



European
Commission



Health for the EU in 33 success stories

**A selection of successful projects funded
by the EU Health Programmes**

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Foreword

By John Dalli,
European Commissioner for Health and Consumer Policy



Health matters for each and every citizen. We are all concerned about our health and the health of our families. We are all patients at some point in time and use health services. We are all growing older and aspire to leading long, healthy and active lives.

In addition, health matters for the economy as a whole, as a key factor in securing a solid workforce and a thriving economy. Health makes all the difference between being able to work or not. The health sector is at the leading edge of innovation and a net creator of jobs. Cost-efficient health systems further contribute to sustainable public finances. Investing in health can therefore prolong healthy life years, reduce preventable diseases and hence help improve citizens' capacity to remain active members of society into old age.

In this context, the EU Health Programme seeks to support Member States in their efforts to improve health, which, in turn, will contribute to delivering a smarter, inclusive and more sustainable Europe by 2020. Since 2003, the Health Programmes have financed projects worth close to 450 million euros. While this represents a small fraction of the overall EU budget, I believe such projects provide substantial added value which benefits EU citizens, for example in terms of exchange of knowledge and co-operation across Europe.

This publication showcases a selection of remarkable projects co-financed by the Health Programme. It presents 33 examples of successful projects covering a wide range of issues such as nutrition and healthy lifestyles, health inequalities, youth health, cancer, health threats and health information.

These projects show, for example, how the Health Programme has helped to better understand the issue of smoking uptake by young people and by women in particular; to raise awareness on cardiovascular disease and diabetes; to help implement screening for cervical and colorectal cancers; or to develop the worldwide online source of information on rare diseases Orphanet Europe. Some projects have also supported innovation in health in concrete ways: improving understanding on how to set up electronic health records or introduce personalised medicine.

As European Commissioner for Health, I am keen to ensure that the EU continues to invest in projects that can make a difference in improving citizens' health and wellness. This is why the European Commission has recently proposed a new Health Programme to begin in 2014, building on the current programme, which comes to an end in 2013. Our aim is for the new programme to support and complement national efforts to achieve four objectives: innovative and sustainable health systems; better and safer healthcare for citizens; health promotion and disease prevention; and protecting citizens from cross-border health threats. I believe that such EU Health Programme will be of great benefit to all EU citizens.

A handwritten signature in black ink, which appears to read "John Dalli". The signature is written in a cursive, flowing style.

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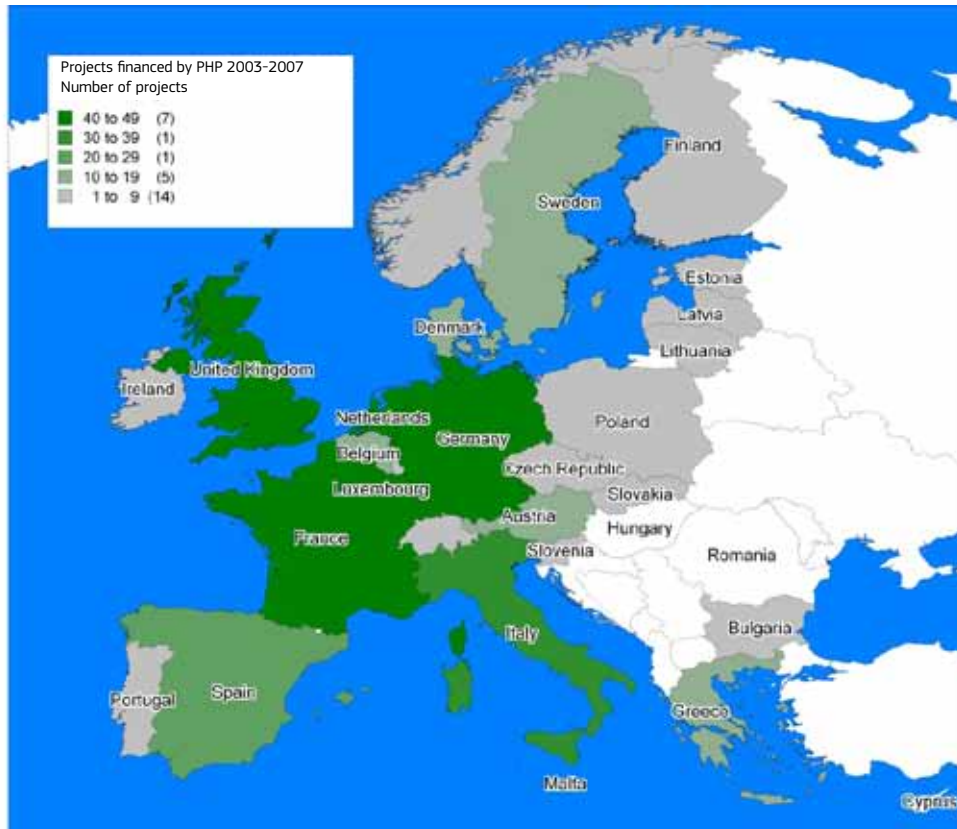
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Introduction

Containing 33 selected projects from different health areas, this booklet is intended to present some meaningful results achieved by the European Union's health programmes. It is a glimpse into the hundreds of projects and actions made possible by these programmes to improve public health in Europe.

The projects have been funded under the Public Health Programme 2003–2007 and the Health Programme 2008–2013. For a full list of projects please refer to: <http://ec.europa.eu/eahc/projects/database.html>



Number of projects funded under the first Health Programme (2003–2007), by coordinator country

The first period: 2003–2007

The Public Health Programme (PHP) 2003–2007 was the first health programme¹, with a total budget of EUR 312 million for six years.

The PHP brought together a series of parallel actions² previously implemented separately during the period 1996–2002, and established a recognised position for public health activities at the European level.

To this end, it was structured around three objectives:

- to improve information and knowledge for the development of public health;

- to enhance the capability of responding rapidly and in a coordinated fashion to threats to health;
- to promote health and prevent disease through addressing health determinants across all policies and activities.

This integrated approach provided opportunities to create EU-added value by promoting synergies among the actions, and by allowing more Member States to participate, sometimes on issues they would not have been able to tackle on their own.

¹ Its full name is Community action in the field of health, 2003–2008, Decision No 1786/2002/EC of 23 September 2002. The action was initially for six years but finally reduced to five.

² These were health promotion, information, education and training, rare diseases, pollution-related diseases, injury prevention, AIDS and other communicable diseases, cancer, prevention of drug dependence, and health monitoring.

The second period: 2008–2013

The Health Programme (HP) 2008–2013³ came into force on 1 January 2008. It has the same objectives as the first programme:

- to improve citizens' health security;
- to promote health, including the reduction of health inequalities;
- to generate and disseminate health information and knowledge.

The programme has a total budget of EUR 321.5 million. It supports the principle of health in all policies. Due to the EU enlargement, emphasis is placed on health inequalities and the transfer of knowledge to the Member States that joined the Union in 2004 and 2007. Projects include and involve actors from different Member States and other countries participating in the Programme (Norway, Iceland, Lichtenstein and Croatia). As such results should be applicable across Europe.

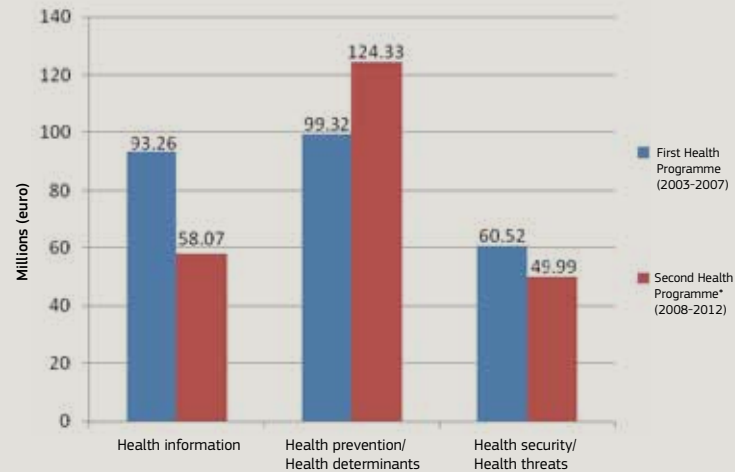
In comparison with the previous period 2003–2008, there has been a significant improvement in the delivery of the programme, mainly related to the outsourcing of the programme management to the Executive Agency for Health and Consumers, created in 2005.

The benefits and the future: 2014–2020

The two programmes strongly support cross-border collaboration between Member States, the establishment and maintenance of networks and sharing of experiences across Europe. Capacity building is ensured, where necessary, by pooling resources across the EU and working on joint solutions. The ultimate beneficiaries of these actions are European citizens.

Due to relevance of the actions undertaken by health programmes and the leverage effect that they can have on health policies at European, national and regional level, the European Commission proposed in November 2011 a third programme⁴, 'Health for growth', for the period 2014–2020. This programme will help EU countries respond effectively to economic and demographic challenges faced by their health systems and enable their citizens to stay healthier for longer, thus improving the quality of their life. The proposed budget is EUR 446 million. It will come into force in 2014.

Funding by health programme and type of action (2003–2012)



* The Health Programme 2008–2012 is currently implemented until the end of 2013. Whilst this booklet was being prepared, an additional EUR 5.1 million has been planned for operating grants and conferences in 2012 and will only be allocated after the selection of the grant recipients.

Health programme actions covering different health issues (2003–2012)

Health issue	
Health indicators, data and support to Member States	109
Rare diseases	59
Nutrition and physical activity	49
Sexually transmissible infections	42
Health inequality	40
Tobacco	37
Blood, organs, tissues, cells	35
Alcohol	29
Patient safety/ Quality of health systems	28
Health workforce	25
Addiction prevention	24
Mental health	24
Cancer	24
Ageing	20
Environmental health	19
Influenza/pandemic preparedness	16
Injuries	14
E-health	14
Vaccination	13
Operating grants 2012 and other actions	9
Cardiovascular disease	8
Cross-border healthcare	8
Pharmaceuticals	7
Health technology assessment	6
Scientific advice	6
Health security and preparedness	6
Innovation	2
TOTAL	673

³ Its full name is Second programme of Community action in the field of health Decision No 1350/2007/EC of 23 October 2007.

⁴ Proposal for a Regulation of the European Parliament and of the Council on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014–2020 (http://ec.europa.eu/health/programme/docs/prop_prog2014_en.pdf)

1. Health Threats

As the world becomes increasingly interconnected, serious cross-border health threats, such as biological agents, including infectious diseases, chemical agents, and environmental hazards, pose a greater risk than ever to health and international travel and trade. The *E.coli* outbreak in 2011, the volcanic ash cloud in 2010 and the global H1N1 flu pandemic in 2009 have shown the urgent need for cooperation on a European level to respond effectively to these threats that affect more than one Member State.

In December 2011, the Commission adopted a proposal for a decision of the European Parliament and of the Council on serious cross-border health threats, which aims to protect EU citizens more effectively against such hazards.

With this proposal, the EU is working to strengthen health security capacities and structures both in EU countries and at EU level to better cope with future health crises. The proposal seeks to increase the inter-operability of national emergency plans by expanding their coordination between EU countries; alert systems to notify threats will be further developed and systems will be put in place to assess the danger of a given threat. Finally, the role of the Health Security Committee, where public health authorities from the EU countries discuss the measures to mitigate health threats, will be strengthened.

The EU is also working with partners in neighbouring countries to improve communication and training of health workers.

ASHT II – An effective cross-border system for chemical and poison alerts

“*By having an alert system in place, countries will be more effective at sharing resources and be able to deal with events more efficiently.*”

Raquel Duarte-Davidson, project leader

chemical health threat, and to improve the risk assessment and risk management of chemical health threats in Europe. This involved developing a strategy for improving information exchange between EU poisons centres and public health authorities.

ASHT II sought to improve communication between poisons centres within different EU countries as well as to better understand the alerting strategies for chemical incidents. Prior to this project no formal mechanism existed to share information regarding chemical exposures at the European level.

Much of the work within the project focused on understanding how to harmonise the way we describe the features of chemical injuries and the circumstances of the exposure so that symptoms could be described without confusion. As there are many words that can be used to describe the symptoms of toxic exposures, such as tearful eyes or vomiting, this was not that straightforward. This was further complicated by the need to adopt a multilingual approach.

