Final Report Summary - EURO-URHIS 2 (European Urban Health Indicators Part Two: Using indicators to inform policy)

Executive Summary:

Urban Health is important due to urbanisation and it requires specific information not captured by national datasets. The EURO-URHIS (European Urban Health Indicator System) project, funded by DG SANCO, identified urban health indicators and their availability. EURO-URHIS 2 (European Urban Health Indicator System Part 2) has taken this further by developing methodology and validated tools useful to policy makers at all levels to make health gains via evidence based policy decisions for urban populations.

The objectives of the project were to
- collect data at urban area level,
- provide tools for evidence based policy,
- develop methods for cross-sectional and longitudinal assessment for urban population health including all relevant determinants of health,
- validate these tools and methods by using existing population-based registries and databases,
- apply the tools in the field and ensure they are easy and intuitive to use by policy makers.

The EURO-URHIS 2 project consists of 18 partners in 14 different countries across Europe and Vietnam and the project identifies health problems in urban areas. The project describes health and health determinants specific to urban areas in Europe, covering cities in North, East, South, and West Europe. This project adds to information that is already locally available, in that it is the first study to enable reliable comparisons of health status between different cities in Europe. Policy makers can use the information to prioritise topics for urban health policy and for interventions in an evidence-based way.

The data was collected using surveys of existing sources; priorities of policy makers in terms of policies and interventions for their urban area, and a lifestyle/environment surveys. A tools were formulated, piloted, translated and disseminated. The data was validated and analysed to develop specific tools for policy makers to use. The meta-data collected has formed the context to investigate trends in policy, major health problems, and it has allowed for investigation of the link between the two. Differences in health indicators can be compared for benchmarking and to make changes. In total, data from 26 urban areas in Europe were available for between-city comparisons and benchmarking.

The EURO-URHIS 2 project collaborated with policy-makers, researchers, non-governmental agencies and civil society through a number of activities including consultation during the development stage, through training workshops and through the European Urban Health Conference in Amsterdam, September 2012.

More detailed information on the justification of methods and instruments that were used, as well as response rates, selection of cities and indicators, and statistical methodology, can be found on our websites: www.urhis.eu and http://results.urhis.eu. The websites also provide data from other participating urban areas and comparisons between specific cities can be made.
The EURO-URHIS 2 project has been disseminated widely via an exclusive supplement of the European Journal of Public Health, four PhDs, a number of other peer-reviewed publications and presentations, links with other organisations including WHO, UN Habitat, the European Public Health Association including conferences such as the Festival of Public Health UK, ICUH, ISUH, EUPHA. Methodology is freely available including the EURO-URHIS 2 “cookbook”. The web platforms provide both access to the data and metadata for the lay population, researchers and policy makers. The future of the EURO-URHIS programme has led to scientific partnerships with existing and new Universities including ERASMUS University of Rotterdam and Georgia State University.

Project Context and Objectives:
Taken from Annex 1 of European Urban Health Indicators System Part 2: Urban Health Monitoring and Analysis System to Inform Policy (Collaborative Project No. 223711). Trends of population health (HEALTH-2007-3.2-7) in urban areas (UAs) are an important topic for research due to the continued urbanisation occurring both across Europe and globally. Urban health can be defined as “health that is specific to urban areas,” which includes healthcare systems and all measures to improve health, including setting up services. The health requirements of urban areas require research because neither national nor regional based methodology will capture the necessary information that policy makers need to make evidence based decisions on resources for health care.

The study included:

United Kingdom
Netherlands
Romania
Norway
Lithuania
Slovenia
Germany
Slovakia
Turkey
Latvia
Macedonia
France
Vietnam
Kuwait
China

The approach required to address this topic was to develop methodologies appropriate for cross-sectional/longitudinal assessment of population health together with validated tools. The objectives were to collect data at UA level, provide tools for evidence-based policy at all levels for urban areas, to develop methods for cross-sectional and longitudinal assessment for urban population health including all relevant determinants of health, to validate these tools and methods by using existing population-based registries and databases, and to apply the tools in the field to ensure they were easy and intuitive to use by policy makers.

Urbanisation is occurring globally but the largest growth in Europe is observed in Central and Eastern Europe. Urban health is a growing field of research internationally. There are a number of issues that affect UAs primarily e.g. internationalisation of metropolitan regions, ageing populations, migration and poor environmental factors. UAs have specific problems associated with health that are different to non-urban areas that national or regional investigations would not identify. The World Health Organisation (WHO) Healthy Cities programme “promotes comprehensive and systematic policy and planning with a special
emphasise on health inequalities and urban poverty, the needs of vulnerable groups, participatory governance and the social, economic and environmental determinants of health”. Many urban areas have health policy determined at local level. Policy makers require data at urban area level to inform these local policies. Resource allocation is usually at local level in many countries. However, national and international policy makers also require data at UA level to not only inform evidence based policy making, but also to evaluate the impact of policies.

Phase one of the European Urban Health Indicator System (EURO-URHIS) had been completed prior to EURO-URHIS 2. Early results demonstrated the potential importance of continuing the work on urban health indicators. EURO-URHIS compiled a comprehensive literature review, which has identified that:

• Most studies about urban health are from North America and there are some studies from West Europe. It is hard to find literature on health from East and South European countries
• There is scope for more attention towards urban issues on the European level
• Important aspects in public health in all countries are diet, exercise, alcohol use and smoking, but these issues are not particular to urban areas
• Urban health requires special efforts for research activities
• Studies emphasise environmental issues, mental health and marginalised populations as important aspects of urban health
• EURO-URHIS concluded that there was no consistent definition of an urban area that was suitable across Europe. A pragmatic “practical approach” is the most appropriate due to the diverse nature of cities/conurbations across Europe. The approach had been highly successful in all 60 urban areas (30 countries) that returned the questionnaire.

EURO-URHIS has used the European Community Health Indicators (ECHI) shortlist and a USA model described by Galea et al, with additions and omissions of indicators that are particularly important in describing urban health (UHI). ECHI describe health indicators as “a concise definition of a concept meant to provide maximal information on an area of interest”. These additions include population density, migration, homelessness, social isolation, sexual minority groups, safe sexuality, single parent families, access to green spaces and local amenities, atmospheric conditions, crime, noise exposure, water quality and sanitation. The EURO-URHIS 45 UHIs were separated into demographic/socio-economic, health status, health determinants and health system indicators, which are listed below.

Population by gender and age
Mother’s age distribution
Regular cigarette smokers
Population by nationality
Causes of death
Alcohol consumption
Birth rate
Prevalence of chronic illness
Use of cannabis
Population projections
HIV/AIDS incidence
Breastfeeding
Populations per square km
Lung cancer incidence
Fruit and vegetable consumption
Migration to the urban area-by nationals, EU nationals and non-EU nationals
Breast cancer incidence
Height and weight
In EURO-URHIS, only information on availability of urban health indicators was collected. EURO-URHIS 2 builds on this knowledge to actually collect, analyse and report on the prevalence of health problems in urban areas. This is to provide global, European, national and local urban health policy makers with a range of (aggregated) health measures and impact measures to help with decision-making. The timing is imperative to work on the foundations made by EURO-URHIS, ECHI, Regional Health Indicator System (ISARE) and Urban Audit. The Urban Audit project has proven that it is possible to collect data at urban area level on a wide variety of indicators to allow comparisons. The comparisons of UAs across Europe will facilitate “exchange of experience and improve the quality of local urban policies” for local policy makers. Other EU projects have investigated UAs for economic indicators, e.g. European Economic Research Consortium (ERECO). One of the EURO-URHIS 2 partners undertakes research in the field of Health Impact Assessments, and has developed methodology and an evaluated tool specific to urban health, furthering their work on European Policy Health Impact Assessment.

The objectives of the second phase of the EURO-URHIS project were to:

• Collect data at UA level
• Provide tools for evidence based policy at all levels (local, national, European, international) for urban areas
• Develop methods for cross-sectional and longitudinal assessment for urban population health including all relevant determinants of health
• Validate these tools and methods by using existing population-based registries and databases
• Apply the tools in the field and ensure they are easy and intuitive to use by policy makers
The research questions investigated were:

- Is it possible to collect health data at UA level?
- How feasible is it to use data at urban area level to produce tools for policy makers at local, national and international level?
- What relevance will these tools have to policy makers? Are they useful? Are they applicable?

EURO-URHIS 2 informed public policy for the purposes of achieving health gains and to improve delivery of healthcare to European citizens living in urban areas by performing research into trends in population health through health profiles, inequalities and policies. More specifically:

1. The development of methodology appropriate to the needs of data collection
2. The collection data based on EURO-URHIS indicator list and cross-sectional surveys focusing on cross-thematic approaches e.g. the environment, food and bioinformatics, with particular attention to the over-arching issues of children, the ageing population and women
3. Presentation of data
4. The description of the health profile of European and non-European urban populations using the data collected
5. The development of tools (for example health impact and policy impact tools etc.), and the demonstration of the application of these on data collected
6. Training and education of doctoral and post-doctoral research students and the wider community
7. The organisation of a European Urban Health Conference
8. The development and provision of a European training package on urban health tools and indicators
9. The consultation with stakeholders and other users throughout the project
10. The dissemination of outcomes by engagement with civil society (especially patient groups) engendering debate and fostering an approach whereby users have initiated and expressed desire to participate in further research activities
11. The self-sustainability of the project by linking with other projects

In addition to the original objectives, EURO-URHIS 2 investigated more deeply with mixed methods, policy making in urban areas. This was due to the financial crises and austerity measures together with many countries/urban areas undergoing unprecedented change and reorganisation. This was approved as a no cost extension by our Project Officer and was within the original budget. In depth analyses of urban policies, non-governmental organisations, interventions and priorities were also undertaken to understand decision-making and contextualise the results.

