with the AIDS service in a complex modeling exercise which showed that the Russian epidemic was "spiraling out of control." The modeling showed that without appropriate and immediate investment in prevention there would 2.3 million cases by 2010 resulting in a drop of GDP by over 4 percent per year¹⁷.

The estimates were clearly off. In terms of GDP, Russia ended 2005 with its seventh straight year of growth, averaging 6.4% per year. As for HIV, the geometrical increases stopped and as of June of this year, cumulatively (since the first outbreak) a total of 350,000 cases were registered.¹⁸

Regardless of the truth, at the time, in order to get AIDS in Russia on the political agenda, we all had an interest in using the World Bank figures to make a successful case. As NGOs, we needed to convince our donors to fund needle exchange, methadone, and

¹⁴ Schwalbe, et al (2005). Draft Chapter: HIV/AIDS and Tuberculosis Control in Post-Soviet Countries.

¹⁵ www.hivrussia.org/stat

¹⁶ www.hivrussia.org/stat

¹⁷ World Bank, Averting AIDS Crises in Eastern Europe and Central Asia – A Regional Support Strategy, 2003

¹⁸ UNAIDS estimates – controversial in their own right - do claim actual numbers to be between 2 and 4 times higher.



other programs. Donor agency staff needed so-called evidence to advocate internally for money, and the Russian AIDS service and World Bank needed the data to convince the government to move forward with a loan. As with the TB, we initiated a very high level campaign, using political connections to engage Peter Piot, Elton John, and others in the fight. The campaign was successful in leveraging donations from many bilateral donors as well as the World Bank and Global Fund for AIDS, TB and Malaria (GFATM). UNAIDS and WHO made the region a "priority region" as the "fastest growing epidemic in the world" and the even the Russian government eventually increased its Federal AIDS budget - from \$5M USD in 2004 to \$110M in 2005/2006.

Although a success, there were unintended consequences from this advocacy effort. Donors governments, like the US and UK, ended most of their other funding and programs on public health education, reproductive health, mental health, civil society building, and health reform were all stopped. Suddenly, the only activities that received financing (or political attention) were for TB and HIV.

So what do we now know about HIV in the region? We now know that the epidemic is extremely concentrated among intravenous drug users and yet most drug users with HIV are not on treatment. Nor are prisoners with AIDS. Why the disconnect? Probably because health services don't want to prioritize these stigmatized groups for access to expensive health care and there is not enough credible data to evidence the discrimination.

What we need is better and more complete data so that we can tease out socio economic and other risk factors like race, sex or drug use. But precisely because such evidence often reveals social inequities, it is not always available. And even when information is available, it can be difficult to decipher. Let me take a few global examples from Lancet articles over the last few months:

- "2 billion people are infected with TB"
- "More than a billion people are infected with at least one species of soil transmitted¹⁹ helminthes"
- "A woman dies every 4 minutes from post-partum hemorrhage²⁰ "
- "More than 2 million children under 5 years of age die from pneumonia each year"²¹
- "Rotavirus is the most common cause of diarrheal deaths in children in developing countries²²"
- Cardiovascular disease is the leading cause of death, with 80% of cases occurring in developing countries²³

How does one make decisions when information is presented in this way? Especially given that so little data are available about vulnerable populations and so many diseases and conditions are termed "the leading cause of death"? How can we as the public health community advise policy makers responsible for allocating resources to public health?

Here I turn to EUPHA's 10 Statements on the Future of Public Health in Europe which provide an excellent framework for moving forward. In section 7, the EUPHA document makes the point that "Policy makers should be trained in how to interpret research

¹⁹ Brethony J, et al (2006). Soil-transmitted helminth infections: ascariasis, trichuriasis, and hookworm. *The Lancet* 367:1521-1532

²⁰ Chong YS, Su LL (2006). Misoprostol for preventing PPH : some lessons learned. *The Lancet* 368: 1216-1218

²¹ Wardlaw T, et al (2006). Pneumonia : the leading killer of children. *The Lancet* 368: 1048-1050

²² Glass RI, et al (2006). Rotavirus vaccines: current prospects and future challenges. *The Lancet* 368: 323-332

²³ Gaziano TA, et al (2006). Cardiovascular disease prevention with a multidrug regimen in the developing world: a cost-effectiveness analysis. *The Lancet* 368:679-686



results.²⁴ This point is critical. And the onus is not only on the public health community, it also on the broader policy community. We must demand and ensure that politicians, almost all of whom make decisions about public health and health care systems, have a basic literacy in public health and statistics. Public health and epidemiology must become an integral part of the social science curriculum for non-health personnel and not just reserved for graduate level study. Civil service exams should include basic public health concepts, like the differences between prevalence and incidence and rates and ratios.

We also must ensure that politicians commit adequate resources to data collection and social science research so that we are able to disaggregate information and tease out inequity. Many of the countries of the region still don't have accurate or accessible health information. Cross-national efforts like EuroHIV and Eurostat are examples of steps in the right direction, but they ultimately rely on country data, and must be sufficiently funded.

Even though I work on TB and HIV, I know that the biggest contributors to morbidity and mortality in the region are heart disease, cancer, accidents and diabetes. Thus the more successful our advocacy on TB and HIV, the more I worry that the policy makers we are convincing lack the basic public health skills to evaluate the information we put before them. With hope, through the education of policy makers at schools like Debrecen, the institution to which Dr. Bojan committed the last years of his life, this might change.

Thus in Dr. Bojan's honor, I end with a call for "public health training for all" and an aspirational (but un-measurable) hypothesis - that the education of policy makers in basic public health will lead to an improvement in the overall health of the population."

Thank you.

²⁴ European Public Health Association (2005). Ten statements on the future of public health in Europe



Track reports

INFECTIOUS DISEASE CONTROL (IDC)

Dieuwke Vos, secretariat IDC section
 Viviane Van Casteren, past president IDC section
 Ruth Gelletlie, president IDC section

At the 2006 EUPHA conference in Montreux, the IDC track provided a varied and interesting programme. The IDC section organised three workshops based on invited abstracts. The other three IDC sessions were devoted to the best submitted abstracts from all over Europe. The whole track was well attended and the discussions that followed the presentations were lively and stimulating.

The conference kicked off with the pre-conference meetings on Wednesday the 15th and Thursday the 16th of November. For those with an interest in infectious disease control two pre-conference meetings were of particular interest: *“New frontiers in the prevention of infections, allergies and asthma”*, and a round table discussion *“New vaccines – New Public Health Paradigms”*.

The three workshops organised by the IDC section illustrated the broad scope of the subject matter which the section is tackling. The first focused on emerging infections, and the tools and policies to enhance international research and control. This workshop resulted in an interesting discussion with several experts recalling the emergence of SARS and how it affected the social and economic structures in their countries. Another workshop dealt with the health economic evaluation of infectious disease control. One contributor examined for instance the cost-effectiveness of various vaccination campaigns. The third workshop was on international outbreaks and stressed, through four examples, the urgent need for early reporting and joint efforts in tackling these outbreaks.

The submitted abstracts sessions tackled many different issues, looking at a whole range of infections in various settings such as; the prevalence of erythromycin resistance in asylum seekers, different methods of measles reporting, the occupational health risk of cytomegalovirus and parvovirus infections, the sexual behaviour of patients visiting outpatients clinics, and the public health challenges of influenza. This latter presentation brought together the many different approaches which countries are using to prepare for a possible pandemic.

A breakfast meeting on Friday morning looked at the challenges of controlling the transmission chain of food-borne zoonotic disease. It featured a recent outbreak and described one country’s approach to managing the risks associated with these zoonotic diseases. To round off the meeting, the role of the ECDC in such outbreaks was discussed with the participants.

The EUPHA Section on Infectious Diseases control was set up in 2003 during the EUPHA conference in Rome. The section has grown rapidly and now has about 365 members.

An important highlight for the IDC section was the Annual General Meeting on Thursday. The meeting was well attended. Viviane Van Casteren, the section’s outgoing president, opened the meeting by welcoming everybody and by giving a report on the section’s



activities over the past year. On behalf of the members Viviane thanked Jelle Doosje and Marielle Jambroes for their important contribution through setting up and running the IDC secretariat for the past few years. She introduced the new secretariat, Marja Esveld and Dieuwke Vos to the members. Then Viviane announced the new president of the section, Ruth Gelletlie. Viviane was thanked for her crucial pioneering work as first section president. She will stay on as active section member to support Ruth in her new role as president and to act as liaison between the EUPHA governing body and the IDC section. Ruth briefly discussed her vision for the section for the coming year saying that she was keen to build on the strong foundations created by Viviane. She explained her plan to attract new members by developing the section website and proposed that, with the support of the active members, she would set out a work-plan to take forward the section's objectives.

Marja Esveld then presented the updated draft of the section's mission statement and the section rules. These will be circulated among members for comments, before being finalised. Lastly Paolo Durando gave a presentation of the preliminary results of the SPHERE project. Viviane then closed the meeting, thanking everyone for their attendance and encouraging new members to join the section via the EUPHA website.

Members of the section Infectious Diseases Control who attended the conference had an enjoyable and useful time at Montreux. During the coffee breaks, lunches, the welcome reception and the conference dinner, there was ample time to meet colleagues from other countries to share knowledge and experiences and to discuss the presentations. At the end of the conference there was general agreement among section members that good progress has been made in strengthening the section and that in turn infectious disease networks among countries in Europe have also been improved.

The section hopes to continue the solid foundation that has been laid in the past 3 years and looks forward to developing new activities in the future.



Track reports

INEQUALITIES IN HEALTH

Johan Mackenbach, Editor-in-chief European Journal of Public Health.

This session had five presentations on inequalities in health, each dealing with some social factor and its relationship with health or health care. Dr Ostergren presented the results of a study looking at the impact of social capital on mental health in southern Sweden. Some of the findings were rather surprising, e.g. that 'bridging social capital' is associated with a higher risk of depression, and point to the necessity for further theoretical and empirical work. Dr Tobias presented the results of a study looking at the association between health attitudes, self-rated health and mortality in Poland. While her study confirmed that self-rated health is an independent predictor of mortality, she also reported some new findings, e.g. that positive health attitudes were also an independent predictor of mortality. Dr Bloomfield presented the results of a study investigating the impact of social capital on binge drinking in Denmark. The prevalence of binge drinking in Denmark is very high, which perhaps explains why no clear associations with social variables were found. Dr Puddu reported the results of a study of inequalities in participation in breast cancer screening in Belgium. She found that women with lower education were less likely to receive mammography. Finally, Dr Messina looked at gender inequalities in coronary surgery, and reported that in Italy, like in other countries, women are less likely to undergo surgery.

Track reports

CHILD AND ADOLESCENT PUBLIC HEALTH CAPH

P.Auke Wieggersma, president section CAPH

For the EUPHA section Child and Adolescent Public Health (CAPH) the conference in Montreux has been very busy, indeed. In total we counted one pre-conference, two workshops, two parallel sessions and one annual meeting. Not only the increase of activities that were (partly) coordinated by the section, but also the growing number of relevant posters as well as the number of related presentations in other parallel sessions, illustrate clearly that child and adolescent health generates increasing interest in the scientific public health community. The quality of related research gradually improves as well, which was unmistakably clear from the various presentations at the parallel sessions.

Apart from this, the contribution of both WHO and the Ministry of Health of The Netherlands to CAPH workshops clearly demonstrates that EUPHA and its sections is becoming a platform of importance for both researchers and policymakers to ventilate their views, present their findings and influence health policy in Europe in general.

In the *pre-conference 'R U Effective? – meeting the health needs of young people.'*, organised by EUTeach and CAPH, it was – subtly I might add – made clear that professionals ought to pay more attention to the different ways adolescents should be approached to be effective in getting across health messages and implement effective preventive activities. Children and adolescents need an approach very different from that used with adults in these matters and professionals are not always aware of that fact. The Summer Schools that EUTeach organises (www.euteach.com) are definitely a must for health educators and professionals that deal with adolescents on a regular basis. Course material can be freely accessed and used by anyone interested. The CAPH section would like to see some (or all) of the material translated into the various other languages for easier use in one's own country. EUTeach staff members are willing to cooperate in this and it could very well be a worthwhile project for CAPH-members to start on. Several other participants of the pre-conference thought so too. Do email me if you are interested in such a project!

Presentations during the *parallel session 'Child and adolescent lifestyle programmes'* showed that especially the danger of alcohol abuse among the young deserves more attention, not only from the health perspective, but also from a societal point of view. The use of alcohol among children and adolescents steadily increases, not only in frequency but also in quantity. This will have far-reaching consequences for future morbidity patterns and health expenditure. Also, societal cost associated with aggression, vandalism, traffic accidents etcetera are substantial and will grow to be a negative economic factor to be reckoned with, unless the abuse of alcohol is somehow curbed. In my view, a ban on alcopops and breezers would be a very important, albeit rather overdue, step in the right direction.

The *parallel session 'Children at Risk'* once again demonstrated that professionals should try and develop new and innovative ways to influence the environment of children in such a way that psychosocial problems are recognised without undue delay and dealt with appropriately. In the same session, the virtues of thorough registration were made clear, not in the least because of the use one can make of adequately maintained records to search for hitherto unexpected relations between exposures and health outcomes.



The workshop 'How to use the European Strategy for child and adolescent health and development' in conjunction with the workshop 'A National Electronic Child Record in the Netherlands, Every Child in View 24/7' could prove to be very important for CAPH. During the sessions it became clear that many participants recognized the need for a national database of child health indicators that furthermore would be compatible with data from international sources. This would not only enable international comparative research, but also make possible a more widespread implementation of the WHO Strategy (see <http://www.euro.who.int/childhealthdev>).

In December I had a meeting with people in The Netherlands, discussing the implementation of ECR and the development of the appropriate software. As the EU is currently allocating huge amounts of money to ICT development, chances are that we can get funding for developing a European ECR, using the CHILD (Child Health Indicators for Life and Development) indicators in several countries. Already, I received letters of support from institutions and universities in 11 countries and the number of participants can be expected to rise if a EU-grant is secured. Of course, nothing is certain in this world, but things are looking good – on February 1st a meeting was arranged in Brussels, so I hope to know more about our chances in the near future. Think of the wonderful things one could do with comparable data from all these countries, the research opportunities!

Even if this effort would prove to be unsuccessful, it has become clear that many countries are interested in developing databases with internationally comparable data, so perhaps even without (ample) EU-funding a project could be started. At the moment, though, hopes are still up – I will keep you posted about developments of course.

Finally, during the *annual meeting* – which unfortunately was scheduled right before the start of the festive dinner, which substantially influenced attendance – developments as presented above were discussed. Also it was mentioned that CAPH now has its own website (www.caph.eu) which needs to be brought into use. I am still hoping someone from our vast membership (more than 200 by now!) with expertise in these matters will come forward and take on this unpaid, rather work intensive, but all the more gratifying and important task – if you feel you are the one (or know someone who is): please contact me!