Within the project a system called MedDRA (Medical Dictionary for Medical Authorities) was adopted to overcome these issues.

ASHT II has also developed the Rapid Alert System for Chemical Health Threats (RAS-CHEM) – an early warning system for the EU Commission where EU countries can share information and act together regarding chemical incidents.

The project is continuing with a third phase of ASHT, which started in 2012.

If a chemical incident or poison outbreak occurs in Europe close to several national borders a co-ordinated cross-border response would be needed in the affected countries. Chemical threats know no borders and can quickly spread over long distances and affect large numbers of people.

The main objective of the Alerting System for Chemical Health Threats phase II (ASHT II) project was to improve the response of public health authorities in the EU in the event of a serious transboundary

The International Federation of the Red Cross has estimated that between **1998 and 2007** there were nearly **3 200** technological disasters worldwide, with approximately **100 000** people killed and nearly **2 million** people affected.

ASHT II

Full name:

Alerting System for Chemical Health Threats

Start date / End date: 01/10/2008 – 30/09/2011

Project coordination: Health Protection Agency, London, United Kingdom

7 project partners from 6 countries:

Belgium, Czech Republic, France, Germany, Lithuania and United Kingdom

EC Contribution: EUR 600 000.00

Website: www.hpa.org.uk/ProductsServices/ChemicalsPoisons/InternationalActivities/ASHT/

CIE Toolkit – Preparing health professionals to deal with chemical incidents

“*Running the project at EU level has offered great opportunities for working with professionals from across Europe on how chemical incidents should be managed.*”

Mark Griffith, project leader

Being prepared for any event is important but when there is a chemical threat and lives and the health of the public are in danger it is more important than ever that health professionals who deal with these incidents are equipped to respond as quickly and as effectively as possible.

The Public Health Response to Chemical Incident Emergencies Toolkit (CIE Toolkit) project aimed to strengthen the national and international response of health professionals to deliberate chemical incidents that are potentially harmful to the public.

The project produced a multidisciplinary website and CD-ROM for public health professionals to help them to better prepare for, and respond to, a chemical disaster more quickly. It covers all areas of planning, preparedness, response and recovery. The specialities covered within the toolkit include scenario development training through exercise cards, risk and crisis communication, and psychosocial aspects. The toolkit is available from the project's website.

A network of experts has been put in place to deliver appropriate training on request, such as 'train the trainer' courses, as well as delivering courses tailored to meet the needs of individual countries.

Through the development and dissemination of all these tools, the project envisages that health professionals can take more effective action when responding to emergency situations involving chemicals. In the end, there should be better and more effective communication and ultimately better protection right across Europe for all citizens.

The production of chemicals has increased 10-fold **in 30 years**, from 1970 to 2000. In addition to this, there were an estimated **2 780** technological-related disasters, with over **144 million** people affected and nearly **95 000** deaths in the 10 years leading up to 2004.

CIE Toolkit

Full name:

The Public Health Response to Chemical Incidents and Emergencies

Start date / End date: 01/04/2008 – 30/06/2011

Project coordination: Health Protection Agency, London, United Kingdom

6 project partners from 5 countries:

Greece, Netherlands, Sweden, Poland and United Kingdom

EC Contribution: EUR 697 430.92

Website: www.hpa.org.uk/ProductsServices/ChemicalsPoisons/InternationalActivities/CIEToolkit/

“ *The availability of healthcare services and the ability of border staff to deal with health concerns directly at borders is one of the best prevention measures against potential public health risks.* ”

Roumyana Petrova-Benedict, project leader

PHBLM – Increasing public health safety along the EU borders

In 2011, there were **301 000 asylum applicants** registered in the 27 EU countries. It is estimated that around 90% of these were new applicants and around 10% were repeat applicants. In 2010, there were 259 000 asylum applicants.

Migration and human rights are not unique to each country, it is a shared problem: they have no borders. EU funding naturally leads to collaboration between countries and best practice exchange.

The PHBLM project focused on public health conditions and healthcare services provided for migrants and the capability of border staff and health professionals working on the border regions to deal with these issues.

PHBLM has dealt with several issues concerning the increased public health risks related to mass migration and mobility around the external borders of the Schengen Area. Firstly, by looking at the human and health rights of the immigrants, and secondly, the occupational health-related risks of

border guards and healthcare workers dealing with social and health problems in their daily work in detention centres.

A survey of borders workers revealed gaps in staff's knowledge of how to deal with health and social issues concerning migrants, including basic first aid practices, particularly for border patrol guards, who can be confronted with migrants in ill health. It was also found that most guards lacked knowledge of human rights and had little understanding of other cultures.

The project has created a publication of guidelines for public health conditions in detention settings. Plus, it has developed training materials designed for the continuing education of border guards and officials with different modules, including cultural, health and human rights aspects.

Some of these modules have been implemented and more recently adopted in some border guard training schools. The Frontex Agency (European Agency for the Management of Operational Cooperation at the External Borders, based in Warsaw, Poland) is now updating its core curriculum based on the projects recommendations. Also, a checklist for assessing public health-related conditions and infrastructure at border points and detention centres has been compiled.

PHBLM

Full name:

Increasing Public Health Safety for the External Borders of an Enlarged European Union

Start date / End date: 05/06/2007 – 04/06/2010

Project coordination: International Organization for Migration, Brussels, Belgium

3 project partners from 3 countries: Belgium, Hungary and Spain

EC Contribution: EUR 501 737.00

Website: www.iom.int/jahia/Jahia/increasing-public-health-safety-alongside-new-eastern-european-border-line/lang/en



“

We must collaborate at European level, not just within one country. The EU funding of this project enabled cross-border collaboration, which makes it easier to respond to outbreaks.

Christos Hadjichristodoulou, project leader

”

SHIPSAN TRAINET – Healthier cruising in Europe

Cruising in Europe is on the increase. It is important to regulate hygiene on ships otherwise there is a higher risk of outbreak of diseases. The risk of disease transmission is not just isolated to ship and ferry passengers but also to citizens living in the ports the ships visit. The Mediterranean is one of the world's highest traffic zones for cruise ships.

Passengers are in close confinement sharing food and water sources as well as water for bathing and swimming. If hygiene measures are not in place, there is also a higher chance of person-to-person transmission of infectious diseases, such as gastroenteritis and Legionnaires' disease and, of course, nobody wants to have a ruined holiday.

The SHIPSAN TRAINET project's aim is to create a common European framework for regulation of hygiene on cruise ships. Through its work, it has already produced a training manual (European manual for hygiene standards and communicable disease surveillance on passenger ships) and conducted training exercises for port authorities and seafarers in Europe.

The project brought together ship industrial and commercial representatives, alongside academics,

health and transport officers and other experts within the area of shipping regulations. It included the European Commission services and agencies, as well as the World Health Organization and the International Maritime Organization.

Through all the actions taken by SHIPSAN TRAINET, the industry is held to high standards, crew work in a safe environment, and passengers are also kept safe and healthy. Prevention of diseases is paramount and all citizens are protected.

There are more than **200 cruise ships** operating in Europe and every year approximately **5 million** people take a cruise and over **400 million** citizens travel using ferries.

SHIPSAN TRAINET

Full name:

EU Ship Sanitation Training Network

Start date / End date: 20/11/2008 – 19/10/2011

Project coordination: University of Thessaly, Greece

14 project partners from 11 countries:

Greece, Ireland, United Kingdom, Slovenia, Spain, Estonia, Lithuania, Germany, Poland, Bulgaria and Sweden

EC Contribution: EUR 779 731.27

Website: www.shipsan.eu/trainet/

EQADeBa – Testing the limits of specialised laboratories

“ *By simulating real situations in laboratories we were able to assess the speed of the diagnosis to prepare for a rapid response reaction.* ”

Roland Grunow, Robert Koch Institute

Pan-European ‘stress tests’ of highly specialised laboratories, usually unique in each Member State, are done by simulating bioterrorist attacks or sudden outbreaks of very dangerous diseases. This is the best way to prepare for a real danger to the EU population, while hoping it will never happen.

The project, supported by the second Health Programme, aimed at improving the preparedness of laboratories designated by the authorities in EU Member States to respond to any potential bioterrorist threat or natural outbreak of diseases caused by highly pathogenic bacteria like anthrax, plague, or tularaemia. In the case of such an attack or outbreak, laboratories must be able to achieve a quick and precise diagnosis of highly potentially dangerous threats.

The project tested the laboratories’ limits and abilities through a series of quality assurance exercises. Each of the laboratories participated in three rounds of such exercises using samples of highly pathogenic bacteria of different complexity.

Two rounds helped to estimate the laboratories’ capabilities, covering all aspects of bio safety and bio security. The efficiency and training of personnel was then validated by the third round of testing.

Being prepared means greater safety for the public. Laboratories are able to recognise outbreaks at international level, while maintaining similar quality standards in diagnosing threats. EU-wide co-operation and support is essential in this field.

‘The infectious diseases in focus in these projects are unequally distributed throughout Europe, and can occur at any time; disease can also be imported and does not respect national borders. It thus becomes clear why this project has to be carried out at a European level. Most countries only have one laboratory operating in this field. So it brings together limited resources in a cost effective manner,’ the coordinator Roland Grunow, from Robert Koch Institute, explains the rationale for this EU action.

Threats which are caused by the use of certain substances or agents can be of natural origin or caused unintentionally or deliberately. They are distinguished by the triggering substance:

chemical, biological, radiological, nuclear, explosive.

EQADeBa

Full name:

Establishment of Quality Assurances for Detection of Highly Pathogenic Bacteria of Potential Bioterrorism Risk

Start date / End date: 01/05/2008 – 30/04/2011

Project coordination: Robert Koch Institute, Berlin, Germany

17 project partners from 15 countries:

Austria, Belgium, Bulgaria, Finland, Germany, Greece, Hungary, Italy, Lithuania, Netherlands, Norway, Poland, Spain, Sweden and United Kingdom

EC Contribution: EUR 1 199 848.51

Website: www.rki.de/EN/Content/Prevention/EQADeBa/EQADeBa_node.html

ORCHIDS – Quick and effective mass decontamination

If a hazardous substance is deliberately released in public, large numbers of people may need to be decontaminated, quickly and effectively, halting the spread of contamination and reducing the potential of injury or disease. Emergency responders and hospital facilities also need to be protected from secondary contamination.

Through laboratory studies and field trials, evaluating the capacity of emergency services to react to incidents, the ORCHIDS project developed recommendations, protocols and procedures on how decontamination can be done on a large scale and in less time. It strengthened the preparedness of EU countries to react to incidents involving the deliberate release of potentially hazardous substances. Response capabilities can be enhanced by identifying ways of optimising decontamination processes for emergencies involving large numbers of casualties.

This project not only looked at incidents involving mass casualties but also at incidents, such as chemical spills or accidents, that happen fairly regularly on a small scale across Europe every day. ORCHIDS paid particular attention to vulnerable populations with respect to decontamination. Recommendations were formulated, for example, on how to approach pregnant women, children and minority or religious groups caught up in such situations, taking into account that decontamination processes can involve public disrobing, showering and re-robing, in accordance with instructions.

A decontamination process according to ORCHIDS procedures takes less time and performs as well as national standards. It is hoped it will be used as a benchmark both nationally and internationally.



It is important that mass decontamination processes are effective, humane and sensitive. Anything that can be done to improve this benefits the public.

Richard Amelôt, project leader



'In doing this work, we are ensuring the mass decontamination can be done quickly and effectively in a way that caters for a diverse population, taking into account cultural differences', says Richard Amelôt, project leader. Decontamination could be difficult and uncomfortable, 'It is important that the public experiences a process which is effective, humane and sensitive'.

According to Amelôt, 'the EU component was essential for the success of ORCHIDS. It gathered specialists from across Europe, working in the same field but with different cultural backgrounds and new ideas. Through the project and field-based trials we were able to gather experience, exchange best practices on a very practical level and disseminate the guidelines across Europe.'

