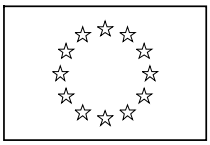

COMMISSION OF THE EUROPEAN COMMUNITIES

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INTERIM REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

on the implementation of the programmes of Community action on the prevention of cancer, AIDS and certain other communicable diseases, and drug dependence within the framework for action in the field of public health (1996-2000) (Decisions N°646/96/EC, 647/96/EC and 102/97/EC of the European Parliament and of the Council)

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Introduction

Following the adoption of three programmes of Community action for prevention of cancer, AIDS and other communicable diseases, and drug dependence by the European Parliament and the Council, the Commission presents hereunder an interim report concerning mainly the implementation period 1996 and 1997. The inclusion of the first half of the budgetary period 1998 has been avoided as it would have unduly delayed a timely presentation of this report.

In this report, the Commission highlights the degree of consistency and complementarity reached between these plans and the other relevant Community policies, programmes and initiatives and to increase the value and impact of the three plans, has performed an evaluation of the actions undertaken. On the latter point, particular regard has been given to effectiveness and the achievement of the objectives of the measures undertaken. For this purpose, the Commission has drawn on the opinions of a group of external experts, and from representatives of the Member States serving on the three management committees. The Commission also reports on the adjustments which are deemed necessary as a consequence of the information gathered.

Consistency and complementarity

The Commission sought consistency and complementarity between its public health and other Community policies, programmes and initiatives by a multitude of efforts on different operational levels, in particular:

The implementation of the 4th Framework programme for research, technological development and demonstration (1994 – 1998) of the European Communities was closely followed by means of the inter-service consultations on publications of calls for proposals and on adoption of projects for financing.

The preparation of the 5th Framework programme for research, technological development and demonstration (1998 – 2002) of the European Union was actively followed by means of the inter-service consultations on the draft proposal, and consultations on project proposals, in order to ensure consistency and complementarity.

Further, officials of the public health directorate were invited to all meetings of the programme committees for the specific research programmes; likewise, officials from the research directorates were invited to the meetings of the public health programme committees.

In the course of the implementation of the programmes, applicants seemed also to have better understood the difference between health and health services research as foreseen under the framework programmes for research and the preventive measures for cancer, AIDS and other communicable diseases, and drug dependence covered under the relevant action plans.

Effectiveness and the achievement of objectives

Given the kind of objectives laid down in the three action plans, the actual coverage by specific actions following the first calls for proposals within the period of 1996 and 1997 were generally quite sufficient. A balance between the various areas of each programme was

made easier by the adoption of annual work programmes allowing proposals for projects to be invited in areas not yet sufficiently covered. There was one reservation that initially the European added value of projects was in many instances under developed, but stress has been placed on the development of network projects in order to resolve this shortcoming.

To ensure subsidiarity, the opinion of Member States was invited through the programme committees as laid down in the specific action programmes. Thus, the necessary support of Member States for implementation of the actions selected in their countries was encouraged. At the same time, the programme committees guaranteed the required transparency of the European Commission's actions towards the Member States. The transparency towards the European Parliament was ensured by the prior transmission to that Institution of reports and documents intended for each of the programme Committees as well as an annual list of projects financed.

To ensure the highest possible standards for the quality of the actions selected, each committee not only gave a favourable opinion on the annual work plans, but was also consulted on the preparation of the calls for proposals, the selection of projects and the follow-up of their implementation. In addition, for the Cancer Programme, the Commission has formalised the existence of an Advisory Committee for Cancer prevention, formerly known as the High Level Cancer Experts Committee, composed of independent scientific experts who provide opinions to the Commission on projects to be financed and on cancer prevention issues in general.

Monitoring

Monitoring of the specific actions has been performed mainly through a continuous follow-up by the Commission Services of the contractual obligations of the projects financed.

Adjustments

To improve the European added value as an important general objective, the Commission Services have embarked on a strategy to ask for enhanced networking of applicants to ensure better cross-border co-operation, e.g., as a means of dissemination of best practice in Europe.

To cover areas of Community interest, which were not covered by specific actions selected to date, following a thorough analysis of the active portfolio, the Commission adapted each annual work plan respectively. In turn, the annual work plans aided in establishing priorities for the next calls for proposals as well as in the selection of the newly proposed actions.

For the Cancer Programme, a document was agreed by the management committee and adopted by the Commission concerning simplification of procedures.

To further improve transparency and simplify dissemination at the same time annual reports have been produced for 1996[1] and 1997[2] by the Commission's Services jointly for the three programmes, which give a comprehensive picture of the work of the respective unit of the Commission's services.

