CHRODIS+

IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

Andalusian Regional Ministry of Health and Families (SPAIN)

General Secretariat of Public Health

Dpt. of Health Promotion and Local Action in Health

FINAL REPORT OF THE ANDALUSIAN IMPLEMENTATION OF JA CHRODIS WORKPLACE HEALTH PROMOTION GOOD PRACTICE

Andalusian Local Implementation Working Group (WP5.2.3.B)

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Junta de Andalucía Consejería de Salud y Familias

The Andalusian Implementation of a Joint Action CHRODIS Workplace Health Promotion Good Practice

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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 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 the single one experience within the Joint Action CHRODIS PLUS (JAC+) focusing on a health promotion intervention on adults and, more specifically, in workplace settings. Following a common implementation strategy defined by JAC+ 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.

With the collaboration of 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 Andalusian existing WHP Programme the best 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 actual Pilot Action Plan aiming 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 battery of health promotion actions, two specific areas to focus and carry out (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 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. Yet, 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. Barriers, enablers and were pointed out as well as useful suggestions for future implementations.

General introduction

The present document focuses on the **Andalusian implementation** of certain elements of the JA-CHRODIS Good Practice "Lombardy Workplace Health Promotion Network[1]". This implementation is the single one experience within JAC+ adapting and focusing on intersectoral good practices of **Health Promotion and Disease Prevention (HPDH)** on adults and, more specifically, in workplace settings.

An adapted version of the SQUIRE (*Standards for QUality Improvement Reporting Excellence*) guidelines[2] is used to report the whole process of all JAC+ pilot implementations. This report you are reading is arisen from the SQUIRE 2.0 framework for reporting new knowledge and improvements in the health sector, to enhance the evidence base and transferability potential of the JAC+ implementation experiences.

The Joint Action CHRODIS PLUS (JAC+) is a three-year initiative under the European Commission´s Third Health Programme aiming to share and implement good practices to alleviate the burden of chronic diseases. In concrete, it focuses in 4 areas: health promotion and prevention, patient empowerment, management of chronic diseases and multimorbidity, and practices in the employment sector. Thus, the JAC+ is monitoring the whole process of implementation of policies and practices with demonstrated success in each of the four cornerstones above mentioned. In total, there are 42 partner organizations, representing 21 European countries. JAC+ is co-funded by the European Commission and the participating partner organizations.

JAC+ has defined a three-step implementation strategy to be followed by all implementation sites, (one of which is Andalusia, Spain, as described below). A common implementation strategy is sought in order to promote the systematic uptake of evidence-based interventions into practice, in settings that are different to the original ones. Reporting on how the whole process evolves will serve as a helpful baseline for a more efficient cross-national learning as well. In fact, one of the objectives of the JAC+ working group (Work Package, WP) of HPDH is "*to generate learning and improve the effectiveness of HPDP through supporting small scale pilots, the scaling-up and/or transfer of good practices through strengthening their adaptation and implementation*".

Problem description

Chronic diseases such as cardiovascular disease, cancer, chronic respiratory diseases and diabetes are the leading cause of death and disability around the world. It has been estimated that they cost, in the European Union, 115 billion euros (0.8% of the GDP), albeit this figure does not stand for additional losses in terms of, among others, lower employment rates and productivity of people living with chronic health problems. Among the most important identified modifiable risk

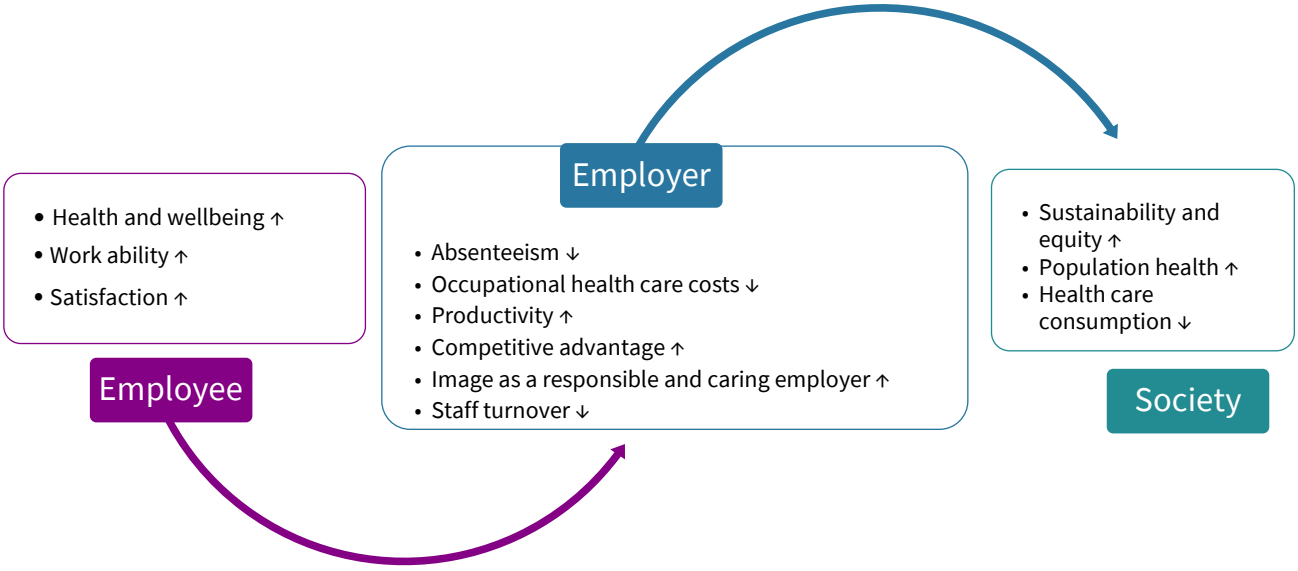
1 http://chrodis.eu/wp-content/uploads/2018/01/the-lombardy-workplace-health-promotion-network.pdf

2 Ogrinc G, Mooney SE, Estrada C, et al. The SQUIRE (Standards for QUality Improvement Reporting Excellence) guidelines for quality improvement reporting: explanation and elaboration. BMJ Quality & Safety 2008;17:i13-i32. http://dx.doi.org/10.1136/qshc.2008.029058

factors for chronic diseases are: tobacco use, inadequate physical activity and poor diets. In this context, HPDP interventions can contribute to improve the health and well-being of people at work and, consequently, **Workplace Health Promotion** (WHP) can be strategic to avoid or delay the onset of chronic diseases.