Incidents involving mass casualties are rare but smaller incidents happen on a fairly tiny scale across Europe every day. For example, in the United Kingdom alone there are about **30–40 small scale incidents per year.**

ORCHIDS

Full name:

Evaluation, Optimisation, Trialling and Modelling Procedures for Mass Casualty Decontamination

Start date / End date: 01/06/2008 – 31/05/2011

Project coordination: Health Protection Agency, London, United Kingdom

4 project partners from 4 countries:

Czech Republic, France, Sweden and United Kingdom

EC Contribution: EUR 1 549 388.00

Website: www.orchidsproject.eu

2. Blood and organs

Donated blood, tissues, cells and organs are vitally important in the treatment of a number of serious and life-threatening medical conditions, including leukemia and heart problems. Care must be taken, however, to prevent the transmission of diseases such as hepatitis and HIV as a result of these treatments.

As demand for these treatments increases, the European Commission is taking steps to encourage voluntary donations and harmonise rules to help citizens access vital transplant organs in other EU countries. The European Commission is also working to protect both donors and recipients by ensuring the safety of medical procedures and the quality of donated blood, tissues, cells and organs.

SOHO V&S – Vigilance and surveillance of substances of human origin

“ *Citizens can be reassured that tissue and cell transplants are safer in the EU due to this widening knowledge, harmonisation and better connectivity between Member States.* ”

Deirdre Fehily, SOHO V&S project

Tissues and cells for human application represent one of the key areas where the EU has introduced legislation to protect public health. It requires Member States to establish systems for reporting of serious adverse reactions and events and for forwarding annual reports of this activity to the European Commission.

Human tissues and cell circulate throughout the EU and beyond. More and more patients are treated with cells or tissues from a different country. Such transplants include amongst others bone marrow, cord blood, heart valves, corneas, bone and skin.

Gametes and embryos also circulate for use in fertility treatment. It is therefore important that high standards of safety and proper vigilance and surveillance of tissues and cells are in place across the whole EU.

The Vigilance and Surveillance of Substances of Human Origin (SOHO V&S) project aims to introduce standard practices in all EU countries on how serious adverse events and reactions are reported, evaluated and investigated. This project builds on the work already done by EUSITITE, a three-year project which ended in 2009 that identified the need for common guidelines on the reporting and investigation of adverse outcomes associated with collection, processing, storage, packaging and distribution of tissues and cells for human use.

SOHO Vigilance & Surveillance is harmonising terminology and documentation, allowing for a consensus on how to exchange information between countries. The guidelines will support the implementation of the regulation of movement of human tissues and cells as well as better control over illegal and fraudulent activities. As part of the project, courses are available for all Member State Competent Authority officials, with an e-learning module and three-day residential module with the objective of training these individuals on how to follow the recommended procedures.

SOHO Vigilance & Surveillance

Full name:

Vigilance and Surveillance of Substances of Human Origin

Start date / End date: 01/03/2010 – 28/02/2013

Project coordination:

Istituto Superiore di Sanità (ISS), Rome, Italy

8 project partners from 6 countries:

Belgium, Ireland, France, Poland, Spain and United Kingdom

EC Contribution: EUR 794 313.00

Website: <http://www.sohovs.org/>

EFRETOS – Pan-European registry of the evaluation of organ transplants

All patients in the EU who have undergone a transplant need to be followed up. Sharing data from surgery and discussing follow-up and outcome is very important for health practitioners. All this should become much easier thanks to the creation of the pan-European registry on post-transplant outcome data. The EFRETOS project is a step in this direction, allowing in the end to make better use of the limited number of donated organs in the EU.

The number of organs available for transplant is still limited. That is why they should be put to best use. However, at present, there is a general lack of data on how organs are used and what the results of transplants are. Where such information exists it is scattered across EU countries. Only very few EU countries (United Kingdom, France, Netherlands) have registries of transplantations and outcomes. This means that learning opportunities on how to ensure optimal use of organs are missed.

EFRETOS has built an inventory; a list of data items to be collected and how they are to be clearly defined has been agreed upon. In other words, a 'data dictionary'. *'This is a major achievement and with this in place, all EU countries will have a blue print to develop their own registries'* – says Axel Rahmel, one of the project leaders and Medical Director of Eurotransplant.

Secondly, the need to document adverse reaction and response has also been agreed upon. Now the legal and technical issues covering the privacy and storing of the data will be addressed and, finally, the quality assurance of these data.

With all these main elements in place, the overall objective of the creation of a pan-European Registry is beginning to take shape. The next step will be national or supranational registries on organ transplantation in all EU countries. The structure of these registries, following the guidance of EFRETOS, should allow for comparable data delivery to the future pan-European Registry.

The transparencies arising from a proper registry will inevitably lead to more public confidence in organs transplantation. This has a twofold effect: transplants become safer and more effective and it increases the public's willingness to donate organs, knowing that they will be used effectively for patients in need.



“ *The inventory is a major achievement. It is the first consensus in the area in 50 years!* ”

Axel Rahmel, project leader

Almost **10 people in Europe die every day** waiting for an organ transplant. There are more than 50 000 patients on waiting lists.

EFRETOS

Full name:

European Framework for the Evaluation of Organ Transplants

Start date / End date: 01/05/2009 – 30/04/2011

Project coordination:

Stichting Eurotransplant International Foundation, Lieden, Netherlands

5 project partners from 5 countries:

Belgium, Finland, Netherlands, Poland and United Kingdom

EC Contribution: EUR 750 000.00

Website: <http://www.efretos.org>

3. HIV/AIDS and STIs

Over 50,000 people in the EU and neighboring countries are diagnosed with HIV/AIDS each year. While current treatments can slow down the development of AIDS and allow sufferers to live long and fulfilling lives, there is still no cure or vaccine.

The EU's policy therefore focuses on disease prevention and support for people living with the disease by helping member countries to improve access to prevention, treatment, care and social services. Efforts are particularly aimed at reaching high-risk groups and migrants from countries with a high prevalence of HIV. The EU is also working to strengthen cooperation between national authorities, civil society and stakeholders across Europe, and is making efforts to standardise surveillance and notification systems to ensure that data on HIV is comparable between countries.

Men who have sex with men (MSM) represent one of the most at risk populations for acquiring HIV. In 2009, **9 023** newly diagnosed HIV infections were reported among this population in Europe, which accounts for 35% of all HIV diagnoses in that year. An average of 56% of HIV-positive MSM were unaware of their infection.

SIALON – Quick and easy HIV test for MSMs

The project's name derives from the Greek word 'sialon', meaning 'saliva', and is symbolic of the core of the project: the use of a non-invasive outreach testing method based on saliva (oral fluid) samples for HIV and sexually transmitted diseases. The target group is mainly hard-to-reach men who have sex with men (MSM). They are one of the populations most at risk of acquiring HIV/AIDS.

The aim of the SIALON project was to obtain reliable and valid information on HIV and other sexually transmitted infections (STI) among MSM on the prevalence, relevant risk behaviour, cultural factors and prevention needs among MSM population.

The project created a non-invasive method that can be widely used to obtain data on the prevalence of HIV and syphilis among MSM, link it to their sexual behaviour risk patterns and the availability of access to voluntary counselling and testing.

The project was carried out in six cities: Prague, Bratislava, Bucharest, Barcelona, Ljubljana and Verona. The survey found that many HIV-positive MSMs were unaware of their infection and that younger men often have only limited access to HIV screening services and prevention programmes.

Thanks to SIALON, decision makers can use reliable data to design long-term policies and strategies for testing, prevention, treatment and care services for MSM. Projects like SIALON and its successor, SIALON II, help to support the implementation of the Commission communication on combating HIV in Europe, which focuses on the most affected populations and priority regions.

SIALON

Full name:

Capacity Building in HIV/SYPHILIS prevalence estimation using non-invasive methods among MSM in Southern and Eastern Europe

Start date / End date: 01/05/2008 – 30/05/2010

Project coordination:

Regione del Veneto, Venice, Italy

8 project partners from 7 countries:

Czech Republic, Greece, Italy, Romania, Slovakia, Slovenia and Spain

EC Contribution: EUR 358 251.43

Website: www.sialon.eu

“*The rising incidence of HIV infections has a tremendous impact not only in terms of human suffering but also in terms of the costs for healthcare systems. Sharing experiences and knowledge maximises the probability of a good result.*”

Massimo Mirandola, project coordinator

Correlation II – Spreading information, not infection

“*At this time of economic crisis, when local government funding is being cut all over Europe, collaboration at EU level is more important than ever.*”

Eberhard Schatz, project coordinator

When speaking to Eberhard Schatz, project coordinator of Correlation II, it is difficult not to notice the passion and enthusiasm when he describes the achievements of this project based in De Regenboog Groep Foundation, in Amsterdam. It aims to provide help and information to people who use drugs, sex workers and migrants without any papers in need of access to health services

that offer treatment for blood-borne infections, in particular for hepatitis C and HIV/AIDS.

The project mobilised a large number of grassroots organisations, service providers, researchers and activists throughout eastern and western Europe providing intervention and healthcare. It fosters a very practical hands-on approach with peer support, counselling, testing and information on HIV/AIDS and hepatitis C. The key is early intervention and reaching out to these people, often homeless, who are rather reluctant to seek help themselves from fear of discrimination. Sometimes they simply do not know where to get help.

Correlation II has produced a manual for outreach workers across Europe illustrating different approaches and ideas to stimulate new ways to reach young, marginalised people. Once contacted, they are given help in accessing healthcare, provided directly by the local health sector or from other civil society groups providing community health services, associated with the Correlation network.

Online intervention is a very effective way of reaching out, too. The Correlation-net portal, in particular the chat rooms, is complementary to existing ways of working and particularly successful with youths and young adults.

The project proved that including the people affected is a way of trying to help to find solutions, through participation in the design, implementation and evaluation of services help to empower drug users to be more responsible for their own lives. The consequences are reduced risk of harm and increased well-being of target groups.

Using its expertise and models, the network guidelines and trainings were implemented and used on numerous spots all over Europe. This demonstrates that European programmes and projects can improve the health of European citizens.

The results achieved by this project have also had an influence on policy recommendations on HIV/AIDS. The European dimension fosters better exchange of knowledge creating cross-border collaboration across Europe to identify best practices and disseminate ideas.

Over **8 million people** are infected with hepatitis C in Europe. Rates of co-infection with HIV are worrying and particularly high in the Baltic countries.

Correlation II

Full name:

European network social inclusion and health

Start date / End date: 01/04/2009 – 31/03/2012

Project coordination:

De Regenboog Groep, Amsterdam, Netherlands

12 project partners from 9 countries:

Belgium, France, Germany, Lithuania, Netherlands, Norway, Spain, Sweden and United Kingdom

EC Contribution: EUR 900 000.00

Website: www.correlation-net.org/

BORDERNETwork – Protecting vulnerable groups against sexually transmitted diseases

“*Prevention works if knowledge is widespread and without taboos.*”
Elfriede Steffan, project leader

health authorities and civil society organisations from the EU and the European Neighbourhood Policy (ENP) countries in the field of HIV, sexually transmitted infections (STI) and co-infections prevention, access to diagnosis, treatment and social care.

Prevention is the most effective intervention to decrease HIV rates among the target groups and their sexual partners. To achieve this, the BORDERNETwork project aims to boost regional networks in the public health sector and to mobilise civil society resources. The project is based on the principle of ‘highly active prevention’: it is inter-disciplinary and addresses both direct causes of disease and underlying social determinants of health (e.g. low social economic status, stigmatisation, recent migration, frequent mobility) for behavioural change.

Out in the field, one example is the Social and Health Community Centre run by HESED in the Roma Community of Fakulteta in Sofia, Bulgaria. This model project involves the socially excluded minority community in the development of their own sexual health programmes.

BORDERNETwork has even crossed the EU border. For this purpose there have been ‘fact finding’ missions to assess the development of HIV, STI and co-infections prevention programmes on the other side of the borders in Ukraine, Moldavia and Serbia. Furthermore, a survey of sex workers in six EU countries was undertaken. The obtained results are expected to clarify the main HIV transmission routes in the region. This finding will enable BORDERNETwork to develop successful innovative collaboration and thus to improve diagnostics, treatment and innovative healthcare systems in the EU borders.

‘EU funding can help projects with a focus on not so easy to tackle subjects, like ours, by recognising that these marginalised groups need help and that it is justifiable to spend money on them’, explains Elfriede Steffan, project leader for BORDERNETwork.