Then, also, a recurring theme was brought up: the international development and use of the DIPEX-site (www.dipex.org) for child related issues. As obesity is now the leading cause for health concerns in many countries, it seems the appropriate time to try and secure funds to set up a module on obesity in children and adolescents (the cost of one such module is app. €150,000). At the moment I am discussing the possibilities of setting up such a module in The Netherlands with the Department of Paediatrics of the University Medical Centre at Groningen. If you are considering a like undertaking, please mail me, so we can join our efforts.

In conclusion it can be said that the EUPHA conference in Montreux, which in my view was one of the best organised conferences I have attended, was not only successful as a whole but also (potentially) very successful for CAPH.

I hope we will meet in the course of one of the future projects and we can join up again in Helsinki in October this year!

Track reports

SOCIAL SECURITY AND HEALTH

Kristina Alexanderson, president section "social security and health"
Angelique de Rijk, member section "social security and health"

Highlights of the activities of the Section of Social Security and Health this year were the pre-conference, a track with a workshop and several oral presentations and posters, as well as a section meeting. Focus in the section is on research on sickness absence and disability pension and some 450 persons have signed up as members. The 2006 conference clearly showed that the EUPHA conference now is one of the main arenas in Europe for sickness absence researchers. Probably to many of us this was a main highlight; apart from the pre-conference and many presentations of increasing quality we also had access to many other such researchers for meetings, project planning, etceteras. [awkward sentence]

For the fourth year we arranged a *pre conference* - a full day activity to which some 70 persons had registered. The theme was "Research on sickness absence and mental health - recent progress in theory and methods". Results from a recent overview of the findings in this area were presented as well as projects and results from the most active research groups in the area. Sickness absence due to mental health problems is increasing in most European countries, and has in some countries now even gone from being the second to the first main reason behind both sickness absence and disability pension. Some results also indicate that mental disorders are underestimated in absentees. Both the theoretical and the methodological challenges in this research are huge, and different approaches to deal with them were presented and discussed. Topics on the agenda were study design, what determinants to focus on, what outcome measures to use, difficulties with diagnostic criteria, validity aspects, and how to make international comparisons. Recent studies indicate that factors such as job insecurity, bullying and injustice treatment play a role in mental illness among employees. British studies and Danish studies have revealed the preventive effect of social support at home and in the workplace. Still though, it is hard to compare different countries.

Also our *workshop* had a more methodological approach and was about alternatives to randomised controlled trials (RCT) regarding return-to-work interventions for sickness absentees. This is a real methodological challenge as prerequisites for RCTs are scarce, yet scientifically based knowledge is urgently needed. Different alternatives were presented; such as randomizing physicians rather than patients, account for randomization in analysis, use quasi experimental designs, exposed and unexposed subjects can be regarded as exchangeable within levels of covariates. In workplace intervention the degree of implementation also needs to be taken account of. Otherwise, effects on sickness absence might be underestimated when comparing with reference groups. A quite different approach called responsive evaluation focuses on the different perspectives the stakeholders involved can have on an intervention and how this may influence the intervention itself and the outcomes for the patients. The study presented showed that well-intended approaches to improve client-participation missed its effect because of un-intended discrimination. Patients who were not able to reflect upon themselves, one of the key-elements in a reintegration program for people with psychological problems, were often labelled as being not motivated and more or less excluded during the training sessions.

In the track and also in other *sessions*, results from several types of studies were presented. Several of these were on the sickness certification practises of physicians, on



what they find problematic how they deal with different types of patients, and whether to focus on the right of sickness benefits or on the consequences of being sickness absent in the discussions with patients. A Danish study questioned the practice of physicians legitimating sickness absence: it demonstrated that self-certification reduces the number of sick-leave days.

Track reports

HEALTH SERVICES RESEARCH AND QUALITY OF CARE

Tit Albreht, president section "health services research"

Health services research deals with the quantitative and qualitative analysis of health care and its processes. Health care reforms²⁵ are now an ubiquitous occurrence, irrespective of the political, economic, social or geographical context. In the historical perspective of the last 35-40 years, health care reforms were related to: cost containing in health care in the 1970s and 1980s, rapid changes of systems in countries of central and Eastern Europe and a strive for increased efficiency and quality of care in the most developed countries. The key priorities of all reforms are equity, efficiency, quality, sustainability and participation²⁶. The ranking of these priorities varies across different countries, as clearly demonstrated by Palma-Solis et al. In the evaluation process of health services the following need to be observed: good baseline (indicator) data, methods for follow-up, intermediate evaluation points, regular reporting and considerations and recommendations for changes.

In Slovenia, a study was performed²⁷ in order to verify and establish criteria for the spatial distribution of medical and dental physicians across the country. It was intended that the study would overcome the simple population/physician ratios, which are most frequently used. The projects brought these additional criteria: distance to the nearest provider, frequency of outpatient contacts per practice, contact time per visit, number of listed patients per practice and dispersion of professionals across several practice locations.

An interesting piece of research was a short report about a study co-ordinated by the London School of Hygiene and Tropical Medicine²⁸ through a questionnaire circulated in 10 countries with mostly ministries and departments of health participating. The study was principally intended to provide additional information for the decisionmaking staff at the Department of Health (DoH) and NHS of England. Apart from that, it provided a broader and further insight into the functioning of 10 different health care systems and their comparisons. Important differences arose that deflected from the original intentions and expectations of the DoH.

Health policy and politics can be analysed through different levels and sciences²⁹: over time in a historical analysis, over the borders of national policy systems in international comparative research and over the borders of professional dominance in political science of health politics. Health revolves around four pillars: health as medical care, as social security during episodes of illness, as public health (e.g. health in all policies) and as health industry. The welfare state is changing and brings about retrenchment in social security, resiliency in medical care, redesign in health as industry and increasing complexing by extending the concept of health. The arena of political actors gains in complexity through: the diversity of labour market parties, the increasing citizen participation, the industry representing its own interest in all branches and, finally, the government and political parties.

²⁵ Albreht T. Health reforms – evidence base and evaluation. *Eur J Pub Health* 2006;16(Suppl 1): 115.

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Track reports

HEALTH PROMOTION AND PREVENTION

Heiko Waller, president section "health promotion and prevention"

Alf Trojan, member section "health promotion and prevention"

Health Promotion has always been a prominent topic at the annual EUPHA meetings. This time it was not only a series of workshops in Track 7 but also a theme in many other workshops. This may be due to the 20th anniversary of the Ottawa Charta, an event which was referred to in many of the sections.

The track was started with a workshop on policy development and public health campaigns for healthy weight. The main feature of this session was the identification of approaches to policy developments and national programmes, defining clearly the role and duties of different actors.

The second session addressed paradigms of Health Promotion. A simple social engineering approach to behavioural change was criticized. Bottom-up approaches in Community Health Promotion were questioned ("How does it fare in reality?"). A plea was made to break with one-sided rationalistic models of behavioural intervention and evaluation.

The workshop in the third session was organised by the EUPHA health promotion section and was dedicated to "Twenty years Health Promotion Research in and on settings". There were four reviews on the most important settings, that is health promoting hospitals, school health promotion, worksite health promotion and WHO's healthy cities project. For us, the organisers, some common topics and challenges emerged from the four excellent presentations:

- the question, whether emphasis should be put on health promotion *in* the settings or on a health promoting organisation *as a whole* (system level),
- the necessity to integrate health into other programmes, for example into quality management, with the intention to contribute to the settings primary goals,
- the limited [generalisability](#) of research results and the problems of the evaluation of complex social interventions,
- the implementation and dissemination on a large scale (beyond "model projects"), and closely connected with this topic
- adequate public health diplomacy (understandable reports and other efforts to reach politicians).

The audience as well as the presenters welcomed the opportunity to discuss general questions of the settings approach and the possibilities to exchange experiences beyond the boundaries of their respective field of action. The discussion will be continued next year (2007) in Vancouver (IUPHE World-Conference, June 11-15) with the special focus "Exchanging experiences in dissemination and implementation of health promotion between settings: cities, hospitals, schools and workplaces".

In the Health Promotion section meeting which immediately followed the workshop, Aileen Clarke from the SPHERE Project gave a systematic overview of literature 1995 to 2005. The presentation concluded with the recommendation to have a "more in-depth investigation into research commissioning policy for health promotion research at the European level and by each country, in particular taking into account evidence on the



most appropriate level for Health Promotion Intervention and exact topic areas where targeting of research would yield the most benefit.”

The fourth session referred to health promotion and settings as well and addressed single projects, such as health promotion in rural areas of Armenia, school health services in Iceland, health promotion in Swiss companies, in primary care (very impressive the programme “Coaching your health” because it was so well adapted to practice requirements of GP’s). A comparison of the legal basis of school health promotion revealed that some school laws in Germany and Switzerland are completely outdated.

The fifth session was organised under the heading “Getting evidence into policy – Models that work”. Ursula Broesskamp-Stone presented the Swiss model for outcome classification in health promotion and prevention and Hans Saan (in his unique manner) explained the development and implementation of the Dutch health promotion framework. Both models can be regarded as the most convincing strategic frameworks of action and evaluation for the organisation.

The last workshop took on the main topic of the last EUPHA conference in Graz: Positioning Health Promotion and Prevention within the health system – the way forward in Europe and beyond. In the discussion between some of the most prominent experts in health promotion it became clear, that the rationale is widely known (see e.g. EUPHA’s Tenstatements on the future of public health in Europe 2005 and a few national policies). Therefore, the workshop focused on HOW to strengthen health promoting policies within health systems and identification of obstacles and solutions.

In addition to the presentations in the workshops of Track 7 there were many other workshops in other tracks which addressed important issues of health promotion, and – not to forget – seventeen posters on various specific aspects and projects of health promotion in Europe.

On Saturday, the primary session was also dedicated to health promotion: S. Leonard Syme gave a stimulating presentation on “The prevention of disease and promotion of health – the need for a new approach”. The evening before, during the conference dinner, participants could watch the absolute highlight: a presentation prepared for Ilona Kickbusch and Hans Saan which succeeded in giving a comprehensive and most amusing review of developments in Health Promotion during the 20 years after the Ottawa conference in 1986 – in only four minutes!

Track reports

CHRONIC DISEASES AND CARE FOR THE ELDERLY

Iveta Nagyova^{1,2}, Jitse P. van Dijk³¹ Kosice Institute for Society and Health, PJ Safarik University, Kosice, Slovakia² SAVEZ – Slovak Public Health Association, Slovakia³ Department of Social Medicine, University Medical Center Groningen, University of Groningen, The Netherlands

The increase of chronic diseases and chronic conditions due to demographic transitions (declining birth rates, increasing life expectancies, ageing populations) has resulted in a growing recognition of chronic diseases as an important public health problem. These transitions represent an imperative that cannot be ignored and bring about a number of major challenges for health and social policy planners. The EUPHA 2006 annual meeting has recognised the importance of this problem and has introduced an independent track dealing primarily with chronic diseases and their consequences. In addition to oral presentations, sixteen poster presentations were devoted to subjects associated with chronic diseases, disability and care for the elderly. The sessions and posters addressed topical issues in this field calling for a broad model of public health guiding comprehensive public health action. *The main common underlying themes discussed within the sessions were: (i) the necessity to shift from 'disease care' system towards 'health-focused' research and practice, and (ii) the shift from risk factor-based paradigm (identification of causal factors for a single disease) to the identification of common pathways to health for people in their communities and in the full context of their lives^{1,2}.* Discussions continued on raising awareness of those pathways to health that have the potential to initiate useful strategies for community interventions and could contribute to sustainable improvements in health.

The track started with presenting new strategies and programmes on social integration and activation of the elderly. Active social involvement is a precondition to successful ageing. Innovative community-based efforts to develop supportive social networks are increasingly seen as an important element of public policy. Three complex strategies based on general capacity building were promoted: (i) incorporating health as a social value into community structures, (ii) developing sustained health-supporting community resources and (iii) fostering effective leadership and strong partnership.

The second session referred to novel strategies on physical activity promotion in the elderly. The scale of inactivity across the population combined with its impact as a significant risk factor for a variety of diseases (e.g. cardiovascular, diabetes) means that it is now recognised as a significant health and social burden. Physical activity promotion in the elderly requires multidimensional approach including health/disease, functional and social aspects. The 'Urbanwalks' is an interesting initiative from the United Kingdom designed for hard-to-reach groups to be more active in their everyday local environment. According to 'Urbanwalks' the health gains of physical activity cover a broad spectrum, incorporating both physiological and psychological factors, and therefore has been labelled a 'best buy for public health medicine'.

The third session dealt with preventive and health promotion measures developed with the aim to shorten the time aged persons will live with severe disability. The important role of supporting personal resources, networking and offering social support in preserving functional ability in elderly was stressed. To achieve benefit, preventive programs must adopt a multidimensional assessment approach and have to be carried out by committed and skilled professionals.



The fourth session raised awareness of the health consequences of the increasing elderly population with special emphasis on preventing injuries and accidents as well as managing consequences of injuries such as physical disability, depression, social isolation but also increased health expenditures associated with medical treatment and rehabilitation. The main feature of this session was the discussion on challenges for public health policy. Elderly injuries can be reduced by relatively cheap and simple methods. The challenge for public health policy lies in developing practical, effective, evidence-based, multi-factorial prevention programmes.

In the fifth session several topics were discussed: (i) **Firstly, contributors** elaborated on the role of psychosocial variables (social class, socioeconomic status, psychological distress) in development of a chronic disease and mortality from chronic disease. (ii) They also referred to the role of social networks and social support in perception of health and quality of life in persons with a chronic disease. During the discussions it became clear that a new framework (health-focused) is needed. This framework should include external life contexts and internal multi-factorial as well as multi-level influences that contribute to an overall degree of health or illness, and it should apply equally well to communities and individuals. (iii) The session furthermore elaborated on the implementation of information and communication technologies in chronic diseases. Developing of an interactive, World Wide Web based, computer-assisted medical decision tool helping to determine prospectively the appropriateness of treatment for chronic diseases was presented in more detail.

The last session reported on epidemiology of chronic diseases. In addition to the 'traditional' epidemiologic approach focusing on identifying risk factors for diseases one at a time at the individual level (disease-specific risk factors) the approach examining common underlying causes of multiple diseases or overall health in populations was discussed. While population disease patterns are transitioning from infectious diseases to chronic diseases, research models and intervention strategies have not undergone a similarly dramatic transition and increasing number of researchers call for epidemiologic theories that move beyond the risk factor paradigm.

To conclude, the burden of chronic disease plays an increasingly important role and it will be a major goal of health policy worldwide to ensure that longer life is accompanied by greater health and less disability.

