GOOD PRACTICES IN THE FIELD OF HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION ACROSS THE LIFE CYCLE (WORK PACKAGE 5)

RECOMMENDATIONS REPORT ON APPLICABILITY AND TRANSFERABILITY OF PRACTICES INTO DIFFERENT SETTINGS AND COUNTRIES

Identification of key steps and factors for the transfer and scaling-up of good practices in health promotion and primary prevention

CHRODIS

ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

JOINT ACTION ON CHRONIC DISEASES AND PROMOTING HEALTHY AGEING ACROSS THE LIFE CYCLE (JA-CHRODIS)

CONTENT

ACKNOWLEDGEMENTS

This document derives from the work on Health Promotion and Disease Prevention (WP5) of the EU Joint Action on Chronic Diseases and Healthy Ageing Across the Life Cycle (JA-CHRODIS).

WP5 leaders: Alexander Haarmann, Katarzyna Mletzko, Thomas Kunkel
German Federal Centre for Health Education (BZgA), Germany
WP5 co-leaders: Anne Pierson, Anna Gallinat, EuroHealthNet, Belgium

Partner institutions within this work package were the following:

Associated Partners

- Andalusian Regional Ministry of Equality, Health and Social Policies (CISPSJA), Spain
- Center for Health Education and Disease Prevention (SMLPC), Lithuania; Task leader 4
- Directorate General of Health (DGS), Portugal
- European Institute of Women's Health (EIWH), Ireland
- Directorate of Health (DOHI), Iceland
- EuroHealthNet, Belgium; Task leader 1 and 5
- German Federal Centre for Health Education (BZgA), Germany; Task leader 2
- Health Promotion Documentation Centre (DoRS), Italy
- Health Service Executive (HSE), Ireland
- Institute of Health Carlos III (ISCIII), Spain
- Institute of Public Health in Ireland (IPH), Ireland
- Ministry of Health (YPE), Greece; Task Leader 3
- Ministry of Health (MINSAL), Italy
- Directorate of Health (HOD), Norway
- National Centre of Public Health and Analysis (NCPHA), Bulgaria
- National Health Institute Doutor Ricardo Jorge (INSA), Portugal
- National Institute of Health (ISS), Italy
- National Institute for Health Development (NIHD), Estonia
- National Institute for Public Health and the Environment (RIVM), the Netherlands
- Progress and Health Foundation (FPS), Spain

Collaborating Partners:

- Associação Protectora dos Diabéticos de Portugal (APDP), Portugal
- BioCruces, Spain
- Canary Islands Health Service, Spain
- Consejería de Sanidad y Asuntos Sociales, Comunidad Autónoma de Castilla-La Mancha, Spain
- Dirección General de Asistencia Sanitaria, Agencia Valenciana de Salud, Spain
- European Health Futures Forum (EHFF), UK
- European Wound Management Association, Denmark
- Ministry of Health, Cyprus
- National Board of Health and Welfare (SoS), Sweden
- Pharmaceutical Group of the EU (PGEU)
- Platform for Better Oral Health in Europe
- Regional Ministry of Health of Cantabria, Spain
- University of Coimbra, Portugal
- University of Deusto, Spain
- WHO Regional Office for Europe, Denmark

We would like to thank all partners who contributed to this report, in particular:

- Partners who took minutes at study visits, finalised summaries or commented on the present report: Teresa Bennett, Clotilde Cattaneo, Luciana Costa, Caroline Costongs, Djoeke van Dale, Kenneth Eaton, Anna Gallinat, Gígja Gunnarsdóttir, Alexander Haarmann, Marieke Hendriksen, Ignas Keras, Thomas Kunkel, Katarzyna Mletzko, Lars Münter, Clive Needle, Astrid Nylenna, Jesus de Pedro-Cuesta, Anne Pierson, Francisco Ruiz Dominguez, Dimitri Varsamis, Evelina Voitonis
- Sibylle Gerstl, who assisted the project at several stages and contributed the main analysis of the categories and the first draft of this report.
- The representatives of the German and the Spanish Ministry of Health as members of the Governing Board for commenting on the draft.
- The two reviewers who were asked to review and comment on an earlier version of this report for the European commission.
- Colleagues of the Aragon Health Science Institute, Spain who conducted the Delphi analysis on practices in the area of health promotion and primary prevention of chronic diseases and the designated experts' panel.

For any comments or further enquiries, please, contact the editors
Alexander Haarmann (alexander.haarmann@bzga.de) or Sibylle Gerstl (sgerstl@aol.com).

1. EXECUTIVE SUMMARY

The objective of the work on health promotion and disease prevention (WP5) reflects the general objective of JA-CHRDOIS and seeks to identify, exchange, and promote the scaling-up and transfer of good practices on health promotion and chronic disease prevention, focusing primarily on cardiovascular diseases, stroke and type 2 diabetes.

This report provides key steps for project managers, policy makers, stakeholders and practitioners on what needs to be considered when scaling-up or transferring existing practices – or elements thereof – and what factors help to make the implementation successful in different contexts. Together, these recommendations (key steps + factors) aim to contribute to more sustainable health systems and to lowering the burden of chronic diseases in Europe.

To arrive at the recommendations, partners reviewed the existing work, situation and needs in health promotion and primary prevention, at the start of the Joint Action. Subsequently, an approach to identify good practice examples was defined and good practice examples were identified. A conference was organised to join forces in health promotion and primary prevention. Finally, partners held study visits to selected good practice examples.

The steps identified in this report should be taken into account and incorporated into an implementation plan, when considering a transfer or scaling-up of a good practice, which has been identified as effective and cost-efficient.

1. Implementers need to know the original good practice. This knowledge should be combined with a needs analysis at the new location.
2. They should perform a feasibility study that analyses external factors, which can help or impede a successful transfer (e.g. support, funding, whether additional training is needed or whether the transfer is ethically acceptable).
3. Implementers should assess the adaptations that will be needed to transfer the good practice.

They should assess the transferability and the potential for success. This report lists several identified success factors, which can be used as an additional guiding tool to support decision-making by project managers and practitioners in particular.

The four suggested key success factors for transferability have been classified in four categories. For each category, questions have been formulated to simplify the assessment of the transferability or scalability. The categories consist of:

- A bottom-up approach with inclusion of target population and strong commitment at highest level;
- Intersectoral, multi-level and multi-professional approach;
- Qualified and highly committed human resources, detailed documentation, monitoring and evaluation;
- Long-term engagement with stable funding.

2. INTRODUCTION

2.1. BURDEN OF CHRONIC DISEASES ACROSS EUROPE AND AIM OF THIS REPORT

Chronic diseases represent the major share of the burden of disease in Europe.[1] They heavily affect individuals and their quality of life – most often for years or even decades. In turn, this affects also their families and places a huge burden on healthcare and social systems. Though many chronic diseases could be prevented or their onset and progression be delayed more effectively, the focus is often more on the treatment and management of manifest chronic diseases. Where health promotion and the prevention of chronic diseases are employed, most often the emphasis lies on developing new programmes (at a national, regional or local level), while the exchange of good practices in the field is rather limited.

Lack of experience of existing good practices and of how to adapt, scale-up and transfer them are the major barriers preventing a higher take-up of existing good practices. Therefore, the aim of this report is to provide recommendations on what needs to be considered when scaling-up or transferring existing good practices and what factors help to make the implementation a successful.

2.2. EUROPEAN JOINT ACTION ON CHRONIC DISEASES AND PROMOTING HEALTHY AGEING ACROSS THE LIFE CYCLE

In 2011, the General Assembly of the United Nations, with EU support, acknowledged the problem and adopted a political declaration on the prevention and control of non-communicable diseases (NCDs).[2] There was unanimous commitment to collaborative partnerships in support of national, regional, and global plans for the prevention and control of NCDs, through the exchange of good practices.

Definition of terminology

GOOD PRACTICE

A good practice is not only a practice that is good, but a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, which has been repeated and deserves to be shared so that a greater number of people can adopt it.

Source: Agriculture Organization of the United Nations (FAO). 2013 (9). Good practices at FAO: Experience capitalization for continuous learning. http://www.fao.org/docrep/017/ap784e/ap784e.pdf (accessed on 3 January 2017)

TRANSFERABILITY

The extent to which the result of an intervention in a given context can be achieved in another setting[/ region].

Source: Cambon, Linda, Minary, Laetitia, Ridde, Valery, & Alla, François. 2013. A tool to analyze the transferability of health promotion interventions. BMC Public Health, 3, 1184. http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1184 (accessed on 3 January 2017).

1 Busse, Reinhard, Blümel, Miriam, Scheller-Kreinsen, David & Zentner, Annette. 2010. Tackling chronic disease in Europe. Observatory Studies Series, 20. WHO European Observatory on Health Systems and Policies. Copenhagen. http://www.euro.who.int/__data/assets/pdf_file/0008/96632/E93736.pdf (accessed on 3 January 2017).

2 Unites Nations General Assembly. 2011. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. 66th session, Follow-up to the outcome of the Millenium Summit. http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1 (accessed 21 December 2016).

Definition of terminology

SCALABILITY

The potential of an intervention in a given context to be enlarged (in a different region) in order to increase the impact of the intervention elsewhere and/ or to handle a growing amount of needs.

