Joint Action on Chronic Diseases & Promoting Healthy Ageing across the Life Cycle

Work Package 5: Good practices in the field of Health Promotion & Disease Prevention across the life cycle

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Annex to the report: Study visits documentation

Recommendations report on applicability and transferability of practices into different settings and countries

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

THIS REPORT ARISES FROM THE JOINT ACTION ADDRESSING CHRONIC DISEASES AND HEALTHY AGEING ACROSS THE LIFE CYCLE (JA-CHRODIS) WHICH HAS RECEIVED FUNDING FROM THE EUROPEAN UNION, UNDER THE FRAMEWORK OF THE HEALTH PROGRAMME (2008-2013).

Annex Study Visit Documentation to the Recommendations report on applicability and transferability of practices into different settings and countries

This annex documents the study visits which took place in the framework of the WP5 Health Promotion and Disease Prevention of JA-CHRODIS between April and June 2016.

It includes a brief overview of the practice visited, a summary of the presentations and discussion minutes as well as an overview of the potential for transferability for each of the good practice studied, based on participants' views and their replies to the questionnaire that was devised for each study visit. The questionnaire is also included at the end of the annex.

More detailed information about the practices visited can be found in the Report "Good Practice Examples In Health Promotion & Primary Prevention In Chronic Disease Prevention; a link is provided for each of them.

Also included in this report is a study visit to the Netherlands, which focused on building national databases. This is not a good practice per se, but the interest on building databases arose among participants at a previous meeting and partners decided to couple the study visit to the good practice JOGG with more insight into how partners build databases.

Many thanks go to the participants who took minutes and who wrapped up the transferability sheets:

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1. Iceland – The Welfare Watch

1.1 Introduction: Aims and objectives of the Welfare Watch

The Welfare Watch is a national level platform, involving key stakeholders from all sectors and levels, providing important data and insight in general, informing policy and actions with the aim to secure welfare (health and social security) for all citizens. It was set up following the economic crisis in 2008, after which all political parties promised to protect the welfare state and to monitor the consequences of the financial crisis on individuals. Its main objectives are to collect information (impact of crisis) and give recommendations (for action) to the ministries, government and the local authorities.

The Welfare Watch consists of one steering group and 8-9 working groups, with a focus on vulnerable groups, which were: children/youth, long-term unemployed and unemployed young people. The main idea was to prevent the formation of a 'lost generation', following feedback from Finland.

The Welfare Watch uses social indicators rather than economic indicators (finding e.g. single parents had trouble finding housing which would have been missed by solely economic indicators). The social indicators collect data for one decade (measuring the difference in 10 years), carried out by the national statistics office.

There is no 'official' budget for the Welfare Watch. People are investing their working time (on average 10-15 hours of work per year as part of a working group) but are also encouraged by their organisations because the Minister of Social Affairs and Social Security saw the benefits of the Welfare Watch and supported it.

Examples of actions proposed and carried out by the Welfare Watch:

- Lunch guaranteed to all school children. Extra costs for families kept lowest if possible.
- Request to authorities to caution in cutbacks in services
- Protect payments to parents in parental leave

A new Welfare Watch was set up in 2014. Many more people got involved and new stakeholders were added to the table. The focus shifted towards extreme poverty and low income families (e.g. single parents).

Further information here, p. 265.

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1.2 The Welfare Watch Approach: Summary of presentations and minutes

Presentations:

- The Icelandic Welfare Watch & 2nd part

The Icelandic Welfare Watch: lessons learnt

Since it was an initiative set up by the ministry itself, the people/stakeholders who were asked to join all agreed, including politicians. At present, the Welfare Watch is highly appreciated and many people want to join. The advice given is always founded and based on own research or literature.

The response to the economic crisis in Ireland was very different, e.g. Ireland supported the banks rather than letting them collapse. There are also no social indicators, so they can't be sure what the effects of the crisis were/are. The support of Ministry of Welfare is crucial

The main outcomes of the Welfare Watch were clear policies and the social indicators. Housing situation and health are the most important aspects on which the crisis had an impact.

The list of social indicators used for the Welfare Watch is unfortunately not available in English, but a brief list could be downloaded from the national statistics office.

Who chose which indicators to use? This was done based on a combination of how group was built; a close working group that split into 4 areas and building up the indicators with sociologists or statisticians. Many indicators came from other countries. The research community, committed politicians and grass root level also had an influence on the choice of indicators.

- Demography (age, gender, immigration, people in schools….)
- Welfare & income
- Health
- Closeness in community

Different sectors were included in the development of the social indicators. More wellbeing indicators will be added in the new Welfare Watch.

The most important social indictors to monitor throughout the recession/crisis included access to healthcare, secure housing, welfare of children, employment, leisure activities for children.

What are the main facilitators for the implementation of the Welfare Watch? First of all, the Welfare Watch was (politically) independent. The chair was not political and did a very good job in chairing the meetings, facilitating engagement and a relaxed environment, so that discussion could be open and free. Authorities prioritised the work of the Welfare Watch and everyone was involved and felt the objectives were important.

The main barriers for the implementation of the Welfare Watch were that municipalities cannot be told what to do. Politicians might disagree with recommendations. Collaboration between sectors was difficult at times (different kinds of NGO with different agendas).

Do you think being a small country helps? Twofold answer: Yes, because you get to meet also in other settings and informally. But when you know a person, it can also hinder.

1.3. Local level experiences

Presentations

- The Suðurnes Welfare Watch – transferring good practice to the local level
- TINNA – project supporting single parents receiving financial aid from the City of Reykjavik

1.3.1. The Suðurnes Welfare Watch

The Suðurnes Welfare Watch was established in 2011 in response to high unemployment rate after a military base closed in 2006 and the economic crisis in 2008. The main objective was to enhance collaboration with the local authorities in the field of welfare and to stimulate employment and education in the region. Various projects are being carried out, e.g. a conference on all social benefits available to unemployed people, annual reports mapping the indicators for the region and a campaign against domestic violence. Much national media attention gave the region a bad name.

Results of Suðurnes Watch:

- Stronger connection between people in welfare
- Awareness of resources available
- Documentation produced
- Participation and awareness of the ministry
- Future cooperation

1.3.2. TINNA

TINNA is a project to support single parents and their children who receive financial aid. In 2011, the welfare department in Reykjavik decided to conduct a survey to get better information about the situation poor parents in Reykjavik are facing, with emphasis on social network, leisure and health of their children. The survey showed a clear social gradient: according to the parents' income, children's participation in leisure and sport activities differed as well as health and social network differed.

With funding from the ministry of welfare, a pilot project was set up for 2 years (2016-2018) funding 2.5 fulltime social workers. The main aim of TINNA is to provide holistic support from both state and local services according to the need of the families on an individual basis and in a group. This includes providing opportunities for education and/or employment, training, assistance concerning housing, parenting, finance and leisure activities.
The Welfare Watch took interest in the project and introduced it to the funding body (Ministry of Welfare) and the Department of Welfare of Reykjavik.

Lessons learnt

Funding is now secured for two years. Do you have any idea to make the intervention sustainable who will ambassador for reading results after two years? A: Hope more financial support. More institutions work together, formal employees from other institutions.

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Core elements of success are first and foremost the exclusive dedication of persons to the project. Also to have base for this outside the service centre. If it goes well, it would be interesting to go where there is social housing, because we need to change the culture there.

1.4. The Nordic Welfare Watch 2014-2017 – Background and overview of the work

Presentations

- The Nordic Welfare Watch 2014-2017 – Background and overview of the work
- The Nordic Welfare Watch – In response to crises
- Welfare consequences of financial crises
- The Nordic Welfare indicators

When Iceland held the presidency of the Nordic Council of Ministers, it set up three projects (2014-2016), one of them was the upscaling of the Welfare Watch: the Nordic Welfare Watch. The aim with the Nordic Welfare Watch project is to promote and strengthen the sustainability of Nordic welfare systems through cooperation, research and mutual exchange of the experience and knowledge acquired. The objective is also to develop solutions and coordinate actions to meet future challenges and to develop welfare indicators which can be useful for policy making. The Nordic Welfare Watch is divided into 3 separate projects (for more info, see following chapters):

- The Nordic Welfare Watch - in response to crisis
- Welfare consequences of financial crises
- Nordic welfare indicators

Discussion

It is good to see the comparison. Ireland lacks strong welfare system from the start. Iceland does not have a strong welfare system and is more like the UK, Portugal or Spain, our story shows that it is possible to make policy changes.

The Nordic Council funds 3 years of the Nordic Welfare Watch. What are the core elements to transfer from Iceland to the Nordic setting? It might be difficult to transfer the Welfare Watch exactly as it is, because of certain circumstances and being a small country. For example, the indicators were adapted. The Nordic Welfare Watch is more like a dialogue, to be more active rather than reactive.

What would be the core recommendations how Ireland could do better from your perspective? Countries are not giving money to the welfare systems. Come to terms with doing more with what we have right now. Let's enhance cooperation. For example, Iceland imported ideas and policies from Finland, who were saying "Learn from our mistakes". Last but not least, it is important to keep in mind that successful policies are imported.

Invisible crisis is the crisis of trust in public institutions (politics, banks, courts)

1.4.1. The Nordic Welfare Watch – In response to crises

The underlying idea is to approach the impact of crisis in terms of health promotion. Crises affect people with chronic diseases and thus appropriate responses to man-made as well as natural disasters are relevant to chronic disease prevention. The aim of the Nordic Welfare Watch in this particular area is to minimise effects of crises and to build strong relationships across all governmental levels and organisations. Vulnerable groups are hit the hardest by crises; class and race have impacts on both recovery and long term effects. The main determinants of degree of consequences following a crisis are (I) economic status, (II) health & age, (III) origin and (IV) family status. It is being said that resilient society "bend but they do not break".

Nordic countries are known for their welfare systems and social services but few studies have addressed their role in crises. This project brings together 30 experts, stakeholders and scholars on national advisory groups.

What are we doing in this project?

1. Examine the role of social services in the preparedness & emergency system
2. Evaluate the activities in Iceland
3. Map the known risks that Nordic countries face
4. Evaluate if there is a need for Nordic countries to develop crises responses

Why we are doing this?

- Interest in lessons learned from the Icelandic Welfare Watch
- Strong welfare system in all countries
- To avoid consequences if a new crisis occurs

1.4.2. Welfare consequences of financial crises

Effects of the economic crisis in 2008 were felt throughout Europe. Iceland was one of the countries that was hit very hard. Economic crises can have destructive effects on well-being. In Iceland, social policy and social policy interventions played a big role in the country's recovery. There are two strategies available for the government to counteract the effects of crises.

- Active fiscal policy
- Active social policy (focus on those affected)

In Iceland, the welfare state was systematically protected, while other sectors experienced cutbacks. Social policy in Iceland included:

- Benefits raised
- Rights to unemployment benefits extended
- Special housing benefits introduced
- Tax burden on lower income groups decreased
- Unprecedented household debt relief

Iceland pursued a mixed approach due to (and leading to):

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Weak fiscal position, massive budget deficit and conditionality attached to IMF loans, which led to fiscal consolidation
Grass roots pressure, economic hardship affected most, political actors in power prioritized welfare state, which led to social protection
The experiences from Iceland point towards the following lessons. Economic crises can have devastating effects on the well-being of individuals. Icelandic authorities actively employed the welfare state to shield those who were severely affected by the crisis, while also consolidating government finances. Iceland was quite successful compared to other European countries in terms of lower unemployment and less poverty due to the crises, without negative consequences for growth. All in all, this indicates that a strategy of redistribution is a feasible approach, which offers an alternative to austerity.

1.4.3. The Nordic Welfare indicators

Icelandic social indicators: Yearly collection of 41 indicators across five chapters (demography, equality, social sustainability, health and cohesion). This is highly influential (government, parliament, social partners, media) and presented by the minister. Special thematic reports focus on e.g. housing, tenure status, quality of life of children and poverty.

Nordic countries: Limited amount of indicators (ca. 30), used to highlight the Nordic dimension and to improve the comparability of the Nordic countries. As these countries are similar, their policy challenges are also similar and the indicators very relevant for policy makers across the Nordic countries.

The Nordic welfare indicators are:

- Health dimension
- Work-life balance
- Educational skills
- Social participation
- Civic engagement and accessibility
- Personal security
- Subjective well-being
- Income and earnings
- Employment
- Housing

It is difficult to measure and to compare indicators on disability. Which definition to use would already lead to difficulties.

1.5. Discussion on transferability

1. **What do you consider the "fundamental nature" of the original intervention that should be preserved?**

    - When in times of crisis, it is essential not to cut from basic services and to support vulnerable groups especially.

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- The utilisation of data (social indicators) to inform policy and practice, focusing on vulnerable groups; Bringing together community resources for prevention and health promotion.
- The outcome of such process, which has been defined as actions at local level and subprojects, i.e. TINNA, Sudurnes, etc., and an attempt to modify the content of the Nordic Council indicators). EU member countries, which actually may be on a lower development level of social services, should be able to understand (to perceive) such development as an alternative either at municipal level or at National Statistical Institutes. The fundamental nature to be preserved is social development and equity.
- It is important to start implementation in a small region and later expand to national level.
- Partnerships with all relevant stakeholders within the community; Independent advice to the government; Monitoring social indicators
- The intersectoral and multi-level approach.

2. **What are essential elements of project management and project governance of the primary intervention?**

- Organisational structures (responsibilities) are clearly defined, sources of funding are specified.
- For the IWW, it would appear that citizens' movements and a public administration sensitive to citizens' needs are such elements.
- Cross-sectional steering and working groups.
- To involve many stakeholders from the different fields, including authorities and NGO's. If the project is implemented in one region – it should be managed by local authorities.
- Support from the government and stakeholders
- The high level intersectoral commitment (four ministries). The creation of working groups to support the steering committee.

3. **What are indispensable conditions of the original context?**

- One of the costliest financial crashes in history started in 2008. Iceland had big bubble economy – in terms of debt accumulation and speculation. Unemployment level was very low before the crush and Iceland had to face very different levels of unemployment. Iceland has also a very small population. Social policy interventions played an important role in recovering from the financial crush.
- Collaboration between different stakeholders across sectors and levels; durable political will and support.
- The population's awareness about the problem (difficult to achieve without external negative factors) determining in some way a defensive action.
- Additional funding is not necessary if people are interested in improving public health.
- Sense of urgency from the Ministry not to cut down on health and welfare during the crisis.

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- The country and population sizes.

4. **What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?**
   - Availability of documents and tools used in primary intervention.
   - Understanding of the nature of the primary intervention and the implications at each decision level. 2. Identification of existing matched elements (for instance in political/administrative institutions and services providers) between the populations where primary and the replica interventions occurred.
   - To present the practices to the authorities and/or ministry of health trying to explain, that only multi-sectorial collaboration is able to implement a good practice.
   - Social indicators
   - A report about the monitoring of implemented proposals, their results and impacts, strengths and weaknesses.

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2. Iceland – The National Curriculum Guides and the Pillar "Health and Wellbeing"

2.1 Introduction: Aims and objectives of the National Curriculum Guides

In 2011, a policy framework for Icelandic schools, the "National Curriculum Guides" for pre-, compulsory and upper secondary schools were published by the Ministry of Education, Science and Culture. This policy achieves a milestone by defining "health and wellbeing" as one of six fundamental pillars of education, thereby confirming the importance of health and wellbeing for education and vice versa.

The Guide describes the role of education in schools according to Icelandic laws and regulations, the objectives and organisation of school operations and the requirements and rights of everyone in the school community. The fundamental pillars are meant to accentuate the principle of general education and encourage increased continuity in school activities as a whole.
Six fundamental pillars have been developed within this framework. These are:

- Health and wellbeing
- Literacy
- Sustainability
- Democracy and human rights
- Equality
- Creativity

Further information here, p. 38ff.

2.2. The National Curriculum Guides and the Pillar "Health and Wellbeing": Summary of presentations and minutes

Presentations

- The Curriculum Guides and the Pillar "Health and Wellbeing"
- Health promoting preschools, compulsory schools and upper-secondary schools as a mean to implement the pillar "Health and Wellbeing"
- Breiðholt – An example of a health promoting district in a health promoting city

Discussion on Transferability

- Schools do not specialise on one of the pillars, e.g. creative or healthy school. They are supposed to implement all pillars throughout school life.
- The Directorate of Education performs external evaluation for The Ministry of Education, Science and Culture as well as the Pillar. They visit pre-, compulsory and upper secondary schools every fifth or sixth year. During this evaluation they look at the laws for schools and the implementation

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on the whole curriculum, including all six pillars. They look at available data on school activities, visit classrooms during school hours and then they interview students, school staff and parents.

- Implementation depends on minister's/ministry's commitment. There is no legislative enforcement or policy about the implementation.
- Specific teaching materials (in Icelandic) have not been produced. However, the website (www.namtilframtidar.is) is available with info for parents. It also holds OECD reports for teachers as well as hands-on materials. Various books have been published for all pillars with ideas for lessons.
- Students from upper secondary schools are involved in decision-making process.

2.2.1 Health promoting schools project

Preschools, compulsory schools and upper secondary schools have started to implement the pillar "Health and Wellbeing" through the project "Health-Promoting Schools". Rather than a project with a specified end, it is seen as a trend or general approach. It aims to support schools for school health and encompasses different themes, like physical activity, mental health and nutrition.

