# Good Practice in the Field of Health Promotion and Primary Prevention

## *Final Questionnaire*

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## WP 5 – Task 1

## I.    Background and Description of Work Package 5,  Task 1: Review of Existing Work, Situation and Needs

The general objective of CHRODIS-JA is **to identify, exchange, scale-up and transfer best practices** and effective interventions on health promotion and chronic disease prevention, multi-morbidity focusing mainly **cardiovascular diseases** including **stroke** and **diabetes** based on a Platform for Knowledge Exchange and a clearinghouse. This will be achieved by collecting experiences, interventions and plans and developing a methodology that will support identification and selection of potentially effective interventions for exchange or transfer to other settings. Major behavioural and individual risk factors such as **diet, physical inactivity, alcohol harm reduction and tobacco use with a special focus on the elderly will be addressed**. **Wider social and economic determinants** will be considered, along with their implications on **inequalities in health.**

Work package 5 will focus on these objectives in relation with Good Practice in the field of Health Promotion and Primary Prevention.  The objective of CHRODIS WP 5 (Objective no 2 in CHRODIS work programme) is *to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices (among older people)*. This will involve the identification, review and validation of interventions on health promotion and primary prevention of cardiovascular diseases, stroke and diabetes type 2 and their modifiable behavioural and social risk factors[1]. This work will not only take into account lifestyles and health-related behaviours, but also the wider social and economic determinants that influence them.

The first Task that all WP 5 partners will undertake is a **"Review of existing work, situation and needs"** in relation to health promotion and primary prevention of cardiovascular disease, stroke and type 2 diabetes.** The purpose is to develop an understanding of the existing situation in the participating EU countries. It aims to provide an overview of existing mechanisms and policies, to identify where good practice exists and where needs lie. The work will establish the foundations needed to achieve subsequent work-package tasks. Task 1 will result in a set of **Country Reviews** from the partner countries **on work and the situation relating to highly promising health promotion and primary prevention approaches on cardiovascular disease, stroke and type 2 diabetes, as well as gaps and needs** in this area.

Responses to this questionnaire will constitute WP5 partners Country Reviews. The responses will shed light on how health promotion and primary prevention is currently being delivered in different countries and set the stage to help partners identify promising practices being applied in their countries to address cardiovascular diseases, stroke and diabetes and their modifiable behavioural and social risk factors. The responses will also be used to identify whether and in what countries health promotion and primary prevention of chronic diseases operate under similar conditions, to support subsequent WP5 tasks.

This questionnaire asks you to:

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[1] In the context of this questionnaire, the term "modifiable behavioural and social risk factors" includes unhealthy diets, physical inactivity and tobacco use and the underlying socio-economic, cultural, political and environmental determinants of chronic diseases http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf

1) **Map and describe the health promotion and primary prevention landscape in your country**. It asks you to outline the mechanisms and policies for primary prevention and health promotion in your country highlighting the main public and non-governmental organisations and financial mechanisms in place.

2) Identify and report on **mechanisms in your country to identify good practice in the area of health promotion and primary prevention of** cardiovascular disease, stroke and/or type 2 diabetes and/or their modifiable behavioural and social risk factors. This includes relevant databases as well the selection criteria that they apply and/or that public authorities apply to select, fund and implement activities in this field.

3) Identify and report on health economic analyses e.g. **cost-effectiveness of programmes/interventions to prevent chronic diseases** (type 2 diabetes, cardiovascular disease and stroke) and/or their modifiable behavioural and social risk factors.

4) Identify and report on the outcomes of any **health-forecasting studies** that have been undertaken in your country.

5) Identify and report on current **gaps and needs** regarding health promotion and primary prevention strategies and practices in your country.