Marginalised populations such as migrants, sex workers and ethnic minorities are amongst the most vulnerable and hard to reach populations in Europe. They are also at high risk of becoming infected by HIV or other sexually transmissible agents.

With the EU enlargement and intensified cross-border migration, mobile populations are on the increase. This is reflected by a higher presence of sex workers at the borders of the EU, which increases the public health risk related to sexual transmissible diseases.

The BORDERNETwork project, based in Germany, focuses on prevention, treatment and care of these vulnerable groups in the border regions of central, eastern and south-eastern Europe.

One of the main aims of the project is to foster cross-border collaboration between local and regional

In 2010, **49%** of new cases of HIV in the EU were diagnosed in migrants born outside their country of residence. Studies show that migrants from countries with wide-scale HIV epidemics are disproportionately affected by HIV/AIDS in at least 16 EU countries.

BORDERNETwork

Full name:

Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE

Start date / End date: 01/01/2010 – 31/12/2012

Project coordination:

SPI Forschung GmbH, Berlin, Germany

13 project partners from 8 countries:

Austria, Bulgaria, Estonia, Germany, Latvia, Poland, Romania and Slovakia

EC Contribution: EUR 1 243 376.69

Website: www.bordnet.eu

4. Chronic diseases

In 2009, chronic diseases, such as cardiovascular disease, cancer, mental health problems and diabetes, caused over 4 million deaths in EU countries with nearly 50% of these caused by cardiovascular disease and diabetes. Many of these health problems, which represent a significant burden on both individuals and societies, have common risk factors and are often preventable through lifestyle changes.

The EU is taking a wide-ranging approach to reducing the burden of chronic diseases by addressing key risk factors such as smoking, obesity and alcohol abuse through campaigns, by taking action to tackle inequalities in access to healthcare, and by encouraging research and innovation.

EUBIROD – Sharing knowledge on diabetes

“*The spread of diabetes is a ticking time bomb.*”
Massi Benedetti, EUBIROD project

A permanent and sustainable online European Diabetes Register for standardised exchange of data and knowledge between Member States on diabetes – this is the main outcome of the EUBIROD project. The register is already used by healthcare professionals and with continued collaboration a number of ideas have been launched to eventually make this system available to all EU citizens.

This innovative project was built on the results of the previous EUCID and BIRO projects. EUCID proposed 35 core indicators on diabetes, while BIRO developed a software system that allows datasets from any computer system anywhere to be safely processed in a standardised way, producing results that are uploaded to the central registry, where the EU report is automatically generated to produce global indicators.

In order to halt the spread of the diabetes epidemic, sharing knowledge about prevention, treatment and patient care is paramount. However, despite the large amounts of data and reports available, current information on diabetes in Europe is scattered, fragmented and, more worryingly, underutilised and undervalued. A national registry is important: it shows rates of complications. It is a good indicator

of performance and it is important to see if a good job is being done to treat the disease. With centralised information and a common dataset, the registry allows for comparison across Europe on how diabetes is treated.

Without EU funding such a system would have been impossible to develop. Based on the success of the diabetes register and by making good use of new technology, it is envisaged that this model could in fact be extended for other chronic diseases.

Over **23 million** adults in the EU have diabetes and a large number are believed to remain undiagnosed. With an increasing prevalence, the impact of diabetes complications threatens health systems across Europe. It is estimated that between 5% and 10% of total health expenditure is spent on providing healthcare for the diabetic population.

EUBIROD

Full name:

EUropean Best Information through Regional Outcomes in Diabetes

Start date / End date: 01/09/2008 – 31/08/2011

Project coordination:

Università degli Studi di Perugia, Italy

22 project partners from 20 countries:

Austria, Belgium, Croatia, Cyprus, Germany, Hungary, Ireland, Italy, Kuwait, Latvia, Luxembourg, Malta, Netherlands, Norway, Poland, Romania, Slovenia, Spain, Sweden and United Kingdom

EC Contribution: EUR 1 114 117.71

Website: www.eubirod.eu



“Every child born in the new millennium has the right to live until the age of at least 65 without suffering from avoidable cardiovascular disease.”
European Heart Health Charter

EuroHeart – An active and healthy heart for life

Cardiovascular diseases are the number one killer in Europe. Around two million people per year die in the EU from cardiovascular diseases, which include coronary heart disease and strokes. Around **45% of mortality in women** is caused by cardiovascular diseases; compared to 38% in men. The current cost to the EU economy amounts to EUR 192 billion per year. Up to 80% of cardiovascular diseases could be prevented through simple lifestyle changes, such as stopping smoking and living a more active life.

The EuroHeart project is about promoting the prevention of cardiovascular-related diseases. The 3-year project (2007-2010) identified areas of policies and public health interventions which can contribute to prevent avoidable deaths and disability across Europe. EuroHeart was very successful in mobilising broad support for cardiovascular health promotion and cardiovascular disease prevention, encouraging stronger cross-sector cooperation.

‘Every child born in the new millennium has the right to live until the age of at least 65 without suffering from avoidable cardiovascular disease’, proclaims the European Heart Health Charter, adopted in 2009, with the support of the first EuroHeart project. The charter outlines policies to promote heart health, sending a strong message to the public to change their lifestyle. It was launched in 30 countries and translated into 24 languages. *‘All action taken at EU and national level to reduce cardiovascular diseases has an indirect impact on health of citizens. The EuroHeart project, in particular, has helped to raise awareness in this area’*, says Sophie O’Kelly, from the European Society of Cardiology, organisation that coordinated the project.

The project included surveys and registries in major cardiovascular fields of interest. These have generated important data on clinical practices: information on over 100 000 patients was collected in 35 countries. Another result is the ‘Heartscore’ calculator (available on the website www.HeartScore.org), where medical professionals can work out individuals risk to cardiovascular diseases. The project also focused on how women are affected by cardiovascular disease, a field often overlooked. The report, ‘Red Alert for Women’s Hearts’ shows that heart diseases and strokes are the leading causes of death of women worldwide. *‘It is important to highlight this issue’*, believes Sophie O’Kelly, *‘but we still need to undertake additional research to fully understand how cardiovascular diseases affect women’*.

There is a strong focus on promotion and dissemination of the outcomes of the project. Over 70 articles have been published and numerous presentations of the data have been given, including during the European Society of Cardiology Congresses. According to Sophie O’Kelly, *‘running a project at EU level generated more interest from the stakeholders, leading to stronger political mobilisation. Best clinical advice has been agreed upon by the best prevention specialists in Europe, thus better clinical practices can be developed across all the EU Member States. With European backing, the project is more powerful and with a better rate of implementation’*.

EuroHeart

Full name:

European Heart Health Strategy

Start date / End date: 01/04/2007 – 31/03/2010

Project coordination:

European Society of Cardiology, Sophia Antipolis, France

32 project partners from 21 countries:

Belgium, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Turkey and United Kingdom.

EC Contribution: EUR 1 023 993.00

Website: www.escardio.org/about/what/advocacy/EuroHeart/Pages/EHI.aspx

5. Cancer

Although significant progress has been made over the last decade in the fight against cancer, it still remains a key public health issue and a major burden on European societies. In 2008, 2.5 million people were diagnosed with cancer in the European Union. This figure will only continue to rise as Europe's population ages. Cancer is also the second most common cause of death in the EU, accounting for 29% of deaths in men and 23% of deaths in women.

The wide variations in access to quality cancer care and survival rates both within and between EU countries pose a major challenge. In 2008, the death rate from lung cancer in men was over three times higher in the worst-performing Member State compared to the best-performing. Through the European Partnership for Action Against Cancer, the European Commission is working to help tackle cancer more effectively by enhancing cooperation between countries, encouraging sharing of best practices and by making better use of existing resources.

AURORA – Cervical cancer screening for all women

Among women aged 15–44, cervical cancer is the second most common type of cancer – only breast cancer has a higher incidence. The problem is even more serious in central-eastern Europe, except in Poland. In the EU countries that joined in 2004 and 2007, the mortality rate is nearly double that of the rest of the EU, except in Cyprus.

The AURORA project started in 2010 to identify workable strategies on how to promote and implement cervical cancer prevention in the 11 countries involved in the project, targeting women 30–69 years old and ensuring coverage of hard-to-reach groups.

Cancer screening varies from country to country. Some have good practices in place – like Italy, for example, but even there it is very difficult to reach migrant women, either because they do not speak the language of the country they are living in and therefore do not understand letters sent by health authorities or were simply afraid when an 'official looking' letter was sent to them. In other countries/regions, there are no screening programmes at all or they do not function well. This is not from lack of expertise or money but from low political interest, where screening is not a priority in the public health programme.

The AURORA project analysed the local context to see where screening programmes are available and whether hard-to-reach groups are actually being screened. It found that even if there was a screening programme in place, take up by migrants or women living in rural areas was in fact very low. Following on from this initial research, the project will now assist in the wide implementation of the prevention for

“ *We hope that through EU funding the issue of cervical cancer will be brought to the attention of policy makers, highlighting the need for better screening, early detection and prevention.* ”

Pillar Montilla, Project Coordinator, AURORA

cervical cancer in partner countries by promoting European exchange of information and expertise on the development and implementation of good practices in prevention and advocacy.

Knowledge acquired through AURORA will be disseminated in the EU. This will be done through conferences, partners' websites, training to healthcare operators and through a pilot centre network and grassroots organisations working in the field of advocacy in this area.

Every year **33 000** cases of cervical cancer are diagnosed in the European Union and **15 000** women die of this disease.

AURORA

Full name:

A European Network on Cervical Cancer Surveillance and Control in the New Member States

Start date / End date: 01/09/2010 – 31/08/2013

Project coordination:

Osservatorio Nazionale sulla salute della Donna, Milan, Italy

15 project partners from 11 countries:

Bulgaria, Czech Republic, Greece, Hungary, Italy, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia

EC Contribution: EUR 615 023.00

Website: www.aurora-project.eu/en



EuroSun – Mapping UV exposure in Europe

“

EuroSun can contribute to health protection, especially in new Member States and candidate countries where the immediate situation is cause for concern.

Mathieu Boniol, Research Director,
International Prevention Research Institute

”

EuroSun findings indicate clearly that the total cumulative UV exposure is mainly acquired at the place of residence. Hence, diseases induced by **chronic exposure** to UV radiation such as skin cancers or ocular pathologies may be prevented by supplying information on the harmful effects of UV exposure at home. For example in late spring and early summer, Nordic countries are as much exposed to UV irradiation than Germany or even France.

The dangers of overexposure to ultraviolet (UV) radiation to human health are very clear. However, the extent of the exposure needs more analysis. This is where the EuroSun project comes in.

One of the main parts of the project has been the creation of an atlas illustrating UV exposure in Europe, based on measurement in random population samples of each EU Member State. This information is now being used to assess the full impact of overexposure. Exposures to the various UV wavelengths have been calculated for every geographical site within Europe. These results can be analysed and published to help convince people to change their behaviour regarding sun exposure, thus resulting in a positive impact on public health.

In addition, the EuroSun project goes much farther in an original and innovative way. Some of the data gathered so far is quite surprising. The dispersion of UV is not as expected and is not always dependent on latitude. For example, in May there is less UV radiation in Northern Germany than in Southern Sweden, which can be explained by cloudiness. However, the public are not necessarily aware of this and naturally assume UV rays are more likely to be harmful in the full sun and in more southern areas where one can feel the warmth. In fact, where temperatures are lower, people do not feel the intensity of UV rays, thus leading to higher incidents of skin cancers in the northern Europe, rather than in the south. This also can be partly explained by cultural behaviour – southerners know that they should avoid the sun.

With increasing mobility of citizens in Europe and economic development comes increasing affluence and a greater number of individuals are now able to take more holidays to sunny climates. People from northern Europe are more likely to go to Spain, Greece or Malta, for example, with little knowledge of the dangers of UV exposure. Between 70% and 75% of Norwegians now take holidays abroad – as a result of this, skin cancer rates in Norway are one of the highest in Europe.

‘With the increasing amount of people’s movements, more data is needed to fully understand the extent of the problem of harmful UV exposure,’ argues Mathieu Boniol, Research Director at International Prevention Research Institute, lead institution for EuroSun.

