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

GOOD PRACTICE EXAMPLES IN HEALTH PROMOTION & PRIMARY PREVENTION IN CHRONIC DISEASE PREVENTION

ANNEX



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An Intervention for Obese Pregnant Women Sweden

Which 'life stage' for CVDs prevention targets the practice?

The target group is obese pregnant women.

Short description of the intervention:

In this prospective intervention study we aimed to control pregnancy weight gain to a maximum of 6 kg, and thus reduce the risks for complications during pregnancy and delivery. Women with BMI ≥ 30 were voluntarily included during a first trimester prenatal visit from all parts of Stockholm, Sweden. The first 25 pregnant women were included in the program and the result was published in Acta Obstetrica et Gynecologica Scandinavica. We have continued with total 182 women in the program. The intervention program included: meeting with the midwife every second week, one meeting with a dietician and a midwife from the delivery ward, exercise 30 minutes every day, water gymnastics once a week, keeping a food diary, fetal ultrasounds and follow-up visits to the obstetrician. Patient assessment was performed by physical examinations, gynecological assessments; somatic health related validated questionnaires, blood tests, urine analyses, depression scales and regular weight measurements.

Please give a description of the problem the practice wants to tackle:

A big problem is to reach all pregnant women with obesity. Some women are not motivated and some have other problems like depression and they do not have the energy to change their food and start exercise during their pregnancy. The midwives must also be educated in what is good food and exercise for pregnant obese women. This education must repeat often and the midwives and the doctors must get feedback from their work. The motivation of the midwives is crucial for the success of the intervention. It is also very important to make sure that the women get all the nutrients that are needed during the pregnancy.

Is this example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, the project is now implemented in all parts of Stockholm and we have had education for different parts of Sweden who have been very interested of the project.

How is this example of good practice funded?

Funding was obtained from Stockholm's läns Landsting, the regional government.

What is the level of implementation of the intervention?

The implementation is regional; all parts of Stockholm County are included.

To which type of interventions does your example of good practice belong to?

Individual Intervention, since the intervention was aimed for obese pregnant women and most of the intervention was made individually

Implementation of your example of good practice is/was:

Periodic. The project started 2006, continued throw 2014 and it's now implemented 2015

What are the main aim and the main objectives of your example of good practice?

The main aim was to investigate whether an intervention program was feasible, both for the pregnant woman and the health care staff involved in the program, and whether it was safe for mother and child

Who implements/implemented the intervention?

The team for education of the Mother healthcare centres in Stockholm who are employed by the Stockholm county council

What core activities are/have been implemented?

All the midwives and doctors who work at the Mother health care centres have got education in good food and exercise for pregnant women. We have also had education in what kind of risk it is for the obese women to be obese and the benefits of a low weight gain during pregnancy for this group. Material is available at internet for all Mother health care centres.

What has been measured /evaluated?

The evaluation was made by the own organization, journal records and of course participants satisfactions

Evaluation of the impacts/effects/outcome:

The project was feasible and well tolerated for the pregnant women and the midwives enjoyed working with the project.

What are the main results/conclusions/recommendations from the evaluation?

All participants were satisfied or very satisfied with the project. About 1/3 of the mothers reach the goal maximum weight gain 6 kg and 2/3 gain maximum 10 kg. The incidence of preeclampsia, gestational diabetes and babies large for gestation age were as a normal.

Is the evaluation report available, preferably in English or at least an English summary?

DOI:10.3109/00016340903428370

Was there a follow-up or is any follow-up evaluation planned in the future?

The follow up in the future will be by "the Graviditetsregistret" a nation based register including 98-99% of all pregnant women in Sweden.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The most important thing is the education of the midwives which must be continued every year. They must also get a chance to discuss with a therapist the failures and who they must get better and better

What are the main lessons to be learned?

The whole group at a Mother health Care Centre must be involved in the project and it's crucial to evaluate the project often.

Web page related to the intervention:

www.vardgivarguiden.se/fler_omraden/barnmorskemottagning/vard_under_graviditet/fetma-riktlinjer_for_gravida

References to the most important articles or reports on the intervention:

Weight control program for obese pregnant women, Acta obstetricia et gynecologica Scandinavica, vol 89, Issue 6, pages 840-3, 2009/

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ToyBox Intervention

Greece

Which 'life stage' for CVDs prevention targets the intervention?

Infancy & childhood: Specifically, the ToyBox-study targets preschool children aged 3.5-5.5 at baseline and their families.

Short description of the intervention

The ToyBox-intervention is a multicomponent, kindergarten-based, family-involved intervention, focusing on the promotion of water consumption, healthy snacking, physical activity and the reduction/ breaking up of sedentary time in preschool children and their families (four EBRBs). The intervention was implemented during the academic year 2012–2013 in six European countries: Belgium, Bulgaria, Germany, Greece, Poland and Spain. Standardized protocols, methods, tools and material were used in all countries for the implementation of the intervention, as well as for the process, impact, outcome evaluation and the assessment of its cost-effectiveness. A total sample of 7,056 preschool children and their parents/caregivers participated in the intervention.

The implementation of the ToyBox-intervention was conducted at four levels. More specifically: *Level 1.* Teachers conducted permanent environmental changes in the classroom/kindergarten, in order to create a supportive environment (i.e. installations of water stations and the 'magic snack plate' to assist water and healthy snack consumption and rearrangements of the classroom/kindergarten to create some free space to assist children's movement). *Level 2.* Teachers promoted the four targeted EBRBs on regular basis and predefined time within each day (i.e. reminding every day children to drink water regularly and do short movement breaks twice in the morning and twice in the afternoon, arranging a daily break for the whole class to eat healthy snacks and performing two physical education sessions per week with a duration of 45 min each). *Level 3.* Teachers implemented interactive classroom activities, minimum for 1 h per week (e.g. children's participation in experiments, kangaroo stories with children following the movements described in the stories, etc.). Teachers were also instructed to use the kangaroo and puppet and perform these four EBRBs themselves, so as to enhance the effects of the intervention via role modelling. *Level 4.* Parents/caregivers were encouraged and advised via simple and friendly to read material (nine newsletters and eight tip cards, as well as four posters which were coloured by their child) to apply relevant environmental changes at home, act as role models and implement these lifestyle behaviours together with their children. All material used during the intervention was the same across participating countries, allowing for some small cultural adaptations at a local level.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The development of the ToyBox-intervention was based on the outcomes of the preliminary phase of the ToyBox-study (systematic literature reviews, pooled analyses and focus groups research), aiming to identify young children's key behaviours and their determinants related to early childhood obesity. The development of the intervention material was based on the intervention mapping protocol and the PRECEDE-PROCEED model.

To which type of interventions does your example of good practice belong to?

European or international project (i.e. implemented in several countries). The ToyBox-intervention was implemented in six European countries: Belgium, Bulgaria, Germany, Greece, Poland and Spain.

How is this example of good practice funded?

European Commission (FP7)/

What is/was the level of implementation of your example of good practice?

Regional and local. Kindergartens from municipalities belonging to three different socioeconomic levels.

What are the main aim and the main objectives of your example of good practice?

Main aim: to prevent overweight/obesity in early childhood. Main objectives: to promote the four energy balance related behaviours which were found to be associated with early childhood obesity in the preliminary phases of the ToyBox-study, i.e. water consumption, healthy snacking, physical activity and the reduction/ breaking up of sedentary time in preschool children and their families.

Please give a description of the problem the good practice example want to tackle:

The prevalence of obesity has reached epidemic proportions in adult populations showing a steep increase over the last decades while childhood and adolescent overweight and obesity has increased markedly across Europe, even though in a few countries the speed of increase seems to have levelled off. Overweight in early childhood has been shown to increase the likelihood of being obese in later childhood but also tracks to adulthood in one-third to one-half of cases, where it becomes associated with an increased prevalence of chronic disease

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. EU platform on Diet and Physical Activity and Health

Implementation of your example of good practice is/was:

Single – it lasted five years (2009-2014).

During implementation, did specific actions were taken to address the equity dimensions?

Both genders from three socioeconomic levels participated in the ToyBox-intervention (including ethnic minority groups and children with disabilities). The intervention material and the intervention overall can be easily implemented in other regions/municipalities/countries.

Which vulnerable social groups were targeted?

Kindergartens/teachers/parents/preschool children from low socioeconomic groups participated in the ToyBox-intervention.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

During the focus groups research the determinants of the targeted energy balance related behaviours were identified separately for each of the six participating countries and were considered in the development of the ToyBox-intervention and material. Moreover, before finalizing the material, it was culturally adapted based on the feedback received from local stakeholders.

Was an effective partnership in place?

Yes, ToyBox comprised a multidisciplinary, inter-sector, multi-alliance team of 15 partners across the EU incorporating the necessary expertise on childhood behaviours, pedagogics, nutrition, physical activity, paediatrics, psychology, health economics, policy and advocacy, school-based interventions:

Harokopio University, Greece – Coordinator

Ludwig-Maximilians University of Munich, Germany

Ghent University, Belgium

VU University Medical Centre, Netherlands

Akershus University College, Norway

University of Zaragoza, Spain

Durham University, UK

State Institute of Early Childhood Research, Germany

Children's Memorial Health Institute, Poland

Medical University of Varna, Bulgaria

International Association for the Study of Obesity, UK

Netherlands Institute for Health Promotion and Disease Prevention, the Netherlands

AOK-Verlag GmbH, Germany

Roehampton University, UK

University of Luxembourg, Luxembourg

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes (according to national plan for Diet and CVD prevention in Greece and other EU countries).

Was the intervention implemented equitably, i.e. proportional to needs?

Yes. Focus groups with parents from three socioeconomic groups (including low SES groups) were conducted prior to the ToyBox-intervention and guided the development both of the ToyBox-intervention and intervention material.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, all participants were asked to sign an informed consent form explaining the purposes of the ToyBox-intervention prior to their participation in the study.

Did the evaluation results achieve the stated goals and objectives?

Yes, positive results have been observed regarding some of the targeted energy balance behaviours and their determinants both in the total sample and across the participating countries.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes, all participating countries used standardized methods, equipment and tools for the evaluation of the ToyBox-intervention. The reliability and validity of the tools was tested before they were used in the main study and was proven to be adequate for the needs of the project. Cost-effectiveness and process evaluation were also assessed via standard questionnaires. The results of the ToyBox-intervention are disseminated through scientific papers in international peer-reviewed scientific journals, presentations in international and national scientific conferences, webinars, newsletters, press releases and through the ToyBox-website (<http://www.toybox-study.eu/>).

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

Specifically, what has been measured / evaluated?

