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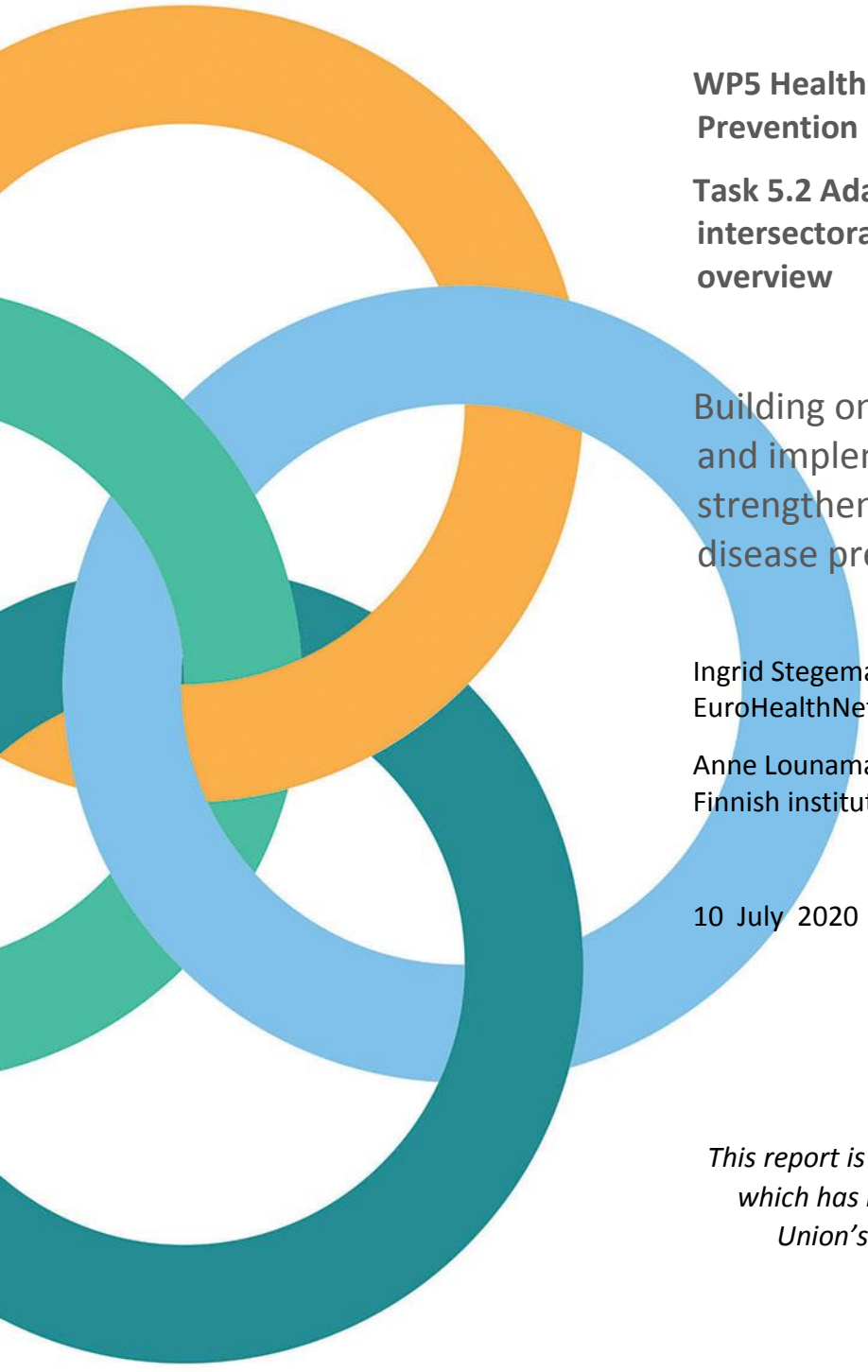
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

D5.3 Recommendations for the implementation of health promotion good practices

WP5 Health Promotion and Disease Prevention

Task 5.2 Adaptation and implementation of intersectoral good practices & Task 5.4 Final overview



Building on what works: transferring and implementing good practice to strengthen health promotion and disease prevention in Europe

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Table of contents

The CHRODIS PLUS Joint Action

CHRODIS PLUS is a three-year initiative (2017-2020) funded by the European Commission and participating organisations. Altogether, 42 beneficiaries representing 20 European countries collaborate on implementing pilot projects and generating practical lessons in the field of chronic diseases.

The very core of the Action includes 21 pilot implementations and 16 policy dialogues:

- The pilot projects focus on the following areas: health promotion & primary prevention, an Integrated Multimorbidity Care Model, fostering the quality of care for people with chronic diseases, ICT-based patient empowerment and employment & chronic diseases.
- The policy dialogues (14 at the national level, and 2 at the EU level) raise awareness and recognition in decision-makers with respect to improved actions for combatting chronic diseases.

A heavy price for chronic diseases: Estimates are that chronic diseases cost EU economies €115 billion or 0.8% of GDP annually. Approximately 70% to 80% of healthcare budgets across the EU are spent on treating chronic diseases.

The EU and chronic diseases: Reducing the burden of chronic diseases such as diabetes, cardiovascular disease, cancer and mental disorders is a priority for EU Member States and at the EU Policy level, since they affect 8 out of 10 people aged over 65 in Europe.

A wealth of knowledge exists within EU Member States on effective and efficient ways to prevent and manage cardiovascular disease, strokes and type-2 diabetes. There is also great potential for reducing the burden of chronic disease by using this knowledge in a more effective manner.

The role of CHRODIS PLUS: CHRODIS PLUS, during its 36 months of operation, will contribute to the reduction of this burden by promoting the implementation of policies and practices that have been demonstrated to be successful. The development and sharing of these tested policies and projects across EU countries is the core idea driving this action.

The cornerstones of CHRODIS PLUS: This Joint Action raises awareness of the notion that in a health-promoting Europe - free of preventable chronic diseases, premature death and avoidable disability - initiatives on chronic diseases should build on the following four cornerstones:

- health promotion and primary prevention as a way to reduce the burden of chronic diseases;
- patient empowerment;
- tackling functional decline and a reduction in the quality of life as the main consequences of chronic diseases;
- making health systems sustainable and responsive to the ageing of our populations associated with the epidemiological transition.

Executive summary

Aim and scope

Policy makers and practitioners have long recognised the contribution that health promotion and disease prevention (HPDP) interventions can make to improving health and well-being and making health systems in Europe more sustainable, but investments in the field remain stubbornly low. There is a wide range of knowledge across Europe about effective approaches to prevent or delay the onset of chronic diseases and to alleviate their impact. JA CHRODIS (2014-2016) identified many good policies and interventions from across Europe, but also confirmed that they are being applied in a piecemeal rather than systematic fashion within and across countries. JA CHRODIS PLUS (2017-2020) built on this work, to identify how and what has proved effective in one setting can be transferred and scaled in another, as an approach to strengthening this field. This report investigates the process of transfer and implementation of five good practices selected by CHRODIS PLUS, to eight new settings across the EU. The five practices involved working across sectors and focused on improving physical activity and/or diet and nutrition amongst different target groups (children, employers, older people). Two were set in schools, one in the workplace, and two in the community, with a focus on ensuring a 'whole of community' approach to health promotion and disease prevention.

Results and Conclusions

The report includes summaries of these transfer and implementation processes, the approaches taken, the facilitators and barriers encountered, and the outcomes. Many implementors faced challenges such as the lack of: qualified staff to deliver the programmes; time available on the part of those delivering the programmes; adequate facilities; and lack of a 'culture' around health promotion, affecting the motivation of some target group participants. Despite such challenges, all the initiatives met their established objectives, and have plans to multiply or scale the full, or components of the programmes, nationally.

CHRODIS PLUS generated useful lessons on how good practice in HPDP can be transferred and implemented from one setting to another, to strengthen collaboration across sectors and foster health promoting 'cultures' and communities. Many implementers attributed their achievements to the CHRODIS PLUS implementation strategy. They also noted the importance of a strong relationship between the good practice owner and the implementer. It was apparent that it was easier for localities with a comparatively stronger foundation in health promotion and disease prevention to trail the new initiatives. The more established the 'culture' of HPDP, the greater the incentive for professionals at all levels to invest their time and energy in relevant activities. The experience of the transfer of good practice in CHRODIS PLUS reflects this can strengthen networks and structures for HPDP in the implementing countries, but requires careful planning and dedicated resources. Investing appropriately can however yield significant returns, since positive outcomes and evidence of effectiveness can motivate the target groups and those delivering the programme and inspire other stakeholders, and activate a process of strengthend capacities and further 'roll-out. Harnessing the power of modern technologies to establish and engage in 'communities of good practice', where those applying interventions within and across European countries share experiences, can also accelerate this process.

CHRODIS PLUS instigated these processes; it is hoped that government authorities and stakeholders will take them further, by investing in the further transfer and implementation of interventions included in e.g. the European Best Practice Portal. The CHRODIS PLUS Governing Board[1] can play a key role by encouraging

[1] The CHRODIS PLUS Governing Board was established in order to generate synergies between EU institutions and EU Member States and EEA countries in relation to the health agenda on chronic diseases and healthy ageing. It is

their national ministries of health to (also) transfer, implement, mainstream, and scale the CHRODIS PLUS good practices and/or others across Europe, and apply the learnings from CHODIS PLUS to do so, to ensure the sustainability of the results. This can contribute to the more systematic application of health promotion and disease prevention across Europe, and to a stronger 'culture' in this field, to reduce the costs of medical care for preventable conditions, whilst above all improving the quality of life and well-being of Europeans and their ability to contribute to society.

Recommendations

CHRODIS PLUS's work in the area of health promotion and disease prevention has led to the following recommendations for all those interested in strengthening their activities, by drawing on, transferring and implementing the best practices that Europe has to offer:

1. Commit to the vision and goal of health promotion as a process of working with other sectors to create environments and communities that support health, and to embedding this role in health systems, to improve health and well-being outcomes while reducing or delaying costs of health care. Draw on good practice from other settings and countries to achieve this.

2. Build on existing motivation and resources: select good practices that address clear needs and national priorities and implement them in sites that already have some relevant structures and resources in place; involve existing networks and staff with pertinent experience. Also invest in building a strong implementation team with committed leadership and the relevant representatives working at different levels of government and sectors that can provide different perspectives.

3. Apply a clear implementation framework to guide the implementation process, like the CHRODIS PLUS framework, which, in the experience of the implementations sites, works. Consider carefully how differences in local contexts (e.g., cultural aspects, social and organisational structures) can affect the implementation of the good practice, and what must be done to address this. Also consider from the outset what is needed to multiply and scale an intervention, and incorporate this in the implementation process. Be realistic when setting objectives and indicators and anticipating resources needed, including those for monitoring and evaluation.

4. Invest in strong links between project 'owners' and 'implementers' in all phases of the intervention. Decide from the outset the nature of the transfer (e.g., exact or loose replication) and sign a Memorandum of Understanding (MoU), setting out the agreements between the two parties. Maintain close contacts through exchange visits and by e-mails, teleconferencing and the use of social media, throughout the process. Allocate sufficient staff time and other resources to enable this.

5. Make the process of transferring and implementing the good practice fun, and invest in creating 'communities of good practice and change', by networking with other stakeholders and making use of opportunities to mainstream, multiply and/or scale initiatives. This includes linking to other national and international initiatives to share learning and experiences through 'communities of good practice' and engaging the media, to inspire broader support and participation.

comprised of representatives nominated by the health ministries of EU Members States, EEA countries, and representatives of the European Commission and the European Region of the World Health Organization (WHO).

1. Introduction

Over the past decades, advances in scientific and technological knowledge as well as in medical care have led to increases in life expectancy in Europe and across the world. As countries grow wealthier, communicable diseases have been replaced by chronic, non-communicable 'lifestyle related' diseases like cardiovascular disease, chronic obstructive pulmonary disease (COPD) and diabetes as a leading cause of illness and death. While the world is currently focused on the pandemic resulting from a new communicable disease - COVID-19, the focus must also remain on chronic conditions, which continue to affect the lives of millions of people across Europe.

Many chronic conditions now affect 8 out of 10 people aged over 65 in Europe. They are linked to aging and genetic predispositions, but also in large part to behaviours like smoking, unhealthy diets (e.g. overconsumption of sugar, salts and fats), alcohol consumption and a lack of physical activity. It has been estimated that in the EU, in 2016, two-thirds of deaths of people under 75, i.e. 1.2 of 1.7 million deaths could have been avoided[i]: 741,000 (62%) could have been avoided through more effective public health and primary prevention interventions; and one third, 422,000 (38%) through more timely healthcare interventions[ii]. Many of the deaths caused by COVID-19 in recent months could also have been avoided had patients had fewer avoidable pre-existing chronic conditions, that made them less able to withstand the virus. There is a risk that an increasing number of people will develop chronic diseases as a result of the secondary effects of COVID-19 (recession, physical distancing) and that the conditions of those already diagnosed will worsen, as people become more reluctant to seek medical treatment and advice, and medical services are over-stretched. The social isolation and physical distancing still required of those who are more vulnerable to infection can negatively affect mental health, physical health, and functional capacity. Health promotion and disease prevention therefore play a crucial role in strategies to contain the spread of the virus and its impact.

Not only do persistent, long term conditions reduce quality of life and people's ability to contribute to societies and the economy, they are also expensive to manage and treat. Since most chronic diseases can be avoided or delayed, the expenditures related to treating them would be better spent on effective measures to keep people healthy in the first place. There is a substantial evidence base suggesting that many health promotion and disease prevention interventions, delivered within the health system as well as in partnership with other sectors, are highly cost-effective[iii]. These resources are also invested in improving the quality of people's lives; being healthier makes people feel better, whilst well-designed activities that promote health are, as this report will showcase, enjoyable and can generate social engagement, which also enhance health and well-being. Yet the vast majority of budgets earmarked for health continue to be spent on curative approaches, as investments in prevention remain stubbornly low[iv]. While national and regional governments indicate a need for a greater emphasis on health promotion and prevention in their health plans, this intention is not being translated into action.

For decades the predominant narrative in relation to health promotion and disease prevention has been that individuals are responsible for their lifestyles and their health related behaviours, and that the role of health promotion is to provide people with the tools that they need to take responsibility for their health. There is much more awareness today that structural factors have an enormous influence on people's ability to respond to health related messages and guidelines. There is also more understanding that factors like income and education levels, the conditions in which people live and characteristics of their direct environment significantly influence their health related behaviours, affecting their capacities, as well as the opportunities and the motivation that they have to act in ways that promote their health and to protect themselves from illness[v]. It is therefore crucial to 'make the healthy choice the easy choice', particularly when it comes to people facing vulnerability[vivii]. This however requires coordinated action and collaboration across sectors to create such conditions and environments. More targeted interventions are also needed, that are designed to address the needs of and attract specific groups at different stages of the life course, like older people or

children, or for groups with a different cultural background. Investments to encourage and enable people to behave in ways that promote health and prevent illness should be targeted at those who are structurally disadvantaged, to ensure that they do not aggravate, but rather reduce health inequalities.

At EU level, health is primarily an EU Member State 'competency'; the EU cannot impose laws and regulations that affect how each Member State choose to run their health systems. The EU can however recommend that EU Member States make changes, in the context of for example the EU Semester process, and encourage EU Member States to learn from one-another's effective practice[viii]. An important part of its approach is also to facilitate a process of identifying and transferring best practice. In 2011, in this capacity, EU Member States requested the EC's DG Health and Consumers (DG SANTE) to reflect on how to optimise the response to the challenges of chronic diseases[ix]. The mandate and the resulting report placed a strong emphasis on health promotion and prevention of chronic diseases. EU Member States, in response, expressed their support for a mechanism to validate and exchange good practice in the areas of health promotion and the prevention of chronic diseases and the management of chronic conditions, including patient empowerment. This initiated the work of the Joint Action[x] on Chronic Diseases (CHRODIS 2014-2017). The work strand focusing on health promotion and disease prevention identified, on the basis of jointly developed set of criteria, 41 good practices in this field to reduce the burden of chronic disease. These interventions were fed into a "Platform for Knowledge Exchange", an up-to-date repository of good practices for disease prevention and chronic care stakeholders. To further encourage the dialogue between Member States and EC in prioritising health challenges for good practice exchange, European Commission has established a Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases[xi]. Ever since its formal establishment in 2018, it became a key communication and consultation mechanism for the Member States and the EC.

CHRODIS's work in the field of health promotion and disease prevention led to a report outlining Health Promotion and Primary Prevention in 21 European Countries[xii]. It reveals that there is a diversity of systems and structures in relation to health promotion and prevention policies, programmes and practice. The report confirmed that most health programmes lack consistent and dedicated funding for health promotion and primary prevention, and structured and coordinated approaches to develop and sustain workforce capacity, for monitoring and evaluation, and for dissemination and use of findings in these areas. More investments are also needed to develop and maintain effective and sustainable partnerships for health promotion and disease prevention. Overall, there are many promising prevention and early detection programmes across Europe, but they are far from well-developed in most countries. The report confirmed that given the severe medical, social and economic consequences of chronic diseases, more effort and resources need to be invested in health promotion and disease prevention.

The Joint Action (JA) CHRODIS-PLUS (2017-2020) built on this work, to promote the transfer and implementation of the kinds of innovative practices selected under CHRODIS for health promotion and primary prevention as well as patient empowerment and the quality management of chronic disease. 23 partners from 14 EU Member States were involved in the work strand on health promotion and disease prevention. The main focus of the work strand was the transfer and implementation of five good practices in health promotion and disease prevention to different regions in five European Member States. The aim has been to make a direct contribution to strengthening health promotion systems in these countries, whilst drawing on these experiences to contribute knowledge on how the EU Member States can strengthen their health systems by drawing on effective practice from across the Europe.
The work has led to a better understanding of how European countries can learn from each other, and successfully plan for, transfer and implement a good practice from one setting to another.

2. Transfer and implementation of Good Practices

The JA CHRODIS identified a range of criteria for good practices, that were subsequently considered by the European Commission and incorporated into the criteria being applied by the Public Health 'Best Practice' Portal[xiii]. This defines 'best practice' as "a relevant policy or intervention implemented in a real life setting and which has been favourable assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes. Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, inter-sectorality and participation of stakeholders"[xiv].

The process of collecting good practices in the context of the first Joint Action CHRODIS (2014-2017) has revealed that there is a wealth of information and experience within EU Member States on effective and efficient ways to prevent and manage cardiovascular disease, stroke and diabetes type-2, and great potential to reduce the burden of chronic disease by making better use of this knowledge. Lack of emphasis and investment in health promotion and prevention is by no means the result of a lack of knowledge of what works. Making use of this knowledge, and strengthening prevention and early detection programmes across Europe by transferring and implementing programmes and interventions that have proven to be effective elsewhere, can however be a complex undertaking. Differences in context, like geography, culture and climate can significantly influence whether what works in one setting is effective in another setting as well.

Transferring and implementing a good practice are inter-related but different processes. Transfer requires the participation of the initial good practice developers or owners, and those involved in implementing a good practice in a new setting. Even if a good practice is thoroughly described, regular support may be needed from the initial developers, to help maintain the integrity of the core elements that made it a success. Transfer therefore refers to the processes agreed to maintain these links, so that the initial developers continue to provide assistance over time. Implementation refers to the process of bringing together the actors involved, and of designing and carrying out an action plan to apply the good practice in the new context.

There are many factors that affect how successfully a good practice can be implemented from one setting to another. Efforts to understand these different factors, and how they interact and influence outcomes has led to the development of the field of 'implementation science' which refers to "the scientific study of methods to promote the systematic uptake of research findings and other evidence based practices into routine practice, and, hence, to improve the quality and effectiveness of health services.[xv]"

Implementation science emphasises the importance of understanding the context into which good practice will be implemented, including the composition and configuration of health systems, how these relate to other sectors and systems, and how health and health promoting activities are delivered. Another key tenet of implementation science is that it is crucial to work with the actual people that will be affected by the implementation.

CHRODIS PLUS has aimed to contribute to knowledge on how good practice identified in one part of Europe can be transferred and implemented into another context. The partnership developed an implementation strategy and approach that was tested in the context of various CHRODIS PLUS work strands (see next section). As part of the design of CHRODIS PLUS, partners involved in this work strand on health promotion and prevention identified five good practice interventions that addressed different groups across the life-course. They were interventions that have been proven effective in promoting health-related behaviours in their original settings, and which could therefore make a contribution to reducing the burden of chronic diseases. Most of the interventions studied were more 'downstream', in that they encouraged the target groups (older people, the working population and children) to adopt new health-related behaviours, but they took place in settings like schools, the workplace, the community at large and required collaboration with other sectors to adapt and create the conditions for good health. The application of the CHRODIS PLUS

implementation strategy was trailed and tested in the process of applying the five good practices in eight new settings.

Table 2 sets out the interventions, and the contexts to which they were transferred and implemented. Fuller short descriptions of these interventions are included in Section III of this report.

Table 2: Good practice interventions in Health Promotion and Prevention that were transferred from one EU Member State to another as part of CHRODIS PLUS

Multimodal Training Intervention in Communities – an Approach to Successful Ageing
A 6-month programme developed in Iceland, to improve physical activity levels of older people and their health-related behaviour. The programme was transferred to Utebo, in Aragón, Spain and to the Klaipėda City and Klaipėda District in Lithuania, in processes led by the Institute of Health Carlos III (ISCIII) (ES), and the Institute of Hygiene, respectively (LT). It was also multiplied across Iceland, by the Directorate of Health (DOHI).

The Irish "Active School Flag" (ASF)
A nationwide initiative that focuses on supporting a whole school approach to enhance physical activity of children between the ages of 5 and 18. Elements of the programme were transferred to Italy, and to the Klaipėda City and Klaipėda District in Lithuania, in processes led by the Institute of Hygiene (HI) (LT), and the Health Promotion Documentation Centre (DORS) (IT) respectively.

The "ToyBox" intervention: a multicomponent, kindergarten-based intervention
An intervention developed in Greece that promotes water consumption, healthy snacking, physical activity and the reduction of sedentary time in preschool children and their families. Elements of the "ToyBox" were transferred to Malta in a process led by the Health Promotion and Disease Prevention Directorate, Malta.

Jongeren op Gezond Gewicht (Youth at a Healthy Weight) - JOGG
A Dutch movement encouraging a 'whole of community' approach to making healthy food and physical activity an easy and attractive lifestyle option for young people (0-19 years). Iceland's Healthy Community Programme drew on elements of JOGG, in a process led by the Directorate of Health (DOHI).

The Lombardy Workplace Health Promotion Network
An Italian approach that aims to achieve healthier work-place conditions by engaging and strengthening collaboration between employees and the main workplace stakeholders: associations of enterprises, trade unions and the regional health system. The approach was adapted and transferred to the Region of Andalusia (Spain) and implemented by the Andalusian Regional Ministry of Health and Families (CSJA).

This report provides an overview of the experiences of those involved in applying the CHRODIS PLUS implementation strategy and the learning gained from the process of transferring and implementing the five good practices in the field of health promotion and disease prevention. It will highlight how partners applied the interventions to their local contexts, the approaches taken and the outcomes attained, as well as factors that acted as facilitators and barriers to the transfer and implementation process. It will then extrapolate the lessons learned from the process, to strengthen health promotion and disease prevention as an approach to reducing the burden of chronic disease across the EU.