In order to become a health promoting school, the school needs to fill in an application and appoint a coordinator. A group is gathered by teachers, other staff, administrator, nurses, counsellors and the canteen. Students and parents should also be involved in the preparation and development. It is important to first discuss the policy the school wants to achieve, and then go through the checklist. The policy also has to be written down in the school's curriculum.

An interactive website containing e.g. information about the steering group, written health policy, checklists, action plans and evaluation will be available soon.

2.2.2.Breiðholt – A health promoting district in a health promoting city

The project showcases how a district can become health promoting. The base for it was the prevention policy in Reykjavik (general matters included: eat, sleep well…) and agreement between the city and DOHI. The support from the political level was essential on a conceptual level, while DOHI's support was essential to carry out the project.

The project is structured: Vision Long term objectives Strategies. The strategies, or action plans, are the ones actually being implemented.

42 organisations signed up (i.e. committed to actions) and 33 of them are implementing them. The organisations range from kindergartens and schools (all levels), sports clubs, homes for disabled people and senior citizens.

Note: HP Breidholt is funded by Reykjavik city (municipality) which funds one position, the coordinator.

2.3. Implementation example from the compulsory school Hamraskóli in Reykjavik

Presentations

- Implementation of the pillar health and wellbeing/Health promoting school, example from the compulsory school Hamraskóli in Reykjavik

Physical education teacher, Erla Gunnarsdottir, explained how the pillar "Health and Wellbeing" was implemented through the project health-promoting schools at the elementary school Hamraskóli in Reykjavik. She is the coordinator for this at her school and very committed.
Part of it since 2011, each year focused on a different health promotion subject (e.g. exercise & diet, mental health & school wellbeing, lifestyle).
LEARNINGS. "The activity is not a sprint but rather a marathon" and the leadership of the headmaster of school is crucial. PE teachers are not strong enough to control the policy of the school. The parents' involvement increased.

Lessons learnt

- Health promotion is for all and must be equitable. Sometimes families in Breiðholt do not have money for food and at the same time they are encouraged to enroll their children in sports.
- Advertising decisions affect health. There is a need for legislation for advertising (alcohol, soft drinks…). But sports clubs need the funding from industry. Offering certain drinks at sports' centre bars to children should not be allowed (e.g. offer sports drinks instead of soft drinks). Answer: if legislation is not feasible, at least rules should be issued that apply to schools. But it differs per schools.
- You need someone to coordinate it but every teacher should take part in the team work. Many teachers and one policy means heterogeneous positioning.
- Are there possibilities to feedback results and successes to politicians? Yes, but mostly only for specific issues such as alcohol.
- There were no changes in schedules of the school. If no extra, special dedicated time in curriculum, how can it be taken up? In the way we teach, in the breaks and through three times per week PE classes. Does this entail extra work for teachers? It needs to be flexible. HP is a support, that can add to your job and that you can tailor to it. In addition, motivation is key. You have to work with the reality available to you.
- How does Iceland rate on physical activity compared to other countries? What is the culture in Iceland? Nordic countries similarly high on physical activity. Children do go outside during recess. The sport association system is also very strong in Iceland.

2.4. Discussion on transferability

1. **What do you consider the "fundamental nature" of the original intervention that should be preserved?**

   - The identification of determinants of behavioural factors behind some chronic diseases incidence and the purpose of their modification by education either by creating an atmosphere of health culture or by specific interventions such as the project of Healthy Cities or Healthy Schools.
   - An effective partnership and the cross sectional (state, municipalities/districts, schools) approach.
   - The health in all policies approach and the fact that policy measures are likely to be far more effective compared to voluntary approaches to implement health and wellbeing in schools. Formal support from the Ministry of Education is essential to implement an effective approach to health and wellbeing in schools. In contrast to the earlier voluntary model of Health Promoting Schools in Iceland it already appears that this model will be far more effective. It is not a stand-alone model but is embedded within a healthy communities approach. Triangulation of this educational policy approach with support from the Health Promotion Schools Project and the healthy communities approach which supports the work of the school looks like it will be very effective.
   - The utilisation of data (social indicators) to inform policy and practice, focusing on vulnerable groups.
   - Bringing together community resources for prevention and health promotion.
   - Health and Wellbeing is one of the six fundamental pillars of education. Pillars should be visible in learning and teaching, working methods, organisation and development plans of schools etc.
   - It is important to start implementation in a small region and later expanded to national level.
   - Evaluation framework; Health promotion schools project; Education material
   - The implementation integrated in the system may assure the sustainability.

2. **What are essential elements of project management and project governance of the primary intervention?**

   - Organisational structures (responsibilities) are clearly defined; sources of funding are specified.
   - The key aspects are (a) the perception at certain administrative or political levels about the presence of an empty space for health in educational plans and (b) the capacity to provide an answer with regard to healthy life habits (physical activity, etc).
   - Cross-sectional steering and working groups.
   - The Ministry of Education, Science and Culture has led out on the development of the Guides and evaluation of the implementation of the Guides is embedded within broader educational policy which places health and wellbeing on a par with other aspects of education in Iceland. The Ministry of Education promotes the Health Promoting Schools Projects, coordinated by the Directorate of

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Health, as a suggested means towards success in implementing the "Health and wellbeing pillar". This ensures that learning from those skilled and experienced in promoting wellbeing in schools is captured and built upon to ensure effective implementation. School principals now take ownership of implementing schools health promotion as it is a requirement of their curriculum.

- The involvement of many stakeholders from the different fields, including authorities and NGO's. If the project is implemented in one region – it should be managed by local authorities.
- Health and Wellbeing is one of the six fundamental pillars of education. Some funding is available to implement the pillars. Education materials for schools are made available by the ministry.
- The freedom of each school to adapt the implementation according to their needs; external evaluations.

3. **What are indispensable conditions of the original context?**

- Collaboration between different stakeholders across sectors and levels; durable political will and support.
- A high level of knowledge about behavioural determinants of health and a notion of wellbeing and health as overlapping with wide human-life areas.
- One of the costliest financial crashes in history started in 2008. Iceland had a big bubble economy – in terms of debt accumulation and speculation. Unemployment level was very low before the crush and Iceland had to face very different levels of unemployment. Iceland has also a very small population. Social policy interventions played an important role in recovering from the financial crush.
- Recognition of the importance of embedding health and wellbeing in schools' educational policy – the health in all policies approach.
    1. Willingness of the Ministry of Education, Science and Culture to advance the health promotion agenda in schools and adopt health and wellbeing as a theme in the Guides.
    2. Recognition of the important role of the Health Promotion Schools Team in implementing the health and wellbeing theme.
    3. Funding to develop supporting tools such as the website and training events.
- Additional funding is not necessary (e.g. in National Curriculum Guides) if people are interested in improving public health.
- Sense of urgency from the Ministry of Education (instead of Ministry of Health), and thus a very strong political commitment at national level.
- The country and population sizes.

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4. **What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?**

- Availability of documents and tools used in primary intervention.
- Understanding of the nature of the primary intervention and the implications at each decision level.
- Identification of existing matched elements (for instance in political/administrative institutions and services providers) between the populations where the primary and replica interventions should occur.
- The process of partnership working between the Ministry for Health, the Directorate of Health and the Health Promotion Schools Coordinators in Iceland to guide future approaches to implementing something similar in other contexts. It would be useful to document this learning in a way that can be easily accessed by others who wish to implement a similar approach.
- A full suite on the background supporting documentation when developing the Guides.
- Documentation on the development of the website to avoid 'reinventing the wheel' if it is going to be implemented in another state; documentation in English on all aspects of the evaluation of the implementation of the Guides.
- A more detailed budget for developing the supporting tools including the website and additional documentation.
- To present the practices to the authorities and/or ministry of health trying to explain, that only multi-sectorial collaboration is able to implement a good practice.
- Employees of the ministry of health contact schools personally to assist the schools with the implementation of the health and well-being pillar. The evaluation framework will help the schools to monitor the progress. Education materials are developed that can be used by schools to implement the health and well-being pillar.
- Detailed evaluation criteria and some examples of good practice.

3. Italy – The Lombardy Workplace Health Promotion (WHP) Network

3.1. Introduction: The WHP aims and objectives

The Lombardy Workplace Health Promotion (WHP) Network is a public-private network, carried out by building partnerships and collaboration with all workplace main stakeholders: associations of enterprises, trade unions and the regional health system. The aim of these joint efforts of employers, employees and society is to improve health and welfare in the workplace. WHP addresses the following issues:

- improvement in work organization and working environment
- encouragement for staff to take part in healthy activities
- promotion of healthy choices
- encouragement of personal development (empowerment)

The programme involves the accreditation as a “Health Promoting Company” for enterprises which introduce practices of proven effectiveness and which may be considered “Good Practices” in the field of health promotion and sustainable development. The areas of good practice are: nutrition, tobacco, physical activity, road safety, alcohol and substances, and well-being. Member companies should implement two new good practice activities every year over three years to maintain the "Workplace Health Promotion Site"- logo. Activities can be of different nature: informational (smoking cessation, healthy eating, etc.), organizational (canteens, snack vending machines, agreements with gyms, stairs health programmes, walking / biking from home to work, smoke-free environment, baby pit-stop, etc.) and collaboration with others in the local community (Associations, etc.).

The objective of the WHP Network is not to award a “certificate of excellence” to just a few leading companies but rather to extend the Network to as many companies as possible in order to promote self-assessment and improvement as regards health promotion, welfare and sustainability.

The results are surprising in terms of network and adhesion. The WHP Network expanded on a regional scale during 2013 and is made up of companies ("Workplaces") which recognize the value of corporate social responsibility and undertake to be "environment conducive to health", with the scientific support of the Local Health Agency where necessary.

3.2. The WHP Approach: Summary of presentations and minutes

Presentations

- Italy's strategy on NCDs and prevention, Daniela Galeone (Ministry of Health)
- Health promotion programmes in the community setting in Lombardy, Danilo Cereda (Lombardia Region)
- Health promotion and corporate social responsibility (CSR): The intersectoral process; Elisa Rotta, Fondazione Sodalitas

3.2.1. Italy's strategy on NCDs and prevention

The national situation in terms of NCDs raises concerns: Cardiovascular diseases account for 38% of deaths, cancer for 30% of deaths, and the incidence is increasing. The Italian strategy to strengthen the prevention of NCDs and to promote health relies on several plans:

- The National Health Plan, which defines all the health priorities;
- The National prevention plan and Programme: "Gaining health: making healthy choices easier";
- CCM National Center on Prevention and diseases control, whose activity is focused on projects dealing with main health themes.

A government initiative led by the Ministry of Health based on institutional alliance (Ministries, Regions and Municipalities) and partnership with the food industry, distribution networks, civil society etc. has led to an intersectoral strategy to prevent NCDs. The tools used include:

- National platform on food, physical activity and tobacco;
- Memoranda of understanding;
- Surveillance system;
- Centre for diseases control.

Examples of partnerships include:

- Partnership between health and education. They adopted an approach based on the model of "Health promoting schools ";
- Voluntary agreement with the main national associations of bakers in order to reduce the intake of salt. The Salt reduction strategy saw a reduction of 5-15% of salt;
- The National prevention plan, which is a programmatic document shared between State and Regions that engages all the Italian regions to implement prevention programmes addressed to the population. The first plan was launched in 2007; the new plan for 2014-2018 reinforces the role of health promotion and prevention as factors of society development. The plan foresees actions in different settings, such as schools, workplace and the community.

The strategy takes into account and shares ways with the EU and the WHO (e.g. global action plan).

3.2.2. Health promotion programmes in the community setting in Lombardy

The Lombardy region has a population of about 10 million people. The healthcare system is governed by the DG welfare (regional governance), 8 ATS (Health Protection Agency) and 27 local social and health authorities. Lombardy's Regional prevention plan for 2015-2018 includes 13 programmes that contribute to the national goals and objectives such as efficacy/effectiveness, sustainability, multidisciplinary approach, intersectoral approach, accountability and equity.

Six programmes aim to improve healthy lifestyles and the promotion of environments as well as preventing NCD risk factors. The Workplace Health Promotion (WHP) Networks is one of the programmes.

The Workplace health promotion (WHP) from a regional point of view:

- Has been established as one of the priority settings;
- The concept helps companies to keep a healthy, qualified and motivated workforce, and to compete in the marketplace. It is also an internal process of continuous improvement;
- However, the health of workers is also affected by non-work related factors.

Companies who participate in the programme receive an annual certificate "Health promoting workplace".

The Health Protection Agencies (ATS) provide methodological expertise and guidance.

Among the recommended key practices, the most implemented ones include:

- Inclusion of fruit and vegetables in the menu
- Intervention in the canteen
- Bread with reduced salt
- Wholewheat bread
- Vending machines with at least 30% of healthy choices
- Promotion of bicycle or pedestrian street to reach the workplace
- Policies and interventions for alcohol free and tobacco free workplaces
- Work-life balance practices.

Lessons learnt

34% of companies who implemented the programme are in the healthcare sector (hospitals, health protection agencies, etc.). The majority of the companies are mid-size or big companies of over 50 employees. The complexity of the programme makes it difficult to evaluate and see the efficacy and in particular the cost-effectiveness of the interventions.

3.2.3. Health promotion and corporate social responsibility: The intersectoral process

The European Commission included the enhancement of CSR visibility and dissemination of good practices in its Agenda for action 2011-2014. Management systems and certification have been foreseen: ISO 26000 on CSR as well as environmental and social certifications (e.g. ISO 14001 and SA 8000).

Michael Porter on Corporate shared values: "*CSV may be defined as the system of policies and operational practices which reinforce corporate competitiveness, at the same time improving the economic and social*

conditions of the community where it is operating. Shared value creation focuses on the identification of connections between economic and social progress."

The CSR Europe Network launched the Manifesto Enterprise 2020, which outlines business contribution to the smart, sustainable inclusive growth of the Europe 2020 strategy and identifies three priorities: employment and workplace innovation; the promotion of sustainable consumption lifestyles; and transparency and human rights. In particular businesses need workplace innovation to address crucial trends such as ageing population and late retirement age.

WHP is a multi-stakeholders programme within the company (it involves HR, communications department, procurement, etc.) as well as outside the company (local health authorities, trade unions, community reach, other companies, etc.). The programme also helps to build local partnerships.

Some of the key strengths of WHP that businesses appreciate:

- Integrate in an organic framework
- Share good practices
- Participate in a well monitored programme, with benchmarking opportunities
- Investment in human capital

Business challenges:

- Implement evidence based practices
- Network outreach beyond enterprise boundaries, with other businesses and existing local resources
- Enhance project ownership, further integrating it in corporate policies

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3.3. Local experience: The WHP programme and the WHP Network of Bergamo

Presentation

- The WHP programme and the WHP Network of Bergamo; Roberto Moretti – WHP ATS Bergamo

Lots of models of WHP exist in theory, but Italy did not have any operational model. The province of Bergamo piloted the WHP Network with two mid-size companies in 2011. As of June 2016, 453 companies in Lombardy were involved in WHP, including 212.673 workers; out of them 100 companies were involved in the province of Bergamo, representing 24.000 workers.

According to Roberto Moretti, WHP was a success thanks to some key components listed here:

1. **Partnership opportunities**: Businesses partner with industrial unions, workers unions, institutions and scientific societies.
2. **Motivation/communication**

Showing life expectancy data and explaining that active ageing makes the difference and that introducing a combination of healthy lifestyle factors help. E.g. a study looked at the impact of the combination of healthy lifestyle factors such as being a non-smoker; a BMI under 30; over 3.5 hours of physical activity a week, and a diet index that is above average. When no healthy factors could be shown, 1 person in 5 developed a chronic disease, when one factor was present, the risk was halved, when four healthy factors were present, a person in 20 developed a chronic disease.

3. **Voluntary adhesion**

Despite some mandatory requirements complying with legal, safety and social security rules and a minimum number of good practices, the WHP encourages businesses to:

- Apply voluntary adhesion (not forcing companies nor employees to participate)
- Act on multiple risk factors (not just one)
- Medium or long term programmes
- Integrate with interventions for safety promotion
- Change the context- make healthy alternatives easy and pleasant
- Evidence based prevention
- Promote workers' participation

The WHP features that appeal to companies include:

- Progressive implementation of good practices ("start small")
- Recognition as health promoting workplace by the health system
- Networking opportunities
- Monitoring- impact of interventions and risk factors

4. **Adaptability and freedom in choices**

Businesses should cover a number of good practices, from 2 thematic areas of work the first year, to 4 the second year and 6 thematic areas at the end of the third year. Each company can propose a good practice in every area. Once validated by the Health system, the good practice is added to the WHP Manual.

5. **Web and e-health tools are available**
6. **Workers' participation is crucial for the success of the WHP.**
7. **Feedback**
8. **Real networking opportunities**: 2 or 3 local meetings take place between the companies participating in the project every year.
9. **Follow-up and timely responses** by the Health system is important.

Discussion and notes

The Health system tries to engage everyone in the programme. Companies that are interesting are companies that are not so perfect. There are no selection criterias for companies to participate in the programme.