Process evaluation: To evaluate the implementation of the intervention, teachers' monthly logbooks were recorded; post-intervention questionnaires were completed by parents/caregivers and teachers; participation and attrition rates were recorded; and audit questionnaires and retrospective information on weather conditions were collected. Regarding the teachers' training sessions, the researchers who performed the trainings completed evaluation forms and documented teachers' attendance after each training and teachers completed evaluation forms after each training.

Evaluation of the impacts/effects/outcome : The following tools/measurements were conducted both at baseline and at follow-up. Impact evaluation (questionnaires available at: <http://www.toybox-study.eu/?q=en/node/124>):

- Pedometers (children's steps taken during six consecutive days, including weekend days)
- Food Frequency Questionnaire and Questionnaire regarding children's eating/snacking, drinking, physical activity and sedentary behaviour and their determinants
- Questionnaires regarding parents/caregivers' and teachers' eating/snacking, drinking, physical activity and sedentary behaviour
- Questionnaire regarding children's medical history (only at baseline)
- Audit questionnaires (regarding the school food and physical activity environment)

Outcome evaluation: Children's anthropometric indices (weight, height, waist circumference, BMI, % overweight and obesity)

What are the main results/conclusions/recommendations from the evaluation?

The ToyBox-intervention resulted to favourable changes of energy balance related behaviours in the intervention group compared to the control group, i.e.:

- Higher increase of water consumption for the children in the intervention group compared to the control group.
- Lower increase of time spent in PC/video-games for the children in the intervention group compared to the control group.
- Higher decrease of sweets consumption for the children and their parents in the intervention group compared to the control group.
- Higher increase of vigorous physical activity for the parents in the intervention group compared to the control group.

Regarding process evaluation, the results showed that the intervention reached the targeted audience and that the intervention (training sessions, material, intervention overall) was appealing to the teachers, parents/caregivers and children who participated in the intervention group.

Was there a follow-up or is any follow-up evaluation planned in the future?

Yes, follow-up was conducted one year after the baseline measurements (i.e. baseline in May/June 2012 and follow-up in May/June 2013).

Was the intervention designed and implemented in consultation with the target population?

Yes, focus groups were conducted with teachers and parents of preschool children from three socioeconomic levels in all six participating countries.

Did the intervention achieve meaningful participation among the intended target population?

Yes, a total sample of 7,056 preschool children and their parents/caregivers, stratified by socioeconomic level, provided data during baseline measurements and participated in the intervention.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes, the PRECEDE-PROCEED model was used to define the needs assessment of the targeted population.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes, local stakeholders (e.g. kindergarten headmasters and teachers) were engaged in the study.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes, all costs related to the development and execution of the ToyBox-intervention was recorded and a cost-effectiveness analysis was conducted.

Were organisational structures clearly defined and described?

Yes, teachers implemented the ToyBox-intervention, whereas the researchers developed the intervention and trained the teachers on how to implement it (via three training sessions).

Is the potential impact on the population targeted assessed (if scaled up) ?

The ToyBox-intervention resulted to favourable changes of energy balance related behaviours for the children in the intervention group compared to the control group (please see above). The results of the process evaluation showed that the intervention was well-received from the targeted audience. Overall, these results seem to be promising and could potentially contribute to the prevention of overweight/obesity in early childhood if scaled up.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The broad variety of classroom activities, the ready-to-use material, the adaptations based on the feedback received from local stakeholders in each of the intervention countries, the training of the teachers and overall the development of the ToyBox-intervention based on insights/information gained through the focus groups with stakeholders which were conducted prior to the intervention.

What were, in your opinion, the main lessons to be learned?

The approach of 'one size fits all' might not be the best approach for the diversity of cultures, local systems and needs across Europe. Preventive interventions should preferably be designed with enough flexibility.

Web page related to the intervention

<http://www.toybox-study.eu/?q=en/node/1>

References to the most important articles or reports on the intervention

<http://www.toybox-study.eu/?q=node/239>

Other relevant documents

<http://www.toybox-study.eu/?q=en/image>

<http://www.toybox-study.eu/?q=public-reports>

http://www.toybox-study.eu/?q=en/news_events_full

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School Fruit Scheme strategy for the 2010–2013 school years Lithuania

Title in original language:

Vaisių vartojimo skatinimo mokyklose programos 2010–2013 mokslo metų strategija

Which 'life stage' for CVDs prevention targets the intervention?

The intervention targets preschoolers and pupils in primary education (years 1 to 4).

Short description of the intervention:

The aim of the School Fruit Scheme Strategy for the 2010–2013 school years was to set up the budget of the programme, target groups, accompanying measures that help the children to recognise the importance of healthy eating habits and distributable products. Fruit and vegetables were distributed, free of charge, to pupils in primary education (years 1 to 4) at Lithuanian general schools wishing to participate in the School Fruit Scheme. The products to be distributed were: carrots, apples, pears, bananas and citrus fruit. Owing to the country's climate, use of chemical fertilisers and plant protection products is lower in Lithuanian agriculture; so much of Lithuania's agricultural produce differs little from organic produce. Priority is therefore given to products grown in Lithuania, except for products that are not grown in Lithuania because of the climate. The quality of the carrots and bananas distributed must meet general commercial standards. Apple, pear and citrus-fruit quality must not be lower than class II. The handling of fruit and vegetables must meet hygiene requirements, and the fruit and vegetables must be washed before they are presented for consumption. The products are distributed to schoolchildren three times per week. Each child receives one portion per day. A portion is made up of one of the following products: an apple, a carrot, a pear, a banana or a portion of citrus fruit. The beneficiaries are required to ensure that schoolchildren receive all of the products indicated in point 18 over the course of the Scheme. At least two thirds of the overall quantity distributed to schoolchildren should be made up of products grown in Lithuania. If products are distributed during the normal school lunch hour, the school must ensure that schoolchildren are informed that the products are being distributed under this Scheme. To make the Scheme more effective, its implementation must be accompanied by awareness-raising and educational measures to help schoolchildren understand the importance of healthy eating habits (accompanying measures). Schools participating in the Scheme are required to organise at least four activities per school year to inform children about healthy eating or the health benefits of fruit and vegetables. At least one additional measure must be taken at least once per school year. Such additional accompanying measures may consist of:

- children's excursions to fruit or vegetable farms to familiarise them with how fruit and vegetables are grown and the product's journey 'from field to table';
- distribution in schools of information material on the benefits of eating fruit and vegetables (booklets, leaflets and other information publications);
- training for teachers on instilling a healthy way of life and healthy eating habits in children; organisation of educational quizzes, drawing competitions and sports events to promote a healthy way of life.

The School Fruit Scheme was implemented in school years 2009–2010, 2010–2011, 2011–2012, 2012–2013. In school year 2009–2010, 171 schools took part in the program, the products were distributed to 21,222 children, in

school year 2012-2013, 1365 schools and nurseries participated in the program, products were distributed to 192,454 children.

How is this example of good practice funded?

The funds for the implementation of the School Fruit Scheme as provided for in the Strategy are allocated from the European Agricultural Guarantee Fund AND the Lithuanian State budget

What is/was the level of implementation of your example of good practice?

National

What are the main aim and the main objectives of your example of good practice?

The aim of the Strategy was to instil in children an awareness of the health benefits of eating fruit and vegetables. In order to achieve this aim, the objective was to increase the amount of fruit and vegetables in children's diets at a stage when their eating habits are developing. The aim of the School Fruit Scheme Strategy for the 2010–2013 school years was to set up the budget of the programme, target groups, accompanying measures that help the children to recognise the importance of healthy eating habits and distributable products.

Please give a description of the problem the good practice example want to tackle:

In the European Union, including Lithuania, an estimated 22 million children are overweight. More than 5 million of them are obese. Healthy eating may prove to be an important means of reducing obesity and serious health problems that arise in later life, such as vascular diseases and type-2 diabetes. It is therefore important to ensure that people eat enough fruit and vegetables. Research indicates that healthy eating habits develop during childhood. People who eat a lot of fruit and vegetables during childhood continue to eat enough fruit and vegetables. People who do not eat a lot of fruit and vegetables usually do not change their eating habits, and pass them on to their own children. The World Health Organisation recommends a daily intake of 400 g of fruit and vegetables per person. The majority of Europeans, especially the young, disregard this recommendation and are consuming less and less fruit and vegetables.

Implementation of your example of good practice is/was:

Periodic. The School Fruit Scheme was implemented in school years 2009–2010, 2010–2011, 2011–2012, 2012–2013. Now there is the Strategy for years 2014-2015.

Which vulnerable social groups were targeted?

The children from poor families had the opportunity to eat fruits and vegetables.

Did the evaluation results achieve the stated goals and objectives?

Yes, the aim of the Strategy was to instil in children an awareness of the health benefits of eating fruit and vegetables. In order to achieve this aim, the objective was to increase the amount of fruit and vegetables in children's diets at a stage when their eating habits are developing. The evaluation showed that aim and objective were achieved.

Who did the evaluation?

An external party

Specifically, what has been measured / evaluated?

Process evaluation: For the first implementation of the Scheme and its efficacy evaluation, covering the period 1 August 2010–31 July 2011, there were randomly selected 50 schools, participated in the School Fruit Scheme and 21 schools, which not participated in the Scheme during the academic year 2010 – 2011. In order to evaluate the Scheme's influence on children's health and nutrition habits, the primary classes' pupils were interviewed by questionnaire. There were also interviewed primary classes teachers and public health specialists, working in the mentioned schools, aiming to found out their opinion concerning the possible Scheme's influence on children's health and nutrition habits and to collect their proposals for increasing the efficiency of the Scheme. The questionnaire for pupils included questions about children's nutrition habits, their knowledge about healthy nutrition and proper nutrition habits and the importance of fruits and vegetables for human health, etc. The appropriate questionnaires for teachers and public health specialists, working in the schools were prepared. The questionnaire's instruction and consent form for parents was distributed accordingly. Consent forms were signed by the parents as the permission for children to be interviewed. The questionnaires were distributed among more than 3.700 pupils from schools participated and not participated in the Scheme; approximately 300 questionnaires in total were distributed among the teachers (150) and public health specialists (150). In total 2586 correctly completed questionnaires (pupils – 2402, teachers – 98, public health specialists – 86) were received back and analysed. The data comparison was made between schools participated and not participated in the Scheme, analysing data of teachers' and pupils' surveys.

What are the main results/conclusions/recommendations from the evaluation?