3. The CHRODIS PLUS implementation strategy and approach

CHRODIS PLUS partners developed a strategy (Table 3) to support the transfer and implementation of good practices across the project. The organisations involved in implementing and transferring the good practices did so by applying the four steps involved in the strategy (see Figure 1, p.13). In the first year, all partners involved reviewed and agreed on the common use of the CHRODIS PLUS implementation framework. Partners worked with local implementers of the good practice to undertake a scope analysis, situation analysis (SWOT), identification of improvement areas and design of the Action Plan. This involved recognizing the existing structures and local resources where the good practice is to be implemented. They then assessed and adjusted the original initiatives to suit their local working culture and situation. During the implementation phase that lasted just over a year, implementing sites monitored the progress of implementations and collected data. During the final post-implementation stage, the implementers of the good practice evaluated whether the implementation was successful based on indicators included in the action plans, identified barriers and enablers, reported their experiences and suggestions for future implementation and sustainability/transferability.

CHRODIS PLUS project leaders, researchers, and good practice owners supported the implementers, provided tools to complete implementation strategy steps, and facilitated group discussions. An external expert reviewed the pilot action plans and provided suggestions on what could be done to make them more effective, and also reviewed the final reports. Work package leaders monitored the implementation process through site visits, while virtual meetings took place once every two months between the work package leads, the original good practice owner and the implementers. Where the good practice owners were not available, work package leaders supported the implementers. In some cases, communication also took place via social media channels.

Table 3: The CHRODIS PLUS Implementation Strategy

The strategy consists of four stages that were followed in all implementation sites. Context is defined here as the local setting in which the implementation of a good practice takes place. The inner context, or setting, refers to the people, guidelines, decision-making structures, etc. The outer context or setting refers to the municipality, local, or national educational and/or health and/or health-promoting systems that can affect implementation. For the interventions transferred in the context of CHRODIS PLUS, this included the executive board, experts, and researchers are part of the outer context.

Step 1: Scope Analysis

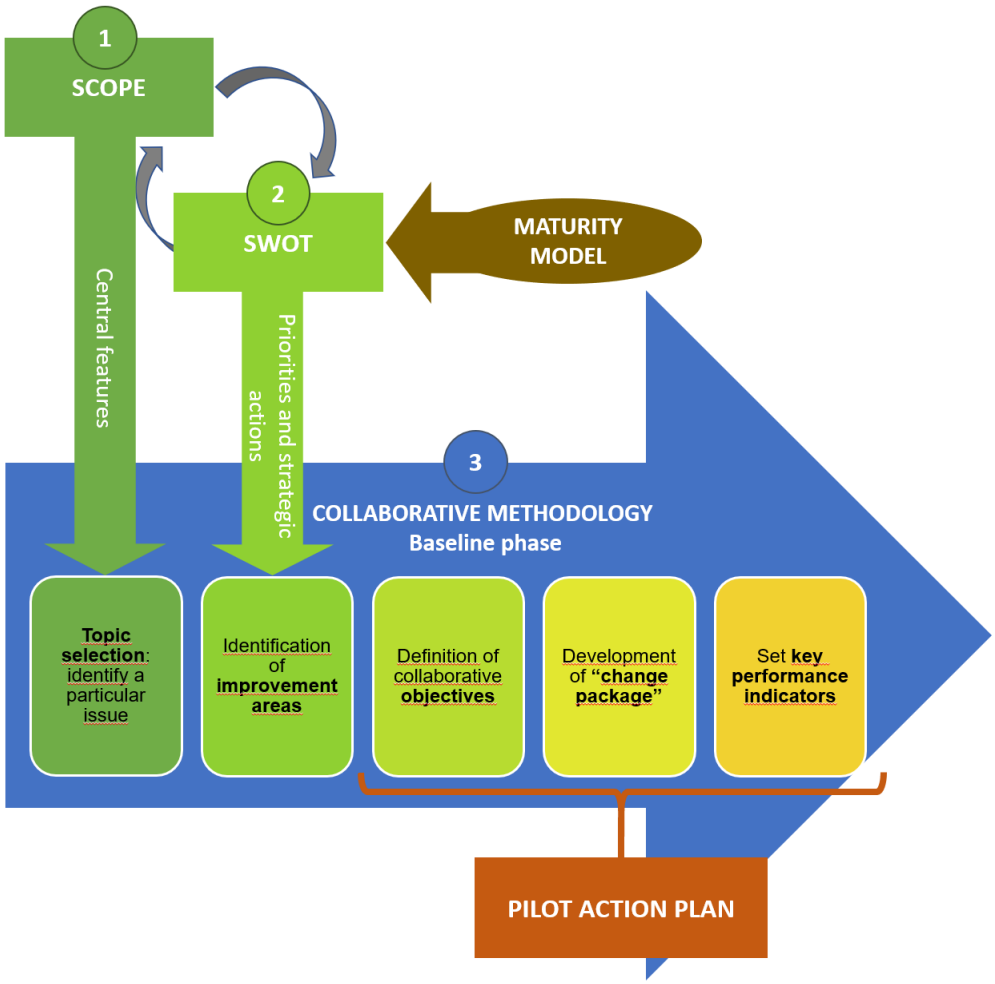
In the scope analysis, implementation working groups at local level considered carefully how the intervention could address specific challenges in the local context. This involved consideration of: the health situation of the local population and local needs, interests, and capabilities. A structured group discussion was applied that involved five steps to: (1) identify and describe the problem/challenge, (2) describe the general purpose of the intervention, (3) describe the target population, (4) analyse the intervention's components and identify the central features that are essential to achieve the desired results, and (5) select the components of the proposed good practice that will be locally implemented.

Step 2: SWOT Analysis

Situation analysis — "strengths, weaknesses, opportunities, threats" (SWOT)—is used to identify the respective organizations' internal strengths and weaknesses, as well as external opportunities for, and threats to, implementing the interventions based on the selected components. The SWOT was designed to help with both strategic planning and decision-making in relation to the planned intervention. SWOT was chosen as a tool because it is a structured, well-known, and easy-to-use method. During the SWOT analysis, the local working group in each implementing site considers the strengths, weaknesses, opportunities, and threats to the implementation of a good practice across five dimensions: (1) sustainability, (2) organization, (3) empowerment, (4) communication, and (5) monitoring and evaluation.

On the basis of a template developed by CHRODIS PLUS to facilitate discussion, all implementing sites prepared a document that presented the most important strengths, weaknesses, opportunities, and threats for their organization, with an overview of major issues, priorities, and strategic actions needed in relation to their planned intervention.

Figure 1. JA CHRODIS PLUS Transfer and Implementation Strategy



Step 3: Elaboration of Pilot Action Plans

Members of the local implementation working groups met to develop and improve their action plans, which provide a concrete set of steps and activities that need to be conducted in order to implement their respective health promotion interventions.

This process involved an adapted version of the iterative cyclic nature of "collaborative methodology" [22] which required the working groups to address three main questions: (1) What are we trying to accomplish? (2) What changes can we make that will result in a successful implementation of the proposed good practice as well as improvement? (3) How will we know that a change is an improvement? These questions were used to develop a concrete action plan, which was devised in five steps: (1) identify the specific issues to work on, (2) detect improvement areas, (3) define specific objectives, (4) develop the change package, and (5) set key performance indicators. CHRODIS PLUS also developed a template that all implementing sites to use to develop their action plans.

Step 4: Plan–Do–Study–Act (PDSA) Cycle

The plan–do–study–act (PDSA) cycle presents a pragmatic scientific method to test for changes in complex systems. The four stages mirror the scientific experimental method of formulating a hypothesis, collecting data to test this hypothesis, analysing and interpreting the results, and making inferences to iterate the hypothesis [23,24,25]. The pragmatic principles of PDSA cycles promote the use of an iterative approach to test interventions. This enables rapid assessment and provides flexibility to adapt the intervention according to feedback to ensure fit-for-purpose solutions are developed.

The steps of the PDSA approach are as follows: (1) plan: plan the actions defined in the pilot action plan. Detail actors (who), functions and roles (what), timeframe (when) and setting (where); (2) do: test the action and, once finished, collect data and document any problem or unexpected occurrences; (3) study: analyse the data obtained during the testing step. Compare the results to the predictions, and summarise the learning; (4) act: based on the lessons learned, refine changes and determine modifications. This improved change is then re-implemented in a new PDSA cycle.

Documents from each implementation strategy step, notes from the meetings, site visits, recorded webinars, and other documentation from the communication were stored to help the analysis of the implementation process and to understand the outcomes. All implementers provided a detailed report setting out their implementation strategy, the enablers and barriers and lessons learnt. The following draws on these reports, to highlight the key factors within the local context that affected implementation, the approaches taken and the outcomes and the lessons learned.

4. Summaries of the experiences of transferring and implementing good practices and the lessons learned

4.1 Multimodal Training Intervention from Iceland transferred to Utebo in Aragón, Spain, and Klaipėda district and Klaipėda city municipalities in Lithuania

Older adults generally have the highest rates of disability, functional dependence and use of healthcare resources. Research has established that 6–10% of all deaths from non-communicable diseases worldwide can be attributed to physical inactivity. This percentage is even higher for specific diseases, such as ischemic heart disease, being about 30%.

The study **Multimodal Training Intervention (MTI) in Communities – an Approach to Successful Ageing** that was designed and first implemented in Iceland, examined and evaluated the effects of a 6-month programme to improve physical activity levels of older people and their health-related behaviour.

The target population is people aged of 65 and older, still living in own residence. The training, developed by Dr. Janus Gudlaugsson as part of his doctoral thesis, includes daily endurance training based on walking (30 min) at least once a week with a trainer. The duration of the training session increases progressively through the 6-month training period. Resistance training is individually-based following a systematic training plan. It takes place twice a week, in a fitness centre, under the guidance of one or more health instructors. The programme also involves four to six lectures on healthy aging, endurance and strength training, how to exercise, and two lectures on nutrition. Lectures can also be provided on measurements at each step/stage, how to train, training and intake of drugs, balance training, sleep and health, and healthy aging. The lecturers are provided given by geriatricians, a physiologist, a nutritionist and health educators.

The intensive training period lasts for six months, and then followed-up every six months to monitor the longer-term effects and sustainability of the intervention.

The result of the Icelandic study suggested that regular MTI can improve and prevent decline in functional fitness in older individuals, influence their lifestyle and positively affect their ability to stay independent, thus reducing the need for institutional care.

More information about the practice is available here.

4.1.1 Implementation in Utebo-Zaragoza, Spain

Context

The population census in Spain for example reflects that 28% of men and 38.8% of women aged between 65-75 are sedentary, a proportion that rises to 38.6% and 58.7% of men and women aged 75-84, respectively. National and municipal health plans therefore include as an objective to increase physical activity levels of older people. The Institute of Health Carlos III (ISCIII) in Spain, decided to collaborate with the Aragón Institute of Research in Health Sciences, both partners in CHRODIS PLUS, to implement the Multimodal Training Intervention in the municipality of Utebo-Zaragoza in Aragón. This municipality has a population of 18.593 in 2017, of which 12.7% over were the age of 65. Physical activity levels here reflect national averages.

One of the reasons that Utebo was selected as an implementation site was that there were existing structures to build on. Health care systems in Spain tend to be very medicalised. The aim of the pilot in Utebo, which was also incorporated into the Action Plan, was not just to implement the Multimodal Training Intervention Programme, but also the model of community based care in which it was embedded in Iceland. The pilot therefore also involved strengthening primary, community based care models, as an approach to using health resources more efficiently and to ensuring the sustainability of interventions like the Multimodal Training Intervention. This entailed a mapping of all health-related community resources in the city of Utebo and including this in a database that could be consulted by primary health care providers. This would enable, for example, primary care nurses to refer older patients to sport centres able to accommodate them.

Approach

The implementation of the pilot involved collaboration between several services. The Health Department in the government of Aragón provided strategic vision the personnel needed to monitor health of participants. The Utebo City Council provided the infrastructure and human resources needed to implement the programme, via its departments of sports and public works, Social work, health and consumption, direction of municipal sports services. These different actors were able to identify and bring together the people and facilities that were needed to implement the programme. The primary health care centres were responsible for helping to recruit and to monitor participants, the municipal sport services provided the training locations and trainers.


MANCOMUNIDAD CENTRAL DE ZARAGOZA

Entrenamientos y paseos que no entienden de edad

Plan de salud para promocionar una vida activa entre los vecinos

Picture 1. Article that appeared in 'Heraldo de Aragon' about the Multimodal Training Intervention (18 March

Before the implementation started in Spain, trainers and project managers came to Iceland for a site visit where they learned all about the MTI, were given the opportunity to take part in measuring a new group in Iceland, visit the training areas and were given lessons on how everything works, from measuring, training, organize and maintain lectures, collecting and working with data and communicating with participants. In addition, before the teams in Lithuania and Spain started, the team from Iceland, Janus Gudlaugsson (PhD) and Lára Janusdóttir (MBA) went to each location to help them get started with the measurements, teach the rest of the teams how everything is done and correct them if needed. This was also very important to make some minor corrections on measurements, so everything would be correct from the start and comparable between countries.

Fifty-two people over the age of 65, who were able live and function independently, were recruited through nurses at the primary care centres, following clinical criteria. Their participation was sustained throughout the trial period. The initiative was also publicised through the local and regional media during different phases of the pilot, while a local television channel also took interest. It was disseminated through social networks (Facebook and Twitter). Visibility was in addition achieved through specially made t-shirts worn by all participants, to create an identity.

Outcomes and lessons learned

The measurements of the health outcomes of the 51 participants reflect improvements in their physical condition, state of health and quality of life. Those who completed the programme experienced measurable improvements in for example lower resting heart rates, greater endurance, improvements in flexibility, strength and balance.

Amongst the barriers identified to the implementation of the programme were the additional burden it places on the work load of all professionals involved, related to bringing together different community resources to refer patients to community resources and to establish specific spaces and times where older people could come together and engage in physical activity. Nevertheless, it was recognised that the initial investments to build community, asset-based health models would bear fruit in the future, leading to better and more efficient models of health. It was however difficult to reach those in most need. The resulting database for example now includes all initiatives in the community relating to health and physical activity, such as occupational therapy services, dance therapy, social theatre for children, municipal voluntary programmes as well as the Multimodal programme, that medical professionals can refer their patients to.

The three main government directorates involved have expressed a commitment to maintain the collaboration and expand the Multimodal training programme and the broader community-based care model that it sits within. The General Directorate of Sport will for example continue with the process identifying people who can implement the programme to guarantee the sustainability of the action in the long term. The Directorates-General for Healthcare and Public Health will continue to recruit participants and recommend the activity, while it also expects it to expand via 'word of mouth' from existing participants.

The team from Iceland was planning to visit the implementers in Spain and have a meeting with politicians and others with the interest in further roll-out in Spain. The meeting had to be postponed because of Covid-19, but will be re-scheduled as soon as possible.

For more information about the transfer and implementation, see Annex 1. p.41.

4.1.2 Implementation in Klaipėda city and Klaipėda district municipalities in Lithuania

Context

The Lithuanian Institute of Hygiene collaborated with Public Health Bureaus of Klaipėda city municipality and Klaipėda district municipality to implement the Multimodal training intervention programme. Klaipėda city municipality (98 km²) has a population of 184,657, while the more rural Klaipėda district municipality (1336 km²) has a population of 50, 617, of which approximately 15.2% is over the age of 65. Results of the adult lifestyle survey conducted in 2018 show that there were 35.2% of physically active adults in Klaipėda city in comparison to 40.5% in Lithuania as a whole.

In Klaipėda district municipality, two groups in the more rural areas, and another in the city of Gardzdai participated in the programme While infrastructure for physical activity is expanding in both districts and there are activities to promote this, the resources available to do so are quite scarce, particularly when it comes to facilities and activities for older people.

Approach

The implementation in Klaipėda city and district municipalities was almost exactly the same as the original practice, since the goal was to transfer the practice as it was rolled out in Iceland. As in Spain, project managers and trainers visited Iceland before the intervention, while the team from Iceland visited each location to help them get started with the measurements, teach the rest of the teams how everything is done and correct them if needed.

Public Health Bureaus involved other public health specialists and recruited students studying physical education, public health and kinesitherapy as volunteers. Municipal governments were also involved, by e.g. buying monitoring equipment.

Participants were recruited through the Public Health Bureaus, who already had some contact with the target populations recruited the participants, in collaboration with other bodies like Alzheimer's and carers

associations in case of Klaipėda city. They also recruited participants by publishing information in social networks and distributing flyers encouraging participation in libraries, churches and other public spaces. In Klaipėda city there was an overwhelming interest to participate in the intervention, while it was more difficult to recruit participants in the more rural Klaipėda district municipality.

In total, in Klaipėda city municipality, 170 participants over the age of 60 took part in the programme and were organised into 11 different groups. The progress was measured of all participants, during the course of 17 sessions that took place during the year-long implementation period. In Klaipėda district municipality, a total of 175 participants were enrolled in the program and 19 measurements took place.

Outcomes and lessons learned

Initially, the implementation faced a number of obstacles. Finding adequate infrastructure proved challenging, as public infrastructure was not adequate, and privately owned sports centres were not keen to participate without financial incentives. It was therefore difficult to find the space to accommodate large groups. It also took more time than anticipated to translate relevant documents from English into Lithuanian, and to retain staff over the year-long period. Maintaining the motivation of some participants was also an issue, particularly in the more rural Klaipėda district, where they had to travel long distances by car to take part in training or monitoring activities.

Despite these obstacles, the intervention was found to benefit the participants. It improved their physical activity, flexibility, endurance, posture, people's body composition, weight, vitamin D levels and their general sense of well-being. Since participants trained alongside other community members, it also improved their sense of inclusion, and improved intergenerational relations in the community. Younger people often helped older people use certain equipment, and learning how to use the exercise machines built their confidence to go to the gym on their own. The implementers indicated that participants often expressed they were happy with the programme and inquired if others could join, and if it would be continued. They noted that factors like family support, positive attitudes of doctors vis-à-vis the intervention and personable trainers who attended to the needs of participants were important and contributed to the overall positive outcomes.

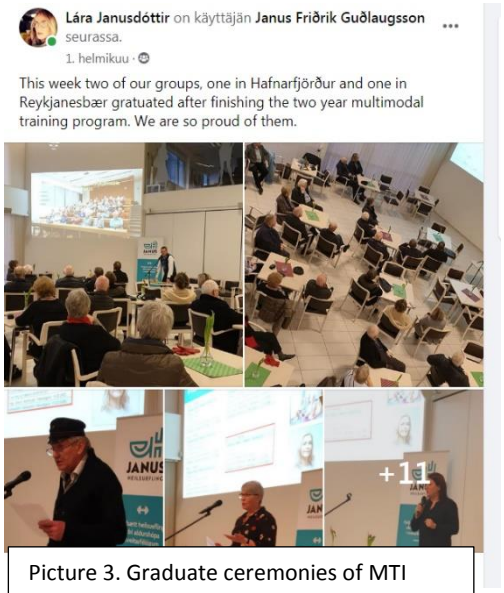
Picture 2. A MTI Nordic walking group in Lithuania (a capture from Twitter)

Klaipėda district municipality shared the information about good practice with the Public Health Bureau of Sakiai District, who showed an interest in the programme. There are two polyclinics in Klaipėda city that are interested in the intervention and would like to cooperate with Public Health Bureau and prescribe the training to their patients. The Multimodal training intervention will be presented during the next annual meeting of all Public Health Bureaus across Lithuania, with the aim of transferring it as a good practice to other municipalities. In January 2020, the Ministry of Health in Lithuania visited the practice owners in Iceland (Janus Health Promotion) as part of their plans to roll-out MTI across the country.

For more information about the transfer and implementation, see Annex 1. p.46.

4.1.3 Further roll-out in Iceland

The Multimodal Training Intervention started out in Reykjanesbær in Iceland with one group of about 100 participants. Another group of 100 was started here six months later, as well as in the municipality of Hafnarfjörður, with over 180 participants. Over 720 participants in four municipalities were taking part in the programme by mid-2020, with plans to implement it in seven municipalities by the end of the year.



Picture 3. Graduate ceremonies of MTI groups in Iceland (pictures from Facebook)

The overall target is to reach about 5% of the population in each participating municipality every 6 months, or around 15–20% over a two-year period. The overall objective is to reach about 60% female (who tend to be more enthusiastic) and about 40% males across Iceland, who are not in the labour market, staying in an independent place of residence and able to get to the training without the help of others.

In June 2019, Dr. Janus Guðlaugsson was rewarded the Medal of Honour by the President of Iceland for his health promotion work with older adults. Dr. Janus Guðlaugsson and his managing team have also been invited to meetings with the Minister of Health, Minister of Finance, and the Minister of Social Affairs. The Icelandic government is very interested in rolling out such health promotion initiatives in municipalities and investigating ways to execute this.

For more information about the implementation, see Annex 1. p.54.

4.2 Active School Flag from Ireland transferred to two schools in the Piedmont Region in Italy and to the Klaipėda city and Klaipėda district municipalities in Lithuania

Children currently spend a lot of time in sedentary activities like watching television or playing video games. Being physically active during childhood and adolescence tends to make these behaviours regular in adulthood. Evidence indicates that interventions linking education on lifestyles and physical activity reduces children overweight and obesity, improves a child's overall health and fitness, but it can also help to improve their mental health and cognitive development. In addition, implementing public health interventions in schools makes it possible to reach large numbers of children. They can play a fundamental role in improving active lifestyle by both creating favourable conditions for structured motor activity, promoting communication with families, and in reducing health inequalities.

'Active School Flag' (ASF) is a Department of Education and Skills initiative. It is supported by the Healthy Ireland framework and forms part of the National Physical Activity Plan. It focuses on supporting a whole school approach to enhancing physical activity. ASF is targeted at school-going children between the ages of 4 and 12, and open to all primary schools, with nearly 800 schools around Ireland are currently flying an "active flag", which has to be renewed every three years. It is awarded to those who can show how they are striving for a physically educated and physically active 'school community', and requires that links be made with organisations beyond the school.

Schools are recruited to the ASF program by invitation and, once engaged with the program, they are supported on a program of action planning and self-evaluation. They must apply a 'whole-school' approach, and review their current provision across the areas of physical education (PE) and physical activity and to commit to a number of improvements. They review areas include elements of planning and PE curriculum, professional development, school PE resources, activity during break times, cross-curricular activities and inclusive physical activity. There is also a strong emphasis on partnership and on working with pupils, parents, the local community and national agencies. The focus on issues of inclusion and partnership may be of particular relevance to addressing inequalities in physical activity and in sustaining physical activity.

More information about the practice is available here www.activeschoolflag.ie

The ASF is an ever-evolving programme. Adjustments are made to the process on an annual basis in response to school feedback. A new ASF for the secondary school (post primary) sector (ages 12-19 years) is currently being designed'.

4.2.1 Implementation in two schools in the Piedmont Region, Italy

Context

According to a survey conducted in selected schools of Piedmont Region in 2016, about 1 in 7 children (15%) are physically inactive. Only 1 in 3 children get the recommended level of physical activity for their age[xvi].