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 a healthy workplace supportive environment. The benefits of fostering the health and wellbeing of the workforce are extremely noteworthy for employees, employers and society in general and they are summarized in Fig. 2[3].

Fig. 1: Benefits of investing in employees' health, wellbeing and work participation.



Available knowledge

In 2016, JA CHRODIS identified the **Lombardy Workplace Health Promotion Network (WHPN)** as a Good Practice, based on a set of 10 ranked and weighted criteria[4]. The Lombardy WHPN targeted adult population at their workplaces, aiming to promote and enhance their healthy lifestyle by implementing a **Workplace Health Promotion Programme**. It adopted an intersectoral approach (according to the Italian-wide national program "*Guadagnare Salute*" -Gaining Health-) and, as a public-private network, it was built on partnerships and collaboration with all workplace main stakeholders: associations of enterprises, trade unions and the regional health system. Its objectives aligned with the strategic guidelines of the European Commission on Corporate Social Responsibility (CSR), and the wider strategy of the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA).

3 Reproduced with permission of Joint Action CHRODIS PLUS Word-package 8 *Toolkit for Workplaces*.

4 http://chrodis.eu/wp-content/uploads/2016/01/Dissemination_brochure_02_WEB.pdf

The Lombardy WHPN has been found[5] to elicit a reduction in some important risk factors for chronic diseases in the workforce after a 12-month participation in the programme. This represents quantifiable and significant behavioural changes that contribute in the prevention of chronic diseases and the onset of positive organizational, social and economic impacts.

Moreover, despite the existing complexities and limitations to evaluate the implementation and impact of WHP interventions, many studies and analyses (conducted since back the 1980s), alongside more recent meta-analysis and systematic reviews of the evidence 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[6] [7].

Rationale & Specific aim

The Luxembourg Declaration on Workplace Health Promotion in the European Union[8] defines WHP as "the combined efforts of employers, employees and society to improve the health and well-being of people at work. This can be achieved through a combination of: improving the work organisation and the working environment; promoting active participation; encouraging personal development". The Lombardy WHP model, certified by the European Network for WHP, can be transferred to another region and test the replicability and usefulness.

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5 Cremaschini, Marco & Moretti, Roberto & Brembilla, G. & Valoti, Marinella & Sarnataro, Francesco & Spada, P. & Mologni, Graziella & Franchin, Donato & Antonioli, Lucia & Parodi, Daniela & Barbaglio, G. & Masanotti, Giuseppe & Fiandri, R. (2015). One year impact estimation of a workplace health promotion programme in Bergamo province. *La Medicina del lavoro*. 106. 159-171

6 Burton, J. WHO healthy workplace framework and model: background and supporting literature and practices. World Health Organization, 2010.

7 Baxter S, Sanderson K, Venn AJ, Blizzard CL, Palmer AJ. The relationship between return on investment and quality of study methodology in workplace health promotion programs. American Journal of Health Promotion. 2014; 28:347–363.

8 https://www.enwhp.org/resources/toolip/doc/2018/05/04/luxembourg_declaration.pdf

In Spain, the region of Andalusia counts with a WHP Programme that can implement elements from the Lombardy WHP Good Practice. This experience of implementation can provide practical and useful evidence to this field of inquiry, help future implementers and serve (if the results are encouraging) for a potential scaling up of the model. Hence, **our intervention aimed at 1) implementing elements of Lombardy´s JA CHRODIS Good Practice "Workplace Health Promotion" in the Andalusian Strategy of Health Promotion at Workplaces (PSLT); 2) gaining evidence from this transferring and implementing to better promote the employees´ health and participation and the continuity of the organizations involved.**

Methods

Context

The region of Andalusia has been certified by the Spanish Ministry of Health as being implementers of the highest number of Best Practices in Health Promotion in Spain[9]. The **Andalusian Programme of Health Promotion at Workplaces** (PSLT[10] by its acronym in Spanish) comes from the seasoned *Smoke Free Companies* intervention (dated from 2005) that evolved, it started including areas other than smoking prevention/cessation (i.e: the promotion of physical exercise, healthy eating and healthy environments) and, in 2012, it was renamed as.

Administratively, 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 General Directorate of Public Health of Andalusia. Because Andalusia is the second largest region in Spain (87.600 km^2) and the most populated (9 million inhabitants), the coordination of the Programme is, in turn, divided into 2 main geographical areas: Eastern and Western, with a representative (contact person) in each. In addition, Andalusia is divided into 8 Delegations (1 per each province) and a number of Health Districts and Health Management Areas, where Health Promotion professionals also act as deliverers of the WHP Programme.

The Lombardy model was identified to fit PSLT the best, above all, because of its comprehensive and detailed continuity system, as PSLT has been facing the challenge to recruit and involve a larger number of companies, and to keep them carrying out for a prolonged period of time. Other features of the Lombardy model are also thought to be source of inspiration for the Andalusian PSLT Programme, such as the involvement of the managerial level, the participation of the workforce and a rewarding recognition system for the organizations. Andalusian representatives met directly with the experts, coordinators, implementers, participants and stakeholders of the Lombardy practice (see Agenda in ANNEX 1). Two visits to real sites were also done to refine and complement the information with the practicalities described by real-life staff and users.

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9 https://www.mscbs.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/docs/MemoriaBuenasPracticasEstrategia_2014.pdf

10 http://juntadeandalucia.es/organismos/salud/areas/salud-vida/adulta/paginas/salud-trabajo.html

As already stated before, we followed the three-step implementation strategy defined by JAC+ for all sites. For the WHP actions in the participant organizations we proceeded according with the guidelines received from the Lombardy counterparts and the operating instructions described in a number of the Italian resources, most notably the *Lombardy WHP Manual* (User´s Guide)[11].

SCOPE definition meetings (Sevilla)

A series of two preparatory meetings took place on May 30 and June 22, 2018, in Seville, in the Central Offices of the Regional Ministry of Health of Andalusia. The core working group participated, composed by the Chief of the Department of Health Promotion in the Regional Ministry, the CHRODIS PLUS Project Managers and the PSLT Andalusian Coordinator. Given the specifics of this WP5.2.3.B task, it was necessary to define the central features or elements of the donor good practice, so that the following meeting with all the *Local Implementation Working Group* (LIWG) could run with more ease. In concrete, the evidence, the information learnt on-site during the study-visit, and the most feasible features were all analyzed and discussed. A battery of features and elements was finally identified so that the LIWG could choose according to their local needs, interests and capabilities. This was to be completed during the first LIWG meeting and SWOT session.