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Track reports

MIGRANT HEALTH

Walter Devillé, president section "migrant health"

The theme Migrant Health was well present and all activities were well attended at this conference. The EUPHA Section on Migrant Health decided at the conference in Graz in 2005, to organize a pre-conference linked to the main conference. The idea was to give the floor to local researchers and public health organisations to present their work during the morning sessions and to invite researchers to present methodological papers during the afternoon sessions. The pre-conference on Migrant Health was organized in close cooperation with the Swiss Forum for Migration and population studies. Papers were grouped in clusters of three and discussed by an invited discussant. During three sessions several projects and research activities were presented which were initiated under the "Migration and Public Health Strategy" in Switzerland, financed by the Federal Office of Public Health.

The pre-conference started with an introduction to this strategy and the need for an overview of the existing evidence about migrant inequalities before being able to advocate for a new programme in the light of the changing political context as is the case in a few countries in Europe. Most Swiss papers presented were based on qualitative research. Most dealt with various issues in cross-cultural care, where local health care providers still have to be trained in transcultural skills which may increase 'trust' of immigrants in GP's or future paediatricians, while migrant health workers have to be sensitized against discrimination on the work floor. Taking account of the socio-cultural background may improve behavioural therapy as well as communication in health care. Depression and anxiety are more prevalent among immigrants from non-western countries, while "stress" is a common concept of illness in these groups. Finally we learned about the living conditions of undocumented migrants and provisionally accepted asylum seekers. Claims that health care costs more for these vulnerable groups were not proven. The methodological papers addressed the possibilities to use retrospectively health data and ways to identify ethnic groups. The often existing lack of a denominator was addressed by a new method of standardisation of rates. The difficulties in guaranteeing follow-up in a cohort study in immigrants and the limited cross-cultural validity of the single question for self-rated health were discussed.

The section organised a workshop dealing with the health services for asylum seekers in different countries in Europe and the consequences for policymaking. The outcome of the workshop was the detected need for more evidence about the various policies, organisation and quality of health care for this specific group, before we may develop recommendations or any EUPHA statement dealing with this issue.

The oral presentations addressed prevention themes in immigrants: hypertension seemed to be less well controlled, while vaccination rates may be high, but for Hepatitis B although often more prevalent in the countries of origin. Programmes addressing obesity in immigrant populations should address specific determinants. Intercultural sensitivity may reduce access barriers in mental health, that may be poorer in first generation migrants. Disability measures in elder immigrants may be worse. When addressing poor health of immigrants context variables as local living area, unemployment rates and lack of public services may have to taken into account.



Poster presentations dealt with HIV and AIDS or sexual beliefs in immigrant populations, prenatal care and pregnancy outcomes, health education and psychosomatic complaints, health and health care use in asylum seekers, and changes in health and health care use over time in a changing societal context.

The EUPHA section decided to study the possibility to organise again a pre-conference at the next conference in Helsinki, inviting researchers from the Nordic region to present their work.



Theme reports

PUBLIC HEALTH EPIDEMIOLOGY

Paolo Villari, president section "public health epidemiology"

Alastair H Leyland, member section "health promotion and prevention"

It is a very difficult task to single out public health epidemiology in the numerous plenary sessions, parallel sessions and workshops of the 14th Annual EUPHA Meeting in Montreux. Epidemiology is the basic science of public health because it deals with health and disease in populations rather than in individuals, and its aim is to identify the factors that increase or decrease the risk of acquiring diseases and to evaluate the efficacy of intervention strategies. This information is essential for the formulation of effective public health initiatives to prevent disease and promote health in the community. Epidemiology, in plain words, is everywhere in public health.

Every field or area of interest of public health needs a strong commitment on epidemiological methods for its development. The activities of the new EUPHA sections established over the last two years are a clear example of that. For instance, clarifying the conditions under which genome-based knowledge can be put to best practice in the field of public health was one of the major objectives of the section on public health genomics. The parallel session on chronic diseases, coordinated at the Montreux conference by the section on chronic diseases, clearly highlighted the need for rigorous methods to identify risk factors, to test the effectiveness of preventive interventions and to improve the quality of care. In both cases, the centrality and importance of an epidemiological approach is prominent.

Epidemiology, however, has its own limits. In his keynote lecture Leonard Syme reminded us that decades of epidemiological research have proven that identifying disease risk factors is very difficult, as well as developing successful preventive interventions. The analysis of the determinants of sleep quality, addressed by Sara Arber in her keynote lecture, may be considered a case study. Sleep, which is fundamental to health and well being, is influenced by the social context in which it takes place, and by the individual's role in the private and public spheres. The quality of sleep varies according to age, gender, marital status, socioeconomic circumstances, and general health status. The complex relationships between the different factors in sleep quality may be elucidated – and effective ways to improve quality of sleep identified – only through a multidisciplinary effort where basic, epidemiological, clinical and sociological research are combined. More generally, innovative approaches and new methods to study health and disease in populations need to be developed by taking into account the population perspective in public health epidemiology.

Public health epidemiology should be concerned not only with techniques but also – and probably more so – with the nature of the issues being addressed. In this way epidemiologists could be more closely involved with the implementation of their research findings. Health inequalities proved to be one of the most "popular" topics at the EUPHA conference in Montreux in as much as six sessions were devoted to the subject. Among these was the official workshop of the EUPHA section on public health epidemiology which took as its theme "Contextual and compositional determinants of inequalities". Although acknowledged that people's health is patterned both by individual socioeconomic circumstances (composition) and by those of the area of residence (context), the issue as to whether it is specific features of the social and physical environment that impact on



health (as opposed to population health differences reflecting different concentrations of socioeconomic deprivation) remains contentious.

Frank van Lenthe questioned whether environmental characteristics may help to explain socioeconomic variation in health related behaviours, with a particular emphasis on poor diet and physical inactivity. In the Netherlands the GLOBE study has shown there to be inequalities in such behaviours patterned by neighbourhood level deprivation. The most likely explanation was a causal mechanism with a contribution from environmental factors. However, our understanding of environmental determinants of health related behaviours is still incomplete, and it was noted that environmental determinants will not always contribute to inequalities.

Øyvind Næss considered the relationship between neighbourhood indicators of social deprivation and air pollution, and the extent to which the effect of air pollution on mortality could be explained by neighbourhood deprivation, using data from the Oslo Mortality Study. Higher levels of deprivation were indeed associated with raised concentrations of NO_2 , although the relationship was not always straight forward, and to some extent the relationship between air pollution and mortality was mediated by area deprivation even after adjustment for individual socioeconomic conditions.

Johan Hallqvist used the SHEEP study – a case control study of myocardial infarction (MI) incidence in Stockholm, Sweden – to investigate the role played by neighbourhood socioeconomic context. Not only did a gradient across the proportion affluent in each area remain after adjusting for individual characteristics, the effect of individual socioeconomic position was attenuated by the neighbourhood context. This paper then opened up a discussion surrounding the difficulties in drawing causal inference from studies of contextual deprivation and questioned what the public health interpretation of such conclusions might be.

A more general discussion focussed on a number of issues raised during the workshop. These included defining the appropriate contexts, consideration of exposure misclassification and measurement error, and the extent to which context may constrain compositional factors and opportunities. These are critical issues for public health epidemiology if we are to understand the roles of context and composition and to design and target appropriate interventions to reduce inequalities in health.

Theme reports

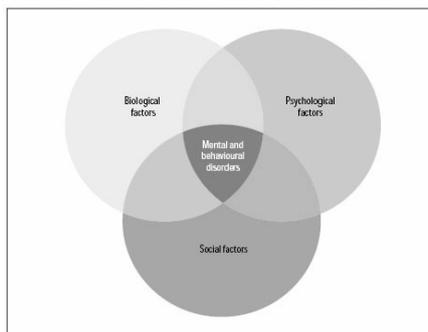
PUBLIC MENTAL HEALTH (PMH)

Jutta Lindert, Gunnel Hensing, Gunnar Tellnes, Lena Andersson, Christina Dietscher, Regula Ricka: members of the scientific committee of the section PMH

Background

Promotion of mental health is one of the main health challenges worldwide. Mental disorders affect about one in five Europeans during lifetime. One in four patients visiting a health service in Europe has at least one mental disorder. Mental disorders are common in all countries and cause immense suffering. Mental disorders are influenced by a combination of biological, psychological, and social factors (Figure 1). Mental disorders affect people of all ages in all countries and symptoms seem to be culturally shaped. Mental disorders tend to begin early in life and often run a chronic recurrent course. Prevalence of mental disorders is increasing, but still there is not enough clarity and understanding about mental health, mental health well-being and mental disorders.

Figure 1: Interaction of biological, psychological and social factors in the development of mental disorders and mental health



World Health Organization 2001

[legibility of figure 1 is bad]

People with mental disorders are often subjected to stigmatisation, social isolation, poor quality of life and increased mortality, even with minor mental disorders. But mental health policies, legislation, community care facilities, treatments for people with mental disorders and Public Mental Health promotion are still not given the publicity they deserve.

The proportion of the global burden of disease attributable to mental disorders is expected to rise in future. The rise will be particularly sharp among vulnerable populations such as people living in absolute and relative poverty, those coping with chronic diseases and those exposed to violence, economic hardships or emergencies.

These reasons were the cornerstones for working towards planning the Eupha-Public-Mental Health Section. The section was initiated at the EUPHA conference in Graz (2005) by Gunnar Tellnes, Norway. Since the Graz conference a Scientific Committee lead by Jutta Lindert, Germany, with members from many European countries (e.g. Austria, Germany, Iceland, Italy, Netherlands, Norway, Slovenia, Switzerland, United Kingdom, Sweden) has been working together towards the new section. The overall aim of the section is to improve Public Mental Health in Europe. The scientific committee agreed on the following specific aims of this section:

- to bring together experts working in the mental health field



- to improve interdisciplinary and transcultural knowledge in the field of Public Mental Health,
- to review and evaluate the community's mental health needs, resources and programs in the European region,
- to disseminate knowledge on Public Mental Health among experts and the public,
- to work together with national and international organisations working in the mental health field.

At the EUPHA-conference in Montreux (2006) the new EUPHA-section on Mental Health was launched and received a large interest. The section on Public Mental Health has responsibility for organising the annual meeting at the annual EUPHA conferences. Additionally we plan workshops and pre-conferences at the annual EUPHA meetings related to Public Mental Health. All workshops and annual meetings are open to the participants of the EUPHA conferences. A Public Mental Health website, organised by Lena Andersson (Sweden), is planned to facilitate communication between members of the section.

The Public Mental Health Section in Montreux: annual meeting and workshop

The new section had the opportunity in Montreux to organise the annual meeting and a workshop on Public Mental Health in Europe.

1. The 2006 Annual Meeting

At the annual meeting of the section on Public Mental Health almost 70 participants discussed the potential themes of the section for the coming years. The lively discussion showed a clear need for participants in this section to learn from each others expertise in the field. The role of communities both as a risk factor for Public Mental Health Illness and as a generator of resources was discussed. The interest in a life course perspective on Public Mental Health was focussed. Experts strengthened the need to focus on specific population groups e.g. children and youth, migrants, elderly or women; groups that in some countries show high prevalence of mental disorders. There was a clear wish to focus both on mental health promotion on prevention, and on possibilities for improvement of detection, treatment and rehabilitation for people with the following priority conditions: depression, anxiety disorders, alcohol and drug dependence, dementia, and the risk of suicide. The section also aims to increase the responsiveness of governments to mental health concerns to reduce the burden of mental disorders and to promote Public Mental Health (PMH).

2. The Workshop

The early bird workshop at 8.30 with almost 100 participants (chairpersons: Jutta Lindert, Gunnar Tellnes) showed a lively interest in Public Mental Health. Two speakers presented community intervention programs to reduce the burden of mental disorders. Further speakers focussed on mental health promotion and on mental health policies. It was obvious that we need further international and interdisciplinary research, to understand more about risk and protective factors for Public Mental Health and for mental disorders.

Outlook: Public Mental Health in the future

We hope that the EUPHA-Public Mental Health Section will contribute towards effective mental health policies and facilitate interdisciplinary research. We expect that the knowledge gathered in the section will act as a stepping stone towards a more complete and integrated response to prevention and health promotion for the European population and towards improvement of care and treatment of people with mental disorders.

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Theme reports

INJURY PREVENTION AND SAFETY PROMOTION

Johan Lund, PhD, President of the EUPHA section on injury prevention and safety promotion

Injuries (including both unintentional ones and violence) are a major threat to life and health in many parts of the world. In the WHO European region injuries are the third leading cause of death. The region has some of the highest and lowest injury mortality rates in the world. Furthermore, the burden is unequally distributed both between and within countries.

Therefore, the World Health Organization and the European Commission have recognised injury prevention and safety promotion as a major priority and have developed policy frameworks, action plans and public health programmes in order to strengthen injury and violence prevention activities within the region. This has led to the European Commission's initiative to have a Communication on 'Actions for a Safer Europe' which is adopted by the European Parliament, and to the WHO-European Region's Resolution on Injury Prevention in the Region (RC55/R9).

A section on injury prevention and safety promotion was established during the conference in Montreux after being prepared since the last conference in Graz. The section arranged two workshops and a section meeting.

Workshop on elderly safety in Europe

This was arranged together with the section on Public health policy and practice. The background is that each year about 100,000 elderly people in European countries will die due to an injury, and many more will survive. A serious injury, especially from a fall can lead to short- or long term physical disability, anxiety depression, reduced confidence and social isolation. The loss of life quality can be very high. In addition to the human suffering, to treat and rehabilitate the elderly people requires a large proportion of the health expenditures. While there are variations in mortality rates due to elderly injuries across countries in Europe, all countries that successfully manage this area will achieve important gains in reducing overall elderly injury and death rates. There is a need to put elderly safety on the agenda for public health policy.

Speakers from all over Europe showed that many promising interventions on reducing the amount of elderly injuries exist. EUNESE (European network for Safety among Elderly) is a European project ran by the University of Athens. A policy manual has been developed which describes the burden of elderly injuries across Europe and how these might be prevented. A list of recommendations to each country in Europe is given. The manual can be found at the EUNESE website (www.eunese.org). Another EU-project, ProFaNE, Prevention of Falls Network Europe has developed practical, effective, evidence-based and multi-factorial prevention programmes to reduce the incidence of falls and fractures amongst elderly people. The ProFaNE website (www.profane.eu.org) has seen registrations from over 1000 people from across the world, who receive a regular e-newsletter. The website not only provides a useful place to find resources on falls prevention, it also has a discussion board so that health professionals can discuss areas of expertise.

An OECD project on Risk Management Policies investigated how the various aspects of prevention on injuries in older people are integrated in a consistent policy approach in Sweden. The roles and responsibilities in the decentralised Swedish democracy were



identified by means of questionnaires and a review team of three experts in injury prevention and elderly care. A list of 14 recommendations has been developed in order to give the government of Sweden proposals on how to make their risk management of fall accidents among the elderly more effective.