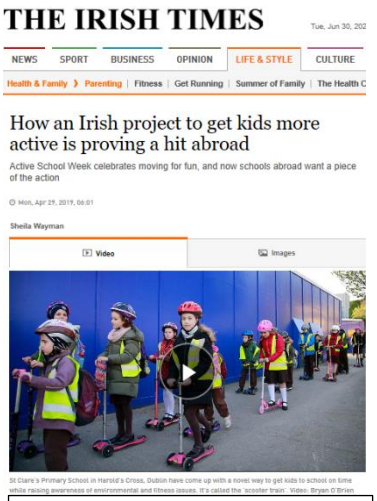
Schools in Italy are generally very big, with 1,200 pupils on average, and have a lot of autonomy. They provide physical activities, but often not in a coordinated manner. Teachers who are not specifically physical activity educators do not receive training in the subject and do not feel confident engaging children in physical activities. The Centro Storico Moncalieri school which is located in a small town in the metropolitan area of Turin, the capital city of Piedmont, in the north-west of Italy, has 1300 students (aged between 3-14) from a variety of socio-economic backgrounds; 20% of students are immigrants, largely from Romania, but also Africa and other countries. The school is comprised of a single building. Istituto Comprensivo "Rita Levi Montalcini" with 1200 students, is based in the historic district of Torino, that has become a well-off residential area, housing public services and businesses. The school is comprised of four buildings in separate locations.

Approach

The Piedmont Regional Health Promotion Documentation Center (DORS), a CHRODIS PLUS partner, and the Azienda Sanitaria Locale di Collegno e Pinerolo (Italy), worked together to transfer and implement ASF in two schools in the Piedmont SHE Network, that expressed an interest in participating in the programme. The two schools appointed a coordinator to implement the activities in the school. Teachers in the two schools (six at primary level at the Rita Levi Montalcini School and five primary and middle school levels at the Centro Storico Moncalieri school) volunteered to implement the activities relating to the ASF. Rita Levi Montalcini school introduced activities in all 6 first classes, Centro Storico Moncalieri school introduced activities in 5 classes.

A delegation of the implementing schools visited the Irish good practice owners (Department of Education and Skills in Ireland) to learn about the programme before the implementation began. A delegation of good practice owners visited the pilot sites in Italy in the middle of the implementation to share experiences and receive suggestions directly from the donors. In addition, the implementing sites exchanged e-mails and experiences through a closed Facebook group.

The schools compared the self-evaluation instrument with those already in the schools of the SHE Network, undertook a context analysis applying the Irish instruments, and introduced a selection of ASF activities, modifying the organisation and the cultures of the school accordingly. They revised their existing physical activity and education programmes to ensure that all received at least an hour a week with wide and broad content. They also introduced a minimum of two physical activities such as stretching, 'The Daily Mile' programme, active homework (ex: "take a walk with parents for 15 min"), active breaks in class and outdoors (using Go Noodle, action songs, wake up shake up activities). The schools in addition collaborated with local sport clubs promoting 'taster session activities' and public sport events in which families could participate (e.g. Bimbinbici, Turin Marathon.) The Rita Levi Montalcini School organized an active school week, pairing with St Clare's school (an Irish school in Dublin). The Centro Storico school organized a "play day" with games and activities for all classes, in the last day of the school year. Each school formed a working group (composed of teachers, parents and students) to embed physical activity in the school policy.


THE IRISH TIMES

NEWS SPORT BUSINESS OPINION LIFE & STYLE CULTURE

How an Irish project to get kids more active is proving a hit abroad

Active School Week celebrates moving for fun, and now schools abroad want a piece of the action

Sheila Wayman

Video Images

Picture 4. Article about ASF in Irish Times

Outcomes and lessons learnt

The programme was implemented as planned, with positive outcomes. More than 21% of students were involved over the implementation period, and teachers found the programme easy and feasible to implement. Initially the implementers wanted to introduce ASF in only two classes but ended up implementing in even more. When other teachers saw the routines and activities, some asked to join in.The reported benefits of the initiative include: increased levels in concentration and focus, greater attentiveness and participation during lessons. Children were eager to come to school for 'Wake Up, Shake Up'. The medical team of a young boy with Down syndrome indicated he benefitted a lot from daily running activities. The programme helped to shift the perception of physical activity as an 'add-on' or a 'waste of time', to a mechanism to enhance the teaching and learning environment with a justifiable place within the school day.

Amongst the factors identified that contributed to the success was the high level of engagement from teachers and school principals, and the fact that the regional authority was involved in the local implementation working group which was important for recruitment and to sustainability. The extent to which coordinator had contact with teachers across the schools was important. The coordinator of the ASF in Rita Moncalieri school had daily contact with her colleagues and implemented activities in her own class. The coordinator in CS Moncalieri school was a teacher in the middle school, which is in a separate building to the primary school. This made it more difficult for her to motivate and engage elementary school teachers. Both schools benefited however, from a highly engaged principal, who embedded ASF in school policy and in school PTOF (three years school educational offer plan).

Crucial were also the exchange visits between the implementers and the original owners of the intervention at the start and during the implementation processes. For example, during the site visit the good practice owner encouraged the school to organise an Active School Week, but advised to start with a small number of activities rather than doing a lot at once. They aslo advised on how to reshape some activities. Finding a mechanism to enable schools to share ideas, activities and successes with one another can help to strengthen the programmes outcomes. The video footage taken during the donor's school visits ('Wake Up, Shake, Up – Daily Running – Active Maths – Breaking Up Sitting Time etc) for example provided rich and valuable material for future development work. The fact that the implementation sites in Lithuania and Italy didn't exchange and compare their experiences was considered a missed opportunity that could have been enriching for everyone.

Italy recently began a project funded by the National Centre for Disease Prevention and Control (CCM), called ”Muovinsieme” (move together): School and local authorities for the promotion of healthy and active lifestyle, that will incorporate elements of the ASF programme. It also addresses physical activity in school settings, and involves Piedmonte and three other Italian Regions. The aim is to incorporate the Active School framework, to continue to promote activities like the active break, morning run, Active School Week and to extend them to all the regions in Italy.

For more information about the transfer and implementation, see Annex 1. p.59.

4.2.2 Implementation in Klaipėda city and Klaipėda district municipality, Lithuania

Context

Physical activity levels in Lithuania are amongst the lowest in Europe; only 9,7 % of children in Lithuania meet the requirement of 60 minutes daily physical activity. This number is slightly higher in Klaipėda city, were 12,1 % of 5th, 7th and 9th grades achieve this. While most children in Klaipėda district municipality, a more rural area, walk more than one hour per day, the overall time that they spend on physical activity is declining.

In Lithuania, schools are committed to a long-term strategy to promote physical activity and healthy lifestyle, via the Healthy School programme led by the Ministry of Health. Nevertheless, national level surveys indicated that there is a lack of public appreciation amongst the general public for the importance and benefits of physical exercise. Infrastructure and equipment in most schools is often lacking or worn out, obsolete or broken while schools lack staff the time to deliver programmes.

Approach

Two schools in Klaipėda city implemented the intervention: Gilijos Primary School (598 pupils) and Sendvario Progymnasium (680 pupils). Three schools in Klaipėda district municipality also piloted ASF, involving 190 children in 11 classes (aged 6 – 11). Supervised by the Institute of Hygiene, employees from the Public Health Bureaus (PHB), responsible for checking and promoting of students’ health and safety, managed the pilots. They worked with each participating school to build an ASF team, consisting of administration workers, teachers and health specialists. The school’s health specialists were primarily responsible for implementing the programme in schools, and for liaising with PHBs, while the Institute of Hygiene (HI) was the main contact with the ASF project owner team in Ireland.

A delegation of the implementing schools visited the Irish good practice owners (Department of Education and Skills in Ireland) to learn about the programme before the implementation began, but no other exchange visits took place during the implementation process.

The approach involved investigating and making improvements in the regular school curriculum in order to ensure that children engaged in at least 60 minutes of moderate physical activity a day. It also involved determining how to involve the whole community, including students, teachers, parents, the school administration and the local community in this process. In accordance with the original programme, the schools created an ASF committee, including a team leader, teachers and parents. The schools were encouraged to organise activities that would best suit their location or interests. Those selected included: introduction of new physical activities (Run around Europe and Lithuania, mile a day, active breaks, active travel and etc.) and the organisation of longer duration events like an Active School Week, active September, and a European mobility week. Where there was a lack of suitable equipment, project partners helped implementers source these. The schools also collaborated with local sport clubs and organisations and took part in local events (Healthy days, Independence Day running).

Outcomes and lessons learned

The implementation project experienced some delays in translating materials and coordinating evaluation process, reflecting a need to receive, adapt and translate methodological material at the pre-implementation stage. The Institute of Hygiene was primarily in contact with the practice owners, but experienced a high staff turnover during the implementation period. This affected the otherwise mutually beneficial link between the practice owner and the local Public Health Bureau employees responsible for the pilots, and their ability to benefit more from the practice owner's experience.

Despite these difficulties, the schools were able to implement all planned activities, and achieve the most important objectives with good results. Measurements of the number of activities organised and students engaged in Klaipėda district municipality reflect that all students were involved. The programme evaluations results derived from the Self-evaluation Questionnaire and Teachers' Questionnaire in all implementing sites were positive. Teachers from both Klaipėda city schools indicated that the intervention increased their confidence in the delivery of the PE curriculum, generated a more positive school atmosphere and improved teacher-student relationships. The qualitative results reflect that teachers noticed children were more attentive, punctual, and that their behaviours improved and they participated more in lessons, with better academic results. Overall, they noticed that the programme created a positive atmosphere in school, and improved children/pupil relations. They also noticed that children who have behavioural and attention problems were more involved in ASF activities. The programme led health promotion activities to be perceived as positive, fun and inclusive. The fact that 19 other schools in the district would also like to implement elements of ASF, and an application has been made and accepted by the Sport Support Fund to enable this, reflects the programme's positive impact. In addition, both schools from Klaipėda city will take part in the National Network of Active Schools that was recently launched in Lithuania. The government of Lithuania is planning a nation-wide physical activity policy that will be advised through the experience of piloting the interventions by the Institute of Hygiene.

For more information about the transfer and implementation, see Annex 1. p.63.

4.3 ToyBox from Greece transferred to schools in Malta

Early childhood is a critical period for addressing obesity prevention since behaviours, psychological traits and physiological processes are largely developed or formed at this young age. The development and adoption of the desired behaviours will help to ensure optimum growth during childhood and increase the likelihood of long-term health in adulthood.

The Greek ToyBox - Taste and move adventures project is an evidence-based, multicomponent, intervention primarily involving the kindergarten setting. The programme targets four energy-balance related behaviours (EBRBs) among 3-4-year-old preschool children and their families that contribute to early childhood obesity i.e. drinking, eating and snacking, physical activity and sedentary behaviour and their determinants, with the aim of promoting water consumption and healthy snacking, increasing physical activity and reducing sedentary behaviour, both within and outside of the school. Teachers are regarded as key role models throughout the project, and are asked to facilitate a health-promoting environment during school hours. Parents are also included in the intervention through newsletters and are encouraged to create a home environment that facilitates these behaviours.

The project was implemented over 24 weeks, with each behaviour (i.e. healthy snacking, increasing physical activity, reduction in sedentary behaviour and promoting water consumption) targeted sequentially over a 4-week period. The cycle was then repeated, with each behaviour being focused upon for a 2-week period. Classroom environments were reshaped at the beginning of the scholastic

year to encourage active movement during lessons, establish a water-station and an area for a 'Magic Snack Plate', and reduce sitting times. Educators are provided with a Teachers Manual covering topics related to a healthy lifestyle, including healthy eating and snacking, water consumption, healthy food for healthy teeth, self-expression and physical exercise. They could adapt the programme to suit their needs. Teachers were also given a hand puppet (Kangaroo) to use for storytelling, and manuals with suggestions for activities, games, etc. for each energy balance related behaviour. In order to promote parental involvement and interest in the project, nine newsletters, eight tip-cards and four posters that could be coloured by their child that provided friendly messages to apply at home were delivered to them throughout the year. Anthropometric measurements of the children (height, weight and waist circumference) were also taken by the researchers. An objective assessment of physical activity pre- and post-implementation was also carried out on a sub-set of children through the use of pedometers.

More information about the practice is available here.

Context

Obesity is a critical public health issue in Malta, where approximately 41% of children and 69% of adults are overweight or obese[xvii], making Maltese adults among the most overweight within the WHO European region.[xviii] A nationally representative study suggests that children as young as six to seven years of age are physically inactive[xix], while Maltese children led country rankings in terms of self-reported rates of soft drink consumption as of 2014. The 2018 HBSC study also showed that Maltese children rank last from all participating countries in terms of brushing their teeth daily[xx].

There is a general lack of awareness of what constitutes healthy eating, particularly among grandparents, who play a disproportionately important role in child-rearing, yet are not as aware as parents of the need for a healthy lifestyle. There are also limited opportunities for children to safely engage in outdoor activities; parental lack of engagement in school activities; resistance among teachers and parents regarding the creation of an 'excessively regulated' school environment, and lack of willingness of teachers and parents to act as role models.

Schools in Malta are run by three main groups: state schools are free and government-led; church schools that are partly subsidized and run by the Roman Catholic Church; and independent schools are a mixture run by different organisations against a set fee. Since there are already programmes on nutrition and physical activity in state schools, the ToyBox intervention was implemented in 13 church and 14 independent schools. A total of 991 children and their families were targeted, of whom 733 consented to have their measurements taken and 624 actually measured (due to some students being absent from school on the day of measurement or their refusal to be measured).

Approach

Representatives of the project owner (Harokopio University Athens, Greece) provided trainings to the local implementation working groups (LIWG) established by the Directorate for Health Promotion in Malta, who in turn selected the schools and provided training to the teachers involved. An additional component regarding dental care and plaque was added, given the comparatively high level of dental problems amongst children in Malta. Teachers were granted some flexibility to adapt the programme to suit their needs, but encouraged to stick to it as much as possible.

The project managers from the Directorate of Health visited the school regularly to check progress and provide guidance as needed. They also contacted the school on a regular basis to proactively identify and resolve any issues and obtain ongoing feedback. A number of teachers found it difficult to stick closely to the exact programme; they simplified the material to make it more engaging and better suited to the attention

of small children. The coordinator sent examples of good practices she observed in some schools to other schools, to learn from.

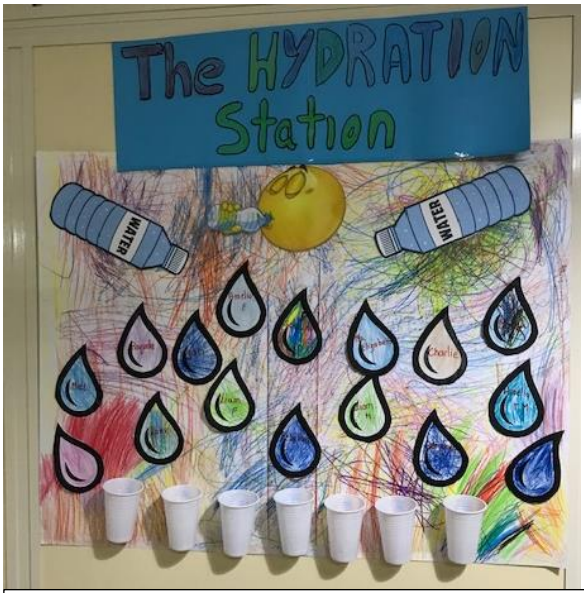
A quantitative approach to study evaluation was undertaken. Anthropometric data was collected from children whose parents consented, and two sets of questionnaires administered to caregivers/parents (i.e. a Food Frequency Questionnaire assessing dietary patterns of the child's intake over the previous 12 months, and a questionnaire aimed at exploring health behaviour, food environment and opportunities for physical activity environment in the home, and socioeconomic background). This was supplemented by informal (solicited) qualitative feedback obtained from heads of schools, teachers and parents throughout the year, every two months, through a short questionnaire, to obtain updates on progress and inquiring about issues encountered and suggestions.

Outcomes and lessons learned

Data analysis was delayed due to Covid-19, and is currently underway. While tangible conclusions are dependent on outcomes as determined by the ongoing analysis of the data collected, teachers anecdotally noted an increase in water consumption amongst children and an improvement in the nutritional quality of lunches. There was more awareness amongst the teachers about the importance of physical activity, and of engaging children in organised moments of movement and not just to depend on free play, to also involve children that might be quieter. Parents also responded positively to the programme in questionnaires that were distributed at the end of the scholastic year.

However, an independent evaluation of the programme was carried out by a university student who interviewed five participating teachers in June 2020. Most of the teachers spoke highly of the programme and its activities as well as its positive influence on the behaviours of the children, with most believing that the programme is effective. However, most teachers did not feel that they received sufficient support from the Health Promotion and Disease Prevention Directorate to enable them to deliver effective ToyBox sessions. More 'hands on' time needs to be spent in schools by implementers to aid teachers. Simply asking teachers to follow the handbook/manual is insufficient. Ideally, creative ideas on how to implement the activities in the handbook would be provided by the implementers.

The rigid format of the programme proved to be challenging for some teachers, as they already had to deliver a set curriculum, and didn't find it easy to incorporate a new element. Teachers had to invest extra time into adapting the programme to suit the existing curricula, as the cycles of the programme did not match well with other material they were expected to teach. If the programme could be better adapted to suit Maltese educational system, and the national curriculum could include energy-balance related behaviours (EBRBs) it would increase the number of schools who would continue to implement the programme in the coming years. This requires the Ministry of Education to recognise the importance and value of the programme, as well as other stakeholders like trade unions, who safeguard the interests of teachers to ensure that they are not over-burdened.



Picture 5. Water drinking station in one of the project's implementing schools. Picture: Roberta Adami Zarb

It was noted that the head of school's support for the programme is very important; if they are not engaged it

is difficult for the teachers to engage also. In addition, it works well if teachers are enthusiastic and find the topic important. The implementers felt that in future, having one of the teachers who successfully implemented the programme, using the correct format, speak with teachers and heads of school during the pre-implementation phase would strengthen their enthusiasm and support for the programme. The explanation offered by an experienced peer who can offer tangible practical ideas for implementation, as well as the opportunity to exchange on their own expriences, can inspire teachers further.

A general learning point was that a programme may be much harder to implement in practice than it looks on paper; the actual resources required to do so should not be under-estimated. The local implementation working group for example lacked the analytical capacity to analyse the data collected, and the expertise that is needed to do this is in general limited in Malta. It is therefore important to speak to people on the ground to get a good sense of how it can be done, and the feasibility of doing it practically.

For more information about the transfer and implementation, see Annex 1. p.70.

4.4 Elements of JOGG "Youth at a Healthy Weight" from the Netherlands transferred to the Health Promoting Community programme in Iceland

Jongeren op Gezond Gewicht (Youth at a Healthy Weight) is a Dutch movement to all relevant stakeholders in shaping communities that promote children and young people's health. This includes making healthy food and physical activity an easy and attractive lifestyle option for young people (0-19 years). JOGG advocates a local approach in which not only parents and health professionals, but also shopkeepers, businesses, 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 EPODE project that originated in France. It 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, 145 municipalities in the Netherlands are applying the JOGG approach to promote healthy weight among their youth. JOGG is coordinated at national level by the national JOGG foundation in The Hague, which is part of the Covenant on Healthy Weight.

Activities at the national level include: advice on creating political and managerial support; training in the JOGG approach for locally involved parties; information on successful interventions and best practices; design and provision of communication and information materials to municipalities; instruction on how to implement the JOGG approach; scientific research how to measure the effects of the approach. At the local level, each city has its own JOGG-coordinator who plans various activities in relation to the 5 JOGG pillars. These activities differ between the municipalities implementing the JOGG approach. They range from drinking water activities in kindergarten to creating playgrounds. Municipalities commit to JOGG for at least 3 years. More information about the practice is available here.

Context

According to the annually published Public Health Indicators in 2018, 42% of 13-15 year olds get less than 7 hours per night, 7.2% consume soft drinks on a daily basis, and 22.4% of youth over 15 use e-cigarettes more

than once a month. Iceland recognises the importance of addressing such public health challenges through comprehensive, data-drive community-based approaches, involving key stakeholders and sectors. Such an approach is being taken through the Health Promoting Community Programme (HPC) that has been under development for in Iceland for some years.

The HPC Programme is managed by the Directorate of Health in Iceland (DOHI) in collaboration and consultation with local authorities and other stakeholders, and embedded in national policy documents like the Public health policy (2016-2030). A network of 32 local HPC coordinators and steering groups has been established via agreements between local governments and DOHI throughout the country. In June 2020 93,2% of the Icelandic population (364.134 in Jan ´20) lived in a HPC municipality.

While the main aim of the HPC programme (well-being) is broader than JOGGs main objective (healthy weight for children), they are both driven by a 'whole of community' approach, and DOHI thought there were strong elements in JOGG that could be applied to strengthen the HPC programme.

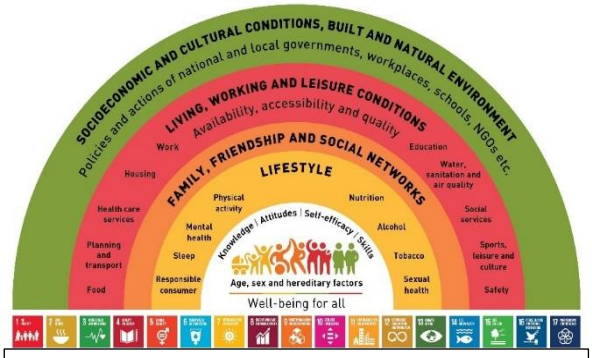


Figure 2. DOHI's adaptation of Dahlgren and Whitehead's model linking SDH to the UN SDGs

DOHI wanted to reinforce, in a more systematic way, the role of the local coordinators and steering groups of the programme and their ability to deliver it, since they are critical to its success. Local HPC coordinators for example needed further support (incl. guidance, material and tools) to conduct their work in efficient and effective way. The overall structure of the HPC programme at national level could also be strengthened by establishing formal, ongoing involvement of key stakeholders, across sectors in the HPC work.

Approach

It was agreed early on in the process that the HCP will not become a JOGG programme but draw on elements of the programme to further strengthen it. Representatives from DOHI had visited JOGG implementation sites during the preceding JA CHRODIS. Building on that experience, DOHIs local implementation working group met with JOGG experts in Helsinki, to gain more in-depth information about the JOGG. This also served as an opportunity to create more casual bond between parties.

The process of applying learning from JOGG to strengthen the Icelandic HCP was a complex one, since it drew on both this process and the national dialogue process in CHRODIS PLUS (WP 4) to establish a national level steering group as well as a consultation platform. It involved engaging a very broad group of national level stakeholders, including the Prime Minister's office and a range of Ministries, to demonstrate the linkages between the social determinants of health, and the UN Sustainable Development Goals (UN SDGs) (Figure 2) to encourage greater buy-in and more coordinated action amongst stakeholders to deliver these.

The DOHI's HPC team used this information to develop and/or improve the quality of supporting material and tools that can be applied systematically to HPC work at the local level, like guidelines/checklists, a roadmap for new municipalities, templates for communication strategies and factsheets. It also drew learning on how e.g. JOGG engages with its Scientific Advisory Board, and involves universities and research agencies in the process of data collection and evaluation, to determine the feasibility of similar action. It developed a web-based platform (www.heilsuefland.is) for participating municipalities, as well as individualised logos HPC for each municipality. The DOHI HPC team also established a high level HPC steering group and a Consultation platform. The steering group is comprised of representatives from the Director of Health, the Prime Minister's Office, the Ministries of Health, Social Affairs and Education and Culture, as well as the Association of Local Authorities and the Development Centre of the Primary health care. The

Consultation Platform for HPC and the SDG is also comprised of representatives of the Ministries of Transport and the Environment, the Directorate of Education, as well as a very wide range of other bodies representing different sectors, like the National Planning Agency, the Icelandic Transport Authority, the Office of Ombudsman for Children and the Icelandic Food and Veterinary Authority. These bodies will provide input on the development of the tools to support local HPC coordinators and bodies.