Effective good practices from previous positive experiences are documented in a Manual which lists the good practices by thematic area. Every company can propose a good practice, once validated it is added to the manual, which can be found online (an older version is in English):
http://Retewhpbergamo.org/manual/

Recommendations to companies include:

- To make a working group in order to attract employees' involvement.
- To support proactive initiatives.
- To communicate with workers in an effective, "non-terroristic" way (a fun theory approach is more effective than trying to scare people with "if you smoke you'll have cancer"), not only on nutrition, smoking cessation and physical activity, but also on road safety, breastfeeding etc.
- To have an evaluation questionnaire at the beginning of the initiative in order to monitor progress and a company report, e.g. with pictures of the actions taken.

The steps, from raising companies' awareness of the programme to the programme's implementation included the following:

- At regional level, the programme was presented by the Lombardy Region (Unit for Health Promotion) to and through major labour organisations and associations e.g. Sodalitas, Confindustria, trade unions.
- At the local level, each Health Protection Agency (ATS) is responsible for its own organisation, the implementation of the programme in its own context and the publicity. The ATS Bergamo did not do any particular publicity of the programme, however the awards played a role. The news were published in newspapers and on the website, which seemed enough. Word of mouth also played a role.
- There is no minimal number of companies to involve and it is better to start small (ATS BG started with 2). It takes a lot of energy in the beginning to get the programme started, then it gets easier to add on more companies. It is not important to have different companies from different sectors, there is no preferred sector.
- Three operational staff at ATS work and manage the WHP Network in Bergamo, including the monitoring and evaluation of the programme. However they involve the network of the health system. Companies register online to the programme.
- Sustainability is another crucial point: if there are no sustainability elements it will not work, nor for the company, nor for the regional system.
- Political support of the Ministry is crucial too. Despite a general lack of financial resources for preventive measures (Lombardy is no exception), it was important to show:

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- That the programme can be done with little funding (e.g. companies want the logo on the documents, which looks great for companies and does not cost a lot);
- That the programme follows a rigorous methodology;
- Finally, that programmes work better than projects, which have a start and an end.

How do we get the engagement from the different groups? Especially the lower social economic groups?

The difficulty for top-down approaches is that at the top someone needs to sign some big money; in the WHP programme, the model starts with individual companies, it is more a bottom-up approach. However you need to work within a national framework. The WHP for example fitted very well with the national plans, like the national prevention plan. All the regions have to work on the different areas of the national plan.

Over 60% of the companies participating in the programme are not public companies. The companies which are described as from the health sector are hospitals.

3.4. A concrete example of implementation: Visit to Tessiture Pietro Radici

Short presentation of the Radici Group of companies, which includes company Tessiture Pietro Radici:

- Multinational group; Family owned.
- Chemical industry: Produces polyamide and synthetic fibres and engineering plastics.
- Ca 3000 employees, 1600 in Italy
- Average age for the Italian employees in the group: ca 50 years
- Low levels of turnover.

3.4.1 The Global Reporting Initiative

The Radici Group participates in the Global Reporting Initiative (GRI), an international independent organisation that helps businesses, governments and other organisations understand and communicate the impact of business on critical sustainability issues such as climate change, human rights, corruption and many others. As such, the Radici Group reports on its sustainability every year, including environmental, economic, labour, product and social sustainability and human rights. The WHP is part of their engagement in the initiative too.

3.4.2. WHP Implementation

The Radici Group started to implement the WHP with about 200 employees in three of their companies. This is not an HR-only initiative, it involves many other departments in the company, starting with the communications department, finances, as well as others such as production

How did the Radici Group implement the WHP?

One tip is to communicate, communicate, communicate.

- The company established a Working Committee on WHP (e.g. employees who voluntarily joined the group and had meetings during lunch time)
- Before the programme started, emails were sent out, e.g. with a message about healthy eating.
- At the start of the programme, they collected data on weight and waist measurement and decided on the first two priorities: promotion of healthy nutrition and physical activity.

Examples of activities the Radici Group organizes include:

- Every Monday morning fruits are made available for all the workers. They are bought from local producers and sellers.
- Promotion of healthy nutrition by providing healthier choices (a tip: push gently, do not exaggerate)
- Arranging seminars with nutritionists, arrange cooking lessons, arrange seminars about "how to read labels" on packaged foods.
- Promotion of physical activity: the company sponsors a ski team, football and volleyball tournaments as well as Sunday morning walks

They use social media to involve the workers' families and the local communities.

Employees voted on next priorities: personal and social welfare and work-life balance. Activities include teaching how to keep a better posture, creating break/rest area, twisting working time, school orientation for employees' children, "Open day" at the office and plant.

The ballot box was converted into a suggestion box.

Lesson learned: it's like running a marathon, not a 100 meter dash.

3.4.4. Lessons learnt

The budget to implement the WHP in 2016 was 8000 euros.

The central management group (ATS BG) provides the facility for workers to register online and fill in the survey with their waist measurement, etc. They do it on a voluntary basis, but it is a nice check-up for participants.

The points which convinced the company / the HR department in the first place were that the programme sounded right. You need to take care of your colleagues. For the company it sounded like a good

investment. You get help from the protocol, the cost is low. The evaluation of the cost/benefit sounded right.

Major difficulties included overcoming the resistance in the culture and changing habits. Physical activity is easier, but eating is harder. Smoking will be harder because it is an addiction. In the suggestion box we received 50 positive suggestions, but also a few negative ones.

The activities are sustainable as people talk about the programme, e.g. they stop one another from taking the elevator. But of course the ones showing up for the walk are the ones who would most likely do it anyway.

In their approach to companies in general, ATS shows them that WHP is good for the health of the employees but also for the health of the company, as employees' good health reduces absenteeism, reduces the turnover, increases their productivity and increases the company's image.

3.5. Discussion on transferability

1. **What do you consider the "fundamental nature" of the original intervention that should be preserved?**
   - The partnership between employers and the regional programme of the intervention. The network is a mixture of public and private with a commitment from a wide variety of stakeholders.
   - High levels of participation and communication between providers/participants on the intervention.
   - High standards of motivation and "fun theory approach" on people engagement process.
   - Flexibility and adaptability on its implementation.
   - Voluntary adhesion and freedom of choices.
   - Clear structure once an employer is taking part, with clear methodology, feedback methodology.
   - The utilization of data to inform policy and practice.
   - A large emphasis is on a communications approach using social media.
   - Tools and important information for companies are available on the website.
   - The recognition award from the Ministry of Health is highly valued by companies.

2. **What are essential elements of project management and project governance of the primary intervention?**
   - A National Health Plan defines the health priorities that underpin the National Prevention Plan and Follow on Programmes. Lombardia Regional prevention plan for 3 years: 2015-2018. Therefore government initiative led by the Ministry of Health based on institutional alliance and partnership with industry.
   - Organisational structures (responsibilities) are clearly defined, sources of funding are specified.
   - Organization of a high self-motivated working group in each company involved in the project, clearly monitored, guided and evaluated by the staff in charge on intervention.

- High expression of flexibility on the governance rules which are adapted to each company context.
- Internal process of monitoring and evaluation allows consistency of the programme and hence continuous improvement.
- Health protection agencies provide methodological expertise and guidance.
- Management and staff participation in the project encourages and sustains motivation, voluntary adhesion and adaptability.
- There is a National platform on food, physical activity and tobacco that feeds into the work.
- Surveillance system led and monitored by Lombardy WHP.

3. **What are indispensable conditions of the original context?**
   - Collaboration between different stakeholders across sectors and levels.
   - Durable political will and support, including commitment required in terms of a strategic national and regional plan.
   - Support of the national ministry as well as the expertise and the willingness of the communities at local level.
   - One indispensable condition on the original context is the “voluntary adhesion” of the companies involved, in which an important “self-decision” model is undertaken with the support and guidance of the central coordination staff. The progressive implementation process seems to be important to create the necessary conditions in order to get additional involvement and commitment from employers/participants.
   - The communication and “light” approach used by the coordination team on implementation process could play in important part in the “participation” and “integration” of high motivated participants.

4. **What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?**
   - Availability of documents and tools used in primary intervention, to be shared by the WHP team in the Lombardy region.
   - It’s necessary to be able to maintain a continuous shared model of communication between providers of the original intervention and the potential replicator. It’s important to access not only to materials and tools but also the exchange of the key lessons learned by previous experience from providers.
   - Pre-existing local programmes in other countries could use the tools and evaluation results, from the Lombardy WHP to engage with their stakeholders, making it an easier transition and communication route for initial buy in from companies.

5. **What do you consider as key lessons learnt during implementation?**

Key lessons include participation of companies in the planning process, voluntary adhesion, comprehensive communication plan, adaptability and freedom to choose priorities, support is provided to companies on a ongoing basis through the availability of online resources and tools.

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4. The Netherlands – JOGG: Young people at healthy weight

4.1. Introduction: JOGG's aims and objectives

JOGG is a movement which encourages all people in a city, town or neighbourhood to make healthy food and exercise an easy and attractive lifestyle option for young people (0-19 years). It focusses on children and adolescents themselves, along with their parents and direct environment. JOGG advocates a local approach in which not just the parents and health professionals, but also shopkeepers, companies, schools and local authorities join hands to ensure that young people keep or regain a healthy weight.

The main aim is to reverse the increasing trend of young people (0-19 years) with overweight/obesity. The sub-aims are to:

1. To increase the amount of young people that achieve the recommended level of daily physical activity;
2. Reduce the intake of sugary drinks and increase the intake of water;
3. Increase the amount of young people that consumes a healthy breakfast;
4. Increase the daily intake of fruit and vegetables and
5. Every setting (neighbourhood, school, home and health care) offers a healthy option, and promotes physical activity.

The objectives of the strategy at national level are to:

- Create structural political and governmental support
- Ensure cooperation between the public and the private sectors
- Work with the principles of social marketing
- Monitor and evaluate the effect and process continuously
- Interlink preventive care and local health care structures
- Implement the JOGG themes (water, physical activity, fruit and vegetables)

The main objectives for 2010-2014 were to change the increase of overweight and obesity among youth (0-19 years) into a decrease; to include 75 municipalities in the National JOGG movement. The main objectives for 2015-2020 are to work on a healthy environment with structural attention for a healthy lifestyle and a healthy weight, reaching at least 1 million children and young people; to obtain a measureable increase in the number of children with a healthy weight in the 75 JOGG-municipalities.

The Dutch JOGG approach is based on the successful French project EPODE and consists of five pillars:

- Political and governmental support

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- Cooperation between the private and public sector (public private partnership)
- Social marketing
- Scientific coaching and evaluation
- Linking prevention and health care

Currently, 84 municipalities in the Netherlands are using the JOGG approach to promote healthy weight among their youth. JOGG is coordinated at national level by the national JOGG foundation in The Hague, which is part of the Covenant on Healthy Weight. Former politician Paul Rosenmoller chairs the Covenant and the Dutch Prince Pieter Christiaan van Oranje and dancer Juvat Westendorp are the national JOGG ambassadors.

Activities at the national level include:

- Advice on creating political and managerial support
- Training in the JOGG approach for locally involved parties
- Information on successful interventions and best practices
- Designing and providing municipalities with communication and information materials
- Directions on how to implement the JOGG approach
- Scientific research on how to measure the effects of the approach Activities at the local level: Each city has its own JOGG-coordinator who plans various activities in relation to the 5 JOGG pillars. These activities differ between the municipalities implementing the JOGG approach. It ranges from drinking water activities at kindergarten to creating playgrounds. Municipalities commit to JOGG for at least 3 years.

4.2. The JOGG Approach

Presentations

The JOGG Approach

4.2.1. Structure

JOGG is based on a public private partnership (PPP). The role of the private partners is the provision of sponsorship advice and incentives. The single JOGG goals (physical activity, water consumption, provision of healthy breakfast, increased fruit and vegetable intake, support of healthy environments) can be found in other European countries' programmes and projects as well, but often lack an umbrella to align all actions.

To facilitate and address potential conflict of interest, guidelines are available on the core values of JOGG:

- Mutual trust is a core base for cooperation
- Transparency on who we work with and why. Definition of mutual ambitions and results
- Reciprocity; cooperation is based on mutual commitment. Both parties beneft from working together.
- Independence. No influence on our approach, strategy and communication
- No commercial targets for private partnerships

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- No marketing/communication to children
- Monitoring: we monitor our activities and publish the results

4.2.2. Communication

The family setting plays an important role in the provision and promotion of healthy eating for children. Parents are addressed through different means but brochures, e.g. theatre plays.

The approach to include parents requires careful balance between the perceptions of support and intrusion into their educational autonomy. Within JOGG, only positive and empowering messages are communicated.

4.2.3. Evaluation

The local JOGG goals are evaluated:

- outcome (impact/ effects)
- behaviour (physical activity, fruit/ veggie consumption)
- healthy environment
- process (5 pillars)

The Evaluation is conducted locally by the JOGG staff and supervised by the leadership (national JOGG bureau). The evaluation is part of the contract with local JOGG partners, but not mandatory to be conducted on the local level.

JOGG's evaluation aims to

- Map the effect of the intervention, improve the local JOGG approach
- influence policy makers and financers to support sustainability
- increase participation and engagement of the members of the JOGG community (by celebrating successes and keeping them informed)
- to benchmark the process and results
- evaluation results justify actions and efforts

Besides BMI measurements in school, sometimes additional physical tests are conducted to benchmark individual parameters. However, these are prone to bias due to unreliable measurements.

Guidance for evaluation process through

- evaluation guide
- step by step action plan
- checklist with recommended measurements
- list with recommended goals (effect and process)
- template for local JOGG evaluation plan

To **guide process evaluation**, a selection of tools is available:

- tool to monitor progress: maps how the JOGG process proceeds
- JOGG monitor: online tool to register and label all JOGG activities

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- Progress conversations with this tool between the national and local JOGG managers. Fosters bi-directional communication

To **guide outcome evaluation** a JOGG questionnaire (based on ChecKid) is provided.

Challenges of evaluation

- budget
- time consuming
- depending on others
- access to reliable data
- skills and expertise
- interest
- misconceptions

Evaluation results from the local level:

- almost all municipalities are undertaking monitoring and evaluation activities
- over half of the municipalities have an evaluation plan
- In 20 municipalities local evaluation reports have been identified

Participation and commitment from academia, with many PhDs researching on the programme, are a key success factor. Professors serve as ambassadors and strengthen political and governmental support.

Lessons for evaluation learned:

- make it easy and small
- limit the number of goals
- manage the expectations in time needed for evaluation
- interpret results in terms of “reason for continuation”
- partners are motivated to evaluate their own interventions, because it can improve their work

4.2.4. Integrated approach

JOGG aims to link prevention and healthcare by aligning screening and dental examinations in the schools.

Implementation and project governance

- Customized support /advice through JOGG coach, JOGG expert, JOGG adviser
- Knowledge transfer/sharing: training workshops, meetings, online platform
- Tools and materials: JOGG wiki, communication materials, campaigns
- JOGG program manager is responsible to overview all pillars

Budget composition:

- Ministry of health (3.8 million per year)
- Annual fee from JOGG municipalities (5000 € for small municipalities, 10.000€ for bigger municipalities)
- Yearly contribution platform partners (5000€ per partner)
- Yearly contribution private partners (50.000€ per partner)

Transfer and Knowledge transfer

In the perspective of the JOGG promoters, the biggest success lies in the establishment of a knowledge transfer process, which is basically a goal in its own. A team in the NL works to provide guidance and advice materials for interested international partners.

To blend JOGG activities on the background of pre-existing local programmes, stakeholder meetings have helped to "smoothen the waters" by providing an open space for discussion with other actors and decision makers and to help to highlight the added value.

The EPODE academy which seeks to sustain the knowledge transfer process on an international level is currently built up, but currently not ready yet to train international colleagues on a bigger scale. JOGG-team is thinking about starting a academy in the Netherlands.

How to start over?

It's important to keep things easy and small in the beginning, e.g. limit the themes to one at a time per school to begin with.

4.3. Local experience: –the Healthy Weight Programme of the Municipality of Amsterdam

Childhood obesity in Amsterdam is almost double the rate compared to the rest of the NL

- Mission: A healthy weight for all children in Amsterdam in 2033
- Vision: healthy weight is a collective responsibility and a healthy choice is the easy choice
- Strategy: Healthier behaviour in a healthier environment

Making a healthy choice should be as easy as possible. Poverty and poor education are risk factors for obesity. Concrete actions:

1. Designing a 'moving city'
2. Lobbying the food industry – no collaboration with coca-cola for example.

4.3.1. Approach:

- Long term
- sustainable
- inclusive
- sharing responsibility ("everyone is needed")
- learning by doing
- making choices: focussing of efforts

Aims for 2015-2018

- Amsterdam must demonstrably become a more healthy organised city
- Significant reduction in the number of children who are overweight and obese in the five heaviest neighbourhoods
- Neighbourhood approach must be extended to cover five other "too heavy" neighbourhoods
- Fewer primary schools with more than 25% of pupils overweight or obese

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- All children who are obese or morbidly obese must be given appropriate care

How support is gathered for the programme

- Create sense of urgency, in particular through facts and figures
- Identify relevant determinants and risk factors ("What is really the problem?")
- Frame the societal dimension, e.g. obesogenic society is a wicked social problem
- Emphasise, that nutrition and healthy weight of children is not solely in the responsibility of parents

The learning approach

- Inherent in the programme management through setting goals and monitoring (plz see slide: "policy rollercoaster")
- Annual planning and control cycle
- Professionals / staff is trained first
- Professionals follow a specific learning process, as they are those in direct contact with the children and their parents.