Workshop on the social patterning of injury and its challenges for injury control and prevention

Preliminary results from a literature review on studies conducted in the European countries indicate that, for most types of injuries, mortality and morbidity are often higher among people from lower social positions and in more deprived socioeconomic areas. The magnitude of differences varies from one cause of injury to another (e.g., self-inflicted, violence-related, traffic-related, burns, drownings) and from one country to another. Whether the greater occurrence of injuries in deprived groups or areas is a phenomenon attributable to the people or areas themselves, or merely a reflection of a wider pattern of injuries affecting lower socioeconomic groups, is unclear. Few interventions have been evaluated considering their differential benefits over socioeconomic groups and few types of injuries have been covered thus far.

There is a significant variation in rates of child deaths from injuries across Europe. The variation across countries of Western Europe is up to three-fold and the differences between countries of central and Eastern Europe are even greater. Mortality rates from injuries in children aged 1-14 years are particularly high in the countries of the former Soviet Union, reaching levels that are nine times higher than in western European countries such as Sweden or United Kingdom.

While most countries of Western Europe have enjoyed a steady decline in childhood mortality from injuries over the last three decades, recent trends in the transition countries appear much less favorable and to a high degree inconsistent. If mortality rates from injuries in the transition countries of central and eastern Europe were reduced to the average level of western Europe, the East-West gap in child health would decrease significantly, saving lives of tens of thousands of children every year.

Section meeting

There is a need for more effective Europe-wide initiatives that facilitate learning from best practice and lead to implementation of effective prevention strategies. The aim of the section on Injury prevention and safety promotion is to enhance communication in injury and violence prevention and safety promotion across Europe, including promoting the dissemination of research results and the exchange of knowledge of evidence based practice in injury and violence. A co-operation with the section on Public mental health was announced with regard to arranging a pre-conference in Helsinki 2007 on psychosocial aspects on injury and violence prevention.

Track Reports

OBESITY AND OVERWEIGHT

Enni Mertanen, president section "nutrition"
Annette Matzke, member section "nutrition"

Throughout the conference, the theme obesity and overweight were discussed in very interesting presentations. The theme was presented at the conference in:

- a pre-conference workshop
- two parallel sessions
- one workshop
- several posters

The presentations showed a wide range of activities and some national differences in needs. More information on the consumption of fruit and vegetables in children was needed in Belgium. In the UK, organising subsidized full fat milk for pupils is an (additional) problem.

There are a number of national and international – European – surveys and studies like HELENA, IDEFICS, EYHS, MRC DASH, HBSC Study – and those without great names – to get more evidence-based information about risk factors for overweight and obesity and effective measures to reduce the prevalence of this epidemic. Presentations also includes projects and programmes which touched the issue of overweight and obesity but were not specifically focused on these problems, like the CUORE Project and the Stockpot Cardiovascular Risk Population Screening Programme.

Several programmes and projects like EPODE (F), Suisse Balance (CH) and Balance Day (NL) aim to enhance healthy eating and physical activity. National strategies are build or will be build.

The results confirm that overweight and obesity have a very complex pathogeneses and also a wide range of consequences. Important aspects are eating behaviour, food choices and physical activity. Both internal and external factors influence eating behaviour, such as unhealthy eating (food choice, "out-of-home consumption"), sedentary lifestyle, ethnicity, genetic disposition. The social economic status and a migrant background are important as well. The consequences of overweight and obesity include increased cardiovascular risk (high blood pressure), cardio respiratory fitness and metabolic syndrome decreased bone mass.

S. Harding (UK) and I. van Valkengoed (NL) emphasized ethnical differences in pathogeneses of overweight which has to be taken into account when planning projects and surveying eating behaviour.

Studies of B. Knöpfli/CH, J. Bruil/NL, U. Toft/DK focused on the therapy of overweight or obese children and showed that an intensive intervention is successful. Long-term effects remain partly to be seen.

One study in Belgium came to a very thought waking result: Only 3-5% of the participants of the study really follow the nutritional guidelines!

Key messages from the conference can be formulated as follows:

- A multidisciplinary, interdisciplinary and intersectional approach is necessary to prevent and reduce overweight and obesity.



- A balance between public health and free choice needs to be found.
- Positive guidelines and positive messages are necessary.
- Overweight and obese persons should not be stigmatised.
- The image of "healthy food" should be better than it is today.
- Implication of knowledge and evaluation of programmes and projects are necessary.
- Significant government interventions will be needed to correct the current market forces (overconsumption/underactivity).
- Search for possibilities to realize the nutritional guidelines.

One chance to improve the situation could be the European Charter Counteracting Obesity which was adopted by the European health ministries in Istanbul, Turkey, at the same time as the 2006 conference. The charter was distributed and discussed in the workshop on Saturday. The EUPHA conference showed the possible contributions in research and experiences to realize the charter.

There are still open questions that public health experts need to look at, including:

- How can we reach the lower social classes?
- How can we enhance fun for healthy eating and (more) physical activity?
- Which role plays the agricultural policy?
- How can we change the offers of vending machines?

An overview of existing programmes and projects, including key factors in any obesity and overweight policy will be published in a EUPHA report on overweight and obesity in 2007.

The growing challenge posed by the epidemic of overweight and obesity to health, economics and development as well as the commitment of the European health ministries confirm the importance of the EUPHA section food and nutrition. Therefore the section president, Enni Mertanen/Finland, decided to enhance the possibility for networking of EUPHA members.



Activity reports

EUPHA IN 2006

Horst Noack, Dineke Zeegers Paget

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The European Public Health Association, or EUPHA in short, is an umbrella organisation for public health associations in Europe. EUPHA was founded in 1992. EUPHA is an international, multidisciplinary, scientific organisation, bringing together around 12'000 public health experts for professional exchange and collaboration throughout Europe. Our mission is to be the proactive platform for public health professionals in research and practice and be a bridge between these professionals and policymakers. At the end of 2006, we have a total of 62 members from 39 countries, divided as follows:

- 40 member associations
- 6 individual members
- 12 institutional members
- 4 associate members

In 2006, the number of active EUPHA sections was expanded to 16. The EUPHA sections are theme-specific sections where experts can interact with each other, joint projects can be organised and workshops and sessions prepared. Each section organises at least one workshop and an annual meeting at every EUPHA conference. The 16 EUPHA sections are:

- Section on Health Promotion: Heiko Waller, Germany, Alf Trojan, Germany
- Section on Food and Nutrition: Enni Mertanen, Finland, Annette Matzke, Switzerland
- Section on Health Services Research: Tit Albreht, Slovenia
- Section on Social Security and Health: Kristina Alexanderson, Sweden
- Section on Child and Adolescent Public Health: Auke Wieggersma, Netherlands
- Section on the Utilisation of Medicines: Pietro Folino-Gallo, Italy
- Section on Infectious Diseases Control: Viviane van Casteren, Belgium
- Section on Public Health Epidemiology: Paolo Villari, Italy, Alastair Leyland, UK, Giuseppe la Torre, Italy
- Section on Public Health Practice and Policy: Natasha Muscat, Malta
- Section on Migrant Health: Walter Devillé, Netherlands
- Section on Public Health Genomics: Angela Brand, Germany
- Section on Chronic Diseases: Iveta Rajnicova Nagyova, Slovakia
- Section on Injury Prevention and Safety Promotion: Johan Lund, Norway, Lucie Laflamme, Sweden?
- Section on Environment Related Diseases: Peter van den Hazel, Netherlands
- Section on Public Health Economics: Maarten Postma, Netherlands
- Section on Public Mental Health: Jutta Lindert, Germany

EUPHA has been involved in a number of projects in 2006, some of which are presented below. As of 2007, a number of other projects will start including:

- European health policy and future of public health in the Unified Europe
- Monitoring the health status of migrants within Europe: development of indicators
- Mapping professional home care in Europe: EURHOMAP



Activity reports

REORGANISATION OF EUPHA

Walter Ricciardi, Dineke Zeegers Paget

Contact person: Walter Ricciardi, wricciardi@rm.unicatt.it

In the past years, EUPHA has grown from a small organisation to a big and influential public health association in Europe. This process of growth has been implemented slowly:

- More members were accepted into EUPHA
- The conferences increased in size of the programme and of participants
- The EJPH was further developed
- The role of the EUPHA sections was expanded
- A permanent EUPHA office was established

The increase in activities is having an impact on the organisation of EUPHA and the responsibilities of the different EUPHA bodies. Also, the constitution and bylaws of EUPHA are no longer reflecting the practical running of EUPHA. The Council of Past presidents of EUPHA, co-ordinated by Prof. Walter Ricciardi, has been very active in formulating a proposal to reorganise EUPHA, which was discussed in detail in the EUPHA Governing Council. The reorganisation will include a reorganisation of activities as well as a reorganisation of the EUPHA structure.

The reorganisation of activities follows the development of EUPHA from research-oriented association to the proactive platform for public health professionals (as formulated in the 2003 Mission statement of EUPHA). The Council of past presidents emphasized that the excellent reputation as a research association should be protected and all agreed to go in the direction of being the proactive bridge between research and policy/practice.

In the reorganisation of activities, EUPHA will base the activities on 4 pillars:

1. Research
2. Policy
3. Practice
4. Training

All these pillars of EUPHA should be implemented following two priority areas: knowledge transfer and capacity building.

The reorganisation is an ongoing process for 2007. For this, the council of past presidents has included the Executive Council as well as representatives from our members and our sections to participate in the further elaboration of the plans. We hope that the reorganisation plans can be adopted by the EUPHA Governing Council in 2007.



Activity reports

SPHERE

Professor Mark McCarthy, UCL

Few of us, I suspect, read through all the abstracts of a conference as large as EUPHA at Montreux -- except the scientific committee and organisers, of course! There is extraordinary diversity of public health research in Europe, both in areas of concern and in disciplinary approaches. And yet, in most countries, public health remains a poor relation to biomedical research.

SPHERE - Strengthening Public Health Research in Europe - is a three-year project funded by the European Commission Directorate for Research and engaging members of EUPHA. There are 18 partners from ten countries, and several of the EUPHA sections have played a prominent role. The project has three broad components - to identify European research literatures in public health, to map the European organisational settings and agendas for public health, and to reflect on parallel issues including research training and international comparisons.

Montreux marked the mid-way stage of SPHERE, the second of three conferences at which the participants held both a pre-conference management workshop together, and also presented issues and results to EUPHA members within the main programme. The two conference events looked both backwards and forward. The first presented the results of six literature reviews undertaken across disciplines - health promotion, environmental health, public health genetics, health management, infectious disease control and health services research - a bibliographic assessment, a specific assessment of the French language literature, and commentaries on the work from two independent experts. A lot of information was condensed here, and the discussion supported the excellent work of the SPHERE partners. The European Journal of Public Health will be publishing this part of SPHERE as a supplement during 2007.

In the second conference workshop, four external speakers - from the European Commission's Directorates of Research and Health respectively, the WHO Global Alliance for Patient Safety, and on behalf of non-governmental organisations - gave their views of future issues in public health research. The forthcoming European Seventh Framework Programme for Research has a much stronger public health pillar than its predecessor, and there will be plenty of opportunities for collaborative research and support for research development. It is up to EUPHA members to respond.

In 2007, SPHERE will address collaboration between national governments and the European institutions, and link with researchers' interests through consultation and a small workshop to be held during the German Presidency of the Council of Ministers. There will also be an EU-supported conference on patient safety research in September, during the Portuguese presidency. These two events will seek to strengthen the interest of ministries of health in the European public health research agenda. And the long-range hope is for a 'European Public Health Research Area' where research crosses nations and supports policies to improve the health of all citizens - a grand ambition indeed!

Activity reports

ACCREDITATION OF PUBLIC HEALTH TRAINING PROGRAMMES IN EUROPE

Dineke Zeegers Paget, Horst Noack

Contact person: Ass.Prof. Jacek Sitko, vice-president of ASPHER: mxsitko@cyf-kr.edu.pl

The main objectives of this ASPHER-initiated project are:

- (1) Establishment of EAAPHE - European Accreditation Agency for Public Health Education,
- (2) Launching the Accreditation Process of PH education on the European level and
- (3) European support building for PH Education Accreditation.

EUPHA is a partner in this project. EUPHA's role in this project has three functions:

- Facilitating
- Expertise
- Disseminating

EUPHA's facilitating role included the use of all EUPHA tools to support the project wherever needed. For instance, the database of 12000 public health experts was used both to identify experts for the advisory board of the project as well as to distribute updates on the project.

The second role for EUPHA in this project was to provide expertise input in the project from the practitioners and researchers' point of view. This role was taken up before the official start of the project and has continued throughout the project.

EUPHA's disseminating role included the use of all EUPHA tools to disseminate information on the project and the progress of the project. For instance, updates on the project were presented both at the EUPHA conferences of 2005 and 2006 as well as in the EJPH – EUPHA column.



Activity reports

PUBLIC HEALTH PROFESSIONALS FROM CENTRAL AND EASTERN EUROPEAN COUNTRIES

Dineke Zeegers Paget

Contact person: Dineke Zeegers Paget, d.zeegers@nivel.nl

For some years now, EUPHA has organised a grant to support the participation of public health professionals from central and Eastern European countries to come to the EUPHA conferences and present their work as well as interact with the European network of public health. In 2006, EUPHA, together with the Swiss Society of Public Health, managed to find 2 major sponsors:

- The Open Society Institute of the SOROS foundation
- The Swiss Cooperation Agency

The selection of experts from CEE countries was based on 4 factors:

- presenting authors (oral or poster presentation)
- Country representatives from countries where Switzerland has set up extensive collaboration (e.g. Tajikistan and Kyrgyzstan)
- Participants in specific conference activities (e.g. Workshop Survey, surveillance and health promotion research in Eastern Europe, organised by the editorial team of the Social and Preventive Medicine journal)
- EUPHA officials (Governing Council members, International Scientific Committee members, the Slovak initiator (and new president) of the EUPHA section on chronic diseases and the proposers for the 2009 EUPHA conference in Poland).

With the 2 grants, together with support from several institutes from CEE countries, the 2006 EUPHA conference could welcome more than 120 participants from CEE countries. The exchange of information and networking was boosted by an active role of EUPHA office to introduce people to each other. The continuous increase in abstracts submitted by CEE public health experts (there were 173 abstracts submitted in 2006 of which 106 were accepted for oral or poster presentation) shows the important role of EUPHA conferences in the East-West exchange.

Activity reports

EUPHA IN 2007

John-Paul Vader

Contact person: John-Paul Vader, john-paul.vader@chuv.ch

One of the top priorities for the coming year is the reorganisation of EUPHA. In its 15 years of existence, EUPHA has developed to an influential partner for public health in Europe. The reorganisation plans as described above are essential to make sure that the EUPHA structure can follow the development made in impact and activities.