Outcomes and lessons learned

The intervention achieved the key performance indicators set out in its action plan, which related to the guidance materials produced, events and meetings organised and surveys reflecting level of satisfaction. The pilot action plan was generally implemented as planned and all the aims were either fully or to some degree fulfilled as planned within the established timeframes. Collaboration with JOGG, as well as a series of meetings and policy dialogues that were also undertaken in the broader context of CHRODIS PLUS have strengthened the Icelandic Health Promoting Community Programme. The HPC structure is now more solid than before, contributing to its relevance and sustainability.

Due to delays in implementation, the main target group in this intervention, local HPC coordinators and steering groups, have not yet been able to benefit fully from all actions, but that is foreseen. One of the main challenges of this implementation was to achieve complex objectives in a relatively limited timeframe. The establishment of a multi-sectoral collaboration at national level was for example critical to the overall structure of the HPC programme. These groups provide a fixed platform and pathway to e.g. share information, dialogue, consult and to some extent make joint decisions. Achieving this milestone took more time and effort than expected. Since it was an important precursor for other key steps, it led to a delay in some other tasks. Since the overall objectives of this initiative are rooted in and relevant to existing work of DOHI, and it is not a standalone project, the remaining tasks will survive the end of CHRODIS PLUS.

The implementers noted that the support of the good practice owner (provision of materials, regular tele-meetings and e-mails) was critical to the success of the intervention and needs to be accounted for from the start. The relationship that was established between DOHI and JOGG team is also likely to continue.

For more information about the transfer and implementation, see Annex 1. p.76.

4.5 Elements of the Lombardy WHP Network approach transferred to the Andalusian WHP Programme in Spain

The Italian "**Lombardy Workplace Health Promotion Network"** is a public-private network building on partnerships and collaboration with the main workplace stakeholders: associations of enterprises, trade unions and the regional health system.

Employees spend a large amount of time at work and employers can contribute to the desirable behavioural change by implementing effective (and relatively inexpensive) health promotion interventions and providing supportive environment. Despite the existing complexities and limitations of evaluating the implementation and impact of WHP interventions, many studies from across workplaces and countries have found promising results in terms of reduced health care costs, positive health outcomes, reduced absenteeism and likely annual return of investments.

The Lombardy Workplace Health Promotion (WHP) Network aims to promote health and welfare through actions targeting 6 areas: healthy eating, smoking cessation, increased physical activity, alcohol reduction, safe commuting (walking/biking), and work-family balance. It has developed a clear step by step implementation model, including assessments to ensure organisations´ compliance with laws,

policies, and regulations relevant to the areas of Health Promotion, Workplace Safety and Environmental Safety; scheduled questionnaires issued at different times of the interventions, offering a WHP accreditation as a Health Promoting Company.

An evaluation based on assessments of employees that had taken part in the programme for 12 months found that it led to a reduction of some important risk factors for chronic diseases. Quantifiably significant behavioural changes were identified that had positive impacts on people's health, as well as the organisation as a whole, with the ensuing social and economic impacts.

More information about the practice is available here.

Context

Andalusia is the second largest region in Spain (87.600 km2) and the most populated (9 million inhabitants). The region places a strong emphasis on health promotion and has been certified by the Spanish Ministry of Health for implementing the highest number of best practices in this area in Spain. Workplace Health Promotion (WHP) is defined by the IV Andalusian Health Plan (2014-2020) and enshrined by the Andalusian Law on Public Health. The Andalusian WHP Programme "PSLT" is run, under the auspices of the Regional Ministry of Health of Andalusia, by the Service of Health Promotion and Local Action in Health, in the Andalusian General Directorate of Public Health. For organizational purposes, the programme is divided into two areas (Eastern and Western), with one person coordinating the programme in each area, while health promotion professionals are also appointed by the different districts and health management areas in Andalusia to deliver and support the programme.

The vast majority of companies in Andalusia are micro or small size and do not have the human resources to implement the interventions on their own. Andalusian WHP Programme therefore had less experience with and had trouble recruiting and engaging with larger organisations over the longer term. They felt the Lombardy model could help them because it effectively engaged managers and the workforce, it had a comprehensive continuity system, follow-up periodic evaluation and a rewarding accreditation system.

Approach

A local Implementation Working Group (LIWG) was brought together, comprised of 16 participants with a range of profiles, such as employees, implementers, trade unions and companies' representatives, decision makers and experts. The Andalusian representatives also met directly with a range of Italian stakeholders from the Lombardy WHP programme in the context of two site visits, to refine and complement the information and identify which elements were core and most transferrable. They adopted the core elements of the Lombardy WHP step by step model: ensuring compliance with laws relevant to the areas of Health Promotion, Workplace and Environmental Safety; promoting employees´ participation in the health promotion actions; carrying out assessment questionnaires and granting certifications to workplaces that have implemented a minimum number of practices. Coordinators of the Andalusian WHP then met with a number of Andalusian organisations that could implement the programme, and selected a medium sized public-private venture and a small trade union to take part in the programme, EMASAGRA and CSIF. EMASAGRA is a joint public-private venture based in the city of Granada that manages all processes related to the water cycle for human consumption in Granada (catchment, treatment, transport, distribution). CSIF, an Independent Trade Union for Public Official's, is one of three most representative trade unions at the state level, with headquarters in Granada.

The LIWG followed the CHRODIS PLUS implementation strategy by undertaking a situational analyses and developing an action plan in the two organisations, outlining five specific actions linked to the implementation of the Lombardy WHP Programme. These involved bringing together a steering group in the selected organisations, ensuring the organisations comply with existing laws in relation to health and safety

at work; carrying out pre and post implementation tests; promoting employee participation in the health promotion actions they selected, and adopting the Lombardy certification system to enhance the correct implementation of Health Promotion actions over the time.

Both participating organisations held introductory sessions on healthy lifestyles that involved more than 50% of the total number of employees in each organization. Then, from the range of possibilities proposed, EMASAGRA decided to focus on physical exercise and set up facilities with equipment accessible for all workers, in-house information campaign encouraging the use of stairs and a corporate walking group. They decided to undertake organisational measures to promote work-life balance & wellbeing, such as flex-time, smart working, time saving facilities. CSIF employees chose to focus on healthy eating. This involved an in-house information campaign, practical workshops in small group, and fresh fruits and/or seasonal vegetables available for employees at least 2 days a week, provided by the organization. They had planned, initially, to focus on smoking cessation measures but this was postponed since the number of participants initially needed to engage in measures was not met. Instead, they implemented the "PUMP - For a Million Steps[xxi]" practice to promote physical activity, which also turned out to be a highly useful tool for group cohesion and support. Qualified professionals advised, supported and provided guidance to each organisation throughout the implementation process, which involved the creation of an internal steering group, and the provision of general or more in-depth practical training sessions.

Picture 6. Employees of SCIF completing a programme "For a Million Steps"

Outcomes and lessons learned

The main objectives of the implementation were successfully achieved. A quasi-experimental pre-post design was conducted (with support from the Andalusian School of Public Health) to monitor a possible shift in different life habits and/or health indicators among the participants. Response rates to the questionnaires were good. After the first 9 months of the intervention, although no statistically significant results were found yet, data already reflected promising increases in physical activity among participants of both organizations, as well as an increase in healthy eating and a decrease in sweets consumption in participants of the larger organization. Respondents from both organizations clearly valued positively the implementation of health promotion action in their workplace and there was an increase in the percentage of people who consider these actions "very useful". The Andalusian Administration will continue piloting the WHP model in both organizations for another two years, to reach the full three-year intervention devised by the Region of Lombardy.

Some of the weaknesses and threats identified at the outset that did materialise as a challenge to the implementers was lack of a culture around health promotion since most of the emphasis in organisation has traditionally has been on health care or risks prevention. There was also a lack of trained personnel and resources to deliver the programme, in terms of time and resources. Some employees´ schedules made it difficult for them to participate in different activities. Some were also reluctant to participate in company-

run activities and to provide private information concerning their life habits in questionnaires that were initially perceived as long and cumbersome. These challenges were overcome by the fact that the institutional support and guidance provided was free and the fact that the programme was endorsed at the managerial level, who freed up some staff time and resources to implement it; this all contributed to increase awareness and engagement.

Picture 7. The High representative of Public Health in Granada issuing certificates of completion of "PUMP - For a Million Steps" programme to the employees of CSIF.

Implementers found that an important element of success was building the capacity of people in each respective organization, so that they became qualified disseminators who amplified the effect of the training and helped raising awareness and knowledge of other people (train the trainers). Those trained became both formal and informal leaders. The fact that there was a clearly defined and systemic approach to follow, with standard documents and guidelines, and the role of the designated steering group to guide and refine actions and celebrate achievements, also facilitated dissemination. Consistent communication and dissemination through a range of channels (newsletters, posters, announcements, as well as the face-to-face sessions, workshops and informal contact) was also vital, to engage participants.

For more information about the transfer and implementation, see Annex 1. p.82.

5. Discussion on lessons learned on transferring and implementing health promotion interventions from one setting to another

An overall analysis of the processes, the outcomes and the lessons learnt by each implementing group generates a number of more overarching lessons that can be valuable to those interested in strengthening health promotion and prevention in their countries and across Europe. These lessons have been grouped under three headings, elaborated below. The first focuses on maximising the potential of each intervention to contribute to a 'culture' and community of health promotion, disease prevention and well-being. The second addresses the importance of applying an implementation strategy and appointing effective, motivated leaders, bringing together a strong steering group, and being realistic about the resources needed. The third involves the need to invest in strong links between project 'owners' and implementers, which involves: agreeing from the outset on the nature of the transfer; investing adequately in exchange visits, maintaining close contacts.

5.1 Build on existing good practice to create communities and cultures of health promotion, disease prevention, and well-being

Most people would like to live and behave in ways that optimise their health and well-being, but numerous societal influences or drivers steer them away from this (e.g., 'obesogenic' food environments, structures that encourage sedentary behaviour). Theories of behaviour change hold that it is possible to change people's behaviours by influencing their capabilities, their opportunity and/or their motivation to do so, to overcome such adverse societal influences[xxii]. All good practices that were transferred in CHRODIS PLUS provided children, employees and older people with the opportunity to engage in more physical activity and to eat more healthfully, and enhanced their abilities to do so. They also enabled people to engage with one another and to have fun, which are important factors for the success of initiatives that aim to instigate change. Sustaining such change however ultimately depends on mainstreaming and scaling such actions, to adapt the environments and systems shaping people's lives, generating communities and cultures of health promotion that help make the healthier choice the easier and more affordable choices and adapt social norms to also make them the more attractive choice. A sister report to this one, that also resulted from this CHRODIS PLUS work strand and sets out recommendations for Health in All Policies (HIAP)[xxiii] indicates that while the focus of health promotion and disease prevention interventions are different (physical activity, diet and nutrition, etc), the approaches underpinning them are generally similar. Effective approaches must engage the relevant stakeholders in addressing the underlying determinants of health.

To achieve this, is it important to have support from those with power and influence to contribute to adapting environments and to sustainable change. Almost all of the trialled interventions received the support of the local and national administrations and other senior figures (e.g. school authorities, managers in primary heath care centres). In the case of CHRODIS PLUS, this was self-evident, since national authorities themselves were identified and selected and/or approved the interventions. It was nevertheless apparent that it was easier for localities that already had a strong foundation in health promotion and disease prevention to trail the new initiatives. This was for example the case in Andalucía, where the government was already investing in workplace health promotion and had the resources available to support the implementation of health promoting programmes in two companies. Utebo-Zaragoza in Aragón, Spain was also chosen as an implementation site precisely because it had some experience and the infrastructure needed to build on. The schools that implemented the Active School Flag Programme in Italy and Lithuania also had pre-existing

experience with the WHO School Health Education programme. Having such existing 'hooks' was an important component of their success, since it made it easier to, for example, find qualified and train additional implementers.

Even where strong policy-level support and a culture for health promotion is not yet strong, focusing on an area where there is a recognised need for action, and that is a policy priority can serve as a way to 'carve-out' further interest. Demonstrating how this approach can be implemented, and its value in one area (e.g. physical activity) can encourage and pave the way for its application in other areas. Utebo, in Aragón Spain, recognised the value of investing in a community health approach. They not only transferred the Multimodal Training Intervention but also the wider approach in which it was embedded, whereby primary care providers also draw on and refer their patients to other community resources available, like MTI, to promote and protect health. While setting up such a database takes time and resources, those involved recognised the benefits that would accrue from these investments. The Directorate of Health in Iceland has taken this the furthest in the context of CHRODIS PLUS, by applying learning from JOGG to strengthen its Health Promoting Community programme across the country. It aims to demonstrate to a wide range of representatives of sectors operating nationally and locally the clear links between health promotion and disease prevention and the implementation of the UN Sustainable Development Goals, so that they recognise their role in achieving these interlinked objectives, and act accordingly.

While the other good practices that were transferred in the context of CHRODIS PLUS were narrower in scope and/or scale, they also hold the potential to instigate wider change. Almost all projects reported that following CHODIS PLUS, the activities undertaken will in some way be multiplied or scaled up. Elements from the Active School Flag programme will be applied in other schools in Lithuania, and in another nation-wide programme. The Andalusian WHP Programme "PSLT" will be upgraded (and renamed) into a new "PSLT PLUS" that will be extended to the whole region, after being enriched with the elements adopted from the Lombardy model and the implementation method refined with the CHRODIS PLUS collaboration. The MTI will also be implemented in other parts of Lithuania and Spain, while Spain will in addition promote the wider-community based programme in which it was embedded. Elements of JOGG were incorporated in what was already a long-term strategy of strengthening and expanding the Health Promoting Community programme in Iceland. The programmes may also instigate a process of policy change, to make it easier to mainstream them. Toy-Box in Malta could for example contribute to ensuring that a focus on energy-balance related behaviours (EBRBs) is included in school curricula. The MTI generated awareness of the benefits of engaging older people in physical activity, as well as the need for more recreational facilities in Lithuania, particularly in rural areas, and may lead to greater investments in such facilities. As such, initiatives like these can stimulate knowledge and awareness and inspire further efforts to remove the structural barriers identified by the implementers to the expansion of the good practices, gradually transforming environments and communities into ones that encourage and enable greater investments in health and well-being, at both the individual and societal level.

5.2 Apply an Implementation Strategy like that developed by CHRODIS PLUS

The experience of the pilots also reflects that, as stated in one of the implementation reports, "the CHRODIS PLUS implementation strategy works". Applying the initial phases of the implementation strategy (Scoping and SWOT analysis), and developing an action plan collectively, were considered crucial to the success of the transfer and implementation process. It helped to focus all partners and ensure that, as phrased in the report on the implementation of the Lombardy WHP programme in Andalucía, "the pathway of programme introduction and delivery … is both paved (practical assistance — specific training, resources, and co-ordination with other aspects of their work) and sheltered (from local or national outside parties who disagree with a programme's focus or approach)." Because for example the local implementation working

group (LIWG) considered, anticipated and discussed potential challenges in the early stages of the intervention, they were better prepared to factor them into the planning and address them if they arose.

Appoint motivated, effective leaders

It was also clear across the interventions that they depend above all on the commitment of dedicated leaders able to bring the LIWG as well as other stakeholders together and to coordinate the day-to-day work. Since sustainable, multifaceted initiatives involve the collaboration of a wide range of people, such leadership is required to maintain the commitment and enthusiasm of those involved, and to implement 'train the trainer' models to ensure adequate and consistent amounts of resources (human and otherwise) are dedicated to implementing and developing the interventions.

Bring together a strong steering group

A strong leader should however not act alone; leaders can initiate action and change, but initiatives that rely too much on the action of a single or a small group of individuals are likely to become unsustainable. As the Icelandic implementation report of JOGG stresses, a pre-requisite of applying the implementation strategy is therefore to establish a solid structure, or steering group, involving key stakeholders across sectors and levels. This takes time and effort to develop but is critical to the relevance, quality and sustainability of the intervention. Such a group helps to ensure further 'buy in' for the initiative both horizontally, across stakeholders and vertically, across governance levels, to not only contribute to the success of the implementation itself, but to also help encourage the process of multiplying and scaling it.

Be realistic

A clear lesson was in this respect the importance of being realistic and practical when setting objectives and indicators and anticipating resource needs. The Icelandic implementation report of JOGG indicates that the implementation team valued the emphasis that CHRODIS PLUS put on setting realistic targets that could be achieved, despite the ambitious nature of their intervention. They still, nevertheless, under-estimated the time and resources required to undertake certain steps, as did other implementing sites. Despite undertaking the SCOPE and SWOT analysis, the interventions in Lithuania for example under-estimated what material would need to be translated, and how long it would take. They also underestimated the difficulty of finding adequate facilities for the intervention. Teachers implementing the ToyBox intervention in Malta, that was also ambitious in scope, valued the programme but felt that they did not receive sufficient guidance and support from the coordinators to deliver it effectively. The ToyBox coordinators recommended talking to those responsible for delivering different components of an intervention in the pre-implementation phase, to ensure the adequacy of planned resources.

Invest in convincing staff, and in their development

It was in some cases difficult to make local implementers enthusiastic about initiatives if they were 'imposed' upon them, as may have been the case with some of the heads of the schools and teachers implementing the Toy Box programme in Malta, or local coordinators of the Healthy Community Programme in Iceland. While they may see the value in theory, the intervention represented yet another obligation to fit into an already full schedule. It is important to demonstrate how initiatives address societal problems and contribute to achieving national priorities to convince those involved to invest the time and resources needed in the delivery of an intervention of its value and the benefits it can generate. If key stakeholders do not recognise the value and importance of investing in health promotion and disease prevention activities, it can be risky for professionals at all levels to invest their time and energy in relevant activities. They may for example fear investing their energies in an area that may not open up further career prospects. If however there is top-level support and adequate financing secured through budgets and subsidies, people will be more willing and able to dedicate their time and energy to initiatives that promote health, and in working with other sectors, and the benefits and rewards of such investments will become more apparent. This will in turn contribute to

their professional qualifications, and to an upwards spiral of investments in human and physical resource development for health promotion and disease prevention.

Invest sufficient resources in monitoring and evaluation

As the ToyBox intervention also reflects, the resources needed for monitoring and evaluation should not be under-estimated at the outset of an intervention, as often happens. Monitoring and evaluation are very important since the information gained can be used to improve the interventions, to demonstrate the value of the investments, and to secure further support and investments from decision makers and funders. The methodologies applied and resulting evidence must however be robust.

Consider multiplying and scaling from the outset

Analysis also showed that interventions could have been multiplied or scaled to an even greater degree in national contexts had local implementers considered this question during the planning phase, and identified steps needed to do so. Such measures, like engaging with relevant stakeholders or government officials could then have been planned as additional tasks in relation to communication and stakeholder engagement, to strengthen the impacts of the intervention. A number of CHRODIS PLUS practices received media coverage, which is also an important way to raise awareness about, generate interest in and multiply and scale an intervention. Strategies to engage the media should also incorporated into implementation plans. More investigation is needed into the factors that support or impede efforts to engage other stakeholders and the media in efforts to scale existing practices.

5.3 Invest in strong links between project 'owners' and 'implementers' at all phases of the intervention

A common lesson drawn from the experiences of the transfer and implementation processes was the importance of investing in a close relationship between the 'owner' and the 'donor' of a good practice during all phases of the implementation process. This is easy to overlook or under-estimate. Most implementers stressed that the availability and support of the good practice owner had been critical to the success of the implementation, and something that needs to be accounted for from the start. A few implementers regarded the inability to maintain and develop this relationship as a lost opportunity.

Agree from the outset what kind of transfer

The good practice donors noted the importance of ensuring that they and the local implementers settle questions relating to 'ownership' and overall expectations at the start of the process. This means clarifying whether the intention is to replicate the intervention fully, or whether only elements of a good practice will be selected, perhaps further adapted to suit local contexts, and then applied.

The nature of the 'transfer' differed across the eight CHRODIS PLUS interventions. For some, the 'owners' and/or implementers felt it was important that the original good practice be implemented as closely as possible in accordance to the original design, and that it be adapted as little as possible. The Multimodal Training Intervention (MTI), for example, derived from a specific study, and the positive results relate to the specific approaches applied, making it important that other sites replicate the exact methodologies as closely as possible. The Active School Flag (ASF) is a broader programme that includes many kinds of activities. Given the differences that exist between education systems in the EU it may be difficult for other sites to implement the programme all at once (as e.g., discovered by the Italian implementers) and possible to transfer only components. The implementers in Spain and Iceland were interested in the Lombardy WHP programme and JOGG programme because they recognised that they could draw learning from them to strengthen existing work in relevant areas; they therefore adapted and applied the programme, or components thereof, to suit their local circumstances, in agreement with the original owners.

A memorandum of understanding (MoU) should be agreed at the outset (according to an example provided by CHRODIS PLUS) to outline the obligations of the donor and the implementer, and establish the parameters within which the programme should be implemented. The agreements reached and the MoU should also cover approaches to monitoring and evaluation. The 'owners' must determine how closely they believe 'their' monitoring and evaluation methodologies and tools should be applied. They can provide evaluation resources that they have applied (measurements, questionnaires, surveys etc.), so that both parties can consider their applicability and suitability to the new setting. If the aim is to replicate the intervention and make results comparable, it is important to agree on this from the outset and to invest resources to ensure this. If the implementing site wants to apply their own methods to monitoring and evaluation, this must be agreed too. Before the MTI teams in Lithuania and Spain started, for example, the team from Iceland, Janus Gudlaugsson (PhD) and Lára Janusdóttir (MBA) went to each location to teach the teams how to take measurements, to ensure this was correct from the start and that data was comparable between countries.

Invest in exchange visits

Most of the implementers reinforced the importance of site visits to learn from one another and build-up trusting and more casual relationships that could be sustained after the initial implementation period. They considered it essential for the implementers to visit the donor before implementation begins, to see the process 'in action' and to speak with key stakeholders face to face. A broad range of representatives should participate in the site visit so that there is awareness of the exchange process at policy, management and staff levels. The implementing team should consider carefully who should attend these, and are best suited to apply it to strengthening the capacities, and multiply the knowledge locally, through a 'train the trainer' approach. In the case of Lithuania, for example, officials at the Institute of Hygiene acted as the main contact point with the donor, rather than those directly implementing the programme, who weren't as a result able to benefit as much as they could have from the exchanges and the relationships generated.

The implementers and the good practice owners also stressed the importance of 'owner' visits to the new implementation sites. At least two of these should be organised; one in the pre-implementation phase and one during the course of the implementation. If the donor country has a clear understanding, from the outset, of the similarities and differences between countries it will enable them to offer meaningful and specific guidance to the implementing countries, and to see where the potential and challenges lie. A visit once the project is up and running provides opportunities for in-situ guidance and recommendations for future development. It also gives a greater range of stakeholders in the implementing country the chance to meet with the donor (e.g. two to three months before the end of the implementation phase). If more than one country is implementing the exchange practice it would be good for a representative from the other implementers to join this site visit to maximise the learning for all parties. Such a visit can also give impetus and visibility to the intervention and help it gain political support.