Fig. 2: Main elements of the Topic identification and Scope definition

ITEM	DESCRIPTION
Problem / Challenge	• Workplaces are strategic places to carry out health promoting actions so as to avoid/delay the onset of chronic diseases. • There is a need to recruit and maintain companies involved in a regional programme to promote health at the workplace.
General purpose of the intervention	• Gaining experience and obtaining evidence from implementing, into the Andalusian PSLT Programme, selected elements adopted from the Lombardy WHP Good Practice so as to promote health & wellbeing of the employees.
Target population	• Employees of all sorts and levels in EMASAGRA, a public-private joint venture for water management, and CSIF, the third trade union at the state level, both based in Granada, Andalusia (Spain).
Topic identification: Central features/elements	• Ensure managerial support and regulatory compliance, • Set cycles for carrying-out the practice, • Continuity and recognition system, • Stimulate participation.

11http://www.ats-bg.it/upload/asl_bergamo/gestionedocumentale/manuale-whp-lombardia-2014-inglese2_784_24919.pdf

LIWG Meeting & SWOT Session (Granada)

The WP5 Andalusian LIWG met on June 27, 2018, in the main headquarters of the *Granada Metropolitan Health District*. The group consisted of 16 participants representing a wide variety of profiles, sectors and experience levels (such as: front-line stakeholders, implementers, trade unions and companies' representatives, decision makers and experts).

A detailed description of the SWOT analyses technique, the meeting, list of the participants and complete results was presented in two reports (*Spanish*[12] *and English*[13]) that were distributed to all participants as well as to the Italian partners.

Fig. 3: SWOT Matrix with the most important categories of selected factors

STRENGTHS	WEAKNESSES
• Previous experience (in WHP). • Managerial involvement. • On-going training. • Communication systems for employees. • Availability of support and resources.	• Low participation of professionals in the company-run activities. • Scarce support staff (from the Administration).
OPPORTUNITIES	**THREATS**
• Health results evidence • Institutional recognition • Commitment and support to Health Promotion interventions	• Consideration of Health Promotion as a low level intervention • Healthcare approach vs Health Promotion.

Fig. 4: Improvement areas ranked by the LIWG

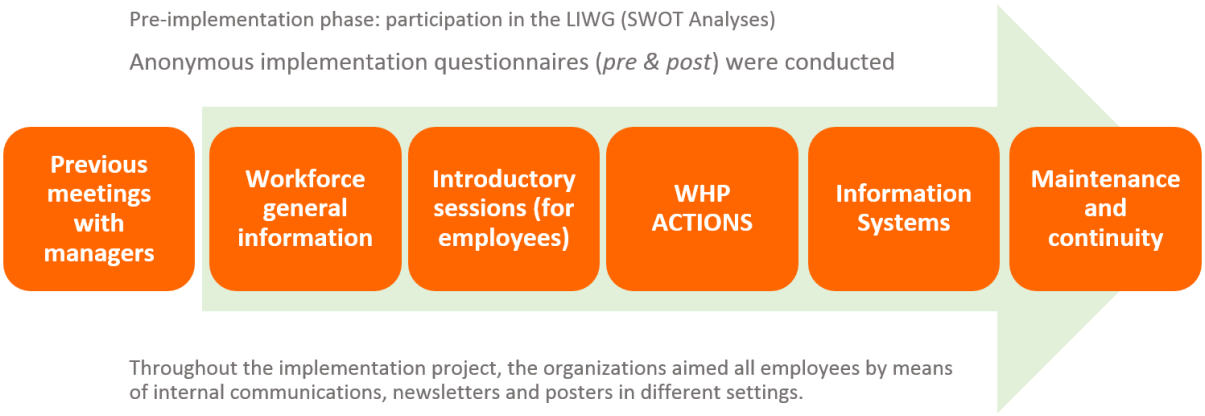
IMPROVEMENT AREAS	RANKING
Managerial involvement in WHP interventions	**1**
Enhancing employee's motivation to participate in HPDP sessions and activities	**2**
Administrative support of the organizations to run WHP interventions	**3**
Compile WHP Good Practices to undertake them in the short, medium and long term	**4**
Enhance communication via new or existing channels (social networks, intranet ...)	**5**

12 Pre-implementación de Buenas Prácticas intersectoriales en Promoción de la Salud. Primera reunión para la implementación local. Consejería de Salud y Familias de la Junta de Andalucía. Julio 2018.

13 Andalusian Local Implementation Working Group. Pre-implementation Phase Report. Andalusian Regional Ministry of Health and Families. September 2018.

Intervention in a nutshell

The departing points were a series of preliminary contacts and explanatory meetings with representatives of each potential participant organization. As they progressed well, meetings frequently involved mutual top managerial levels and typically led to a formal agreement of collaboration in the implementation to be piloted. The organizations finally recruited to participate in the pilot implementation were EMASAGRA and CSIF-Granada for their features, public-private venture vs trade union and, respectively, medium- and small-sized organizations (see profiles in page 14). Subsequent mutual exchange of information was necessary to detail and refine collaboratively the next steps to take, i.e.: preparing the change package and indicators, ensuring the organizational regulatory compliance, preparing the information for the workforce, conducting the introductory sessions as well as the anonymous assessment questionnaires, deciding and carrying out the WHP actions, and finally retrieving the information from the implementation of the actions.



Pilot Action Plan

Derived from the previously mentioned improvement areas (Fig. 4), and based upon the situational analysis above described, the actual Pilot Action Plan (PAP) was agreed containing the selected Lombardy´s WPH Good Practice elements to implement in Andalusia (five essential categories of actions), the objectives and the quantitative and qualitative indicators (see definitions and descriptions in Fig. 5). They were all presented to and consented with the Italian counterpart. Conclusions from the process and outcome indicators and all other relevant collected data are presented in Results (p. 15).