The responses to this questionnaire will not be used to examine the performance of policies or programmes in any given country, to rank countries according to their policies and programmes or as a benchmarking tool. The aim is to capture information that can help to detect health promotion and primary prevention policies, programmes and interventions that are proving effective in addressing cardiovascular disease, stroke and diabetes and their modifiable behavioural and social risk factors. The aim is also to identify participating countries' strengths, gaps and needs in this field, and how they may be able to benefit from one another's strengths and expertise.

A guidance document (Annex) has been developed to support your efforts to respond to question 1 and in particular to question 5 on Gaps and Needs. The questions in the document address different dimensions of health promotion and disease prevention policy and practice. They can stimulate your thinking and help you take a structured approach to identifying your countries strengths, needs and gaps in these areas in relation to cardiovascular disease, stroke and diabetes and their modifiable behavioural and social risk factors.

## II. Approach

Please fill out this questionnaire to the best of your abilities by:

1) Consulting internal, ministerial reports as well as those produced/applied by public health institutes and agencies and all main relevant bodies working in the field;
2) Contacting and consulting relevant experts;
3) Consulting relevant health-related databases for literature (including grey literature) for forecasting studies and cost-effectiveness studies.

If there is more than one organization in WP 5 representing a country, we suggest that each organization fills out the questionnaire independently, and then meets to discuss outcomes and merge the responses into a single Country Review.

We also encourage you to organize an **expert focus group workshop** to help develop and/or discuss and refine your responses. This entails that you identify and invite persons with expertise in health promotion and primary prevention in your country (e.g. experts working in this area from the Ministry of Health, national, regional and local health institutes or public authorities, and specific foundations, NGOs and insurance companies) to check the responses for completeness and correctness and to complement the information in relation to current gaps and needs. The goal is to reduce the subjectivity of the results and to ensure that the responses to the questionnaire are based on a consensus.

Please send the response to this questionnaire to Cristina Chiotan (c.chiotan@eurohealthnet.eu) and Cc to Ingrid Stegeman (i.stegeman@eurohealthnet.eu ) by **27 July 2014**. Your responses will be used to support the subsequent Tasks in WP5.

Your detailed responses to all the questions in the questionnaire will constitute your Country Review. EuroHealthNet will develop then draft an overview report that will focus on the existing situation and work that is taking place in participating countries in relation to health promotion and primary prevention of chronic diseases, and the identified needs and gaps. The overview report will be designed to meet the needs of subsequent tasks in WP 5 Task 2, including the identification of best practice criteria. A draft of the overview report will be circulated and discussed with all partners.

The Country Reviews on health promotion and primary prevention approaches (including existing work, current situation, gaps and needs) will be edited and re-formatted for consistency and made available on the CHRODIS Website, as the first Milestone under WP 5.

For any questions or clarifications please contact Cristina Chiotan at c.chiotan@eurohealthnet.eu or Ingrid Stegeman at i.stegeman@eurohealthnet.eu.

# Questionnaire on "Good Practice in the Field of Health Promotion and Chronic Disease Prevention"

## 1) The Health Promotion and Chronic Disease Prevention Landscape

A. Please explain briefly the decision making mechanisms for policy development and implementation.
- How and at what level are policies for health promotion and primary prevention **initiated, developed and approved** in your country (centralized vs decentralized, distribution of competencies across governing bodies, etc.)?

- How and at what level are policies for health promotion and primary prevention **implemented**? (e.g. role of national vs. regional vs. local level and how/at what level available funding is distributed.)

B. Please list the **main current policies** (national strategies, laws, regulations, ministerial orders, etc) that relate to health promotion and the primary prevention of cardiovascular disease, stroke and type 2 diabetes, and their modifiable behavioural and social risk factors in your country, specified at the national, regional or local level.

Are there separate policies on health promotion and primary prevention, or is this part of a broader health policy? Are there separate policies on cardiovascular disease, stroke and/or type 2 diabetes?

Do these policies include a monitoring and evaluation framework, time frame for implementation and/or target indicators?

Do these policies include a focus on health inequalities and the socio-economic gradient?