Following external suggestions and internal review of shortcomings the linkages between the three programmes and other public health programmes have been improved.

Excerpt from the experts' report on the three programmes

Finally, excerpts from the findings of a group of independent experts who, under contract to the Commission, analysed each individual programme, are presented below:

THE CANCER PROGRAMME

With few exceptions, the projects have been evaluated as appropriate or very appropriate and relevant in relation to the objectives of the programme. Mostly, they properly address the various actions in terms of aims, specific objectives, design and achievements. However, in some cases such as health education projects, the targets and methods are quite often badly specified.

Nevertheless, the projects in general appear to be competently implemented and managed. In addition, the timing of outputs in comparison with the proposed schedule has generally been maintained, with some exceptions.

However, the dissemination of results has basically followed quite traditional pathways, such as scientific conferences and publications within scientific journals. Although these means of dissemination are certainly appropriate, they are undoubtedly not sufficient to ensure involvement of the general public or even of a majority of health professionals.

Positive results of note include:

– The expansion and development of European networks, especially in the fields of: nutrition and cancer (mainly through the EPIC project), breast and cervical cancer screening, fight against tobacco and cancer registration;

– The production and diffusion of consensus documents, guidelines, appropriate software for increasing comparability and uniform quality of data registration and anti-cancer activities over Europe;

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1 Directorate Public Health and Safety at Work, Unit V/F/2, Implementation of action programmes targeted on diseases, Annual report 1996, Implementation of the actions: - Europe against cancer -, - AIDS and other communicable diseases -, - drug addiction prevention -, Internal document CE-V/3-97-002-EN-C.

2 Directorate Public Health and Safety at Work, Unit V/F/2, Implementation of action programmes targeted on diseases, Annual report 1997, Implementation of the programmes - Europe against cancer, - AIDS and other communicable diseases, - Drug addiction prevention, Internal document CE-V/3-98-009-EN-C.

– The implementation of prevention and early detection programmes of appropriate quality in European areas previously uncovered or with little coverage; and,

– The diffusion of quality control practices in the fields of data registration and cancer health services, according to common criteria and aiming to obtain a more uniform quality of these activities across Europe.

However, a greater amount of innovation would be welcome, especially in some actions. For example, more innovation is recommended in the fields of health education techniques; fight against tobacco; teaching methods for health professionals; application of new techniques for improving the performance and the effectiveness of public health programmes such as in breast and cervical cancer screening, of screening for cancers other than breast and cervix, and of methods for quitting smoking in high risk groups.

In general, from a review of the reports it is clear that all the listed projects greatly benefited and indeed were often made possible by the financial support of the Europe Against Cancer programme. For many of them, the Community financial support allowed a high intensity of inter-country exchanges, the agreement on methods, the achievement of a uniform quality and the production of common documents and statements.

It is quite remarkable that in no case do the projects' activities, given the programme framework, appear to conflict or even overlap with national programmes. On the contrary, some project documents claim synergy and beneficial effects on national health activities. However, the relation with other agencies active in the field is not always clear. For some clusters and actions, it was difficult to evaluate if there is an overlap with other activities supported by the European Community, such as BIOMED.

Finally, in terms of European added value, the evaluation identified some contributions and some room for improvement. A significant majority of the projects is multinational. The tendency to finance multinational projects should be maintained and encouraged. However, multi-nationality does not automatically guarantee an acceptable level of European added value, for which a rigorous methodology, a sufficient degree of innovation and a good dissemination of results are also needed. These features characterise many, but not all the projects and actions.

THE AIDS AND COMMUNICABLE DISEASES PROGRAMME

With few exceptions, the projects have been evaluated as appropriate and relevant in relation with the objectives of the programme. In general, these projects delivered a range of effective and appropriate studies and interventions. Unfortunately, action 10 was not addressed by any project in 1996 and 1997 (Member States vaccination policies and programmes).

Funded projects provided a mix of innovative approaches and expansion of pre-existing effective projects. In general, these properly address the various actions in terms of aims, specific objectives, design and achievements. In a few cases, such as the EchinoEuroReg project (about echinococcosis), activities do not really fit into the

annual priorities defined for the programme, but this relates to only a very small part of the cluster's budget.

Populations targeted by the projects were generally appropriate. However, sometimes projects excluded high priority sub-populations, which should be redressed in the future. For example, greater attention within the cluster on combating transmission of AIDS should be allocated to projects targeting the range of men who have sex with men, and also to intravenous drug users whether or not they are 'marginalised young people'.

Projects were usually well managed, and resources used cost-effectively.