Source: Cambon, Linda, Minary, Laetitia, Ridde, Valery, & Alla, François. 2013. A tool to analyze the transferability of health promotion interventions. BMC Public Health, 3, 1184. http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1184 (accessed on 3 January 2017).

In 2013, the European Commission's Directorate General for Health and Consumers published the final report of the 'Reflection process on chronic diseases'.[3] It stated that the burden of chronic diseases is of central priority for the European Union and its member states and emphasizes the need for sustainable and coordinated approaches, which fully explore the potential of disease prevention and build upon the identification and dissemination of good practices.

Following this reflection process, the European Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS) was launched in January 2014. JA-CHRODIS helped to improve the effectiveness of actions taken by policy makers, health professionals and citizens in tackling the determinants of chronic diseases and associated functional and quality of life limitations.

Apart from three horizontal work packages (WPs 1 to 3), which covered the coordination, dissemination, and evaluation of the Joint Action, JA-CHRODIS was divided into four core WPs (WPs 4 to 7). Three of these four were thematic: "Good practices in the field of health promotion and chronic disease prevention across the life cycle" (WP5), "Development of common guidance and methodologies for care pathways for multimorbid patients" (WP6), and "Diabetes: a case study on strengthening health care for people with chronic diseases" (WP7). The fourth core WP was cross-cutting with a platform for knowledge exchange (WP4), the CHRODIS Platform.

2.3. GOOD PRACTICES IN THE FIELD OF HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION ACROSS THE LIFE CYCLE

There is a wealth of good practices tackling chronic diseases across Europe. The general objective of JA-CHRODIS was to facilitate the exchange of these good practices between different European countries and regions. This objective is reflected in the work package on health promotion and disease prevention. It sought to identify, exchange, and promote the scaling-up and transfer of good practices and effective practices on health promotion and chronic disease prevention, focusing on cardiovascular diseases, stroke and type 2 diabetes. The work package was comprised of 34 organisations (20 associated and 14 collaborating partners) from 14 member states of the European Union, Norway, and Iceland.

The work consisted of five consecutive tasks, building upon one another and leading to the recommendations outlined below. The subsequent chapters will briefly describe the tasks in order to give a broader idea of the context of this report and the process of defining key factors for transferability and scaling-up.

3 Council of the European Union. 2013. Reflection process on chronic diseases. http://www.eular.org/myUploadData/files/EU_contibution_reflection_process_Chronic_Diseaseas_final_report.pdf (accessed 21 December 2016).

2.4. FIVE TASKS TO MOVE FORWARD HEALTH PROMOTION AND DISEASE PREVENTION

1. Review of existing work, situation and needs in the area of health promotion and primary prevention
2. Defining an approach to identify good practice examples
3. Identification of good practice examples
4. Conference to join forces in health promotion and primary prevention
5. Study visits to good practice examples

2.4.1. Review of existing work, situation and needs in the area of health promotion and primary prevention

In task 1, country reports focusing on the health promotion and primary prevention landscapes in partner countries were developed. They identified good practices, strategies, and programmes and revealed gaps and needs in this area. The 14 country reports can be downloaded here: http://chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports.

The overview report showed that there is a strong need for consistent investment in health promotion and primary prevention in order to reduce the burden of chronic diseases and to make healthcare systems more sustainable. Further needs included, among others, capacity development, monitoring and evaluation. The dissemination of highly promising and evidence-based good practices should be used as a basis in advocating for dedicated and sustained funding streams.

2.4.2. Defining an approach to identify good practice examples

Subsequently, partners defined key criteria for identifying good practices, based on existing approaches, a review of existing databases, and literature key criteria. This was carried out using a modified Delphi methodology, developed by RAND.[4] The process involved a group of more than 25 European health promotion experts in collaboration with the leaders of the work packages 5 and 4.

The result was a list of key criteria for the identification of good practices in health promotion and primary prevention of chronic diseases (HPPP). These criteria can be ranked and weighted, which allows for both a comparison of practices and an assessment of the overall practice. The full report that includes a detailed description of the Delphi method and the final set of weighted criteria can be downloaded here: http://chrodis.eu/wp-content/uploads/2015/08/INTERIM-REPORT-1_Delphi-on-Health-promotion-and-prevention-1.pdf.

4 http://www.rand.org/topics/delphi-method.html (accessed 26 April 2017)

2.4.3. Identification of good practice examples

Based on the list of ranked and weighted criteria, a template was jointly established, which allowed a unique assessment and description of the different practices for HPPP. Partners collected, described, and assessed existing practices according to this template. As a result, 41 detailed examples of local, regional, or national good practices (i. e. policies, programmes, and clinical or public health interventions) in HPPP were identified. They came from 13 partner countries in Europe with a main focus on cardiovascular diseases, stroke and type 2 diabetes. They target different life stages (childhood, ageing, all age cycles) as well as different target groups, including vulnerable populations.

The summary report on the 41 good practice examples can be downloaded here: http://www.chrodis.eu/wp-content/uploads/2015/09/Summary-Report-CHRODIS-WP5-Task-3_Version-1.3.pdf.

The link to the annex outlining all 41 good practice examples in full detail can be downloaded here: http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-.pdf.

2.4.4. Conference to join forces in health promotion and primary prevention

A conference "Joining Forces in Health Promotion to Tackle the Burden of Chronic Diseases in Europe" was organised in Vilnius, Lithuania, on 24-25 November 2015. The conference gave JA-CHRODIS partners and stakeholders at all levels the opportunity to discuss the state of health promotion and primary prevention in Europe and to share examples of good practices.

Materials and documentation relating to the conference can be downloaded here: http://chrodis.eu/event/joining-forces-in-health-promotion-to-tackle-the-burden-of-chronic-diseases-in-europe/.

2.4.5. Study visits on good practice examples

In the final task of the work package, partners conducted a series of study visits to selected good practice examples out of the 41 identified above. Seven study visits took place in six partner countries – Iceland, Italy, Norway, Portugal, the Netherlands, and the United Kingdom – between April and June 2016.

The main results of the study visits were threefold

- To exchange experiences and knowledge between the partners, who are implementing the good practice examples and the partners interested in investigating whether the good practices could be implemented in their specific context
- To identify how a certain good practice could potentially be transferred and/ or scaled up
- To discuss core elements as well as other components that need to be adapted to the situation of the new area if transferred and/ or scaled-up

An overview of the seven study visits is given in the Appendix to this report. Links to the various study visits and more information can be found here: http://chrodis.eu/our-work/05-health-promotion/wp05-activities/transfer/.

3. THE PROCESS TOWARDS THE RECOMMENDATIONS

The process to define the recommendations for transferability and scalability involved several stages, in which the majority of the work package's partners actively participated. These included the following:

- **A literature review** which was conducted in order to identify strategies and frameworks for possible transfer and scaling-up of health promotion practices, such as "ASTAIRE" ("Assessment of transferability and adaptation of health promotion practices")[5] and the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA)'s European Scaling-Up Strategy in active and healthy ageing.[6] The requirements of the EIP-AHA Maturity Model for Integrated Care, also used in SCIROCCO, for a good practice to be adopted in another setting, were also taken in consideration.[7]

- The **list of Delphi criteria** developed by experts and JA members in task 3 helped identify good practices in health promotion and primary prevention of chronic diseases.

- The **selection of 41 good practice** examples acted as another source of information and as a basis for the choice of study visits. Good practices can be programmes, policies, and projects that are carried out at national, regional, and local level. Practices that have been scaled-up or transferred already were of particular interest.

- Of the 41 good practice examples, seven were selected for **study visits** in a consultative approach with all WP5 partners. They combined different examples of life stages (childhood, ageing, all age cycles), geographic-administrative levels (national, regional, local), as well as target groups and approaches. They also covered as broad a range of Delphi criteria as possible.

- **Exchange between partners** to identify success factors when considering the transfer of a proven good practice into another area.

- **Analysing and comparing the documents of the study visits** to assess key success factors for transferability and scalability according to the study visits. Documents for the analysis were the minutes of the different study visits and their key lessons.

5 Cambon, Linda, Minary, Laetitia, Ridde, Valery, & Alla, François. 2013. A tool to analyze the transferability of health promotion interventions. BMC Public Health, 3, 1184. http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1184 (accessed on 3 January 2017).

6 The European Innovation Partnership on Active and Healthy Ageing. 2015. European scaling-up Strategy in Active & Healthy Ageing. https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/scaling_up_strategy.pdf (accessed 21 December 2016).

7 Scirocco. 2016. Maturity Model for Integrated Care. http://www.scirocco-project.eu/maturitymodel/ (accessed on 28 February 2017). Anderson, Stuart and Alexandru, Cristina-Adriana. 2017. SCIROCCO Tool to Assess Readiness for Integrated care (presentation). http://www.scirocco-project.eu/resources/#presentations2017 (accessed on 28 February 2017). Txarramendieta Suarez, Jon. 2017. Maturity Requirements of Good Practices. http://www.scirocco-project.eu/resources/#presentations2017 (accessed on 28 February 2017).