Is there a specific focus on older populations (65 and over)?

Is there a gender specific dimension included?

C. What **financing mechanisms** are available to implement the policies identified? (e.g. public funds, health insurance, general taxation, out-of pocket payments, public vs private provision of services, EU Structural and Investment Funds etc.)?

If possible, please provide an estimation of the percentage of health budgets that are allocated to these activities

D. Which are the main **public bodies at the national, regional and local level** in your country with a mandate for health promotion and primary prevention?

Which are the **main other organisations** (NGOs, health insurance companies, private enterprises, community based organisations, public-private, etc.) that are implementing policies and programmes to prevent cardiovascular disease, stroke and type 2 diabetes and/or to address their modifiable behavioural and social risk factors, particularly amongst those 65 and over?

## 2. Identifying Good Practice and existing databases

(1) Outline if any procedure / mechanism or criteria exists to identify good practice in relation to health promotion and primary prevention in your country. Please describe and provide examples of existing procedures and criteria (who is applying it, how practices are evaluated, the main criteria used etc.)

(2) Are there procedures/criteria to select and fund health promotion and primary prevention interventions? Please describe the existing procedure and criteria (who applies it, how practices are evaluated, the main indicators/criteria used etc.)

(3) Are there databases in your country on/that include good practice to reduce cardiovascular disease, stroke and/or type 2 diabetes and/or their modifiable risk factors?

Yes / no

If yes: how many*?
Please list these databases: ………………

Regarding the database mentioned:
- What criteria have been applied to identify good practice?
- Have good practices been ranked according to those that best meet these criteria?

*Note: please list up to five databases. If you can identify more than five, please select those that you consider to be of highest quality in relation to the rigor of the good practice criteria applied, their size and their influence.

### 3. Forecasting Studies

*Forecasting is the process of making statements about events whose actual outcomes (typically) have not yet been observed. Forecasting studies in the area of chronic disease aim to identify the burden of specific diseases in the future, on the basis of current trends. Forecasting can be important in the design of public health strategies.*

Have **forecasting studies\*** been undertaken in your country in relation to health promotion and primary prevention?  If yes, please provide short abstracts of the results of these studies (up to five).

Have the outcomes of these studies been taken into account in policies and programmes to prevent chronic diseases and in particular cardiovascular disease, stroke or diabetes? Please provide a separate answer for each of the studies listed.

**\*Notes:**
- Please report on studies that have been undertaken *in your countries*.
- Please report only on studies undertaken after the year 2000.
- We recognize that it might not be possible to find health forecasting studies in some countries. We therefore ask you to identify any relevant studies that you can find in these areas, but understand if there is little information available on this from your country.
- Should you, on the contrary, identify a large number of studies, please report on the five that you consider to be the best in relation to quality of implementation and influence on policy-making.

## 4. Cost-effectiveness studies

Please specify if any **studies on cost-effectiveness\*** of health promotion and/or primary prevention programmes/interventions to prevent chronic diseases (type 2 diabetes, cardiovascular disease and stroke) and/or that address their major risk factors have been performed in your country. If yes, please provide examples and short abstracts of these studies (up to five).

**\*Notes:**
- Please report on studies that have been undertaken *in your countries*.
- Please report only on studies undertaken after the year 2000.
- We realize that cost-effectiveness studies of health promotion and disease prevention initiatives and projects/practices that incorporate economic components may be rare, we therefore ask you to identify any relevant studies that you can find in these areas, but understand if there is little information on this from your country.
- Should you, on the contrary, identify a large number of studies, please select and report on the five that you consider to be of the best relative quality in relation to scope and relevance and the quality of implementation, and on those that were undertaken on health promotion/chronic disease prevention interventions that reflected promising results in terms of cost effectiveness and efficiency.

## 5. Gaps and Needs

Please identify the main **gaps and needs** in your country in relation with health promotion and primary prevention.