The results from a number of projects are quite impressive. Many of the multinational networks supported by the programme seem at first sight to be a cost-effective way of creating Community added value. However, the project reports of the networks quite often fail to give a convincing picture of actual capacity to gather expertise and experience from all the Member States and from all the relevant agencies in the Member States, as well as to disseminate information provided by these networks.

It will be important to pay substantially greater attention to the issue of discrimination, which is seldom dealt with adequately in the projects, and which should be integrated into the framework of the response at all levels to AIDS, sexually transmitted and other communicable diseases.

Positive results of note include:

– Improvement of the co-ordination of communicable disease surveillance systems and the co-ordination of the Community response, with initial efforts focused on HIV/AIDS, tuberculosis, drug resistance;

– The regular production of the monthly bulletin 'Eurosurveillance' and a weekly electronic bulletin.

– Building of a network (EARSS), standardisation and validation of antibiotic resistance susceptibility testing and reporting;

– Creation and development of a European network for HIV/STD (Sexually transmitted diseases) prevention for prostitutes resulting from the merging of two existing networks: EUROPAP and TAMPEP;

– Analysis of border issues with regard to HIV/AIDS, STDs and development of co-operative, border crossing methods of prevention;

– Maintenance and enhancement of the European network on HIV/AIDS and hepatitis prevention in prisons; expansion and further development of the European public policy network on HIV/ AIDS (EPPNA); creation of a European AIDS and enterprise network (EAEN);

– Creation of two European centres for AIDS prevention, information and education (addressing youth and mobility respectively).

Some critical issues were identified, in particular:

– Dissemination of results often occurs only through traditional pathways, such as scientific conferences and publication within scientific journals. These approaches need to be enhanced to ensure that a much wider audience is aware of the results and conclusions of funded projects;

– Vaccination policies and programmes with respect to HIV/AIDS are assuming greater significance, and projects investigating this area should be encouraged in the future.

For many projects, Community financial support allowed a high intensity of inter-country exchanges, agreement on methods, the achievement of a uniform and enhanced quality, and the production of common documents and statements. In most cases, projects appeared to clearly demonstrate synergism with national actions.

The assessment in terms of European added value is quite complex. However, the project results in the majority of cases have significant practical relevance, and theoretically, should better inform the HIV/STD policy framework and the design and delivery of programmes in the Member States. At present, there is only limited evidence that project results are actually being disseminated widely and influencing key policy-makers regarding future direction on HIV/STD issues within the Member States and in the European Community as a whole.

THE DRUGS PROGRAMME

Implementation of most of the actions of the programme commenced during the first two years of the 5-year programme. However, much remains to be achieved in areas such as: relapse prevention and rehabilitation; evaluating the effectiveness of information and health education campaigns; tools with polysubstance dependence; the extension of European network of 'test towns' and promoting initiatives to improve the drug prevention aspect of vocational training of teachers; and, health and social care professions and other professionals responsible for young people.

Much also depends on the follow up of the projects and on opportunities for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and other European institutions to disseminate results, because dissemination by the project contractors often remains quite restricted. In the same vein, funding of European networks in the field of public health action related to drug dependence should be a priority, with the aim of disseminating project results.

There are quite impressive results from a number of projects. Many of the multinational networks and teams supported by the programme seem to be a quite cost-effective way of creating Community added value. However, the project reports of the networks quite often fail in giving a convincing picture of their actual capacity to gather expertise and experience from all the Member States and from all the relevant agencies in the Member States, as well as to disseminate information when provided through these networks. A positive development is the number of networks that have proceeded in providing electronic information channels such as websites, electronic databases and other uses of the Internet.

The projects funded seem to emphasise approaches targeted directly to individuals, contrasted with a lack of projects with a broader public policy approach towards

public health problems related to drugs. Such projects would be needed to increase knowledge about the impact of the larger public policy context on the drug phenomenon and on the feasibility of specific intervention models in different public policy contexts.

As there are large political debates, both at international and European level as well as at national and municipal level, on future public policy strategies with regard to drug problems, there is a great need for research-based evidence to help policy makers to choose between different strategic alternatives.

The linkages between the programme and other public health programmes managed by Directorate General V seem weak. The projects that are funded seldom use, to the maximum extent, experience in policy development outside the field of drugs, such as with addictions to chemical substances (drugs, nicotine, alcohol) or with the general training of professionals or peer training programmes.

The decision to adopt the programme placed a significant emphasis on co-operation with other international and intergovernmental organisations as well as with other Community programmes and initiatives and the EMCDDA. The projects' documentation indicates that there have been quite a few links to the EMCDDA, while the indications of co-operation with other international agencies are rather few.