According to the data of the School Fruit Scheme first stage implementation and efficacy evaluation covering the period 1 August 2010–31 July 2011, it is noted, that the Scheme is successfully implemented in the schools. In the opinion of the majority of teachers and public health specialists, the pupils consumed the fruits and vegetables willingly. Analysis of the respondents answers concerning Scheme usefulness showed, that the majority of teachers and public health specialists evaluate the Scheme as useful and very useful, they also believe, that the continuity of the Scheme and its long-term implementation can help to develop the healthy nutrition habits among pupils, especially since two thirds of teachers and public health specialists stated, that healthy nutrition habits among pupils are not formed yet.

It is established, that pupils from participating schools consume fruits and vegetables at school slightly more often, but still insufficient number of pupils are eating fruits and vegetables at schools every day and this indicates the fact, that healthy nutrition habits and skills among pupils currently are not formed completely. Thus, it can be assumed, that not all pupils are aware enough about the importance of fruits and vegetables. It is great, that most pupils knew how many times per day they should eat and that is necessary to consume fruits and vegetables every day and they would like to get fruits and vegetables at school. But only one third of pupils had breakfast every day and only 60% of them had hot lunch at school.

Most of the pupils (more from participating schools) knew that healthy and sufficient nutrition is necessary to keep the health and this could be partly explained because of possible positive influence of the special events, provided within the Scheme. It is noticeable, that irrespective of school participation in the Scheme, every seventh pupil indicated, that parents are sharing with their knowledge about fruits and vegetables daily consumption importance and every third pupil specified teachers as an information source. As the pupils stated, another sources of information were TV and radio, books and textbooks, booklets about fruits and vegetables, etc. Pupils also highlighted their parents and teachers as the main persons, who provides pupils information concerning healthy nutrition. Although most of pupils believed, that their nutrition is good and sufficient enough to keep health, but there were slightly more such pupils from participating schools quite big part of them would like to learn more about healthy nutrition. Most of the teachers and public health specialists emphasized, that parental education and family influence are the most important factors for pupils' healthy nutrition habits development; and certainly, after the family impact, teachers should be the most important providers of educational activity at schools. Almost every tenth respondent mentioned, that radio and TV could affect pupils' healthy nutrition habits development, so the importance of information dissemination using mass media was emphasized among the most popular

mentioned suggestions how to increase Scheme's efficacy and healthy nutrition development among pupils. Aiming to improve the efficacy of the Scheme, it was suggested to provide more information in order to educate pupils as well as parents; to ensure wider schools involvement into the Scheme, to implement teamwork principles', to create the same Scheme for high classes' pupils, to motivate schools' staff directly related to this Scheme, etc. Thus, it can be concluded, that after parents' and teachers' influence to pupils' healthy nutrition habits development, the School Fruit Scheme is and should be one of the most important factor, which could change pupils' nutrition habits in a positive direction.

Is the evaluation report available, preferably in English or at least an English summary?

http://ec.europa.eu/agriculture/sfs/documents/lt_summary_evaluation_report_-_2010-2011_en.pdf

Who implemented the intervention?

The intervention was implemented by network of organisations. The implementation of Strategy was coordinated by the Lithuanian Ministry of Agriculture. The Agricultural and Food Products Market Regulation Agency, a state enterprise, was responsible for the implementation of this Strategy. The National Paying Agency under the Ministry of Agriculture was responsible for the disbursement of support funds, in accordance with the data provided by the Agricultural and Food Products Market Regulation Agency, and for keeping correct accounts of the funds disbursed. The Lithuanian Ministry of Education and Science made recommendations on the accompanying measures to the schools participating in the Scheme, which are responsible for implementing them. The Lithuanian Ministry of Health made recommendations on the range of products to be distributed to schoolchildren and, together with the Ministry of Education and Science, actively engaged in informing schoolchildren of the health benefits of eating fruit and vegetables.

What core activities are/have been implemented?

Fruit and vegetables were distributed, free of charge, to pupils in primary education (years 1 to 4) at Lithuanian general schools wishing to participate in the School Fruit Scheme. The products to be distributed were: carrots, apples, pears, bananas and citrus fruit.

To make the Scheme more effective, its implementation was accompanied by awareness-raising and educational measures to help schoolchildren understand the importance of healthy eating habits (accompanying measures). Schools participating in the Scheme were required to organise at least four activities per school year to inform children about healthy eating or the health benefits of fruit and vegetables. At least one additional measure was taken at least once per school year. Such additional accompanying measures consisted of:

- children's excursions to fruit or vegetable farms to familiarise them with how fruit and vegetables are grown and the product's journey 'from field to table';
- distribution in schools of information material on the benefits of eating fruit and vegetables (booklets, leaflets and other information publications);
- training for teachers on instilling a healthy way of life and healthy eating habits in children; organisation of educational quizzes, drawing competitions and sports events to promote a healthy way of life.

Did the intervention achieve meaningful participation among the intended target population?

Yes, in school year 2012-2013, 1365 schools and nurseries participated in the program, products were distributed to 192,454 children and it amounts to 87 percent of the children eligible for the aid.

Web page related to the intervention

http://ec.europa.eu/agriculture/sfs/eu-countries/lithuania/index_en.htm

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Promotion of Fruit and Vegetable Consumption among Schoolchildren - 'PROGREENS' Bulgaria

Title in original language:

Промоция консумация на плодове и зеленчуци при ученици, PROGREENS

Which 'life stage' for CVDs prevention targets the intervention?

Infancy and childhood. The intervention described focuses on 11- to 12-year old children.

Short description of the intervention:

The aim of the Intervention was to educate children for the positive change in eating behaviour. The intervention was developed within the European Union's 7th Framework Programme, funded by the European Commission and included 11 Member States. Its objective was to develop, pilot and evaluate an intervention, which aimed to increase fruit and vegetable consumption. The intervention in Bulgaria took place in the period of 2008 – 2011, targeting 6-grade students (11-12-year olds) in Sofia. In 2009, the design of the intervention was prepared, followed by the organization and conduction of a survey within 13 schools in Sofia, involving 1300 children and their parents. The survey aimed to assess dietary intake, eating behaviour and knowledge related to fruits and vegetables, as well as the school environment conditions. Developed, published and provided were educational materials for students, information brochure and guidelines for teachers, a shop visit brochure, informational materials for parents, poster project and organized was also an explanatory seminar for teachers.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes, the intervention was fully built on theory and relevant data on fruit and vegetable consumption among students and was implemented into the context of an overall healthy diet by guiding students on how to strengthen and protect their health.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes, the intervention used the experience of the countries within the programme and was described thoroughly in terms of location, concrete activities, timeframe, etc.

To which type of interventions does your example of good practice belong to?

European or international project (i.e. implemented in several countries). The intervention was developed within the European Union's 7th Framework Programme, funded by the European Commission and included 11 Member States.

How is this example of good practice funded?

National/regional/local government; Institution of education, public health and/or research; and Private sector company/organization. The intervention was a project under the VII Framework Programme of the European Commission, and the leading financing body was the European Commission as well as the National Centre for Public Health Protection (now NCPHA). The intervention was also financially supported by private sector companies as their active contribution (financial, human resources) generally improves the healthy choice on the population.

What is/was the level of implementation of your example of good practice?

Local (municipality level). The intervention in Bulgaria took place in the period of 2008 – 2011, targeting 6-grade students (11-12-year olds) in Sofia.

What are the main aim and the main objectives of your example of good practice?

The main objective of our example was to increase consumption of fruits and vegetables among 11-12-year old children with the aim to strengthen, promote and protect health in the context of an overall healthy diet, which will result in reduced risk of NCDs, as adequate fruits and vegetables consumption plays a significant role in NCDs prevention. Following the positive results of the project, currently the intervention serves as a model for implementation.

Please give a description of the problem the good practice example wants to tackle:

In the second half of the 20th century significant changes were observed in nutrition and lifestyle that contribute for the epidemics of non-communicable chronic diseases such as cardiovascular diseases (coronary heart disease, hypertension), cancer, diabetes type 2, obesity, etc. One of the main unfavourable trends and characteristics of the nutrition of the Bulgarian population included low consumption of fresh fruits and vegetables. Furthermore, surveys across Europe have demonstrated that eating habits and diets of children in different countries are unbalanced, and do not contain enough fruit and vegetables. Based on numerous research evidence, school fruit and vegetable scheme was considered an effective approach that is beneficial for both public health and agriculture. Thus, the programme 2008-2011 served as stable and promising basis to improve fruit and vegetable consumption among children.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, the intervention contributed to the “Food and Nutrition Action Plan 2005-2010”, which aimed to increase public awareness and to reduce salt, fat and sugar content in different foods.

Implementation of your example of good practice is/was:

Single - from 2008 to 2011.

During implementation, did specific actions were taken to address the equity dimensions?

The intervention included 1300 children, 11- to 12-year old children and parents in Sofia, aiming to increase the availability of fruit and vegetables in schools.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

The intervention was a school-based one, involving children and their parents within of different socio-economic status. The project investigated the determinants of fruit and vegetable intake from gender, cultural, educational and socio-economical perspective and investigated effective communication and promotion strategies.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, and using different strategies?

Yes. The main approach of the intervention was directed to health education of children, teachers and parents to increase fruit and vegetable consumption with the aim to reduce the influence of risk factors related to NCDs. Moreover, it used different strategies to raise awareness among the targeted population and also to build capacity.

Was an effective partnership in place?

The intervention was characterized by a highly effective partnership, including international organization, school representatives, healthcare professionals and contacts with branch organizations of producers.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes, the intervention was supported by the government and fully supported (and led) by the National Centre of Public Health and Analyses, a governmental structure, and the European Commission.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes. The objectives were transparent to the target population as well as to the stakeholders; moreover, there was active use of mass media sources to promote the objectives of the intervention.

Did the evaluation results achieve the stated goals and objectives?

The intervention provided data on consumption of fruits and vegetables, a platform for collaboration with retailers and producers and a basis for design school health policies. It achieved its objectives to assess the level of consumption of fruit and vegetables in children before and after a school-based intervention and to develop and test effective strategies to promote fruit and vegetable consumption among school children.

Did the intervention have a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. To monitor the process of implementation of the program, standardized procedures described in particular PRO GREENS documents were included.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

The intervention had monitoring system in place, which was in accordance with the described procedures in PRO GREENS. Monitoring has been conducted to evaluate the process of change and technical and financial reports were identified and hand in according to the PRO GREENS Grant Agreement rules.

Who did the evaluation?

Both – internal and external parties.

Specifically, what has been measured / evaluated?

The level of consumption of fruit and vegetables in children before and after a school-based intervention. The evaluation of the implementation of the intervention was carried out on the basis of data collection and data analyses.

What are the main results/conclusions/recommendations from the evaluation?