EuroSun

Full name:

Quantification of Sun Exposure in Europe and its Effects on Health

Start date / End date: 31/05/2007 – 31/05/2011

Project coordination:

International Prevention Research Institute, Lyon, France

4 project partners from 2 countries:

France and Sweden

EC Contribution: EUR 738 594.00

Website: <http://eurosun-project.org/Home>

WELAS – Understanding the causes and effects of smoking in women

In recent decades the incidence of lung cancer has been rising among women in almost all EU countries, with the situation in Denmark, United Kingdom and Hungary being the most worrisome. As smoking is currently very prevalent among younger women, a further increase of the female lung cancer rates can be unfortunately expected.

The results of the WELAS project, which ran from 2007 to 2010, are intended to raise awareness amongst citizens and policymakers of the increasing trend of lung cancer mortality for European women and to contribute to an understanding of who is more likely to start smoking among European women.

The project assessed lung cancer trends using mortality and cancer registry data. A population-based survey of 5 000 European women was conducted in Italy, Sweden, France, Czech Republic and Ireland, in order to understand European women's knowledge and beliefs on lung cancer risk and tobacco.

'We were interested in understanding how the differences in tobacco control across European countries affect smoking prevalence and knowledge about harm from tobacco in European women' said Mia Hashibe, project leader for WELAS. This study was followed up with a survey on lung cancer patients for survival.

Traditionally starting smoking was associated with being older, being divorced, and having friends or family who smoke. Now, the mean age of smoking initiation is 18.2 years. The highest levels of young smokers were found in Sweden, with 29.3% of women taking up smoking at age of 14-15 and 12% starting smoking younger than age 14.

“*Since many European countries have high lung cancer incidence rates among women, it is beneficial to study the region as a whole and then further study differences by country.*”

Mia Hashibe, project leader

In contrast to men, whose lung cancer mortality rates have been decreasing in the last two decades, mortality rates among women in Europe are still increasing in many countries, though rates are starting to stabilise in a few of them. Despite this, it was found that the majority of European women are knowledgeable about the effects of cigarette smoking.

Each year in Europe approximately **102 000** lung cancer cases are diagnosed among women and **290 000** among men. It is the third most common cancer in European women (after breast cancer and colorectal cancer)

WELAS

Full name:

Women in Europe against Lung Cancer and Smoking

Start date / End date: 01/05/2007 - 30/04 /2010

Project coordination:

International Agency for Research on Cancer, Lyon, France

6 project partners from 4 countries:

Czech Republic, France, Italy and Norway

EC Contribution: EUR 654 334.00

Website: <http://welas.iarc.fr/>

CRCS – Better quality screening for colorectal cancer

Colorectal cancer is the most common newly-diagnosed cancer and the second most common cause of cancer deaths in the 27 EU countries with approximately **330 000** new cases and **149 000** deaths estimated for men and women combined in 2008.

Colorectal cancer screening practices are not glamorous but it is essential that the public is aware of the potential of being screened, even if they are healthy. The aim of screening is to lower the burden of cancer in the population by discovering disease in its early latent stages. Early diagnosis enables for more effective treatment.

The colorectal cancer screening (CRCS) project was launched following a recommendation from EU Health Ministers to all Member States to introduce a full cancer screening programme. The project developed guidelines for implementing this programme based on successful developments of previous editions of other EU screening guidelines.

It takes over 10 years to set up a full screening programme. The guidelines stemming from the recommendation by the EU that all countries have a screening programme strengthened the interaction

between the project and Member States, thus stimulating countries into taking action. The project acted as a kind of catalyst.

At the start of the CRCS project no country in Europe had a fully implemented screening programme in place the way the EU had recommended, i.e. population-based. The project began in 2006 and by 2007 12 EU countries had population-based screening programmes, seven had non-population based programmes and eight had no screening programme at all. By 2011, based on the guidelines produced by the CRCS project, 17 countries were running nationwide population-based screening programmes. For example, the United Kingdom and the Netherlands now have official screening programmes.

The guidelines developed by the project involved over 90 experts from 32 countries, including 21 EU countries.

The comprehensive guidelines cover the entire screening process from invitation to be screened to management of screen-detected lesions, and include recommendations for standardised procedures, monitoring and evaluation. The guidelines are available on the web and in printed format.

It is envisaged that the availability of the new European guidelines for quality assurance in colorectal cancer screening and diagnosis will create a standard across Europe.

“

Working with the EU increases the development and dissemination of things that work. Everyone is working together trying to solve the same problem – no one country is big enough to solve all problems.

Lawrence Von Karsa, project leader

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CRCS

Full name:

Development of European Guidelines for Quality Assurance of Colorectal Cancer Screening

Start date / End date: 01/07/2006 – 29/02/2010

Project coordination:

International Agency for Research on Cancer (IARC), Lyon, France

5 project partners from 5 countries:

France, Italy, Hungary, Netherlands and the United Kingdom.

EC Contribution: EUR 1 241 776,00

Website: www.iarc.fr/en/publications/pdfs-online/prev/index2.php

“ *It is important to avoid duplication of work, especially as resources for cancer are limited. It is also crucial to make sure the public are more aware of cancer prevention so they can make better informed decisions regarding lifestyle.* ”

Sandra Radoš Krnel, project leader

EPAAC – Taking care of cancer right across Europe

The European Partnership for Action Against Cancer (EPAAC) was launched in 2011, after the European Commission published its Communication on Action Against Cancer.

The EPAAC has set itself a broad range of goals across different areas of cancer prevention and control: health promotion screening and early diagnosis, identification of best practice in cancer-related healthcare, the collection and analysis of comparable data and information and a coordinated approach to cancer research.

EPAAC is a large and ambitious project and a unique disease-specific ‘joint action’ bringing together different stakeholders involved in cancer prevention and control: national health ministries, EU policymakers, regional agencies, professional organisations, patient groups, health NGOs and interest groups and industry.

It is intended that, as a result of the projects’ extensive work, all EU countries will have access to screening guidelines and, therefore, will be able to offer the best diagnosis, treatment and care possible.

As part of the EPAAC project there have been many conferences and workshops aimed at spreading the news about cancer care and treatment and to disseminate information across Europe.

The Conference on European Standards of Care for Children with Cancer took place in Warsaw in October 2011, organised by the European Society for Paediatric Oncology and the Polish Ministry of Health. Its aim was to disseminate the ‘Standards of Care for Children with Cancer’ document created by a multidisciplinary team of experts across Europe.

Another conference organised by EPAAC and hosted by the Spanish Ministry of Health was where the EPAAC successfully launched its first Open Forum and cast a spotlight on healthcare and research in the cancer field.

The EPAAC Joint Action should contribute to the long-term aim of reducing cancer incidence by 15% by 2020, and it is hoped that all EU countries will have integrated cancer plans by the end of the project.

The European Code Against Cancer sums up **11 steps** people can take to protect themselves against cancer and to find the disease early. They can be found at www.cancercode.eu

EPAAC

Full name:

European Partnership for Action Against Cancer

Start date / End date: 10/02/2011 – 09/02/2014

Project coordination:

Inštitut za varovanje zdravja Republike Slovenije, Ljubljana, Slovenia (National Institute of Public Health NIPH)

36 associated partners from across Europe and over 90 collaborating partners

EC Contribution: EUR 3 154 994.00

Website: www.epaac.eu

6. Rare diseases

In the EU, any disease affecting fewer than five people in 10 000 is considered a rare disease. These diseases are often treated using so-called 'orphan drugs', which the pharmaceutical industry has little incentive to develop and market since they benefit only a small number of patients suffering from very rare conditions.

The European Commission is working to improve the treatment of rare diseases by encouraging research and by helping professionals in different countries to share knowledge and expertise on the best ways to treat them. The development of orphan drugs is also a priority.

Orphanet Europe – Online knowledge on rare diseases



One of the problems with rare diseases is that no country alone can provide expertise on all of them. Knowledge has to be exchanged across Europe. It is important to have all the information in one place for both health professionals and patients.

Ségolène Aymé, former Orphanet project leader



towards improving diagnosis, care and treatment of patients. It includes an inventory of rare diseases, a professional and patient encyclopaedia, a directory of expert services, medical laboratories dedicated to diagnosis, research projects, emergency guidelines, clinical trials, registers and bio banks. This information is gathered from experts across Europe. The disease and gene database contains 8 461 diseases or groups of diseases and their synonyms.

The website has 31 000 users daily. Of this, 51% are health professionals and researchers, 23% are patients and their families, and 26% is made up of journalists, industry managers and other interested parties. A free bimonthly newsletter, with 14 000 registered readers, keeps the rare disease community up-to-date with policy decisions, scientific developments and progress on orphan drugs.

More recent developments include an international coding system, complementary to the ICD one (International Classification of Diseases), known as 'Orpha code', which can be used anywhere for classification of rare diseases, enabling easier integration into existing medical databases. The 'Orpha code' is available as a free download from the website. In addition to the six languages already used (French, English, Spanish, German, Italian and Portuguese), new ones will be added from 2012, including Japanese and Chinese, marking its importance in the rare diseases community all over the world.

The action has pooled scarce resources that are currently fragmented across individual EU countries. It enables patients and professionals to share expertise and information across borders. Specific measures include improving recognition and visibility of rare diseases and encouraging more research into these diseases. The EU support for rare diseases has highlighted the need for better treatment and drugs both locally and nationally. Even though rare diseases are, by name, rare, they are numerous and affect millions of citizens across Europe.

From its modest beginnings in 1997 in France, Orphanet has grown into the number one worldwide online source of information on rare diseases. Via its website, it provides comprehensive information on rare diseases and a range of services for medical professionals and the public. In 2011, an important step forward was taken with the launching of the Orphanet Europe Joint Action, an instrument that combines funding from the European Commission with each of the participating EU countries, as well as from Switzerland, a collaborating partner.

The Orphanet portal is continuously contributing

Orphanet Europe

Full name:

Joint Action Orphanet Europe

Start date / End date: 01/04/2011 – 31/03/2014

Project coordination:

Institut National de la Santé et de la Recherche Médicale (INSERM), Paris, France

36 project partners from 36 countries:

Armenia, Austria, Belgium, Bulgaria, Canada, Czech Republic, Croatia, Cyprus, Denmark, Estonia, France, Germany, Greece, Finland, Hungary, Ireland, Israel, Italy, Lebanon, Lithuania, Latvia, Luxembourg, Morocco, Netherlands, Norway, Poland, Portugal, Romania, Serbia, Sweden, Slovenia, Slovakia, Spain, Switzerland, Turkey and United Kingdom

EC Contribution: EUR 3 295 857.00

Website: www.orpha.net/

It is estimated that between **6 000** and **8 000** distinct rare diseases exist today, affecting between 6% to 8% of the population in total. In other words, **27-36 million people** in the EU are affected or will be affected during their lifetime by a rare disease.

7. Nutrition and healthy lifestyle

In Europe 130 million people are obese. The European Union is actively engaged in the fight against obesity. One of the key ways the European Commission delivers on this is through the High Level Group on Nutrition and Physical Activity and the EU platform For Action on Diet, Physical Activity and Health.

The number of those affected continues to rise at an alarming rate, particularly amongst children. It is estimated that as many as one in two adults can be classed as overweight, and in certain countries, over one in five will be classed as obese. Obesity is reckoned to already be responsible for 2-8% of public health costs and 10-13% of deaths within the European Region. A severely obese person is likely to die 8-10 years earlier than a person of normal weight. An obese person incurs 25 % higher health expenditures than a person of normal weight in any given year.

EPODE European Network – Preventing childhood obesity

One in four European school children are overweight or obese. This figure is expected to rise by well over a million children a year with more than 300 000 of them becoming obese.

Beginning at community level is the key to the fight against childhood obesity and paramount to the success of the EPODE ('Ensemble Prévenons l'Obésité Des Enfants' or 'Together Let's Prevent Childhood Obesity') methodology. It is based on several studies providing evidence that the prevention of obesity in children is possible through local intervention aimed at modifying eating habits and increasing physical activity and by bridging the gap between awareness of the problem and practical implementation of necessary lifestyle. Taking this information on board the first EPODE pilot research met with great success in two cities in Northern France between 1992 and 2004, where obesity levels were successfully reduced by 50% in comparison with control towns.