Another priority for 2007 is to clarify and organise our role in a number of projects financed by the European Commission where EUPHA is an active partner. Over the years, we have seen an increase in requests from our contacts to be a partner mainly to ensure the efficient dissemination of information and the provision of experts for the project. EUPHA is a partner in the following projects (non-inclusive):

- *European health policy and future of public health in the Unified Europe*
- *Monitoring the health status of migrants within Europe: development of indicators*
- *Mapping professional home care in Europe: EURHOMAP*

Again, in 2007 we intend to increase our visibility in Europe by further developing our existing tools, among which the EJPH, the electronic newsletter and the EUPHA website. We also will invest in active participation in public health conferences in Europe (both national and international).



Activity reports

15TH EUPHA CONFERENCE ON PUBLIC HEALTH: THE FUTURE OF PUBLIC HEALTH IN THE UNIFIED EUROPE

Ilmo Keskimäki, Hannamaria Kuusio, Mika Gissler, Dineke Zeegers Paget

Contact person: Hannamaria Kuusio, hannamaria.kuusio@stakes.fi

In 2007, the European Conference on Public Health will be organised in Helsinki, Finland, on 11-13 October. The main theme of the Conference is 'The Future of Public Health in the Unified Europe'. The structure of the Conference programme will follow the tested pattern of the earlier EUPHA Conferences with plenary presentations, workshops and parallel sessions which are planned to highlight the sub-themes of the Conference, including:

- social determinants of health
- health in all policies
- evaluation of health care reforms
- alcohol in public health policy
- genetics and public health

The Conference will also provide a substantial pre-conference programme with a number of planned satellite meetings and workshops, such as

- The 18th Nordic Conference in Social Medicine and Public Health on the Future of the Nordic Welfare Model
- Workshop on population interventions in health promotion
- Workshop on social security and health
- Training seminar on health services research

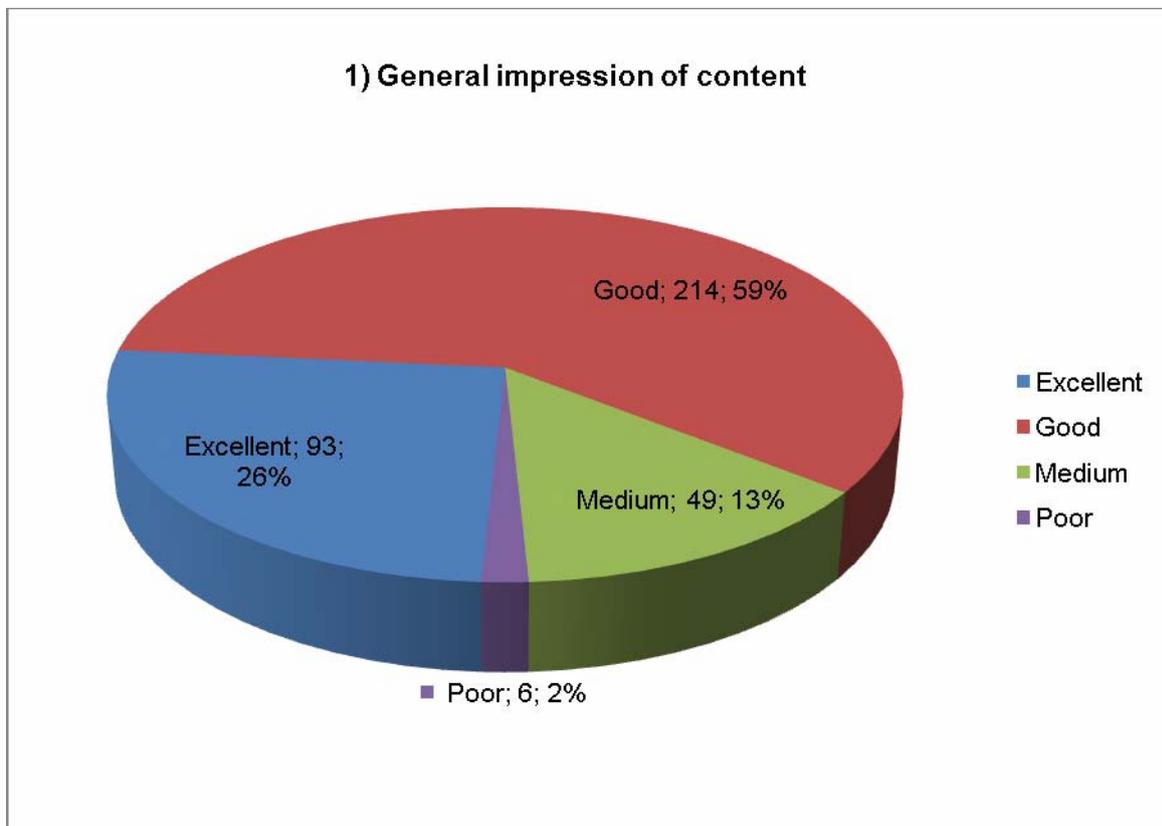
Updated information on the Conference programme, submission of abstracts and registration can be found on www.eupha.org by clicking the Helsinki Conference banner.

Important dates and deadlines:

<u>May 1 2007</u>	Deadline for the submission of abstracts
Mid-June 2007	Notification of acceptance
<u>May 1 2007</u>	Beginning of the conference registration
30 August 2007	Deadline for early registration (reduced registration fees)

RESULTS OF THE EVALUATION OF THE CONFERENCE

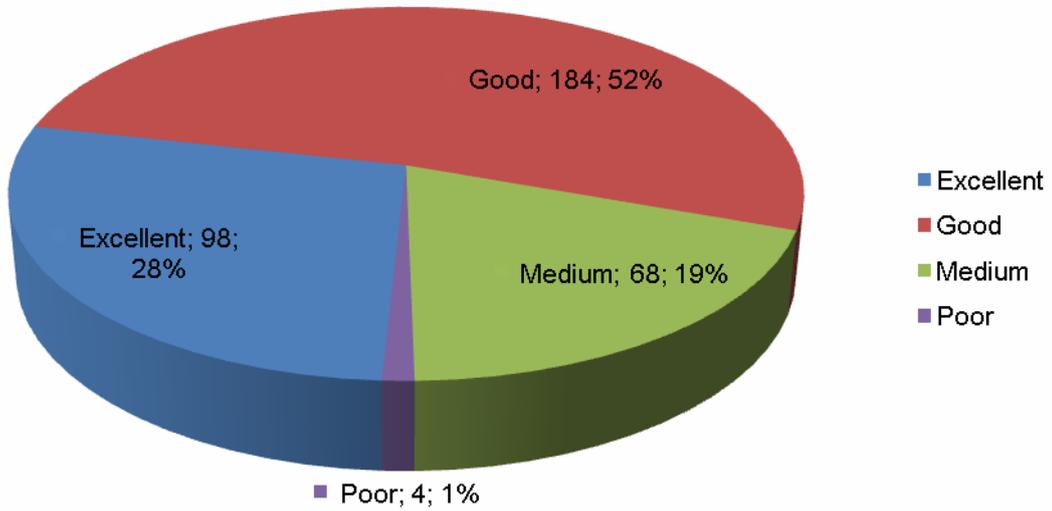
A) Plenary sessions



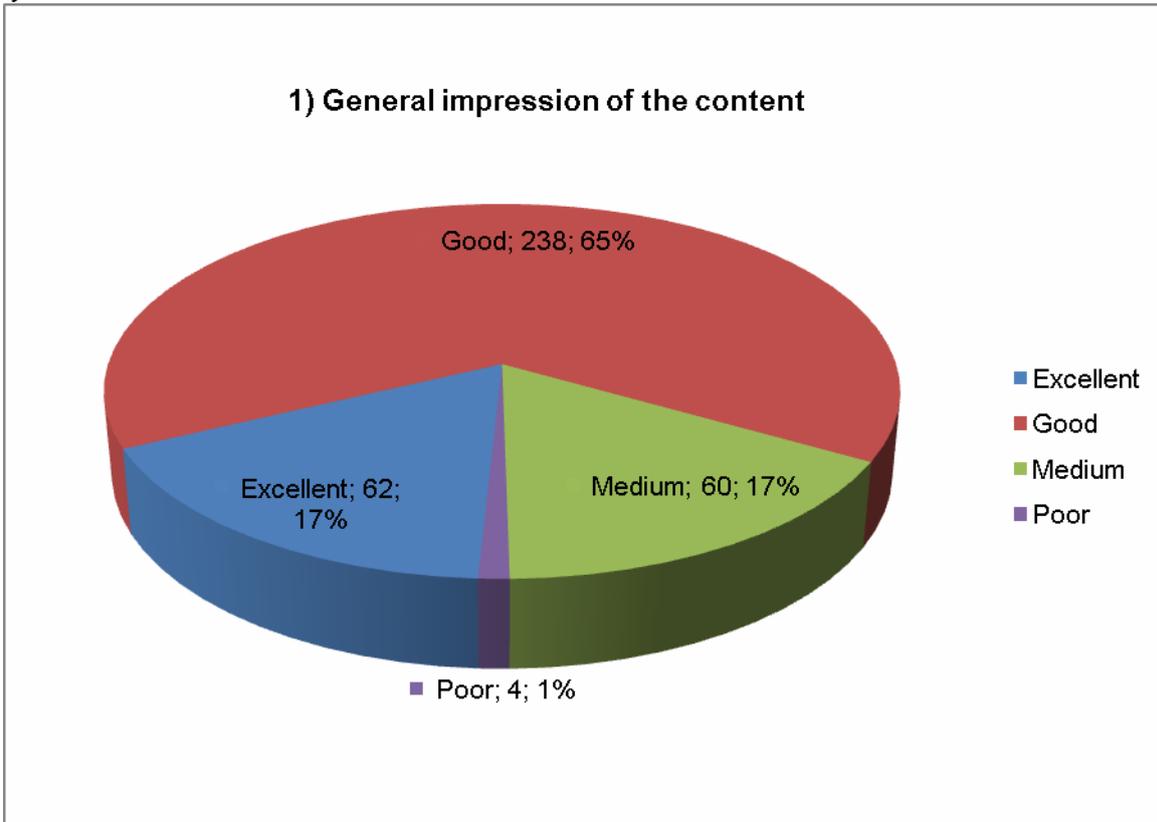
An example of comments received :

- I did appreciate the variety of the topics. I would have appreciated that the officials took part of the debate.
- I liked the entertainment components, which enhanced nicely the atmosphere. I especially liked plenary sessions Friday and Saturday.
- The use of entertainment and exercises was a good idea to keep people alert, because the speakers were well worth being alert to!
- Would be desirable to see power point presentation of all lectures

2) General impression concerning the choice of key note speakers



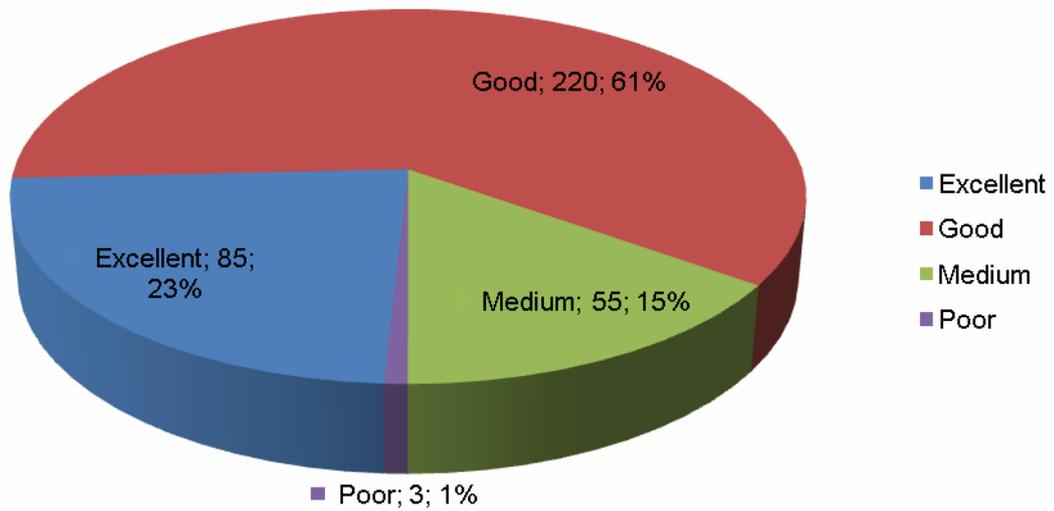
B) Parallel sessions



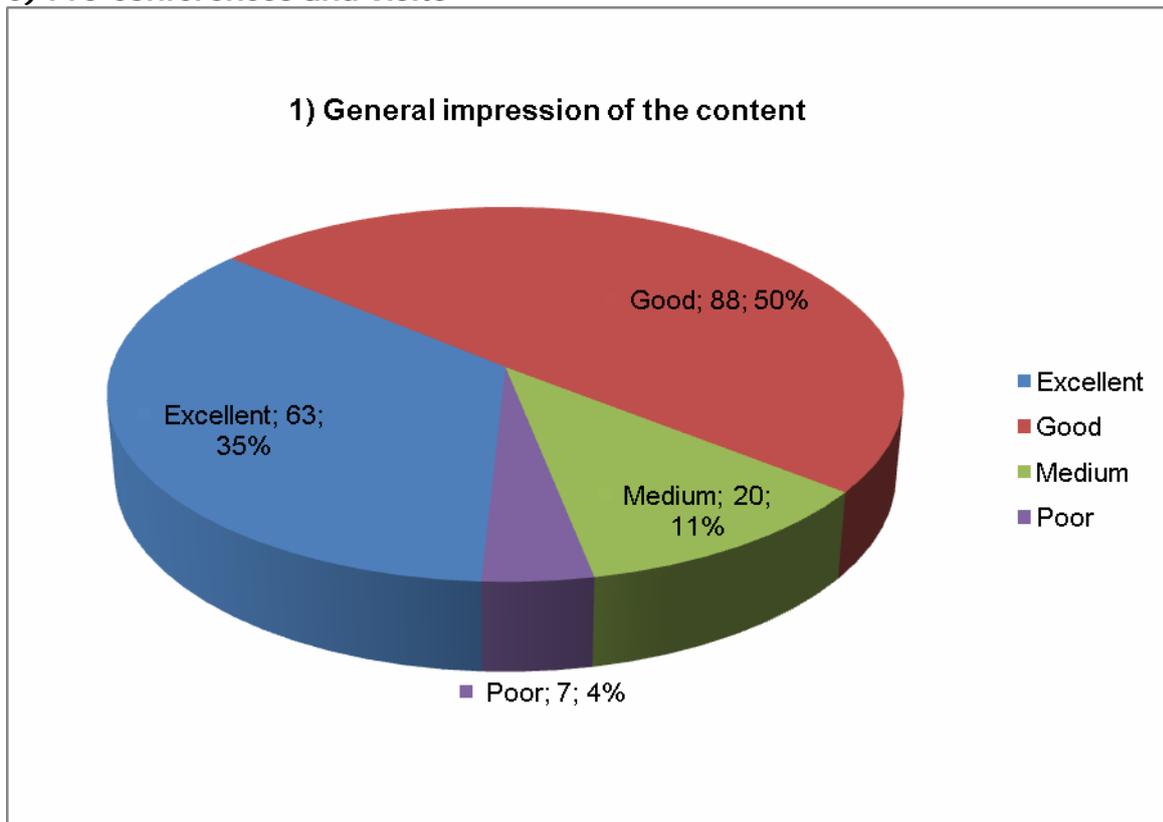
An example of comments received :