General recommendations based on the work of all EU Member States encompass:

- Recommendation on training curricula of teachers and pupils
- Recommendations on best practice for fruit and vegetable promotion in school: a manual targeted to public health nutritionists
- Recommendations for formulating and using school health policies to promote fruit and vegetable consumption
- Recommendations for using public private partnerships to promote fruit and vegetable intake through schools
- Recommendations for food based dietary guidelines on European school children's intake of vegetables, fruits and berries* based on their knowledge and needs
- Recommendations for how to evaluate vegetable, fruit and berries* intake of children aged 6-14 years.

Is the evaluation report available, preferably in English or at least an English summary?

Yes. Available at: <http://www.progreens.org/results.html>

Who implemented the intervention?

The intervention was part of a project within 11 European countries, forming a team of different institutions. Considering the implementation of the intervention in Bulgaria, it was guided by the National Centre of Public Health and Analyses (previously National Centre of Public Health Protection), led by a team of healthcare professionals.

What core activities are/have been implemented?

- Development of a design of the intervention and study protocol;
- Meetings with representatives of the Regional Health Inspectorates, school principals;
- Training sessions;
- Publishing different materials; distribution of leaflets;
- Organizing and conducting two-day workshop with partner countries;
- Organizing and conducting a contest for a picture;
- Poster presentation in the Second World Congress on Public Health.

Was the intervention designed and implemented in consultation with the target population?

Yes, the intervention was designed in accordance with the needs of the target population.

Did the intervention achieve meaningful participation among the intended target population?

Yes, the targeted populations as well as the stakeholders were actively involved in the activities within the program.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes, the intervention had positive impact in terms of raising awareness of the health benefits of increased fruit and vegetables consumption, which was also expanded by the provided guidelines and education materials.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes. With the objective to increase the consumption of fruits and vegetables in 11-12-year old children, the design of the intervention also included their parents, teachers within their school environment as well as popular branch companies that could easily promote health benefits through other mass media sources.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes. The intervention was funded by the EC, the government, together with branch companies. Being an intervention within a European-supported project, the team was fully supported by other associated and collaborative partners, exchanging best practices and intervention implementation strategies in fruit and vegetable promotion.

Is there a broad support for the intervention amongst those who implement it?

Yes. The intervention activities were carried out with the support of different institutions and organizations, both at local level, governmental and European level.

Is there a broad support for the intervention amongst the intended target populations?

Yes. The targeted population actively participated in the intervention activities.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes. A team within each country's institution was established to plan, organize and report on both human and financial resources necessary for the activities implementation.

Were sources of funding specified in regards to stability and commitment?

Yes. The intervention relied on funding, ensured by the government and the EC. Other sources of funding were also used provided by private sector companies.

Were organizational structures clearly defined and described?

Yes, the intervention followed strict plan in terms of responsibilities, information dissemination, capacity and partnership building activities. The intervention activities were monitored by NCPHA and the leaders of the project.

Are there specific knowledge transfer strategies in place (evidence into practice)?

Different methods and approaches to increase the knowledge of the population were applied, using good practices examples from countries participating in the program.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The intervention was successful as it tackled the described problem taking into account important psychosocial and socio-demographic determinants of fruit and vegetable consumption among school children, including behaviour characteristics, theory, environmental changes, developmentally appropriate strategies, family involvement and teacher training. A set of different evidence-based strategies were applied, which ensured not only accountability, but also the ability to share best practices, surveillance and monitoring.

What were, in your opinion, the main lessons to be learned?

The main lessons to be learned are related with the potential to promote fruit and vegetable consumption in the school environment through the development of school health policies and strengthening the public-private partnership to ensure a more multi-sectoral approach in increasing fruit and vegetable consumption.

Web page related to the intervention

European webpage of the project PRO GREENS: <http://www.progreens.org/index.html>

References to the most important articles or reports on the intervention

- <http://www.progreens.org/index.html>
- Eva Roos, Tuuli Pajunen, Carola Ray, Christel Lynch, A' sa Gudrun, Kristiansdottir4, Thorhallur I Halldorsson, Inga Thorsdottir, Saskia J te Velde, Michael Krawinkel, Isabel Behrendt, Maria Daniel Vaz de Almeida, Bela Franchini, Angeliki Papadaki, Joanna Moschandreas, Cirila Hlastan Ribic, Stefka Petrova, Vesselka Duleva, Irena Simc'ic, Agneta Yngve. Does eating family meals and having the television on during dinner correlate with overweight? A sub-study of the PRO GREENS project, looking at children from nine European countries, doi:10.1017/S1368980013002954 Public Health Nutrition 03/2014:1-9
- Lehto E, Ray C, te Velde SJ, Petrova Stefka, Duleva V, Krawinkel M, Behrendt I, Papadaki A, Kristjansdottir A, Thorsdottir I, Yngve A,12, Lien N, Vaz de Almeida MD, Hlastan Ribic C, Simčic, Lynch C, Ehrenblad B, Roos E. Mediation of parental educational level on fruit and vegetable intake among schoolchildren in ten European countries". 2013, Public Health Nutrition doi:10.1017/S136898001300339X Public Health Nutrition 01/2014

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Let's Take on Childhood Obesity – The Childhood Overweight and Obesity on the Island of Ireland campaign Ireland

Which 'life stage' for CVDs prevention targets the intervention?

Childhood and Adolescence

Short description of the intervention:

Let's Take on Childhood Obesity is a public health campaign to take on childhood obesity aimed at parents of children aged 2-12 years, on the island of Ireland. This is a 3 year campaign and was launched in October 2013 by SafeFood¹ in partnership with the Health Service Executive² and Healthy Ireland Framework³ in the Republic of Ireland and the 'Fitter Futures for All' Implementation Plan in Northern Ireland⁴. The campaign urges parents to make practical changes to everyday lifestyle habits which would make a big difference to their children's future health. Tackling Childhood Obesity is a public health priority, with 1 in 4 children across the Island of Ireland carrying excess weight. There is growing evidence underlining the impact of obesity on short and long term health and well-being. Children who are obese are likely to remain obese through to adulthood. The aim of the campaign is to halt the rise in both overweight and obesity levels in children by:

1. Communicating practical solutions that parents can adopt in order to tackle the everyday habits that are associated with excess weight gain in childhood.
2. Maintaining awareness of the health challenges posed by excess weight in childhood and the negative impact this can have on the quality of life.

The campaign provides parents with practical solutions that they can adopt to tackle everyday habits associated with excess weight. It specifically addresses: a) Sugary drinks, b) Treat foods, c) Portion sizes, d) Physical activity, d) Screen time and e) Sleep.

¹ SafeFood, is an all-island implementation body set up under the British-Irish Agreement with a general remit to promote awareness and knowledge of food safety and nutrition issues on the island of Ireland.

² Health Service Executive provides all of the Republic of Ireland's public health services, in hospitals and communities across the country.

³ Healthy Ireland -A Framework for Improved Health and Wellbeing 2013 – 2025, is a new national framework for action to improve the health and wellbeing of everyone in the Republic of Ireland. Based on international evidence, it outlines a new commitment to public health with a considerable emphasis on prevention, provides for new arrangements to ensure effective co-operation between the health sector and other areas of Government and public services, concerned with social protection, children, business, food safety, education, housing, transport and the environment.

⁴ Fitter Futures for All is An Obesity Prevention Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The campaign was designed and developed taking account of the research showing the relationship between socioeconomic status and childhood obesity through to adulthood. The

evidence is in relation to factors associated with childhood obesity (both relationships and evidence) was collated for campaign development and was also reviewed for new data on a regular basis.

To which type of interventions does your example of good practice belong to?

This type of intervention is a public health campaign that uses communication channels including television and radio advertisements, social and digital advertising.

How is this example of good practice funded?

The campaign is funded by SafeFood, an all-island implementation body set up under the British-Irish Agreement with a general remit to promote awareness and knowledge of food safety and nutrition issues on the island of Ireland.

What is/was the level of implementation of your example of good practice?

National – cross jurisdictions (i.e. in both the Republic of Ireland and in Northern Ireland)

What are the main aim and the main objectives of your example of good practice?

The aim of the campaign was to halt the rise in both overweight and obesity levels in children by: Communicating practical solutions that parents can adopt in order to tackle the everyday habits that are associated with excess weight gain in childhood. Maintaining awareness of the health challenges posed by excess weight in childhood and the negative impact this can have on the quality of life. The campaign provided parents with practical solutions that they can adopt to tackle everyday habits associated with excess weight. It specifically addresses: a) Sugary drinks, b) Treat foods, c) Portion sizes, d) Physical activity, d) Screen time and e) Sleep.

Please give a description of the problem the good practice example wants to tackle:

Worldwide obesity has more than doubled since 1980[6]. In Ireland, the obesity epidemic is of significant concern across all age groups. Prevalence of obesity amongst men increased from 8% in 1990 to 26% in 2011, and among women it increased from 13% to 21% over the same time frame..[7] While the prevalence of childhood overweight and obesity remains high in Ireland, there is some indication that rates may be stabilising.[8] Particular concerns exist both in Ireland and internationally in the context of overweight and obesity amongst those living in disadvantaged circumstances, among certain ethnic/cultural minority groups and among people with a disability.[9,10,11]

Overweight and Obesity in Adults: In Ireland 2 in 3 adults are overweight or obese. 37% of adults are overweight (men 44%,women 31%) and 24% are obese (men 26%, women 21%).[7]

Overweight and Obesity in Children: 1 in 4 boys and 1 in 5 girls aged 4 to 5 years are overweight or obese (25 % boys, 21 % girls) (National Preschool Nutrition Survey, 2012).[12]. 1 in 4 nine year old children are overweight or obese, with girls more likely to be overweight (22 %) or obese (8 %) than boys (17 % and 5 %). Among nine year olds a total of 30% of girls and 22% of boys are defined as overweight or obese and there are pronounced social-class inequalities in the prevalence of overweight and obesity. 19% of boys and 18% of girls from professional households are overweight/obese. This increases to 29% of boys and 38% of girls from semi- and unskilled social-class households. [13] Recent data suggests that the prevalence of overweight and obesity in 9-year- old children has stabilised, and among 7-year-olds the prevalence seems to have fallen, but this was not observed in children attending schools in areas of disadvantage. [14]

Physical activity in Children: Levels of physical activity in children are a particular concern with changing lifestyles. The Children's Sport Participation and Physical Activity survey 2009 estimated that 19% of primary school children and 12% of post primary school children achieve the minimum physical activity recommendations of at least 60 minutes of moderate to vigorous physical activity every day. [15]

Weight status of the population in the Republic of Ireland can be found on <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Professional/Nutrition/Adult-and-children-obesity-trends-ROI.pdf>

Weight status of the population in Northern Ireland can be found on <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Professional/Nutrition/Adult-and-children-obesity-trends-NI.pdf>

The cost of obesity: The cost of obesity in Ireland in 2009 was estimated to be €1.13 billion with direct costs to the health service of circa €400,000 million (35%) and indirect costs €730,000 million (65%). The direct costs represent 2.7% of the total healthcare costs. [16]

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The campaign covers two jurisdictions, i.e. The Republic of Ireland and Northern Ireland, and is aligned with priorities set out in government strategies in both jurisdictions. Currently, in the Republic of Ireland a National Obesity Policy and Action Plan are being developed by the Department of Health and will be completed by end of 2015. To date, a number of key policy documents have addressed issues of overweight and obesity and have set out healthy weight targets. Changing Cardiovascular [17] Health and Healthy Ireland – A Framework for Health and Wellbeing[18], set targets to increase by 5% and 6% the number of adults and children respectively with a healthy weight between 2009 and 2019.