Research and Development

- Continuous monitoring of the primary outcome (weight) in the population in Amsterdam (Youth Health Care Department). For instance, body mass index is measured annually
- Evaluation studies (process and effect evaluation) of interventions (both preventive and care interventions)
- Internal quality expert team
- External scientific advisory board
- Dissemination of knowledge among stakeholders

Key success factors on community policy level have been

- to bring up long-term effects of childhood obesity to the decision makers
- to have allies among decision makers
- to stress the ethical dimension of the problem ("morbid childhood obesity is child abuse")
- to communicate absolute numbers ("25.000 children" instead of "25% of all children")
- to shape positive public perception of the program, e. g. by overcoming general concerns ("Mind your own business") and initial resistances among some of the parents. Support parents e.g. by offering courses on healthy cooking and affordable healthy shopping

4.4. Discussion on transferability

1. What do you consider the "fundamental nature" or fundamental elements of the original intervention that should be preserved?

- The five pillars of JOGG are at the heart of the intervention
    - Monitoring and Evaluation
    - Public Private Partnership
    - Commitment at policy level
    - Social Marketing

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- Connecting prevention and health care sector

- There's a great investment on communication and social marketing: many tools and materials are on the website; many campaigns are promoted by JOGG and support municipalities ("Move and play everywhere, for free", "Drink water" (https://www.youtube.com/watch?v=CjWp7TfI22E); JOGG team has produced a fact sheet with a look on BMI (to show the decreasing trend in Holland)
- The underlying theory: childhood obesity is influenced by environment (you change the environment in order to change the behaviours)
- Some success factors:
  - commitment from a wide variety of sectors: e.g. the academic sector (it gives credibility); the methodology itself (which has been proven effective); financial injections from the ministry of health and some private organizations; the adoption of a community approach (to develop the local actions).

2. What are essential elements of project management and project governance of the primary intervention?

- Customized support /advice for all the Municipalities through JOGG coach, JOGG expert, JOGG adviser
- Knowledge transfer/sharing: training workshops, meetings, online platform
- Tools and materials: JOGG wiki, communication materials, campaigns
- JOGG program manager is responsible to overview all pillars

3. What are indispensable conditions of the original context?

- 'Sense of urgency' and resulting political commitment on national and local level
- Support of the ministry as well as the expertise and the willingness of the communities, therefore, support and commitment at the local level as well as from a bigger context
- It's an integral community-based initiative, based on EPODE methodology: engaging all the settings (city and suburban areas) such as school, sport club, social organizations, churches, dietitians, supermarket, general practitioners

4. What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?

- In the perspective of the JOGG promoters, the biggest success lies in the establishment of a knowledge transfer process, which is basically a goal in its own. A team in the NL works to provide guidance and advice materials for interested international partners.

- To blend JOGG activities on the background of pre-existing local programmes, stakeholder meetings have helped to "smoothen the waters" by providing an open space for discussion with other actors and decision makers and to help to highlight the added value.
- The EPODE academy which seeks to sustain the knowledge transfer process on an international level is currently built up, but currently not ready yet to train international colleagues on a bigger scale

5. What are key lessons learnt during implementation?

Prerequisites:

Identify relevant determinants and risk factors ("What is really the problem?")

- Frame the societal dimension, e.g. obesogene society is a wicked social problem
- Emphasise, that nutrition and healthy weight of children is not solely in the responsibility of parents

Key success factors on community policy level have been

- to bring up long-term effects of childhood obesity to the decision makers
- to have allies among decision makers
- stress the ethical dimension of the problem ("morbid childhood obesity is child abuse")
- to communicate absolute numbers ("25.000 children" instead of "25% of all children")
- Shape positive public perception of the programm, e.g. by overcoming general concerns ("Mind your own business") and initial resistances among some o the parents. Support parents e.g. by offering courses on healthy cooking and affordable healthy shopping

Challenges identified include:

- budget
- time consuming
- depending on others (help by local authorities)
- access to reliable data
- skills and expertise
- lack of interest locally

The evaluation aims at:

- Mapping the effects of your interventions
- Improving the local JOGG approach (the progress)
- Influencing policy makers and financers (sustainability)
- Increasing participation and engagement
- Benchmarking

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75 local JOGG coordinators are responsible for development evaluation framework and coordination of implementation. They do not have a common procedure, neither a standard approach for evaluation except from some standard set of indicators (for example BMI every 3 years, etc.); as regards to behaviors indicators, there are locally defined goals.

The JOGG process and outcome evaluation guide contains:

- some instrument to monitor progress, for example 1 questionnaire for parent on physical activity and healthy eating (based on check list), etc.
- An action plan (step by step)
- a checklist with recommended measures (neat & nice)
- a list with recommended goals (linked to the effects)

Lessons for evaluation learned:

- make it easy and small
- limit the number of goals
- manage the expectations in time needed for evaluation
- interpret results in terms of “reason for continuation”
- partners are motivated to evaluate their own interventions, because it can improve their work
- evaluation is a knowledge transfer process

5. The Netherlands – Databases study visit

Note: Partners discussed their interest in how to build a database of good practices at a previous WP5 meeting. Although this study was not related to a good practice in Health Promotion / Disease Prevention per se, it took place at the same time as the study visit to good practice "JOGG" on several participants' requests. We include the minutes of this meeting here too, for partners' convenience.

5.1. Feasibility and applicability of the CHRODIS Platform for health promotion practitioners

Presentation

- CHRODIS Platform (formerly called Platform for Knowledge Exchange - PKE) Enrique Bernal-Delgado, Leader of WP4 and the development of the PKE

The Platform's modules and roles

Engineers based in ICIII have put into practice ideas. The basic structure of the platform is as follows:

(a) Digital library= functioning as a classic repository
(b) Clearing house = all evaluated practices are stored in here
(c) Help desk = acts as the backstage of any action

To access any content you need to register (for safety reason + collecting useful information on users) – There are two different registration profiles: User and referee/reviewer

A search engine is interconnecting the content of PKE.

Progress so far: the clearinghouse and digital library in piloting phase. Other features will soon be tested in the piloting phase.

Help desk manager: in charge of the maintenance of knowledge base, online toolkit and experts database and assisting users. In charge of putting practice's owners and experts in contact.

WP4 will ask Delphi participants to become experts or reviewers/referees.

Practice owner= submits practices and can become expert if the practice is successfully stored. Reviewer/referee (top individual behind final decision and final score given to the evaluated practices) –

A list of experts in different fields is needed – names from all meetings were gathered by WP4 (either associated partners or collaborating partners). The experts should not necessarily be people involved in the Delphi process.

At the moment there is no governing body behind PKE, but it could prove necessary in the future.

The PKE is for the moment a concept - no guarantees that it will be continued in the future.

The Platform is prepared to be scaled up in terms of the number of people interacting with it and not implement functionalities that might be needed in the future. A business plan has been also prepared.

Experts can be recruited for increased reputation by being JA-CHRODIS platform expert (that would be part of the success if the platform has an impact – countries are using it, etc.)

The Platform's Registration process

Account profile

Identification/user information area gathering useful information about the user profile: According to the information entered by the user, and if the user agrees on being a reviewer, a good practice for review can be sent.

Dashboard – depending on your profile you have access to different content. As regular user you have access only to "add content" and "activity". As a reviewer/referee you have access to the assessment functionality. Some headings and terms needs to be reviewed and changed as they are too medical (suggestions coming from Irish participants).

All kind of content (policies, strategies, videos, leaflet, publications, etc.) can be uploaded on the Digital Library. The content will be checked before publication to verify it is relevant – no evaluation process.

To upload on the Clearinghouse there is a different process:

Submission process

Add content – 4 possible entries representing CHRODIS WPs + 1 representing patient empowerment (multimorbidity and organizational interventions grouped together). Reviewers can self-assess their submitted practices.

Work flow process for reviewing process

Two peers reviews (blinded peers), then the referee receives both assessments. Good practices (GPs) have to fulfil all criteria. The referee takes final decision and approves the GP for upload to the Clearinghouse if the final score is above the threshold (percentile 10 – threshold to be updated each 2/3 years). GPs not scoring enough are stored and the referee sends a report to the submitter.

Reviewer– As a reviewer you receive the assessment form and the description of the GP. You have to agree or not to the self-assessment done by the submitter. There is a 0 - 5 points scale for evaluators: 5 if you fully agree with the self-report, 0 if you totally disagree.
Different points are given according to level of agreement.

Referee profile – sums and checks the scores given by the two peer reviewers

List of content: those with the higher scores are on the top of the list. Content is divided under 4 different tabs.

Contents: policies are included in the practices; there's a list of other contents, for example videos, etc.

Issues to solve / concerns:

- People don't have particular benefits in participate, except from the reputation (further, they can become experts)
- Is there a government embody or commitment? At the moment no, but there's a business plan in case of any governments interested in PKE
- Terms: they are nearer the clinical fields vs health promotion (taxonomy from Mesh)

5.2. Policy on the Good Practice database in the Netherlands

Synthesis from the Q&A round

The responsibility for the initiative lied within the directorate of health. It was important to establish means of communication between different levels (local to national) to recognize demands and needs “from the ground”.

An incentive system has been established to stimulate the uptake of interventions from the database.

The policy cycle is set up for a four year turn and based on the 4-annually published health status and forecast report. The congruency with the 4-year elections cycle can be of advantage but also pose challenges due to the changing political priorities.

A national white paper is published every four years with certain priorities. Currently these priorities are: smoking, drinking, diabetes, obesity. It’s a national responsibility: the ministry finances municipalities to reduce socio-economic inequalities. But the main message is: “Health is a responsibility for all, not only for the ministry”. Additionally, white papers are also published on the local-regional level and they ideally align with the national priorities.

Local units apply national policy, but they have to follow the evidence-based interventions.

The municipalities are not linked into the “health care service”. ‘Service’ in the Dutch understanding means public service, whereas in Ireland it is seen as health care.

The role of the Ministry in the support of recognition system is to provide financial support in specific settings and domains, e.g. schools, sports, healthy ageing.

Furthermore the definition of conditions for research projects. For instance, projects financed by the MoH can receive a clause that they need to be uploaded in the recognition system.

Three main domains:

A - To improve public health and health service

B - Environment and safety

C - Infectious diseases

Public health policy cycle in the Netherlands

According to the recognition system, in 2005 we had 3000 interventions in public health, with:

- no insight in quality and effectiveness of interventions
- no coherence in local health policy (not very developed local actions and not clear adherence to national policy papers/statements)
- different organizations

So the Ministry started a formalized centre for healthy living with an assessment system and database to have an insight in quality and effectiveness of the interventions.

Current status: Database with 350 good practices; up-to-date database (1900 interventions)

There are a few effective interventions, and a lot of subjects/partners involved (among the stakeholders: ambassadors)

Helpful tips (to promote the database filling):

- create a sense of urgency (to start to do something…) through a strong report *
- risk to waste money because of ineffective interventions
- timing is important
- there are some groups working but they are not coordinated

Tips and advice

1. Create collaboration and commitment within your department or ministry
2. Involve parties, knowledge institutes, research institutes, experts
3. Keep it Smart…start with a restricted number of issues
4. Create financial support and…a guaranty for continuity!
5. Stimulate research on the effectiveness of interventions or on the implementation of effective interventions
6. Do not support interventions that have insufficient evidence
7. Develop a 'brand awareness': refer to the database and recognition system in letters, white papers etc.

5.3. Good practice databases (criteria, procedure, funding resources). What are the key elements of a good practice database?

Presentations

- Praxisdatenbank Germany; Roger Meyer, Gesundheit Berlin-Brandenburg, Germany
- Pro.Sa database, Italy; Rita Longo, DoRS, Health Promotion Documentation Centre, Italy
- Recognition System, the Netherlands; Djoeke van Dale, RIVM, NL

5.3.1. Praxisdatenbank, Germany

General info on the database:

- Run in a joint collaboration with Gesundheit Berlin-Brandenbrug and BZgA
- It contains: 2798 health promotion projects, 119 HP good practices
- Health situation – health potential (there's a gap)
- Focus: projects aiming at socially disadvantaged people
- Selection process: self-entry forms, external assessment of practices
- Twelve GP criteria, which have been "operationalised"
- It's a tool for self-reflection
- "Centres for equity" (regional centres) are independent; they propose potential projects

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- It's a possibility for the project leaders to exchange their projects
- It allows to describe step-by-step the process of evaluation in different systems.

Synthesis from the Q&A round

The creation of the database approach followed a sense of urgency imposed by the persistence of social health inequities. The project originated in 2003 to target socially vulnerable people and projects should have a focus on it, although in reality it is sometimes difficult if that focus exists or not.

Twelve good practice criteria were developed. The criteria development is a constant process and criteria are developed out of existing projects. The operationalisation of criteria can follow different stages, e.g. the criteria "participation" defines different levels of involvement.

Human resources involved include one to two persons for technical work only, while the actual assessment process is very time consuming. A small monetary compensation is therefore paid to reviewers (two people review one practice).

The review is a question and answer process, based on the documentation of the practice. Over the course it's about one full day of work per reviewers, while the question and answer process to receive full documentation per practice can take around three to four weeks.

The actual "core work" is done through documentation staff from the database provider, not by the submitter. The procedure is not a self-assessment during the submission of the documentation.

An advisory board with 15 members is established for regular consultation.

The incentive for the projects to undergo the process of evaluation in the database is not monetary. The "Good Practice"-label comes with a positive reputation in the field.

Over the course of time, the sustainability and stability have increased, but it is getting harder and harder to find new projects for upload.

The existence of the database has gained high visibility in Germany, but no strong evidence exists on whether the uptake of practices in general has increased or whether it's direct impact on social health inequities. The database stipulates inspiration through the knowledge transfer process that comes with it.

5.3.2. Pro.Sa database, Italy

The project of database started in 2000 to document all regional experiences and projects. Good practice area started in 2004. In 2011 it was converted from a regional to a national instrument.

The aims of the system are:

- To obtain regional and local data of HPP interventions
- To share project materials and results
- To help development through methodological guides, of evidence based projects and interventions
- To evaluate and to highlight GPs
- To create synthesis tables and maps with loco-regional details

Structure: Health promotion projects can be uploaded; an extra possibility to submit good practices for evaluation exists. There's a *public area* with open access with guided search function + *reserved area*, to

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which only regions have access, to monitor and evaluate its own projects. Regions appoint workers who are experts in projects for submitting the projects to the database. The database collects qualitative and quantitative data. A project guide helps professionals to improve and write projects along good practice criteria (18 criteria).

Each project is evaluated by two independent readers (one expert in methodology and the other expert in the project's specific field (smoking, physical activity…). The review process goes along a cascade and results in a scoring system. Procedure leads to a final score.

The purpose was to not only evaluate but also highlight good practices, train professionals, support decision making. However, only 12 out of >1000 practice submitters have "applied" for evaluation. In future, it would be desirable if the procedure can be included in national Prevention Plan and consequently in Regional prevention plan to provide the reader activity (that is an activity that can't be paid but must be institutionally provided).

5.3.3. Recognition System, the Netherlands

Key elements:

- database
- assessment system
- presentation of good practices
- implementation activities

Recognition system is a collaboration of seven organisations:

1. NL youth institute
2. Centre for healthy living
3. National centre of youth and health care
4. Knowledge centre for sports
5. NL centre for social development
6. Mental health
7. Chronic care

Stepwise system:

1st stage: peer review: 3 professionals from national institutes

2nd stage: assessment by 3 experts (science, policy, and practice)

second assessment then in a meeting (10 meetings per year)

two different committees (youth and adults/ageing)

Resources: Submission advice and feedback about 10 hours per interventions

Submission of an intervention in total about 50 hours

Many GP criteria are implicit in the intervention's description and to be assessed by joint meetings; therefore the submission can be a lengthy process.

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A list of recommended interventions according to topics is available for different settings.

The implementation of feedback mechanisms on uptake and transfer of good practices is difficult. Few monitoring studies exist in the field; the main feedback comes from web statistics.

Some points of reflection:

- People that have used the db say that they are most aware of the process (they are more conscious of qualitative criteria when they design a project now)
- People need help to fill the form (training?), especially when projects aren't simple and focalized
- Some projects are well described but they forget specific elements (effective elements)
- If you do not have a database you do not know what works
- You can get inspiration and example from a db, it's not only the case that I take the effective elements
- If there are effective elements and specific interventions, the government could make them apply
- They must be not only databases but also an opportunity to learn, share, etc.
- Db must provide practical information vs theoretical speech
- It can make sense for the user if he becomes more aware
- How can we convince policy makers? Social marketing strategies
- Db are a powerful tool for reflection

Criteria: they do not have explicit criteria on equity.

Dissemination: digital magazine and infographic (they proved to be useful!)

5.4. The process of the beginning, the implementation and sustainability of a good practice database; successes and failures

After a short introduction participants were invited to ask their questions about the experiences with submitting and the implementation of an intervention.

Group Praxisdatenbank

The geographic and political range of the database is nationwide, the office is based in Berlin.

The impact on the health of socially disadvantaged people is not directly measured. It is assumed, that if all the good practice criteria meet the practice, then we can expect an impact, even though it is hard to quantify.