4. KEY STEPS

New practices do not need to be designed from scratch but can rather be inspired by other existing practices. Quite often, however, it is difficult to decide what needs to be considered when transferring or scaling-up existing good practices. This report highlights some of the points that should be taken into account. It should be considered to be a guiding tool for project managers, policy makers, stakeholders, and practitioners rather than providing absolute requirements. In that sense, the steps should be studied carefully, and be incorporated into the implementation plan. They include:

4.1. KNOWING THE GOOD PRACTICE

Based on our experience and relevant literature, such as the EIP on AHA and SCIROCCO Maturity Model, a good first step is to get to know more about the practice. For this, an extensive description is needed. Furthermore, even though the direct exchange of information and experience can occur via modern telecommunication media a thorough study visit to the existing practice is recommended.

This should be done in combination with a needs analysis of the area where the practice is intended to be scaled-up or transferred to. It is important to note in this context that good practices do not necessarily need to be transferred in their entirety, but that also single elements of practices can be transferred. If, for instance, there is a well-designed practice that needs improvement in one respect, which can be found in another existing practice, a transfer may include only a number of or one single element of the practice in question. Transferring and implementing single elements requires a thorough analysis in order to not jeopardise the success of the new addition, as evaluations are usually conducted on practices as a whole. In order to assess the different elements of a practice, the above-mentioned Delphi criteria of good practice can help.[8] As well as identifying overall good practices, they can also help to identify elements that require specific attention.

4.2. FEASIBILITY STUDY

Once it is decided whether the existing practice in question, or elements thereof, are actually tackling existing needs in the new area, a feasibility study can follow as a second step. This should primarily focus on "external" factors such as:

- The availability of support by politicians, stakeholders, and network partners,
- the availability of (sustainable) funding,
- the maturity of the implementing organisation, i. e. whether it is sufficiently experienced and has the capacity to implement it, and to what extent additional training is necessary,
- the extent to which the transferred practice is perceived acceptable and ethical by significant stakeholders and target groups, and
- the extent to which competing programmes and (political) targets interfere with the aim of the practice and thereby hamper its implementation.[9]

8 http://chrodis.eu/wp-content/uploads/2016/03/Delphi-1-report_HPPP.pdf

9 On these and related points cf. e. g. Ciliska. 2007. Tool for Assessing Applicability and Transferability of Evidence. www.nccmt.ca/pubs/A&T_Tool_-_FINAL_English_Oct_07.pdf (accessed on 3 January 2017). The European Innovation Partnership on Active and Healthy Ageing. 2015. European Scaling-Up Strategy in Active & Healthy Ageing. Wang, Shuhong, Moss, John R., & Hiller, Janet E. 2005. Applicability and transferability of interventions in evidence-based public health. Health Promotion International, 21(1), 76–83.

4.3. ADAPTATION

The question of adaptation should be tackled in parallel with the feasibility study. Often, practices or some components cannot be transferred as they are due to different contexts, but (functional) equivalents need to be found. For example, if there is another type of sponsor available, which likewise guarantees the practice's independence. This is less problematic than finding a proper equivalent for a specific type of network partner. Requiring thorough consideration, since the impact of different equivalents vary, that the guiding principle should be that having functional equivalents adapted to the new area is more important than transferring elements as such.

4.4. ASSESSMENT OF TRANSFERABILITY

A list of success factors was identified to assess and influence transferability and scalability of good practices in different contexts, both within the same country and across borders. The factors and their underlying principles served to assess both the transferability of a good practice and its scalability, as no differences could be determined. These success factors are described in the next chapter.

Scrutinising these four factors is a good basis upon which to decide whether the practice in question is likely to bring about change in the new place and whether this can be done in a cost-effective way.

It has to be noted though that a positive impact of a good practice can be a direct outcome of the practices themselves but positive impact can also be related to external factors which cannot be influenced by the practice (e. g. the context, the policy framework, legal competencies, or social acceptance where the practices are embedded). Successful practices in one setting might not per se be transferable with the same positive results to another setting.

5. FOUR SUCCESS FACTORS

The list of success factors and their underlying principles serve as a checklist once the decision about transferring an existing practice is taken. The list is intended to help transfer and organise an existing practice. At the same time, altering the perspective from a focus on the implementation of a transfer process to one designing/ adapting a practice, it can also help to get a better understanding of the existing practices that are considered for transfer. It supports the decision-making process on whether to implement the practice in its entirety, to implement single elements, or to not implement it at all.

The success factors are organised in four categories that are neither balanced against each other nor listed in any particular order. The study visits did not reveal any evidence that a category has more influence on successful transferability and scalability than others, but it is rather the specific combination of underlying principles that yield the success of practices. It is evident that some criteria are more applicable to one setting or another.

The four categories are:

1. Balance of bottom-up and top-down approach with inclusion of target population
2. Intersectoral, multi-level and multi-professional approach
3. Qualified and highly committed human resources, detailed documentation, monitoring and evaluation
4. Long-term engagement with stable funding

The four factors have been broken down into several principles. For each of them, questions have been formulated to create a tool to analyse the transferability or scalability of a practice.

5.1. BALANCE OF BOTTOM-UP AND TOP-DOWN APPROACH WITH INCLUSION OF TARGET POPULATION

- **Application of the entire practice to local settings and customs**

  Does the existing practice suit the context in which it will be transferred?

  Is the overall practice designed in a way to be adaptable to different local settings and customs?

- **Flexibility at local level when implementing and adapting the programme**

  (This principle would apply e. g. to different neighbourhoods of a practice in one municipality or different municipalities in a region etc.)

  Does the existing practice show a high degree of flexibility at a local level?

  Is this flexibility transferrable and applicable to a new setting?

  Are adaptations possible during the duration of the project?

- **Inclusion of 'all' (all ages, backgrounds), taking into consideration especially the most vulnerable groups/ areas**

  Do all target groups (e. g. different age classes, socioeconomic status, gender) of the existing practice coincide with the ones in the target area? Is there a need to transfer all of them?

  Does the transferred practice adequately address vulnerable groups? Are any adaptations necessary?

- **Involvement of target group(s) when doing the needs assessment**

  Does the transferred practice include a needs assessment with the intended target groups?

- **Involvement of communities in decision making on programmes and their practices**

  (In contrast to the previous principle, this one focuses rather on the implementation of the practice and the decision-making process about its content.)

  How was the decision-making process conducted in the existing practice?

  In which way can this be transferred?

  Is the participatory approach together with the intended target group(s) and communities taken into account?

- **Engagement of communities in planning and organising the programme**

  (In contrast to the previous two principles, this one is less of a one-time involvement, but a continuous process to adapt and recalibrate the implementation (also) according to ideas, wishes, and expressed needs by the population at the lowest level of implementation.)

  How was regular community engagement facilitated in the existing practice?

  In which way will this develop strengths and resources in the intended target population?

  Is there any need for additional or differing engagement?

- **Voluntary participation**

  Can the existing practice be transferred and rely on an entirely voluntary participation?

  Are there any negative implications for people not participating in the transferred practice?

  What differing context factors need to be considered that may create negative outcomes?

  Is there a perception of coercion to take part?

- **Support of programme in communities**

  How far is there broad and voluntary support of the existing practice in the target population and in the communities safeguarded?

- **Strong commitment at highest level within relevant institutions**

  (This point focuses rather on the governance aspect and general political support.)

  Is there a commitment at the respective highest level to support the transferred practice at all levels involved?

  Is top-down commitment assured?

  Is there political support in the relevant area where the practice is to be implemented?

- **"Think big, but start small" concept**

  How was the existing practice created in terms of size and process?

  Does the intended transferred practice still have a manageable size in its new context?

  Is it possible to concentrate the common efforts and not to disperse them?

  Is the practice designed to later transfer it to further regions and/ or scaling it up?

5.2. INTERSECTORAL, MULTI-LEVEL, AND MULTI-PROFESSIONAL APPROACH

- **Health in all policies approach (inter-sectoral linkage, multi-level)**

  Can all relevant sectors be transferred into the new context to achieve positive results?

  What additional sectors need to be taken into account?

  Is this comprehensible approach feasible in the new context?

- **Collaborative, partnership approach at all levels (work with everybody at all levels)**

  Is it possible to include the same stakeholders at all levels as in the existing practice?

  Will people at all levels (from national government to municipalities) feel equally responsible for the transferred practice?

  Are equivalent partnerships at all levels and alliances (local, national, international), intersectoral (public-private), and multidisciplinary (different professional backgrounds with different areas of expertise) possible for the transferred practice?

- **Strong political commitment and support at highest level**

  Is there political commitment in the relevant area where the practice is to be implemented?

  Is there support of the transferred practice by the highest level of the involved sectors, professions, and levels?

- **Programme embedded in national plans/curricula/policies and/ or specific legislation and regulation**

  Is the transferred practice already aligned with policy plans or curricula and/ or specific legislation and regulation at various levels?

  Did the specific practice transform specific policies into legally defined rights? Would that be equally possible in the transferred practice?

- **Transparency of the programme to shape trust**

  Is the existing dissemination strategy transferrable in a way to ensure transparency of the practice's objectives, aims, and strategies to stakeholders and the general public?

  Does the practice ensure that everyone interested knows what is done by whom, with whom, and why?

5.3. LEADERSHIP, QUALIFIED AND HIGHLY COMMITTED HUMAN RESOURCES, DETAILED DOCUMENTATION, MONITORING & EVALUATION

- **Committed, persistent, and stable human resources with high social skills including volunteers**

  Can the transferred practice rely on the equivalent amount of well-qualified, clearly defined and committed human resources as the existing one?