Please address different areas, such as: leadership/strategic vision, evaluation (policy level), human resources, program delivery structures, training and development, cross-governmental action, financing, data/monitoring, implementation, evaluation (of programmes and interventions), partnerships and multidisciplinary work and knowledge development.

Please consult the Needs Assessment Guidance Document in the Annex. This comprises of questions relating to different relevant dimensions of public health capacity[2] that can help you identify the main gaps and needs in your country relating to health promotion and the primary prevention of cardiovascular disease, stroke and type 2diabetes, and their modifiable behavioural and social risk factors.

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[2] Aluttis C, van den Broucke S., Chiotan C., Costongs C., Michelsen K., Brand H., "Public health and health promotion capacity at national and regional level: a review of conceptual frameworks" Journal of Public Health Research 2014, 3:199.

# Glossary of Terms

The following definitions and terms have been used in the development of the questionnaire or relate to the themes discussed. Please adhere to these definitions when completing the questionnaire, in order to assure standardization in responding to its questions.

**Best practice:** An intervention, program/service, strategy or policy which has demonstrated desired changes on the basis of appropriate well documented research and evaluation methodologies. It has demonstrated through multiple implementations, the ability to be replicated, scaled up, and the potential to be adapted and transferred. A best practice is one that is most suitable given the available situation and context (*From Canadian Best Practice Portal*)

**Cost-effective**: effective or productive in relation to its cost. Cost-effectiveness analysis is a decision-making assistance tool. It identifies the economically most efficient way to fulfil an objective. In evaluation, the tool can be used to discuss the economic efficiency of a programme or a project.
*http://ec.europa.eu/europeaid/evaluation/methodology/examples/too_cef_res_en.pdf*

**Determinants of health** – the forces predisposing, enabling, and reinforcing lifestyles, or shaping environmental conditions of living in ways that affect the health of populations. *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4th edition. McGraw-Hill Higher Education. Appleton, 2004*

**Disease prevention:** this covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established.
*Adapted from Glossary of Terms used in Health for All series. WHO, Geneva, 1984*
Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours.
*WHO Health Promotion Glossary, 1998  http://www.who.int/healthpromotion/about/HPG/en/*

**Efficacy** – the extent to which an intervention can be shown to be beneficial under optimal conditions. *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4th edition. McGraw-Hill Higher Education. Appleton, 2004*

**Efficiency:** a measure of how economically resources/inputs (funds, expertise, time, etc) are converted into results. The ratio between costs and outcomes. It is to put ressources in their most valuable use (*Stokey E, Zeckhauser R. A primer for Policy Analysis. Norton & Company USA; 1978*). It may mean allocative efficiency puting ressources to produce the best output, or producing the output at the lowest cost (technical efficiency). Other definition: The proportion of total costs (eg. money, resources, time) that can be related to the number of people served or reached, or sometimes to benefits achieved in practice.
*Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4th edition. McGraw-Hill Higher Education. Appleton, 2004*

**Effectiveness:** the extent to which the development intervention's objectives were achieved, or are expected to be achieved, in real conditions, taking into account their relative importance. *OECD glossary of key terms in Evaluation and Results based management, 2002.* (In contrast to efficiency, effectiveness is determined without reference to costs.
Other definition: the extent to which the intended effect or benefits that could be achieved under optimal conditions are also achieved in practice. *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4th edition. McGraw-Hill Higher Education. Appleton, 2004*

**Enabling factor:** any characteristic of the environment that facilitates action and any skill or resource required to attain a specific behaviour. (Absence of the resource blocks the behaviour, barriers to the behaviour are included in lists of enabling factors to be developed. Skills are sometimes listed separately as predisposing factors or intermediate outcomes of education). *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4<sup>th</sup> edition. McGraw-Hill Higher Education. Appleton, 2004*

**Equity in health:** means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being. *Equity in health and health care. WHO, Geneva, 1996*