Implementation of your example of good practice is/was:

The childhood obesity campaign is a planned 3 year campaign that has and continues to be implemented on a phased basis. Each phase focuses on a different message and practical solutions for parents around particular topics such as Sugary drinks, Treat foods, Portion sizes, Physical activity, Screen time and Sleep.

Target group(s):

The target group of this public health campaign were parents of children aged 2-12 years. However, during campaign design and implementation there was a focus on parents (mothers and fathers) from both rural and urban settings and those from lower socioeconomic areas.

During implementation, did specific actions were taken to address the equity dimensions?

Yes, during implementation, several media channels were used (TV advertisements, outdoor posters, radio newspapers, digital and social media) where all the audience for certain outlets were a higher percentage of low socioeconomic groups e.g., use of tabloid newspapers, local press and radio stations, as well as timing of TV advertisements.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

The campaign's design and implementation phases aimed to address equity dimensions such as gender, rural-urban areas and low socioeconomic status through various approaches. During campaign design, material was tested through focus groups with parents (mothers and fathers) from both rural and urban areas with a prioritisation to those from low socioeconomic areas. Research shows that there is a relationship between socio-economic status and childhood obesity through to adulthood. During the implementation phase, several media channels were used (TV advertisements, outdoor posters, radio, newspapers, digital and social media) where all outlets had a higher percentage of low socioeconomic groups – tabloid newspapers, local press and radio stations, as well as the timing of TV advertisements.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, and using different strategies?

This campaign took account of factors addressing relevant determinants of health such as gender, socioeconomic status, geography, health literacy at the design, development and implementation phases. The campaign is complementary to other on-going initiatives and programmes to tackle the issue of childhood overweight and obesity in the school and community settings. The campaign aimed to engage parents through the use of mass media in a range of settings – e.g. community setting (e.g. a number of community food initiative projects used campaign resources) and in the healthcare setting.

Was an effective partnership in place?

The public health campaign is implemented in partnership with the Irish Health Service Executive, Healthy Ireland, Department of Health, Safefood and Northern Ireland's Public Health Agency – Choose to Live Better campaign.

Was the intervention implemented equitably, i.e. proportional to needs?

Childhood obesity rates are higher among lower socio-economic groups. Campaign development research was prioritised towards these groups. The campaign's design and implementation phases aimed to address equity dimensions such as gender, rural-urban areas and low socioeconomic status through various approaches. During campaign design, material was tested through focus groups with parents (mothers and fathers) from both rural and urban areas with a prioritisation to those from low socioeconomic areas. Research shows that there is a relationship between socio-economic status and childhood obesity. During the implementation phase, several media channels were used (TV advertisements, outdoor posters, radio, newspapers, digital and social media) where all outlets were skewed towards low socioeconomic groups – tabloid newspapers, local press and radio stations, as well as the timing of TV advertisements.

As part of the Community Food Initiatives (CFIs) programme targeting low income families in areas of socio-economic disadvantage, 10 Safefood funded CFIs were engaged and campaign material was shared amongst these groups. As a result, individuals identified ways to utilize and apply the materials and messages at a local level to those low income and vulnerable groups in disadvantaged areas. Feedback from target audience was sought at every stage of campaign planning. Feedback was taken on board and the necessary amendments made. The language used in the campaign was also consumer tested. One piece of work for e.g. is 'A guide for parents - Communicating with your child about a healthy weight'.

Were potential burdens, including harm, of the intervention for the target population addressed?

A language group was established comprising of safefood staff, a panel of experts from child psychology, psychiatry as well as stakeholders from various childhood obesity interventions at a local level. This specialist group advised on campaign wording on material, imagery and language which was then tested with the public. One piece of work for e.g. is 'A guide for parents -Communicating with your child about a healthy weight' (www.safefood.eu/Childhood-Obesity/A-guide-for-parents.aspx).

Other challenges included – alerting parents but safeguarding against them feeling blamed, while ensuring parents or children aren't stigmatized; any health risk disconnect; raising this issue so parents identify themselves as responsible and also part of the solution, providing support and encouragement to parents and maintain awareness of the importance of tackling this for the long-term.

Safefood engaged with and sought expert advice from the eating disorder organization Bodywhys to ensure that any potential unintended consequences around the campaign messages or materials were minimized and eliminated. For example, many parents fear that they may evoke an eating disorder if they talked about body weight, while at the same time the campaign needed to be sensitive to those with an eating disorder.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, stakeholder meetings were held on a regular basis to update the relevant parties and for the target population, all material was tested prior to development and a dedicated website hub to Childhood Obesity (<http://www.safefood.eu/Childhood-Obesity/Welcome.aspx>) was also created which included background information and additional supports such as answers to FAQs etc.

Did the evaluation results achieve the stated goals and objectives?

Yes, the evaluation results achieved the stated objectives by increasing parents awareness (by 6 %) of the key issues connected to childhood overweight and obesity. There was also strong recognition for the campaign overall, including both television and radio advertisements and outdoor advertisements. Parents also had increased knowledge on the effects obesity has on health. Parents behaviour also changed as a result of the campaign with a significant reduction in the number of parents giving treat foods to children every day (down 9%) and an increase in the number of parents open to discussing the issue of weight if they needed to (up 7%). 4 in 10 parents reported to have tried to reduce consumption of sugary drinks since the beginning of the campaign and daily consumption of fizzy drinks by children was down by 5%. Attempts to provide more age-appropriate portion sizes being served to children increased by 4% and 65 % of children were getting one hour of physical activity a day (up 6%).

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Consumer research was carried out by Millward Brown to assess the knowledge, attitudes and behaviours of the target audience towards childhood obesity throughout the campaign. A nationally representative sample of adults with children under the age of 12 years was sampled pre campaign and 12 months later. On both occasions participants were asked to complete a questionnaire during face-to-face interviews. The key elements asked in both surveys included the following: Issues Facing Children, Campaign Evaluation – including topics such as treats & supermarket themes, treats, drinks, portion sizes, physical activity, screen time, sleep and support for parents. The field work for the baseline/pre-campaign research was carried out in October 2013 and included 909 adults, 559 in ROI and 350 in NI. The research was repeated one year later between 8th and 28th October 2014 and included 919 adults, 567 in ROI and 352 in NI. The research also included parent's ability to recognise and recall television and radio advertisements. The campaign questionnaire was designed in collaboration with public health, nutrition and communications experts from safefood to ensure appropriateness and relevance.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes – both a benchmark and annual consumer surveys were carried out before and after each phase (message) of the campaign, to facilitate this. Measures such as TV advertisement recall and greater awareness and openness among parents around messaging, were used to monitor the impact of campaign. Social media engagement and interaction were also tracked to measure consumer sentiment towards the campaign, address any issues and to give support and further information sources to parents.

Who did the evaluation?

An external party – Millward Brown, one of Ireland's leading marketing and research consultancy agencies.

Specifically, what has been measured / evaluated?

There were two different aspects to the evaluation of this campaign. The first was pre-campaign research that was carried out to assess the attitudes and behaviours towards childhood obesity before the campaign began and this served as a benchmark to evaluate the campaign. Research was carried out by Millward Brown in October 2013 pre campaign to assess the attitudes and behaviours towards childhood obesity before the campaign began. The benchmark research was done by face-to-face home interviews with a nationally representative sample of adults (n=909) and children under the age of 12.

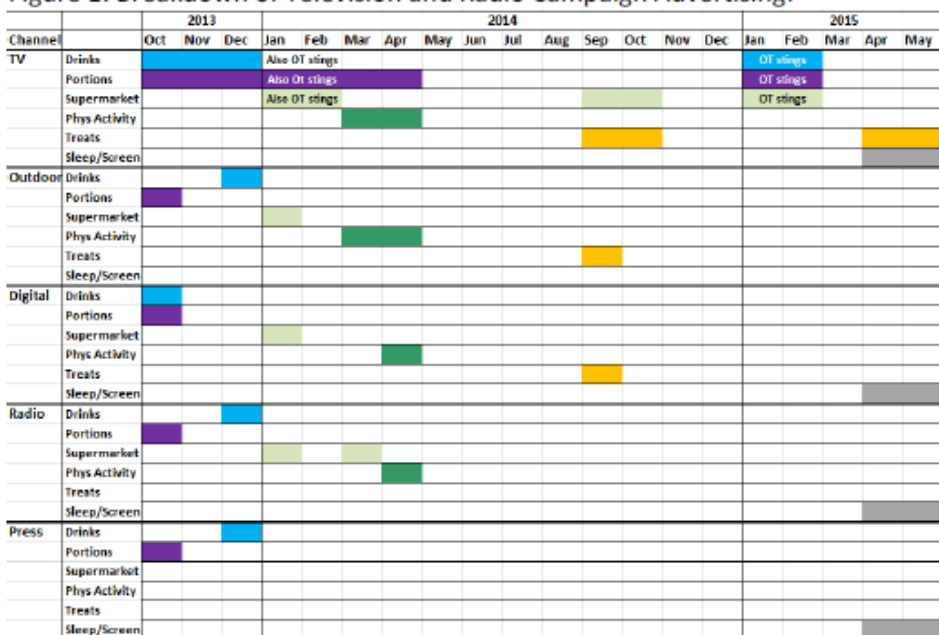
The second part of the evaluation focused on an evaluation of advertising for the childhood obesity campaign to test the effectiveness of the campaign and provided an initial consumer reaction to the campaign advertisements. Advertising channels used included, television, radio and outdoor advertisements, Digital communications, and social media channels. The effectiveness of the campaign was evaluated from the aspects of changing parental knowledge, attitudes and behaviours. Quantitative research was carried out by undertaking face to face focus groups with parents in multiple locations across the country, as well as accessing the latest population dietary research. The research also included parent's ability to recognise and recall television and radio advertisements.

Campaign Channels

Television and Radio Advertisements:

The childhood obesity campaign included 6 television and radio advertisements.