  Does the new context require a shift of human resources to different institutions, stakeholders and/ or the configuration of new roles for professionals?

  Is there a key person with a high level of social skills available in the practice to be transferred in order to drive the process and foster networks, i. e. are leadership skills available?

  Are volunteers involved in the practice to be transferred?

  Is the new context suitable to engage them?

Clear definition of terms used in the practice

Are the definitions and technical terms used (e. g. transparency, inclusiveness, community involvement and engagement) the same ones as in the existing practice in order to arrive at the same foundation for the practice?

Are all technical terms and definitions transparent, clearly defined, and understandable for everybody involved in the transferred practice?

Are there any indispensable prerequisites that require a modification of these definitions?

Practice documentation

(This includes all types of documents throughout the project cycle and highly visible reporting.)

Can the documentation strategy be transferred entirely?

What kind of documents need to be adapted to the new context?

In what way can positive and empowering reporting be transferred?

Continuous practice monitoring with appropriate indicators

(This includes all kinds of documents for quality assurance of the ongoing project.)

Can the monitoring system be transferred entirely?

What kind of objectively verifiable performance indicators need to be adapted or added to the transferred practice?

Evaluation framework

Three kinds of evaluation need to be taken into account here:

a) the evaluation (ideally) conducted in the existing practice,

b) the planned evaluation for the transferred practice in order to find out how things have been implemented in the new context, and

c) an evaluation of the transfer process itself.

While the first should be existing already, the second is absolutely recommended. The latter is optional but may be enlightening not only for other practitioners but also for the ones implementing the transfer. Common recommendations regarding evaluations (e. g. preferably external evaluation, preferably process, outcome, and impact evaluation) as well as the documentation of key processes apply.

Can the existing evaluation framework be transferred to assess process and outcomes of the practice, including sufficient funding and time?

Is an evaluation by people not directly involved feasible in the new context?

Is there willingness in the transferred practice to readapt elements of the practice based on the recommendations of the evaluation?

Knowledge transfer group

(This relates predominantly to the existing good practice even though it might make sense to establish a separate group also in the new area. Both, the existing as well as the to be implemented practice team can form a "community of practice",[10] thereby not only closely exchanging information and experience but also motivating each other and further improving the practice in question.)

Is there a knowledge transfer strategy available in the existing practice?

To what extent can a knowledge transfer process team be of help in the transferred practice?

Is a knowledge transfer team indispensable for the success of the transferred practice?

10 Hasanali, F., C. Hubert, K. Lopez, B. Newhouse, C. O'Dell, & W. Vestal. 2002. Communities of Practice: A Guide For Your Journey to Knowledge Management Best Practices (Passport to Success, 1). Amer Productivity Center.

5.4. LONG-TERM ENGAGEMENT WITH STABLE FUNDING

- **Commitment to long-term programmes and/ or long-term approach**

  Is (the same) long-term planning guaranteed in the transferred practice as in the existing one?
  In which way can institutional ownership in the practice be transferred?

- **Stability of funding for several years**

  Is funding of the transferred practice secured over several years on a regular and continuous basis?

Apart from projects which aim to pilot new practices, most other practices usually seek mid-to long-term funding. If a long-term assurance of funding is not available, long-term commitment is the more important of the two, since the perspective of time strongly influences the whole approach.

6. CONCLUSIONS

This report offers a guidelines for stakeholders and practitioners which support the transfer, scaling-up, and implementation of good practices in health promotion and primary prevention. It neither substitutes a proper feasibility study, needs assessment, an assessment based on experience gained in transferring and implementing good practices, nor an assessment of external factors. For example, even if ideal circumstances are encountered, they will not make a transfer succeed if it is perceived to be socially unacceptable, it does not fit into the legal framework, it is not prioritised on the political agenda, or essential network partners do not have the time to invest.[11] Competing programmes or achieving political targets can, of course, impose obstacles as well. All this needs to be taken into consideration when making the overall decision whether or not to transfer an existing practice.

Similarly, we have defined success factors that can influence the transferability and scalability of a good practice, which are not intended to be used instead of the usual planning and management processes. Literature on the organisational, managerial, financial, and other practical aspects of the planning and implementation of projects primarily focused on new projects, while literature on transferring a project was scarce.[12] In that sense, the four success factors mentioned in this report fill this gap and complement the

11 Considering these aspects cf. e. g. Ciliska. 2007. Tool for Assessing Applicability and Transferability of Evidence. www.nccmt.ca/pubs/A&T_Tool_-_FINAL_English_Oct_07.pdf (accessed on 3 January 2017). Wang, Shuhong, Moss, John R., & Hiller, Janet E. 2005. Applicability and transferability of interventions in evidence-based public health. Health Promotion International, 21(1), 76–83.

12 For a selection of these cf. e. g. Hartmann, Arntraud & Linn, Johannes F. 2008. Scaling up – a Framework and Lessons for Development Effectiveness from Literature and Practice. Working paper, 5. Wolfensohn Center for Development. https://www.brookings.edu/wp-content/uploads/2016/06/10_scaling_up_aid_linn.pdf (accessed 3 February 2017).
The European Innovation Partnership on Active and Healthy Ageing. 2015. European scaling-up Strategy in Active & Healthy Ageing. https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/scaling_up_strategy.pdf (accessed 21 December 2016).
Centers for Disease Control and Prevention. 2011. Program Performance and Evaluation Office (PPEO) – Program Evaluation. https://www.cdc.gov/EVAL/steps/index.htm (accessed on 3 February 2017).
European Project Getting Evidence into Practice. 2005. European Quality Instrument for Health Promotion (EQUIHP). http://ec.europa.eu/health/ph_projects/2003/action1/docs/2003_1_15_a10_en.pdf (accessed on 3 February 2017).
IEMAC-ARCHO. Assessment of Readiness for Chronicity in Health Care Organizations. http://www.iemac.es/data/docs/Formulario_IEMAC_english_version.pdf (accessed 3 February 2017).
Highly Adoptable Improvement. http://www.iemac.es/data/archo/docs/Formulario_IEMAC_english_version.pdf (accessed on 4 May 2017).
Lavis, John N, Oxman, Andrew D, Simon Lewin, & Fretheim, Atle. 2009. SUPPORT Tools for evidence-informed health Policymaking. Health Research Policy and Systems, 7, 1 http://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-7-S1-I1 (accessed on 3 February 2017).

existing literature. The four factors derive from the analysis of study visits and reflect practical experience from practice-internal processes on the ground.

This is what makes this report different, for instance, in comparison with the more theoretical ASTAIRE framework and EIP-AHA approaches. Nevertheless, findings regarding the transfer and scaling-up of good practices seem to be consistent with theoretical findings as well as with the results of the Joint Action's work packages on multimorbidity and diabetes. In particular, the recommendations about early detection, prevention, and quality of care for diabetes[13] list the following similar points among their key messages: "Promote the empowerment of the target population", "Define an evaluation and monitoring plan", "Comprehensiveness of the practice", "Interaction with regular and relevant systems", and "Governance approach" (pp. 6-7).

As a result, the success factors suggested in this report can prove useful beyond health promotion and prevention of chronic diseases. A next step would be to find out whether it makes sense to synthesise them or whether recommendations would be too general to be of use for practitioners and other interested actors. In addition, specific components, which are usually not part of practices within health promotion and disease prevention, would need to be kept in mind. In any healthcare setting, for instance, aspects related to reimbursement policies, joint IT standards, or a stricter definition and distribution of responsibilities might need to be added.

In order to safeguard the identification, distribution of information and knowledge, and the transfer of good practice examples on health promotion and chronic disease prevention national databases can provide a first overview. The CHRODIS Platform (http://platform.chrodis.eu) is an attempt to collect HPPP good practices, which over time has the potential to become the first address to get a broad overview of what practices exist in Europe. Uniform assessment criteria are a strong point of the Platform, which enables practitioners seeking to transfer (elements of) a good practice to easily compare between different options.

Furthermore, the overview of success factors that can influence the transferability and scalability of good practices, listed in this report, will hopefully provide a helpful decision-making tool for practitioners and contribute to decreasing the burden of chronic diseases in Europe.