**Health**
*Various useful definitions:*

**Health:** a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. *WHO 1946*
**Health:** a dynamic condition resulting from a body's constant adjustment and adaptation in response to stresses and changes in the environment for maintaining an inner equilibrium called homeostasis. http://www.businessdictionary.com/definition/.
**Health:** a state of equilibrium between humans and the physical, biological and social environment, compatible with full functional activity. *John Last, Public Health and Human Ecology. Norwalk. CT: Appleton & Lange. 1987*
**Health:** the ability to adapt and to self manage, in the face of social, physical and emotional challenges. *Machteld Hubert in British Medical Journal in 2011*

**Health promotion:** this is the process of enabling people to increase control over, and to improve their health. *Ottawa Charter for Health Promotion. WHO, Geneva,1986*
**Health promotion** represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action. *WHO Health Promotion Glossary, 1998  http://www.who.int/healthpromotion/about/HPG/en/*

**Health inequalities** can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between **inequality in health** and **inequity**. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to **inequity in health**. *WHO Glossary of Terms, http://www.who.int/hia/about/glos/en/index1.html*

**Healthy Ageing:** The process of optimizing opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality life.
*From: Healthy Ageing, a Challenge for Europe,2007*
*http://www.healthyageing.eu/sites/www.healthyageing.eu/files/resources/Healthy%20Ageing%20-%20A%20Challenge%20for%20Europe.pdf*

**Primary prevention** is directed towards preventing the initial occurrence of a disorder. *WHO Health Promotion Glossary, 1998*
*http://www.who.int/healthpromotion/about/HPG/en/*
We use primary prevention methods before the person gets the disease. Primary prevention aims to prevent the disease from occurring. Primary prevention reduces both the incidence and prevalence of a disease.
Secondary prevention is used to arrest or retard existing disease and its effects through early detection used to detect the presence of the diseases. The goal of secondary prevention is to find and treat disease early.  Tertiary prevention seeks to arrest or retard existing disease and its effects through appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation. The goals of tertiary prevention are: to prevent

damage and pain from the disease, slow down the disease, prevent the disease form causing other problems (complications), give better care to people with the disease, make people with the disease healthy again and able to do what they used *to (CDC Levels of disease prevention,* http://www.cdc.gov/excite *).*

**Health promotion intervention:** Any planned and goal-oriented activity to influence the behaviour of citizens and their circumstances aiming to promote health or prevent illness.

**Health Care Intervention:** Any type of treatment, preventive care, or test that a person could take or undergo to improve health or to help with a particular problem.  Any type of treatment, preventive care, or test that a person could take or undergo to improve health or to help with a particular problem. Health care interventions include drugs (either prescription drugs or drugs that can be bought without a prescription), foods, supplements (such as vitamins), vaccinations, screening tests (to rule out a certain disease), exercises (to improve fitness), hospital treatment, and certain kinds of care (such as physical therapy). *Agency for HealthCare Research and Quality,* http://effectivehealthcare.ahrq.gov/index.cfm/glossary-of-terms/?pageaction=showterm&termid=95
This comes from 'intervene' which means "to become involved in something (such as a conflict) in order to have an influence on what happens" http://www.merriam-webster.com/dictionary/intervene

**Intersectoral collaboration:** a recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.
*Modified from Intersectoral Action for Health: A Cornerstone for Health for All in the 21st Century. WHO, Geneva, 1997*
*WHO Health Promotion Glossary, 1998*  http://www.who.int/healthpromotion/about/HPG/en/

**Older person:**  Ageing is multidimensional (see e.g. "New definition for old age":
http://www.sciencedaily.com/releases/2013/12/131212100144.htm*.)*
Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion, but the UN agreed cutoff is 60+ years to refer to the older population.