- The sessions could have been more linked to the theme of the congress.
- More microphones - didn't hear anything
- Chairs could have insisted more on time-limit.
- too much parallel sessions some rooms were very small
- Interesting works, but sometime poorly presented. Few sessions on health policies
- Very complicated to get between the floors from one room to another. In the sessions on migration, more migrants with colour should have been placed as chairs and invited presenters. It feels very paternalistic that white people talk about migration
- there was politics/policies, but little about politics, and very little about implicit politics of e.g. health promotion
- Quality of presentations varied. Too many presentations and too little room for discussions within the sessions. Chairs should ensure adequate time for discussion and encourage participation from the floor.
- to little relation to practice - to much focussed on research
- Subjects of presentations were sometimes too different in the same session.
- Whilst I realise that the cost of simultaneous translation is probably to high, I certainly feel that many opportunities were lost by making English the only presentation language at the conference.
- in some rooms because of lack of microphones speaker were hard to understand after start of sessions rooms should be closed the come and go was very disturbing
- In some sessions, big difference between speakers. Some of them really had problems with English.
- In some of the rooms there were hard to hear what people said

2) General impression of the chairs



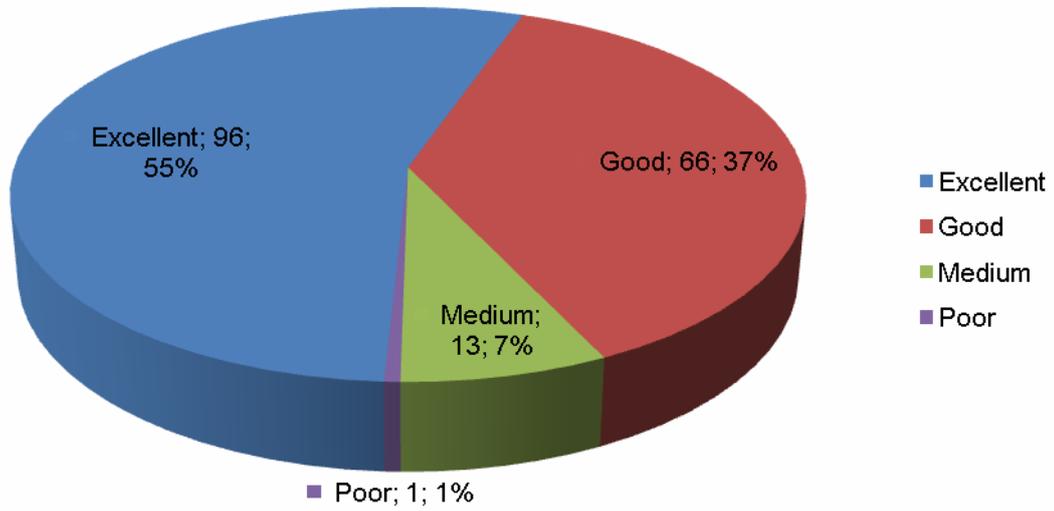
C) Pre-conferences and visits



An example of comments received :

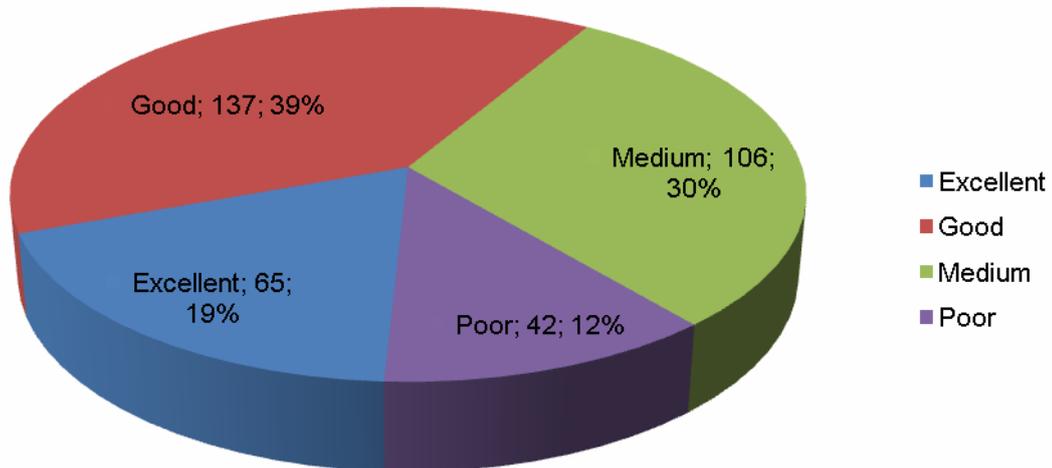
- It was a shame that the visits to WHO could not have been earlier to enable people who attended the pre-conference sessions, to also participate in these visits
- pick from the CCM to WHO should have been arranged
- a bit too much of course and not enough interactivity (most participants were experimented in the field and were keen to hear and discuss other experiences)
- Very effective and simple to register.
- Very difficult to see slides unless sitting near front of room. No vegetarian option at lunchtime.

2) General impression of the organisation



D) Poster Exhibition

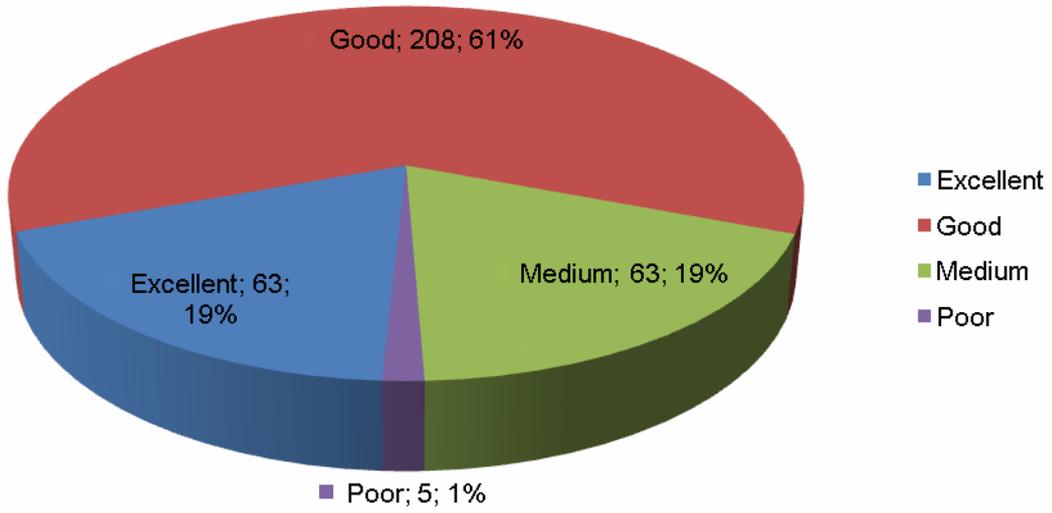
1) General impression of the location



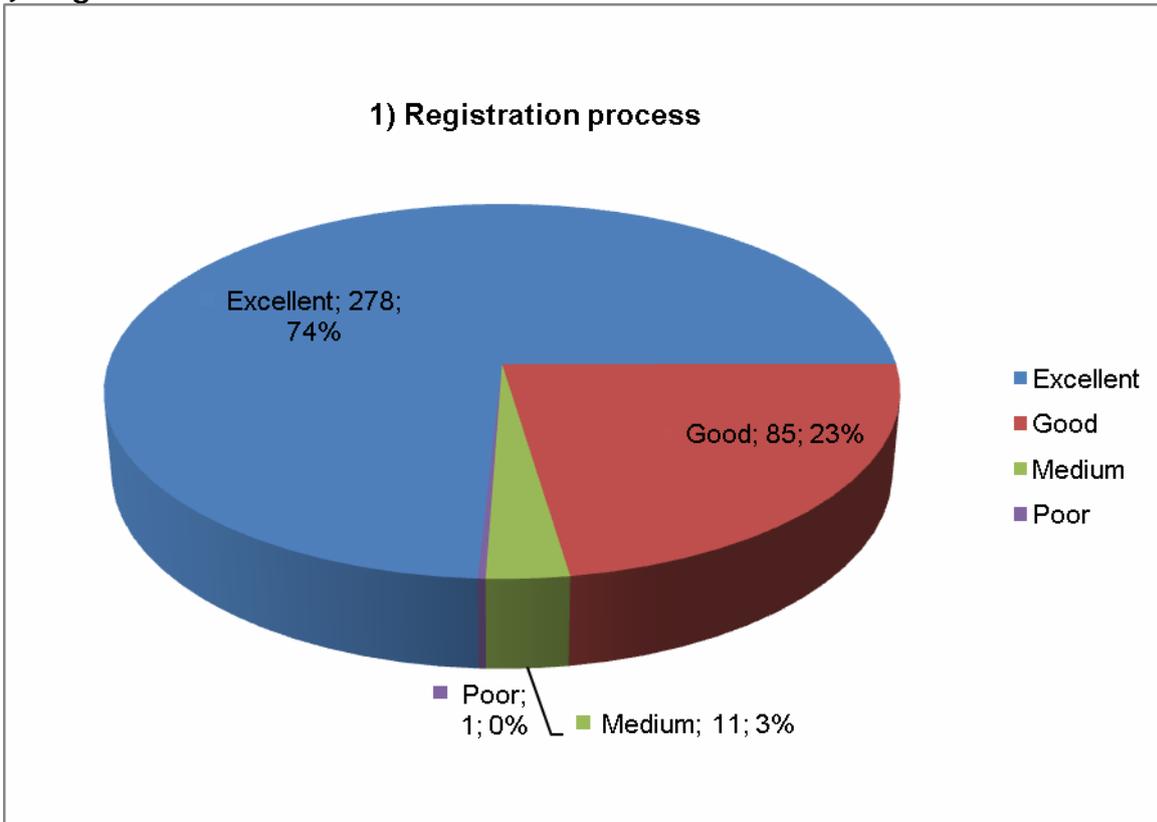
An example of comments received :

- The area was not central - could have been were we took the coffee breaks etc instead to increase interest in the posters
- seems that will be good to request from each participant to provide A4 printed copies of their posters
- The large number of posters was great. I would have preferred 2 poster sessions to allow time to get around and see them all and speak to authors
- Probably the poster session could be a little bit longer.
- Smart idea to make us walk through the posters several times a day!
- Nice set up in that one walked past them often to get to other things and could look quickly here and there.
- Should have been located in a more open space with more light. Too dark - hard to even read some of the small printing in the last dark corners of the poster halls.
- Too many posters to look at !!
- There were too many posters. some Posters you can see at every conference.
- "Good" refers to the posters, effectiveness of poster set up and facilities. However, the allocation of one hour to contacting the poster presenters is to my mind insufficient. In addition it excludes those who adhere to the request to stand at their poster
- A bigger and more open space, and with more light, would have been appreciated.

2) General impression of the presentation



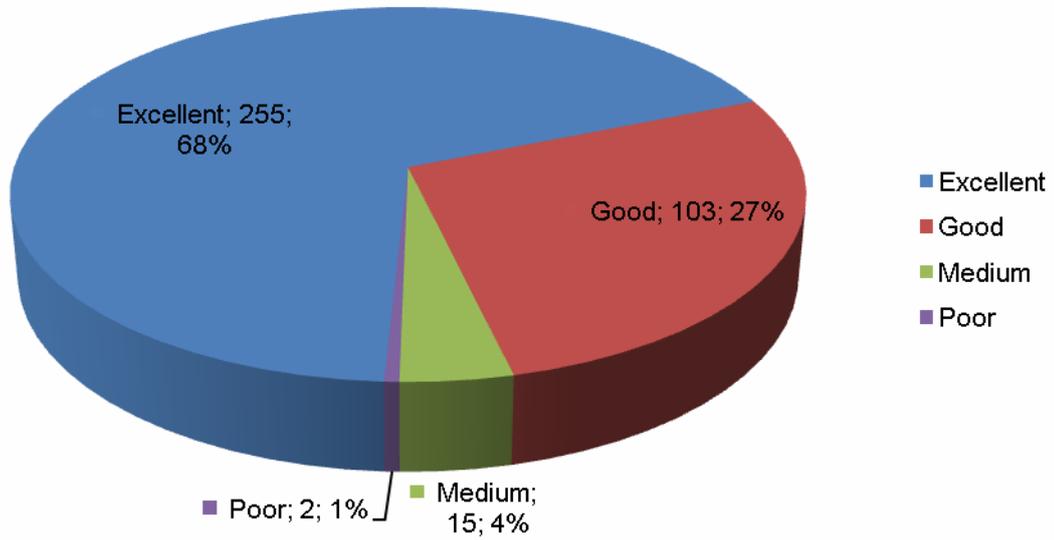
E) Registration and conference venue



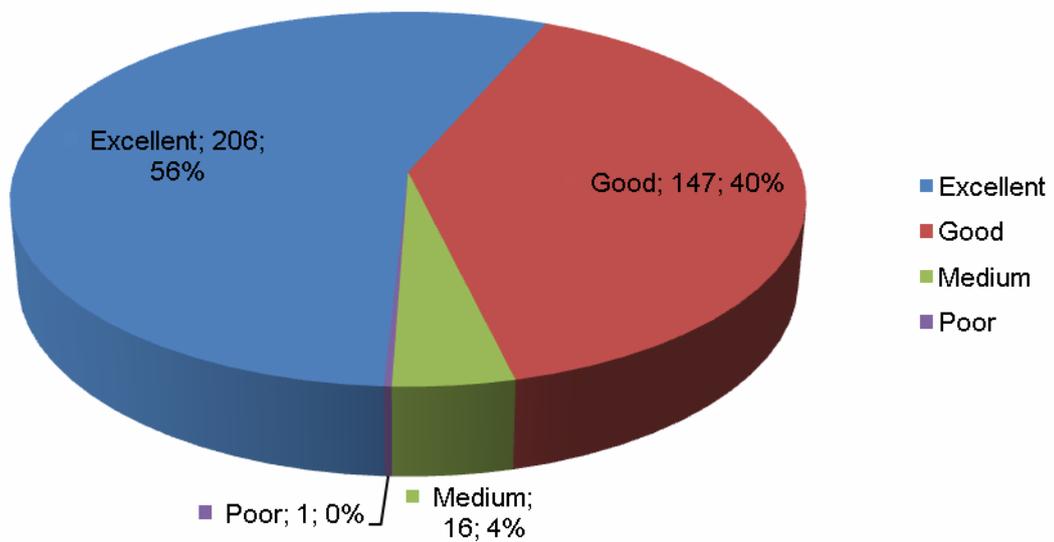
An example of comments received :