Participation was entirely free of cost and voluntary. No conflicts of interest were declared by the members of the LIWG. No specific ethical considerations were required. WHP activities were communicated and offered to all the employees in each participant organization. Collected data was treated confidentially according to the EU General Data Protection Regulation and was stored in protected files. Health data and profiles from the health and safety services of each organization were anonymous. Questionnaires and satisfaction surveys were also completed anonymously and the identification of individual respondents was not possible.

Fig. 5: Definition and details of actions and indicators

ACTION CATEGORY	***Definition***	***Objectives***	***LIWG ranked areas /Lombardy model***	***Time line***	***Key performance indicators***
1. CREATION OF A STEERING GROUP	Efficient starting and functioning of a Steering Group in the organizations where the JAC+ implementation are to be piloted.	1) To ensure the endorsement of the implementation by the company´s highest managerial levels. 2) To specify, refine and complement any information about the actions to implement. 3) To strengthen cooperation, both internally and externally, to efficiently carry out the implementation.	*Corresponds with the first ranked improvement area selected by the LIWG.*	From month (M) 1 forward.	a) 2 or more representatives of the company´s steering group involved in LIWG meetings (Y/N). b) Number of work meetings and communications to exchange and refine the information on the PAP (2 or more).
2. ENSURING REGULATORY COMPLIANCE	Certifying that the company is aware of and takes the steps to comply with laws, policies, and regulations relevant to the areas of Health Promotion, Workplace Safety and Environmental Safety.	1) To confirm that the organization complies with the national and regional regulation on the following areas: a) Social Security. b) Workplace and environmental safety. c) Occupational risk prevention.	*Essential preliminary step in the Lombardy WHP Model.*	M 1-2	a) Certified compliance in all the areas specified (Y/N/NA).
3. PRE & POST IMPLEMENTATIO N TESTS	Carrying out anonymous assessment questionnaires previous and after the implementation.	1) To detect any specific areas where a particular attention or emphasis should be given. 2) To document any possible shift occurring after implementing the activities.	*Follows Lombardy WHP Model*	Pre-test: M 1. Post-test: M 12.	a) At least 50% of the personnel of each participating organization respond the questionnaires.
4. PROMOTING EMPLOYEE PARTICIPATION IN THE WHP ACTIONS	Encourage the communication with and the participation of the largest number of employees in the WHP activities.	1) To carry out small group sessions where the delivery of the messages and the participation of employees will be enhanced. 2) To ensure that the majority of workers participate in the proposed activities (achieve at least 60% of the total number of workers attending the introductory sessions).	*Corresponds with the second and fifth ranked improvement area selected by the LIWG.*	M1 forwa rd.	a) Number (and P%) of employees participating in the introductory sessions and proposed WHP activities. b) Number of newsletters and board notices on the HP activities… c) Logbooks and (graphic) records of activities.
5. ADOPTION OF A WHP CERTIFICATION SYSTEM	Accreditation system in line with Lombardy´s WHP Programme to enhance the correct implementation of Workplace Health Promotion actions.	1) To be able to offer a recognition system to enhance correct implementation of Health Promotion actions in the Workplaces.	*Follows Lombardy WHP Model.* *Corresponds with the third and fourth ranked improvement area selected by the LIWG.*	M 1-12.	a) WHP certification will be offered after confirmation that a minimum number of (at least 2) good practices has been carried out in two different intervention areas (Y/N/NA).

EASP: Andalusian School of Public Health; E: EMASAGRA, C: CSIF; CSJA: Andalusian Regional Ministry of Health and Families

Fig. 6: Profile of organizations participating in the pilot

EMASAGRA is a joint public-private venture* based in the city of Granada (Andalusia, Spain) that provides service to the city of Granada as well as to 14 municipalities in the metropolitan area of Granada. It manages all processes related to the water cycle: catchment, drinking water treatment, transport and distribution for human consumption with full health guarantees in the city of Granada and 14 municipalities in the metropolitan area of Granada (population served: 384.874 inhabitants; area of supply: 275km^2).

(*) Granada City Council as its main public shareholder (51%) and Hidralia SA as private partner (49%).

Number of workers: 200 (70% male).
Website welcome page (in Spanish): https://www.emasagra.es/presentacion

Areas proposed (Lombardy WHP model)

Promotion of Physical Activity:
Promoting opportunities to do physical exercise: setting up an exercise room with equipment accessible for all workers, in-house information campaign encouraging the use of stairs, corporate walking group…

Work-life balance & Welfare area:
Organizational measures (such as flex-time, smart working, time saving facilities) to foster conciliation of personal- and work-life balance.

CSIF is the Public Official's Independent Trade Union, being consolidated as the third trade union at the state level. It is integrated in the European Confederation of Independent Trade Unions. The implementation will take place at the Granada Headquarters.

Number of workers: 35 (50% female).
Main CSIF Website (in Spanish): https://www.csif.es/contenido/nacional/general/203671

Areas proposed (Lombardy WHP model):

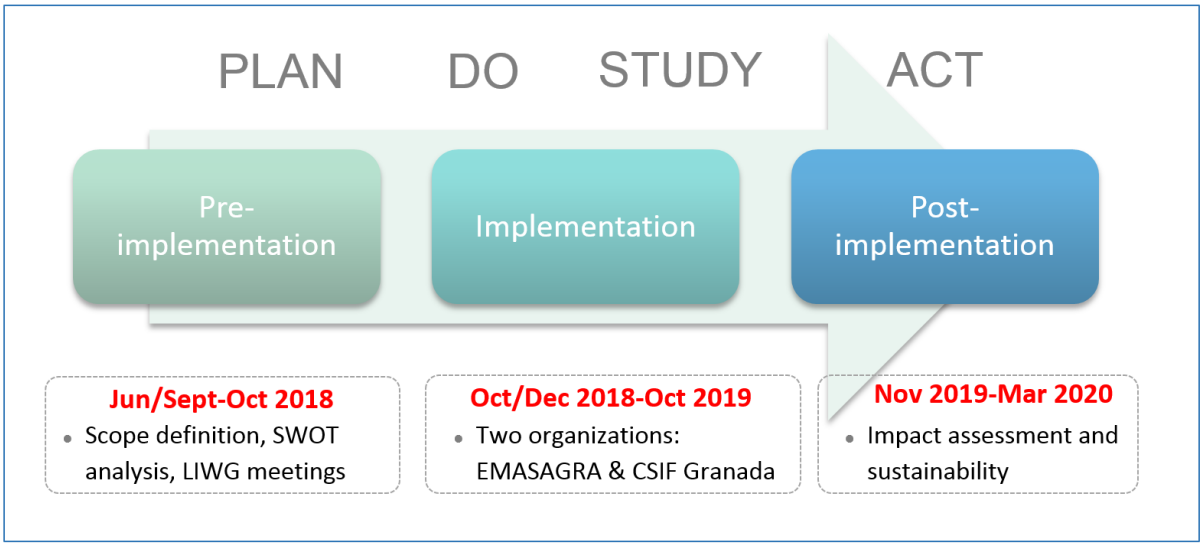
Promotion of Healthy Eating:
In-house information campaign, practical workshops in small group, and fruits and/or fresh seasonal vegetables available for employees at least 2 days a week, provided by the organization.