Maintain close contacts

Beyond site visits, it is also important that the owners and the implementers are in regular contact, by e-mail and through teleconferencing. Regular online meetings (every two months) were for example organised and emails exchanged frequently between the owners of each of the practices, the implementer and the CHRODIS PLUS coordinators. A number of partners indicated that these interactions are key to the success of the implementation processes. They forged the relationships between the main stakeholders and helped to ensure a practical and flexible approach, that improved understanding of the specific features and characteristics of the context and the implementer site's needs. Here again, it is important to consider carefully who should be involved and is best placed to pass on and multiply the learning, to strengthen capacities in the implementation site and help ensure the sustainability of the intervention. There are many opportunities to apply social-media and other e-tools in a fun and effective way to exchange between parties: these were, for instance, applied by the 'owners' and the implementers of the Multimodal training and Active

School Flag initiative to share pictures, films, ideas and experiences, helping them overcome language difficulties while forging links between the groups in the different countries.

It is above all important to recognise the time and work that efforts to facilitate and engage in knowledge exchange requires, also on the part of the practice owner. Sufficient budget needs to be allocated to allow for this, and for site visits. Practice owners should also be involved in relevant networking events and given the opportunity to meet with other donors and practice owners to discuss the exchange mechanisms. While this may imply investments in staff time and travel funds for all parties involved, the returns on these investments in terms of enhancing the effectiveness and sustainability of the interventions are likely to be considerable.

This process can be accelerated when more 'communities of good practice and change' come together to inspire one another and others. Just as CHRODIS PLUS stimulated the transfer and implementation of good practice between and within countries, this process can be continued. The coordinators of the ASF interventions in Italy and Lithuania for example felt they missed an opportunity to bring together representatives of the different schools implementing the programme, to exchange, learn from and inspire one another. but can still do this. Those coordinating the implementation of the ToyBox programme in Malta would also, in future, facilitate more exchange amongst the different teachers implementing the programme. Social media can be used to strengthen such ties between teachers and schools. Communities of good practice can be established not only within, but also between countries, by e.g., twinning, on a small scale, schools engaging in the ASF Active School Week. National administrations can also draw on the methods and learning from CHORDIS PLUS to encourage similar approaches to transferring good practice in different regions in their countries, and link these to similar initiatives in other EU Member States, to motivate and inspire relevant implementers, and create a sense of a broader European community, that is investing in health and well-being.

6. Conclusions and Recommendations

This report has provided an overview of the experiences of eight teams of implementers in five European countries that transferred five good practices in the area of health promotion and disease prevention in their community, schools and workplaces. National administrations taking part in CHRODIS PLUS selected the good practices to address health related needs and priorities in their country, and identified local partners willing to take up the challenge of implementing them. Together, they established local implementation working groups, that applied the CHRODIS PLUS implementation strategy.

The overall results reflect that all interventions achieved the objectives set out in their action plans, despite the relatively short period for implementation, monitoring and evaluation. Many implementers faced challenges such as: qualified staff to deliver the programmes; time available on the part of those delivering the programmes; adequate facilities; and lack of a 'culture' around health promotion, affecting the motivation of some target group participants. The evaluation outcomes nevertheless reflect that the actions were broadly delivered as planned, that they led target groups to engage in healthier behaviours, and that programme participants were positive about their experiences. This and the fact that almost all implementation sites reported follow-up actions suggest that the transfer and implementation processes were successful.

The full "success" will however only be apparent through a future assessment of whether and to what extent the initiatives contributed to strengthening the foundations, or 'culture' of health promotion in the settings, regions and countries in which they were implemented. Each intervention had the potential to do this, albeit on the basis of very different starting points. The concept of health promoting communities (HPC) is for

example already quite advanced in Iceland, where HPC coordinators have already been appointed in local areas across the country. The municipality of Utebo-Zaragoza in Aragón, Spain recognised the value of investing in strengthening links between primary health care system and initiatives like the multi-modal training programme, so that they could also be 'prescribed' as 'treatment'. Interventions like the Active School Flag and the Toy Box programme focussed more narrowly on encouraging schools to integrate issues around diet and physical activity more in their curricula, while the multi-modal training programme emphasised to seniors and community members alike the importance and value of improving their levels of physical activity and diets. All of the programmes therefore depended on collaboration with other sectors to achieve success. The better the results of forging such collaboration and the more effective the programmes, the more likely they are to 'catch-on' and encourage other stakeholders to engage too. This can generate new work opportunities for implementers involved in the processes, and strengthen capacities in, and the fabric and 'culture' of health promotion.

The fact that a HPDP programme has proved effective in one setting does not guarantee that it can be transferred and implemented successfully in another. Many of the CHRODIS PLUS initiatives attributed their success to the guidance received on the implementation strategy and to the motivation of the professionals involved in the local implementation groups. Important differences can exist between the good practice 'owner' and implementation sites and it is important to analyse and plan for how to address these from the outset. A clear lesson was the need to be realistic and practical when setting objectives and indicators and anticipating resource needs.

The results also reflect the importance of ensuring that the 'owners' and the 'implementers' of a good practice agree on the terms of the transfer at the start of the initiative, and invest in a close relationship during all phases of the implementation process. Both parties also stressed the value of site visits to learn from one another and build-up more casual relationships that could be sustained after the initial implementation period. They considered it essential for the implementers to visit the donor before implementation begins, to see the process 'in action' and to speak with key stakeholders face to face. Both parties also highlighted the benefits of harnessing the facilities of modern communication technologies to engage in "communities of good practice" to share experiences and motivate actions.

While the world is focused on managing and attempting to find solutions for the COVID-19 crisis, it is important not to lose sight of the need to create more health promoting communities to provide people with more opportunities to adopt healthier lifestyles and behaviours across the life-course. It is crucial that health professionals leverage the current attention on health, and heightened awareness of health as a number one individual and societal priority, to invest in intersectoral interventions like the ones transferred and implemented in the context of CHRODIS PLUS. Such interventions can help to ensure that people become less susceptible to threats like the COVID-19 virus. Monitoring and evaluation are very important, since the information gained can be used to improve the interventions, and to demonstrate the value and potential of such investments to reduce the costs of medical care for preventable conditions, whilst above all improving the quality of life and well-being of Europeans and their ability to contribute to society.

The common lessons drawn from the implementation reports on the process of transferring and implementing interventions in the field of health promotion and disease prevention are summarised in the following recommendations below, for all those interested in strengthening this field of work:

1. Commit to the vision and goal of health promotion as a process of working with other sectors to create environments and communities that support health, and to embedding this role in health systems, to improve health and well-being outcomes while reducing or delaying costs of health

care. Draw on good practice from other settings and countries to achieve this.

2. Build on existing motivation and resources: select good practices that address clear needs and national priorities and implement them in sites that already have some relevant structures and resources in place; involve existing networks and staff with pertinent experience. Also invest in building a strong implementation team with committed leadership and the relevant representatives working at different levels of government and sectors that can provide different perspectives.

3. Apply a clear implementation framework to guide the implementation process, like the CHRODIS PLUS framework, which, in the experience of the implementations sites, works. Consider carefully how differences in local contexts (e.g., cultural aspects, social and organisational structures) can affect the implementation of the good practice, and what must be done to address this. Also consider from the outset what is needed to multiply and scale an intervention, and incorporate this in the implementation process. Be realistic when setting objectives and indicators and anticipating resources needed, including those for monitoring and evaluation.

4. Invest in strong links between project 'owners' and 'implementers' in all phases of the intervention. Decide from the outset the nature of the transfer (e.g., exact or loose replication) and sign a Memorandum of Understanding (MoU), setting out the agreements between the two parties. Maintain close contacts through exchange visits and by e-mails, teleconferencing and the use of social media, throughout the process. Allocate sufficient staff time and other resources to enable this.

5. Make the process of transferring and implementing the good practice fun, and invest in creating 'communities of good practice and change', by networking with other stakeholders and making use of opportunities to mainstream, multiply and/or scale initiatives. This includes linking to other national and international initiatives to share learning and experiences through "communities of good practice" and engaging the media, to inspire broader support and participation.

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Annex 1. Abstracts, Short template for reporting and most important elements of implementations

1.1 Multimodal Training Intervention from Iceland transferred to Aragón in Spain

Abstract

The aging population needs actions that foster physical activity as a key element to promote health and prevent chronic diseases. Scientific evidence shows that the modification of certain lifestyles in the elderly (such as physical activity, smoking, alcohol intake, diet, primary care surveillance) have a positive impact on the prevention of chronic diseases. With the pilot action of the Multimodal Training Intervention Program 65+, it is intended to: raise awareness and modify lifestyles of old people in Utebo, in order to delay the functional decline with age and prevent frailty; implement a program of physical activity and health education in nutrition and healthy lifestyles; empower the target population to improve self-management of health; coordinate different health-related institutions to promote the prescription of community health assets; raise awareness and motivate the aging population, creating a favourable environment for social interaction and physical activity practice; provide adequate training for old people to increase their knowledge and skills to improve their lifestyles with special emphasis on physical activity and nutritional aspects; achieve a more efficient use of resources by institutions with competences in the area of health and focus on common objectives and joint actions; establish communication between health centres and community assets in order to identify the stakeholders, the pathway and the information to exchange; to complement the information of professionals of different profiles regarding the complementary skills of the other (health in physical activity and sports for Primary care personnel).

To accomplish this, the following interventions were established: a system of people recruitment; implementation of a physical activity program; development of training activities; establishment of collaboration between institutions, creating a multidisciplinary team; creating and updating a community assets search engine related to health, integrating the community resources search engine into Primary Care tools, providing Primary Care professionals with a tool to refer the user to the community asset, follow-up meetings between the implementers and users. All agents were involved in work as planned. The Multimodal Training Intervention was carried out as originally designed. The facilities were ideal for the activity, as well as the environment close to them. The pressure on healthcare system may be a handicap for the full participation of these professionals in the future. However, the model based on community assets as developed in Aragon, as well as the implementations carried out in computer systems, can reduce the burden. The aging population has discovered the ability to perform a physical activity for which they initially did not feel able. Health related measurements were taken at baseline and at the end of the activity, collecting clinical parameters, and those cantered on flexibility, balance, strength and quality of life. The subjects who carried out the program experienced steady improvements at the end of the training period. There has been a positive evaluation

of results, acceptability of participants, as well as process assessment. Now, the institutions involved are already working on scaling the activity to other centres.

Short template of reporting

General Objective Comprobar la adaptabilidad de la práctica islandesa en Utebo, así como la reproductibilidad de sus resultados	**Indicators**			
	Process	**Outcomes**		**Sources of information**
		Baseline	**Current value**	
Specific Objectives **SO1** Promocionar la práctica del ejercicio físico en las personas mayores proporcionándoles entorno de interacción y formación. **SO2** Conectar el mundo sanitario y el de la gestión deportiva a nivel comunitario, creando equipos multidisciplinares y compartiendo sus competencias. **SO3** Dotar a los profesionales sanitarios de herramientas que permitan conocer las posibilidades de actividad en la comunidad fomentando la comunicación.		1.3 Mediciones basales: SBP: 138.6; DBP: 76.3 1.4 Personas captadas 52 2.3 Instituciones a involucrar 3.2 Planificación de reuniones	1.3 Mejoría en los parámetros SBP: 126.9; DBP: 71.1 Walking test: mejora >32 m Flexibilidad brazos >3cm Test SPPB: > 75% máxima puntuación. 1.4 % de personas que acaban programa 51 (98.1%) 2.3 Instituciones involucradas: 6 3.2 Reuniones realizadas (9)	Registros propios
Activities (change package) **SO 1:** - Establecer un sistema de captación en el centro de salud (con/sin difusión previa, cartelería, medios, según necesidad) para la creación de un grupo de ejercicio físico. - Realización de los Programas de ejercicio físico, educación grupal sobre hábitos de vida y de educación nutricional.	1.1 Nº de acciones de difusión realizadas 7 1.2 Programas realizados: SI	1.3 Mediciones basales: SBP: 138.6; DBP: 76.3 1.4 Personas captadas 52	1.3 Mejoría en los parámetros SBP: 126.9; DBP: 71.1 Walking test: mejora >32 m Flexibilidad brazos >3cm Test SPPB: > 75% máxima puntuación. 1.4 % de personas que acaban programa 51 (98.1%)	Medios de comunicación Registros propios
SO 2: - Establecer una colaboración estable entre instituciones con el fin de compartir recursos, información y destrezas. - Crear y actualizar un catálogo de activos comunitarios relacionados con la salud.	2.1 Colaboración establecida: SI 2.2 Catálogo creado e integrado en el programa de historia de salud clínica: SI	2.3 Instituciones a involucrar	2.3 Instituciones involucrada: 6	Actas de trabajo del LIWG Página WEB de la Estrategia de Acción Comunitaria del Gobierno de Aragón

SO 3: - Integrar en las herramientas de trabajo de Atención Primaria el catálogo de recursos comunitarios, dotando al profesional de una herramienta para derivar al usuario - Reuniones de seguimiento entre los implementadores.	3.1 Integración del catálogo y un módulo de derivación en el programa de historia electrónica de Atención Primaria (OMI) SI	3.2 Planificación de reuniones	3.2 Reuniones realizadas (9)	Registro en el programa OMI de atención primaria Actas de reunión

Essential Elements of the Pilot Action Report

Implementation Elements of the Good Practice:

- Componentes: bases para reclutamiento, criterios, evaluacion personal inicial, diseño adaptado personal y grupal, programa Actividad Fisica (AF) resistencia (30 min, 5 dias/semana, grupal) y potencia (2 veces/semana, esta individualmente), actividad formativa (nutricion/dieta, relacion con AP).
- Bases fisicas: Centro municipal de deporte de Utebo y Centro de Salud de Utebo.
- Profesionales: Técnicos Deportivos Municipales (implementadores de las acciones relacionadas con actividad física) y personal sanitario (educacion para la salud, seguimiento de la condición de salud), asi como coordinadores de grupos de transferencia (IACS, ISCIII).

Major Barriers and Enablers identified during the implementation of the Good Practice

Barriers:

- La carga de trabajo de los sanitarios.
- Falta de procedimientos communes de trabajo y de organización entre los distintos entes que promocionan la actividad física y el deporte en la población.
- Preservar tiempo de agenda y de personal, así como espacio en los recintos deportivos para la actividad (Coste oportunidad).
- No todos los municipios tienen las infraestructuras dedicadas al deporte que tiene Utebo.
- Falta de recursos tecnológicos más ágiles que permitan la monitorización de los sujetos y la comunicación entre el mundo sanitario y el deportivo.
- El individualismo y aislamiento de la población.

Enablers:

- Las personas responsables de la implementación se mostraron muy colaboradoras, incorporando las metodologías a sus procedimientos de trabajo.
- Tener la metodología clara y haber realizado entrenamiento en la misma, facilitó la tarea.
- Que la estrategia de Acción Comunitaria sea una estrategia del Gobierno de Aragón es una fortaleza con respecto a la sostenibilidad.
- El Ayuntamiento de Utebo, a través de sus servicios deportivos, tenía experiencia en la promoción de la actividad deportiva en la población.
- Las instalaciones deportivas puestas a disposición del piloto resultaron idóneas.
- La incorporación de las herramientas informáticas adecuadas en el ámbito de la Atención Primaria de Salud facilitó el circuito de recomendación de los participantes, que en un primer momento se detectó como una debilidad.
- La coordinación entre los distintos perfiles implicados (sanitarios y deportivos)
- La accesibilidad de la población a los distintos servicios implicados.
- Las completas instalaciones de que disfruta el municipio de Utebo.
- La experiencia previa de los técnicos de deporte del municipio.
- La experiencia previa en actividades comunitarias del Centro de Salud de Utebo.
- Conectar la experiencia con la estrategia de atención comunitaria en salud del Gobierno de Aragón.
- La creación del equipo multidisciplinar (LIWG) que facilitó el intercambio de experiencias y la coordinación.
- El training y supervisión de los técnicos deportivos por parte del diseñador del piloto.
- La aparición en los medios de comunicación ha facilitado la difusión en la población de la experiencia.
- Disponibilidad de la historia clínica electrónica.
- Formación de los técnicos de deportes en la cultura de la evaluación.

Major Results of the Implementations:

Los sujetos que realizaron el programa experimentaron mejoras constatables a pesar del corto tiempo de seguimiento:

- En cuanto a los aspectos cardiovasculares han mejorado, como por ejemplo la frecuencia cardiaca en reposo, que ha mejorado pero también su capacidad para recuperar, de hecho en el test de caminar han mejorado la recuperación en 4'4 pulsaciones al cabo del minuto de reposo a pesar de haber incrementado la distancia en 32'2 metros.
- Tambien se objetivan mejoras en flexibilidad, fuerza y equilibrio.
- En el test EQ_5D_5L se observan mejoras en todos los parámetros salvo en actividades cotidianas aunque estas diferencias antes-después no presentan significación estadística debido al número de participantes y al tiempo en observación.
- En el test Geriatric Depression Scale (GDS) no se observaron cambios significativos.
- En cuanto a las variables clínicas, se produjeron ligeras mejoras en los parámetros en todas ellas.

En cuanto a los componentes del LIWG la colaboración fue estrecha. Las diferentes Direcciones Generales del Gobierno de Aragón cubrieron su espectro de actuación ampliando la colaboración entre ellas. Así la Dirección General de Deportes propuso el implementador en cuanto a la realización de la actividad física y se ha comprometido a continuar con el proceso de detección de implementadores a lo largo de Aragón con el fin de garantizar la sostenibilidad de la actuación en el largo plazo. Por otra parte el desarrollo y la implementación de la estrategia de atención comunitaria por parte de las Direcciones Generales de Asistencia Sanitaria y la de Salud Pública ha permitido pilotar el Sistema de captación de sujetos y de recomendación de la actividad. El compromiso de las tres direcciones generales citadas y el desarrollo de la estrategia de atención comunitaria garantiza el escalado de la experiencia y su sostenibilidad.

Benefits for Patients:

- Los sujetos participantes han tenido acceso a un programa novedoso y contrastado impartido por profesionales cualificados y entrenados específicamente en la materia.
- Los resultados obtenidos muestran mejoras en su condición física, estado de salud y calidad de vida.

Stakeholders and Policy Makers Involvement and Actions:

Policy makers:

- Dirección de Atención Primaria Sector III del Servicio Aragonés de Salud (SALUD; Gobierno de Aragón). Selección del Equipo de Atención Primaria para el pilotaje de la experiencia facilitando la participación del mismo en el reclutamiento y valoración clínica de los sujetos. Seguimiento.
- Ayuntamiento de Utebo. Puesta a disposición de los recursos humanos y de infraestructura necesarios para la puesta en marcha del piloto en cuanto a la actividad deportiva. Seguimiento: Concejalía de Deportes y Obras Públicas, Concejalía de Acción Social, Sanidad y Consumo, Dirección de los Servicios Municipales Deportivos de Utebo.

Stakeholders:

- Gobierno de Aragón. Visión estratégica. Seguimiento y establecimiento de las bases para la sostenibilidad futura de la experiencia: Dirección General de Deportes, Dirección General de Salud Pública, Dirección General de Asistencia Sanitaria.

Suggestions for future Implementations, Sustainability and Replicability/Transferability of the Good Practice:

- Aprovechar la experiencia acumulada por las personas encargadas de la implementación en el piloto para formar a futuros implementadores.
- La implicación de la Dirección General del Gobierno de Aragón en materia deportiva resulta fundamental a la hora de coordinar los recursos en promoción del deporte y la actividad física disponibles en el entorno.

- Que las acciones no dependan de la voluntad de ciertos profesionales, sino que se incorporen como estrategias a las instituciones o centros en busca de identificar un modelo regional de desarrollo sanitario compatible con la estructura descentralizada de la administración estatal española.
- Consenso entre autoridades para la promoción de la actividad física en mayores y la disposición de recursos para ello.
- Facilitar la formación de los distintos profesionales implementadores.
- Optimizar futuras acciones comenzando por aquellas con mejores infraestructuras disponibles.
- Aprovechar la estructura y experiencia de la estrategia de atención comunitaria en salud del Gobierno de Aragón.
- Continuar con la política de reforzar la imagen con impactos en medios de comunicación local y con identificación con el grupo (tipo camisetas)
- Incorporar los activos comunitarios correspondientes al buscador de activos disponible para los sanitarios.
- Facilitar mecanismos de coordinación entre los profesionales sanitarios y de deportes.

1.2 Multimodal Training Intervention from Iceland transferred to Klaipėda district and Klaipėda city municipalities in Lithuania

Klaipeda district municipality

Abstract

In Klaipeda District municipality there are 8500 people older than 65 years (15,2 percent of the population). According to the results of the study on the lifestyle of the adult population in Klaipeda District Municipality done by Klaipeda District Municipal Public Health Bureau, from 2007 to 2018, 60 and older persons who have been engaged in energetic physical activity for at least 30 minutes and 4-6 times a week to accelerate the respiration and pulse, increased from 5,6 to 60,3 percent ($p < 0.05$). In 2007, there was only 16,7% of the elderly population that engaged in energetic physical activity for at least 30 minutes daily, and in 2018 the number rose to 22.4%. Just 31,3 % of population 60 + evaluate their health as good and only 47% evaluate their quality of life very well and well.

In Klaipeda district, the main problem of physical activity of the elderly is that there is no specialized program for evaluation of the results before the start and after the program ends. There is no method that would specify actions like how to measure, how to monitor activity and train the staff.

Nonetheless, the main problems are associated with the low interest of participants and their motivation to be physically active, as well as the lack of infrastructure needed to fully implement the intervention. Furthermore, there is no geriatrician counselling for participants.

For all population, there is more and more outdoor places for sport and physical activity in municipality, but multimodal training programs for target groups, especially with focus on the health promotion of older age groups were still missing. The objective of the Multimodal Training Intervention – An Approach to Successful Aging is to improve the health of the elderly and to promote healthy aging. The intervention was piloted in rural and urban Klaipeda district for participants 60+.

Before the launch, the intervention was presented to the communities of Klaipeda district, from them, Gargždų, Kvietinių ir Endriejvo communities expressed their interest to engage in the program. The cooperation with the Lithuanian Institute of Hygiene as well Icelandic team help to implement the intervention correctly. The main problem was the translation of the material to Lithuanian as well as lacking appropriate infrastructure like covered sports arena for activities in winter, adequate sports halls where the measurements can be taken.

The intervention was launched in October 2018. A total of 175 participants were enrolled in the program. 19 measurements were made and data analysed. The first results were presented to Klaipeda district municipal administration on 15 Oct 2019. As a result of the intervention, Klaipeda District Municipality has prepared an Act describing physical activity rules for people of all ages in municipality.