Obesity tends to be more prevalent in families from lower social economic groups with poor education levels. This is why educating parents about nutrition, healthy eating and the benefits of a more active lifestyle is the first step. Secondly, involving schools, pre-schools, local sports and parents associations, catering structures, health professionals, elected representatives and local public and private stakeholders made this project work. From town planners creating greener, more open spaces to live and exercise to local shops selling healthier food choices.

The concept relied heavily on getting everybody in the community to join in the fight against obesity. Based on the success of the French experience, the EPODE European Network has been implemented in Community-Based Programmes (CBPs) across 98 cities in Spain, 14 in Greece and 16 in Belgium. Recently the Netherlands and Romania joined

“ *It is important to start treating children now before the situation gets out of hand.* ”
Jean-Michel Borys, EEN Director

the network with the implementation of national programmes named JOGG (13 towns) and SETS (215 schools).

The first results are very encouraging with a significant decrease of overweight and obese children from 2004 to 2009 by 9% in France and by 22% in Belgium in the VIASANO programme between 2007 and 2010.

Building on the success of the first EPODE project, the EPODE International Network has already unified 27 programmes in 20 countries around the world. The mission of the network is to help reduce childhood obesity through strategies based on CBPs by actively supporting them.

An obese child faces a lifetime of increased risk of diseases including diabetes, cardiovascular disease and cancer. Obesity causes psychological distress and can also be linked to underachievement in school and low self-esteem. These children are tomorrow's adults. If levels of obesity are not reduced dramatically they will inevitably become a social and economic burden to society mainly through **rising health costs** and loss of working days.

EPODE European Network

Full name:

The EPODE European Network

Start date / End date: 01/06/2008 – 31/05/2011

Project coordination:

Proteines SAS, Paris, France

6 obesity prevention programmes from 6 countries:

VIASANO in Belgium, EPODE in France, JOGG in the Netherlands, THAO in Spain, PAIDEAITROFI in Greece, SETS in Romania

4 associated partners and 4 private partners

EC Contribution: EUR 700 000.00

Website: www.epode-european-network.com/

EEN Book of recommendations: www.epode-european-network.com/en/ressources-center/224-een-recommendations.html

“ *The road show has generated significant media interest. This is always a good barometer of public interest.* ”

Nathalie Renaudin, project leader

FOOD – Promoting healthy diet at work

The cost to society from inadequate food habits and lifestyle and obesity is enormous. Up to **6%** of health costs in the WHO European Region are due to obesity in adults. In addition, there is an indirect cost due to the loss of lives, productivity and related income that is at least two times higher. In Spain alone, for example, the total cost attributable to obesity is estimated to be EUR 2.5 billion per year. People suffering from obesity or from a chronic disease linked to overweight are also more likely to be absent from work due to ill-health.

Promoting healthy and balanced nutrition in the workplace can bring benefits to companies and their workers. Employees that have access to healthy eating increase their productivity by up to 20%, according to the International Labour Organisation.

The FOOD project addresses rising concerns of obesity in adults by promoting healthy eating habits during the working day. The project has two goals: firstly it wants to improve the nutritional habits of employees by raising their awareness of health issues and, secondly, by working with restaurants it aims to improve the nutritional quality of the food on offer.

FOOD has successfully developed useful tools for the public, employees and restaurants by providing practical advice to assist people in healthy food choices, via its website in English and all six languages of the partners of the project. So far over 200 000 restaurants and 170 000 companies with 4 million employees have been reached!

Health food advertising on meal vouchers and shopping lists with healthy recommendations are just two of the many tools available. Others are aimed specifically at restaurants and include a certificate for those which are part of the FOOD network and have made a commitment to apply the recommendations of the programme. There are also menu holders, placemats etc. which all display FOOD information about the healthy eating.

The project was launched to the public in October 2009 with a very successful road show. The campaign ‘kicked off’ with a double decker bus travelling to all countries involved: Paris, Brussels, Stockholm, Prague Milan and ending in Madrid. During the road show seminars were organised on healthy food, nutritional advice, cooking demonstrations, measurement of body mass index, uses of an overweight simulators and quizzes and tests about healthy food.

The balanced eating campaigns were run in parallel in six countries on a common basis but messages were adapted to the lifestyle and cultural habits of each of them. FOOD was so successful that even when the project officially ended in April 2011, 23 partners signed a new consortium agreement, taking on board Slovakia in February 2011 and Portugal in 2012 and launching a set of tools adapted to the specificities of these two additional countries.

FOOD

Full name:

Fighting Obesity through Offer and Demand

Start date / End date: 01/01/2009 - 30/04/2011

Project coordination:

Edenred, Malakoff, France

14 project partners from 6 countries:

Belgium, Czech Republic, France, Italy, Spain, Sweden

EC Contribution: EUR 499 655.00

Website: www.food-programme.eu/en/

A healthy stadium is one which promotes the health of visitors, fans, players, employees and the surrounding community. It is a place where people can go to have a positive, healthy experience playing or watching sport.

Heart of Mersey, 2004

**In 2012
Europe's biggest
football tournament,
Euro 2012, hosted by
Ukraine and Poland, was
played in tobacco-free
stadia!**

Healthy Stadia – Sport and community health

Ask anyone in Europe which team they support and they will immediately know you are talking about football. Millions of people attend a sports stadium each week to either watch the game, to work, to volunteer or to use the stadium's facilities. Sport plays an important role within society, so why not use stadia to promote health initiatives? Of course, the project is not just limited to football stadia.

Beginning in July 2007, the European Healthy Stadia Network followed on from a project initiated in the North-West of England by local charity, Heart of Mersey. Recognising the important role that sports facilities play within communities, the project initially set out to work with six stadia in Merseyside. From there the initiative has spread all over Europe and is now supported by the World Heart Federation through its partnership with UEFA.

The project emphasised the social determinants of health using sports stadia to promote community health and healthy lifestyle. It started with simple questions: Is your stadium a smoke-free place? Does it have healthy food and snacks for sale? Is active travel promoted to and from the stadia? Secondly, the project wanted to use the stadia for outreach interventions such as offering physical activity and healthy eating sessions to youngsters, free cardiovascular checks or other health initiatives such as men's health interventions. And it worked.

The European Healthy Stadia Network disseminated and shared examples of good practice and lessons learnt from different sports stadia across Europe. Over 30 case studies of good examples were developed and are shared on the network's website, under the themes of lifestyle, social and environment. In the United Kingdom, at St. Helens Rugby League

Football Club, over 500 health checks were taken, following which, men were encouraged to become more physically active. In Latvia, swimming lessons were given to orphans in the Olympic Sports Centre, increasing the number of children who know how to swim. In Finland, car pooling was promoted amongst team players to reduce pollution due to the car use.

The project has raised significant interest across Europe with its toolkit of best practices step-by-step guidance available in nine languages. After a kick-off financing from the EU Health Programme, the project is living its own life and more and more clubs and stadia join the network. It is now supported by key national and European governing organisations concerned with sports and public health, including the World Heart Federation. Its members include over 200 large and small stadia, including some as famous as the Etihad Stadium, home of Manchester City FC. In October 2012, it will host the second European Healthy Stadia Conference (the first one, in 2009, was hosted by Liverpool FC).

The amount of physical activity we take impacts on levels of physical health, mental health and wellbeing. Lack of physical activity is one of the critical components that has contributed to the current epidemic of overweight and obesity that is posing a new global challenge to public health. The WHO estimates that physical inactivity can be attributed to nearly **600 000** deaths per year in the WHO European Region.

Healthy Stadia

Full name:

European Healthy Stadia Network

Start date / End date: 01/07/2007 – 31/12/2010

Project coordination:

Heart of Mersey, Liverpool, United Kingdom

8 project partners from 8 countries:

Finland, Greece, Ireland, Italy, Latvia, Poland, Spain and United Kingdom

EC Contribution: EUR 531 629.05

Website: <http://healthystadia.eu/>

8. Health inequalities

Health inequalities have become a central concern of policymakers in the EU. There are large differences in health between countries of the EU.

The level of disease and age that people die are strongly influenced by factors such as employment, income, length of education and ethnicity. The EU is working directly (through EU policy) and indirectly (through national authorities and stakeholders) to reduce such health inequalities.

DETERMINE – Reducing health inequalities across Europe

“ *The number of life years lost due to deaths that can be attributed to health inequities in the EU is approximately 11.4 million.* ”

DETERMINE final report

DETERMINE was very influential in taking forward the health inequalities agenda in the EU. Amongst its outputs were contributions to the development of the EU strategy on health inequalities ‘Solidarity in Health’.

The DETERMINE Consortium identified numerous examples of how good policies in other areas such as housing and education can improve health. It sought the views of policy makers and politicians about incorporating health into their work, and explored economic arguments that could be used to convince them to invest in better policies to improve the general health of the population. It produced a European directory of good practices to reduce health inequalities and extensive documentation of national level policies which can be consulted on its website.

DETERMINE’s final report stated that, ‘*further work must also go into raising awareness about the economic benefits of health equity to society. This can generate the support of the highest levels of government, including the finance ministry, which is a crucial actor to get on board. People further down the socio-economic ladder face twice the risk of serious illness or premature death than those at the top. This unjust and unacceptable situation will most likely be exacerbated by the current economic crisis.*’

Much of the valuable work of DETERMINE is now being taken forward in the EU Joint Action on health inequalities ‘Equity Health’. See website <http://www.health-inequalities.eu/HEALTHY/EN/home>

The chance of a child dying before their first birthday differs by a factor of five between EU Member States, life expectancy at birth varies by eight years (for females) and **14 years** (for males) across the EU regions.

The DETERMINE project aimed to help reduce health inequalities in Europe. It set out to find successful strategies which could narrow health gaps and to encourage its partners, Member States and the EU to implement them. It built directly on the outputs from a previous project (‘Closing the Gap: strategies for action to tackle health inequalities’).

DETERMINE

Full name:

An EU Consortium for Action on Socio-Economic Determinants of Health

Start date / End date: 01/06/2007 – 01/05/2010

Project coordination:


National Institute for Public Health, Czech Republic, and EuroHealthNet

29 project partners from 26 countries:

Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Iceland, Italy, Latvia, Lithuania, Malta, Norway, Netherlands, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, Sweden, Switzerland and United Kingdom

EC Contribution: EUR 907 359.00

Website: www.closing-the-gap.org



“ *Most money spent on health is for short-term projects rather than long-term investments. The reality is that plans are not being made with long-term strategy.* ”

Jonathan Watson, project leader

EUREGIO III – Helping EU regions to use Structural Funds for health effectively

Health is closely linked to economic and social development. However, good health is not enjoyed equally across countries, regions and social groups. The ‘Cohesion and Structural Funds’, are a key financial instruments of the EU for implementing the Europe 2020 strategy and tackling the significant economic, social and health inequalities that still exist between Europe’s regions.

The EUREGIO III project was created to help EU regions to use Structural Funds (EU SF) for effective investments in health. Procuring these funds is complex and often potential beneficiaries find it difficult to access them. EUREGIO III has created a platform for analysing and sharing best actions on how to access funds and has developed guidance for an effective use of EU SF for health.

At the heart of the project are 18 case studies from all across the EU. The areas studied include eHealth, hospital and medical care centre investments, improving health workers’ competencies, and master planning in order to ensure long-term and sustainable strategic investment. This material has been carefully selected to make sure it looks forward to the new challenges affecting the EU – an ageing population, the current financial crisis and the slowdown of the economy.

The project has illustrated that EU SF could become a more important source of funding for health projects.

As the Council of the EU confirmed in 2011, the type of healthcare needed across the EU is shifting from hospital-centred care to new models of community care. EUREGIO III demonstrates how strategically oriented EU SF funding can support this aim.

In doing so, the project acts as a knowledge broker for regional and national authorities, NGOs and other stakeholders in health policy. Master classes and training workshops have been organised in a number of EU countries.

EU funding to **improve healthcare standards**, whether through investments in infrastructure, equipment or training, is currently possible through the Structural Funds: the European Regional Development Fund (ERDF) and the European Social Fund (ESF). The ERDF constitutes the major funding opportunity.