Project Results:
Please provide a description of the main S & T results/foregrounds. The length of this part cannot exceed 25 pages.

Summary

Work Package 4 and 5

The results referred to in this section come from Work Package 4, which developed the strategy for collecting the data required, and Work Package 5, which disseminated the instruments, collected and validated the data collected. All outputs were disseminated via the activities of Work Package 2, 8, 9 and 10.

Work package 2

Dissemination activities include, email lists resulting in a database of local, regional, national and European contacts, newsletters, a press release, support for other work packages, and links with networks within and outside the EU.

Work package 6
WP6 has converted, cleaned, and recoded data collected from existing sources, youth and adult surveys in 41 UAs collected in WP4 and 5. Data has been weighted to create datasets that are representative of the UA. Eligibility criteria were developed to ensure high quality data. Information on survey methodology and response rates was used to decide if UAs met the eligibility criteria. A subset of relevant indicators was selected for the health profiles. Statistical methods to calculate average health scores on indicators in UAs, and to compare indicators between UAs were evaluated. A storyboard was developed, for the graphical lay-out and contents of the health profiles. Most recently, the health profiles were drafted.

Work package 7

A review of methodologies used to calculate future predictions of health trends has been completed and a model developed. Sample predictions have been conducted. A review of Healthy Life Years (HLYs) methodology and calculation of provisional estimates have been completed. A review of Disability Adjusted Life Years (DALYs) methodology in relation to smoking and alcohol consumption, analyses using existing national level data and additional data collection have been undertaken. Forty-five indicators have been mapped against the Health Impact Assessment (HIA) conceptual framework and the structure of a community health profile. The development and piloting of the draft urban HIA screening tool has taken place and the synthesis of methodology has begun. A review of the utility of Population Impact Measures (PIMs) has been completed and the impact of the engagement of policy makers on WP7 had been evaluated. Additional work to investigate the impact of the financial crisis, policy makers adaptation to the crises, in-depth qualitative work on decision making in urban areas and non-governmental organisations has also taken place. James Higgerson and Stephanie Steels have completed and been awarded their PhDs based on EURO-URHIS 2 WP7 work.

Work package 8

An updated website platform was required as the original platform was not suitable. The new website was launched in June 2011 and there have been in excess of 2000 visitors since the launch. Feedback is very positive and planning of the results section of the new website is underway. Twitter and LinkedIn are being used to promote the project. Through Twitter, the project has been contacted by the Guardian newspaper to take part in an online discussion on NHS health reforms, invited to submit journal articles, and asked for further information.

Work package 9

The EURO-URHIS2 final conference will be held in Amsterdam, Sept 12-14, 2012. The programme has been finalised and a call for abstracts made. Collaboration with the International Society of Urban Health (ISUH) and the European Public Health Association (EUPHA) has resulted in the project featuring at the International Conference on Urban Health (Brazil, Nov 2011) and the EUPHA conference (Denmark, Nov 2011). The World Health Organisation (WHO) will be fully engaged in all aspects of the project.

Work package 10

In addition to the stated workshops, one additional workshop was added in light of feedback. Workshop A (Sept 2009) introduced data collection tools and ideal survey methods. Workshop B (Jan 2010) finalized the data collection tools and identified UA specific survey methodologies. Workshop C (July 2010) ensured that each partner reviewed an operational manual describing the data collection procedure. The first dissemination workshop (D) was delivered to policy makers on 19th Sept 2011. Workshop E (Jan 2012) and the workshop F (at the EURO-URHIS2 final conference) has consolidated the training for using the EURO-URHIS 2 tools.

Specific Work for WP6-10
Preparation of dataset –

WP6 cleaned and recoded the collected data and created three different datasets containing adult survey data, youth survey data, and routinely available registration data. These datasets were used to make the urban area health profiles, to perform the scientific studies, and were distributed to the URHIS partners for local analysis. Respondents were excluded for a variety of reasons, such as missing data, incomplete questionnaire, outside required age or geographical range.

Urban area health profiles –

Data from the adult and youth surveys and routinely available data on both urban area and country level were used to create the health profiles. Since not all urban areas were able to collect all data, the exact content of the health profiles may differ between the urban areas.

Validation of country level existing data –

After considerable research and discussion within the Project, the following recommendations were made for data collection:

Population size (x1000):
- Accept figures from Eurostat for population size (x1000) for 2008

Population density - Population density per km²:
- Accept all figures provided for population density for 2007 following Amsterdam/Utrecht acceptance of the “land mass excluding inland water” definition for their population density.

Population age 0-19 & Population aged 65+:
- Accept all figures provided for Population age 0-19 & Population aged 65+
- Note Turkey findings on atypical demographics for age ranges 0-19 & 65+ in Key Findings and add textual comment in body of report in a line with the population pyramid.

Live births:
- Accept figures derived from Eurostat for aggregated live births and from UNECE for women aged 15-44 years at 2008 mid-year population.
- Note high increase in live births for Latvia, Slovenia and the UK which is compatible with the trend between 1999-2009.
- Note decreasing live birth rate in Turkey which is compatible with 10 year time period trend in some other countries but it is still at the highest rate of the EURO-URHIS 2 countries.

Teenage pregnancies & Pregnancies after age 35:
- Accept figures derived from Eurostat for teenage and aged mothers’ pregnancies for 2008 provided for age bands 15-19 and 35-44 respectively.
- Note increase in the numbers of teenage pregnancies in Romania and, to a lesser extent Latvia, between 2005 and 2008.
- Note that the trend is rising for ageing mothers’ pregnancies for all countries.
- Note that the more affluent countries (France, Germany, The Netherlands and The UK) show the highest levels of ageing mothers’ pregnancies.
- The exception to the relationship to affluence and a high level of ageing mothers’ pregnancies is Turkey and we recommend comparing this with the urban-level data.

MMR and DTP vaccinations:
Accept figures for MMR and DTP vaccination coverage derived from HFA-DB and WHO-UNICEF for 2008.

Note low levels of coverage for MMR in France and the UK as above.

Life expectancy at birth: male and female:
Accept figures derived from Eurostat for life expectancy at birth

Infant mortality:
Accept figures derived from Eurostat for 2008

Low birth weight:

Male and Female HIV/AIDS Incidence per 100,000:
Note high incidence HIV for France, Latvia, UK and Norway as above in main text of relevant health profiles.
Do something similar for Netherlands reporting on predominant transmission route MSM and demographic as appropriate.

Tuberculosis incidence per 100,000:
Accept all figures provided for tuberculosis incidence per 100,000.
Note elevated incidence rates for Latvia, Lithuania and Romania in Health Profile text.

Lung cancer incidence per 100,000:
Accept figures provided for lung cancer incidence per 100,000 derived from Globocan for 2008.

Malignant neoplasms
Accept figures provided for male and female malignant neoplasms derived from Eurostat.

Diseases of the circulatory system:
Accept figures provided for male and female diseases of the circulatory system derived from Eurostat.

Diseases of the respiratory system:
Accept amended figures provided for male and female diseases of the respiratory system derived from Eurostat.

Transport accidents:
Accept figures provided for male and female transport accidents derived from Eurostat.

Suicide and intentional harm:
Accept figures provided for male and female suicide and intentional harm derived from Eurostat.

To ensure that the health indicators collected by EURO-URHIS 2 can be used in practice, policy makers and public health experts were actively involved in the process of developing health profiles. Their comments and advice were taken into consideration and were used to adapt and improve the urban area health profiles.

The final health profiles can be downloaded from the website: [www.urhis.eu](http://www.urhis.eu).

The final urban area health profiles were released during the final conference on 12-14th September 2012 in Amsterdam. The health profiles are included as an attachment. All 26 health profiles can also be accessed through the website: [www.urhis.eu](http://www.urhis.eu) Health Profiles. Each profile has been assigned a unique DOI.
Intra urban health differences within Greater Manchester and Merseyside:-

Differences within EURO-URHIS 2 urban areas were studied using the different boroughs of Greater Manchester and Merseyside. These UK larger urban areas offer excellent data for these intra-urban analyses given the large numbers of respondents.

Three indicators were chosen through a review of key reports on health determinants, the similarity of questions asked in EURO-URHIS 2 Adult Survey and the Integrated Health Survey England (HIS) and local Health and Wellbeing surveys which could provide a contrast. The indicators were: recommended activity, current smokers and obese adults. We also looked at locally-generated Health and Wellbeing Surveys for around the same time period and were able to provide a comparison between their data, URHIS and IHS for 2 of the UAs for these three indicators.