Figure 1. Breakdown of Television and Radio Campaign Advertising:



*OT Stings represents advertising around Operation Transformation.

Outdoor Advertisements: The message about childhood obesity was advertised by safefood in October 2013 on 130 outdoor posters located near supermarkets and 5,000 trolley handles across the Island of Ireland. The advertisements included drink choices, treat foods, portion sizes and physical activity. This type of advertising ran in different phases between October 2013 and May 2015.

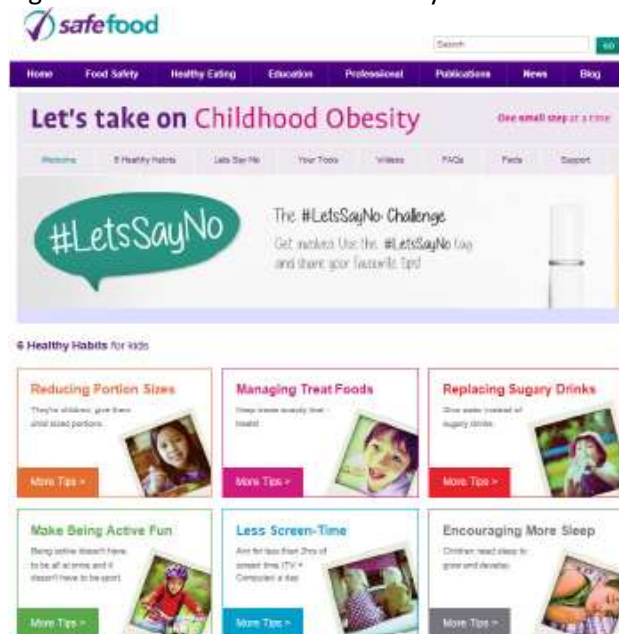
Digital Communications:

Mini Hub: The safefood website featured a quick link to the mini-hub on childhood obesity for the duration of the campaign. The mini hub includes information on:

1. Reducing portion sizes – They're children, give them child size portions.
2. Managing treat foods – Keep treats exactly that, treats!
3. Reducing sugary drinks- Give water instead of sugary drinks.

4. Make being active fun- Being active doesn't have to be all at once and it doesn't have to be sport.
5. Less Screen Time- Aim for less than 2 hours screen time a day.
6. Encouraging more sleep – Children need sleep to grow and develop.

Figure 4. safefood childhood obesity mini hub.



Blogs: Outside of the mini-hub, blogs were posted on the website by the safefood CEO, various safefood staff and guest experts. The blogs were under the following titles:

Making a TV ad about childhood obesity

Bringing back play, one kerb at a time

Why reduce treats?

Avoiding unhealthy food treats

How to use treat foods

Top 10 tips for a better bedtime routine for your kids

Good night's sleep

Each section of the campaign was advertised on digital communications for a period of a month after their launch, with the exception of the sleep campaign which ran for April and May 2015.

Social Media Channels: safefood used social media channels including Facebook and twitter to share the campaign message on childhood obesity to a wider reach. safefood regularly updated their social media sites, supplying their followers with information on childhood obesity. This information includes infographics on treat foods and sugary drinks. Favourite tips and ideas were shared by followers to other parents by using #LetsSayNo, #BringBackPlay and #ItsBedtime. Vox pop videos and parent blogs were uploaded sharing the public's ideas on reducing children's portion size, how to say no to treats and incorporating regular exercise into their children's daily routines. Expert's tips on how to achieve a healthier lifestyle for children are also shared through the means of social media.

Evaluation of the impacts/effects/outcome:

Pre Campaign: 1 in 2 parents were concerned about children being overweight and obese and a large proportion of people failed to identify themselves or their children as being overweight. 1 in 10 parents were intent on cutting portion size and 1 in 5 was looking to cut down the consumption of sugary drinks.

Post Campaign: Overall, there was a 6% increase in awareness among parents of the immediate and future health challenge posed by excess weight in childhood. There were strong levels of recognition for the campaign overall, including both television and radio advertisements and outdoor advertisements with significantly stronger recall rates in the Republic of Ireland than Northern Ireland (85% of people in the ROI and 78% of people in NI recalled seeing at least one of the ads).

As shown in the table 1, the campaign has had an effect on all five channels of behavioural change with parents across the Island of Ireland (IOI). Parents now have an increased awareness around the importance of these particular changes and have attempted to improve their child's habits; with smaller portion sizes and water at meals times, taking more physical activity as well as consuming less fizzy drinks and treat foods each day. Key findings

- A significant reduction in the number of parents giving treat foods to children every day (down 9%)
- An increase in the number of parents open to discussing the issue of weight if they needed to (up 7%).
- 4 in 10 parents reported to have tried to reduce consumption of sugary drinks since the beginning of the campaign and daily consumption of fizzy drinks by children was down by 5%.
- Attempts to provide more age-appropriate portion sizes being served to children increased by 4%.
- 65 % of children were getting one hour of physical activity a day (up 6%).
- Parent's lack of knowledge on childhood obesity is more notable amongst those from lower socio economic groups. This is particularly evident in reducing the frequency of treats and knowing the recommended hours of sleep for their children.

The campaign analysis and evaluation is available in English and will be available on <http://www.safefood.eu>.

Table 1. Summary of research results for pre and post campaign for island of Ireland based on behavioural change.

Key Issue	Pre-Campaign Results	Post-Campaign Results	% Difference
Attempt to reduce portion size	12%	16%	+4%
Consumption of fizzy drinks once a day or more	45%	40%	-5%
Consumption of water at mealtimes	31%	38%	+7%
At least an hour of exercise per day	59%	65%	+6%
Food treat at least once a day	33%	24%	-9%

What are the main results/conclusions/recommendations from the evaluation?

Overall, there was a significant increase in awareness by parents that excess weight in childhood is associated with poorer health in later life (up 6%) and there were strong levels of recognition for the campaign overall, including both television and radio advertisements and outdoor advertisements. Conclusions:

- The Childhood Overweight and Obesity on the Island of Ireland campaign has been strongly recognised and successful to date in changing parent's knowledge, attitudes and reported behaviours towards the issue.

- The use of television and radio advertising, outdoor advertising, digital communications, social media channels and press coverage allowed for the effective spread of the message against childhood obesity.
- Overall, parents are making positive and practical changes to their children's diets and physical activity levels in an effort to reduce childhood obesity.
- These are encouraging findings from an evidence based campaign showing changes in parent's knowledge, attitude and reported behaviours towards issues connected to childhood overweight and obesity.

Who implemented the intervention?

A childhood obesity team (consisting of staff from human health & nutrition, marketing and communications and corporate operations) within Safefood worked on implementing the various threads of the campaign. Safefood, the HSE, the Department of Health, Republic of Ireland, and partners in Northern Ireland (NI) – Public Health Agency worked collaboratively on this project for the years 2013 to 2015. An inter- Government departmental steering group was formed - including two government agencies and two government departments, including the Department of Health, the Department of Children and Youth Affairs, as well as the Regional Obesity Prevention Implementation Group (ROPIG) in NI and the Department of Health's Special Action Group on Obesity (SAGO) in ROI.

What core activities are/have been implemented?

- Consumer research was carried out by Millward Brown to assess the knowledge, attitudes and behaviours of the target audience towards childhood obesity throughout the campaign, to inform the creative development of the campaign.
- 6 television and radio advertisements were broadcasted across the relevant media streams on the Island of Ireland (IOI). The message about childhood obesity was advertised by safefood in October 2013 on 130 outdoor posters located near
- supermarkets and 5,000 trolley handles across the Island of Ireland. Digital communications - a mini-hub on childhood obesity was linked to on the safefood website including resources and information for parents, for the duration of the campaign.
- Outside of the mini-hub, blogs were posted on the website by the safefood CEO, various safefood staff and guest experts.
- Direct Marketing - 250,000 family booklets - Your Child's Weight were also distributed via the HSE and www.healthpromotion.ie
- Health Professional Support - in ROI A guide for health professionals – Assisting Parents and Guardians in communicating with their children about body weight, was developed and distributed by the HSE.
- The Health professional guide was included with the parent booklet 'Your Child's Weight booklet' and made available for all GPs for the start of the under 6yrs contract. They are also both listed on the HSE's info sheet for available supports.
- 2,500 posters of an infographic illustrating the amount of sugar in children's commonly consumed drinks were distributed by the Dental Health Foundation in ROI.
- Safefood attended agricultural shows across the IOI - the ROI ploughing championships and NI Balmoral show in order to increase awareness of the campaign messages amongst parents across the IOI.

Was the intervention designed and implemented in consultation with the target population?

Yes. During campaign design, material was tested through focus groups with parents (mothers and fathers) from both rural and urban areas with prioritisation to those from low socioeconomic groups. During the implementation

phase, several media channels were used and all outlets were skewed towards low socio economic groups e.g. tabloid newspapers, local press and radio stations, as well as timing of TV advertisements.

Did the intervention achieve meaningful participation among the intended target population?

Yes. Social media provides a good indication of consumer engagement. Both safefood Facebook and Twitter pages were monitored as part of the social media analysis. Reports of the social media analytics showed that as the campaign went on there was growing success in terms of engagement and reach through Facebook. For example, figures on the Organic reach i.e.: the total number of unique people who were shown campaign-related posts through unpaid distribution grew significantly from 12,240 in phase 2 to 400,130 in phase 5 and which could be due to the volume of posts, the quality of the posts and the growing number of fans. The organic engagement rate on Twitter was also high and consistent and ranged between 2.8% and 4.8%. Most brands aim for a rate anywhere from 1% -3%.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

While a needs assessment per se was not conducted with the target audience, precampaign research was carried out in nationally representative sample of adults with children under the age of 12 years at the pre campaign stage and 12 months later. Focus testing of campaign materials and messages was also conducted with target audiences that took account of gender, geography, and socio-economic class.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

SafeFood engaged with a range of stakeholders and intermediaries by undertaking the following:

1. actively engaged with Health professionals, Health representative bodies, Parental organisations, Health charities, Community and voluntary groups and Schools.
2. thorough carefully planned communications to ensure regular and ongoing engagement with national media to amplify the campaign core messages and using creative touchpoints to highlight important messages. The campaign was awarded 'Best Public Information Campaign 2015' by the Public Relations Institute of Ireland. <http://www.prca.ie/article.aspx?cat=7&sub=39>.
3. the campaign partners included the Irish Health Service Executive (HSE), the Healthy Ireland Programme at the Department of Health, the Public Health Agency in Northern Ireland (NI) supported by the Choose to Live Better campaign as well as the Department of Health's Special Action Group on Obesity (SAGO) in the Republic of Ireland. Other intermediaries included the Chartered Institute of Physiotherapists NI, the Irish Society of Chartered Physiotherapists, Diabetes Ireland, the Irish Heart Foundation, Early Years Ireland, the Department of Health, the Irish College of General Practitioners and the Irish Nutrition and Dietetic Institute (INDI).
4. safefood also wrote to the top retailers across the island of Ireland with regards to the issue of treats at the tills, showcasing its consumer research that 65% of customers backed confectionery-free checkouts. Shortly after this Tesco announced their move to put sweet-free checkouts across all stores in Britain and Ireland, including Metro and Express outlets.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes. The campaign was seen as an integral part of obesity plans in both the Republic of Ireland and in Northern Ireland. The Fitter Futures for All Framework for Preventing and Addressing Overweight and Obesity in Northern

Ireland, the Department of Health Republic of Ireland and the Regional Obesity Prevention Implementation Group (ROPIG) also support the campaign.