For the purposes of this work, older people refer to those 65 and above.
http://www.who.int/healthinfo/survey/ageingdefnolder/en/

Ageing is an important marker of the accumulation of modifiable risks for chronic disease: the impact of risk factors increases over the life course. http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf

**Policy:**
A)  definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions
B)  a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body
http://www.merriam-webster.com/dictionary/policy
A Policy is a principle or protocol to guide decisions and achieve rational outcomes. A policy is a statement of intent, and is implemented as a procedure or protocol. Policies are generally adopted by a senior governance body or Board within an organization whereas procedures or protocols would be developed and adopted by senior executive officers. The term may apply to government, private sector organizations and groups, and individuals. Presidential executive orders, parliamentary rules of order and corporate privacy policies are all examples of policy. Policy differs from rules or law. While law can compel or prohibit behaviors (e.g. a law requiring the payment of taxes on income), policy merely guides actions toward those that are most likely to achieve a desired outcome. http://en.wikipedia.org/wiki/Policy
Other definition: the set of objectives and rules guiding the activities of an organization or an administration and providing authority for allocation of resources. *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4th edition. McGraw-Hill Higher Education. Appleton, 2004*

**Plan –** the instrument for policy implementation**.** *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological  Approach. 4<sup>th</sup> edition. McGraw-Hill Higher Education. Appleton, 2004*
A plan is implemented through specific programs and projects.

**Planning –** the process of defining needs, establishing priorities, diagnosing causes of problems, assessing resources and barriers and allocating resources to achieve objectives. *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological  Approach. 4<sup>th</sup> edition. McGraw-Hill Higher Education. Appleton, 2004*

**Programme:** a plan of things that are done to achieve a specific result
*http://www.merriam-webster.com/dictionary/program*

**Public health:** Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.

**Risk factors**: this is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury.
*http://www.who.int/topics/risk_factors/en/*
A small set of common risk factors are responsible for most of the main chronic diseases. These risk factors are modifiable and the same in men and women: unhealthy diet, physical inactivity and tobacco use.
*http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf*

In the context of this questionnaire the modifiable behavioural and social risk factors includes unhealthy diets, physical inactivity and tobacco use and the underlying socio-economic, cultural, political and environmental determinants of chronic diseases (including globalisation, urbanisation and population ageing) *http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf*

The majority of cardiovascular disease (CVD) for example, is caused by risk factors that can be controlled, treated or modified, such as high blood pressure, cholesterol, overweight/obesity, tobacco use, lack of physical activity and diabetes. However, there are also some major CVD risk factors that cannot be controlled (age and heredity). In terms of attributable deaths, the leading CVD risk factor is raised blood pressure (to which 13 per cent of global deaths is attributed), followed by tobacco use (9 per cent), raised blood glucose (6 per cent), physical inactivity (6 per cent) and overweight and obesity (5 per cent).1
*http://www.world-heart-federation.org/press/fact-sheets/cardiovascular-disease-risk-factors/*
Risk factors for diabetes depend on the type of diabetes. Weight (obesity and overweight, often linked to a diet over-reliant on processed foods) and inactivity are major risk factors for diabetes 2.
*http://www.idf.org/about-diabetes/risk-factors*

**Socioeconomic status (SES)** is associated with chronic disease in large part through its effect on modifiable risk factors such as obesity, tobacco use, and sedentary lifestyle. Several recent studies have explored the association between neighborhood deprivation and risk factors and chronic disease incidence and mortality. Whereas prevention efforts that focus on individual characteristics that control behavior are important, environmental and social elements also affect personal choices, are modifiable risk factors, and deserve attention.
*http://www.cdc.gov/pcd/issues/2012/11_0305.htm*

**Social determinants of health** – the cumulative effects of a lifetime of exposure to conditions of living that combine to strengthen or compromise optimum health, and many of which are beyond the control of the individual. *Green, L.W.; Kreuter, M.W. – Health Program Planning. An Educational and Ecological Approach. 4<sup>th</sup> edition. McGraw-Hill Higher Education. Appleton, 2004*