Intra urban health differences within Slovakia and the Netherlands:-

Next to the intra-urban investigation in the UK urban areas, Behanova et al. have studied the association of area-level and individual-level socioeconomic factors with poor self-rated health among urban citizens in Slovakia and in the Netherlands, using EURO-URHIS 2 data. They concluded that individual level socioeconomic status is associated with poor self-rated health more strongly than with area deprivation.

Intra urban health differences within all EURO-URHIS 2 urban areas:-

Beyond the matter of studying intra-urban differences within the UK and Dutch/Slovak urban areas, we also investigated whether it is possible to study intra-urban differences in urban areas all over Europe.

Following analysis of the data, it was concluded that there is insufficient common neighbourhood classification in the URHIS urban areas to allow intra-urban analysis,

The work on intra-urban health differences within EURO-URHIS 2 are covered by:
1) A report on significant intra-urban area differences in Greater Manchester and Merseyside, University of Manchester [www.urhis.eu].
2) A scientific paper on the association of area-level and individual-level socioeconomic factors with poor self-rated health among urban citizens in Slovakia and in the Netherlands has been submitted by Martina Behanova.

In future international monitoring projects, it will be necessary to increase the sample size when planning to perform intra-urban analysis. However, simply increasing the sample size can still result in an uneven distribution of respondents over the various neighbourhoods. This can easily lead to bias, since response rates are correlated to neighbourhood characteristics like demography and socio-economic status. In order to get enough respondents per neighbourhood, it is recommended that such samples should be stratified by neighbourhood. Preferably, information/estimates about the expected response rate should be used to inform decisions on the sample sizes per neighbourhood. A drawback of such increase in sample size is of course the inevitably increased costs of doing this.

WP6 performed a series of scientific studies which can all be found on the website www.urhis.eu. The following papers have been published in peer reviewed journals:

• Association of demographical and environmental characteristics with health and lifestyle in European urban areas between 2005 and 2010
• Health status in Europe: comparison of 24 urban areas to the corresponding 10 countries (EURO-URHIS 2)
• Differences in adults’ health and health behaviour between 16 European UAs and the associations with socio-economic
status and physical and social environment
• Are area-level and individual level socioeconomic factors associated with self-rated health in adult urban citizens? Evidence from Slovak and Dutch cities
• Effect of urban-area deprivation on mental health of citizens differs between Slovak and Dutch cities
• Elderly from lower socioeconomic groups are more vulnerable to mental health problems but area deprivation does not add: a comparison between Slovak and Dutch cities

In order to develop a methodology for data analysis, share good practice, identify priorities of health policy makers, present and discuss data, and promote the use of EURO-URHIS 2 data and health profiles, WP6 delivered several products:

- Cleaned and recoded datasets, separately for routinely available data, youth data, and adult data
- Data for the interactive WP8 website: http://results.urhis.eu
- WP6 cookbook
- Background document on the development of health profiles
- 26 Health profiles
- Scientific studies:
  o Ecological determinants of health
  o Comparison of health in cities versus countries
  o Intra-urban health differences
  o Explaining health differences between urban areas
  o Differences in risk groups
  o Differences in local health policies

All products are available on the website: www.urhis.eu.

To ensure that the health indicators collected by EURO-URHIS 2 will be used in practice, policy makers and public health experts were actively involved in the process of developing health profiles and writing scientific papers. The following EURO-URHIS 2 meetings were used to present and discuss the work:

- Workshop E: Initial findings from EURO-URHIS 2 (31st January - 1st February 2012, Manchester)
A draft version of the health profiles was presented to EURO-URHIS 2 partners, health professionals, and policy makers. The aim of this meeting was to identify policy makers' needs and priorities specific to their urban area.

- Project Management Group meeting (21-22nd May 2012, Amsterdam)
First drafts of the scientific studies were discussed.


The scientific papers about ecological determinants of health, comparison of health in cities versus countries, and explaining health differences between urban areas were discussed with Peter Achterberg, a public health expert.

- Workshop F: From Indicators to Implementation (13th September 2012, Amsterdam)

The final urban area health profiles were presented to international policy makers.
The final WP6 results from EURO-URHIS 2 were presented to a wider audience on various occasions:

- European Urban Health Conference: From Research to Policy (12-14th September 2012, Amsterdam)

During the final conference of EURO-URHIS 2, WP6 presented their work on the urban area health profiles during workshop F. In the plenary session, we presented our work on the scientific papers about ecological determinants of health, comparison of health in cities versus countries, and explaining health differences between urban areas. During the parallel session, WP6 gave an overview of results from EURO-URHIS 2 data regarding urban environment, healthy ageing, and urban mental health and wellbeing.

- 5th Annual European Public Health Conference 2012, European Public Health Association (EUPHA, 7-10th November 2012, Malta)

WP6 provided three oral presentations:
- Association of demographical and environmental characteristics with health and lifestyle in European urban areas between 2005 and 2010, Laurens van Buren
- The association between family affluence and health and healthy lifestyles in adolescents aged 14-16 years in 20 European urban areas in 2010, Rianne de Gelder
- European health status (2005-2009) in 24 urban areas compared to national level data, Emmy Koster

Alongside the dissemination activities of WP6, the local partners were also asked to distribute the health profiles. The health profile template has been provided and local partners were encouraged to translate the health profiles to make them more accessible to their local policy makers. The partners were asked for their dissemination plan, which varied from posting on national public health websites and presenting at (inter)national conferences and courses, to sending them to policy makers and the city council and reporting back to the surveyed schools.

Disability Adjusted Life Years

Alcohol consumption is known to be associated - either wholly or in part - with more than 60 disease and injury conditions. Alcohol was the third leading risk factor impacting health globally in 2010, exceeded only by high blood pressure and tobacco smoking. Alcohol-attributable Disability-Adjusted Life Years (AA-DALY) have been calculated at intervals using Comparative Risk Assessment (CRA) since 2000.

DALYs are a time-based metric, most notably used to describe the Global Burden of Disease (GBD) across the world. They combine estimates of cause-specific mortality with estimates of incidence and prevalence of morbidity for a comprehensive range of disease and injury conditions. One DALY equates to one year of healthy life lost, either through premature mortality or living with a disease (where each year lived with an illness is a fraction of a DALY, based on the perceived impairment). DALYs measure the difference between the current health status of a population against a hypothetical desired alternative (the counterfactual scenario). DALYs can be calculated for a complete set of disease and injury conditions, or for subsets of conditions. DALYs attributable to selected risk factors can also be calculated, using the CRA process referred to above.

CRA is the process by which proportions of DALYs are attributed to specific risk factors, reflecting what is known from the global literature about the relationship between disease and risk factor exposure. CRA for alcohol, therefore, measures the amount of premature death and disability in a population that would not have occurred without the observed exposure to alcohol. For each sex-age-disease category, a population attributable fraction (PAF) is generated; that is, the proportion of the disease in each sex-age category due to alcohol exposure. By quantifying the burden of disease attributable to alcohol for different regions, a clear message can be sent to public health professions on the extent of the problem, which is essentially avoidable through modification of exposure to alcohol.
Global estimates of DALYs and risk factor attributable DALYs are currently presented by WHO at the sub-regional level. For Europe, this means three sets of estimates, for the Europe-A, Europe-B and Europe-C sub-regions. Within each sub-region are a heterogeneous set of countries with different health-care systems and social circumstances. For estimates to be relevant to policy-makers concerned with national or sub-national decision-making (such as the UA level), estimates are required that are specific to the populations under their jurisdiction. Analyses at the sub-regional level and national levels can mask differences between and within countries respectively. Therefore, calculations for urban populations using UA specific data can be useful when providing evidence for urban level public health governance.

Two indicators mediate the relationship between alcohol and health outcomes – average total consumption and patterns of drinking. EURO-URHIS 2, as one of its aims, sought to provide tools for evidence-based policy. To make the present estimates more relevant to policy-makers in participating UAs, a scale of alcohol policy strength was required to see whether low alcohol policy strength was associated with a higher rate of alcohol-attributable years of life lost (AA-YLL) and AA-DALY.

The present study was designed to assess whether AA-YLL and AA-DALY could be calculated at the urban level in Europe using a standardised methodology. Europe is the region of the world with the highest level of per capita alcohol consumption, and the highest levels of alcohol-attributable harm. Using the sample of UAs participating in EURO-URHIS 2, it aimed to establish whether the requisite inputs were available to calculate AA-YLL and AA-DALY at the sub-national (ie, urban) level. It also aimed to calculate AA-YLL and AA-DALY for as many EURO-URHIS 2 UAs as possible, using a standardised methodology to facilitate comparison between settings.

EURO-URHIS 2 existing data collection provided three indicators used in the calculation of AA-YLL/DALYs. These were population by age and sex, total fertility rate and causes of death.

On the whole, this phase of data collection has shown that the demographic data used to underpin the calculation of AA-YLL/DALY can be collected at the urban level. For RF exposure, however, this was less achievable, and highlights the need for good quality survey data at the urban level.

Healthy Life Years

Briefly, life expectancy (LE) at each age was calculated using population by age and sex estimates alongside estimates of all-causes mortality for each urban area population. Healthy life expectancy (HLE) was calculated by using, for adults, survey responses to the question:

How is your health in general?
Very good/good/fair/bad/very bad/don’t know

In the youth survey, the same question was asked with slightly different wording:

In general, would you say your health is…?
Excellent/very good/good/fair/poor

Weighting of survey responses allowed for estimations of proportions of males and females in each age band who were either in good perceived health or poor perceived health.