13 JA-CHRODIS. 2016. Diabetes: a case study on strengthening health care for people with chronic diseases. Recommendations to improve early detection, preventive interventions, and the quality of care for people with diabetes. Definition and agreement on a common minimum set of indicators. http://chrodis.eu/wp-content/uploads/2017/02/wp7-deliverable-recommendations-final-draft.pdf (currently only draft version)

7. APPENDIX

OVERVIEW OF THE SEVEN STUDY VISITS

- JOGG – Young People at a Healthy Weight (The Netherlands)
- PNPAS – National Programme for the Promotion of Healthy Eating (Portugal)
- Welfare Watch (Iceland)
- NGL– Icelandic National Curriculum Guides for schools, health and wellbeing (Iceland)
- Lombardy Workplace Health Promotion Network (Italy)
- Well London (Well communities) Programme (United Kingdom)
- Norwegian Public Health Act (Norway)

OVERVIEW OF THE SEVEN HEALTH PROMOTION STUDY VISITS

PROJECT	JOGG - Young People at a Healthy Weight	PNPAS - National Programme for the Promotion of Healthy Eating	Welfare watch	NGL- Icelandic National Curriculum Guides for schools, health and wellbeing	Lombardy Workplace Health Promotion Network	Well London (Well communities) Programme	Norwegian Public Health Act
COUNTRY	The Netherlands	Portugal	Iceland	Iceland	Italy	United Kingdom	Norway
STUDY VISITS	20-21/4/2016	23-24/5/2016	1-2/6/2016	1-2/6/2016	23-24/6/2016	28-30/6/2016	13-14/6/2016
PROJECT AIM	To reverse the increasing trend of young people with overweight / obesity	To improve the nutritional status and health of the Portuguese population in order to prevent common chronic diseases	To reduce the impact of economic crisis on health	To improve physical, mental and social health	To improve health and welfare in the workplace	To improve healthy living	Improve public health
LEVEL OF INTERVENTION	National strategy, projects implemented in municipalities	National policy locally implemented	National strategy	National school policy	Regional project	Community intervention	National policy
LOCATION / SETTING	Schools and communities	Population level	Population level	Schools and communities	Workplaces	Communities	Population level
TARGET GROUP(S)	Children, parent, local communities	All age groups; deprived neighbour-hoods	All age groups (focus on children/youth, long-term unemployed, unemployed young people)	Children, youth and staff in pre-schools and schools	Adults (employees)	All age groups	All age groups
TRANSFER / SCALING-UP	Transferred from EPODE (France), adapted to the Dutch situation	Based on key European and WHO policies	Built on the Icelandic Welfare Watch		European Workplace Health Promotion Network	Scaling-up	

In what follows the practices of the seven study will be summarised. A more extensive version can be found here: http://chrodis.eu/our-work/05-health-promotion/wp05-activities/transfer/

JOGG – YOUNG PEOPLE AT A HEALTHY WEIGHT	
TYPE OF GOOD PRACTICE	Pre-natal environment, early childhood, childhood and adolescence
COUNTRY	The Netherlands
AIM	To reverse the increasing trend of young people with overweight/obesity
OBJECTIVES	• To increase the number of young people who achieve the recommended level of daily physical activity • To reduce the intake of sugary drinks and increase the intake of water • To increase the number of young people that consume a healthy breakfast • To increase the daily intake of fruit and vegetables • Every setting (neighbourhood, school, home and health care) that offers a healthy option, and promotes physical activity
LEVEL OF INTERVENTION	National strategy, projects implemented in municipalities
LOCATION / SETTING	Schools and community (07/2016: in 84 municipalities)
TARGET GROUP(S)	• Children (1-19 years of age) • Parents • Local communities (e. g. shopkeepers, companies, schools, sport clubs, local authorities)
TRANSFER / SCALING-UP	Transferred from EPODE (France), adapted to the Dutch situation by adding an additional pillar (linking prevention and health care)
MAJOR CHARACTERISTICS	• Integrated community-based approach • Targets neighbourhoods (make the healthy choice the easy choice) • Advocacy and social marketing • Intervention activities adjusted to the local situation • Public Private Partnerships • Evaluation framework
SHORT DESCRIPTION	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. It focuses on children and adolescents themselves, along with their parents and the direct environment. The main aim is to reverse the increasing trend of young people (0-19 years) who are overweight/obese. 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 remain at a healthy weight. The Dutch JOGG approach is based on the successful French project EPODE and consists of five pillars: political and governmental support; 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 (of 390 municipalities) to promote healthy weight among their youth. JOGG is coordinated at national level by the national JOGG foundation in The Hague. The ministry of Health, Welfare and Sport supports and finally contributes to JOGG. Activities at the national level are: • 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 local level (among other things): • 'Drink water' campaigns at schools and at sport clubs • Healthy school canteen and healthy sport canteen • Discount access to sport clubs • Safe walking and cycling routes to schools • Vegetable gardens at schools • Integrated approach of the treatment of obesity (schools, youth health care, primary health care and hospital) • Lessons about healthy food

STUDY VISIT	**JOGG**
DATE	20–21 April 2016
INVITING PARTNER	National Institute for Public Health and the Environment (RIVM)
VISITING PARTNERS	Andalusian Regional Ministry of Health-CSJA (Spain), Directorate of Health-DOHI (Iceland), EuroHealthNet (Belgium), German Federal Centre for Health Education – BzgA (Germany), Health Service Executive-HSE (Ireland), Institute of Public Health in Ireland-IPH (Ireland), National Institute of Health-ISS (Italy), National Health Institute Doutor Ricardo Jorge-INSA (Portugal)
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	National strategy is based on 5 pillars: • Monitoring and Evaluation • Public Private Partnership • Commitment at policy level and from a wide variety of sectors • Social Marketing • Connecting prevention and health care sectors Implementation of each pillar in the intervention differs according to local needs.
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• National coordination of JOGG bureau • Customized support /advice for all municipalities • JOGG program manager at national level is responsible to overview implementation of all pillars at local level
INDISPENSABLE CONDITIONS FOR SUCCESS OF THE ORIGINAL CONTEXT	• Political commitment at national and local level • Support at the local level as well as from a bigger context • Community engagement • The use of well-known ambassadors for the dissemination of the program (for JOGG it is a Dutch Prince)
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	• The establishment of a knowledge transfer process • To blend/implement JOGG activities against the background of pre-existing local programmes (open space for discussion with other actors and decision makers to highlight the added value)
WHAT COULD BE DONE BETTER IN A TRANSFERRED PROJECT?	Make the local interventions easy and small Limit the number of goals Manage the expectations for the evaluation results over time Partners are motivated to evaluate their interventions, because it can improve their work
GOOD TO KNOW	Challenges for the project are budget constraints, time consuming procedures, lack of access to reliable data and skills and expertise and lack of local interest.
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-pdf, p. 43 et seq. www.jongerenopgezondgewicht.nl

PNPAS – NATIONAL PROGRAMME FOR THE PROMOTION OF HEALTHY EATING	
TYPE OF GOOD PRACTICE	All life cycles
COUNTRY	Portugal
AIM	To improve the nutritional status and health of the Portuguese population in order to prevent common chronic diseases.
OBJECTIVES	• To increase the knowledge about food consumption by the Portuguese population, its determinants and consequences • To modify the availability of certain foods, namely in schools, workplaces and public spaces • To inform and empower the population in general, especially the most disadvantaged groups, on how to purchase, cook and store healthy foods • To identify and promote cross-cutting actions to encourage the consumption of good nutritional quality foods with the collaboration of other public and private sectors, namely in the areas of agriculture, sports, environment, education, social security and municipalities • 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
LEVEL OF INTERVENTION	National policy locally implemented
LOCATION / SETTING	Population level
TARGET GROUP(S)	All age groups; deprived neighbourhoods
TRANSFER / SCALING-UP	Based on international documents and key European and WHO policies, strategies and recommendations in the area of food and nutrition.
MAJOR CHARACTERISTICS	• Health education activities • Intersectoral collaboration • Collaboration with the food industry, catering, advertisement sectors etc. • Key stakeholders training
SHORT DESCRIPTION	The PNAPS is a national policy for healthy eating, which was designed and coordinated by the Directorate General of Health. The PNPAS has five general goals that are reached by a set of activities: a.The systematic collection of indicators on nutritional status, food consumption and its determinants, the assessment of food insecurity situations, and the dissemination of best practices. b.The change in the marketing of certain foods (with high sugar, salt and fat content), by controlling their supply and sales in schools, health and social support institutions and in the workplace, through a coordinated action with the food industry and the catering sector and as well through other activities. c.The increase in food and nutrition literacy, particularly the most disadvantaged ones, towards healthy choices and eating practices, and the encouragement of best practices on labelling, advertising and marketing of food products. d.The identification and promotion of cross-sectional actions with other sectors of society, namely agriculture, sports, environment, education, municipalities and social security, should encourage the consumption of foods of vegetable origin, develop electronic tools that enable planning healthy, easy-to-use and affordable menus with price information, and develop a network at municipality level for monitoring best practices and projects in the area of the promotion of healthy eating for citizens. e.The improvement of education, qualification and mode of action of different professionals who can influence quality eating habits, namely at the level of the health sector, schools, municipalities, the tourism and catering sector or social security. The PNPAS is articulated with National Health Plan 2012-2016. Monitoring in 2013 and 2014 shows that the indicators are reaching their targets. Monitoring and some evidence show a need for information about nutritional status, food and nutritional literacy campaigns, specifically to healthcare professional and the older population.

STUDY VISIT	**PNPAS**
DATE	23-24 May 2016
INVITING PARTNER	Directorate General of Health (DGS), Portugal
VISITING PARTNERS	European Platform for Better Oral Health in Europe, German Federal Centre for Health Education – BzgA (Germany), Health Service Executive-HSE (Ireland), Ministry of Health-MINSAL (Italy), National Health Institute Doutor Ricardo Jorge-NSA (Portugal)
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	• Scientific evidence of the problem as a starting point • Good personal networks and relations for effective communication • One key figure with passion, strong persistence (already for 20 years!), good negotiation and social skills with a vision • Large network of diverse partners from all public and private sectors • Flexibility for the local partners to adapt the programme according to the local needs
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• The programme is governed under a central framework by the Directorate General of Health • Practical implementation with regional and local coordination teams • Proper documentation and constant mapping of the programme • Transparency of the program to open access to the data
INDISPENSABLE CONDITIONS FOR SUCCESS OF THE ORIGINAL CONTEXT	• Political commitment on national and local level • Looking for existing initiatives and focus on changing and improving current practice and approaches rather than designing new national health promotion programmes
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	• Clear and detailed description of the methodology adopted to develop the strategy • Identification and documentation of strengths and weaknesses
GOOD TO KNOW	A key feature in the successful implementation of this programme is the establishment of public-private partnerships and the strong presence in social media.
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-.pdf, p. 187 et seq.