*Annex*

# Needs Assessment Guidance Document

This guidance document has been developed to support your efforts to respond to question 5 on Gaps and Needs of the CHRODIS WP 5 Questionnaire on "Good Practice in the Field of Health Promotion and Primary Prevention". It was developed based on an Assessment Tool for Public Health Capacity developed under the EC Tender project Developing Public Health Capacity in the EU (2010-2012) as well as Quality Improvement Tools identified through the Joint Action on Improving HIV Prevention (Quality Action, 2013-2015). The themes/questions below highlight different dimensions relating to the development of effective policies (and good practice) programmes and interventions to promote health and prevent cardiovascular disease, stroke and type 2 diabetes. Going through the document can stimulate your thinking and help to make apparent the strengths, needs and gaps of your country in these areas.

You are not obliged to respond directly to all of these questions or to submit your responses. You are however strongly encouraged to think through these questions and to summarize outcomes and relevant reflections regarding needs and gaps in your response to question 5 of the Good Practice Questionnaire. The questions can also be useful in relation to question 1 of the Questionnaire, which asks you to describe the health promotion and primary prevention landscape in your country.

Please note that this is not an exhaustive list - you may identify other gaps and needs relating to the development of effective policies (and good practice) programmes and interventions to promote health and prevent cardiovascular disease, stroke and diabetes type 2. We also ask you to consider these questions from a national as well as regional/local perspective.

## Leadership/Strategic Vision

- Are there clearly identifiable leaders in the public health sector to advocate for health promotion and primary prevention[3] and healthy and active ageing issues on the political agenda and across sectors?

- Are there clear policy frameworks in place relating to health promotion and the primary prevention of chronic disease in general or for cardiovascular disease, stroke and diabetes type 2 in particular?
  - o Do policy frameworks address health inequalities in relation to socio-economic groups and regions?
  - o Do policy frameworks address healthy/active aging?

- Are there periodical (i.e. yearly) government reports that define strategic priorities and common objectives priorities in relation to primary prevention and health promotion?

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[3] If health promotion and disease prevention in your countries are considered as separate policy areas, please consider these questions in relation to each of these areas.

- Do the Ministry of Health and other relevant public bodies issue guidelines for the implementation of the most effective methods of health promotion and primary prevention for cardiovascular diseases, stroke and diabetes and their modifiable behavioural and social risk factors?

## Evaluation (Policy level)

- Do national and regional governments periodically evaluate the implementation of primary prevention and health promotion policies and programmes?
  - o Do the policy evaluations take into account differential impact on socio-economic group and/or regional inequalities?
  - o Do policy evaluations focus on differential impact on age groups?

- Are these policies and programmes regularly reviewed and revised to take into account the outcomes of policy evaluations, as well as changing trends and health priorities identified through an analysis of health information systems?

- Are there mechanisms to scale-up those policies, programmes and interventions that have been identified as 'good practice' and/or transfer these from one region to another?

## Cross-governmental action

- Do the policy frameworks support strategic planning for health promotion and primary prevention by improving synergies across sectors, policies and programme areas (e.g. health in all policies)?

- Are Health Impact Assessment Tools being applied to evaluate the potential impact of other policy sectors on population health including cardiovascular disease, diabetes and stroke?

- Do policies and plans in sectors other than health acknowledge their implications and impact for population health, in relation with healthy and active ageing, cardiovascular diseases, diabetes type2 and stroke and their main risk factors?

- Are there cross-governmental mechanisms in place to ensure coordination and effective implementation of interventions to address chronic disease prevention and their risk factors, including health inequalities and the socio-economic determinants of health?

- Are public officials in sectors that impact on health provided with information /training on chronic disease and their risk factors?

## Financing

- Are there sufficient resources for health promotion and primary prevention?

- Is there a stable and predictable flow of financial resources for health promotion and primary prevention programmes (i.e. annual allocation of funds) endorsed by financial regulations?