Short template for reporting

General Objective (Specific Aim): To improve healthy ageing in older person 65+ in selected Municipalities of Klaipeda district Lithuania.	**Indicators**			
	Process	**Outcomes**		**Sources of information**
		Baseline (2018)	**Current value** (02/2020)	
Specific Objectives **SO1**. Improve older persons understanding of healthy lifestyle and wellbeing		1. Quality of life questionnaire before program starts (74 participants): - Normal mood 12.5 % - Mild depression - 86.3 % - Severe depression 1.3%	1. Quality of life questionnaire after 6 months (74 participants): - Normal mood 18.8% - Mild depression 80% - Severe depression 1.3%	QOL Questionnaire

SO2: Improve older persons health status through training and physical activity		2. Participants' measurement indicators before programme starts (74 participants): 2.1. 4-stroke test: measurement I- 4,2 s. 2.2. Hand force measured with dynamometer: measurement I- 54,2 kg. 2.3. 6 min walk test: measurement I – 400 (m).	2. Participants' measurement indicators after 6 months (74 participants): 2.1. 4-stroke test measurement II- 3,4s. 2.2. Hand force measured with dynamometer: measurement II - 55,5kg. 2.3. 6 min walk test: measurement II – 460 (m).	Program data collection system
SO3: To disseminate the results through social media		3.1 People expected to be reach by social media campaign:100	3.1 Persons reached by social media campaign: about 100	Social media analysis system
Activities **SO1:** 1.1 Political commitment and dedicated budgeting for implementation 1.2 Meeting with municipal administration 1.3. Provision of education and communication materials for trainings and lectures	-Meeting with municipal administration organized: Yes -Communication materials provided: Yes -QOL questionnaire collected: Yes -Eight lectures organised on various topics (about 90 participants) -Meeting held to present the obtained results			
SO2: 2.1. Collaboration with Sport centre 2.2. Training on physical activity and lectures for older persons 2.3. Organise strength training twice a week 2.4. Organise once a week walking classes. 2.5. Translation of the health surveys instruments	- A contract signed with the sports centre and the equipment for exercise provided - About 120 participants visited the Sports Centre - Lectures provided by specialists on healthy ageing, nutrition, cardiovascular diseases, physical activity and hearth rate measurement (100 participants). - Strength training provided 2 times a week - Walking groups in the stadium according to a prepared plan for 24 - 28 minutes (about 40 participants). - Health surveys instruments translated: Yes			Program questionnaires and data collection system

2.6. Measure participant's data every 6 months: 4-stroke test (s), Hand force measured with dynamometer (kg), 6 minute walk test (m).	- Performed participants survey and measurements every 6 months: Yes (12 types of measurements) - Participants continue training. -The program has 175 participants.			
SO3: 3.1 Planning of media campaign 3.2 Evaluation of media campaign	3.1 Media campaign planned through the Facebook page of Public health bureau, newsletter, etc 3.2 The number of reached population has been evaluated: (please insert value)			Social Media data analysis system

Essential Elements of the Pilot Action Report

Major Barriers and Enablers identified during the implementation of the Good Practice

Barriers:

- The Administration of Klaipeda District does not have gyms that meet the requirements for intervention (e.g. do not have the necessary equipment, or small size of the gym that would not reach 20 meters in length, which is needed to conduct precise measurements).
- Klaipeda District does not have a covered sports arena to practice walking during the winter season.
- Translation of relevant documents from English into Lithuanian.
- Passive public attitudes towards active and healthy lifestyles.

Enablers:

- Cooperation with the sports centre and Klaipeda district municipal health department.
- Contract with a health centre for blood testing. Public Health Bureau staff volunteering for measurements.
- Fitness lectures and motivation of participants once the program has started.
- The family support to carry on with the training, positive attitudes towards the intervention of participants' doctors and GPs, as well as very personable trainers who takes care of the participants are conducive to good results.

Major Results of the Implementations:

- Results showed that intervention is beneficial for older people. The participants improved their physical activity, flexibility, endurance and vigour. Overall, it improved their general well-being.

Benefits for Patients:

- Physical activity of participants improved: flexibility, strength, endurance, posture.
- Vitamin D levels in the blood test improved.
- Improved general well-being.

Stakeholders and Policy Makers Involvement and Actions:

- During the implementation, the participation of Department of Health of Klaipeda District, the Sports Center and the Primary Care Center of Gargzdai were essential.
- After the presentation of the first results of the intervention, Klaipeda district municipality prepared an Act for physical activity in the municipality, which will make it easier to implement similar programs in the future.

Suggestions for future Implementations, Sustainability and Replicability/Transferability of the Good Practice:

- The development of the intervention involved the Ministry of Health of the Republic of Lithuania, the Hygiene Institute, the Public Health Offices as well s Municipal leaders and administrative staff. All the parties responsible to deliver the program should be involved from the early stages.
- To involve as many participants as possible in the intervention. For that, it is needed to secure the financial support to cover the costs of trainers, sports equipment and administration of the intervention.

Klaipeda city municipality

Abstract

Elderly people don’t do enough of daily physical activity. According to the recommendations of the World Health Organization (WHO), adults must engage in vigorous physical activity for at least 30 minutes 5 days a week or more. Results of the first adult lifestyle survey conducted in 2018 show that there were 35.2% of physically active adults in Klaipeda city in comparison to 40.5% in Lithuania as a whole. It was also determined that there was no gender difference in relation to physical activity in Klaipeda (35.3% physically active women and 35.1% men). The survey showed that a total of 15.7% of women and 11.9% of men in Klaipeda are not practicing any physical activity.

The purpose of the multimodal training project is to improve and maintain health of old age adults (60+) in Klaipeda city through regular physical exercise. Intervention was launched in Klaipeda city in December 2018. Cooperation with the Institute of Hygiene, as well as the with the Icelandic team on how to correctly implement the Multimodal training method was established. A total of 171 participants were enrolled in the intervention, 17 measurements were taken and data analysed. There were 11 groups of participants. During the evaluation process, the participants of the first group stood out as they were more independent during the strength training sessions and generally showed better results. This was the case because they were already taking part in other physical activities for the elderly organized by the Public Health Bureau.

The basis of daily training is walking. The training load increases gradually during the 6-month training period. The main results related to physical activity indicate that the majority of participants did not have enough physical activity before the intervention. The positive effect on endurance after intervention lasted a year later, physical capacity after half a year restored to primary indications for many participants. Body composition, weight, BMI and body fat have improved after multimodal workouts. By gradually increasing the physical activity load, the physical strength, weight control and mental health of the participants were monitored. Municipalities and private sector are starting to understand and showing interest in multimodal intervention results. This intervention can be adapted to both young and older people, as well as to small and larger communities.

Short Template for reporting

General Objective (Specific Aim): To improve healthy ageing in older persons 60+ through implementation of the Multimodal intervention program (6-MTI)	**Process Indicators**	**Outcome Indicators**		**Sources of information**
		Baseline (2018)	**Current value** 02/2020)	
Specific Objectives **SO1**: To improve older person knowledge and attitudes toward healthy lifestyles through training on physical activity and nutrition**.**		1.1: Expected No of older persons performing physical activity: 90 1.2 165 older persons participating in the intervention	1.1: Older persons performing physical activity: 171 1.2 171 older persons participating in the intervention	Klaiped City Public Health Bureau. *https://www.sveikatosbiuras.lt/lt/projektai/chrodis/*
SO2: To assess the changes obtained in older persons health status and quality of life.		2.1 Strength change: 45,3 2.2 Mean blood pressure ACS systolic: measurement I -143 2.3 Body mass index 20,7 2.4 6 minute walk test (m): measurement I – 450 (m)	2.1 Strength change: 44,1 2.2 Mean blood pressure ACS systolic: measurement II -135 2.3 Body mass index 20,4 2.4 6 minute walk test (m): measurement II – 500 (m).	Klaiped City Public Health Bureau. https://www.sveikatosbiuras.lt/lt/naujienos/ivyko-projekto-chrodis-

		2.5 Quality of life base line: • Normal mood 13,5 % • Mild depression 84,2 % • Severe depression 1,2%	2.5 Quality of life after 6 months: • Normal mood 17,8 % • Mild depression 80 % • Severe depression 1,2 %	plus-konferencija-17375.html
SO3: To promote healthy life styles and disseminate the results		3.1 Older persons to reached by social media campaign: 90	3.1 Older persons reached by social media campaign: 120	Public health bureau news website Link here
Activities **SO1:** Preparation of instruments for individual oriented training: - Provide lectures for older persons on healthy aging, nutrition; -Personalized social support; - Establish collaboration with local stakeholders (incl. sport centres) - Provision of education and communication materials for trainings and lectures -Training on physical activity -Organise strength training -Organise walking classes.	1.1 Mapping of services performed: Yes 1.2 Report on older person perception and needs: Yes 1.3 Report on professionals and community actors knowledge and capacity: No 1.4 Five lectures organized (on nutrition, Nordic walking, physical activity): 92 participants 1.5 Education material provided: Yes 1.6 Agreement with sports centres formulated: Yes 1.7 Lectures on nutrition, cardiovascular disease and healthy aging performed: Yes 1.8 lectures were organized on nutrition, Nordic walking, physical activity. 1.9 Online physical activity trainings planned 1.10 Walking classes organised once a week: 78			-Services mapping available and updatable on web cloud -Focus Group Report -Assessment Report
SO2: 2.1 Translation and use of health surveys instruments 2.2-3 Perform regular health survey and measurements (every 6 months)	2.1 Surveys instruments translated and provided: Yes 2.2 Measurements performed: 172.3 2.3 Results of survey and measurement used to assess the program: Yes			Klaiped City Public Health Bureau link here

SO3: - provide a communication plan - prepare communication materials (e.g. infographics, leaflets) - distribute the leaflets to the target population - perform the social media campaign	3.1 Communication materials provided: Yes 3.2 Flyers and posters created and disseminated in the community (libraries, churches, other public institutions): 1000 units. 3.3 People reached by social media campaign: 120			Public health bureau news website Link here

Essential Elements of the Pilot Action Report

Implementation Elements of the Good Practice:

- Existing experience working with elderly people.
- Cooperation with the community and establishment of new contacts.
- All working team have necessary education.
- All information about Multimodal training 60+ is published in social networks.
- Multimodal training 60+ has Municipal support during all the program.
- The program participants have possibilities to train in sports centres and in enclosed rooms during cold season.
- This program can be used for young and elderly people, small and big communities.

Summary of major barriers and enablers identified during the implementation

Barriers:

- Finding more locations for exercise (sport centres).
- Low participants motivation.
- No wish from private sector to participate in intervention without additional financing opportunities.
- Scarcity of structural resources (personnel time and allocated funding).

Enablers:

- Managerial endorsement and workforce involvement in the implementation from the early stages.
- Availability of structural resources (dedicated personnel with enough hours to dedicate to the activity, some funding).
- Exposition of different communication channels (newsletters, posters, announcements).

- Face – to – face general sessions, workshops and informal channels of communication.

Major results of the implementations:

- The intervention is aimed at the 60+ age group to improve the prevention of chronic, non – communicable diseases. Physical activity plays a meaningful role in decreasing frailty and has shown positive results in the participants in Klaipeda city.
- Healthy lifestyle and awareness of how it helps the elderly were enhanced in employees and they found the intervention very useful.

Stakeholders and Policy Makers Involvement and Actions:

- Klaipeda City Public Health Bureau implementing the activity with the active support from the Klaipeda City Municipality and coordination from the Institute of Hygiene.
- It was possible to implement the intervention because of close collaboration with city's sports clubs: ,,Šansas",,Eola",,Kapitolijus" and Klaipeda City athletics centre.

Suggestions for future implementations, sustainability and replicability/transferability:

- Define the evaluation tools at the early stage of the implementation, receive, adapt methodological material in pre-implementation stage.
- Ensure continuation of the Multimodal training in communities to achieve sustainable results.
- Expand cooperation wish sports bases and private sports centres.
- It is needed to secure the financial support to cover the costs of trainers, sports equipment and administration of the intervention.
- Building upon pre – existing collaborative structures prompts mutual support and networking.

1.3 Further roll-out of Multimodal Training Intervention in Iceland

Abstract

Multimodal health promotion (MHP) is of special interest for older individuals, because of their high rate of disability, functional dependence and use of healthcare resources. The purpose of this health promotion and research project was to assess the immediate and long-term effects of a MHP on functional fitness (FF), body composition (BC), health and quality of live (HQL), and cardio metabolic risk factors (CMRF). The main objectives of the project are; 1) to promote the health of older age groups so they; a) can take part, both better and longer, in the activities of daily life in the future, b)

can live longer in an independent residence, c) prevent or delay entry into residential and nursing homes, d) have the opportunity to work longer in the labor market; 2) to improve the quality of life of older age groups; 3) to reduce government and municipalities expenditures.

The MHP consisted of three 6-month periods, with emphasis on daily endurance training and twice-a-week strength training. This was supported by monthly lectures with emphasis on nutrition, use of medicine in connection with training, healthy ageing, mindfulness, goal-setting in old age, endurance, strength and flexibility training, and guidance on how to train. The design was a suitable sample with baseline assessment and repeat measurements at the end of each 6-month MHP phase.

After each MHP phase, positive improvement was seen in FF, BC, HQL and CMRF. Males and females retained achieved changes and improved further at the end of each 6-month measurement. Improvement was seen in all variables after 18-month training in comparison to baseline. MHP is feasible and beneficial in older populations as an integral part of prevention in municipalities and management of chronic age-related disorders. The results suggest that regular MHP can improve and prevent decline in functional fitness in older individuals, reduce or prevent cardio metabolic risk factors, influence their health and lifestyle and positively affect their ability to stay independent, thus reducing the need for institutional care.

Short Template for reporting

General Objectives:	Indicators			
To promote the health of older age groups 65+ with the Multimodal Training Intervention (MTI) in Hafnarfjörður and Reykjanesbær (6-MTI)	Process	Outcomes		
		Baseline (June 2017)	Current value (June 2019)	Sources of information
Specific Objectives **SO1:** To enhance stakeholder engagement to successfully conduct the 6-MTI intervention **SO2:** To reduce or prevent cardio metabolic risk factors and functional decline in older persons through promotion of lifestyles and training on physical activity **SO3:** To measure the changes obtained in older persons health status and functional fitness		3.1. Blood pressure: 147.9 (MMHG2) 3.2. Muscle mass (KG): 28.05; Fat mass (KG): 29,78 3.3. Daily activity (min per day): 13, 98	3.1. Blood pressure: 136.3 (MMHG) 3.2. Muscle mass (KG): 29.46 Fat mass (KG): 27,32 3.3. Daily activity (min per day): 32,93	Multimodal Training Intervention – An Approach to Successful Aging - here Internal project records

[2] MMHG: A millimetre of mercury is a manometric (mmhg)

Activities (change package) **SO1:** - Identify trainers - Contract with municipalities and older people associations for promotion activities. - Find suitable facilities for endurance, strength training, measuring the results and giving lectures. -Organize promotion and dissemination activities (interviews, articles, posters, social media campaign and ads in local newspapers). -Organize introduction meeting -Online registration	1.1 Established contracts with municipalities: Yes 1.2 Involved elderly association in municipalities: Yes 1.3 Identified suitable facilities for training and lectures: Yes 1.4 Organized promotion and dissemination activities: Yes			Internal project records
SO2: -Organize daily endurance training and strength training. -Monthly lectures on nutrition, use of medicine, healthy ageing, mindfulness, goal-setting in old age, endurance, strength and flexibility training, and how to train. -Follow up of participants attending training by phone calls, emails or sms -Weekly meetings with trainers.	2.1. Performed endurance training once a week with trainers: Yes 2.2. Organized strength training with trainer with equipment: Yes 2.3. Performed 4-5 lectures during 6 months: Yes			Internal project records
SO3: Measuring participants health and functional status (before the training and every 6 months): -Blood pressure and blood analysis - Body mass index and Whole-body composition (InBody scale) -Daily physical activity -Strength training -6 MW-test: Strength test SPPB-test and 8-foot up-and-go test		3.1. Blood pressure: 147.9 (MMHG) 3.2. Muscle mass (KG): 28.05; Fat mass (KG): 29,78 3.3. Daily activity (min per day): 13, 98 3.4. Strength training (times per week) 0.34 3.5. 6 min walking test (M): 437.1	3.1. Blood pressure: 136.3 (MMHG) 3.2. Muscle mass (KG): 29.46 Fat mass (KG): 27,32 3.3. Daily activity (min per day): 32,93 3.4. Strength training (times per week) 2.05 3.5. 6 min walking test (M): 494.4	Internal project records

Essential Elements of the Pilot Action Report

Results of the Implementation:

- The regular multimodal training intervention can affect and improve long-term retention of functional fitness for up to 24 months or even much longer after the 24-month intervention.
- The training has an effect on functional fitness, endurance performance and can maintain strength performance and quality of life (health) in this population. Moreover, the training affects cardio metabolic risk factors positively as it reduces FM, waist circumference and BP, and may increase HDL and FFM. Finally, the intervention may influence lifestyle behaviour with regards to exercise.

Summary of major barriers and enablers identified during the implementation

Barriers:

- Few participants had previously practiced targeted training and very few participants have done strength training before starting the intervention.
- To start teaching strength training it is desirable to have 2-4 instructors for about 8-10 participants in each 60 min class.
- Find the desired training period and keep it for over a 6- to 24-month period.
- To follow established rules on nutrition before and / after exercise; adopt a new lifestyle in terms of nutrition and physical exercise.
- Lack of heart rate monitors that everyone would have impedes monitoring the heart rate during endurance training.
- For participants to follow the training program (home exercises) and stay engaged throughout.
- Not all senior citizens are connected to the internet or own a computer or smartphone, which makes them difficult to reach with news and upcoming events.
- Difficult to make sure that all participants take part in each measurement every 6 months during the 2 years period.
- Teaching participants how to read and understand their measurement results.

Enablers:

- Following the protocol and being patient to achieve the success.
- Every participant is different, and it is necessary to take an individual approach despite working with small groups each time.
- Listening to participants and finding ways to accommodate them throughout the program.
- Using technology to reach participants, via email, sms, Facebook or other communicational apps.
- Use a communication platform and CRM (Customer Management System).

- Follow up on the participants with email or phone call if they haven´t been attending.
- Participants encouraged to announce when they go on vacation or take a sick leave.

Suggestions for future Implementations:

- Do not relax the requirements to participants; use measurements as a catalyst for sustainability and increased productivity.
- Do not underestimate importance of educational mission that the intervention has.
- Make a handbook of guidelines with all the tasks, small and large that need to be done.
- Give participants new challenges when they are ready, and keep them motivated.
- Calling every participant is time consuming especially if the group is large. If possible, set up an app that participants, stakeholders and institutions could follow.
- Make sure to plan an extra measurement day for those who were unable to attend during the scheduled measurement days.
- Inform municipalities regularly about the results and status of the project.
- Report on the project in the media.

Benefits for the elderly:

All parameters/measurements have moved to a positive direction:

- An increase in daily activity of endurance training, an increase in total minutes per day, an increase in weekly activity of strength training
- A decrease in blood pressure**, a** decrease in heart rate rest *beats per minute
- A decrease in body fat mass (kg) and an increase in muscle mass
- An increase in the Quality of life

Stakeholders and Policy Makers Involvement and Actions:

- Municipality: 1) First approved by politicians within the municipality, 2) As project stared a contact person was identified by the municipality.
- Public Health Care Center (Heilsugæslan – vegna blóðsýna og greininga).
- Elderly Association involved in the municipality.
- Strength Training Facility owner (Within municipality in Reykjanesbær but private in Hafnarfjörður).
- Endurance Training Facility – Sports Club funded by the municipality.
- Place for lectures, available within the municipality and agreement made with contact person there.

1.4 Transfer of the Active School Flag from Ireland to two schools in the Piedmont Region in Italy

Abstract

According to a survey conducted in 2016 (Okkio alla Salute Survey) in selected schools of Piedmont Region (Italy), about 1 in 7 children (15%) are physically inactive, more girls than boys. Only 1 in 3 children have a recommended level of physical activity for their age, although the benefits for children of being physically active are well documented in the literature (World Health Organization WHO 2010, Lee et al., 2012). The acquisition of active behavioural models during childhood and adolescence tends to make these behaviours regular in adulthood (Janssen, 2009; WHO, 2011) and Public health interventions in schools are key elements due to the large number of children reached. Italy chose to implement Active School Flag programme to enhance the level of physical activity in primary school children.

The Active School Flag (ASF) is an Irish initiative which aims to enhance levels of physical activity for children through developing a physically active and physically educated school community. The ASF is a nationwide initiative focused on supporting a whole school approach to enhancing physical activity. The ASF mirrors other "active school" models operating throughout Europe and internationally, for example, the Centre's for Disease Control and Prevention Comprehensive School Physical Activity Program in the United States. The target group is school-going children between the ages of five and 18 years old. It is open to all primary, post-primary, special needs education schools, and youth centres. Schools are recruited to the program by invitation and, once engaged with the program, they are supported in action planning and self-evaluation. Schools are required to review their current provision across the areas of physical education (PE), physical activity and partnerships, as well as to commit to a number of improvements. The review areas include elements of planning and PE curriculum, professional development, school PE resources, activity during break times, cross-curricular and extra-curricular activity, inclusive physical activity, and active travel.

Azienda Sanitaria Locale di Collegno e Pinerolo (Italy), via the Piedmont Regional Health Promotion Documentation Centre (DORS) transferred and implemented the ASF in two schools in the Piedmont SHE Network, voluntarily recruited (one school is located in a rural area and one in an urban area). The implementation of Irish ASF has been inserted into a local institutional framework (training proposed by Regional Authority) and that was important for recruitment and crucial for sustainability. The two implementing schools introduced new activities into the daily school routine, such as active class breaks, active outdoor breaks, The Daily Mile programme, active homework, children and family's participation at local sport events.

From the qualitative point of view, the two school Principals enhanced and supported the programme, the participating teachers found the ASF process easy and feasible and reported that children were more attentive and collaborative during lessons, enjoyed the activities and those with disability showed improved motor coordination. Key elements for future implementation, sustainability and replicability were site visits between the Irish good practice owners of ASF and the implementers in Italy (conducted in June 2018 in Ireland and in October 2019 in Italy); these site visits were crucial to enter the process, to share experiences, and to receive suggestions and directions from practice owners. There is a need for one site visit to

implementers at the early stage of the process for the understanding of the specific features and characteristics of the context and one at the middle/end of the process to redirect activities and introduce any changes/additions to the implemented activities.