The general procedure is: submission, interview with submitter, feedback round(s) and review. The interview part can take up to six months with questions pinged back and forth.

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Workload: The documentation of one good practice description requires around one to two weeks of full time equivalent.

What would you do different with the lessons learned?

The operationalisation process was important to develop and shape our own understanding on how the criteria translate into reality.

Group Dutch Recognition System

The initial sense of urgency was good to have to start over with the centre and the database; everyone was talking about starting doing it but not actually doing it. Essential precondition is the financial support either from the ministry or another organization.

The practitioners “on the ground” have been consulted and asked for a database to facilitate the knowledge exchange.

The mapping of existing approaches is one important function of the system. The quality assessment is important to acquire support from the practitioners. It's important to find the balance between inclusiveness for interventions and strictness of quality criteria. There is a 3-5 years expiration date for assessed interventions.

The system follows a stepwise procedure:

1. Who do we target with the database?

2. Who is our target population?

3. Criteria development

It is difficult to “chop” the interventions into criteria/pieces because you don't know in the end if it's still effective.

Challenges: While collecting the good practice examples it is often difficult to convince effective practices to submit their information because it's extra work.

Pro.SA – Italy

Reviewers come from different regions, their work is conducted during regular working hours.

Reviewers are psychologists, sociologists, doctors and veterinaries, in total. It is mandatory to be an expert in health promotion planning, and be acquainted with the GP assessment form. Local unit health coordinators are being trained to use the form.

Recommendations to start a database based on the Italian experience:

- Define main objective.
- Conduct mapping of existing approaches in the region/field. In Italy many fragmented databases existed on a local level, but a more comprehensive approach was needed.
- Spark reflection process about good practice criteria

- Disseminate the knowledge emerging from good practices to improve other existing projects. This has resulted in an Italian guidance document

The number of practices in the Dutch system is inspiring. The number of submissions for evaluation should be increased in Italy. A reflection might be necessary whether the criteria are too strict.

However, the assessment depends strongly on the quality of the submitted information. Maybe a project is really promising but the submission is not well written. More time is needed to advise and guide submitters.

Challenges:

The motivation to submit a project derives from the positive reputation through a „Good Practice Award“.

At this point, good practice examples come geographically only from three regions mainly due to the pilot character. However, it is still a challenge to spark interest among other regions and to promote the added value of the database approach. In some cases, local health units in regions are interested in submitting projects, but the regional authorities are not.

5.5. Success factors and challenges of successful implementation of the database

Key lessons learned from practical perspectives

User's perspective:

- Database submission facilitates reflection process ("Forces you to sit down and reflect on what are you doing?")
- The reflection process benefits future project design
- Personall, having effectiveness as a focus can give a different perspective. The use of the database can help to grow professionally.
- Time burden is a key barrier for submitters from the ground
- The development of an operationalisation manual for the good practice criteria has helped to support the self-learning/-reflecting process
- The database helps to increase visibility and support documentation. Facilitates to obtain information on "what works" fast. It's important that the intervention is "owned" by someone who feels responsible for a knowledge transfer process
- Knowledge transfer process is needed. Sometimes people pick up certain elements of interventions, but miss out key parts and call it "adaption" without it actually being effective anymore
- It's important that the providers conduct the submission themselves as a learning process, but it's favourable to do it with other colleagues.
- The db is useful to get information
- The structure is well described, it is helpful for users, like a sort of consultant

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Personal lessons learned by user(s):

- "We can tell better about effects (what works)"
- "It's near to reality"
- "What should you do different?"
- "What should I do different?"

Challenges

- How to score/quantify the effectiveness of an intervention?
- Lack of integrated approaches.
- Self-reflection is often hindered by time constraints

Final discussion: reflection about the study visit and take home messages

Iceland: We're in a preparation phase, received valuable information. Start as mapping and later on build the quality assessment part, according to resources. The Italian approach it's clever to leave it to the submitters whether information is public or not. We consider database as a complementary element to existing activities.

Ireland: Details of review process, depth of levels, How to tackle discrepancies between submitters and reviewers. Dutch model shows how much assessment is too much assessment. Starting point has to be: Document what is actually out there. Most important step of database is at submission step because of high impact on review process – this is also a strong implication for the PKE.

It's interesting, that some databases provide training for the uploading process.

Spain: Emphasise learning experience

Portugal: Have a high need for a database. A personal meeting like this helps to shape a better picture and makes sense to understand the fuller picture. How can we convince the policy makers that the implementation of such a database makes sense.

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6. Norway – The Norwegian Public Health Act

Note: This study visit was a bilateral meeting including only one visiting partner, the Directorate of Health of Iceland (DOHI). Therefore the format of the report is different from the other study visits, but we include it here too, for partners' convenience.

6.1. Introduction: Aims and objectives of the Public Health Act

The new Public Health Act was introduced in Norway on 1st January 2012. The purpose of this Act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries.

The Act establishes a new foundation for strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. The Act provides a broad basis for the coordination of public health work horizontally across various sectors and actors and vertically between authorities at local, regional and national level. Only by integrating health and its social determinants as an aspect of all social and welfare development through intersectoral action, can good and equitable public health be achieved.

Further information here, p. 259

6.2. The Public Health Act Approach

Presentations

The participants from the Directorate of Health of Iceland were mostly interested in receiving information and learning more about the responsibilities of the local level (municipalities and/or regions) as outlined in Norway's comprehensive Public health act from 2011/2012 and other relevant policies. This includes what support is provided by the government to the municipalities to fulfil their responsibilities (e.g. financial support, availability of data, checklists and other material and professional support) as well as practical information: how it is working, what is going well and what are the main challenges for the municipalities.

Secondly, the participants were interested in learning about the Healthy Life Centers, which is an interdisciplinary primary health care service which offers effective, knowledge-based programmes and methods for people with, or at high risk of disease, who need support in health behaviour change and in coping with health problems and chronic diseases. These centres are a way for the municipalities to fulfil their responsibilities according to the Public Health Act.

6.3. A local example: the Sørum Kummune

The Municipality established:

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- A joint, interdiciplinary public health team, with a chief medical doctor (public health medicine), a public health coordinator, an advisor of environmental health, a leader of the Healthy Life Center.
- A collaboration between the Planning unit and the Public Health Team, to ensure the public health perspective in the local plans, including a Planforum and a checklist for ensuring public health in other plans (public hearing)
- All units have to have yearly public health goals, the units report on public health twice a year

The Municipality made an overview of the public health and the facors that influence it, which served as a basis for the municipality's planning strategy. They made a plan for health promotion and local public health work and established a larger interdiciplinary group called the Public Health Forum, led by the Public Health Coordinator, which

- Contributes in the work with the overview
- Contributes with advise and input on how to follow up the local public health work (according to the plan)
- Are meant to be local «public health ambassadors»

Lessons learnt in terms of criteria addressed by the Norwegian Public Health Act

The Public Health Act is based on five fundamental principles that shall underpin policies and action to improve population health. Health equity is one of them.

Health equity

Health inequities arise from the societal conditions in which people are born, grow, live, work and age ± the social determinants of health. Social inequities in health form a pattern of a gradient throughout society. Levelling up the gradient by action on the social determinants of health is a core public health objective. A fair distribution of societal resources is good public health policy.

Healthy life centres (HLS): Serve as an interdisciplinary primary health care service which offers effective, knowledge-based programs and methods for people with, or in high risk of disease, who need support in health behaviour change and in coping with health problems and chronic diseases. According to a report from statistics Norway it seems to be a tendency that the municipalities where social inequalities pose the reatest challenges are not the ones with a Healthy life centre. In Municipalities with HLC's, the Centres may have contributed to a reduction in social inequality.

Comprehensiveness

The Public Health Act is **very comprehensive**, for further information see here: https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/123.pdf and https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/1234.pdf

It states that "one of the main features of the Act is that it places responsibility for public health work is as a whole-of-government and a whole-of-municipality responsibility rather than a responsibility for the

health sector alone. In public health work the municipalities must involve all sectors for the promotion of public health, not just the health sector."

Description

https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/1234.pdf

"The purpose of the Act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries. The Act establishes a new foundation for strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. The Act provides a broad basis for the coordination of public health work horizontally across various sectors and actors and vertically between authorities at local, regional and national level. Only by integrating health and its social determinants as an aspect of all social and welfare development through intersectoral action, can good and equitable public health be achieved."

Ethical considerations

The Public Health Act is based on five fundamental principles that shall underpin policies and action to improve population health. Precautionary principle is one them:

***Precautionary principle**: If an action or policy has a suspected risk of causing harm to the public or to the environment, the absence of scientific consensus that the action or policy is harmful, cannot justify postponed action to prevent such harm.*

Evaluation

Requirements regarding evaluation are included in the Public Health Act. Evaluation is a part of the internal quality assessment requirements. An evaluation of stated goals, strategies and efforts should be conducted for each planning period (4 years). An annual review of all public health efforts should be undertaken by the elected municipal council (annual public health report).

Evaluation of the implementation of the Public Health Act:

- Hege Hofstad. (2016). The ambition of Health in All Policies in Norway: The role of political leadership and bureaucratic change.
- Arild Schou et.al. (2014). Samhandlingsreformens effekt på kommunen som helsefremmende og sykdomsforebyggende aktør. NIBR-rapport 2014:21

Empowerment & participation

The Public Health Act is based on five fundamental principles that shall underpin policies and action to improve population health. Participation is one them:

***Participation:** Public health work is about transparent, inclusive processes with participation by multiple stakeholders. Promotion of participation of civil society is key to good public health policy development.*

Target population is the whole population of Norway

Governance

Systematic public health work: One of the main features of the Act is that it places responsibility for public health work is as a whole-of-government and a whole-of-municipality responsibility rather than a responsibility for the health sector alone. In public health work the municipalities must involve all sectors for the promotion of public health, not just the health sector.

Potential of scalability

As explained here, https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/1234.pdf , "Instead of detailed requirements, the Act prescribes procedural requirements that will provide the municipalities and counties with a foundation for systematic and long term public health work across the sectors, based on the municipalities' own planning and administration systems. The municipality shall implement the measures that are necessary for meeting the municipality's public health challenges."

6.4. Discussion on transferability

1. **What do you consider the "fundamental nature" of the original intervention that should be preserved?**
   - Responsibilities at the local (municipality), regional (county) and national (state) levels are specified.
   - The local and regional levels are key stakeholders, making the healthy choice the easy one where people live, work and play. Also clear responsibility for the national level to support the work.
   - The responsibility for public health work has been moved from the Health Service sector to the Municipality itself. Therefore Municipalities/counties:
     - Have an overview of the status of health and the determinants of health in their population, which represents the basis for other responsibilities in the act.
     - define their public health challenges and priorities as well as concrete overall goals and strategies to meet the public health challenges (systematic planning every 4th year).
     - implement measures to meet the public health challenges, addressing not only health related behaviors but also social determinants, including housing, education, employment and income.
     - conduct evaluation of stated goals, strategies and efforts each planning period (every 4th year). Also, annual review of all public health efforts should be undertaken by the elected municipal council.

2. **What are essential elements of project management and project governance of the primary intervention?**

The Public Health Act is comprehensive, stating responsibilities at the local (municipality), regional (county) and national level. Local and regional level are key stakeholders but the national level has clear responsibility to support the implementation. The responsibility has been moved from the Health service sector to municipalities who are now responsible for primary health care service and public health work. All counties and most municipalities have public health coordinators.

3. **What are indispensable conditions of the original context?**
   - Systematic public health work with the new Public health act in 2011, stating the responsibilities at the national, regional and local level. Long term instead of short term focus. At the same time revised Muncipal Health Care Act and National Health and Care Service plan introduced.
   - The National level provides various support for monitoring and capacity building. It provides data to municipalities/counties regarding the status of health and determinants of health in their population. Also for example seminar/courses at least 2-3 times a year, platform for networking and evidence based guidance for implementation of measures.
   - Based on the data municipalities/counties shall define their public health challenges and overall goals and strategies to meet these challenges. These are to be included in the local planning strategy which is revised every fourth year. Municipalities shall then implement measures according to their plan.
   - Public health coordinators to coordinate the work at the regional and local level. Interdiciplinary team is very useful.
   - Evaluation of stated goals, strategies and other public health efforts.

4. **What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?**

The Health Promoting Community (HPC) project is currently in preparation/early implementation phase in Iceland. It´s run by the Directorate of Health in collaboration with key stakeholders. The main aim of HPC is to support communities all around the country to create supportive environments that promote healthy behaviour and lifestyle, health and wellbeing of all inhabitants. This is done, in part, by encouraging the engagement of a Health in All Policies approach to political decision making, as well as applying scientifically sound, holistic methods. Indeed, the project encourages the inclusiveness of key stakeholders, the use of evidence based methodologies, and the application of key health indicators, provided by the Directorate.

For DOHI it was therefore very valuable to be able to visit Norway and get more in-depth information about (who, what, why, how …):

- The Public Health Act
- The Healthy Life Centres
- How Norway collects and uses Public Health Data (Public health profiles, Municipal statistics databank, Fact sheets etc.)
- How Norway connects data, policy and actions by building bridges between research and actions.

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- How Municipalities have the flexibility and are organizing the public health work in different ways.

However, it has been shown e.g. that it matters where public health work is stationed within the administration of the municipalities.

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7. Portugal – National Programme for Promotion of Healthy Eating (PNPAS)

7.1. Introduction: The PNPAS aims and objectives

The Portuguese national programme on healthier eating (PNPAS) is a multifaceted strategy based on several measures and a collaborating network of different partners. Its design is based on international documents and key European and WHO policies, strategies and recommendations in the area of on food and nutrition. The main aim is to improve the nutritional status and health of the Portuguese population in order to prevent common chronic diseases. The PNPAS has five general goals:

a) To increase the knowledge about food consumption by Portuguese population, its determinants and consequences.

b) To modify the availability of certain foods, namely in schools, workplaces and public spaces.

c) To inform and empower the population in general, especially the most disadvantaged groups, on how to purchase, cook and store healthy foods.

d) To identify and promote cross-cutting actions to encourage the consumption of good nutritional quality foods in coordination and integrated with other public and private sectors, namely in the areas of agriculture, sports, environment, education, social security and municipalities.

e) To improve the qualification and mode of action of the different professionals who, through their activity, may influence knowledge, attitudes and behaviours in the food area.

Activities focus on health education, availability of healthy food in schools, workplaces and public spaces and collaboration with other public and private sectors, namely in the areas of agriculture, sports, environment, education, social security and municipalities. The target group is the general population with a focus on inhabitants of disadvantaged neighbourhoods.

An adequate food consumption and the consequential improvement of the nutritional status of citizens has a direct impact on the prevention and control of the most prevalent chronic diseases at national level, but should also enable, simultaneously, the economic growth and competitiveness of the country in other sectors such as those related to agriculture, environment, tourism, employment or professional qualification.

The PNPAS programme was designed and coordinated by the Directorate-General for Health. The programme coordinates its strategies with different partners of the sector, from food producers to consumers, represented on its Advisory Board, with the technical support of its Scientific Council. The PNPAS considers particularly relevant the collaboration of local and regional health structures in the operation and supervision of the different strategies and structures and in the coordination with educational institutions and municipalities.

Further information here, p. 187

7.2. The PNPAS Approach: Summary of presentations and minutes

Presentations

- The PNPAS Approach
- Communication and literacy in nutrition
- Nutrition education: Nutri Ventures Project; Jorge Oliveira – Business Designer and Founder, *Active Media Ltd.,*
- Development of innovation: portable measuring device for salt

7.2.1. The PNPAS approach

PNPAS is one of eight priority health programmes delivered by the Directorate General of Health (DGS). Formulating and implementing national food and nutrition policy goes back to the 1970s with the establishment of the Centre for Nutrition Studies, recommendations for healthy food were issued in 1990, the National Programme Against Obesity was launched in 2005 and was replaced by the platform against obesity in 2007. The focus is no longer on obesity alone but has been broadened to include healthy eating in general, social aspects as e.g. accessibility to good food or socio-economic aspects of inequality.

- PNPAS sought to influence specific types of food, environment, education that would impact on CVD, diabetes etc., and sought to stimulate the growth and economic competitiveness of the country's other sectors e.g. agriculture.
- Achievements and successes of the PNPAS include:

  1) Integration of data sources (e.g. nutritional status, nutrition and disease, determinants of nutrition status) and improving quality of data – there was a need to integrate all the various silos of data into one area;

  2) Working with all citizens within society to improve purchasing, cooking and storing of foods;

  3) Working cross-sectorally to promote healthy eating;

  4) Working with municipalities;

  5) Developing guidelines for health professionals and

  6) Working with all people who could influence knowledge and attitudes towards food e.g. catering and restaurant sector.