WELFARE WATCH	
TYPE OF GOOD PRACTICE	All life cycles
COUNTRY	Iceland
AIM	To reduce the impact of economic crisis on health
OBJECTIVES	• Monitor social and financial consequences of the economic crisis • Publish recommendations for the government on how to protect vulnerable groups • Get together various stakeholders to have a realistic feel for what is going on • See that the 'Social indicators' are collected and published • Newest focus is especially on the very poor and families with children
LEVEL OF INTERVENTION	National strategy
LOCATION / SETTING	Population level
TARGET GROUP(S)	All age groups Focus on children/youth, long-term unemployed and unemployed young people
TRANSFER / SCALING-UP	The Nordic Welfare watch was a project that built on the Icelandic Welfare Watch and has three main components: (1) Nordic Welfare Indicators, (2) response to crisis and (3) welfare consequences of financial crises.
MAJOR CHARACTERISTICS	• Focus on families and individuals in poverty • Coordination of policy and actions • Focus on living conditions • Intersectoral collaboration
SHORT DESCRIPTION	The Welfare Watch was established in accordance with a cabinet resolution in 2009 as a response to the economic crisis and it was re-established in 2014. The Minister of Social Affairs and Social Security appointed the Welfare Watch, a Steering Committee, with the main task of monitoring systematically the social and financial consequences of the economic situation for families and individuals in Iceland and to propose measures to help households and in particular vulnerable groups. Originally the Welfare Watch had representatives from 19 stakeholders, among others from six ministries, social partners, NGOs, Union of Local Authorities, The City of Reykjavik, the Directorate of Health, the Directorate of Labour and the Council of Equal rights of man and women. In 2014 the Welfare Watch expanded and is now a platform with 35 stakeholders representing all sectors and levels of the society. The Welfare Watch is a governmental enterprise, with a chairman and an employee provided by the Ministry of Welfare. Other stakeholders do not get special payment for their participation but donate the time of their representatives to the work (is considered a part of their daily work). The Welfare Watch established the Social Indicators which have been published every year since 2012. The Social Indicators are a collection of indicators regarding democracy and activities, standard of living and welfare, health and social cohesion. The Welfare Watch has frequent meetings and has smaller working task groups. Several proposals and reports have been delivered by the Welfare Watch. A social gradient in health is a fact in Iceland, as in other European countries. The report of the social determinants and the health divide in the WHO European Region informed the development of Health 2020, the European Policy framework for health and well-being. The report emphasises that without improvements in all the social determinants of health, there will be no significant reductions in health inequities. Health 2020's ultimate goal is to achieve health equity by reducing the socially determined inequities in the WHO European Region. The key to success is engagement of stakeholders across sectors and levels, as has been facilitated by the work of the Welfare Watch. Originally, the main aim was to monitor the social and financial consequences of the economic situation for families and individuals and propose measures to help households. In 2014 the objectives where narrowed to focus on families with children and those living in severe poverty. In January 2015 proposals regarding these groups were published and introduced by the Minister of Social Affairs and Housing. The main themes were: child benefits and child social insurance; criteria for the minimum subsistence; the housing situation; basic service; case coordinators; cooperation with NGOs and a project fund.

STUDY VISIT	**Welfare Watch**
DATE	1-2 June 2016
INVITING PARTNER	Directorate of Health (with an introduction from Ministry of Welfare)
VISITING PARTNERS	Carlos III Institute of Health – ISCIII (Spain), Centre for Health Education and Disease Prevention – SMLPC (Lithuania), City of Pori (Finland), Directorate General of Health – DGS (Portugal), EuroHealthNet (Belgium), Institute of Public Health – IPH (Ireland), National Centre of Health and Analyses (Bulgaria), National Institute for Health Development – NIHD (Estonia), National Institute for Health and Welfare (Finland), National Institute for Public Health and the Environment – RIVM (Netherlands), National Institute of Health Dr. Ricardo Jorge (Portugal)
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	• Social development and equity should be preserved • Effective partnerships with all relevant stakeholders • Start in a small region and later expand to national level • Intersectoral and multi-level approach
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• Organisational structures (responsibilities) are clearly defined • Sources of funding are specified • Management by local authorities • Cross-sectional steering and working groups
INDISPENSABLE CONDITIONS FOR SUCCESS OF THE ORIGINAL CONTEXT	• Collaboration between different stakeholders across sectors and levels • Durable political will and support • The population's awareness about the problem
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	• Documents and tools used in original intervention to fully understand this intervention • Report on the monitoring of implemented proposals, their results and impacts, strengths and weaknesses • Identification of existing matched elements (for instance in political/administrative institutions and services providers) between the populations of the original and replica intervention
WHAT COULD BE DONE BETTER IN A TRANSFERRED PROJECT?	• Keep the objectives clear • Incorporate evaluation from the start • Include relevant stakeholders • Adjust to your own country but be aware not to lose touch with people in the field
GOOD TO KNOW	• Challenges to manage such a large group as we had and keep focus on the objectives. • Important to have good management and moderators. • Could be good to hear from the Nordic Welfare Watch about their experience of transference and adaption.
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-.pdf, p. 265 et seq. https://eng.velferdarraduneyti.is/media/velferdarvakt09/29042010The-Welfare-Watch_Report-to-the-Althingi.pdf

NGL- THE ICELANDIC NATIONAL CURRICULUM GUIDES FOR PRESCHOOLS, COMPULSORY SCHOOLS AND UPPER SECONDARY SCHOOLS: HEALTH AND WELLBEING ONE OF SIX FUNDAMENTAL PILLARS OF EDUCATION	
TYPE OF GOOD PRACTICE	Pre-natal environment, early childhood, childhood and adolescence
COUNTRY	Iceland
AIM	To improve physical, mental and social health
OBJECTIVES	• From the national curriculum • Key competence that students: • Are responsible for themselves and their actions • Show responsibility for their own health and wellbeing • Are aware of themselves as sexual beings • Are aware of the value of regular exercise, and that they exercise regularly • Are aware of the importance of varied and nutritious diet • Show responsibility towards intolerance, bullying and other forms of violence • Are aware of the damage caused by smoking and other use of tobacco, alcohol consumption and the use of other intoxicants.
LEVEL OF INTERVENTION	National school policy (for preschools, compulsory schools, upper secondary schools)
LOCATION / SETTING	Schools and community
TARGET GROUP(S)	• Children, youth and staff in: • Pre-schools (2-5 years) • Compulsory Schools (6-15 years) • Upper Secondary Schools (mainly 16-19 years)
TRANSFER / SCALING-UP	It has been very helpful for Health Promoting School projects to build on the curriculum and use it as a foundation and reason for schools to participate. Health Promoting school projects (DOHI) are in fact a tool/way for schools to implement the curriculum.
MAJOR CHARACTERISTICS	National curriculum guides as a foundation and Health promoting school projects (DOHI) as tool for implementation: • Whole school approach • Teachers' training • School health policy, checklists, action plan, health indicators and evaluation • Website as a working tool • Toolbox for themes • Health education - health literacy
SHORT DESCRIPTION	The National Curriculum Guide is a policy framework for Icelandic schools across educational levels: children in pre-schools (2-5 years), compulsory schools (6-15 years) and upper secondary schools (mainly 16-19 years). In 2011, new National Curriculum Guides for pre-, compulsory and upper secondary schools were published in Iceland by the Ministry of Education, Science and Culture. In that policy a milestone was made by defining "health and wellbeing" as one of the six fundamental pillars of education, thereby confirming the importance of health and wellbeing for education and vice versa. The policy describes the role of education in schools according to Icelandic laws and regulations, the objectives and organization of school operations and the requirements and rights of everyone in the school community. Six fundamental pillars have been developed within this framework that forms the essence of the educational policy in Iceland. In addition to "health and wellbeing", the other pillars are "literacy", "sustainability", "democracy and human rights", "equality" and "creativity". The main health factors that are to be encouraged are: positive self-image, physical activity, nutrition, rest, mental wellbeing, positive communication, security, hygiene, sexual health and understanding of one's own feelings and those of others. How the Directorate of Health uses the curriculum: The National Curriculum Guide and particularly the pillar "health and wellbeing" is an important foundation for the Health Promoting School projects. The well-established Health Promoting School project likewise provides an important support for schools to implement the pillar "health and wellbeing" in all their work. The number of Health Promoting Communities (municipalities) is also increasing and one of their priorities is to encourage and motivate their schools to take part in the Health Promoting School projects.