- May have been useful to have the map of transport links prior to arrival at the venue.
- appreciated that drinks and fruits were available at all times
- I liked the bar code registration and the conference train ticket!
- bicycles very much appreciated, also freely available fruit, staff very nice and helpful
- I was glad there was vegetarian offers!
- The vegetarian meal was really tasteless, uncreative and out of time
- I was dismayed to find Nestle was a sponsor of the conference and hope that EUPHA will develop a policy on sponsorship including ethical aspects.
- food was medium, we hoped for an after party with a band and possibility for dancing
- did not participate at conference dinner
It was a pity that there was no music and dance at the dinner catering could have been better concerning alternatives to sandwiches (e.g. have celiac disease)

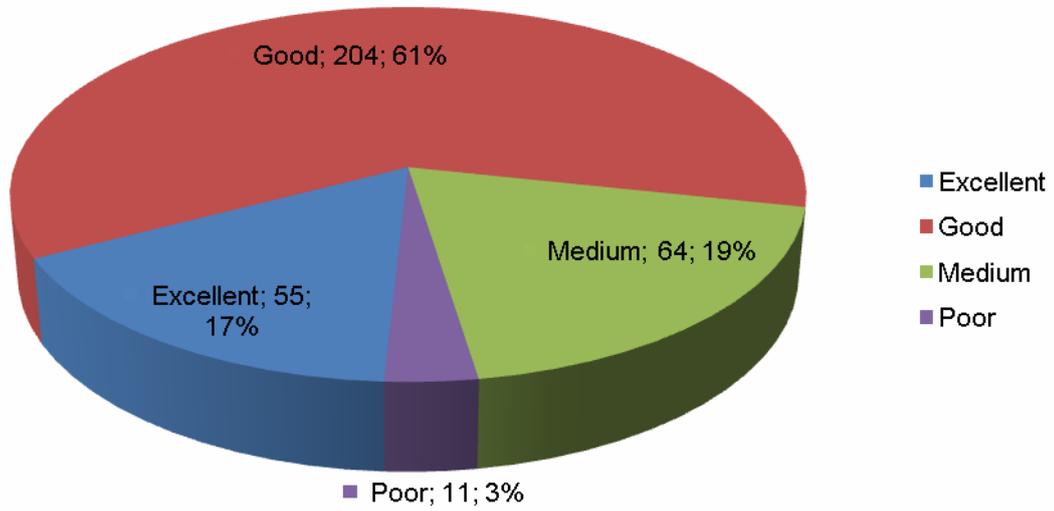
2) Information received prior to the conference



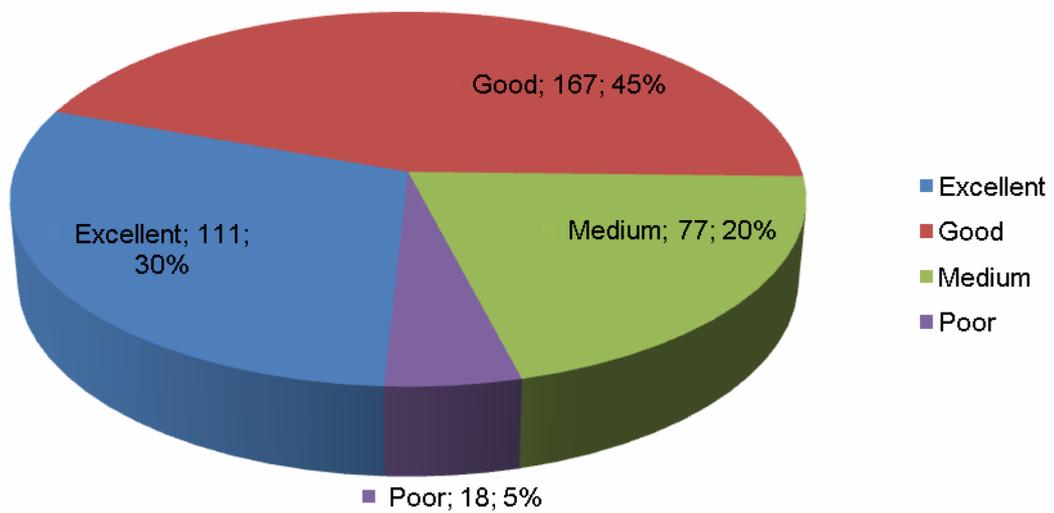
3) Conference venue (CCM) in general



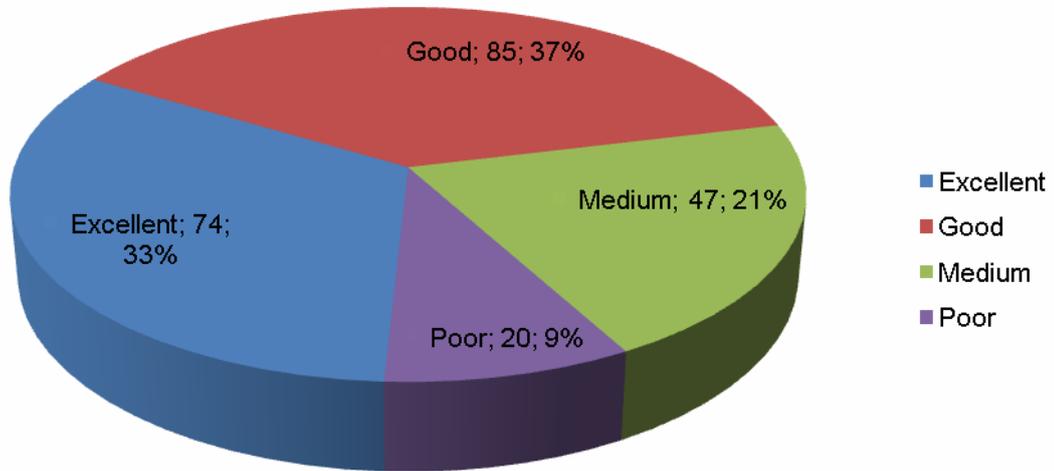
4) Presence of sponsor and partner stands



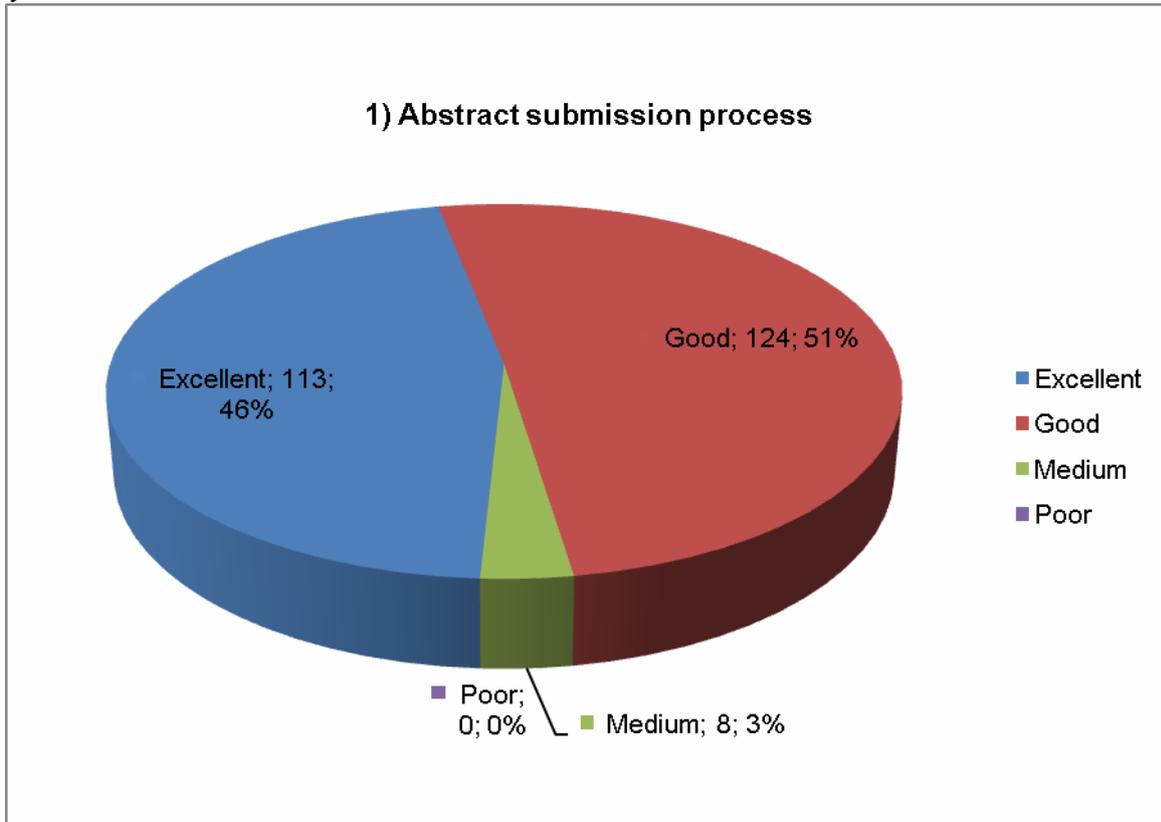
5) Catering



6) Conference Dinner



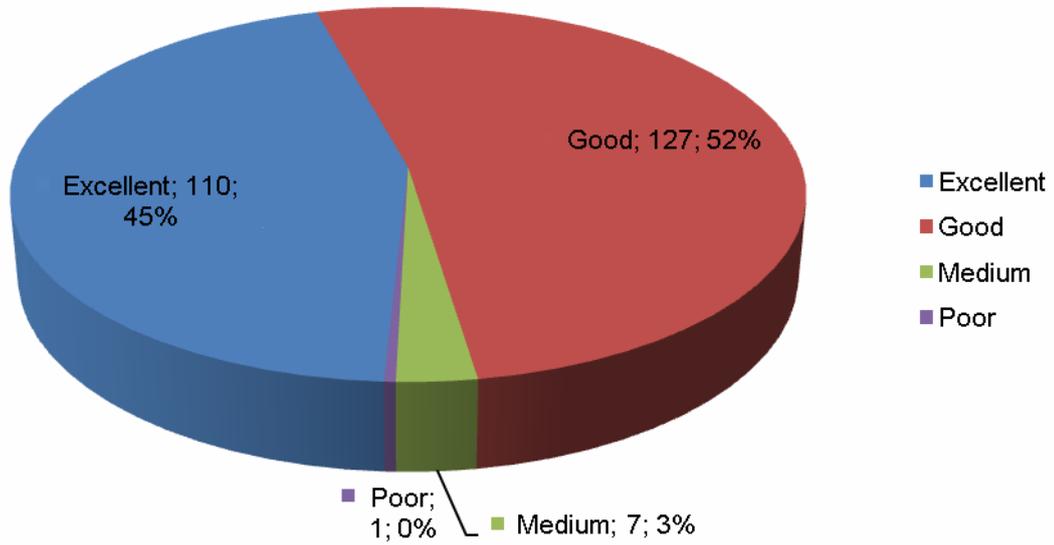
F) Abstract Submission



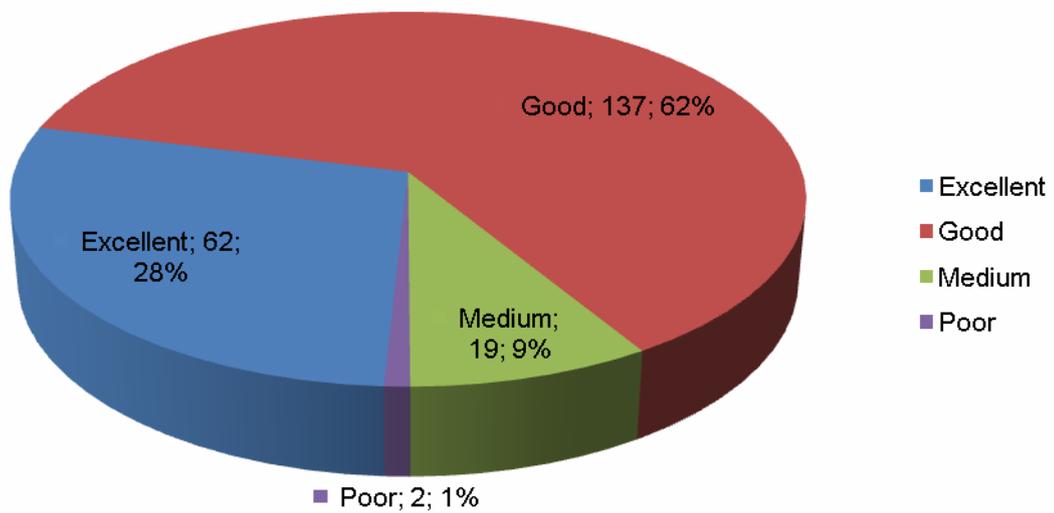
An example of comments received :

- Scoring system and info were excellent, but some sessions resulted in low-level or not focused presentations.
- Important to have abstracts before the conference.
- It was very strange that the abstracts for the pre-conference were not published. This would have been very useful