Short Template for reporting

General objectives - To implement Active school Flag programme in 2 school (voluntarily recruited) of Piedmont Region - To study the conditions for transferability and scalability	**Indicators**			
	Process	**Outcomes**		**Sources of information**
		Baseline (October 2018)	**Current value** (January 2020)	
Specific Objectives **SO1**: to improve Physical activity in school aged children **SO2**: to modify organization/culture of the 2 implementers schools regarding PA by focusing the school policies on physical activity and healthy lifestyle		Schools including twice daily playground breaks for all classes (0/2 school) PTOF embedding ASF activities /PTOF of implementers school: 0/2	Schools including twice daily playground breaks for all classes (100% 2/2 school) PTOF embedding ASF activities / PTOF of implementers school: (100% 2/2 school)	Activities records (one for each school) School policy and PTOF content; International Success criteria List
Activities (change package) **1.1:** each school complete the Self Evaluation questionnaire (SEQ Physical education, SEQ physical activity, SEQ partnership)	School completing the SEQ (100%)			SEQ completed (one for each school)
1.2 introduction of ASF activities during school daily routine - stretching - a mile a day run before lesson, - 2 active playground break, - active breaks during lesson.	1.2.1 Children involved/number tot children: (20% 140/684 Rita Levi Montalcini School in Turin (RLM); 24%128/528 Centro Storico School, Moncalieri, CS) 1.2.2 Classes involved/number tot school classes: (20% 6/30 RLM, 17% 5/28 CS)	School including new activities in the daily school routine: (0/2)	School including new activities in the daily school routine: 100% (2/2)	Activities records International Success Criteria List
1.3: organization of an Active School week (ASW)		Schools including "ASW" as part of the annual school calendar: (0/2 school)	Schools including "ASW" as part of the annual school calendar: 50%, 1/2 school)	Irish journal article published (link)

2.1: ASF activities are embedded in school policy and PTOF (three year educational offer plan)		n. PTOF embedding ASF activities / number PTOF of implementers school 0/2	n. PTOF embedding ASF activities / number PTOF of implementers school (100%, 2/2 school)	School PTOF (published on school website);
2.2 schools ensure that all PE activities are planned so that they are accessible by all pupils	2.2 International Success criteria met: yes 100%			
2.3 schools inform pupils and parents about physical activity opportunities available in the local community	2.3 International Success criteria met: yes 100%			

Essential Elements of the Pilot Action Report

Implementation Elements of the Good Practice:

- Site visit in Dublin with school teachers (June 2018) was a **KEY Step**
- Italian translation of Irish self-evaluation questionnaires (SEQ, teachers' questionnaire, international ASF success criteria) and ASF resources (challenges charts and activities booklet)
- Context analysis of the two implementing schools with SEQ
- Introduction of new activities and new school daily organization
- Bi-monthly supervision and support from Irish colleagues
- Site visit from the Irish colleagues to the implementer schools (**KEY step**)
- Communication strategies: activities highlighted on school website
- Introduction of Physical activity into the school policy and PTOF (three years educational offer plan)

Major Barriers and Enablers identified during the implementation of the Good Practice

Barriers:

- Strong differences in Italian school organization due to autonomy (different policies/schedules/priorities)
- School dimension: Italy has very big schools with on average of 1200 pupils
- Underdeveloped school physical activity
- Teachers' confidence: Italian teachers do not have physical activity in their training portfolio
- Italy has strict safety rules in school

- Competition with other schools, other projects
- Cultural diversity between Ireland and Italy

Enablers:

- Schools with existing PA programmes and assessment
- Regional and local commitment and policies on Physical activity
- Being part of the regional network "Health Promoting School" (SHE)
- Good teachers, well-motivated
- Good weather conditions for outdoor activities
- Interdisciplinary and multidisciplinary approach
- Teamwork habit
- Focus on the inclusion of children with special needs
- Support and supervision from Irish donors

Benefits for children:

- More energized and fun school day
- Improvements in concentration and attention
- Motor coordination improvement for a child with Down Syndrome

Stakeholders and Policy Makers Involvement and Actions:

- Principals gave their trust and support to the programme
- Regional stakeholder and policy makers came to meet Karen Cotter (ASF national Irish coordinator)

Suggestions for future Implementations, Sustainability and Replicability/Transferability of the Good Practice:

- Pre-implementation assessment and description are crucial
- Implementers visit to the good practice donor premises during the school year (before implementation begins)
- Donor visits implementing sites (at the beginning and at the middle of the implementation process) are key elements
- Teachers engagement and school Principals' support are very important

1.5 Transfer of the Active School Flag from Ireland to schools in the Klaipėda city and Klaipėda district municipalities in Lithuania

Klaipėda city municipality in Lithuania

Abstract

Children physical inactivity problem is a world-wide issue. Children Lifestyle Survey conducted by Klaipeda City Public Health Bureau (2016) revealed that Klaipeda city is facing this problem, too. In Klaipėda only 12,1 % of children meet the requirement of 60 minutes daily physical activity while the Lithuanian average is even lower – 9,7 %.

Two schools in Klaipėda city took the opportunity to implement Active School Flag (ASF) initiative: Gilijos Primary School (598 pupils) and Sendvario Progymnasium (680 pupils). Target population was 1-8th grade schoolchildren. The aim of the implementation was to encourage children to become more physically active in an enjoyable way. The following are the elements of the ASF that were adapted and re-used in Klaipėda schools: Running challenges (Run around Europe); European Week of Sport; Active School Week; Walk to School week; Active breaks (Go Noodle, Drop Everything and Dance, 30 Second Active Breaks).

During the pre-implementation phase the ASF self-evaluation instruments and teacher's questionnaire have been translated into Lithuanian and adapted to the local context. The process of implementation was evaluated using quantitative criteria: Number of classes, pupils, teachers involved against Expected nr. of classes, pupils, teachers to be involved; Number of meetings with school administration, teachers, children, parents; Number of physically active school children against the total number of schoolchildren.

Short Template for reporting

General Objective (Specific Aim): Promote physical education, physical activity including games, sports, physical exercise in the context of family, school and all community.	**Indicators**			
	Process	**Outcomes**		
		Baseline (incl. year)	**Current value** (incl. date/year)	**Sources of information**
Specific Objectives **SO1:** To improve Physical Activity in school aged children **SO2:** To involve children, parents, teachers and public health specialists in Physical Education planning		1.1: 12,1 % of children (5,7 and 9th grades) meet the requirement of 60 minutes daily physical activity (2016); 1.2: Inclusion of the ASF into the school curricula (NO) 2.1: involved public health care specialists working at schools and teachers (2018-2020): none	1.1: % of physically active children will be available in June 2020 1.2 Inclusion of the ASF into the school curricula (YES) 2.1: 2 involved public health care specialists working at schools (2018-2020) 21 involved teachers: (2018-2020)	Report of Children Lifestyle Survey in Municipalities (2016) Administrative documents (employment contracts) of Klaipėda City Public Health Bureau
Activities (change package) **SO1** 1. To translate the ASF self-evaluation instruments. 2. To introduce new elements/ activities in selected schools: Run around Europe, Active school week, Active breaks.	1.1: Translated and adapted ASF self-evaluation (YES) 2.1: Adopted 3 elements/ activities from ASF initiative			ASF self-evaluation instruments; Bi-monthly reports. Records, photos, videos from schools events, adaptation of ASF elements/ activities; Bi-monthly reports.
SO2 2. To inform children, parents, teachers, school administration about the intervention, provide training about the motivation, team building.	2.1: Involved classes, pupils, teachers (1278 pupils, 37 teachers); 2.2: Organised 10 meetings with school administration and teachers			Records, photos, videos from schools events, adaptation of ASF elements/ activities; Bi-monthly reports.

Essential Elements of the Pilot Action Report

Implementation Elements of the Good Practice:

- Run around Europe (the class chooses a European capital and a distance to it, runs in the stadium, laps are converted into kilometres until the distance to the chosen capital is reached)
- European Week of Sport (schools can contribute by organising their own sport events)
- Active School Week (schools organise it as part of their school calendar)
- Walk to school week
- Active breaks (Go Noodle – videos with energetic music and actors showing moves which children have to repeat);
- Drop Everything and Dance – children stand up and dance.

Mayor Barriers and Enablers identified during the implementation of the Good Practice:

Barriers:

- Lack of teachers or their time to focus on the implementation of activities,
- Parents' involvement and motivation,
- Change of coordinating personnel impedes smooth coordination of the process,
- Lack of internal communication about implementation and evaluation matters.

Enablers:

- Inclusion of the ASF elements into the school curriculum, enthusiastic and motivated teachers, school administration, collaboration with public health care specialists ensures continuation of the ASF intervention, established external and internal communication channel.
- Public health care specialists working together with teachers, parents and specialists of psychological and social assistance help schoolchildren to form a positive view to their health, to encourage children to preserve and improve their health. Public health care specialists are employed by Klaipėda City Public Health Bureau, thus it ensures the continuation of implementation of projects and initiatives aiming to strengthen children health and form healthy lifestyles.

Results of the Implementations:

- Promotion of physical activity at school, using whole-school approach;
- Enjoyable way to increase the level of children physical activity by implementing new activities/ elements.

Benefits for Beneficiaries:

- The ASF initiative is focused on promotion of children physical activity, include more playful, interesting elements in the physical education curriculum, contribute to children wellbeing.

Stakeholders and Policy Makers Involvement and Actions:

- The Institute of Hygiene main coordinator of the implementation, Klaipėda City Public Health Bureau is directly supporting the implementers and monitors the process. Klaipėda City Municipality supports the initiative. The involvement of major stakeholders and policy makers in the planning and implementation of the ASF initiative strengthened intersectoral collaboration and future sustainability.
- Implementing schools: Gilijos Primary School and Sendvario Progymnasium.

Suggestions for future Implementations, Sustainability and Replicability/Transferability of the Good Practice

- Define the evaluation tools at the early stage of the implementation, receive, translate or adapt methodological material in pre-implementation stage.
- Ensure continuation of the ASF intervention by introducing new activities/ elements in the physical education curriculum.
- Allocation of human resources and funding (e.g. prizes to motivate children, equipment).

Klaipėda district municipality in Lithuania

Abstract

Insufficient levels of children physical activity are observed worldwide. Most of their time children spend being sedentary. Research shows that physical activity for children in Klaipeda District is on the decline and they are not motivated and do not show interest in physical activity. Active School Flag is an initiative aiming to enhance physical activity levels for children (aged 6 to 11) through developing a physically active and physically educated school community through:

- Reviewing and improving Physical Education in the regular school curriculum (athletics, dance, gymnastics, games, outdoor and adventures activities, aquatics);
- Getting at least 60 minutes of moderate intensity Physical Activity (PA) for children every day;
- Cooperation with ALL community in ASF project intervention, including students, teachers, parents, school administration and local community.
- Organisation of special events, that emphasise promotion of daily, inclusive and entertaining Physical Activity (PA) in schools.

Three schools had voluntarily entered the ASF intervention with a total number of 190 children participants aged 6 – 11. The interventions included: translation of documents and questionnaires, introduction of new physical activities (Run around Europe, Active Breaks, Active Travel and etc.), organising an Active School Week. After implementing the ASF intervention children's physical activity hours have increased. More children got engaged in physical activities, especially children with disabilities. School teachers believe that pupil had improved school attendance, punctuality, became more engaged in physical activities and during lessons overall. At the end of intervention schools prepared five-year plan of physical activity.
To ensure sustainability of physical activity promotion and further development in schools, the intersectoral collaboration between health and education sectors must be ensured.

Short Template for reporting

General Objective: Promote physical education, physical activity includes play, games, sports, physical exercise in the context of family, school and all community.	**Indicators**			
	Process	**Outcomes**		**Sources of information**
		Baseline (2018)	**Current value** (02/2020)	
Specific Objectives **SO1:** To improve Physical Activity (PA) in children aged 6-11		**1.1** Children (aged 6-11) performing at least 60 min of moderate intensity PA every day /Total children (aged 6-11) involved = 0	**1.1** Children (aged 6-11) performing at least 60 min of moderate intensity PA every day /Total children (aged 6-11) involved = 190 children	-SEQ -International Success Criteria List - Teacher questionnaire -Logbook
SO2: To promote an integrated response involving students, teachers, parents, school administration and local community.		2.1 ASF activities embedded in PTOF/policy or similar document = 0/3 participating schools	2.1 ASF activities embedded in PTOF/policy or similar document = 2/3 participating schools	- PTOF -Policy documents
SO3: To enhance awareness and practice on Physical Activity (PA) through promotional activities		3.1 'Active School Week' (ASW) organized = number of schools organizing the ASW 0/3 participating schools	3.1 'Active School Week' (ASW) organized = number of schools organizing the ASW 3/3 participating schools	- Logbook - ASW activities plan -School websites

Activities **SO1** - Translate and adapt new activities materials to Lithuania. - Organize new activities in school process: Active Break, Run Around Europe/Lithuania, Playground Leader Time, Wake up Shake up, 60 min challenge.	1.1 New activities material translated = Yes 1.2 Meeting with teachers organized = 3/3 1.3 Participating schools: 3 1.4 Introduction of new activities in 100% of involved classes 1.5 Schools providing twice daily playground breaks for all classes: 2/3			-SEQ - Activities resources -International Success Criteria List -Logbook
SO2 **-** Revision and inclusion of Physical Education (PE) in school curriculum (included areas: athletics, dance, gymnastics, games, outdoor and adventures, aquatics) – Involving local partners and visiting trainers.	2.1 PE curriculum revised: 3/3 2.2 Included PE curriculum areas: Yes 2.3 Involved local partners and visiting trainers: Yes 2.4 Teachers perception of positive project impact: 15/20			-Logbook -SOQ - International Success Criteria -Schools website -Teachers questionnaire
SO3 - Prepare Active School Week (ASW) annual plan and activities. - Invite parents and local partners. - Collect photos and videos of ASW activities.	3.1 ASW plan prepared: Yes 3.2 ASW activities organized: Yes 3.3 Participating parents: 22 3.4 Participating partners: 4			- PTOF -Photos and video

Essential Elements of the Pilot Action Report

Implementation Elements of the Good Practice:

- Time doing physical activity per week has increased for school children,
- More children joined physical activities at school,
- School yearly events calendar added new physical activity events,
- School started to develop physical activity policy.

Mayor Barriers and Enablers identified during the implementation of the Good Practice

Barriers:

- Limited resources (time, personnel, funds) and low number of full-time working staff in selected schools prevented institutional leadership and collaboration (school, health, sport)

Enablers:

- Communication system: bi-monthly web-conferences with good practice owners and other implementers of the intervention
- Already available materials and documents supporting the implementation, giving ideas for activities to implement.
- Defined and standardized analysis system
- Multidisciplinary teams (public health specialist, teachers, school administration worker)

Major Results of the Implementations

- Enhanced levels of physical activity for children (age 6 to 11), as a result, more physically active and physically educated school community. Three schools from Klaipeda district implemented various ASF activities (active break, sports events and initiatives, etc).
- School teachers observed that pupil had improved attendance, punctuality, became more active during lesson and had engaged in physical activities.
- Prior to the intervention, none of the participating schools had a physical activity policy. Two of the schools now have prepared a five-year Active School plan implementing ASF components.

Activities implemented:

- Review and Improve Physical Education in the regular school curriculum.
- Implement 60 minutes of moderate intensity Physical Activity (PA) for children every day.
- Everyday children in school have two active breaks which are attractive and inclusive.
- Active School Week
- New physical activities: Wake up Shake up, Active Break, Run Around Europe/Lithuania.

Benefits for Beneficiaries:

- The hours of physical activity per week in school has increased more children got involved.
- The school yearly events calendar added new physical activities.
- The school started to adopt a physical activity policy, resulting in a five year physical activity plan.

Stakeholders and Policy Makers Involvement and Actions:

- The Institute of Hygiene and the Ministry of Health was involved in ASF initiative development in Lithuania. The Institute of Hygiene was a coordinator and responsible for the implementation to take place.
- Public Health Bureau was assisting the School management and administration as well as teachers and parents to implement the ASF.

Suggestions for future Implementations, Sustainability and Replicability/Transferability of the Good Practice:

- Implement and continue physical activity promotion in schools, creating and improving national intervention to include ASF components.
- Prioritize children physical activity promotion in Lithuania in health and education sectors.

1.6 Transfer of the ToyBox good practice from Greece to schools in Malta

Abstract

Obesity is a critical public health issue in Malta, where approximately 41% of children and 69% of adults are overweight or obese. Early childhood is a critical period for addressing obesity prevention since EBRBs, psychological traits and physiological processes are largely formed and adopted at this age. Given the persistent low levels of physical activity (PA) and a preference for food high in fat, sugar and salt (HFSS food) among children, urgent action is needed. Other contextual elements of relevance in Malta include general lack of awareness of what constitutes healthy eating; limited opportunities for children to safely engage in outdoor activities; lack of parental engagement in school activities; resistance among teachers and parents regarding the creation of an 'excessively regulated' school environment, and lack of willingness of teachers and parents to act as role models.

Malta implemented the ToyBox programme as an evidence-based, multicomponent, intervention primarily targeting four energy-balance related behaviours (EBRBs) that contribute to early childhood obesity among 3 to 4-year-old preschool children and their families. The main objectives of Malta's implementation of Toybox were to: increase healthy dietary behaviour; increase overall physical activity levels; reduce sedentary time; increase water consumption and improve oral hygiene. A secondary aim was to evaluate the implementation of the ToyBox programme and assess the feasibility of its implementation on a national scale.

The target population of the study was children aged 3-4 years who attend Kindergarten 1 class in Church schools and Independent schools. State schools chose not to participate in this study. A total of 13 Church schools (18 classes, 251 eligible students) and 14 independent schools (42 classes, 740 eligible students) agreed to participate in the study. Ethical approval was obtained for the study from the Health Ethics Research Committee at the University of Malta. Intervention in participating schools was carried out after obtaining written permission from each Head of School.

ToyBox encouraged the creation of supportive physical environments at school and at home to promote these five behaviours. Two meetings with heads of participating independent/church schools and Kindergarten 1 teachers were held prior to the start of the scholastic year to obtain feedback on the proposed/draft pilot action plan, with the intention of amending the plan as necessary. Parents were included in the intervention through newsletters, tip-cards and posters sent with their children and were encouraged to create a supportive home environment.

The project was implemented over 24 weeks starting in October 2018, with each EBRB being targeted sequentially over a 4-week period. The cycle was then repeated, with each behaviour being focused upon for a 2-week period. Teachers were given guidelines and a Teacher's Manual to follow, however they were free to alter the programme as they deemed fit. Teachers were also given a hand puppet (Kangaroo) to use for storytelling, and manuals with suggestions for activities and games for each EBRB. The classroom environment was reshaped at the beginning of the scholastic year to encourage active movement during lessons and reduce sitting times, and a water-station and an area for a 'Magic Snack Plate' was established. Proper dental hygiene was demonstrated to students using a dental model and toothbrush which were supplied to each class.

Heads of schools were contacted on a regular basis to proactively identify and resolve any issues and disseminate any pertinent feedback or best practices to other heads of schools. Anthropometric data (and pedometer data from a sub-sample) were collected from children whose parents had consented, and two sets of questionnaires were administered to caregivers/parents (i.e. a Food Frequency Questionnaire assessing dietary patterns of the child's intake over the previous 12 months, and a questionnaire aimed at exploring health behaviour, food environment and opportunities for physical activity environment in the home, and socioeconomic background). A dental plaque assessment was carried out pre- and post-implementation by a dental hygienist and a questionnaire on dental care distributed to parents pre- and post-implementation.

Analysis of quantitative results is currently underway, having been delayed for some months as all public health resources have been directed towards the national response to the COVID-19 pandemic response. This included study researchers and statisticians. However, an independent evaluation of the programme was carried out by a university student who interviewed five participating teachers in June 2020. This qualitative evaluation identified strengths, weaknesses, and opportunities for future implementation which are elaborated below. Most of the teachers spoke highly of the programme and its activities as well as its positive influence on the behaviours of the children, with most believing that the programme is effective. However, the less engaging parts of the programme, and the lack of support received by teachers require much needed attention. It is also evident that the parents may not be truly appreciating the value of such a programme, and thus more work needs to be done in that regard to raise awareness of its benefits. With more involvement from the Health Promotion and Disease Prevention Directorate, the ToyBox programme could be much more effective and fruitful than it is now. It would be ideal to keep this project going on in the future as it is perceptibly making a difference in educating pupils and changing their behaviours to match them with a healthier lifestyle.

Suggestions to improve future implementations and general sustainability of the programme include engaging teachers who have already successfully carried out the programme to promote ToyBox with their peers (i.e. other teachers) and Heads of School and offer support/ideas throughout the

scholastic year; reworking the ToyBox manual and stories to make them more appealing to pre-school children; and integrating the ToyBox programme into the general curriculum.

Short Template for reporting

[Analysis of quantitative results was post-poned due to COVID-19]

General Objective: to increase healthy dietary behaviour and overall physical activity levels among 3 to 4-year-old preschool children	**Indicators**			
	Process	**Outcomes**		
		Baseline (incl. year)	**Current value** (incl. date/year)	**Sources of information**
Specific Objective **SO1**: Promote healthy lifestyles in 3-4-year-old children through 4 EBRBs (dietary behaviour, physical activity, sedentary time, water consumption) and dental care.		October 2018 – anthropometric data, pedometer data, plaque assessments, food frequency, sociodemographic and dental questionnaires	June 2019 - anthropometric data, pedometer data, plaque assessments, food frequency, sociodemographic and dental questionnaires. And third set of anthropometric data taken in November 2019	-Original ToyBox programme -Material used in the original programme including teachers' manuals and parent material, -Dental material produced by LIWG
Activities (change package) **SO1:** Organization of meetings with all schools and stakeholders before initiation of the programme, midway throughout the programme to obtain feedback, provide guidance and motivation and at the end of the programme.		1.1 No. of children 3-4 yrs old involved: 991 1.2 No. of parents involved: n/a 1.3 % parents giving positive feedback/total parents involved: n/a	1.1 No. of children 3-4 yrs old involved: 991 1.2 No. of parents involved: n/a 1.3 % parents giving positive feedback/total parents involved: n/a	
SO2: Training of teachers and educators		2.1 No. of teachers involved: 60	2.1 No. of teachers involved: 60	

SO3: Implementation of environmental changes in the classroom	3.1 No. of water stations introduced: 53 3.2 No. of spaces created to be physically active in schools /total schools involved: 27			
SO4: Supporting and providing material for classroom activities including stories, games and experiments		4.1 No. of schools performing the activities throughout the scholastic year: 27 4.1 No. of schools performing a combination of these for at least 1 hour/week /total schools involved: 27	4.1 25/27 of the schools performed the activities throughout the scholastic year always, often or sometimes, while 2 schools did not perform the activities often 4.2 25/27 of the schools performed a combination of the activities for at least 1 hour/week always, often or sometimes, while one school did not perform these activities often and one school never performed these activities for 1 hour/week	
SO5: Distribution of informative material to parents (posters, newsletters, tipcards)	5.1 Material distributed to parents via students/total students involved: 991			

Essential Elements of the Pilot Action Report

[Analysis of quantitative results was post-poned due to COVID-19]

Implementation Elements of the Good Practice

- 2 school types (church and independent) participated in the programme, which included 27 schools. 991 children aged between 3-4 years and their families benefited from the programme which targeted 4 EBRBs and a dental aspect. Implementation on a national scale including state schools would give a better picture of the situation and the programme's effectiveness.
- Anthropometric and pedometer data collection, dental plaque assessment, andquestionnaire administration were carried out pre- and post-implementation. Collection of anthropometric data was carried out for a third time one calendar year after the start of the programme.

- Teachers noted an improvement in healthy lunches and an increase in water consumption of the children (awaiting confirmation or otherwise of this through analysis of quantitative data)
- Positive feedback about the programme was received from parents.
- Familiarity with the programme over time would make implementation of the programme easier for the teachers to carry out. The rigid format of the programme proved to be challenging for the teachers due to curriculum restraints. Adaptation of the programme to suit the Maltese educational system might increase the number of schools who would continue to implement the programme in the coming years, as would discussions for the ToyBox programme to be included in the national curriculum. Future discussions to adapt the content for younger children might also increase its uptake.
- Qualitative results indicate that the most popular activity was the 'Magic Plate' activity, as these sessions exposed the children to a variety of new and healthy foods. Teachers reported that children were observed tasting new foods simply because they saw their friends or their teacher trying them out. She also noted that the children took pride in bringing foods that were prepared from home to their class, and were excited to share them with their classmates. One teacher encouraged children to bring a "magic snack box" filled with healthy food, and most of the students kept doing so after the food and snacking sessions were completed.
- A substantial change in the eating habits of kindergarten students was observed by teachers. One teacher noted that many children started asking their parents for healthier foods and were excited to show off such food to her.