Estimates of HLE were completed for males and females aged 15 and 60 years. Urban areas were excluded when the requisite data for the calculation of HLEs were not available. Following exclusions, estimates were generated for 25 urban areas.
This study has found that longer LE does not always translate into a higher proportion of life expectancy, with no clear relationship emerging from the data. Whilst females live longer and – in general – have more years of healthy life ahead of them at a given age, the results are mixed when considering life in good perceived health as a proportion of remaining life expectancy. Within the sample of urban areas, there was evidence for expansion of morbidity, compression of morbidity and dynamic equilibrium theories.

HLE measured in years was found to vary more than LE in all age-sex categories, indicating a larger disparity between urban areas with regards to quality of life.

These results can be used by policymakers to provide a broad overview of the health situation in their urban area compared to others participating in EURO-URHIS 2. Attention should be drawn not just to the differences in remaining life expectancy, but to the differences in prevalence of good and poor health states between urban areas. It is this indicator that highlights the potential burden of health-care costs.

Future work would replicate the methodology described here with more urban areas from more countries, either within Europe or globally. Surveys would be completed by a larger proportion of each urban area population to assist in making the disability prevalence estimates more robust. Such work should consider using the other questions from the European Minimum Health Module to generate estimates of DFLE and healthy-life years.

**URHIA**

Following a literature search and synthesis of the URHIA methodology, an urban health impact screening tool (URHIST) was drafted and tested with subsequent modification in light of feedback from policy makers and other stakeholders. A literature search for development of the urban health impact methodology (URHIA) was undertaken, and the Guide for Urban Health Impact Assessment (URHIA) was produced and published on the EURO-URHIS 2 website.

**Population Impact Measures**

**What are Population Impact Measures?**

Population Impact Measures (PIMs) provide a means to quantify the impact of an intervention on a particular population, and can be used by policy makers to estimate the risks and benefits of an intervention and assess the economic implications. (4;5) PIMs have been used in a variety of ways, for example, to assess the impact of the same intervention in different settings: an urban area, a mega city and at national level and to help policy makers prioritise interventions and resource allocation.

In EURO-URHIS 2, PIMs have been used to meet objective 2 of WP7 'exploring and using methods to assess the impact of policies and interventions on population health.'

**Using PIMs to compare interventions at urban level**

In EURO-URHIS 2, PIMs were used to compare interventions at the urban level, allowing policy makers to make decisions in the context of other populations, or to compare interventions in similar urban areas.

**Identifying appropriate systematic reviews**

During a Workshop and Scientific Advisory Group meeting in Manchester in early 2012, policy-makers, academics and other interested parties were asked to list their priority areas. From their feedback, the top ten priorities were identified. These
priority areas were chosen to calculate PIMs using the University of Manchester Population Health Decision Support & Simulation tool (PHSIM).

Using PRISMA guidelines, appropriate Systematic Reviews were found for four of the priority areas and four PIMs were successfully calculated, including three ‘Numbers of Events Prevented in your Population’ (NEPP), calculated for between 15 and 36 urban areas, and one ‘Population Impact over t years Eliminating a Risk factor’ (PIN-ER-t) calculated for 31 urban areas.

Conclusion

PIMs were easy to calculate, and have also been found to be easy for policy makers to interpret. However, it is often difficult to get urban level data in order to populate PIMs calculations.

Future Trends

As health care, infrastructure and other socially beneficial activities have rapidly improved over the last century; people are living longer, which leads to an increasing strain on the population’s resources. 10 million people in the UK are over 65 years old, and it is estimated that this figure will nearly double within the next 40 years. Increasing longevity has led to a rapid increase in life expectancy; however healthy life expectancy has not increased at the same rate, meaning that the demands on public services such as the NHS is, and will continue to, increase.

It is the role of policy makers and decision makers to ensure that provisions are made for the future when developing their health based policy. Policy makers “do not always have the skills, tools and capacity to find and use available evidence”. This creates a knowledge gap between where the evidence is, and where the evidence needs to be. This has increased the necessity for knowledge transfer, where the evidence gained can be transferred into a tangible format for policy makers, removing the barriers to their understanding and acceptance. By developing future predictions, the future burden of specific diseases, infections and illnesses can be anticipated. Policy makers can take this information into account when allocating resources for diagnosis, treatment, interventions and rehabilitation.

The health requirements of urban areas, however, require evidence based decisions to be made from urban area level information, rather than national or regional based information.

Part of the data collection phase of the project (WP5) was collecting existing data from external sources that were available. As much data was collected between the urban areas, for similar dates and standardised criteria as was available. The existing data included accurate measurements on past trends as well as population projections for the urban areas involved in the study.

The data collection finished in January 2011, and was converted, cleaned and recoded in June 2011. This data was now available to be used in future trend calculations.

Significant Results

From the data that was collected, the calculations were narrowed down to seven indicators.

The underlying data required for future trends calculations were the population projections for the urban areas included in the study. For the future trends calculations, the years 2015 and 2025 were to be used.

Because of restrictions on the data that were available, future trend accuracy was classified into three categories:
1. If the population base year was the same as the incidence year then each indicator was calculated and accepted.

2. If the population base year was different to the incidence year then the indicator was calculated but not classed as wholly reliable.

3. If the year of the data was not known then the indicator was calculated but not classed as wholly reliable.

For the seven indicators, future trends were calculated for between 25 and 37 urban areas, depending on the data availability. Of these, between 14 and 23 were classified as category 1, i.e. the highest accuracy.

From the Future Trends work, for most indicators there were no significant differences observed between the time periods, or by gender.

The significant differences observed between Urban Areas were of importance, and this included Manchester, Amsterdam and Salford having significantly higher incidence rates of HIV/AIDS than other urban areas.

The added value of the EURO-URHIS 2 project for the development of future (trend) predictions is that:

- data can be collected at urban area level to populate future trend models
- results can be demonstrated graphically to help with policy making
- future trends are a function of population predictions and estimates of incidence/prevalence
- 95% CI can help to demonstrate the variation of these estimates
- Comparison between subgroups and urban areas can be calculated using 95%CI

WP 6 & 7 Policymakers Interviews: methodology

An online policymakers’ survey was devised to contribute to WP6 (Using EURO-URHIS indicators to monitor urban health) specifically to examine between urban area health policy differences and interventions. Further to this we conducted policymakers’ interviews which would contribute to WP6 and would also enhance WP7 (Development and application of aggregate health policy measures) in determining health policy regarding the use of aggregate health measures at the urban level. Pilot work had been completed by interviews with policymakers from 9 urban areas across Europe in 2008 as part of the EURO-URHIS project.

Ethical and local UK Research and Development (R&D) approval

We designed the research instruments for the policymakers’ interviews and a follow up survey based on our findings from the 2008 pilot study. Our University Research Office advised that this discrete study was “marginal for requiring ethics permission”. We therefore applied and were granted University of Manchester Ethical approval. In order to recruit within the UK, we also submitted R&D applications for all the relevant urban areas within Cardiff, Glasgow, Merseyside, Birmingham and Greater Manchester. We achieved approval from all of the overarching R&D offices for 13 out of 16 UK UA areas that we targeted.

Recruitment

For non-UK policymakers, we contacted EURO-URHIS 2 partners and asked them to identify and recommend potential participants who were responsible for public health policymaking in their urban area. We then contacted the potential participants directly by email and/or telephone.

A pragmatic sampling method for recruiting non-UK interviewees was employed and we achieved representation for the North/South/West/East regions in Europe. We requested an interview with the senior policymaker identified by our project partner but invited them to include colleagues in the interview if they wished. We indicated that (if necessary) they could include a colleague for English translation purposes but also offered the assistance of our project partner for this.
According to measures outlined in the UK Government’s Health and Social Care Act 2012, from April 2013, all Public Health staff and functions were transferred from NHS Primary Care Trust to Local Authority (local government) administration. This major change was imminent/effective around the time of our recruitment. However, despite the consequent expectation of an extension to the timeframe for this part of the study, we anticipated this as an opportunity to gather some rich data at an historic time for public health in England.

Interviews and Post-interview Survey

In-depth interviews were carried out by two members of the research team who travelled to the participants’ workplace. Interviews were recorded and transcribed verbatim. An interview schedule was employed and we also sent out a post-interview survey that allowed for a reflective response to many of the issues covered in the interview as well as a more structured response to the questions about important health problems, policies and interventions. This survey has been returned by 11 of the 20 participants so far.

Analyses

Thematic analysis was conducted on the interview transcriptions with a view to describing the responses to the questions asked throughout the interview. We utilised the post-interview survey responses in order to validate the textual responses from the interview transcripts and gather quantitative data on priorities.

Differences between local health policies

EURO-URHIS 2 has conducted a total of 21 interviews throughout Europe so far (10 UK and 11 non-UK) and have 2 UK policymaker pending interviews. All of the UK policymakers in the UAs authorised (by their overarching R&D offices) to approach for interview have consented to be interviewed.