Tobacco Control:
Smoke-free organization providing support for smoking cessation.

Results

In brief, after the series of preliminary meetings and communications with the participant organizations, both of them were already undertaking their Pilot Action Plan (PAP) actions in December 2018 (for a concise implementation timeline, see Fig 7). The Regional Ministry of Health first collected from each organization the essential documents that certified their **compliance with the pertinent national and regional regulation** (basically referred to social security; workplace and environmental safety; and occupational risk prevention) -this aligns with specific objective 1 (*SO1*) and provided key performance indicator 1.1 (*KPI 1.1*; the main objectives, outcomes and indicators can be tracked easily in Fig 8). In parallel, a **Steering Group was created in each organization** and representatives from all parties were engaged from the very beginning: employees, managers, risk prevention and human resources professionals (representatives from the public Administration also participated in several of these meetings). The average number of Steering Group meetings in each organization was at least 2 per month (*KPI 1.2*) and the number of people involved in them was an average of 6 in the medium-sized organization, and 3 in the small-sized organization (*KPI 1.3*). To **encourage the participation of the workforce** (*SO2*) in the face-to-face sessions (WHP selected actions), organizations made use of different communication channels (posters, newsletters and announcements…) and facilitated that the majority of employees could take part in them. As an example (accounting for *KPI 2.1* and *KPI 2.2* respectively), attendance to the 12 introductory sessions was 62% of the employees in EMASAGRA; and 85% of the employees to the 2 introductory sessions held in CSIF. Personnel unable to attend the sessions (e.g: due to impeding shift hours) received the transmission from a trained colleague who had (formally or informally) been designated as disseminator. Subsequent WHP sessions continued to be announced and effectively endorsed by the organization. Pre-existing informal collaborative networks were also used, which added on, and enhanced, the visibility and gradual uptake of the WHP actions.

Figure 7: Implementation timeline



According to the Lombardy WHP model, each organization had to implement, in total during the first year, at least three actions, chosen from a pool of 6 health promotion areas[14] and more than 60 proposed actions. As shown in Fig. 6, the practices adopted by EMASAGRA were, on the one hand, the "**Physical activity**" area: promoting opportunities to do physical exercise, mainly by means of setting up a health and exercise

14 Promotion of physical activity, Promotion of healthy eating; Promotion of sustainable mobility and road safety; Work-life balance and welfare; Tobacco Control; Alcohol & addictions.

hall accessible to all workers, encouraging the use of stairs, and sponsoring the HPDP intervention "*For a Million Steps*" (corporate walking groups with the aim to achieve the goal of making a million steps together). On the other hand, the other area adopted by EMASAGRA was "**Work-life balance and welfare**", in which they fostered the introduction of different work organizational measures, such as flex-time, city-pack and smart working, all ending up included in the organization´s detailed conciliation plan. In turn, CSIF focused, on the one hand, in the "**Healthy eating**" area by: making fruit and/or fresh seasonal vegetables available for employees 2 days a week, and conducting small-group practical workshops on healthy eating. On the other hand, although they initially thought of conducting smoking-cessation groups, this plan was discarded (postponed for a following year) because the number of participants initially needed to start these groups was not met. In exchange, "**Physical activity**" area was adopted and the HPDP intervention "*For a Million Steps*" was carried out, turning out to be a highly useful tool for group cohesion and support, as will be later discussed. Both organizations also run in-house information campaigns encouraging participation and putting forward key messages of the respective chosen areas.

It is relevant to mention that, in an attempt to detect a possible shift in life habits and/or health indicators, a quasi-experimental pre-post design without control group or randomization of participants was conducted. For this purpose, a translated Spanish version of the original Italian questionnaire was used. The survey, normally employed in Lombardy in months 1, 12 and 36, enquires respondents about subjects such as frequency of fruit and vegetables intake, sweet or tobacco consumption, physical exercise, among others. For this JAC+ pilot action plan, **the pre- and post-implementation questionnaires** were conducted at the initial and final months of the actual implementation of the WHP actions (this meant, in our case, after an average period of 9 months). Questionnaires were anonymous. To be able to link answers with respondents before and after the intervention to enable the subsequent analyses, participants were asked to use as an identifying variable the last 5 digits and the letter of their national identification number. Organizations provided all the necessary conditions for these questionnaires to be responded on-line; for those few cases when this was not possible, printed copies were supplied. As seen in the following table, more than 50% of the employees (*KPI 2.3*) responded to these questionnaires. 74 participants were identified who completed both pre and post questionnaires.

Participant Organization	PRE-Questionnaires	POST-Questionnaires	PRE-POST linked respondents
EMASAGRA	113 (*57%*)	119 (*60%*)	65
CSIF Granada	33 (*94%*)	20 (*57%*)	9
TOTAL	**146**	**139**	**74**

The *Andalusian School of Public Health* (EASP) was responsible of the technicalities of the on-line survey as well as the analyses of the data[15]. Basically, two types of analyses were carried: T-tests for continuous variables in related samples, and percentage comparisons for descriptive tendencies and qualitative variables. In general, statistically significant changes were not observed when analysing data from the first and second questionnaire. Comparing pre-post percentage differences when carrying out organization-segmented analyses shows certain positive tendencies such as the following. In the group of respondents from EMASAGRA there seems to be a decline in the frequency of sweets consumption (4 or 5 times/week: 10.8% vs. 4.6%) as well as in the absence of physical activity (from 70.8% to 58.5%). In the opposite side, an increase there seems to be observed in the percentage of people declaring they practiced some physical activity almost every day (from 23.1% to 35.4%). In relation to CSIF, some positive changes related to

15 A complete 27 pages Report authored by the *Andalusian School of Public Health* (in Spanish) is available upon request.

healthy eating and physical activity also appear to be observed, although the total number of participants who completed both questionnaires is very small and this makes comparability difficult. Respondents from both organizations clearly valued positively the implementation of health promotion action in their workplace and there is an evident increase in the percentage of people who consider these actions "very useful".