Major Barriers and Enablers identified during the implementation of the Good Practice

[Analysis of quantitative results was post-poned due to COVID-19]

Barriers

- Overall sustainability of the programme is questionable unless ToyBox is directly included in the school curriculum. Some teachers found it difficult to add on ToyBox activities to their regular curriculum
- The indpendent evaluation revealed that teachers did not find sufficient support from the Health Promotion and Disease Prevention Directorate to enable them to deliver effective ToyBox sessions. More 'hands on' time needs to be spent in schools by implementers to aid teachers. Simply asking teachers to follow the handbook/manual is insufficient. Ideally, creative ideas on how to implement the activities in the handbook would be provided by the implementers.
- Lack of interest from some parents due to over-saturation of school activities. Teachers claimed that parents do not take the programme seriously enough and that the programme is not as successful as it could be for this reason.
- Lack of analytical capacity on the part of the local working group (including economic cost-effectiveness analysis)

Enablers

- Engaging with schools which already have a 'healthy school' policy in place
- Heads of schools who were interested and engaged with the programme were more likely to encourage and provide support to their teachers to implement ToyBox.
- When teachers set an example by also participating in the activities, this often meant that the children would copy the actions of the teacher
- Increased teacher familiarity with the programme (over time and through early/refresher training) would aid sustainability over time
- Regular communication by members of the Local Implementation group with teachers (i.e. offering support; visiting participating schools and classes; providing feedback; providing ideas and examples of best practice from other participating schools, etc.)

Benefits for children

- Qualitative results indicate that children's behaviour improved substantially during the year. All educators noticed that the behaviours taught during the ToyBox sessions occur throughout normal classroom time as well, and that children encouraged each other to partake in these behaviours.
- Children became more aware of the foods that they consumed, and parents were reportedly sending their children off to school with healthier lunches.
- Healthy habits from an early age contribute to a healthy weight with decreased risk of developing chronic conditions over time. Good dental health also contributes to overall well being.

Suggestions for future Implementations

- Approaching schools and teachers at a very early stage prior to implementation to allow them to factor in the ToyBox programme in their curriculum is likely to improve sustainability.
- Obtaining feedback from teachers with regards to implementation difficulties which were encountered to be able to better adapt the programme to the Maltese educational system.
- The programme could be streamlined, with any unnecessary workload removed to assist educators in keeping up with their curriculum while still implementing ToyBox.
- Meetings with teachers should be held well before the beginning of the scholastic year to offer guidance and outline what is expected from them when delivering the sessions. Ideally, training would also be provided by teachers who have previously rigorously and succesfully implemented the programme; such training by their peers would promote teachers' ownership of the programme and improve implementation.
- The creation and dissemination of behaviour-specific PowerPoint presentations to accompany the different readings is highly recommended to aid the pupils in visualising the stories. These should also be simplified for this age group.

- If physical activity monitoring is included as part of the programme, finding a more effective way to monitor the children's steps during the exercise activities is essential. Pedometers should be appropriate for the children's age
- Parents should be more involved - their awareness of the value of the ToyBox programme should be heightened through seminars and support offered by providing summarised guidelines on home activities
- Educators should be made more aware of their role model influence on the children, and formal or informal sessions held to encourage them to take part in the activities with the pupils
- Engaging experts from various fields (e.g. dental hygienists; physical educators) to visit the children and animate ToyBox sessions at least once a year would increase engagement by both teachers and children

1.7 Transfer of elements of JOGG "Youth at a Healthy Weight" from the Netherlands to the Health Promoting Community programme in Iceland

Abstract

According to the annually published Public Health Indicators, insufficient sleep, daily consumption of soft drinks and use of e-cigarettes are examples of public health challenges (problems) among children and young people in Iceland. It is known that comprehensive, data driven, community approach, involving key stakeholders across sectors and levels is an effective way to address such challenges. The Health promoting community programme (HPC) has been under development for some years, learning from e.g. previous work in Iceland, the Ottawa Charter, the Health in All Policies approach, WHO Healthy Cities and Health Promoting Schools and similar work in other countries. HPC is managed by the Directorate of Health (DOHI) in collaboration and consultation with local authorities and other stakeholders. The main aim of HPC is to support participating municipalities (local governments), including pre-schools, compulsory schools and upper-secondary schools, in systematic public health work, creating supportive environments and conditions that promote healthy behaviour and lifestyle, health and well-being for all, including children. With the main focus on overall well-being, the scope of HPC is broader than JOGGs main aim i.e. healthy weight. Among the strengths of the HPC programme is that it is embedded in national policy documents like the Public health policy (2016-2030). One of the main goals of such policies is that all municipalities should become Health promoting communities. The main aim of HPC also fits in well with the key focus of the Sustainable Development Goals (SDGs) that no one should be left behind in their implementation. With already set up network of 32 local HPC coordinators and steering groups around the country, one of the programmes strengths is the coordinators interest and willingness to succeed in their work. One of the main threats is that the coordinators have different experience and professional background and are likely to lack capacity and/or resources to do the work in systematic way. In June 2020 93,2% of the Icelandic population (364.134 in Jan ´20) lived in a HPC municipality. The programme has therefore a great potential to positively influence the health and wellbeing of the whole Icelandic population, including children.

The JOGG programme is built on elements known to be effective and was therefore considered a workable option to contribute to the further development of the HPC programme in Iceland. The implementation included learning from how JOGG conducts their expert support (who, how long, material etc.), including the roadmap provided for new JOGG municipalities. Also, how JOGG supports communication of the work both overall and in each municipality e.g. providing templates for communication strategies and factsheets. Following the CHRODIS PLUS implementation strategy, including the PDSA cycle, DOHIs HPC team lead the work, supported by the HPC local coordinators development team and later the national level HPC high level steering group and the Consultation platform for HPC and the SDGs.

Local HPC coordinators and steering groups are key actors and as such critical part of the structure needed for successful, systematic public health work in municipalities. The better quality of the HPC work, the more likely it will result in positive health outcomes for the final beneficiaries (target groups) i.e. children and other inhabitants in municipalities. Overall, the main aim of this intervention was to improve the quality and sustainability of the HPC programme, using innovative and practical approach when implementing selected parts of the JOGG programme. An important part of this implementation was conducting a national policy dialogue (PD, WP4), contributing to the formation of the multi-sectoral, national level HPC steering group and the Consultation platform for HPC and SDGs. Both the CHRODIS PLUS implementation strategy and the guidelines for the PD organisation were useful tools in the implementation process.

When formulating the key performance indicators and selecting the methods to monitor them, the emphasis was placed on being realistic and practical based on e.g. the nature of the intervention and available resources, including manpower. The pilot action plan was implemented fundamentally as planned and all the specific aims were either fully or to some degree fulfilled. One of the success factors in the implementation was the valuable support provided by the JOGG team, including generosity in providing material and willingness to help, e.g. regular phone meetings and contact via e-mails. The site visit was a very important part of the preparation phase, providing in-depth information about the JOGG work and opportunity to create more casual bond between parties. The availability of support from the good practice owner is critical for the implementing site and needs to be accounted for from the start. Another related lesson is the question of ownership. In this case it was settled between the implementer and the good practice owner themselves early in the process. Given the nature of the implementation, the HPC programme will not become JOGG programme but will refer to JOGG as contributor to its development.

One of the main challenges in the implementation was the extent and complexity of the overall task and the limited time frame and resources allocated it. As an example, establishing multi-sectoral platform at national level for information sharing, dialogues, consultation and to some extent joint decision making took more time and effort than anticipated. Since it was an important precursor for other key steps, the project delivery experienced delays. Since this implementation was rooted in and relevant for the existing work (not isolated, standalone project) the remaining tasks will survive the end of CHRODIS PLUS.

Short Template for reporting

General Objective: Enhanced health and wellbeing of all, incl. children, by improving the quality and sustainability of Health promoting community (HPC), implementing selected parts of JOGG and utilising National PD (WP4).	**Indicators** (1=not started, 2=in process, 3=finished)			
	Process	**Outcomes**		**Sources of information**
		Baseline	**Current value**	
Target group (TG): HPC local coordinators and steering groups (→ HPC work at local level → health and wellbeing of final beneficiaries i.e. children and others). **Specific Objectives** **SO1**: Increase the availability of supporting material and tools for local HPC coordinators and steering groups. **SO2**: Improve the capacity of local HPC coordinators to do their work in systematic way. **SO3**: Improve the structure of HPC at national level.		-TG reports need for more expert support, material and tools: Y -National level HPC Steering Committe: IP -National level Consultation platform for HPC and SDGs: IP	-More expert support provided to TG: IP -TG use of material, tools and support: IP -Steering Committee: Y n. of stakeholders involved: 7 -Consultation platf: Y n. of stakeholders involved: 22	-Material and tools developed for the HPC programme - Surveys -Meeting reports/memos -Data from the on-line working area.
Activities (change package) **SO1** -Finalize the HPC impl. guidelines/checklists, learning from the JOGG municipality roadmap. -Produce template to local communication learning from JOGG local factsheet. -Produce individualized HPC logo for all HPC. -Further develop the on-line working area heilsueflandi.is, also for monitoring of SDGs implementation (see SO3).	1.1: Publication and dissemination to TG the HPC implementation guidelines/checklists: Yes 1.2: Publication and disseminate to TG template for communication of HPC work: IP 1.3: Individualized HPC logo and the guidelines for appropriate use delivered: Yes 1.4: Version 1.0 of the on-line working area finalised and made available for TG use: Yes			- Publication (checklists etc.) available on heilsueflandi.is. -Meeting reports/memos. - Individualized HPC logos in use -The on-line working area heilsueflandi.is

SO2 -Assess the expert support and material provided. -Provide face to face workshops and on-line meetings. -Provide training webinars and/or videos. -Explore possibility to train experienced HPC coordinators to provide peer support, inspired by the expert support provided by JOGG to municipalities.	2.1: Survey among TG conducted before (3) and after publication of supporting material and tools: IP 2.2: Feasibility analysis regarding peer-training: IP 2.3: Number of events, participation and satisfaction: 5			- Surveys, reports - Meetings, reports/memos
SO3 -Learning from JOGGs, explore the feasibility to establish Scientific Advisory Board. **-**Utilise the C+ Policy Dialogue (WP4), focusing on creating synergy between the impl. of HPC programme and the SDGSs, to facilitate the involvement of key stakeholders, including ministries and agencies, in the intersectoral HPC high level steering group and the Consultation platform for HPC and the SDGs.	3.1: Feasibility of Scientific Advisory Board explored and decision made: Yes 3.2: HPC High level steering group established: Yes 3.3: HPC Consultation platform for HPC and SDGs established: Yes → Number of meetings: 3			-Meeting reports -CHROSID PLUS National Policy Dialogue report for Iceland.

Essential Elements of the Pilot Action Report

Implementation Elements of the Good Practice:

To improve the quality and sustainability of the Health Promoting Community programme (HPC) in Iceland, the CHRODIS PLUS National Policy Dialogue for Iceland was used and the following elements of the JOGG programme were explored and adapted to meet the needs of local HPC coordinators and the steering group:

- The JOGG roadmap for new JOGG municipalities.
- The JOGG communication strategy.
- Template for communication of the JOGG work at municipal level.
- The extensive expert support provided to JOGG municipalities by JOGG.
- The JOGG Scientific Advisory Board.

Major Barriers and Enablers identified during the implementation of the Good Practice

Enablers

- The valuable support provided by the JOGG programme team, including generosity in providing material and willingness to help, e.g. regular phone meetings and contact via e-mails.
- With already established network of 32 local HPC coordinators around the country, one of the most important enablers of the implementations was the coordinators interest and willingness to succeed in their work. That resulted in active involvement of selected HPC local coordinators in the implementations development team.
- Contribution of the multi-sectoral, national level HPC steering group and the Consultation platform for HPC and SDGs.
- Broad expert knowledge and good teamwork within DOHI.
- HPC programme is already embedded in national policy documents like the Public health policy (2016-2030). One of the policies main goals is for all municipalities to become Health promoting communities including preschools, compulsory schools, upper secondary schools and workplaces.
- Practical and flexible approach, real needs ahead of “fit the box”.

Barriers

- The extent and complexity of the overall task.
- Limited time frame and resources to complete the task.
- Domino effects of delays in early tasks that needed to be executed ahead of proceeding tasks.
- Unexpected challenges like moving offices twice in the period.

Major Results of the Implementation

- The pilot action plan was implemented fundamentally as planned and all the specific aims were either fully or to some degree fulfilled within the timeframe of CHRODIS PLUS. Since this implementation was rooted in and relevant to the existing work (not isolated, standalone project) the achievements will survive the CHRODIS PLUS.
- With the contribution of the CHRODIS PLUS Policy Dialogues and JOGG, the Health Promoting Community programmes quality has improved. The programme’s structure is now more solid than before, contributing to the relevance and sustainability of the programme. Due to delays in implementation, local HPC coordinators and steering groups (the main target group in this intervention) have not fully benefitted from all actions but that will be achieved in coming months.

Benefits for target groups

It is known that comprehensive, data driven, community approach, involving key stakeholders across sectors and levels is an effective way to address public health challenges. Local HPC coordinators and steering groups are key actors and as such critical part of the structure needed for successful, systematic public health work in municipalities. They were therefore defined as the target population in this intervention. The better quality of the HPC

work, the more likely it will result in positive health outcomes for the final beneficiaries (target groups) i.e. improved health behaviours, health and well-being of children and other inhabitants in municipalities.

Stakeholders and Policy Makers Involvement and Actions

In addition to DOHIs HPC team following groups provided fixed platform and pathway for e.g. sharing of information, dialogues, consultation and to some extent joint decision making.

- **Local HPC Coordinators development team.** The main LIWG in this work, involving local HPC coordinators in the Capital area.
- **The HPC high level steering group.** Representatives from DOHI, including the Director of Health, The Prime minister's office, The Ministry of Health, The Ministry of Social Affairs, The Ministry of Education and Culture, The Association of Local Authorities and The Development Centre of the Primary health care.
- **Consultation platform for HPC and the SDGs:** Representatives from the Ministry of Transport and Local Government, Ministry for the Environment and Natural Resources, Directorate of Education, Environment Agency, National Planning Agency, Icelandic Transport Authority, National Commissioner of the Icelandic Police, The Office of Ombudsman for Children, Icelandic Food and Veterinary Authority, Administration of Occupational Safety and Health, VIRK – Vocational Rehabilitation Fund, The UN Association in Iceland, The Multicultural Centre, The National Olympic and Sports Association of Iceland, The Icelandic Youth Association, Association 78 and National Association for the elderly. More stakeholders might join in the near future.

Suggestions for future Implementations, Sustainability and Replicability/Transferability of the Good Practice

- The availability of support from the good practice owner is critical for the implementing site and needs to be accounted for from the start. Another related lesson is the question of ownership and overall expectations of both parties. In this case it was settled between the implementer and the good practice owner themselves early in the process.
- Frame the work in line with current national and local governmental priorities if possible, in this case among other things the UN SDGs.
- Establishing solid structure, involving key stakeholders across sectors and levels, takes time and effort but is critical prerequisite for the relevance, quality and sustainability.
- Practical and flexible approach, taking into count different context (good practice site vs. implementing site), focusing on meeting the implementing site real needs.

1.8 Transfer of the Lombardy Workplace Health Promotion Network approach to the Andalusian WHP Programme in Spain

Abstract

Chronic diseases such as chronic respiratory conditions, cardiovascular diseases, cancer and diabetes are the leading causes of death and disability around the world. As the most important identified modifiable risk factors for chronic diseases are tobacco use, inadequate levels of physical activity and poor diets, **Workplace Health Promotion** interventions are thought to be strategic to avoid or delay the onset of chronic diseases. The present report documents the **Andalusian pilot implementation** of certain elements of the "Lombardy Workplace Health Promotion (WHP) Network" (a Good Practice identified by the Joint Action CHRODIS for the prevention of chronic diseases). This implementation is a single experience within the Joint Action CHRODIS PLUS focusing on a health promotion intervention for adults and in workplace settings. Following a common implementation strategy defined by the JA, that enables an evidence-based reporting of the defined intervention, this report shares the systematic implementation process conducted and illustrates the experience of the cross-national transfer of a practice, providing useful guidance, ideas and suggestions for future similar attempts.

In collaboration with the **Lombardy Region**, the Andalusian Regional Ministry of Health coordinated the pilot implementation in two sites: a public-private venture and a trade union (a medium- and small-sized organization, respectively). The Lombardy model was identified to fit the existing Andalusian WHP Programme because of its comprehensive and detailed continuity system, as well as the high managerial and workforce engagement attained, and the rewarding accreditation system they defined. Based upon a series of situational analyses, five categories of actions and their quantitative and qualitative indicators were decided for the Pilot Action Plan. With it, the implementers aimed to ensure, among other objectives, the organizational endorsement of WHP, the workforce participation in the actions, and the sustainability and continuity of participating organizations. Introductory sessions (on the implementation areas of healthy lifestyles) were first broadly presented to at least 50% of the total number of employees in each organization. Then, according to the Lombardy model, each organization chose, among a range of health promotion actions, two specific areas to implement (mainly, but not exclusively, healthy eating and physical activity). Each organization was advised by qualified professionals who supported and provided guidance throughout all the implementation process (creation of an internal steering group, conducting the series of general and/or in-depth practical sessions, etc.).

A quasi-experimental pre-post design without control group or randomization of participants was also conducted in an attempt to monitor a possible shift in different life habits and/or health indicators among the participants. After the first 9 months of the intervention, global results from the T-test were not found statistically significant, although specific results (comparing pre-post percentages) pointed out promising increases in physical activity among participants of both organizations, as well as an increase in healthy eating and a decrease in sweets consumption in participants of the larger

organization. Furthermore, employees in both organizations were very satisfied with the actions initiated and they regarded them as being highly useful. The highest managerial level of each organization significantly contributed to the implementation and made conditions for employees to participate. The piloting will continue for an additional two-year period, to follow-up the complete implementation of the original Lombardy 3-year cycle.

Short Template for reporting

General Objective: To implement elements of Lombardy´s JA CHRODIS Good Practice "Workplace Health Promotion" in the Andalusian Strategy of Health Promotion at Workplaces (PSLT).	**Indicators**			
	Process	**Outcomes**		**Sources of information**
		Baseline (´pre´ questionnaire)	**Current value** (´post´ questionnaire)	
Specific Objectives: **SO1**: To ensure organizational endorsement of WHP. **SO2**: To encourage workforce participation in the WHP actions. (Physical activity, Work-life balance and welfare, Healthy eating, etc.).		**2.4**: 2.4.1. 23% physical activity almost every day. 2.4.2. 11% participants consume sweets 4-5 days/week. 2.4.3. 11% participants regard healthy eating activities very useful. 2.4.4. 11% participants regard physical activities very useful.	**2.4**: 2.4.1. 35% participants do physical activity almost every day. 2.4.2. 5% participants consume sweets 4-5 days/week. 2.4.3. 90% participants regard healthy eating activities very useful. 2.4.4. 78% participants regard physical activities very useful.	EASP: ✓ Quasi-experimental pre-post analyses.
Activities (change package): **SO1**: - Certifying that the organizations are aware and take the steps to comply with regulations relevant to: Health Promotion, Social Security, Workplace and Environmental Safety. - Efficient starting and functioning of a Steering Group in each participant organization.	**1.1**: E & C certified compliance in all areas specified. **1.2**: >2 steering group meetings per month. **1.3**: >2 attendees to the steering group meetings.			CSJA: ✓ Original certifying documents. ✓ Listing of message communications and meetings (calls and minutes).
SO2: - Ensuring the majority of workers can participate in the WHP activities.	**2.1**: % employees attending the sessions: *E: 62%; C:85%*.	**2.4**: 2.4.1. 23% physical activity almost every day.	**2.4**: 2.4.1. 35% participants do physical activity almost every day.	✓ Pre&Post: EASP Analyses.

- Conducting small group sessions to deliver the messages in a practical way. - Pre & Post Assessment Questionnaires (health data, health-related habits, usefulness of intervention).	**2.2**: Number of introductory sessions: *E: 12; C: 2.* **2.3**: >50% employees responded pre-post assessment questionnaire.	2.4.2. 11% participants consume sweets 4-5 days/week. 2.4.3. 11% participants regard healthy eating activities very useful. 2.4.4. 11% participants regard physical activities very useful.	2.4.2. 5% participants consume sweets 4-5 days/week. 2.4.3. 90% participants regard healthy eating activities very useful. 2.4.4. 78% participants regard physical activities very useful.	✓ Sessions attendance lists. ✓ SS: PSLT Corporate Information System.

Essential Elements of the Pilot Action Report

Major barriers and enablers identified during the implementation

Barriers

- Lack of Workplace Health Promotion culture, awareness and knowledge (exclusive healthcare-centred approach).
- Scarcity of structural resources (personnel time and dedication, allocated funding).
- Implementation difficulties related to specific characteristics of each organization (e.g: night-shifts, attention to the public...) and employees´ daily tasks and agendas.
- Difficulty or impossibility to participate in face-to-face activities.
- Workforce reluctance to participate in company-run activities and to provide information concerning their life habits.
- Data retrieval could represent a long cumbersome additional task.
- Lack of trained personnel, particularly in the case of small and medium-size organizations.

Enablers

- Strong institutional support, close guidance and capacity-building (free-of-cost, in each specific workplace).
- Managerial endorsement and workforce involvement in the implementation from the beginning.
- Training of trainers provided by experts.
- Availability of structural resources (workhours, dedicated personnel, some funding).
- Adaptation to different times and shifts.
- Adherence to a clearly defined systematic approach.
- Broader WHP awareness.
- Availability of standard documents and guidelines.

- Exposition to different communication channels (newsletters, posters, announcements…).
- Face-to-face general sessions, workshops and informal channels of communication.
- Steering group meetings to refine any necessary action or to celebrate short term achievements.

Major results of the implementations:

- Elements of the Lombardy WHP Good Practice were efficiently implemented in two workplace settings in Andalusia (Spain).
- Main objectives of the implementation were successfully achieved:
  1) Compliance with relevant regulations was certified, WHP actions were satisfactorily carried out and planning for future engagement was also confirmed;
  2) All parties were involved from the beginning and the workforce actively participated in the WHP actions;
  3) Healthy lifestyles and awareness were enhanced in employees and they clearly valued the as very useful.
- Sustainability: continuity of the piloting to complete a full 3-year period (strongly supported by the Andalusian Administration to upgrade the original Andalusian WHP Programme ("PSLT") according to the arisen results.

Suggestions for future implementations, sustainability and replicability/transferability:

- Share a WHP long-term vision, receive support from and be accompanied by the Public Administration.
- Allocate flexible but sustained resources.
- Involve all parties from the beginning: managerial level, organizational leaders, workforce representatives, human resources, occupational & risk prevention professionals, key informants...
- Plan and define a WHP systematic uptake that embeds WHP within the organizational long-term health-related plans and strategies.
- Build upon pre-existing collaborative structures.
- Contribute to the development of legislation with clear-cut indications.
- Make use of subsidies and aids (tax allowances, agreements…) to enforce WHP implementations.
- Offer gradual but constant capacity-building, particularly of key personnel and disseminators.
- Enhance (inner & outer) visibility via new or existing communication channels and formats.
- Document all steps through.
- Collect evidence and indicators (obtain collaboration or support from experts).