We are able to complete analysis and report on the results of 13 of all of the UAs represented (3 UK and 10 non-UK interview subjects) in 8 countries for the ongoing study. Ten of these returned the post-interview survey allowing for a degree of validation in the analysis. Our completed analysis of these subjects finds us confident that we have achieved saturation of thematic responses for our interview questions within this study overall.

The PMs that we recruited and interviewed had a wide range of influence. We had aimed to recruit the most senior public health representation for the UA jurisdictions where there was such a person with a local specific or overarching responsibility for Public Health (PH). We achieved this in all but one instance. This exception was in the case of our interview with senior representatives of a regional PH Bureau when we could not access their geographically adjacent UA equivalent (PM 4). They were very familiar with their UA equivalent institution and were able to comment on any differences that would apply for the UA in their responses. For the other 12 UAs we interviewed, variously, Directors and Deputy Directors of City Council/Municipal/Regional Departments or Institutions with specific responsibility for PH or for an overarching responsibility in Health and/or Welfare/Social Care. Three Deputy Mayors in UAs were included in these participants.

In terms of the topography of the UAs, most were predominantly urban with varying degrees of green belt and suburban areas within their jurisdiction. The demographic characteristics were similarly diverse but the most predominant themes that emerged in discussions about the UAs populations’ centred around age-range and/or ethnic and socio-economic differences. These issues had primacy for policymaking decision making from both epidemiological and administrative perspectives.

For all of our UAs, healthcare was the overall responsibility of national government with responsibility for the delivery of some aspects devolved to a greater or lesser extent to local or regional levels. The strongest theme that emerged from most of our interviewees was on the geographical level at which they could make decisions about PH but this was inquired upon and
responded to within the context of all healthcare provision with an emphasis on the UA level of activity.

Of the 13 UA representatives, all but one indicated that they were able to influence health policy making in their UA to some degree. They all had to conform to their country’s national directives in essence but most were able to make decisions to add policies or interpret these directives according to their UA profile. The discussions around their ability to do this often involved exploration around the differences between the concepts of “guidance” and “directives” as well as detailed discussion about the process of decision making at the UA level.

Reporting no autonomy for UA PH policymaking

The one country that reported not being able to influence health policy making at the UA adhered uncompromisingly to the national directives:

“So the city absolutely does not have any way of changing the policies of the government. They have to obey perfectly the parliament. They do not have an agenda on health it is [all] at the...state level. The [city level] agenda is social services and social care” - PM 20

However, at the time of interview, the local PM was engaged in the early stages of raising the local focus on and impact for health strategies via a specific city-led initiative:

“there is...the city strategy...and for this...there are four pillars and one of [these] is health...We have to establish a department that will monitor the health in the city, of the citizens and the impact of policies...This is...[a] new co-operation between the university and the Faculty of Medicine...They have to put it into... the planning of the city...It starts in 2013. The first thing that they want to do is establish this Department of Health that will have some competencies for [local] policies” - PM 20

Reporting very little autonomy for UA PH policymaking

For one other country’s UAs there was little autonomy reported but there was, nevertheless, some mechanism whereby approval for some level of adjustment of the national directives at the UA level:

“...for all public health...they are directly subordinated to the Minister of Health. They have to implement their public health policy as the Minister of Health asks. At the same time, from an administrative point of view they are...co-ordinated by...local government [but if local government] asks something to be done, to be performed by the Public Health Authority, that demand must be approved by the Ministry of Health” - PM 11

This policymaker clearly expressed finding this situation prohibitively laborious. When we inquired about more freedom to make decisions about the UA, the response was:

“We would very much like to be decentralised [and] would be extremely pleased [to] establish some priorities in... implementing public health policies without approval every time for everything. [In that case] even the existing, not too much money would be much more useful.” - PM 11

Otherwise, our UA representatives in other countries reported having established mechanisms for making independent PH decisions at the UA level that they exercised to some degree. One of our PMs who reported this is here describing a similar two step process of gaining approval to diverge from national directives and guidelines via local government approval:

“...on national level all the decisions...are mainly made by the Ministry of Health...[regarding] decisions made in the local level
under supervision of the municipality...the suggestions might be initiated by different institutions such as the Bureau of Public Health or any other organisation that is performing a provision within the municipality but someone in administration of municipality have to consider them and...Local Government have to approve it ...” - PM 4

Nevertheless, they reported that they didn’t feel the need to diverge from the national guidelines to any great extent and rarely did so in practice. However, when we asked the question about whether they would like to have more freedom to make decisions for their area of jurisdiction they said:

“...that example that we have about [the proximity of] schools [to places that have] alcohol licences this is...where we could intervene if we had more freedom...maybe freedom is not the right word. More power” - PM 4

This response was very similar to the same question asked of PM 1 who had a long-established and high level of autonomous PH decision making at the UA level, in that both PM 1 and PM 4 cited the issue of needing local powers for alcohol harm reduction measures.

Reporting significant autonomy for UA PH policymaking

Another UA’s PM expressed their institution’s function with regard to healthcare as primarily compliant with national guidelines but indicated a significant degree of autonomy in formulating and implementing interventions specifically for their UA. They went on to describe examples of a considerable range of PH activities specific to their UA performed with the aid of publicly tendered contracts with NGOs:

“...a lot of prevention is on the local level and...is carried out in clinics and other health institutions and a part of it is carried out by NGOs which are co-financed by the municipality...there are workshops that deal with prevention in terms of how we eat, how we stay active and to deal with alcoholism, diabetes......there are many NGOs and many of them deal with...individual diseases.”- PM 24

This PM’s institution had responsibility for both health and social care for their UA and they also indicated strong working relations within other municipal departments with regard to promoting a PH agenda:

Reporting highly significant autonomy for UA PH policymaking

One UA PM explicitly reported experiencing ongoing and increasing transition to greater UA autonomy for both primary and public health care:

“The municipality is co-financing these parts...especially in public health [and] in primary healthcare it’s depending more and more on the municipality level so it’s more and more depending on [the] municipality level so it’s more and more in terms of each municipality what the budget pay” - PM 16

This UA represented a population that was nearly half the size of the host country in total. They cited WHO and EC initiatives that provide funding and credence to their work in progress as being a highly significant driver for positive change:

“As you know the work is very big to [raise] this awareness, this understanding of this health promotion and this is the work we are trying to do with our strategy, we are trying to do with our Healthy Cities status and so it’s easy for governments and easy for municipalities on local level to bring out these Health in All policies in national level...There are two more municipalities in [country] but who already have this status of Healthy Cities... but they do not have strategy of public health promotion and prevention as we have now and this status is a part of strategy so it’s bigger [and] deeper [in this UA]” - PM 16
As they indicated here, a couple of other UAs in their country were also promoting the health agenda for their city via such initiatives as Health in All and their commitment to gaining and maintaining Healthy Cities status (11)(12). We interviewed the nominated PM in another UA in PM 16’s country and, despite their far smaller population size and density (nearly 1/10 population of PM 16), they also had a local dedicated health department that indicated a strong PH awareness in its focus.

Reporting highly significant and long-established autonomy for UA PH policymaking

All our Western European policymakers reported a high degree of long established responsibility for PH at the UA level compared to those from the other European regions. They had to adhere to national health policy but they reported a highly significant level of ability to make local interpretations of directives and guidance to suit the specific demographics within their UA:

“the public health area [is] mostly...organised at the local level by regulations at national level…[our local plan is] based first of all on the plan of the national health level and then we [look at] the situation in [UA] and see what kind of problems we have here adding to the directives already given by the national level...And try to identify risk groups, target groups [etc]...and then we sort of formulate an idea where we want to end up. We have to [also discuss] this with the [head] of the city council...even when it’s coming from the national but it’s also a problem in [UA]...we fine-tune in the sense that [for example] we give more insight into specific race groups” - PM 1

At the time of interviews the UK Western European PMs were in or had recently experience a period of transition from NHS Primary Care Trust (PCT) to Local Authority (LA - local government) administration (13). Nevertheless mostly their geographical jurisdiction under the new administration continued to be coterminous with their original PCT area. Where this was not the case they had experienced at least a year of PCTs being merged to become LA coterminous.

“even when there’s...national drivers, which, if you chose to pick those up and run with them…you could do it. So it felt responsive in that sense, but also that the national policy… you could see that that was reflected in [UA] as well [but] there’s so much room for innovation still within that framework and the potential to not do things as well. We can all see the... inconsistencies in the way [different UAs] do tackle their similar health problems so even within the national framework...there’s other things which you can choose to give more emphasis to.” - PM 33

Aside from this there were pre-existing long-standing formal forums and organisational structures operational to facilitate collaborative working in PH between PCTs and LAs. Generally speaking our UK PMs expressed optimism (ranging from cautious to enthusiastic) about the opportunities for working in a field that offered the potential to work in closer collaboration with departments that had the remit to engage with the wider determinants of health:

“…For local authority it will [have a] major task in public health and that will be to do wider policies to improve health as well as running health improvement programmes...[and to] consider some of the policies that we put forward.” - PM 31

However there were clear concerns voiced about the fact that the overarching national PH body (Public Health England), was not in place operationally until the date of the transition:

“I think the biggest mistake [that] was made...[was that] they changed to the local authority at the same time they established Public Health England. Public Health England needed to be established at least a year beforehand...” - PM 31

“we’re slightly uneasy at the moment cause we’re...not quite sure what Public Health England’s role is going to be...they’re promising a lot but there’s basic things [missing]” - PM 33

Constraints on access to data and the loss of related key support services were cited as being of particular concern:
“people have said “Yes, We should be looking at that” we said that actually CURRENTLY we can’t access that data...one of the challenges is...as you’ll know, a lot of the health data lags behind. That’s where there’s a cultural differences...councillors, the politicians like more real time data, the here and now, jobless figures...and crime data is more up to date...so we had some of those issues” - PM 32

“...we’ve lost our library contacts so, how we get journals at the moment I don’t know...That kind of thing is a concern for us at the moment...I fully expect the lines of communication to be re-established around access to data, even population demographic data...it’s not entirely lost but it feels a bit shaky at the moment, so just getting that all that up again would be great. It would take a concern away” - PM 33

With regard to their role in providing safe access to data, PHE’s Chief Knowledge Officer Directorate, noted that they were:

“...aware that there have been significant concerns about ongoing access by local authority public health teams to NHS record-level and patient indentifiable data (14)."