- Success in the fight against obesity among children (6-8 years) is shown in the table:

	2008	**2010**	**2013**
Obese Children 6-8 yrs	15.8 %	14.7 %	13.9 %
Overweight and Obese children	37.9 %	35.7 %	31.6 %

	2006	**2014**	
Adults (overweight and Obese)	51 %	52.8 %	

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- A logical model for the national programme (PNPAS) has been developed and is under review with WHO: situation, inputs, objectives, strategies), outputs
- Key Initiatives and Programmes:
  - A strategy for reducing salt intake in Portuguese population by modifying availability
  - A mapping of national nutrition programmes to get a better understanding of the range of initiatives delivered by whom and where. A database of nutrition initiatives is in development.
- 15 Reference manuals and resources for health professionals e.g. guidelines on nutrition for different population groups are available.
- Some Nutrition/Dietary Issues in Portugal:
  - 6.6 % of Portuguese households have severe Food insecurity. In particular before the backdrop of the economic crisis: 1 of 14 Portuguese families had their food compromised due to lack of money
  - Salt intake is higher than in other countries. Average dietary intake is 10.9 g/day, which is double the recommended intake for salt (<5 g/day).

Lessons learnt

The DGS acted as the lead agency in developing and providing nutrition knowledge and content for all nutrition matters in Portugal. DGS also influenced the food security agenda by influencing the Dept. of Social Security to provide guidelines on choosing healthier food choices/healthier food baskets.

DGS produced a manual and website, and a set of guidelines for healthcare professionals to support low income groups eat and cook low cost healthy meals.

7.2.2. Communication and Health information

When providing information to the general public, new media are important, old media are still viable for a larger share of the population. Digital marketing needs to be taken into account, as well as the fact that audiences want to take part and get active. Transmedia is a framework in which different media are used to encourage participation and interaction with target audiences.

At the beginning DGS had a website but no social media platform. Active Media helped to launch the 'Nutrimento' blog and App. With no other social media support, Nutrimento is growing organically on its own content. Nutrimento shares an official DGS facebook page which increases more visitors but not engagements. One year after the launch of Nutrimento, the website was rebuilt with one clear objective to make it easier to understand the relationship between health and food and to increase access to website by the general public rather than health professionals.

The website was relaunched as "food roulette". All content is interconnected e.g. content includes the name of a food, which when 'clicked' brings you to a recipe with that food as the main ingredient; the food may also bring you to a list of nutrients in that food; there are different suggestions for preparing the food; different search options: specific ingredients, specific conditions. The website also contains:

- New tools like BMI calculator – one feature of this tool is that the information is checked against several levels of health literacy so as to be more accessible by those with low literacy.
- Specific suggestions for food according to the seasons
- Videos: showing how easy it is to prepare food (e. g. porridge; 3,000 clicks in only one week; most clicked and commented video on the DGS page ever); format is important in order to fit the format of the respective platform (square vs. wide-angle)
- Content to support researchers, teachers

- Constraints: funding, no specific experts on social media; crossing boundaries across different population groups and networks
- The website content has not yet been focus tested with the target audiences, especially low income groups. However DGS ensures that the content of its website is appropriate for, readable and understood by the general public. The use of videos supports those with low literacy levels.

7.2.3. Nutri Ventures

Nutriventures (NV) is the first worldwide entertainment brand designed exclusively to promote healthy products (not that much processed food, fresh cooking, food literacy). NV's mission is to develop entertainment contents that encourage children to eat healthily, in particular through entertainment. NV brand is sold in 30 countries and appears in the top 5 TV ratings.

- The target audience is children aged 4 – 10 years, parents and educators.
- NV drives children's food preferences for healthy products and brings positive connotations to healthy food by using animated video clips and music.
- A study of 147 children by the University of Liverpool and University of Porto, found that the amount of healthy foods chosen by children who watched NV TV was double that of those who didn't watch NV TV.
- NV is a private not-for-profit organisation, which has a number of international partnerships, including with governments. It has an official partnership with DGS. Its extensive licensing allows companies to profit from the brand by a positive image and higher turnover. NV is independent of the Food Industry and has no relations with it.
- There are 2 sources of funding for NV in Portugal: Food/product licensing and Sponsorship

NV and DGS partnership is mutually beneficial in that both organisations jointly work to combat childhood obesity and to develop and improve the contents of NV materials. It is the view that there are no conflicts of interests in the partnership arrangement, between NV and DGS as NV's commercial side of the business is focused only on the honest promotion of healthy foods and does not promote unhealthy foods.

Note: DGS is selective in their partnership arrangements and they have some guidelines in place (in Portuguese). Broadly, these guidelines include:

- No monetary exchange in such partnerships
- The DGS involvement is in an advisory capacity to help improve scientific and consumer content
- There is no promotion of any product or company

- There is no association or relationship with any major food company
- Support is only provided for scientific projects and not commercial /profit making projects
- DGS works with the five largest food distribution chains (e.g. Lidl), who have a 70-80% of market share, so in effect DGS are covering a majority of food retailers, which in effect influences almost other retailers in Portugal as well.
- There is no brand association when generating nutrition content/recipes.
- There is scope for the food company/retailer/distributor partnering with DGS to work with other food industries where there may be a vested interest.

Lessons learnt

- It is not possible to look at all food issues at one time e.g. salt, fat, sugar etc., but instead adopt a step by step approach and tackle one issue at a time. In Portugal, salt was the first issue to be tackled and currently DGS is approaching the issue of a sugar tax.
- Discussion needs to start with some 50 actors/ stakeholders trying to find a compromise; personal relations play an important role for 'buy-in', be it in favour of change or opposing it; this can be highlighted by one example: in the case of reducing salt levels it was almost impossible to find a consensus; after one member of the circle/ board to decide about lowering salt levels has left, compromise was found: 0.2g salt/ 100ml soup; regulation might be the only way out, though government might not be strong enough to do it for all areas, so negotiations might be the only choice;
- A vending machine policy will be introduced in hospitals in Portugal shortly and guidelines on food in vending machines will be available in schools – but this will not address issues around the origin of food; attempt is to start with a certain share of organic and local food sources for school food provision**.**
- A major success is high visibility of the PNPAS and possibility to transfer; Algarve and north are good examples Starting a campaign with provocative content may be another successful strategy.
- In general, PNPAS is an example of a National Programme, based on healthy eating policy incorporating a concerted and cross cutting set of actions to ensure and encourage access to and consumption of healthy foods in Portugal. Implementation lies at national level with regional level support.

Success factors in transferring practices

- Networks of Professionals (i.e. Nutritionists and Dietitians) that are connected to one another and ability to have easy access and reach to peers in the nutrition and dietetic community.
- Nutritional scientists are young, first started in 1970s; very immediate personal relations stemming almost exclusively from one faculty is of major importance; personal exchange, knowing each other by name, getting in contact with each other; small country and homogeneous structure eases the process considerably; important to have one leading figure

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- **Challenges:** Given the extensive use of digital and social media by young people today, it is very difficult for both healthcare professionals and parents to keep pace.

7.2.4. Development of a portable equipment to monitor salt content of foods

A study conducted by the University of Porto found that in Portugal, salt intake is more than double the recommended ratio; the main sources of salt are in vegetable soups. It's difficult to raise awareness in chefs, as there are no common routines available.

- Development of a device to measure salt in food (different approaches existed but were complex and time-consuming): User-friendly interface for 5 different types of food (rice, bread, soup, vegetables, meat and derivatives); preparation steps are shown on-screen
- Next steps are a small sample of 20 industrial prototypes in order to test them in schools and the NHS; dissemination of results
- Funded by the DGS in the beginning; DGS has some leeway and resources of providing money to interesting projects; advantage: good collaboration; university of Porto has patent on the device; selective for sodium; sample needs to be homogenous and in-solution.
- Aim is to control the level of salt in big canteens, in particular in soup
- Suggestion to feed back the values electronically to school boards, dieticians, caterers
- It would be more difficult to use a similar device to measure levels of sugar in foods
- Food safety authority positive about purchasing devices (potassium, nitrite, chlorite possible)

7.3. Regional experience: The PNPAS in the Algarve Region

Presentations

- The PNPAS in the Algarve Region; Teresa Sofia Sancho, Nutritionist and Regional Administration of Health Algarve
- Oral Health School Libraries – An Inclusive Public Dental Health project; Dr. Cristina Ferreira, Oral Health and Nutrition
- Intervention in Schools; Dr. Rui Lima, Ministry of Education
- Evaluation of the situation, Carla Ferinha
- Back to School with Super Gang dos Frescos; A campaign to promote fruit and vegetable consumption among children, Sara Santos, LIDL

7.3.1. National Programme for the Promotion of Healthy Eating at Algarve Region

The coordination team and structure is reflected in the following table:

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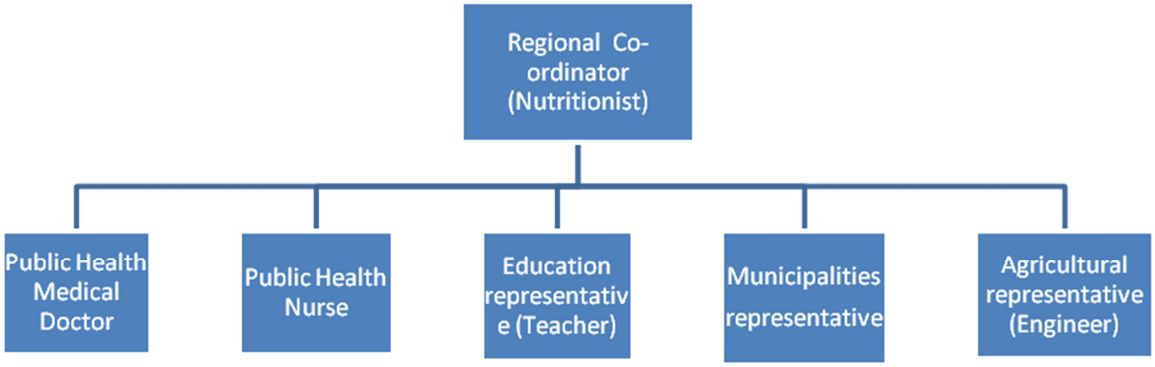

- **Aims are:** to collect data on food consumption, physical activity, and nutritional status of population; information about nutritional quality in the food supply especially school canteens, school bars, vending machines; promote healthy eating;

Methodology: social ecological model as base for project across a number of settings

Activities include:

- Projects and partnerships (university of Algarve, municipalities, regional hospitals, regional education authority, regional health authority, regional sports authority, parents' representatives, agricultural association, Algarve bank),
- Improve qualifications of healthcare professionals (primary health care staff [doctors, nurses, psychologists, dietitians, nutritionists, physiotherapists, occupational therapists] and teachers, pre-school staff, physical education teachers), through provision of training sessions.
- Collecting and monitoring data for the region

Improve Food Environment by:

- **1.** Promoting healthy menus in school canteens, monitoring compliance of school canteens and implementation of corrective measures.
- **2.** Developing guidelines on Foods offered in school bars and canteens.
- **3.** Supporting Citizen Empowerment through local and regional projects:
  - **Local projects** including physical activity and food literacy; social vegetable gardens (users are most often deprived citizens).
  - **Regional projects** (e. g. Food Education in Health Centres, food education in schools for parents and children, food education in the work environment; social vegetable gardens; collaboration with the local health authority, with Algarve Food Bank Against Hunger; Public awareness campaigns and education material to improve awareness of healthy eating; support material for different age groups; platform of communication with the community using a website ('Open Window to the Family'); Nutrition Consultation in health centres and hospitals.

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- **Examples of Regional Programmes that contribute to PNPAS**
  1) Programme targeting childhood obesity, programme “escola active”
  2) Active School Project – to increase quantity and quality of physical activity in the whole school community (Note: The WHO Health Promoting School model is not implemented in Portugal – this was abandoned a few years ago)
- Work with healthcare professionals and teachers; they are used as multipliers.
- COSI study is sampled to represent the regional, national, and local level.
- Good data set is very important; otherwise there is no opportunity to compare to others; when community is collecting data, it is easier to tackle related and other problems: comparing schools in municipalities, shortcomings can be identified.
- Lack of data about disadvantaged and deprived; often, the difficulty in gathering data from disadvantaged groups lies in gaining access to the groups as there are many different organisations/groups working with them, not organised or coordinated;
- National database, same software where all nutritionists are included and feed the database: anthropometry, fruit and vegetable consumption, physical activity level, breast feeding rates, weaning age; can be combined with data about chronic diseases; reasons for this unitary approach was scarcity of money, so that only one software was programmed.

Lessons learnt: success factors of the PNPAS at regional level

- Cross sectoral working and partnerships at regional level, for example, with Public Health Medical staff, public health nurses, municipality representative, hospital representative, education representative and agricultural representative.
- Having a network and an experienced team at local level to support implementation and delivery.
- Training of other healthcare professionals to support delivery of nutrition education, information and initiatives.
- Collecting, analysing and monitoring data on risk factors at municipality level particularly on overweight and obesity, provides a much richer picture of the issues specific to a location. Local data analysis prompts municipality to investigate problems and take appropriate actions. This will help target those in most need but also enable comparison of prevalence rates of overweight and obesity to national and international rates.
- Having a national nutrition enquiry system to collect nutrition indicators. The system enables access to all nutritionists and primary healthcare professionals supporting them to collect and enter nutrition indicators data. Some indicators include physical activity levels, fruit and vegetable consumption, weaning age of children, breastfeeding rates etc.

7.3.2. Oral Health School Libraries – An Inclusive Public Dental Health project

Cooperation with oral health school exists already; further development is to bring together schools and libraries trying to incorporate issues into national curricula.

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- Different ways to relate to these information: teachers and students can draw upon these information to use them in different contexts
- Biscuit box to colour and draw on, while content contains CDs, books, brochures; another version was drawn by an artist to be recognised in schools, to provide papers to colour/ fill in; protagonists are vegetables and fruits
- Huge success; they started to produce posters and hang them in healthcare centres (different topics are covered: bread, oil, health of teeth, cheese, fruits, vegetables, sugars); collaboration is also very requested by schools
- Vouchers to the 7, 10, 13 yrs. olds to receive some preventive treatment and advice about oral health; up to 6 yrs. of age they can go to a clinic to receive treatment for first teeth; after that children can receive treatment for caries and prosthesis; pregnant women can receive treatment free of charge as well, as well as patients with oral cancer; reduced amount for low-income takers
- Further information at www.sobe.pt

7.3.3. Intervention in schools

All schools are obliged by legislation to have a health promotion policy in place with one teacher dedicated to health education in their school. What works very well in Portugal is the collaboration at local level between teacher and nurse or physician and health centres. Teachers' role in health education is additional to their role in teaching the curriculum.

All schools in one particular area cluster together and decide on the priority issue(s) to be addressed. This reduces resource requirements, helps coordination of efforts between teachers and health educators and local primary care centres. Sometimes schools work together with kindergartens in order to have a continuous scheme for one area from 1st level to 3rd level schools.

A mapping of all initiatives conducted by DGS and database of initiatives developed, free access to everyone; evaluation is still to follow in a 2nd step; compilation of indicators that are crucial for the success of the project. There is a national indicator set and local set of indicators which influences the design and implementation of interventions to report and monitor on agreed indicators

- Lunch plan is centrally set up; priority is given to local and fresh ingredients, provided by municipalities
- The programme is subsidised by ministry of education, low income takers are fully subsidised and do not need to pay. Payments at school are done by vouchers, so no cash money is needed; this helps to prevent pupils to buy additional, unhealthy food just outside the schools
- The challenge is to look around the area of a school and avoid that anything that is forbidden at school is provided in close proximity of them
- UK scheme: little school gardens to grow vegetables; food education includes to learn how to prepare and cook food; in Portugal almost all first level schools have their own garden; cooking classes are tried, but only 10-50 % of schools have these classes; overprotection is an issue: kids do not know how to peel fruits, how to use a knife;

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- Problems to have chefs promote healthy food in Portugal are: most of them are associated with specific brands; Mediterranean diet is associated with cultural heritage and tradition, so chefs would be the wrong bearers of tradition. In conclusion, a figure like a trustworthy, well-known grandma would be needed.

7.3.4. Evaluation of the situation

Risk factors do not change too much over times and do not vary too much across Europe. However Portugal's inhabitants have a high level of intake of salt.

The PNPAS is one of the 9 Priority National Programmes (Nutrition and Healthy Eating; Prevention of Tobacco Consumption, Alcohol and Drugs, Cardiovascular disease prevention; Cancer Prevention; Mental Health……..)

- All programmes have reporting mechanisms in place; need to introduce system to measure the current situation with up to date data.
- Data collection is required to provide knowledge on nutritional status, dietary intake/consumption and its determinants of health; assessing food safety issues; assessing monitoring and dissemination of good practices.
- One of the challenges in Portugal is the multiple sources of data being produced by a variety of people and agencies. Too many databases with very little sharing of data and often the data is of poor quality.
- Top-down approach is sometimes important in Portugal as it brings people together who otherwise would not have met or done this particular type of work and get things started in the first place

Lessons learnt

- Negotiation and agreement by all players was challenging. This was achieved by personal connections and persistence; took them about 20yrs.; directive of ministry is the key factor: the ministry needs to drive the process to make it work.
- Lengthy reports provide good quality information and data, but are often not read by decision-makers due to too much detail. One solution might be to present the top line data in the form of info graphics, as well as producing a detailed report for additional reference.