STUDY VISIT	**NGL**
DATE	1-2 June 2016
INVITING PARTNER	Directorate of Health (with an introduction from the Ministry of Education)
VISITING PARTNERS	Carlos III Institute of Health – ISCIII (Spain), Centre for Health Education and Disease Prevention – SMLPC (Lithuania), City of Pori (Finland), Directorate General of Health (Portugal), EuroHealthNet (Belgium), Institute of Public Health – IPH (Ireland), National Centre of Health and Analyses (Bulgaria), National Institute for Health Development – NIHD (Estonia), National Institute for Health and Welfare (Finland), National Institute for Public Health and the Environment – RIVM (Netherlands), National Institute of Health Dr. Ricardo Jorge (Portugal)
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	• Health in all policies approach (not a stand-alone model, but embedded within a healthy communities approach) • Formal support from the Ministry of Education • Start the implementation in a small region and later expanded to national level
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• Organisational structures (responsibilities) are clearly defined, sources of funding are specified • Health Promoting School Projects (DOHI) as a framework/tool • The freedom of each school to adapt the implementation according to their needs
INDISPENSABLE CONDITIONS FOR SUCCESS OF THE ORIGINAL CONTEXT	• Willingness of the Ministry of Education, Science and Culture to advance the health promotion agenda in schools • Recognition of the important role of the Health Promotion School Projects (DOHI) in implementing the health and wellbeing theme • Available funding to develop supporting tools such as the website and training events
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	Availability of documents and tools used in the original intervention in order to avoid 'reinventing the wheel' if it is going to be implemented elsewhere
WHAT COULD BE DONE BETTER IN A TRANSFERRED PROJECT?	• Involve relevant stakeholders from the start in making curriculum changes as these. • Make sure that the ones implementing it (school staff) have the means and time to do so. • Important to have a project manager in every school to ensure the implementation and have overview of what is being done.
GOOD TO KNOW	• The tools that we (DOHI) provide with Health Promoting School projects are free of charge but expects the schools to put resources to manage it and adapt it to each school. • It has been very helpful to have a curriculum to support Health Promotion on a national level.
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-pdf, p. 38 et seq. https://eng.menntamalaraduneyti.is/publications/curriculum

THE LOMBARDY WORKPLACE HEALTH PROMOTION NETWORK	
TYPE OF GOOD PRACTICE	Adulthood & Aging
COUNTRY	Italy
AIM	To improve health (diet, smoking, physical activity, road safety, alcohol etc.)and welfare in the workplace
OBJECTIVES	• 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)
LEVEL OF INTERVENTION	Regional project
LOCATION / SETTING	Workplaces
TARGET GROUP(S)	Adults (employees)
TRANSFER / SCALING-UP	European Workplace Health Promotion Network
MAJOR CHARACTERISTICS	• Advocacy • Supportive organizational and environmental measures at workplaces • Promotion of an internal process of "continuous improvement" of the companies with the active participation of workers and managers, in order to facilitate the adoption of healthy lifestyles for the prevention of chronic diseases
SHORT DESCRIPTION	The Lombardy Workplace Health Promotion Network (WHP) involves 284 workplaces, employing 139186 persons in November 2014. It 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 development of this Italian pilot project started in 2011 in Bergamo, by identifying and selecting good practices, and by experimenting the feasibility and effectiveness in two mid-sized companies before extending the project to other companies. A system of accreditation was later defined. Member companies should implement good practice activities over three years and four new activities every year to maintain the "Workplace Health Promotion Site"- logo. The areas of good practice are: nutrition, tobacco, physical activity, road safety, alcohol and substances, and well-being. The results were 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 an "environment conducive to health" systematizing, with the scientific support of Health Local Unit where necessary, evidence-based actions of different nature: informational (smoking cessation, healthy eating, etc.), organizational (canteens, snack vending machines, agreements with gyms, stairs health programmes, walking / cycling from home to work, smoke-free environment, baby pit-stop, etc.) and collaboration with others in the local community (Associations, etc.). The "Lombardy WHP Network" programme is imbedded in the Regional Prevention Plan for 2010-2013 and 2014-2018, in the National Prevention Plan 2014-2018 and fits into the strategies of EUROPEAN INNOVATION PARTNERSHIP on Active and Healthy Ageing (EIP-AHA). At the end of 2014 there were 284 companies in the network and a total of 139,186 employees were involved. From 2013 to 2014 the regional increase was equal to 103% in relation to the number of companies and 132% in relation to the number of employees. The chosen interventions and strategies influence multiple levels of the organization including the individual employee and the organization as a whole. The evidence based actions are continuously updated according to the literature data. The one year Bergamo impact evaluation showed that after 12 months there was a reduction in some important risk factors for chronic diseases in workers participating in the programme, particularly for fruit and vegetable intake and smoking cessation.

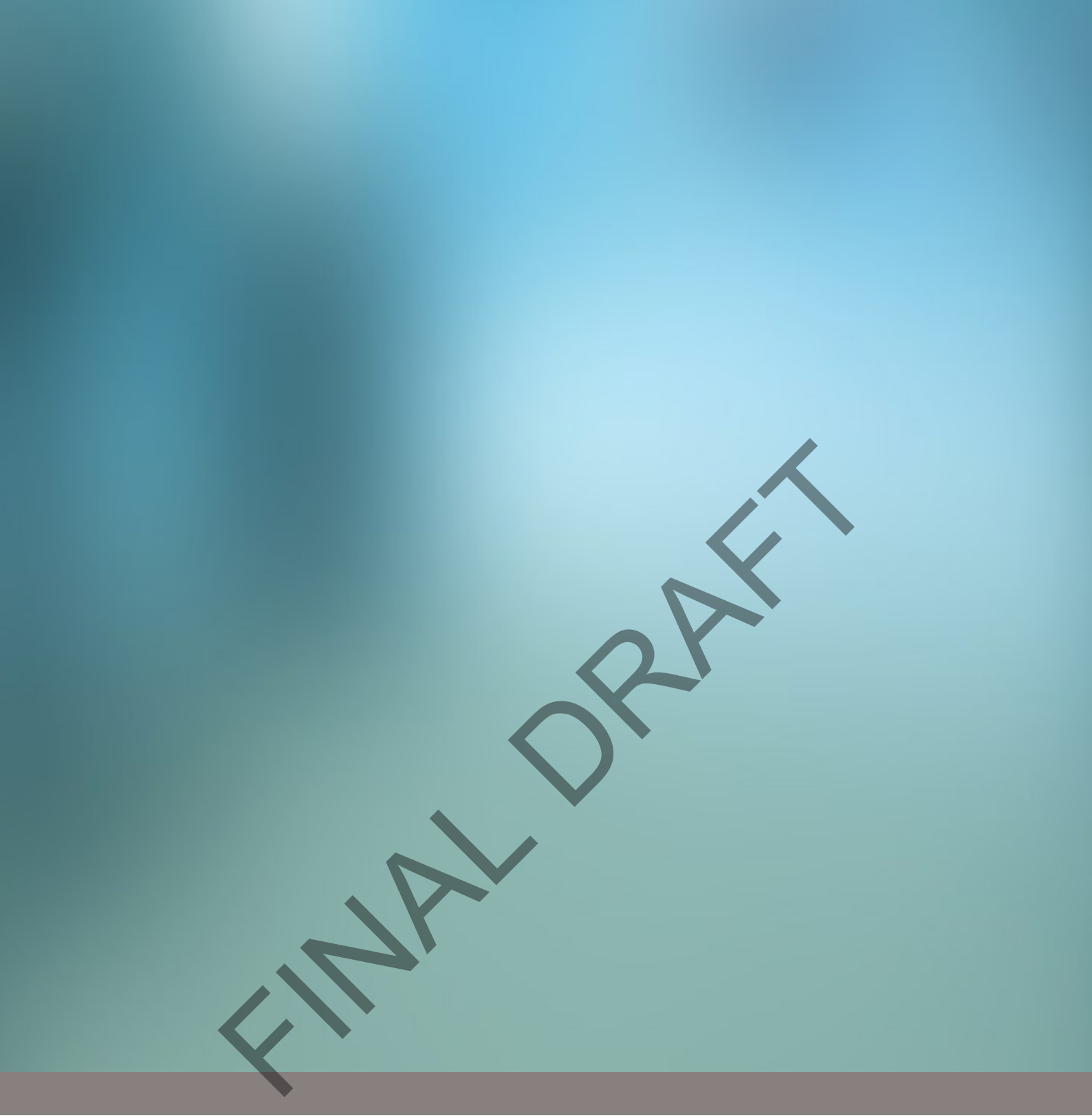
STUDY VISIT	**Lombardy Workplace Health Promotion Network**
DATE	23-24 June 2016
INVITING PARTNER	Ministry of Health
VISITING PARTNERS	Agenas (Italy), EuroHealthNet (Belgium), European Institute of Women's Health (Ireland), Fondacio IRCCS Istituto Neurologico C. Besta (Italy), FUNKA (Italy), Health Protection Agency (Italy), Health Services Executive – HSE (Ireland), Lombardy Region (Italy), Ministry of Health (Italy), Ministry of Health and Services (Norway), National Institute for Health Development – NIHD (Estonia), National Institute of Health Dr. Ricardo Jorge (Portugal), NHS (England), Piedmont Region (Italy), Sodalitas Foundation (Italy)
LESSONS LEARNT	
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	• Public and private network with a commitment from a wide variety of stakeholders • High levels of participation and communication between providers and participants • High standards of motivation ("fun theory approach"), 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 • Utilization of data to inform policy and practice • Emphasise on a communications approach using social media • Availability of tools and important information for companies on the website • Recognition award from the Ministry of Health is highly valued by companies
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• National platform on food, physical activity and tobacco that feeds into the work • Clearly defined organisational structures (responsibilities) • Specified sources of funding • High expression of flexibility on the governance rules which are adapted to each company context • Internal process of monitoring and evaluation for consistency of the programme and its continuous improvement
INDISPENSABLE CONDITIONS FOR SUCCESS 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 "Voluntary adhesion" of the companies involved, "self-decision" model
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	• Availability of documents and tools used in original intervention to be shared with replica intervention • Exchange of key lessons learned • Continuous communication between providers of the original intervention and the potential replicator
WHAT COULD BE DONE BETTER IN A TRANSFERRED PROJECT?	In the planning of the various initiatives with the enterprises involved the characteristics of the employees could be better assessed. The aim would be to customize the actions with regard to specific aspects such as gender, education, training, etc., to reduce or prevent inequalities, and to reach more specific objectives of health and wellbeing (for examples promoting a diet rich in folic acid for women, attention to pregnant or breast-feeding women, informational materials understandable for all education levels, etc.)
GOOD TO KNOW	Key lessons for a successful intervention include the participation of companies in the planning process, a voluntary adhesion, a comprehensive communication plan, the adaptability and freedom to choose priorities, and support to companies on a ongoing basis through the availability of online resources and tools.
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-pdf, p. 96 et seq.