EUREGIO III

Full name:

Health investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period

Start date / End date: 01/01/2009 – 31/12/2011

Project coordination:

Health ClusterNET

5 project partners from 5 countries:

Netherlands, Italy, Hungary, Netherlands and United Kingdom

EC Contribution: EUR 933 847.00

Website: www.euregio3.eu



There is a need to provide healthcare and protection from deportation for seriously ill undocumented migrants in the EU, who cannot access adequate healthcare in their country of origin, because sending them back to a country where they will not receive adequate care leads to the serious deterioration of their health and, in certain circumstances, death.

Nathalie Simonnot, Médecins du Monde/Doctors of the World International Network



AVERROES – Equal access to healthcare

Undocumented migrants and asylum seekers are at a higher risk of health problems and tend to have worse access to healthcare than the general population.

asylum seekers to healthcare and treatment without any discrimination on the basis of legal status or financial means and now covers 16 countries in the EU.

'There is a need to provide healthcare and protection from deportation for seriously ill undocumented migrants in the EU, who cannot access adequate healthcare in their country of origin', says Nathalie Simonnot from Médecins du Monde/Doctors of the World International Network, organisation that runs the AVERROES project.

AVERROES has published three reports on migrant health. By working directly with the migrants, the real state of their health was determined and the barriers to healthcare documented.

The AVERROES project aimed to improve access to healthcare for asylum seekers and undocumented migrants in the EU and to highlight the plight of these vulnerable groups. It supported the development of a network of non-governmental organisations (NGO) called HUMA (Health for Undocumented Migrants and Asylum Seekers) offering direct access to healthcare. HUMA advocates for the rights of migrants and

The project helped raise awareness of the plight of these migrants and has brought the issue to the attention of national and EU institutions, health professionals and the public. It did this through conferences, publications and a dedicated website. The 'Exile, Exit?' photo exhibition of Médecins du Monde toured Europe illustrating the living conditions and difficulties faced by undocumented migrants trying to access healthcare.

The declaration asks for four objectives. Firstly, health professionals should determine, in all circumstances, the type and level of care that patients need, using as sole basis their clinical judgment, without regard to the patients' status; secondly, in cases where individuals are unable to pay, healthcare for undocumented migrants should be paid for by public funds; thirdly, no illegal immigrant would be reported to the authorities whilst seeking treatment; and lastly, health professionals call for the removal of any and all institutional impediments that prevent them from providing healthcare to vulnerable groups, this includes undocumented migrants.

The action of Médecins du Monde/Doctors of the World contributed to the adoption of a European Parliament's resolution in March 2011 calling on Member States to tackle health inequalities for undocumented migrants in accessing healthcare.

Inspired by the AVERROES network, over 140 European organisations representing over **3 million health professionals** signed in 2010 and 2011 a declaration against discriminatory access to healthcare.

AVERROES

Full name:

Improving access to health care for asylum seekers and undocumented migrants in the EU

Start date / End date: 01/04/2008 – 31/03/2011

Project coordination:

Médecins du Monde, Brussels, Belgium, Paris, France and Madrid, Spain

24 project partners from 19 countries:

Austria, Belgium, Czech Republic, Cyprus, Finland, France, Germany, Greece, Hungary, Italy, Netherlands, Malta, Poland, Portugal, Romania, Slovenia, Spain, Sweden and United Kingdom

EC Contribution: EUR 692 262.16

Website: www.mdm-international.org/spip.php?article103

9. Youth

Currently, the health of young people in the EU is better than it has ever been. Nevertheless, there are still many causes of concern like rising mental stress, alcohol abuse, smoking, poor levels of nutrition and physical activity, accidents, and sexually transmitted diseases. The EU is actively working to address key determinants which affect young people's health in areas such as tobacco, alcohol and obesity.

Smoking in Movies – Protecting young people from addiction

Smoking remains the single greatest preventable cause of mortality in Europe. Adolescents usually start smoking for social reasons and films are an extremely important part of young people's social environment. Watching a film in which people smoke may encourage young people to light up a cigarette and become addicts for life – warns the World Health Organization, calling upon countries to enact enforceable policies that would severely restrict such depictions.

The project Smoking in Movies provided additional evidence on the association between smoking in movies and smoking uptake of young people, based on a study conducted in Germany, Iceland, Italy, Poland, the Netherlands and the United Kingdom. The group of European researchers recommends strengthened EU cooperation by enforcing existing legislation on tobacco advertising, promotion and sponsorship, and by including clear rules and guidelines on rating movies based on smoking scenes. Currently, there is no consistent approach within the EU, although most films are distributed in all countries and in all languages.

Within the project, more than 16 000 young people aged 12-15 years were asked which of the commercially most successful films of the past five years they had seen. In addition, all included films were analysed for tobacco scenes. One result was that 71% of the box-office hits of the years 2004-2009 contained at least one smoking scene.

“By being able to do this study at EU level, we found that the association between watching people smoke in movie scenes and young people trying cigarettes is present in all European countries. The study confirmed the need to act on a larger scale, as it is a global effect.”

Reiner Hanewinkel, project coordinator

The more films with smoking scenes a young person had seen, the higher the likelihood that they would start to smoke.

The project also revealed that smoking in movies is currently not taken into account in the movie ratings systems of the participating countries.

'The project concluded that changing the film rating system to take into account smoking images in films would be an effective method of reducing child and adolescent exposure to smoking in films without interfering with film content. This could reduce future social and economic costs for all EU countries', concludes Reiner Hanewinkel, coordinator of the Smoking in Movies project.

Although the vast majority of smoking-related deaths occur among middle-aged and elderly people, smoking behaviours are very often acquired during adolescence.



Smoking in Movies

Full name:

Smoking in movies: Impact on European Youth and Policy Options

Start date / End date: 01/01/2009 - 31/12/2011

Project coordination:

Institut für Therapie- und Gesundheitsforschung gemeinnützige Gesellschaft mbH, Kiel, Germany

5 project partners from 5 countries:

Iceland, Italy, Netherlands, Poland and United Kingdom

EC Contribution: EUR 521 207.00

Website: www.smokefreemovies-europe.eu

10. Health information

Improving access to healthcare to all citizens regardless of income, social status, location and nationality is a vital part of the EU's efforts in tackling the substantial inequalities in health both within, and between, member countries. One way the EU is working to bridge these inequalities is by increasing access to information and medical expertise through its European Reference Networks.

These networks, which cover a wide range of health issues, including air pollution, life expectancy and maternal health, provide a framework for national authorities and health professionals to develop shared solutions and guidelines across national borders. By exchanging expertise and best practices, quality of healthcare and patient safety can be improved throughout the EU.

Aphekom – Air pollution continues to kill thousands, costing billions

“ *Significant health benefits result when effective EU policies on air pollution are implemented and complied with over time.* ”

Sylvia Medina, project coordinator

While air pollution has diminished significantly in Europe, in recent years it has stabilised at levels that still cause serious health problems. The Aphekom project gathered and analysed data to determine the health and monetary benefits that can be achieved by further lowering those levels in cities across Europe.

By providing information for policy making, its ultimate goals were both to reduce avoidable deaths and serious illnesses due to respiratory and cardiovascular diseases caused by exposure to urban air pollution in Europe; and to improve citizens' quality of life.

Combining the efforts of 60 scientists in 25 cities across Europe, Aphekom showed that reducing levels of fine particles, in compliance with World Health Organization guidelines, could add up to 22 months to the lives of persons 30 years of age (depending on the city they live in and its average level of particles). Because these guidelines are exceeded,

19 000 people die each year in the cities studied from pollution-related illnesses, including 15 000 deaths from cardiovascular diseases.

The project's report points out the enormous cost of not reducing air pollution. Meeting the WHO guidelines in the 25 cities studied would save up to EUR 31.5 billion annually in reduced health spending, absenteeism at work and intangible costs such as well-being, life expectancy and quality of life.

Aphekom's analysis of the effects of EU legislation to reduce the sulphur content of fuels showed not only a marked, sustained reduction in ambient SO₂ levels in 20 cities but also the resulting prevention of some 2 200 premature deaths valued at EUR 192 million.

Based on research in 10 EU cities, Aphekom also estimated that living near busy roads could be responsible for 15-30% of asthma cases in children, and possibly similar or even higher percentages of coronary heart diseases and chronic obstructive pulmonary diseases in adults.

'Taken together, these important findings underscore the health and monetary benefits from drafting and implementing effective EU policies on air pollution and ensuring compliance with them over time. And they point to the benefits that could result from regulating pollution near busy roads,' said Sylvia Medina, the project's coordinator.

Comparisons across Europe, funded by the project, aid in developing local and EU policies aimed at reducing both air pollution and its health impact. And Aphekom's work is particularly relevant now when EU and national agendas are preparing to implement existing regulations on air pollution and will be revising current EU legislation in 2013.

Finally, Aphekom has developed a process to help decision makers draft policies on environmental-health issues in general. Based on an online deliberation-support tool (<http://aphekom.kertechno.net>), the process frames and structures exchanges between stakeholders involved in devising policy options.

If WHO guidelines are not followed and air pollution in EU cities is not reduced, the resulting public-health costs could total **EUR 31.5 billion** annually.

Aphekom

Full name:

Improving Knowledge and Communication for Decision Making on Air Pollution and Health in Europe

Start date / End date: 01/06/2008 – 31/03/2011

Project coordination:

Institut de Veille Sanitaire (InVS), Saint-Maurice, France

17 project partners from 12 countries:

Austria, Belgium, France, Greece, Hungary, Ireland, Italy, Romania, Slovenia, Spain, Sweden and United Kingdom

EC Contribution: EUR 800 000.00

Website: www.aphekom.org

“The EHR is a tool that will expand the frontiers of health throughout Europe.”

Laurence Esterle, project leader

EHR-IMPLEMENT – A potential new innovation in eHealth across Europe

An electronic health record (EHR) is a complete record of a patient's health, which would help share information on diagnosis, treatment, tests, etc. by all health professionals and the patient.

The idea of the EHR-IMPLEMENT project, which ran for three years from 2007, was not to try to implement EHR but to do pilot studies to see how it would work and identify best practices. The development of eHealth is without doubt a great step forward.

A detailed study was conducted in six different countries: Denmark, England, France, Belgium, Ireland and Slovenia. For example, the Danish, English and French governments launched major initiatives to implement EHR, but all failed. This showed that the process needed to be more gradual and that it is probably better to focus on developing tools which will facilitate a future EHR for all.

The project has outlined the advantages of EHR from both the patients' and medical professionals' perspectives. However, despite the many advantages of having a complete health record, there are still many technical challenges to overcome, plus social

and cultural differences between countries, often underestimated by policy and decision makers.

Ultimately, the idea is for healthcare professionals to have access to medical records in all European countries and for citizens to be able to use them anywhere in Europe. The EHR is a groundbreaking tool that will benefit citizens throughout Europe. Finally, it is hoped that the lessons learned from the project have been, or will be, useful to policymakers and healthcare managers in all European countries.

The EHR has **several advantages** over paper health records. One is the larger storage capability. Also, the record can be continuously updated and available concurrently for use everywhere. Information can be immediately accessible at any unit workstation whenever it is needed.

EHR-IMPLEMENT

Full name:

National policies for EHR implementation in the European area: social and organizational issues

Start date / End date: 01/05/2007 – 30/04/2010

Project coordination:

Institut National de la Santé et de la Recherche Medicale (INSERM), Paris, France

7 project partners from 6 countries:

Belgium, Denmark, France, Greece, Ireland and Slovenia

EC Contribution: EUR 372 560.00

Website: www.epractice.eu/en/cases/ehrimplement

EHLEIS – Adding a dimension of quality to the quantity of life lived



We need comparable data from all countries to be able to assess standards across Europe. Information without comparison has no value, which is why doing this project at EU level is very important.

Jean-Marie Robine, project leader



For years, the only indicator available for comparison was rates of mortality. Although accurate, just looking at mortality is too crude and simple to give a real picture of the health of Europe. Instead, the EHLEIS project uses healthy life years indicators measuring how many years people live are in good health. A population with a higher life expectancy may not necessarily be healthier, as chronic diseases, frailty and disability tend to become more prevalent at older ages. Thus HLY add a dimension of quality to the quantity of life lived.