The bulletin that included this statement was circulated in February 2013. In August 2013 PH intelligence departments and professionals, now established in local authorities, are still woefully lacking access to the important data and key information support that is vital to the performance of many of their core functions.

Overarching common themes

Irrespective of their differences in levels of ability to make decisions about PH at the UA level, several overarching themes were identified as common to most of our policymakers' with regard to policymaking at the UA level.

Political perspective acting as a barrier to evidence-based policymaking

An overarching strong theme for this emerged through many of our interviewees’ responses. This was evidenced by reported specific incidences as well as more generalised concerns that elected politicians, at both local and national level, were often reluctant to implement evidence-based policy decisions where the consequences might be seen to be unpopular. Ultimately it was felt that the fear of negative opinion on behalf of the general population was a strong driver in this issue however subsections deemed to be influential such as commerce or representatives of the media were both cited as being in the frontline of politicians’ concerns:

“There was a...demand...initiated by...[the] Ministry of Healthcare and municipalities were given the task to decide what is the minimal distance from schools, educational institutions...to open the shops to have licence to sell alcohol and schools suggested that it should be around between 500 metres to 2 kilometres. When politicians, local politicians [discussed] that it was just reduced to 50 metres...This kind of shows where they will prioritise their decisions. Is it health or is it commerce? Business wins” - PM 4

Policymakers’ reaction to the media’s perspective was filtered through an understanding of the zeitgeist but also, as illustrated below, predicated by their awareness of current “hot” topics that had and were therefore likely to have, a negative impact via press coverage:

“Sometimes...we have [health issues that come] into the news quite often so then we have to react to that somehow although if you see, in terms of the health impact, it might not be so major issue but then...you have to react on that because the media comes into the...political view” - PM 1
Elsewhere, PMs noted that the issue of politicians being reluctant to endorse “controversial” PH policies, was likely to be especially acute in the run up to election time.

Importance of regular and effective communication with politicians to facilitate PH policymaking at UA level

We asked our PM participants how best to present data and, at that stage but also mainly in response to enquiries about how health policy decisions are made, many of them responded with comments about the need for regular and effective communication. This was especially cited with regard to the interaction between local politicians and PH policymakers and other experts in the field:

“For example last year we organised a discussion evening with the [head of the city council] and a number of... experts in the field of public health but also connected to the health policy and health in general to see how politics and science interact together...and to see if they can influence each other as well. And we already had an outline where we thought this plan should be going...so the result of that process was that we gained more insight in the wishes of the [head of the city council] but also for ourselves [so that we can] fill in our own policy based on effective things, evidence...” - PM 1

This was described as an ongoing dialogue which nurtured common understanding. Their was a strong reemphasis on the importance of finding innovative ways to present PH agenda in such a way that it would be understood by the “political” mindset and thereby raise and maintain the PH agenda:

Influential and qualified health professionals facilitate PH policymaking at UA level

Related to the above theme on effective communication, another common theme was cited as a strong driver in the ability to promote and sustain the PH agenda at the UA level. This was the existence of a qualified health professional in a position of influence within the UA. In the case of PM 16 this characteristic pertained to the head of their municipal welfare department:

“Our head of department is very energetic. She is a [an academic and vocational] doctor and so... understands the health level and politician level so she is trying to reach the politicians and go on for the [health] targets. So...it’s more easy for us to do it” - PM 16

This was from a PM in an UA that was experiencing a highly significant and increasing move in the direction of greater autonomy in PH policymaking at the UA level. This thematic response was also explicitly expressed by one of our PMs from an UA with a long-established tradition of autonomous PH policymaking at the UA. It was also voiced by our one PM who reported having no ability to influence PH policymaking outside of national directives. This was in the context of emerging future plans for a UA health agenda:

“...the situation in [UA] is one of the best in [the] cities [of the country]... it’s really important what kind of people are at the position of city governing so...because the city mayor and the vice-mayor are medical doctors...they understand that...it’s very important to influence the health of the citizens...they know if they invest into city’s health it will also have an impact on the future productivity of those people” - PM 20

As with all such in-depth qualitative research, the resources required for this piece of work were considerable. However, we believe that the outcomes more than justify this investment. The generous co-operation of our participants has resulted in a valuable and substantial source of very rich data which will be the basis for continuing interrogation and dissemination, thus continuing the legacy and influence of EURO-URHIS 2 for many years to come.

Health policy regarding the use of aggregate health measures at the urban level
Thus far we have conducted a total of 21 interviews throughout Europe (10 UK and 11 non-UK) and have 2 UK policymaker pending interview. All of the UK policymakers in the UAs authorised (by their overarching R&D offices) to approach for interview have consented to be interviewed.

We are able to complete analysis and report on the results of 13 of all of the UAs represented (3 UK and 10 non-UK interview subjects) in 8 countries for the ongoing study. Ten of these returned the post-interview survey allowing for a degree of validation in the analysis. Our completed analysis of these subjects finds us confident that we have achieved saturation of thematic responses for our interview questions within this study overall.

The PMs that we recruited and interviewed had a wide range of influence. We had aimed to recruit the most senior public health representation for the UA jurisdictions where there was such a person with a local specific or overarching responsibility for Public Health (PH). We achieved this in all but one instance. This exception was in the case of our interview with senior representatives of a regional PH Bureau when we could not access their geographically adjacent UA equivalent in (PM 4). They were very familiar with their UA equivalent institution and were able to comment on any differences that would apply for the UA in their responses. For the other 12 UAs we interviewed, variously, Directors and Deputy Directors of City Council/Municipal/Regional Departments or Institutions with specific responsibility for PH or for an overarching responsibility in Health and/or Welfare/Social Care. Three Deputy Mayors in UAs were included in these participants.

In terms of the topography of the UAs, most were predominantly urban with varying degrees of green belt and suburban areas within their jurisdiction. The demographic characteristics were similarly diverse but the most predominant themes that emerged in discussions about the UAs populations’ centred around age-range and/or ethnic and socio-economic differences. These issues had primacy for policymaking decision making from both epidemiological and administrative perspectives.

Of the 13 UAs representatives, all but one indicated that they were able to influence health policy making in their UA to some degree. Those that could do this all said that, in so doing, they used evidence-based measures.

PMs indicated that the data that they used or were influenced by was available in all cases at the national level (13) and, in most cases, at the UA/city (12) and regional (11) level. For a few of the UAs, PMs told us that they were able to use data that informed them about the lower locality/neighbourhood level. Broadly speaking the practice of calculating data to the lower levels within UAs that had a strong correlation with the level of autonomy PMs had for making PH policy making decisions at that level. The exceptions to this were reported as being because of the relatively small size of the UA population and/or the population lacking sufficient diversity between districts within the UA. PMs reported ability to influence PH policy making at the UA is discussed in greater detail within the WP6 report.

The majority of respondents commented that standard measures such as prevalence, incidence, and mortality were used to inform health policy decisions. Life expectancy was frequently cited as being used but fewer respondents commented that they used more complex aggregate measures such as healthy life years (HLYs). Still less use was made of disability adjusted life years (DALYs) or quality adjusted life years (QALYs).