Both organizations reported (audio visually and in written) their running of the activities (*KPI 3.1*) as well as confirmed the areas and actions to perform during the following period (*KPI 3.2*). It should be noted that, although the JAC+ PAP only comprises a 1 year period, the Andalusian Administration is aiming to continue the piloting of the WHP model in both organizations for another 2 years, in order to reach a full 3-year round period as it is originally devised by the Region of Lombardy. KPI 3 credited the concession of the award (or institutional certification) from the Andalusian Regional Ministry of Health to the participating organizations to **certify and recognize the correct implementation of the WHP actions** (*SO2).*

Discussion

Implementation process

Members of the implementation group reflected upon the barriers, enablers and suggestions for future implementations (see Table in p 24). The **main facilitators** reported were: a) the strong institutional support and close guidance free-of-cost and conveniently offered in each specific workplace; b) this allowed a useful and operative capacity-building of key-people (*training of trainers*) in each respective organization (they became qualified disseminators who amplified the effect of the training, making other people in each organization be aware and informed about the WHP actions); c) they also became both formal and informal leaders of the implementation and adhered to the clearly defined systematic approach; d) each organization made some structural resources available (workforce time availability, dedicated personnel, some allocated budget) which signified the clear high managerial support and endorsement of the implementation; e) the workforce involvement in the *Steering Group* from the very beginning.

Some of the **barriers** found during the implementation included: a) lack of a WHP foundation culture and knowledge (which was gradually overcome by the exposition to standard documents and guidelines, face-to-face general sessions and workshops; regular communications); b) difficulties related to specific characteristics of each organization (e.g: night-shifts, geographic dispersion....) –they were overcome by offering different schedules and/or by means of the trained employees; c) initial workforce reluctance to participate in company-run activities and to provide information concerning their life habits by questionnaires that were perceived long and cumbersome (the initial reluctance was greatly overcome in the introductory general sessions, and/or practical workshops, as well as by means of the different channels of internal communication used; the questionnaires would need to be shortened in future editions).

Some **suggestions for future implementations** follows: a) Involve all parties from the beginning (organizational leaders, workforce representatives and human resources/occupational & risk prevention professionals); b) plan, define and share a WHP systematic uptake, embedding WHP within the organizational long term health-related strategies; c) invest in capacity-building of key personnel and disseminators and build upon pre-existing collaborative structures; c) document all steps and collect evidence and indicators; d) enhance visibility via different channels and formats; e) contribute to private or public networks; f) aim to allocate flexible but sustained resources; g) receive support from or be accompanied by the Public Administration; demand legislation with clear-cut indications; e) Receive support from and be accompanied by the Public Administration.

Fig. 8: Main outcomes of the Pilot Action Plan

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 Objective 1 (SO1): To ensure organizational endorsement of WHP.				
Activities 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.	**1.2**: Certified compliance in all areas specified. **1.2**: >2 steering group meetings per month **1.3**: >2 attendees to the steering group meetings	N/A	N/A	CSJA: ✓ Original certifying documents. ✓ Listing of message communications and meetings (calls and minutes).
Specific Objective 2 (SO2): To encourage workforce participation in the WHP actions.				
Activities SO2: • Ensuring the majority of workers participate in the WHP activities. • Conducting small group sessions to deliver the messages in a practical way. • *Pre & Post Assessment Questionnaires* (health data, health-related habits, usefulness of intervention).	**2.1**: % employees attending the sessions: *E: 62%; C:85%*. **2.2**: Number of introductory sessions: *E: 12; C: 2.* **2.3**: >50% employees responded pre-post assesment questionnaire	**2.4**: (sample highlighted items) ➢ E: 23% physical activity almost everyday. ➢ E: 11% participants comsume sweets 4-5 days/week. ➢ C: 11% participants regard healthy eating activities very useful. ➢ C: 11% participants regard physical activities very useful.	**2.4**: (positive differences) ✓ E: 35% participants do physical activity almost everyday. ✓ E: 5% participants comsume sweets 4-5 days/week. ✓ C: 90% participants regard healthy eating activities very useful. ✓ C: 78% participants regard physical activities very useful.	✓ Pre&Post: EASP Analyses. ✓ Sessions attendance lists. ✓ SS: PSLT Corporate Information System.
Specific Objective 3 (SO3): To enable the continuity of the engagement of participating organizations.				
Activities SO3: • Accredit correct implementation and planning of continuation. • Institutional certification of the correct implementation of actions (in line with Lombardy´s WHP Model).	**3.1**: ≥ 2 good practices in two different intervention areas.	N/A	**3.2**: Existing 2-year planning of continuation with ≥ 2 new good practices per year/per organization.	CSJA: ✓ Reports of activities and meeting minutes. ✓ WHP certification.

Legend: C: CSIF; CSJA: Andalusian Regional Ministry of Health and Families; EASP: Andalusian School of Public Health; E: EMASAGRA; SS: Satisfaction survey.

Summary

The Lombardy WHP Good Practice was identified to fit the Andalusian existing 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 the series of situational analyses above described, five categories of actions and their quantitative and qualitative indicators were decided for a Pilot Action Plan aiming 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 healthy lifestyles were first broadly presented to more than 50% of the total number of employees in each organization. Then, following the Lombardy model, each one organization chose among a different health promotion areas and a number of actions, at least two specific areas to focus and carried out more elaborate actions (finally, they mainly focused on 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 detect a shift in different life habits and/or health indicators among the participants. After the first 9 months of 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. Yet, 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.

Limitations

On the one hand, having been a pilot, it could be put forward that conditions might slightly differ to standard situations. Organizations might have received a close monitoring (which is desirable to extend to all prospective organizations), but it should be kept in mind that all organizations taking part in the implementation of WHP actions do so in a voluntary way, so equally positive predisposition may be inferred to all.