7.3.5. Back to School with Super Gang dos Frescos; A campaign to promote fruit and vegetable consumption among children

The partnership started in 2011 with school roadshows in 11 elementary schools and "My 1st recipe book". In 2014 cuddly toys were introduced (mushroom, orange, plum, pear, broccoli, fig, strawberry, eggplant, tomato and others, you needed stamps to get one), as well as swapping cards (different values, different issues are given on the cards, nutritional values of various fruits and vegetables are provided in order to counteract the conditions presented). School roadshows included shopping simulation with healthiness assessment of each cart; quizzes based on 52 game cards; dance shows with fruits, promoted by VIPs. Results:

- High identification with the cuddle toys; after the game children preferred to have fruits

- Well known chef came for launch event, many people were reached by social media; estimated overall return of value: €460,000
- No flow of money, free of charge for DGS; evaluation of facts through DGS
- Goodness gang project is over as license has expired; needs of elementary schools need to be assessed before continuing with programme. First evaluation after three years shows that children continue to eat fruits after the game stopped

7.4. Discussion on transferability

1. **What do you consider the "fundamental nature" or fundamental elements of the original intervention that should be preserved?**
   - The starting point is rooted in *scientific evidence* (too high average rates of sugar and salt intake in population).
   - Data from Portuguese Food Balance sheet 2003-2008 and other dietary intake surveys provided evidence that between 2003-2008, in comparison with 1990's, the eating pattern of the Portuguese population had deviated from healthy eating recommendations.
   - The Ministry of Health is the driving factor behind the programme and called for action around the topic of nutrition. Here, *one key figure is needed with passion, good negotiation and social skills, who has a vision* that is compatible with the work of partners. In addition, a strong persistence is needed in order to accomplish change, as it is a lengthy process which, in this case, has taken 20 years so far.
   - In addition to that, *a large network of diverse partners* is needed to cover a broad share of everyday life. They can be municipal, private for-profit or private not-for-profit cooperation, the healthcare system, associations, media, cooperation between different municipalities, regions, or ministries. Each *network partners profits from cooperation*, while they need to *comply with standards set by the ministry*.
   - *Good personal networks* and relations are a contributing factor to effective communication and in the process to come to terms with each other.
   - However, despite the centrally set standards it is essential to give *leeway and flexibility* to the local partners to adapt the programme according to the local needs.

2. **What are essential elements of project management and project governance of the primary intervention?**
   - While a larger number of different actors and many different initiatives/ interventions are involved, the programme is *governed under a central framework by the DGS* (Directorate General of Health). Though the five regions of continental Portugal are merely of administrative character and the practical implementation takes place at the municipal level, they are involved and take over coordinating tasks. *Regional and local coordination teams* are essential for the implementation on the ground and usually consist of a nutritionist, a municipality representative, a representative for education, a representative for the agricultural sector, a public health medical, public health nurse, and a representative of the respective hospital(s).

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- The *central governance* is based on the principles of the Health in All Policies approach with the aim of involving different sectors of society and promoting cross-sectoral policies and measures.
- *Proper documentation and mapping* of all measures taken was key to the evolution and improvement of the overall programme. Partners from all over the country feed databases with indicators/ measures they have taken, the experience they made with them, and process data. They have access to the data from all other partners, so that a transparent improvement process can start.

3. **What are indispensable conditions of the original context?**
   - A political commitment on national and local level and the support of the Ministry of Health (Directorate General of Health (DGS)).
   - A unified structure of the state administration and healthcare system.
   - Scarce resources resulting from the financial crisis forced DGS to look at existing initiatives and focus on changing and improving current practice and approaches rather than designing a new national health promotion programme. This also led private actors to refrain from actions they otherwise would have pursued. It also fostered cooperation between DGS and the private sector, since need was present, but no money was available for competing projects (e. g. for databases or websites).

4. **What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?**
   - It is necessary to have a clear and detailed description of the methodology adopted to develop the strategy, which elements worked well and not so well. Central documentation and a constant exchange between the different sites and users and elements of the programme contribute to the description and ease the identification of strengths and weaknesses.
   - Documenting practices ensures that it so can be shared and used by others.

5. **What are key lessons learnt during implementation?**

   The main lessons are related to:

   - The capacity to develop a multisectoral intervention, involving different ministries and the private sector.
   - The establishment of public-private partnerships with strict guidelines governing the Public-Private partnerships that the DGS is engaged in.
   - *Cross sectoral working* and partnerships at regional and local level are very important (e. g. partnerships with universities, municipalities, regional hospitals, regional education authority, regional health authority, regional sports authority, parents' representatives, agricultural association, etc.)

- **National and local level implementation**

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- A key to success is *coordination and governance at national level*, while *implementation is at the regional and local level*. Skilled coordination teams at every level of conceptualisation and implementation are necessary to achieve this. Cross sectoral teams at the municipality level drive programme implementation. The team is comprised of a coordinator (a Nutritionist), public health medical doctor, public health nurse, and a representative each from the municipality, the local hospital, the local school, and agricultural setting.
- Skills to mediate with other stakeholders are also necessary. In order to advertise the programme, to get politicians and stakeholders interested in it, and to improve it the collection of appropriate data is highly relevant.
- Flexibility at *local level to choose most relevant interventions* to address regional and local needs in the context of local needs and settings (differing according to different focuses/ problems (culture, migration, socio-economic factors) and settings (toddlers, disadvantaged areas) etc.).

- **Data collection and monitoring at local level:**
  - An agreed *set of indicators* developed at national level are cascaded to regional and local levels where the same indicators are collected locally. Primary health care professionals are responsible for collecting and reporting of indicators. Financing of primary health care centres is dependent on achieving indicators/ targets at local level. Collecting, analysing and monitoring data on risk factors at municipality level (as opposed to national level) particularly on overweight and obesity, provides a much richer picture of the issues specific to a location. Local data analysis prompts municipality to investigate problems and take appropriate actions, if needed.
  - Having a *national nutrition enquiry system* to collect nutrition indicators. The system enables access to all nutritionists and primary healthcare professionals supporting them to collect and enter nutrition indicators data. Some indicators include physical activity levels, fruit and vegetable consumption, weaning age of children, breastfeeding rates etc.
  - There needs to be *sufficient and effective IT resources* and capacity at national level to support data/ indicator collection and monitoring.

- **Communication**
  - *Networks of Professionals* (i. e. Nutritionists and Dietitians) that are connected to one another enables easy access and reach to peers in the nutrition and dietetic community.
  - Legislation to support 7 *different types of healthcare professionals* (e g., psychologists, nurses, doctors etc.) to deliver nutrition information and support to the general public.
  - *Training of other healthcare professionals* to enable those professionals (e. g. primary health care staff [doctors, nurses, psychologists, dietitians, nutritionists, physiotherapists, occupational therapists] and teachers, pre-school staff, physical education teachers) to deliver nutrition education, information and initiatives.
  - Having a *Social media* (e. g. Facebook) *presence*
  - *Website re-development*: One-stop-shop for all nutrition related information – scientific information for dietitians/ HCP's and tailored information for general public

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8. UK – Well Communities

8.1. Introduction: Well Communities' aims and objectives

The Well London (now renamed to Well Communities) is an innovative framework that started in 2007 which enables disadvantaged communities and local organisations to work together to improve health and wellbeing, build community resilience and reduce inequalities. It consists of a series of programmes run in 20 of London's most deprived areas. It was devised in the context of the Mayor of London's health inequalities strategy. The objectives are to:

- Increase levels of healthy eating, physical activity and mental health, especially among those who have experienced barriers to accessing services in the past;
- Increase levels of responsiveness of local service deliverers to community need;
- Build the knowledge and skills of local residents and communities in order to improve their own wellbeing and promote a sense of community;
- Achieve leverage on existing services - making them more responsive to local needs;
- Help build ambition and aspiration in communities by empowering people to take up services and make small changes;
- Help make the community engage more meaningfully by mobilising participants who would not otherwise take part;
- Provide feedback to local providers of health and social care.

The project is an approach to engage and empower people in local communities using a grass roots upwards approach. Each project recruits teams of volunteers from deprived areas who receive training in outreach and health promotion and then go out into their communities to signpost local residents to services and activities that promote health and wellbeing.

Two phases have been completed and phase 3 has just started. So far it has run in 33 areas across 20 London boroughs. Phase 1 ran from 2007 to 2011 and included a suite of 14 projects aimed at building community capacity and cohesion. It focused on physical activity, healthy eating, mental wellbeing, local environments, arts and culture. Its collective aim was to improve health and wellbeing. Over 47000 people took part in phase 1. It was evaluated in 2011/2012 and was found to have had very positive impacts in improving diet and physical activities. The results of the evaluation have informed the development of Phase 2 of the programme which has run from 2012 to 2015 and is being evaluated. Phase 1 was largely funded by the Big (National) Lottery. In phase 2, local authorities and other organisations have provided funding for the project and for its independent evaluations.

The activities seek to integrate with existing local actions, to build individual and community confidence, social cohesion, sense of control and self-esteem through formal and informal community and social support networks. See Figure 1 for a summary of the project's framework and Figure 2 for a summary of how phases 1 and 2 have led into phase 3.

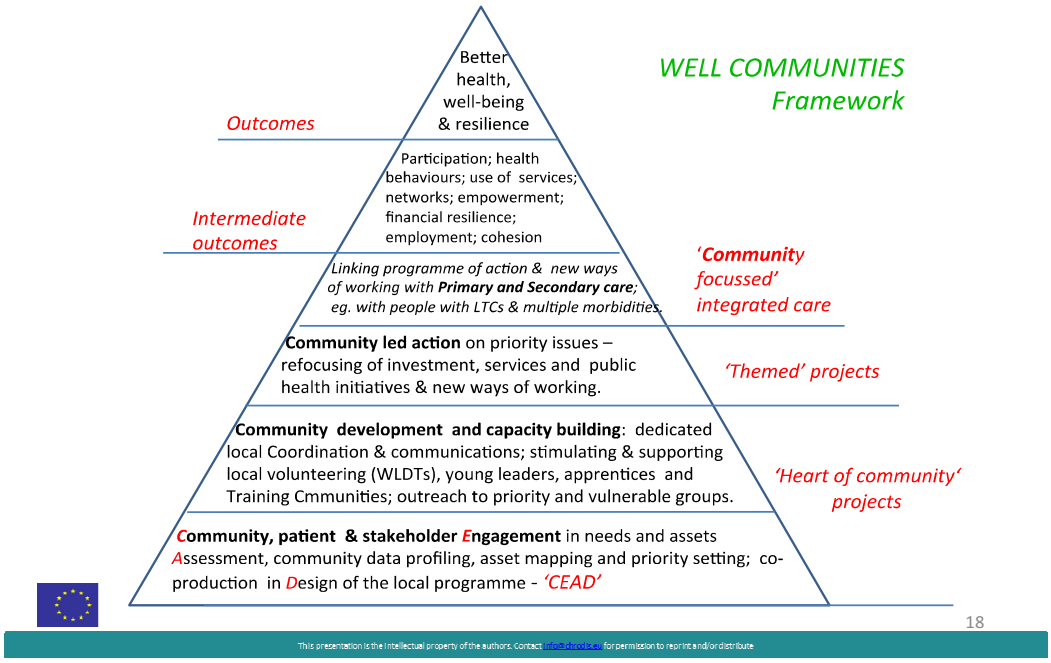

Figure 1 – Summary of the Well London (Communities) Framework

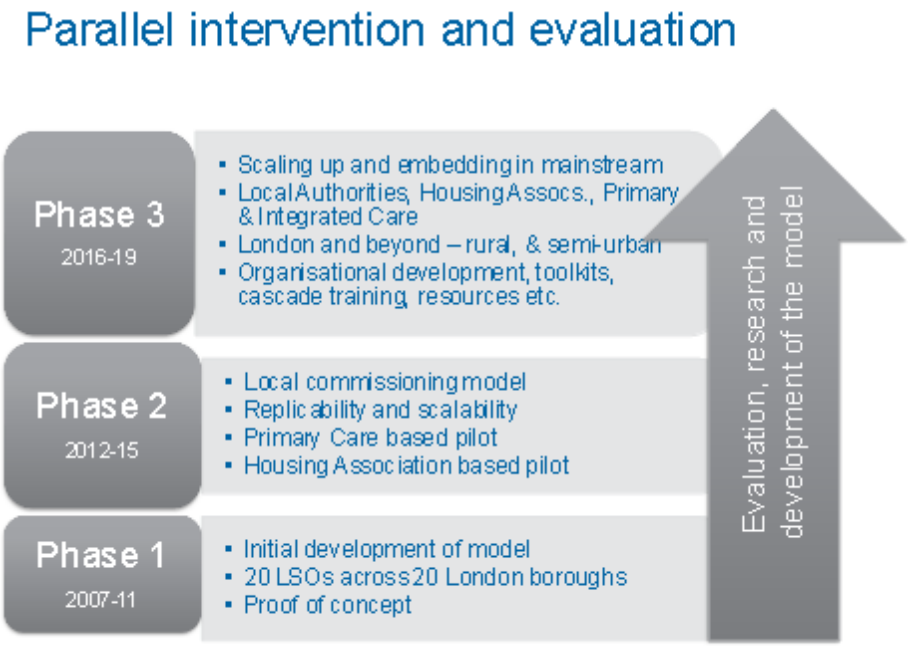

Figure 2 – How Phases 1 and 2 Lead into Phase 3 with Parallel Evaluation and Research

Further information here, p. 273

8.2. The Well Communities Approach: summary of presentations and minutes

Presentations

- The history and development of the Well Communities model, in theory and in practice; Gail Findlay, Institute for Health and Human Development, University of East London
- The vision for Well Communities as a national framework, Dr. Heather Davison, Royal Society for Public Health
- The parallel programme of evaluation, research and development; Dr. Patrick Tobi, University of East London

8.2.1. The history and development of the Well Communities model

The development of Well London started in 2007 under the coordination of the Greater London Authority in partnership with the University of East London and five other organisations. Funding came from the National Lottery. From the beginning the aims were to develop a robust, evidence-based framework for communities to work together, to influence policy, and to achieve a new way of working rather than stop-start or time-limited projects.

The **mission** of Well Communities is to empower local communities who can take control of and improve their own health and well-being, to develop a robust evidence-based framework and build a wider Well Communities alliance to share learning and the further development of the framework. The focus of the ***Well Communities*–approach** is on:

- Work at a very local level – focusing on the most deprived need areas
- Re-focusing of investment to realize and develop community assets – especially people themselves in the target areas
- Building on, and adding value to, existing local work; this includes coordination, integration and application of a coherent and more systematic approach
- Development of strategic and commissioning organizations, and *local* delivery organizations
- Rigorous project management, monitoring and evaluation

Robust evaluation running parallel to the programme is also integral to the approach (approximately 10% of the total budget), as is a longer-term perspective than usual in many other projects as well as the idea to transfer the approach to other areas outside of London

Three phases: The programme started in 2007. Besides the National Lottery, new partners are funding the programme such as local authorities:

1. Phase 1 (2007-2011): 20 LSOAs (Local Super Output Areas) across 20 London boroughs
2. Phase 2 (2012-2015): Testing out a local commissioning model, replicability and scalability; including housing association and primary care based pilots; some neighbourhoods worked out better than others; learning what factors were important for success

3. Phase 3 (2016-2020): scaling up, embedding; partnerships with housing associations, primary and integrated care, local authorities.

How does it work: Framework of Well Communities

- The basis is the **CEAD project (*Co*mmunity, patient and stakeholder *E*ngagement in needs and assets *A*ssessment and mapping and *D*esign)**. This incorporates community cafes; appreciative enquiry; priority setting; co-production in ***D***esign of the local programme. They knock on doors for a simple survey and invite members of the community to world cafes for setting priorities and possible activities. Commitment to and collaboration with the local authorities is important in this phase.
- A second step is **community development and capacity building**. The local coordinator with the right set of skills is absolutely essential. Training is also integral to the programme for example the training delivered to Well London volunteers by the Royal Society for Public Health, but also in the different neighbourhood (e. g. on food hygiene courses, piano lessons, urban living).
- A third step is the **community led action on priorities issues**; refocusing of investments, services and public health initiatives
- A new step in phases 2 and 3 is linking the programme and new ways of collaborating with primary and secondary care. This appeared to be an important factor for success.
- Evaluation and monitoring: programme evaluation's **intermediate outcomes:** such as participation; support networks; empowerment; self-esteem; resilience; cohesion of communities; employment; behaviour; use of services
- And finally this should lead to **outcomes as** better health, resilience and well-being

The programme has been implemented in 33 neighbourhoods. General issues have included the easy availability of fast food, mental health, bringing the community together, the local environment, young people, which mirror the wish to have a community inhabitants can feel part of. One of the key characteristics is that it is driven by local/ community needs in a bottom up approach, while the central level provides support and a certain extent of structure to the programme. Issues such as effective local communications and coordination and sustained support are important and build into all project activity.

Results: Over 36,000 people participated in phases 1 and 2 (35 % of the target population). 80 % of the respondents gave positive feedback in the questionnaire. There are significant improvements in physical activity, fruit and vegetable consumption and wellbeing. Outcomes agreed with the Lottery around increased levels of healthy eating, physical activity and mental well-being were met. Other outcomes are: numbers accessing training and qualifications, qualitative evidence (e. g. more paid employment, increased community cohesion, increased capacity of local communities (Council for volunteering service (CVS)), transformed community spaces and additional resources levered into deprived areas.
An example of the impact of the programme is the decreased turnover of inhabitants in one of the first neighbourhoods of the project. First, there was a high turnover in the neighbourhood, but now residents would rather stay as a result of the programme.