THE MANAGEMENT OF THE PROGRAMMES

Programme management since the first years of the implementation of these programmes has improved, but there are still opportunities for further improvement.

The cancer and AIDS and communicable diseases programmes were adopted in 1996, with the drugs programme not being finalised until January 1997. Thus, the creation of the formal management infrastructure, including the setting up of the programme committees and their rules of procedure and working practices, only occurred after the formal commencement of the programmes at the beginning of 1996.

There has been some continuity in the management of public health actions by the Commission, from the period prior to the establishment of the programmes, to the development of management practices of the new programmes in its first years. Those responsible for managing the programmes were the same until mid-1998, but several changes among the collaborators took place, affecting continuity of knowledge.

Due to the late setting up of the formal management structure for the programmes, a proper evaluation of the management can only be done in the second phase of the evaluation. However, it is possible to make some preliminary comments at this stage of the implementation. A more detailed evaluation of management will be undertaken during the second phase of the evaluation.

A number of suggestions for further improving the timing and procedures for processing and deciding on project applications need to be carefully considered. Among the points emerging, the most important were: the institution of an

independent evaluation of all project proposals by external experts[3]; the need for some means of stable funding for the various European networks that were being established and that should function as a key mechanism in the accumulation and dissemination of knowledge; improved documentation through better specification of what was required both in applicants' proposals and in contractors' reports; a need for better links within and between programmes, with other Commission activities and with other bodies involved in public health in Europe. Various recommendations are made to address these concerns.

In summary, there does not appear to be any obvious mismanagement of any aspect of the European public health programmes, but there are many opportunities for refinement of procedures and practices.

LINKS WITH MEMBER STATES POLICIES AND PROGRAMMES

A questionnaire was dispatched to members of the programme committees for each of the three public health programmes on 30 October 1998. The information requested focused on a description of national prevention policies, links between it and Community policy, and how these links had developed. Further questions asked for information on the management of the programmes.

This attempt to canvass responses from Member States should be seen, at least, as an important step forward in the larger task of creating coherence and synergy between Community level, national and local initiatives in tackling public health problems, the seriousness of which is recognised throughout the European Community. Although unsuccessful in achieving a comprehensive picture of the specific impact of these three programmes in all Member States, these responses from a third of the Member States, nevertheless give some indications of the complexity of what is needed (21 clusters in 15 Member States, not mentioning the regionalisation of public health programmes in most of these).

It is proposed that before the end of the programmes, an independent, comprehensive and comparative study be commissioned to investigate the relevant policies and practices in all Member States and to review the contribution of Community policy and initiatives to the national and local level in the Member States.

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[3] NB. Commission Services: this role is already carried out by the Advisory Committee for Cancer Prevention in the case of project proposals submitted to the Europe Against Cancer Programme.

Budget

An overview of the budget allocation for the years 1996 and 1997 for the three programmes is presented as follows

Budget allocation for the Europe against cancer programme:

	1996		1997		1996 & 1997	
Area	**Number of projects**	**Budget (~MECU)**	**Number of projects**	**Budget (~MECU)**	**Number of projects**	**Budget (~MECU)**
A-Data collection and research	15	4.191	9	3.901	24	8.092
B-Information and health education	29	2.746	16	2.532	45	5.278
C-Early detection and screening	32	1.721	27	1.591	59	3.312
D-Training and quality control	24	1.757	14	1.339	38	3.097
TOTAL	**100**	**~10.416**	**66**	**~9.363**	**166**	**~19.779**

Budget allocation for the Europe against AIDS and other communicable diseases programme:

	1996		1997		1996 & 1997	
Area	**Number of projects**	**Budget (~MECU)**	**Number of projects**	**Budget (~MECU)**	**Number of projects**	**Budget (~MECU)**
A - Surveillance and monitoring	6	3.246	9	3.316	15	6.562
B - Combating transmission	15	2.190	17	2.351	32	4.541
C – Information, education and Training	18	2.757	16	2.148	34	4.905
D – Support for persons with HIV/AIDS and combating discrimination	10	1.329	10	1.348	20	2.677
TOTAL	**49**	**~9.522**	**52**	**~9.163**	**101**	**~18.685**

Budget allocation for the Europe against drug dependence programme:

	1996		1997[4]		1996 & 1997	
Area	**Number of projects**	**Budget (~MECU)**	**Number of projects**	**Budget (~MECU)**	**Number of projects**	**Budget (~MECU)**
A- data research and evaluation	16	3.080				
B- Information, health education and training	18	3.420				
TOTAL	**34**	**~6.500**	**33**	**~4.908**	**67**	**~11.408**

[4] NB. For 1997 a breakdown into rubrics A and B was not done. Instead the summary figures have been used.