On the other hand, the business fabric of Andalusia is quite different from that originally existing in Lombardy. In general, large organizations may find it easy to engage in this type of intervention, through their Human Resources Dept. and/or Occupational Health and Risk Prevention Services. The majority of companies in Andalusia, however, since they are small or medium size, would find more difficult to carry out this type of interventions on their own. To overcome this, expert support is provided by the Public Administration. In the past, Andalusia have also relied upon entrepreneur associations, employers' confederations, and associations of healthcare mutual insurers to channel the assistance.

Conclusions

- 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: Strong back-up from the Andalusian Administration, continuity of the piloting up to a complete 3-year period; plans to upgrade the Andalusian "PSLT" according to the results that arise.

Funding and sustainability

The specific implementation reported in this document arises from the Joint Action CHRODIS PLUS, co-funded by the European Commission Health Programme 2014-2020 and the Regional Ministry of Health and Families of Andalusia.

The Regional Ministry of Health and Families of Andalusia (Spain) is the main conceiver and primary driver of WHP actions in this region, which is the average size of an EU MS (87.597 km^2; 8.5 M inhabitants). WHP is defined by the *IV Andalusian Health Plan* (2014-2020) and is enshrined by the *Andalusian Law on Public Health* (art. 33), so its implementation is embedded in the long-term plans and strategies of the present leaders and policy makers. In concrete, the WHP Programme (´PSLT´) is run and coordinated by the Service of Health Promotion and Local Action in Health, under the General Directorate of Public Health of Andalusia. Around 50 people are currently on the payroll of the Andalusian government involved in carrying out Workplace Health Promotion in Andalusia.

All necessary guidance, training and accompaniment is offered by the Andalusian Public Health Administration completely free-of-cost. Notwithstanding, some organizational structural resources might be needed in addition to the personnel dedication but they are entirely to be decided by each participating organization. This implementation has received sustained political back-up and, in fact, the piloting will continue for another two (2) years, fully sponsored by the Andalusian Administration, to enable testing the model as originally devised.

2. Barriers, enablers and suggestions for future implementations (table)

	Barriers	Enablers	Suggestions
S	• Lack of Workplace Health Promotion culture and knowledge (exclusive healthcare-centred approach).	• Strong institutional support, close guidance and capacity-building (free-of-cost, in each specific workplace).	• Share a WHP long-term vision. • Receive support from and be accompanied by the Public Administration. • Allocate flexible but sustained resources.
O	• Scarce structural resources. • Workforce reluctance to participate in company-run activities and to provide information concerning their life habits. • Implementation difficulties, related to the characteristics of each organization (e.g: night-shifts, attention to the public...) and employees´ daily tasks and agendas.	• Managerial endorsement and workforce involvement from the beginning. • Training of trainers provided by experts. • Availability of structural resources (workhours, dedicated personnel, some funding -optional) • Adaptation to different times and shifts.	• Involve all parties from the beginning: managerial level, organizational leaders, workforce representatives, human resources, occupational & risk prevention professionals... • Plan and define a WHP systematic uptake embedding WHP within the organizational long-term health-related plans and strategies.
E	• Lack of trained personnel, particularly in the case of small and medium-size organizations.	• Adherence to a clearly defined systematic approach. • Broader WHP awareness. • Availability of standard documents and guidelines.	• Development of legislation with clear-cut indications. • Subsidies and aids (tax allowances, agreements…) to enforce WHP implementations.
C	• Geographic dispersion of Centres. • Difficulty or impossibility to participate in face-to-face activities.	• Exposition to different communication channels (newsletters, posters, announcements…). • Face-to-face general sessions, workshops and informal channels of communication.	• Gradual but constant capacity-building of key personnel and disseminators. • Enhance visibility via new or existing channels and formats. • Building upon pre-existing collaborative structures prompts mutual support and networking.
M	• Long cumbersome questionnaires.	• Steering group meetings to refine any necessary action or to celebrate short term achievements.	• Document all steps through. • Collect evidence and indicators (obtain support from experts).

***S**= Sustainability; **O**= Organization; **E**= Empowerment; **C**= Communication; **M**= Monitoring & Evaluation*

3. Short Guidance on Sustainability and Replicability/Transferability

Institutional: The Andalusian Regional Ministry of Health (CSJA) in Spain delivers various health promotion programmes and actions for the whole region of Andalusian (87.597 km2; 8.5 M inhabitants; the average size of an EU MS). Workplace Health Promotion is defined by the *IV Andalusian Health Plan* (2014-2020) and enshrined by the *Andalusian Law on Public Health* (art. 33), making CSJA be the main conceiver and primary driver of WHP actions in Andalusia. This implementation has received sustained political back-up and it is embedded in the long-term plans and strategies of the present leaders and policy makers. In fact, the piloting is being extended for another two (2) years to enable the testing of the whole Lombardy model as was originally devised.

Stakeholder's involvement: Diverse parties have been directly involved since the very beginning (policy makers, healthcare professionals, workforce in the private and public sector, trade unions, academy…) and they all have representatives participating in the Local Implementation Working Group. Strong managerial endorsement and workforce involvement in the implementation has been identified as a key collaboration factor.

Intersectoral collaboration: The creation of a steering group (where members of the Health Public Administration and each participant organizations were represented) was an example of a successful and enriching intersectoral collaboration. A carefully tailored adaptation of the Lombardy Model to each specific organization was possible with the guidance of the Administration and the valuable contributions of all other partners involved (including the practice owner representatives). Furthermore, the inter-sectoral action has stimulated both inter- and intra-sectoral collaboration: Healthcare District professionals, Regional officers and Public Health experts working alongside with Human Resources Departments, Occupational Health & Risk Prevention professionals; workers representatives, etc ...who, in turn, also worked side by side in the implementation at their workplace (see Annex 2 and acknowledgements).

Allocation of resources: All necessary guidance, training and accompaniment is offered by the Andalusian Public Health Administration completely free-of-cost. However, in addition to the time the workforce may dedicate to meetings, informative sessions or participation in practical workshops (if they are to be carried out during workhours), some structural resources might also be needed. They may range from a very basic time dedication of certain personnel (for training, preparation of WHP actions or

dissemination of activities) to a more dedicated contribution of a team; or from making available some already existing facilities to funding the acquisition of consumables goods (such as to provide seasonal fruits) or to install brand new equipment (e.g: for a gym). Nevertheless, the allocation of these resources is flexible and entirely to be decided by each participant organization.