In neighbourhoods with a high fidelity to the programme (more on that cf. p. 7), results were better.

Lessons learnt and success factors

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- It is important to identify natural neighbourhoods (not formal boundaries)
- There is a need for
  - intensive, inclusive and transparent engagement
  - Skilled coordination
  - Time and effort to (re-)build trust
  - The 'heart of the community' capacity building projects (residents of the target area only, early identified and trained volunteers and resources for ensuring young people's engagement)
  - Local steering group and neighbourhood advisory groups
  - Senior representation
  - Strong positive partnerships between all strategic, local players and community

Key messages

- It is not an individual health behaviour change approach
- ….a *'causes of the causes'* approach!
- A very different way of working – not a fixed term intervention
- Long term, organisational and *system* change
- Long term investment/re-focusing of investment
- Building the evidence base – using *appropriate* measures and indicators

Well Communities is now in phase 3 in which the programme will be scaled up and mainstreamed. Programme activities are directed towards organisational development, toolkits, cascading the training. Also in this phase, there is a broader collaboration with housing associations and primary and secondary care.

In the next years Well communities will be implemented in other areas outside London

The lottery funding aimed to work on healthy eating and physical activity; not a conventional behaviour change programme. Now the themes are more diverse such as well-being, social cohesion and arts.

There is no public-private partnerships collaboration yet, but they are working on it

www.welllondon.org.uk (watch out for the new Well Communities Website)

8.2.2. The vision for *Well Communities* as a national framework

The Society for Public Health is a charity and established in 1865. They want to represent the voice of the public. Their focus is on developing health education and understanding what helps to improve the public's health. They trained for example over 50,000 Health Champions who volunteer in their communities, workplaces and other settings to provide signposting information and support to colleagues, friends and family. In the Well London programme, they train and enable the volunteers.

In England, severe health problems exit: a high share of alcohol-related admissions, a low level of physical activity, high share of obese population, 7 out of 10 pounds are spend on management of long-term issues while the healthcare budget is decreasing. Because of these problems, the Government made a fundamental shift from treating ill-health towards promoting prevention and decision making on local level.

Public health services and interventions now rest with Councils and there is more democratic involvement of local people in community health led initiatives.

Public Health England documented this view in "Fit for the future" a document about the future of public health. It is a road map to 2020: public health delivered through a wider range of partners that differs from one neighbourhood to the other and a community centred approach with decision making at local level, greater focus on community engagement and a stronger social movement to value and promote health and wellbeing.

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8.2.3. The parallel programme of evaluation, research and development

The evaluation of Well London takes place parallel to the development of the programme. Evaluation is based on the Theory of Change model. Ten percent of its overall budget is spent on evaluation. The evaluation is multilevel, theory based, using mixed methods and directed at the process and its outcomes.

Evaluation takes place at four levels: information on **participants** (outcome, background, motivation, experience**); area/ neighbourhood** (coherence, population level effects); **project** (process evaluation); **programme** (fidelity, legacy and transferability).

The **methods** are:

- **Qualitative methods** (document review, interviews, focus groups, case studies, reflective sessions, workshops; film about projects and different stages) and
- **Quantitative methods** (registration, attendance, monitoring reports, questionnaires (socio-demographic questions, physical activity, food and drink behaviour, wellbeing, friends, family and neighbourhood general health, volunteering and participation with validated scales)).

Well London developed **fidelity criteria** for the implementation of the programme: There are criteria for areas such as coordination (e.g. skilled local coordinators), community engagement (door knocking coverage), capacity building (trained volunteers and youth engagement), themed activities (local people's involvement in design and/ or delivery), partnerships and networks (engagement of local stakeholders). Another 10 % of the total budget is spent in order to meet these criteria.

Lessons learnt

- Cost are around 60,000 pounds/ neighbourhood*year (for around 5,000 to 7,000 residents). Other programme "troubled families" cost some 60,000 pounds/ family.
- There is a small programme management team of four to five and some staff time at University of East London for support.
- Use natural neighbourhood. In the first phase statistical areas were chosen, rather than natural ones, which led to a number of problems.
- There was a broad spread of areas across London in phase 1. All areas were in the 11% most deprived in London as measured by the indices of deprivation.
- Initially there was resistance in some areas because local organisations, institutions, or residents can feel that Well London has come along to take over.

- Well London is a good example of a community development approach and driver for change. A system change is needed.
- Proportional universalism

8.3. Concrete examples: site visits

Presentations

- GLA Opportunities and challenges for a global city; Dr Helen Walters, Head of Health
- Oral health; Richard Watt, Epidemiology and Public Health, University College London (UCL)
- Alcohol; Annie Britton, University College London (UCL)
- Neighbourhood effects on health and wellbeing; Stephen Jivraj, University College London

We spoke to residents in two Well London areas. On the **Aberfeldy Estate** some women gave us their account: Before Well London, they were isolated, depressed. They came to the community centre and with the help of the coordinator they became volunteers, received training in English and health courses and started their own activities (such as handicrafts, Paula's food coop, Leah's film project, David's mobile garden, Rikki's wellbeing project, Hannifa's football, Kerry's media project, Shuili's independent Women). They improved their speaking skills, their self-confidence (e. g .they liked to speak with us), started their own small business or got a part time employment. A result of the engagement of the younger people is the boxing academy.

On the **Woolwich Dockyard Estate** we saw a public gardening project and one site of the "men in sheds" project, where men were crafting wood, metal or other materials depending on their interest. As well as that and the general activities that are similar in all Well London communities (e. g. community events, door to door contact), computer classes are offered and classes for people (non-professionals) to recognise patterns of mental problems and disorders and how to deal with them. To increase physical activity in the elderly population, a "walking football" group has been established, in which football is played, but without running. Overall, it seems that the programme is boosting the self-confidence of many participants while others have gotten a more structured everyday life, social contacts and increased self-esteem.

First brain storming after site visits:

- A good area coordinator is essential for the success of the local project. A job description for coordinators is in place but what is decisive in the end is not necessarily knowledge and experience but attitude to the programme and community development.
- Coordinators need support too. They are networked to other coordinators and receive support from the central Well London Team.
- Is there a risk to the local programme if a Coordinator leaves? Volunteers gain some of these skills and have the opportunity to develop as leaders and take on new roles. In that sense, participants are taking their own leadership in the area they get active in, mirroring the basic idea to enable them. There are examples of role development of volunteers, who became contact person and treasurer.
- Some people are opposed to receive money from a lottery, but overall it is not an issue, as the National Lottery has a very good reputation.

- It is extremely important that people are asked at the earliest possible stage what their priorities are and what they would like to see in their area. Many people want to get involved.
- Gender mix: 30 % men, 60 % of participants are women; “men in sheds” is one way to get men involved
- Many of the volunteers are unemployed and looking to gain skills and qualifications that will help them find work. Some of the volunteers have a part-time job. Even full-time employees can benefit though – directly or indirectly.
- There are similar projects (Andalusia, Wales, and the Netherlands) but Well London is the most sustainable project.

Question: *What is the main target: health or communities?*
It was health right from the start. Originally, the idea was to provide courses for physical activities and healthy eating. The offer was not taken up too well. So, Well London started asking what inhabitants of the respective neighbourhoods perceived necessary to contribute to and improve their health. This is the basis upon which the Well London programme rests: Supported, yet self-organised community building is at the heart of it. In effect, so the conviction of the team, this helps to improve health via physical, mental and social strata. Wherever possible, health education is interwoven through other activities. E. g. neighbourhood festivals can incorporate healthy food and physical activity.

8.3.2. GLA Opportunities and challenges for a global city

Greater London is divided into 33 boroughs (with councils as their local authorities), while the NHS is split into 32 districts. The mayor presides over these boroughs, even though his powers are limited. His responsibilities include planning, housing, transport, and policing and crime. Other powers, for example social services and education are devolved to local authorities. The mayor does not have power over the NHS but has a statutory duty to

- Have regard for health and health inequalities in all policies
- Publish a health inequalities strategy

Consequently, the GLA has a number of initiatives to improve health for all Londoners. These include:

- Getting health into all Mayoral strategies. This recognises that planning and regeneration, transport, arts and culture etc. all have a role to play in health promotion. The approach is rather broad and does not only target health issues, as e. g. good public transport is seen as *one* way to improve health. In that way, health in all policies can build bridges and create win-win situations as better public transport will make more people walk and cycle while improving the environment and decrease traffic jams. Thereby, goals can be joined with other sectors. This is continued with an action plan for the transport system and the London plan, a development plan for London. In that sense, health permeates most societal areas.
- The Healthy Schools Awards programme is a scheme that encourages schools to promote good health through bronze, silver and gold awards for example for healthy school meals. 75% of the schools have at least the basic healthy school award already. The initiative for the award goes back to the staff at schools.
- Healthy Workplace Charter. This recognises and rewards employers for investing in workplace health and wellbeing.

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8.3.3. Oral health

Oral diseases like all other chronic conditions are not equally distributed across population. The affluence of neighbourhoods is highly correlated to health indicators, amongst them oral health. This is in effect even in early life making oral health a reliable indicator for social status with much evidence on the social gradient.

- Collaboration with many other partners, international and national, including local engagement in public health and the International Centre for Oral Health Inequalities have shown first successes in reducing these inequalities.
- UCL would like to see more attention and concern from professionals of the NHS. Now there is also more concern from WHO for oral diseases.
- Oral Health deserves the same attention as other chronic diseases.

8.3.4. Alcohol

- There is no safe limit for alcohol. The minimum recommendation, however, is to not exceed 14 units per week for men and women
- Evidence most often disregards life course changes and age specific effects. In order to arrive at the right conclusions, we need to take a life course perspective.
- A project at UCL is collecting/ gathering cohort studies with different groups of people including one who drank a minimum of three units of alcohol a day. One of the questions to be answered was whether or not previous drinking matters when estimating (chronic) conditions in later life, which was found to *have* an effect.
- We need more evidence to improve the understanding of the interplay between those times in the life course when alcohol is consumed and its effects.

8.3.5. Neighbourhood effects on health and wellbeing

This project is mapping social and health related inequalities across London. There are huge spatial differences even within small distances. As a general rule, the further out of the centre and the further east you head, the lower the social gradient and health status.

- One of the questions in the project is, whether living in a neighbourhood has a health related effect in later life?
- Grand theory for influence of living in a neighbourhood is needed:
    - Social interactive mechanism
    - Environmental mechanism
    - Geographical mechanism (spatial mismatch, no access to employment)
    - Institutional mechanism

8.4. Discussion on transferability

1. What do you consider the "fundamental nature" or fundamental elements of the original intervention that should be preserved?

- Bottom up approach with strong elements of "basic democracy" (community engagement asking local people what they want)
- Clear partnership and collaboration between communities and all interested organisations including strategic partnership with Mayor's office
- Stability of funding over many years
- Localised and "owned" by the community
- Sustainability in foundation
- Capacity building/ volunteering, community building
- Two way/ flexible central framework
- Strategic partnership from the start – all with own expertise – collaborative, partnership approach
- Connecting with local organisations and institutions; members of the respective networks differ from one neighbourhood to the other in order to guarantee the best fit between need and measures
- Involvement of young people throughout
- Social rather than medical basis
- Responsive/ ongoing engagement
- One big project in London rather than several smaller ones

2. What are essential elements of project management and project governance of the primary intervention?

- Local coordinators and volunteers (the driving force to get things going)
- Stability of funding
- Programme has been designed with sustainability of outcomes and, to a lesser extent, programme in mind
- Programme has been designed with scale-up in mind
- Dual level policy management and governance
- Professional support and training for coordinators and for local volunteers
- Knowledge exchange and shared learning across intervention areas (big learning events)
- Evaluation (third party funded) and connection to an academic institution for impact
- Long-term perspective is key
- Portraying the approach in an accessible way with framework and case studies (descriptive narratives and website content "less is more") and area profiles
- Continuous monitoring and documentation of barriers and supporting factors for success; the analysis of the reasons for this are based on this tight documentation
- Identification of weaknesses, such as pre-existing conflicts on the ground and the consequences, to understand them better in the future as a potential barrier to local collaboration and to overcome them

- Emphasis on how the approach influences and improves health
- Bringing different groups together

3. What are indispensable conditions of the original context?

- Clear definition of meaning of the following terms in the context of the project: transparent, inclusiveness, community involvement and engagement.
- General support from high profile organisations/individuals (e.g. National lottery and Mayor of London)
- Align with local authorities (government)
- Base (coordinating office) in local community to allow easy access to local coordinator for community members
- Socially aware and friendly coordinator
- Engagement and empowerment of local people
- Takes place in the most deprived areas

4. What do you consider necessary (and realistically feasible) elements of a knowledge transfer process?

- Well defined documentation of process such as manuals for administrative procedures, training, mapping assets, evaluation techniques used, etc.
- Focus on what is working, in what context.
- Focus on what is the return on investment
- Building up confidence of school leavers (teenagers) and local volunteers
- Knocking on doors and listening to people

5. What are the key lessons learnt during implementation?

- Collaboration (at all levels and on a continuing basis) is essential
- Networking prior to and during project to create an alliance of many interested groups each providing different expertise.
- Remove barriers to participations such as organising affordable day care for pre-school infants
- The right people in the right positions
- Central funding (from the big lottery in England) will probably not be available in many other countries, where it is likely to be sought locally from municipalities
- Plus all answers to questions

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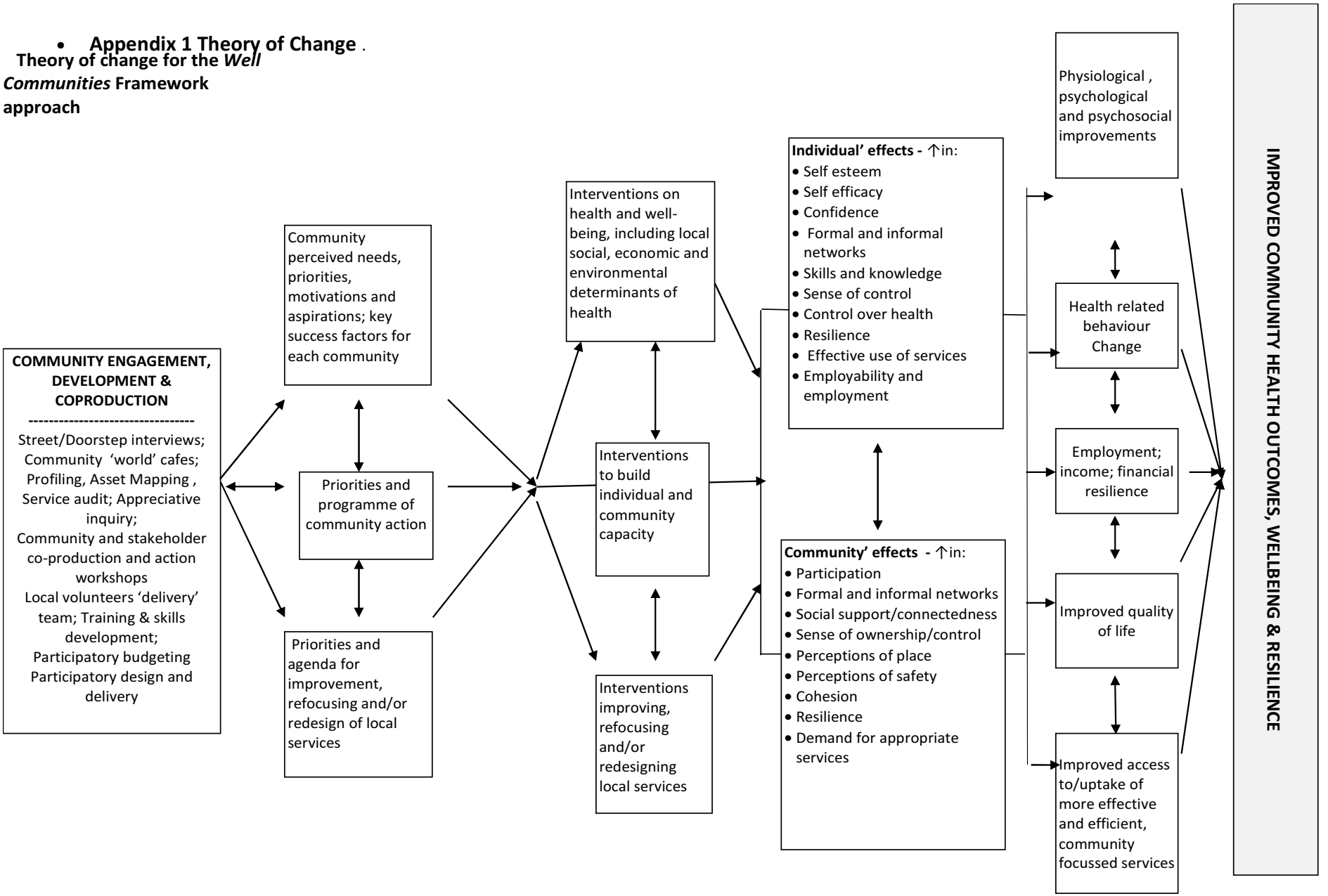
- **Appendix 1 Theory of Change** .

Theory of change for the *Well Communities* Framework approach



Annex II – List of participants

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Marieke Hendriksen	RIVM	The Netherlands
Ignas Keras	SMLPC	Lithuania
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