A great deal of work was needed to analyse, check the quality and, in the end, harmonise data collected from all EU countries – this was the biggest challenge for the EHLEIS project.

EHLEIS uses a wide range of means to disseminate quality information on health expectancies, including a dedicated website, ad-hoc technical reports, country reports, a training seminar, and the acts of its European conference. This work is provided by a group of experts surrounded by a network of public health professionals in the current 27 EU countries.

The European Health and Life Expectancy Information System (EHLEIS) project provides annual comparable data for all EU countries. Working in association with Eurostat, the EU statistical office, it aims to increase knowledge, understanding and use of the structural indicator 'healthy life years' (HLY).

This project built on the European Health Expectancy Monitoring Unit (EHEMU, 2004-2007) project, which established an information system that facilitated the calculation of life and health expectancies in all EU countries.

The new EU structural indicator, **healthy life years**, has been developed to add a quality component, specifically to monitor whether healthy life expectancy is increasing faster or slower than life expectancy.

EHLEIS

Full name:

European Health and Life Expectancy Information System

Start date / End date: 01/07/2007– 30/06/2010

Project coordination:

Institut National de la Santé et de la Recherche Médicale (INSERM), France

7 project partners from 6 countries:

Belgium, Czech Republic, France, Germany, Netherlands and United Kingdom

EC Contribution: EUR 544 656.89

Website: www.ehemu.eu





“The examination of this vast collection of information enables the identification of sectors where policies are well developed, and those where there is still room for further development.”

Luciano Vitozzi, project leader

EUGLOREH – The report on the status of health in the European Union

More than 170 European experts have provided their knowledge and analysis of the many health subjects dealt with in ‘The Report on the Status of Health in the European Union’, which was the main outcome of the EUGLOREH project.

With the enlargement of the EU in 2004 and 2007, there was a need for an overview on health information and the integration of new Member States. EUGLOREH was set up to provide this information. The project collaborated with health authorities and institutions from all EU countries plus Croatia, Turkey, Iceland and Norway, major intergovernmental, international and European organisations and agencies.

The report included the following health subjects: reduced fertility, increased life expectancy, implications of ageing on the labour markets and the national health systems, increasing migrations toward EU countries and persistence health inequalities among disadvantaged groups.

According to the study, the significant increase in life expectancy clearly indicates that health status has improved in the EU in the last decades, in spite of the smaller increases recorded in the eastern European Member States.

Main reasons for this improvement are the more effective control of infectious diseases and a reduced mortality attributed to cardiovascular and respiratory diseases since the 1970s and of most cancer types (but not lung cancer) in the 1990s. Increased life expectancy, together with the increased use of birth control, has resulted in the ageing of populations of all EU countries.

Taking into account that the elderly are more susceptible than the young to a variety of diseases and health problems, it is not surprising that the increase in life expectancy does not result in an increase in the life years spent in good health. This is the case for women, who, despite their higher longevity – by about six years with respect to men – live in good health only two years more than men.

The results of EUGLOREH provided the initial content for **Heidi wiki (Health in Europe: Information and Data Interface)**, an internet based wiki tool for European health information and data. It aims to offer a broad spectrum of articles and data, relating to health status, diseases, determinants, health systems and policies (<http://ec.europa.eu/health/heidi>).

The EUGLOREH report showed that, as for **male-female gender differences**, mortality rates are similar up to the age of 15, while, between 15 and 65 years of age, men have a mortality rate much higher than women for all the main causes of death, being around four times higher for transport accidents. If gender-specific cancers are excluded, men develop cancer earlier and show lower survival. Similar considerations hold for cardiovascular diseases.

EUGLOREH

Full name:

Global Report on the Status of Health in the European Union

Start date / End date: 15/11/2005 – final report presented on 20 March 2009

Project coordination:

Health Ministry Italy

26 project partners from 26 countries:

Belgium, Cyprus, Czech Republic, Germany, Denmark, Spain, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Lithuania, Latvia, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Sweden, Slovenia, Slovakia, Turkey and United Kingdom

EC Contribution: EUR 700 609.00

Website: www.eugloreh.it

“ One of the key tasks of PHGEN is to prepare European policymaking and healthcare systems for the shift towards personalised medicine and healthcare. The future is being built today!

Angela Brand, project leader

”

PHGEN II – Preparing the way for personalised medicine

‘The right diagnosis and therapy at the right time for the right patient’ is a catchphrase many experts use to sum up the potential that new approaches such as genomics have introduced into medical science. The goal: tailor-made individualised diagnostics and therapy that take into account the genetic differences among humans. In other words, **personalised medicine**.

A genome is both the comprehensive blueprint of the individual organism and the entirety of an organism’s hereditary information. In other words, it is an inbuilt information system in the human body and plays a key role in the understanding of any disease, including hereditary ones.

To develop a common understanding of public health genomics in the EU, the first EU Health Programme funded a project called PHGEN I, which ended in 2008. This project was a networking exercise and identified the need for European coherent guidelines in that field. PHGEN II has built on the work of PHGEN I by developing these guidelines and producing the first edition of the

European Best Practice Guidelines for Quality Assurance, Provision and Use of Genome-based Information and Technologies.

Modern research in ‘omics’ technologies offers new opportunities for the promotion of the population’s health, like personalised medicine. Public health genomics is the integration of genome-based knowledge and technologies into public policy and into health services for the benefit of citizens’ health. Thus, genome-based information is very holistic and includes not only all ‘omics’ data, but also environmental, socioeconomic and lifestyle factors, as well as information on health systems.

The guidelines developed by the project are in line with international standards and include a public consultation process via internet, a pilot document and an Endorsement Panel. The guidelines acknowledge the diversity and cultural differences in Europe. Key experts from different areas are involved in PHGEN II, such as public health experts, EU lawyers, human geneticists, ethicists, systems biologists, health technology assessment experts and patient groups.

In the long run, PHGEN II aims to serve as an ‘early detection body’ for scanning, fact finding, and monitoring of the integration of genome-based knowledge and technologies into public health.

PHGEN II

Full name:

Public Health Genomics European Network

Start date / End date: 01/06/2009 - 31/11/2012

Project coordination:

Institute for Public Health Genomics, Maastricht University, Netherlands

24 project partners from 21 countries:

Netherlands, Germany, Denmark, France, Slovenia, Belgium, Italy, Poland, Hungary, Spain, Austria, Bulgaria, Norway, Portugal, United Kingdom, Sweden, Malta, Israel, Turkey, United States and Canada

EC Contribution: EUR 1 301 939.00

Website: www.phgen.eu

“A real learning opportunity was created by running the project at EU level and by being able to compare data across Europe.”

Jennifer Zeitlin, scientific coordinator

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EURO-PERISTAT Action – Learning more about the health of mothers and babies

A healthy pregnancy and safe childbirth is a goal of all European healthcare systems. But, despite recent advances in perinatal care, some mothers and babies are still at risk during pregnancy, birth and post-natal care. EURO-PERISTAT Action aims to improve the health of mothers and babies in the EU by promoting good policies and exchange of best practices.

This will be done by building a European perinatal health surveillance system, providing detailed information about the current state of health and care, which in turn can be used by policymakers, clinicians and citizens for better decisions on healthcare policies.

The European Perinatal Health Report, released by the EURO-PERISTAT team, is the most comprehensive report on perinatal care to date. The study gathered information using data from European birth registers to probe the wide variations in maternal and child health outcomes and care between EU countries.

The report paints a full picture by presenting data on mortality, low-birth weight and preterm birth alongside data about healthcare and other factors that can affect the outcome of pregnancy. It also illustrates differences in the ways that data are collected and explains how these can affect comparisons between countries. *‘The diversity of EU health systems makes these comparisons very*

interesting especially taking into account cultural and social differences across Europe. It also gives benchmarks for where countries should aim’, says Jennifer Zeitlin, scientific coordinator of the project.

Understanding the reasons why outcomes vary between countries can provide the insights needed for prevention and improvement of perinatal health, including foetal and neonatal mortality, low-birth weight and preterm births, maternal mortality and cerebral palsy, which is associated with adverse perinatal events.

Caesarean sections rates vary enormously between countries. In Italy, **38%** of babies are born by Caesarean section, while in the Netherlands and Slovenia only **15%**. Through using the results of EURO-PERISTAT Action, countries may start to think differently about how they handle perinatal care.

EURO-PERISTAT Action

Full name:

A comprehensive health information and knowledge system for evaluating and monitoring perinatal health in Europe

Start date / End date: 01/04/2011 – 31/03/2014

Project coordination:

Institut National de la Santé et de la Recherche Médicale (INSERM), Paris, France

5 project partners from 5 countries:

Belgium, Finland, Netherlands, Poland and United Kingdom. All EU countries, except Bulgaria and Romania, are included in the network, which also includes Norway and Switzerland.

EC Contribution: EUR 607 343.00

Website: www.europeristat.com

EuroNeoStat II – Better care for premature babies

“ *If we can see how other neonatal intensive care units are performing, we can assess if there is room for improvement in our own.* ”

Adolf Valls-i-Soler, project coordinator

Prematurity (born under 37 weeks of gestation) rate has

increased across Europe in the last 10 years (except for Sweden). Premature babies are more likely to suffer from chronic diseases, such as chronic lung disease, neurological developmental diseases, such as cerebral palsy, and learning and cognitive problems.

With the general progress of medicine and research, most doctors thought that premature birth could be prevented. Nevertheless, surprisingly, premature birth rates are increasing in the EU. Statistics show that 7% of all babies born are now premature, i.e. before 37 weeks of gestation. Two per cent of these babies are born either before 32 weeks or with a weight below 1.5kg. It is these 2% of infants that the EuroNeoStat II project is particularly concerned with. It aims to generate and create an information system across the EU of the best way to care for them so that these infants have the best possible chance of survival.

Thanks to the project doctors can now compare results on premature babies through monitoring and gathering information on care all over Europe.

By defining standard indicators, such as degree of prematurity or birth weight, and looking at other factors, such as whether the mother was given drugs to help support the baby's lungs or whether the baby was born vaginally or by caesarean, the EuroNeoStat II hopes to harmonise and standardise treatment and care of all premature babies. This way each will be able to receive optimal treatment.

The first EuroNeoStat project developed the European Information System for monitoring short and long-term morbidity in order to improve quality of care of premature babies of very short gestation and low birth weight. EuroNeoStat II takes the platform one step further and offers quality improvement tools and quality assessment to European neonatologist to again improve the care and reduce adverse outcomes of very low birth weight babies.

EuroNeoStat has grown slowly but steadily. The project started with 26 neonatal units from and has now grown to over 200 neonatal units from 27 European countries. The project is an up-to-date technological neonatal platform based on the Internet (www.euroneonet.org).

With this system in place, citizens can be assured that care will improve and babies who survive will go on to have a better quality of life. Some early results have shown a trend towards a decrease in mortality among low birth weight babies in some EU countries. By harmonising care across Europe it means that all babies, wherever they are born, have the same chance of survival.

EuroNeoStat II

Full name:

Expanded European information system to monitor short and long-term outcomes and improve quality of care and safety for very-low-birth-weight infants

Start date / End date: 01/11/2009 – 31/10/2012

Project coordination:

Fundación Vasca de Innovación e Investigación Sanitarias (BIOEF), Sondika, Spain

12 project partners from 9 countries:

Finland, France, Germany, Italy, Norway, Spain, Sweden, The Netherlands and United Kingdom

EC Contribution: EUR 649 969.98

Website: www.euroneostat.org/



More information:

European Commission – Public Health website

http://ec.europa.eu/health/index_en.htm

Health-EU Portal

http://ec.europa.eu/health-eu/index_en.htm

Health-EU Newsletter

http://ec.europa.eu/health-eu/newsletter_en.htm

Executive Agency for Health and Consumers – Project database

<http://ec.europa.eu/eahc/projects/database.html>

Library publications public health

http://ec.europa.eu/health/publications/index_en.htm

European anti-tobacco campaign – Ex-smokers are unstoppable

<http://www.exsmokers.eu/>

EU Health Prize for Journalists

http://ec.europa.eu/health-eu/europe_for_patients/prize/index_en.htm

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Commission



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