Organizational changes: Health issues are complex problems determined by and interrelated with many different circumstances. WHP interventions closely relate to the *Health in All Policies* approach which, in turn, usually refers to all those various factors that significantly can determine the health status of individuals and populations. Rising awareness about WHP brings benefit to all interested parties: employees, employers and society in general. A sensible organization will look at these WHP actions also as their Corporate Social Responsibility and contribution to society and should be part a long-term strategy and vision. Taking part in this action was signalled by the presence of relevant Regional Ministry Officers and enjoyed of a wide dissemination (both internally and externally), this aspect seems to be a very attractive bonus.

4. Essential elements of the Pilot Action Report

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.		**2.4**: ➢ E: 23% physical activity almost everyday. ➢ E: 11% participants comsume sweets 4-5 days/week. ➢ C: 11% participants regard healthy eating activities very useful. ➢ C: 11% participants regard physical activities very useful.	**2.4**: ✓ E: 35% participants do physical activity almost everyday. ✓ E: 5% participants comsume sweets 4-5 days/week. ✓ C: 90% participants regard healthy eating activities very useful. ✓ C: 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. • Conducting small group sessions to deliver the messages in a practical way. • Pre & Post Assessment Questionnaires (health data, health-related habits, usefulness of intervention).	**2.1**: % employees attending the sessions: *E: 62%; C:85%*. **2.2**: Number of introductory sessions: *E: 12; C: 2.* **2.3**: >50% employees responded pre-post assesment questionnaire.	**2.4**: ➢ E: 23% physical activity almost everyday. ➢ E: 11% participants comsume sweets 4-5 days/week. ➢ C: 11% participants regard healthy eating activities very useful. ➢ C: 11% participants regard physical activities very useful.	**2.4**: ✓ E: 35% participants do physical activity almost everyday. ✓ E: 5% participants comsume sweets 4-5 days/week. ✓ C: 90% participants regard healthy eating activities very useful. ✓ C: 78% participants regard physical activities very useful.	✓ Pre&Post: EASP Analyses. ✓ Sessions attendance lists. ✓ SS: PSLT Corporate Information System.

Legend: C: CSIF; CSJA: Andalusian Regional Ministry of Health and Families; EASP: Andalusian School of Public Health; E: EMASAGRA; SS: Satisfaction survey.

Summary of 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 (strong backed from the Administration and plans to upgrade the Andalusian "PSLT" according to the results that arise.

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.
- Building upon pre-existing collaborative structures prompts mutual support and networking.
- Contribute to the development of legislation with clear-cut indications.
- 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).

5. ANNEXES

ANNEX 1. Agenda of the Milano study-visit

Co-funded by the Health Programme of the European Union

CHRODIS+
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

Adaptation and implementation of intersectoral good practices: the Lombardy Program
"Workplace Health Promotion: the WHP Lombardy Network" (WP5 – Task 5.2)
Study Visit 22nd – 23rd May 2018

22nd May 2018
Milano, Piazza Città di Lombardia 1
Lombardy Region Building (Orange Room n°10, 8th floor, Nucleus 4)

10.00 –10.15	Welcome note	Liliana Coppola, DG Welfare, Lombardy Region Roberto D'Elia, Ministry of Health, Italy Matilde Leonardi,Foundation IRCCS Neurological Institute Carlo Besta, Chrodis Plus, WP8 Coordinator
10.15 -10.30	CHRODIS+: Transfer and translation of good practices in health promotion and disease prevention	Claudia Marinetti, EuroHealthNet, Chrodis Plus, WP5 Coordinator
10.30 – 11.00	The Andalusian "Health Promotion at Workplaces" Programme	Francisco Javier Dolz López, Distrito Sanitario Granada Metropolitano
	Promociòn de la salud en los lugares de trabajo	Francisco Ruiz Domínguez, Andalusian Regional Ministry of Health
11.00 – 11.30	The Workplace Health Promotion network: detailed presentation of the programme	Liliana Coppola, DG Welfare - Lombardy Region
11.30 -12.00	The role of trade associations and Corporate Social Responsibility	Fulvia Richiardi, Confindustria Varese
12.00 – 13.00	Questions and answers	Open discussion
13.00 – 14.00	Lunch	
14.00 – 17.00	Working session on implementation	Lombardy Region and Andalusian Regional Ministry of Health
19.30 – 22.00	Dinner with partners (at each participant's costs)	Stelvio Restaurant Via Sebenico, 14, Milano

23rd May 2018
(Site Visits)

9.00	Meeting point (Central Station, Milan, in front of Hotel Gallia)
10.00 – 12.00	Visit to productive site "*Alfa Laval sri*" in the territory of the Brianza - Health Protection Agency (ATS)
13.00 - 14.00	Brunch
14.00 – 16.00	Visit to productive site "*Novartis Farma Spa*" in the territory of the Insubria - Health Protection Agency (ATS)
16.00	Close of the works and travel to airport/Central Station

Fondazione I.R.C.C.S. Istituto Neurologico Carlo Besta
Sistema Socio Sanitario Regione Lombardia
Ministero della Salute
Tutti per la salute
Regione Lombardia

www.regione.lombardia.it
www.promozionesalute.regione.lombardia.it

ANNEX 2. Image compilation

Lombardy Region describing the WHP Network

CHRODIS PLUS study-visit to an actual site

Andalusian Local Implementation Working Group

Follow-up meeting (EMASAGRA – Andalusian Regional Ministry of Health)

Practical WHP session (CSIF-GRANADA)

Special acknowledgements to:

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The Andalusian School of Public Health (EASP), for their unconditional support in conducting the pre and post questionnaires and the data analysis.

The Andalusian CORE TEAM OF CHRODIS PLUS-WP5 are:

F. Javier Dolz López, Granada Metropolitan Health District, Andalusian Health Service.

M. Dolores Fernández, Head of the Dpt. of Health Promotion and Local Action in Health. Andalusian Regional Ministry of Health and Families.

Rafael Rodríguez Acuña, Andalusian Public Foundation of Progress and Health.

Francisco Ruiz Domínguez, Andalusian Regional Ministry of Health and Families.

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