Is there a broad support for the intervention amongst those who implement it?

Yes - the campaign is implemented by Safefood and the HSE, who have dedicated resources for this 3 year campaign. Also the campaign is supported by the All-island obesity action forum, Healthy Food for All (an all-island charity combating Food Poverty by promoting access, availability and affordability of healthy food for low-income groups in areas of socioeconomic disadvantage) as well as the Department of Health's Special Action Group on Obesity.

Is there a broad support for the intervention amongst the intended target populations?

Yes. The broad support for this campaign among the intended target audience is reflected in the impacts the campaign has had on the target audience. Individuals on the ground see childhood obesity as an important issue and there is greater awareness among parents that excess weight in childhood is associated with poorer health/excess weight in later life - up 16% to 51%. As well as this there is also greater awareness & openness among parents to discuss the issue if needed with their children - up 21% to 80%.

Pre-campaign, 45% of children had a sugary drink at least once a day. This has dropped to 32%. Water consumption at mealtimes has also increased from 1 in 4 children to 4 in 10. 96% of parents in the benchmark study had tried to reduce their child's portion size. 74% of parents who have since been exposed to the 'Portions' campaign believe they need to start cutting down on the size of their children's portions, with 1 in 3 parents actively trying since launch

Were organisational structures clearly defined and described?

An inter Government departmental steering group was formed - including two government agencies and two government departments, including the Department of Health, the Department of Children and Youth Affairs, as well as the Regional Obesity Prevention Implementation Group (ROPIG)(NI) and Department of Health's Special Action Group on Obesity (SAGO)(ROI) to provide direction and oversight in the development and management of this campaign.

In the ROI – a memorandum of agreement was drawn up between safefood, HSE and DoH- working collaboratively on this project for the years 2013 to 2015. safefood manage the development of the integrated advertising campaign and the day to day running of the digital elements of the campaign whilst live. Safefood will have the final say in the development of the consumer communications. The HSE manage the development and roll out of the training and materials for health professionals. The DOH will support where appropriate in policy areas. The proposed materials will be shown to the campaign group. safefood manage the development of the integrated consumer communication's campaign. The HSE and DOH will be involved in the development of the brief(s). HSE will play an active role in campaign message development. All marketing, PR and other communications activities activity to be carried out around the campaign will be agreed between the three parties. In NI – safefood had full responsibility for the campaign as part of the Fitter Future for All Framework and the Choose to Live Better brand. A project management plan, outlining budget, timescales and expected outcomes, is in place, which helps ensure that the campaign is delivered in a cost effective and efficient manner. Organization structures roles and responsibilities of all involved are clearly defined A dedicated budget was committed to this campaign for 3 years.

safefood provided funding for the campaign development and delivery. HSE funded the resources and distribution of same among health professionals and staff.

Is the potential impact on the population targeted assessed (if scaled up) ?

Yes, the impact of this campaign has been demonstrated in both the Republic of Ireland and Northern Ireland in terms of changing parent's knowledge, attitudes and reported behaviours towards issues connected with childhood obesity. Parents are making positive and practical changes to their children's diets and physical activity levels in an effort to reduce childhood obesity. As well as this, the campaign also aims to establish long term weight and health awareness among parents.

Are there specific knowledge transfer strategies in place (evidence into practice)?

While there is no specific transfer strategy documented, it is reasonable to assume that some of the supporting campaign resources could be readily transferred and/or adapted to other jurisdictions. These resources include: a campaign support booklet for parent's, infographics – (on sugary beverages, childhood obesity and nutritional information on sweets, crisps, chocolate and biscuits etc.), printed resources for parents (reward charts and stickers), digital and online support as well as health professionals supports (a guide for assisting parents and guardians in communicating with their children about body weight) and the ICGP blended learning pack on childhood obesity.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Yes, partially. Some of the governance and project management arrangements are detailed above. While the potential for the transfer or scaling up the campaign has yet to be explored in more detail, it is reasonable to assume that some of the campaign elements and material could readily be adapted and translated into different languages and transferred to other countries. This is a large scale evidence based campaign that is being implemented in two jurisdictions on the island of Ireland, i.e. in the Republic of Ireland and in Northern Ireland, that so far has been successful in changing parent's knowledge, attitude and reported behaviours towards issues connected to childhood overweight and obesity.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Commitment and support from across Government Departments.
- Political leadership and commitment – embedded in obesity implementation plans north and south
- Leadership and commitment within the organisations responsible for implementing the campaign.
- Key success factors around campaign development and implementation included: 1) target audience engagement during campaign development informed the creative advertising approach, ensured that the correct and most appropriate stakeholders were engaged, and informed the development of relevant campaign messages.
- Partnerships with key stakeholders across many disciplines and sectors.

What were, in your opinion, the main lessons to be learned?

- Tackling overweight and obesity requires a multi-disciplinary, multi-agency, multilevel and coordinated approach that engages all stakeholders.
- Strong leadership, commitment and support from Government is essential to set the national government policy landscape and to provide a national policy approach.
- Partnerships with key stakeholders are essential to foster cross collaboration and co-operation for implementation.
- A Dedicated budget.
- At the campaign design and development phases reviewing and revising messages was critical to ensure that the key points were bold, frank and relevant to the target audience. Post campaign message research showed that the target audience appreciated clear and straightforward messages for example, 'give ½ a portion to a 5 year old'.

- Engagement of appropriate target audiences to focus test campaign materials and messages prior to campaign development.
- Conducting pre-campaign testing for both research purposes and to serve as a benchmark to evaluate the campaign.

Communication details

Communication details e.g. web page on the intervention can be accessed here

<http://www.safefood.eu/Childhood-Obesity/Welcome.aspx>

Weight status of the population in the Republic of Ireland can be found on

<http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Professional/Nutrition/Adult-and-children-obesity-trends-ROI.pdf>

Weight status of the population in Northern Ireland can be found on

<http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Professional/Nutrition/Adult-and-children-obesity-trends-NI.pdf>

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The Icelandic National Curriculum Guides for Preschools, Compulsory Schools and Upper Secondary Schools: Health and Wellbeing One of Six Fundamental Pillars of Education Iceland

Title in original language:

Aðalnámskrár leikskóla, grunnskóla og framhaldsskóla: Heilbrigði og velferð einn af sex grunnþáttum menntunar

Which 'life stage' for CVDs prevention targets the intervention?

Children in pre-schools (2-5 years), compulsory schools (6-15 years) and upper secondary schools (mainly 16-19 years).

Short description:

In 2011 new National Curriculum Guides for pre-, compulsory and upper secondary schools were published in Iceland by the Ministry of Education, Science and Culture. In that policy a milestone is made by defining “health and wellbeing” as one of the six fundamental pillars of education, thereby confirming the importance of health and wellbeing for education and vice versa.

The National Curriculum Guide is a policy framework for Icelandic schools across educational levels. It describes the role of education in schools according to Icelandic laws and regulations, the objectives and organization of school operations and the requirements and rights of everyone in the school community. Six fundamental pillars have been developed within this framework that forms the essence of the educational policy in Iceland. In addition to “health and wellbeing”, the other pillars are “literacy”, “sustainability”, “democracy and human rights”, “equality” and “creativity”.

The fundamental pillars are meant to accentuate the principle of general education and encourage increased continuity in school activities as a whole.

The National Curriculum Guide and particularly the pillar “health and wellbeing” is an important foundation for the Health Promoting School projects (pre-, compulsory and upper secondary HP Schools). The Health Promoting School projects likewise provide an important support for schools to implement the pillar “health and wellbeing” in all their work.

Preschools and compulsory schools are generally run by municipalities with additional funding from the state. Upper secondary schools are run by the state. The Health Promoting Schools Projects for all school levels are becoming well-established. They are run by the Directorate of Health in collaboration with The Ministry of Education, Science and Culture, The Ministry of Welfare and many other, key stakeholders. The number of health promoting municipalities is also increasing and one of their priorities is to encourage and motivate their schools to take part in the Health Promoting School projects.

To which type of interventions does your example of good practice belong to?

Policy/strategy. The National Curriculum Guide is a policy framework for Icelandic schools across educational levels. The National Curriculum Guides have the same status as regulations in Iceland.

How is this example of good practice funded?

The Ministry of Education, Science and Culture publishes The National Curriculum Guides for preschools, compulsory schools and upper secondary schools and funds the implementation partially, e.g. by publishing extra material and by funding courses and projects in development. Preschools and compulsory schools are generally run by municipalities, with their own funding and with funding from the state. Upper secondary schools are funded by the state.

What is/was the level of implementation of your example of good practice?

Preschools and compulsory schools are run by municipalities. Upper secondary schools are run by the state.

What are the main aim and the main objectives of your example of good practice?

With the implementation of the new National Curriculum Guides for all school levels (pre-, compulsory, and upper secondary schools) the pillar “Health and wellbeing” is now one of the six fundamental pillars of education. As children and youth spend large part of the day at school it is an important setting to create supportive environment that promotes healthy behaviours and lifestyle. With this policy document (National Curriculum Guides) schools now have an even larger role in providing health promoting environments as all school activities are now supposed to encourage health and wellbeing. It is the schools role to create a positive atmosphere and a health promoting environment where health and wellbeing are systematically supported in various ways. The main health factors that are to be encouraged are: positive self-image, physical activity, nutrition, rest, mental wellbeing, positive communication, security, hygiene, sexual health and understanding of one’s own feelings and those of others.

The fundamental pillars, including the pillar of “Health and wellbeing”, refer to social, cultural, environmental and ecological literacy so that children and youth may develop mentally and physically, thrive in society and cooperate with others. The fundamental pillars also refer to a vision of the future, ability and will to influence and be active in maintaining society, change it and develop. The fundamental pillars are based on the view appearing in school legislation that both social objectives and the educational objectives of the individual are to be achieved. They are socially oriented as well as they are meant to promote increased equality and democracy and to ensure well-educated and healthy citizens, both for participating in and for changing and improving society and also for contemporary employment.