WELL LONDON (WELL COMMUNITIES) PROGRAMME	
TYPE OF GOOD PRACTICE	All life cycles
COUNTRY	United Kingdom
AIM	Improve healthy living
OBJECTIVES	• Improving wellbeing and equality • Capacity building • Participation as delivery of better services
LEVEL OF INTERVENTION	Community intervention
LOCATION / SETTING	Community
TARGET GROUP(S)	All age groups (35% of total 'target' population)
TRANSFER / SCALING-UP	Scaling-up
MAJOR CHARACTERISTICS	• Community mobilisation • Focus on poor urban areas • Multicultural activities • Social support • Focus on volunteers
SHORT DESCRIPTION	The Well London Programme started in 2007 and has run since then. It has been funded by the national lottery and 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 and was led by an alliance of representatives covering major development priorities for London. The Well London delivery team contributes to policy objectives such as improving wellbeing and equality, capacity building and participation as delivery of better services. Its aim is to improve all these areas. 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. 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 programme has been designed following community research carried out by the University of East London, which identified a need to provide local residents with skills to increase opportunities for volunteering to work in their communities to improve health and wellbeing and raising awareness around health issues. Relevant data showed that the residents in the areas targeted had worse than average health (for London). The project was based on the social marketing theory which recognises that a peer-to-peer approach is often effective in motivating people to take up activities and make lifestyle changes. There are a wide variety of activities to achieve the aims of the project. They included such activities as helping people to grow their own healthy food, to buy healthy food at low cost and cook it, physical activities, reaching out to hard to reach groups, etc. The Well London Phase 1 evaluation is freely available online and the plans for the phase 2 evaluation (http://www.welllondon.org.uk/1145/research-evaluation.html). The scale and complexity of the Well London programme mark it out as a nationally and internationally significant initiative applying a community development approach in neglected urban areas. It is generating learning and evidence not only to support its integration locally but also to inform wider policy and practice in a field of growing importance

STUDY VISIT	**Well London**
DATE	28-30 June 2016
INVITING PARTNER	Greater London Authorities health team
VISITING PARTNERS	Andalusian Regional Ministry of Equality, Health and Social Policies – CISPSJA (Spain), Centre for Health Education and Disease Prevention – SMLPC (Lithuania), Directorate General of Health – DGS (Portugal), Directorate of Health – DOHI (Iceland), EuroHealthNet (Belgium), German Federal Centre for Health Education – BzgA (Germany), Ministry of Health – YPE (Greece), Ministry of Health and Services (Norway), Institute of Public Health – IPH (Ireland), National Institute for Public Health and the Environment – RIVM (Netherlands), National Institute of Health – ISS (Italy), Platform for Better Oral Health in Europe (Belgium)
LESSONS LEARNT	
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	• Bottom up approach with strong elements of "basic democracy" • Clear partnership and collaboration between communities, all interested organisations and stakeholders • Capacity building, volunteering, community building • Members of the respective networks differ from one neighbourhood to the other in order to guarantee the best fit between need and measures • Stability of funding over many years Social rather than medical basis
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• Clear definition of following terms in the context of the project: transparent, inclusiveness, community involvement and engagement • Coordinating office based in local community to allow easy access • Socially aware and friendly coordinator • Evaluation (third party funded) with connection to an academic institution for impact
INDISPENSABLE CONDITIONS FOR SUCCESS OF THE ORIGINAL CONTEXT	• Programme has been designed with sustainability of outcomes • Knowledge exchange and shared learning (big learning events) • General support from high profile organisations/individuals • Engagement and empowerment of local people • Emphasis on how the approach influences and improves health • Long-term perspective is key
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	• Original programme designed with scaling-up in mind • Well defined documentation of process • Continuous monitoring and documentation of barriers and supporting factors for success • 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 • Knocking on doors and listening to people
WHAT COULD BE DONE BETTER IN A TRANSFERRED PROJECT?	Issues of fidelity are very important. New programmes, particularly in new contexts, would have to be monitored and evaluated carefully to ensure the fidelity of the overall approach, and so that any new learning could be incorporated into the framework.
GOOD TO KNOW	• 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. • Networking prior to and during project to create an alliance of many interested groups each providing different expertise
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-pdf, p. 273 et seq.

NORWEGIAN PUBLIC HEALTH ACT	
TYPE OF GOOD PRACTICE	All life cycles
COUNTRY	Norway
AIM	Improve public health
LEVEL OF INTERVENTION	National policy
LOCATION / SETTING	Population level
TARGET GROUP(S)	All age groups
TRANSFER / SCALING-UP	
MAJOR CHARACTERISTICS	• Overview of public health and health determinants • Development of public health plans • Collaboration of key stakeholders • Focus on health inequities • Focus on living conditions
SHORT DESCRIPTION	The new Public Health Act was introduced in Norway 1 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 will promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders and 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. One of the main features of the Act is that it places responsibility for public health work 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. Each municipality will implement the measures that are necessary for meeting the municipality's public health challenges. This may, for example, encompass measures relating to childhood environments and living conditions, such as housing, education, employment and income, physical and social environments, physical activity, nutrition, injuries and accidents, tobacco use, alcohol use and use of other psychoactive substances. The counties (19 altogether) have the responsibility to support public health work in the municipalities. The county governor shall supervise the legality of the municipality`s and county authority`s fulfilment of the duties imposed in or pursuant to the Act. The Norwegian Directorate of Health will monitor implementation of the Act. Evaluations have showed that the municipalities do not consider the health sector to be the most important sector in the health promotion work. This corresponds with the basic idea of HiAP (Health in all policies) and the importance of SDH (social determinants of health) and the policy behind the Public Health Act. The municipalities regard the Public Health Act as a helpful tool for systematic, inter-sectoral health promotion work in the municipality.

STUDY VISIT	**Norwegian Public Health Act**
DATE	13–14 June 2016
INVITING PARTNER	• Ministry of Health and Care Services • The Norwegian Directorate of Health
VISITING PARTNERS	Bilateral visit of Directorate of Health – DOHI (Iceland)
ELEMENTS OF THE ORIGINAL INTERVENTION TO KEEP AFTER TRANSFER / SCALING-UP	Local and regional levels 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 as a whole.
ESSENTIAL ELEMENTS OF PROJECT MANAGEMENT OF ORIGINAL INTERVENTION	• The national level provides various support for monitoring and capacity building (platform for networking and evidence based guidance for implementation of measures) • Evaluation of stated goals, strategies and other public health efforts • All counties and most municipalities have public health coordinators
INDISPENSABLE CONDITIONS FOR SUCCESS OF THE ORIGINAL CONTEXT	• Systematic public health work with the new Public Health Act in 2011 • Long term instead of short term focus • Inclusion of key stakeholders
NECESSARY (AND FEASIBLE) ELEMENTS OF A KNOWLEDGE TRANSFER PROCESS	• Engagement of a HiAP approach to political decision making • Application of scientifically sound, holistic methods • Use of evidence based methodologies • Application of key health indicators
WHAT COULD BE DONE BETTER IN A TRANSFERRED PROJECT?	• A national policy and act like the Public health Act needs to be adjusted to setting. • The Act can give ideas to implement in other settings.
GOOD TO KNOW	Norwegian institute of public health provides statistics for the municipalities on public health issues in the local community: https://www.fhi.no/en/hn/health-in-the-municipalities/hent-folkehelseprofil-for-kommune-fylke-eller-bydel/
FURTHER INFORMATION ON THE PROJECT	Annex of the Report on Good Practice examples in Health Promotion & Primary Prevention in Chronic Disease Prevention, http://chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-pdf, p. 259 et seq.



CHRODIS

ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

This publication arises from the Joint Action CHRODIS, which has received funding from the European Union, in the framework of the Health Programme (2008-2013). Sole responsibility lies with the author and the Consumers, Health, Agriculture and Food Executive Agency is not responsible for any use that may be made of the information contained therein.