Although many of the policymakers had no experience of using aggregate measures to inform health policy decisions 11/12 who were able to make policy decisions at UA level stated that they would like to use them/use them more. The UA that reported being an exception to this felt that there UA was quite distinctly unique in a regard that these measures were at odds with their particularly healthy aged demographic:

“a lot of these measures are made for a different population than ours. We have an enormous number of very healthy elderly people…I’m not certain that these aggregate measures do measure our population accurately” – PM 18

Where they felt able to comment on the geographical level of use of aggregate measures, there was a strong bias within the
collective PMs views that, except for HLYs, they were most useful and most often calculated at the national level for reporting. Some expressed explicitly that the reasons for not calculating them at UA level was that their population demographics in their UA did not differ in sufficiently compelling respects from the national picture overall due to the relatively small size of the country’s population:

“...this falls out of [our] scope but there are certain aggregate measures or data being collected...on a national level and then of course [we] can obtain this data and in the past [we] have done so...[We] believe that [the country] is so small that the data is only relevant on a national level so there really is no need for aggregate measures on a local level” - PM 24

In a similar vein, the UA that represented a population that was nearly half the size of the host country in total reported having DALYs and HLYs calculated (by their national statistical agency) for their UA and commented that they found little difference at that level from the national picture:

“...[in] our strategy document we put it Disability Adjusted Life Years or Healthy Life Years [and] we have this municipality data from the Bureau of Statistics they work it out for every region that we need....it’s not changing on municipality level...there’s the same situation in the whole country...the situation in [our country] is that...inhabitants are concentrated here in [UA]” - PM 16

Healthy life years were the most commonly utilised of the aggregate measures at UA level that we enquired about. They were described as being more useful to the UA context mainly because they were easier to calculate and therefore not requiring addition resources within the local administration:

The use of DALYs and QALYs was in many cases restricted to the reporting function and in this they were used as a backup to strengthen the case for evidence otherwise expressed:

“We’ve reported on them and we discussed them...I think we’ve certainly reported on stuff on aggregate measures before, but...not really systematically, or made the impact [with them] that...we want” - PM 32

The perception that DALYs and QALYs were difficult to calculate was seen as a barrier partly due to the lack of local skills and/or capacity in terms of time and manpower and also available data at the UA level:

“...there is scarcity of human resources. People [and finance] to work on that [and] there is need of time as well” - PM 11

“...so in saying what the barriers are, I just don’t think there’s any sense of...understanding. Timeliness [also] will be an issue. The sense that if you want to take a decision on something in 6 months time, then you should start doing this work on it now...it’s all of that we’ve got to work through...“ - PM 33

Whilst lacking the capacity themselves, some PMs noted that they were able to occasionally incorporate the use of DALYs and QALYs into their work with the help of other agencies such as universities. This was usually as a result of, often externally funded, discrete projects. These were often cited as including international and European funding streams:

“we don’t really have the skills directly here so we have to be connected to universities, probably research...it takes a bit more effort so if there’s not really a priority to do so you just don’t do it” - PM 1

“there is a problem right now that the budget for these research is coming from the WHO office in [country] or the official in Denmark so we have this problem but we are trying to reach out more research in municipality level [but]...it costs and the researchers need money for this. If it’s not possible to get it, from [these] external resources...like WHO...and European Commission we can’t do this research” - PM 16
Related to this, it was noted by many of our policymakers that the use of aggregate measures was considered a low priority especially at the higher political level. In addition, the process for arriving at as well as the resulting concepts of aggregate measures were often cited as being complex or at least difficult to arrive at and to understand:

“All those [politicians] they probably don’t know a thing about that kind of data or they don’t have a very clear clue about healthcare in general or public health care maybe not well known for them because public health is still a newer field of healthcare so they don’t really know how to approach it or how to understand it so there probably would be some resistance from them because they’d have to learn new things.” - PM 4

“I think it’s something which we ought to explore make a greater commitment to, but... there’s lip service, but very little understanding of how you would use evidence in decision-making...and that’s not even getting into those aggregate measures we were talking about... I think there’s quite a long way to go just to get the idea of evidence-based decision making...and of...accepting that some decisions need time to do them...” - PM 33

One of our PMs had a long history of working with PH academia and, of all our participants, had an exceptional and sophisticated understanding of the use of aggregate measures in PH policymaking. He was able to articulate his view of the advantages and disadvantages of incorporating aggregate measures into PH policymaking presentation and decision making. This PM was less enthusiastic about using DALYs for PH policymaking but did incorporate QALYs in PH practice. He described his beliefs about some of the misconceptions about aggregate measures as well as some caveats for the appropriate use of QALYs:

“...people don’t trust them, but I think one of the other things is that...people regard it as a shopping-list approach rather than an integrated holistic approach, that uses a wide architecture...to look at health. So...I would say that a strategy is that you take the cheapest per QALY [but]...there will be exceptions, because...where you get the cost per QALY...is to some extent unpredictable and doesn’t necessarily lead to a very even service and a lot of people don’t like that...you do have to have some element of balance...but...you wouldn’t start by making a balance and work the other way round, you would start by [getting the best benefit for the least cost] and then balance it out later with some more expensive cost per [benefit] things” - PM 31

As with all such in-depth qualitative research, the resources required for this piece of work were considerable. However, we believe that the outcomes more than justify this investment. The generous co-operation of our participants has resulted in a valuable and substantial source of very rich data which will be the basis for continuing interrogation and dissemination, thus continuing the legacy and influence of EURO-URHIS 2 for many years to come.

Showcasing the project results

The project results have been made available in print in the form of Health Profiles and online via the results website http://results.urhis.eu.

Health Profiles

The EURO-URHIS 2 project has described the health profile of European urban populations using the adult and youth survey, existing data collection and aggregated health measurements to achieve the main objective of informing public policy. These have been disseminated by all partners at multiple local, national and international conferences.

Press
The EURO-URHIS 2 results were reported in at least 18 online magazines and newspapers nationally and internationally as well as several T.V. and radio interviews given by members of the investigating team, including high audience stations such as the BBC and Sky News.

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Twitter and LinkedIn were the social networking platforms chosen, whilst all beneficiaries exploited their own networks to disseminate the results.

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Tweeting promoted the project, its website and the results as well as highlighted other related projects and opportunities such as an invitation by the Guardian newspaper for online discussions on NHS Health reforms.

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LinkedIn disseminated information about the final conference and project results by posting information across different network message boards.

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Podcasts produced with the cities@manchester network assistance focussed showcasing different aspects of the project.

The dissemination activities of Beneficiary 1 have led to links with important international bodies and institutions resulting in further networking opportunities. This has led to now sending regular updates to over 700 interested people and organisations.

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National and global lectures and conferences to health professionals have been used to disseminate EURO-URHIS 2 and its results. The Principal Investigator Dr Arpana Verma has discussed the project in 13 international meetings leading to collaborative projects with Georgia State University, Fudan University and WHO Kobe Centre.

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EURO-URHIS 2 has exhibited results at the annual Festival of Public Health UK including plenary lectures on the project. The Festival is attended by approximately 400 delegates each year.

Newsletters

There have been 9 newsletters that have been widely disseminated as well as being available on the website, as per feedback from key stakeholders over the course of EURO-URHIS 2.

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Within the University of Manchester (UoM), the National Drug Evidence Centre (NDEC), Directed by Dr Michael Donmall, has
recently developed a visualisation tool called ViewIt™ that provides a simple way of visualising data using tables, bar and pie charts and via interactive maps allowing detailed comparisons at national and local levels. This tool has been used to showcase the EURO-URHIS 2 results on the website http://results.urhis.eu.

The platform has been designed after extensive consultation with the PMG, Steering Group and Scientific Advisory Group, including lay members of the public. The minutes of meetings were made available on the website to receive feedback which was incorporated in the final design. The results website was “launched” at the final conference where all delegates could comment on the utility of the platform for demonstration of data.

Public Health Professionals, researchers and policy makers

The final conference and workshops, meetings with interested organisations and newsletters have facilitated the dissemination of the location of the results website to a broad international audience of over 3000 contacts.

Lay audience

Inputs from lay members in SAG meetings and delegates at different events helped to ensure that the website is user friendly and applicable to a wider audience.

EURO - URHIS 2 Final Conference (including Workshop F)

The EURO-URHIS 2 final conference was held from the 12 – 14 of September 2012 in Amsterdam, the Netherlands. It was entitled European Urban Health Conference: From Research to Policy and represented 24 different European countries and 7 countries outside of Europe.

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EURO-URHIS 2 Training Workshops

The University of Liverpool was the lead partner planning and delivering workshops for partners and other stakeholders.

The results and minutes from all workshops and meetings were documented on the standard EURO-URHIS 2 templates and
made available online via the website.

A detailed review of the literature and critical appraisal of existing health surveys (both local and National) was used to identify the lists of urban health indicators (UHIs), the methods of collecting UHI information and ensuring quality appraisal and standardisation of sourced data which were appraised in expert groups and presented to partners through the development phase of the project for refinement, local adaptions, and synchronicity of data collection.

Workshop D invited European health related policy makers for the first time to a EURO-URHIS 2 workshop to the Committee of the Regions in Brussels to receive training in two presentation methodologies employed by the project While Workshop E, conducted in Manchester UK, extended it to a wider sample of health related policy makers and researchers.

The final workshop, conducted as part of the EURO-URHIS 2 final conference, was used to demonstrate the utility and applicability of finalised EURO-URHIS 2 dissemination products to inform decision making for policies to maximise health gain.

Workshops D, E and F were specifically targeted at individuals with executive responsibility for health related policy making and other health professionals for utilisation of EURO-URHIS2 results and training stakeholders for its application.

Web-based tools were developed and used to advertise and recruit participants to workshops for WP10, make available outputs from the workshops and also to summarise and disseminate urban area UHI data to partners, policy makers and practitioners utilising this information.

Conclusions

The EURO-URHIS 2 consortium are pleased to be able to conclude that they have been able to exceed the Annex and Description of Work by collating existing, survey, contextual, meta-data and policy making data from across Europe, Vietnam, Kuwait and now China using comparable methodology for indicators important for urban citizens. At all stages of the planning, execution and dissemination, lay society, researchers, experts, policy makers and other stakeholders have been involved. Thus answering the main research questions, that it is possible to collect health data at urban area level, these data can be converted into useful tools and policy makers find these tools helpful. The results have been augmented by the development of new partnerships working to improve the health of urban citizens.