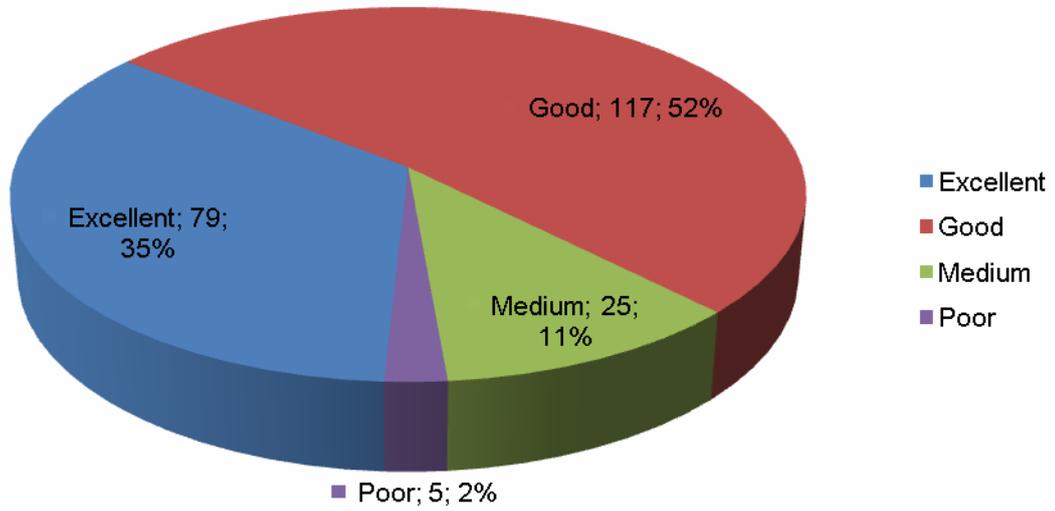
2) Information on Abstract submission



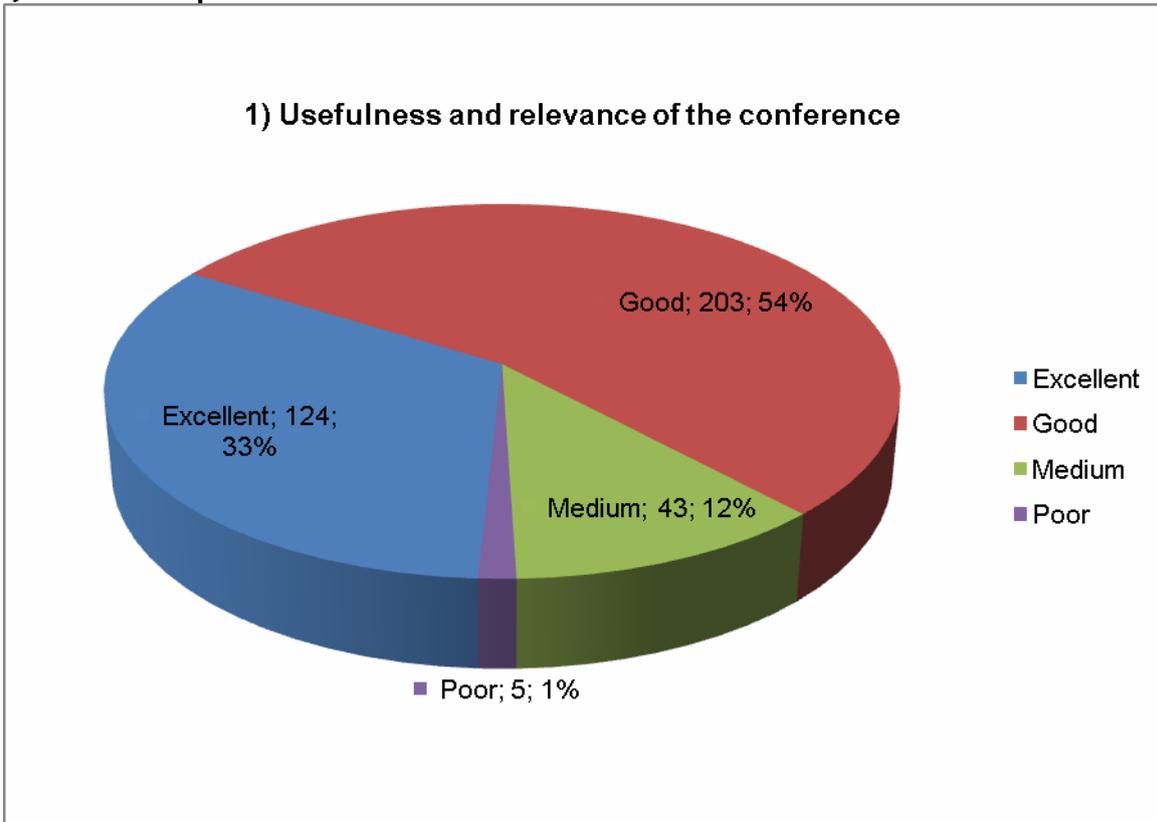
3) Selection process



4) Information on selection process



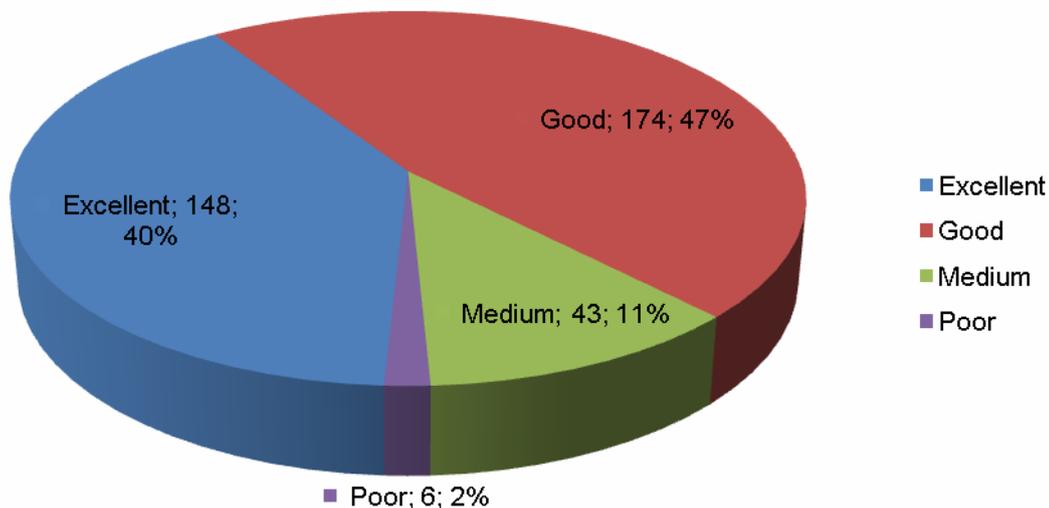
G) General aspects



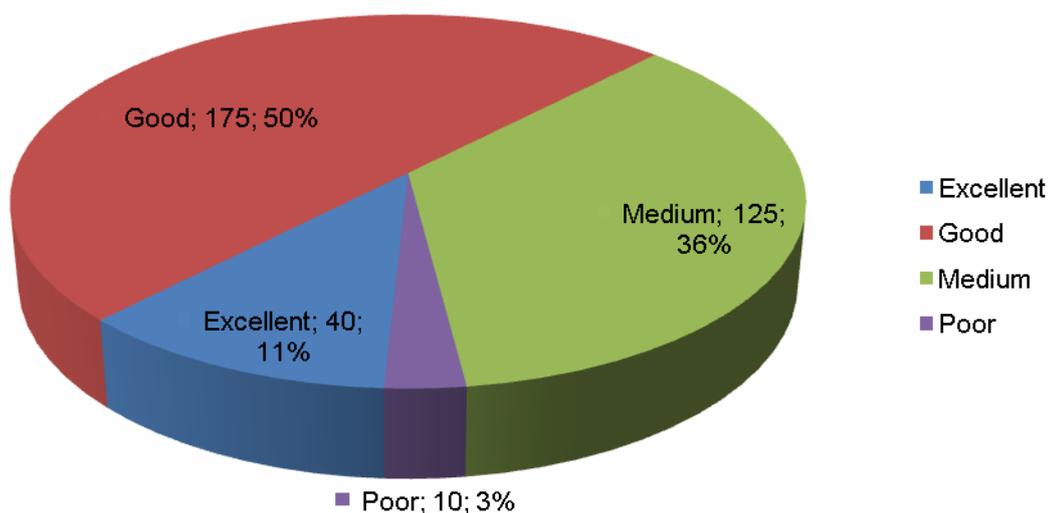
An example of comments received :

- EUPHA conference is a nice and prestigious conference. it is a special occasion to meet researchers and other professionals working in the same area of interest.
- Train tickets, free public transportation and bikes as well as all information provided in advance was very useful and thorough.
- The size of the conference makes networking difficult
- Too many parallel sessions, sometimes speakers were not focused on session theme. Conference need more time to cover all aspects with less overlapping, but fees should be reduced.
- The pre-conference sessions enabled more contact between the group members.
- networking was not easy if you hadn't planned it in advance

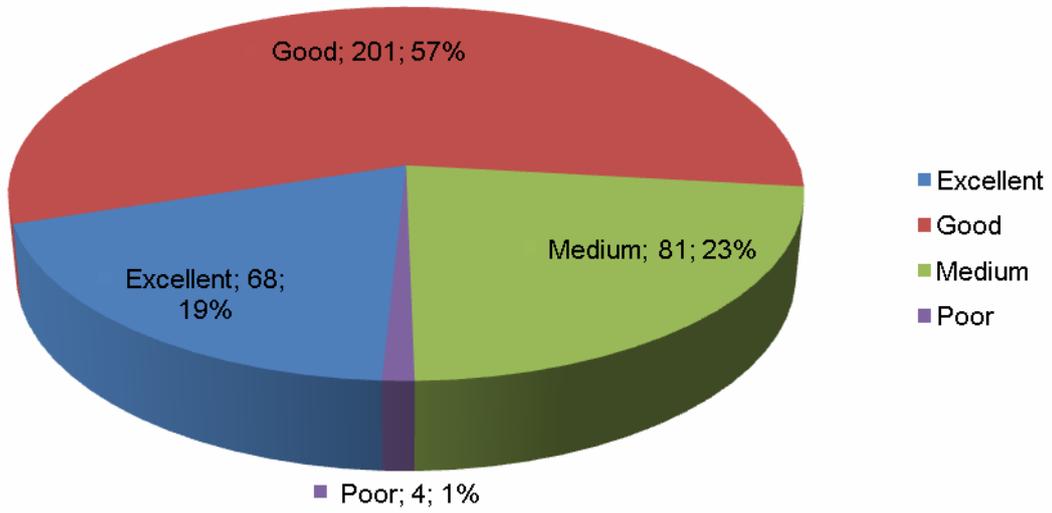
2) Networking possibilities



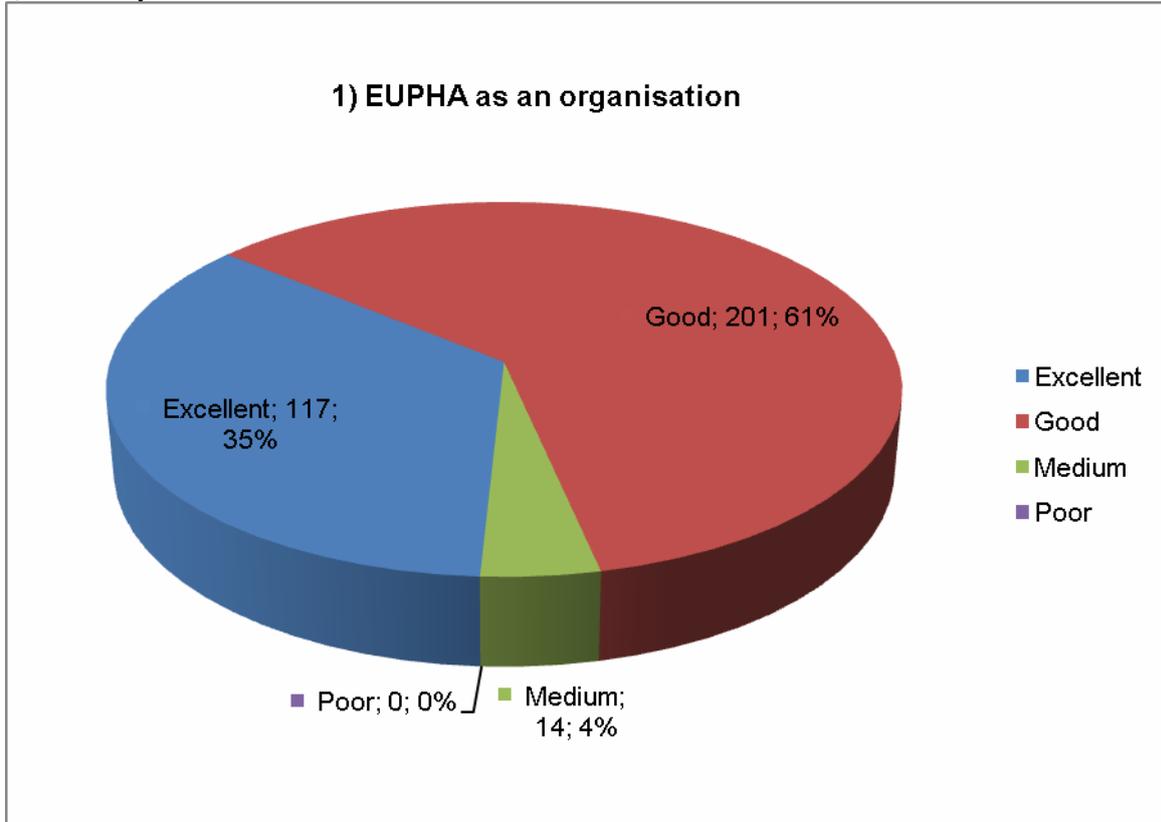
3) Conference fees (compared to similar conferences you have attended)



4) Overall cost / benefit ratio for their investment in attending the conference



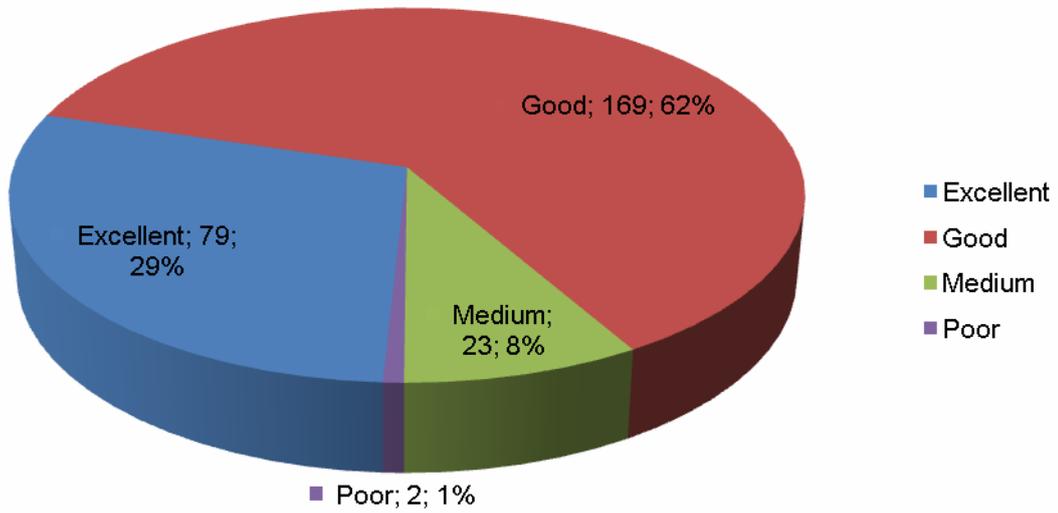
G) Your opinion on EUPHA



An example of comments received :

- Some important public health subjects were missing such as e-health and sexual and reproductive health, too bad...
- It is worth to start thinking about ASPHER as a section of EUPHA or creating section dealing with education.
- Please think on current "hottest" topics involving the general public/citizens e.g. risks & benefits of eMedicine, danger of terrorism vs. civil rights, risk of violence at home/family, homicide.
- a section on advocacy and communication
- It needs to be more active in the field of health advocacy, especially at EU level. This requires representation in Brussels - perhaps more collaboration with EPHA is required?
- more emphasis on practical and clinical implications of research and theoretical knowledge, especially in a field of chronic diseases
- interdisciplinary and resource oriented approaches are missing

2) EUPHA section



3) Do you plan to attend the EUPHA conference 07 in Helsinki?