- Do budgetary timeframes enable medium and long-term planning to address chronic diseases?

- Are processes to allocate funding for primary prevention and health promotion transparent and publicly known?

## Data/Monitoring

- Does the national health information system collects, processes and analyses data in relation to cardiovascular disease, stroke and type 2diabetes adequate?
  - Is the health information system collecting data in accordance with EUROSTAT, EU-level surveys and WHO data reporting requirements?

- Are there periodical (i.e yearly) publications/reports on the health of the population in relation with cardiovascular diseases, diabetes and stroke and their modifiable risk factors (tobacco, poor diets, lack of physical activity)?
  - Is it timely (e.g. tracking on a yearly basis)?
  - Is the data stratified by at least two social markers (e.g. education, income/wealth, occupational class, ethnicity/race?
  - Is the data broken down by age groups?
  - Is the data stratified by sex?
  - Is the data stratified by at least one regional marker (e.g. rural/urban, province)

- Is there access to/can health related data be correlated with data from other sectors addressing the socio-economic determinants of health (e.g., employment, education, environment, transport, etc.)

## Implementation

- Are policies relating to health promotion and the primary prevention of chronic disease in general/cardiovascular disease, stroke and type 2 diabetes in particular being implemented in practice?

- Is there adequate coordination between the different bodies in the health sector (Ministry of Health, national and regional health institutes, foundations and NGOs focusing on chronic disease, insurance companies, private organisations) involved in the implementation of primary prevention and health promotion policies and programmes?
    - o Are there legal mechanisms and policies in place to support formal partnerships between NGOs, civil society, and government to address priorities in primary prevention and health promotion

- Are programmes and interventions sensitive to specific needs of more vulnerable groups (such as: adolescents, socio-economic disadvantaged, elderly, migrants, ethnic minorities and others)? Are there specific programmes/interventions that are targeted to the needs of more vulnerable groups?

- Are programmes and interventions sensitive with regards to gender, age and other cultural, social or linguistic dynamics?

- Is there adequate capacity, in terms of human resources, to deliver health promotion and primary prevention programmes and interventions?
    - o Are there opportunities and incentives (e.g., career development options, salaries, better working conditions) for professional development in relation to public health/chronic disease prevention and health promotion?
    - o Do public health training curricula include information on health equity and the socio-economic determinants of health?

## Evaluation (of programmes and interventions)

- Are health promotion and primary prevention programmes and interventions evaluated on a regular/systematic basis?
    - o Is there a sufficient resource base/capacity to evaluate the health promotion and chronic disease prevention programmes and interventions?

- Is the cost-effectiveness of health promotion and primary prevention programmes and interventions analysed on a regular basis?
    - o Is there sufficient resource base/capacity to undertake cost-effectiveness analyses

- Are outcomes of evaluations and cost-effective analysis used to inform and revise practice?

## Partnerships and multidisciplinary work

- Are health promotion and primary prevention programmes and interventions integrated into the practice of health care services?

- o Do health care professionals receive training to develop primary prevention and health promotion competencies as part of their basic training curriculum?
- o Are there multidisciplinary teams in place in primary health care that address health promotion and primary prevention?
- o Are there structures and mechanisms in place within the health care services to respond to the needs and priorities of more disadvantaged or vulnerable groups?

- Do effective partnerships exist amongst health authorities/organisations and other public and private sector organisations active in areas that relate to the social determinants of health and health inequalities?
  - o Is there e.g. adequate coordination between the health sector, the social care sector and care services for the elderly?

## Knowledge Development

- Are there an adequate number of university departments and research institutes engaging in research on effective primary prevention and health promotion programmes and interventions?

- Is there adequate professional expertise and capacity within university departments and research institutes to establish the effectiveness of primary prevention and health promotion programmes and interventions?

- Are research findings and results communicated to policy and decision makers and taken up in relevant policies?