Potential Impact:
EURO-URHIS 2 has produced profiles for each participating city, to be used for benchmarking and future monitoring of urban health. These included calculation of summary measures of population health (DALYs, HLYs, future trends and PIMs) in relation to risk factors to health and disease, providing public health policymakers with information to make informed decisions about their populations. It is anticipated that different risk factors will be more prominent in some cities compared to others, with some congruence between those cities with similar fundamental conditions.

The project provided information on a wide range of determinants of health specific to urban populations and offer insight into the feasibility of conducting uniform surveys in multiple languages in different cultural contexts. Differences expected between cities, both within and between countries were observed. It is expected that different public health priorities will emerge in different cities from our project.

The potential impact of research results includes:
• Minimum of 4 PhD theses
• 78 peer-reviewed publications, conference abstracts, presentations etc
• Validated existing, adult and youth survey instruments
• Urban Health Impact Assessment and Screening tools
• Health Profiles for 26 Urban Areas
Development of the European Public Health Association Urban Health section with annual conferences and satellite conferences, including the Festival of Public Health UK (annual) and the International Conference on Urban Health 2014

EURO-URHIS supplement in the European Journal of Public Health

Evaluation and feedback from policymakers in each urban area via workshops, Scientific Advisory Groups and conferences. In-depth analysis via policymaker interviews and post-interview surveys

Workshops A – F with evaluation and feedback

EURO-URHIS 2 website and results website including metadata and all publishable reports. This includes relevant handbooks and guidelines.

EURO-URHIS 2 objectives will contribute towards the impacts listed in the activity “Optimising the delivery of healthcare to all European citizens” and more specifically, section 3.2 “Quality, efficiency and solidarity of health care systems including transitional health systems” in providing the “scientifically validated tools to allow countries to learn from the experience of other health systems”. EURO-URHIS 2 has contributed towards the impacts by “developing new research methods” that will be “generating the necessary scientific basis to underpin informed policy decisions on health systems” and “scientifically validated tools to allow countries to learn from the experience of other health systems”. The project has looked at national and urban level context by collecting priorities of the policy makers. The project has investigated the elderly, as well as children, migration, education and socio-economic status. Policy makers have given their most important interventions for their urban areas, and the efficiency, benefits and outcomes have been investigated through the other surveys. The data collected encompasses the cross-thematic and overarching themes through collecting data on the environment, bioinformatics and obesity in the young, the aging population and women.

New methodology for collecting health data at urban level has been developed through:

- existing data e.g. selecting UHIs from the EURO-URHIS 45 list which includes population characteristics
- validated epidemiological instruments e.g. utilising validated European and international health surveys
- new surveys investigating each UA’s priorities in health policies and main interventions
- tools that have sound scientific basis to help policy makers e.g. healthy life expectancy (HLE), Disability Adjusted Life Years (DALYs) and trends for future predictions

By collecting urban health data, we already advance the state-of-the-art as most health data is collected at international, national or regional level. This has been furthered by producing and validating tools that demonstrate the use of the data in evidence based policy making. Policy makers have been trained on how to use the tools, allowing comparisons, benchmarking and future research opportunities. Members of civil society have been trained on why data collection is necessary and access in line with the Aarhus convention. Where there are gaps in data collection, through demonstration of the devised tools, we have shown the importance of data capture, storage and utility to policy makers.

The partnerships with ICPCs, other EU funded projects and related experts will enhance the cooperation between researchers in Europe and other geographic regions to perform high quality work that is user-friendly. The scientific base for researching healthcare systems in all Member States and other countries will be enhanced through EURO-URHIS 2 as the outcomes of the project are methodology developed for the assessment of population health (i.e. the instruments for data collection and tools for policy makers) and validated models using the existing national and European registries/databases. Therefore, we are able to give European, international, national and local policy makers an armamentarium of tools for them to make evidence based policy for their urban areas. With rapid urbanisation across Europe and globally, health in urban areas is or will become a priority. EURO-URHIS 2 will facilitate evidence based policy making for local, national and European policy makers, and through the developed methodology and its wide dissemination, influence the health of populations and save lives. EURO-URHIS 2 has now been implemented in Kuwait and China with plans for Brazil and India.

The steps required to bring about these impacts have been addressed in the WPs but can be summarised as:-
• Engage policy makers in EURO-URHIS 2 as part of SAG
• Develop instruments for data collection
• Demonstrate health data can be collected at urban level
• Demonstrate application of data into various validated tools
• Disseminate how tools can be used for evidence based policy making
• Policy makers evaluate the usefulness of the developed methodology and tools

The project is required to be at European level to allow all countries associated with Europe and ICPCs to examine the health of their urban populations. There are specific health problems that are associated with urban populations that would not be detected at national level especially in countries who are currently undergoing development and urbanisation of their population. Local level projects would not have consistent, validated methodology that would allow comparison with other urban areas in other countries. Only through validated epidemiological paradigms, will true comparisons and the conclusions from these tools be useful for benchmarking.

Other national and international research activities in this field were mapped as part of the EURO-URHIS project. Links were developed with a number of these projects and they were extended to facilitate EURO-URHIS 2. A number of the participants in EURO-URHIS 2 have worked in the field of urban health and have links with international groups which were encouraged to engage in the SAG.

The EURO-URHIS 2 methodology is applicable to any urban area in Europe and has been validated and evaluated by policy makers making it potentially useful to EU Policy Committees. The findings can be discussed with EU, national and local politicians through the relevant policy processes.

The local impact is the health gain in UAs collecting data, using the tools and the development of evidence-based policies but for UAs that are less developed, EURO-URHIS 2 identifies the gaps in data collection.

Results of EURO-URHIS 2 were presented at a final conference in September 2012, aimed at European urban policymakers, and will demonstrate the applicability of the results to urban planners. The project and the results were aimed at informing decision making, for cost-effective and appropriate allocation of resources that are particularly applicable to their populations. By collecting this data at the sub-national level, differences within countries can be considered and placed in the context of the environment.

Methods and instruments employed by the project were designed to be replicable and could be applied to the remainder of urban Europe and beyond. The instruments lend themselves to longitudinal research, with monitoring over time giving a strong indication to policymakers of changing priorities for their urban areas. Comparison between cities and countries will highlight to the EU which urban areas require attention to achieve the standard desired by the commission in their EU health strategy.

The societal impact was large ranging from:-
• Lay population impacting on the design of EURO-URHIS 2 via the Scientific Advisory Group meetings, workshops and final conference
• Direct liaison of the lay urban communities with the beneficiaries
• Policy makers in depth work especially during financial crisis and organisational changes
• Peer-reviewed publications and presentations
• Links with other organisations, networks, agencies and projects
• Successful future urban health research projects
• Formulation of new research questions for future grants and applications
The results will also provide opportunities for further consideration on how the urban condition impacts the health of city-dwellers and will be the basis of future proposals. Dissemination activities were undertaken by four WPs. Due to the nature of the project, we felt that it was important to have the different dissemination routes separated and found experts in these fields to undertake the work.

There were a number of reports and newsletters detailing the project and its course over 54 months. The public relations activity was under WP2. The EURO-URHIS 2 information platform, WP8, required very different skills for its initiation and maintenance. WP9 organised the conference and WP10 arranged the various workshops required. All the participants disseminated the results to their local population.

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Intellectual property rights remain under the whole consortium should there be any exploitation of the results. UNIMAN has a centre who co-ordinate all activities. The advice would be received through the SSAG into the project team via the regular
meetings. UNIMAN would protect IP rights through the consortium agreement of any knowledge resulting from this project.

Studies on socio-economic aspects were assessed as part of WP6, 7 and 10 as well as through the factors such as standardisation, ethical and regulatory aspects.

The management of knowledge was discussed by the project team with advice from SSAG to promote exploitation of any results in the best format for the right audience using the appropriate methodology. This was under the ownership of the consortium as a whole and again, agreed in the consortium agreement.

Contribution to policy development

• Gaps in data essential for urban health were identified and resulted in beneficiaries being able to advise policy developments to bridge the gaps
• City reports provided data to support evidence based policy decisions on urban health issues
• Tools, benchmarking and monitoring for urban health policy development
• Increased awareness of urban health, advocacy and empowerment of urban populations that help in evidence based policy developments
• Training and a conference to support evidence based policy decisions
• Network of urban health professionals to help with policy development

Lay audience

EURO-URHIS 2 was administered and channelled by public health experts from over forty urban areas however in order to achieve the mission of providing urban data on an individual level, in a format appropriate for policy makers, it was essential to have representatives from the lay population. The laypeople were integrated throughout the project and played fundamental roles in the development of the data collection strategies by regularly meeting with the Scientific Advisory Group and mediating the decisions that defined the focus of the research. Furthermore they were integral with the development of the EURO-URHIS 2 Health Profiles and the website which displayed results in a simplified manner through graphs and diagrams which were both visually stimulating and useful to the general public.

List of Websites:
http://www.urhis.eu
http://results.urhis.eu
http://www.icuh2014.com
http://www.festivalofpublichealth.co.uk
http://www.population-health.manchester.ac.uk/epidemiology/MUCH/

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