The fundamental pillars are meant to accentuate the principle of general education and encourage increased continuity in school activities as a whole.

In evaluating school activities, the influence of the fundamental pillars on teaching, play and studies have to be taken into consideration. The fundamental pillars are an intrinsic part of school activities. The concepts that the fundamental pillars are based on are to be reflected in the working methods, communication and atmosphere of schools. They should be evident in all educational activities and in the content of school subjects and fields of study, both regarding the knowledge and the skills that children and youth are to acquire fields of study. This can be specialisation of the tasks of school activities, across subjects and school levels. The fundamental pillars are an intrinsic part of all curriculum guides at all school levels and their stipulations for all school activities:

- Choice of material and content of study, teaching and play should reflect the fundamental pillars
- Working methods and techniques that children and youth learn are influenced by ideas which appear in discussions of the fundamental pillars
- Procedures of teachers and other school personnel are to be based on the fundamental pillars and thus encourage independence, initiative and development of school activities
- When school activities are evaluated, it should be observed whether and how the fundamental pillars are reflected in study, teaching and play

Please give a description of the problem the good practice example wants to:

By placing “Health and wellbeing” as one of the six fundamental pillars in the curriculum guides, the government highlights the important role of health and wellbeing in achieving the main objectives of education in Iceland. At the same time this emphasis is also a very important step towards implementing Icelandic health policy and Health 2020. In Health 2020 one of the key messages is that improvements in health are the product of not only the actions of the health system but of effective policy across all parts of government (HiAP) and collaborative efforts across all levels of society.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The National Curriculum Guide is based on the Preschool Act, No. 90, 12 June 2008, the Compulsory School Act, No. 91, 12 June 2008, and the Upper Secondary School Act, No. 92, 12 June 2008.

The Guide is issued by the Ministry of Education, Science and Culture in the same manner as regulations and serves diverse purposes. It is both a means of control to execute provisions of these law, instructions of the educational authorities on school policy and a compilation of the common objectives for school activities in the whole country.

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Vulnerable social groups:

Ethnic minorities; Migrants; Disabled people/children; Low income groups

Who implements/implemented the policy?

The Ministry of Education, Science and Culture is responsible for the implementation of legislation for all school levels and the operation of secondary schools. The municipalities are responsible for the pre- and compulsory schools and the implementation of this policy; usually the schools have some liberties within the framework.

What core activities are/have been implemented?

To introduce the six fundamental pillars of education and support their implementation, the Ministry of Education, Science and Culture has developed a website and videos (Icelandic). <http://namtilframtidar.is>

The Ministry of Education promotes the Health Promoting Schools Projects, coordinated by the Directorate of Health, as a suggested means towards success in implementing the “Health and wellbeing pillar”.

The Home and school association has on behalf of the Ministry introduced the national curriculum guide throughout the country (in 2013).

The city of Reykjavik introduced for example all the six pillars, including “Health and wellbeing”, at The Reykjavik Children’s Culture Festival in 2014.

Who did the evaluation?

Internal and external parties. Included in the Compulsory Schools Act nr 91/2008 there is a section on Evaluation and quality assurance in compulsory schools with a discussion on

- a) the objectives of the evaluation,
- b) internal evaluation,
- c) external evaluation by municipalities,
- d) external evaluation by the Ministry. The external evaluation is outlined in the regulation nr. 658/2009.

The implementation is done by the institute “Námsmatsstofnun”.

What has been measured / evaluated?

The Ministry of Education makes a plan for evaluation at all school levels and places it on its website. The national Curriculum Guide is the basis for criteria on evaluation of school activities but school curriculum guides, created by each school, further detail the objectives and criteria that are stipulated in the national Curriculum Guide and, depending on circumstances, school curriculum guides.

The national Curriculum Guide is to serve different parties. It describes the objectives and requirements common for all pupils, teachers and school authorities and other school personnel at the same time, it is criteria for standardised assessment in compulsory schools, evaluation of school activities, guidelines for those who produce study material or are engaged in teacher education, it is the basis for writing school curriculum guides and self-evaluation in schools and for the policy making of local authorities.

Evaluation of school activities is by law part of the supervisory work of schools and school authorities in order to ensure the rights of pupils and promote school improvement.

The objectives of evaluation and supervision are primarily divided into three parts:

- 1) Firstly, it is to examine whether school activities are in line with the provisions of law, regulations and the national Curriculum Guide;
- 2) Secondly, to improve the quality of educational work and encourage improvements, ensure that the rights of pupils are observed and that they are provided with the service that they are entitled to in accordance with law;
- 3) Thirdly, it is to provide information about school activities, their results and development. Schools are responsible for internal evaluation but the Ministry of Education, and depending on circumstances, local authorities carry out the external evaluation.

External evaluation

The institute “Námsmatstofnun” conducts external evaluation on behalf of the Ministry of Education. The goals of the external evaluation is to be guiding and reform-based. External evaluation comprises, for example, evaluations of school activities as a whole or specific aspects of these activities, comprehensive evaluation of the activities of individual schools, evaluation of school subjects and aspects of learning, and supervision of internal evaluation of schools. Additionally, the Ministry is responsible for supervising that local authorities fulfil their relevant responsibilities created by laws on schools. Furthermore, the Ministry is to supervise the status and development of the educational system to that end.

Compulsory schools

External evaluation in compulsory schools is done according to criteria on quality in compulsory schools. The main theme in external evaluation is that it is supposed to be guiding and reform-based and that it promotes improvements in the schools. The basis of the external evaluation in compulsory schools are quality criteria in these three areas:

I Management, II Learning and teaching, and III Internal evaluation. The criteria are built on laws and regulations on schools and the national curriculum guide for compulsory schools.

Upper secondary schools

There is an external evaluation in each upper secondary school every five years. Criteria for external evaluation is being implemented.

Internal evaluation of compulsory school

The Ministry of Education publishes detailed directions on internal evaluation that schools can use, if they wish. Internal evaluation should specify the connection with the objectives stipulated in the school curriculum guide. Each school develops methods that take into account the unique emphases of the school in order to determine to what extent these objectives have been achieved. The methods of internal evaluation take into account the educational work that is being carried out. In each case the internal evaluation of each school is based on a systematic method that is described in the school curriculum guide. Each school year, the school operation plan presents what aspects are to be targeted in the internal evaluation. The school internal evaluation is an effective part of everyday work and includes all aspects of school activities, such as administration, teaching, study requirements, assessment and communication within and outside the classroom. Emphasis should be on the active

participation of personnel, pupils, parents and other interested parties, depending on circumstances. Information has to be collected by various means in order to evaluate school activities realistically.

The internal school evaluation is based on diverse data. The selection of information and data that the evaluation is based on is determined by the research topic each time. Objectives and means are to be evaluated regularly. Internal evaluation gives information about the strengths in the activities of the school and where improvement is needed with regard to the findings of the internal evaluation, improvements are defined and planned. Schools publish the outcomes of the internal evaluation and improvement plans. Personal information is exempt from publication.

It is important that internal and external evaluation incorporates all the objectives of school activities stipulated by law, including the role of schools to encourage pupils to participate in democratic society, support initiative and independent thinking, social skills and other factors that are, among other things, related to the fundamental pillars of education. Further information about quality assurance in school education: https://webgate.ec.europa.eu/fpfis/mwikis/eurydice/index.php/Iceland:Quality_Assurance_in_Early_Childhood_and_School_Education

What are the main results/conclusions/recommendations from the evaluation?

Evaluation reports (Icelandic):

Preschools: <http://www.menntamalaraduneyti.is/mat-og-uttekir/leikskolar/>

Compulsory schools: <http://www.menntamalaraduneyti.is/mat-og-uttekir/grunnskolar/>

Upper-secondary schools: <http://www.menntamalaraduneyti.is/mat-og-uttekir/framhaldsskolar/>

Web page related to the intervention:

The Ministry of Education, Science and Culture (English):

<http://eng.menntamalaraduneyti.is/publications/curriculum/>

Legislations that the curriculum builds on:

The preschool act http://eng.menntamalaraduneyti.is/media/MRN-pdf_Annad/Preschool_Act.pdf

The Compulsory School act <http://eng.menntamalaraduneyti.is/media/law-and-regulations/Compulsory-School-Act-No.-91-2008.pdf>

The Upper Secondary Education Act <http://eng.menntamalaraduneyti.is/media/law-and-regulations/Upper-Secondary-Education-Act-No.-92-2008.pdf>

The Health promoting school projects (Icelandic):

HP compulsory schools: <http://www.landlaeknir.is/hgs>

HP upper secondary schools: <http://www.landlaeknir.is/hef>

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Young People at a Healthy Weight 'JOGG' Netherlands

Title in original language:

Jongeren op Gezond Gewicht- JOGG

Which 'life stage' for CVDs prevention targets the intervention?

It specifically focuses on childhood and adolescence. In principle includes all children aged 0-19 years.

Short description of the intervention:

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

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

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

Activities at the national level:

- Advice on creating political and managerial support
- Training in the JOGG approach for locally involved parties
- Information on successful interventions and best practices
- Designing and providing municipalities with communication and information materials
- Directions on how to implement the JOGG approach
- Scientific research how to measure the effects of the approach

Activities at the local level:

Each city has its own JOGG-coordinator who plans various activities in relation to the 5 JOGG pillars. These activities differ between the municipalities implementing the JOGG approach. It ranges from drinking water activities at kindergarten to creating playgrounds. Municipalities commit to JOGG for at least 3 years.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The logic model has been based upon the EPODE logic model. The clear difference between the EPODE model and the JOGG model is the starting point of the four critical components. Moreover, the JOGG approach consists of five pillars: political commitment, co-operation between the public and private sectors, social marketing, scientific support and evaluation, and linking prevention with health care. The JOGG model is being used as a model of

reference for implementation and evaluation of the local JOGG approach by the JOGG central coordination office and the JOGG communities. It is thought that the five pillars will enable intersectoral collaboration, community capacity building and increase the activities on nutrition and physical activity (output). This will lead to changes in the environment (home, schools, care and neighbourhoods) and to changes in the individuals (attitudes, awareness, skills and knowledge) and this will change the child behaviour on physical activity and healthy nutrition, leading to an increase in percentage of children with a healthy weight (outcome).

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Please see the answers on the individual components (objectives, methods & activities).

To which type of interventions does your example of good practice belong to?

Policy/strategy

How is this example of good practice funded?

National/regional/local government

What is/was the level of implementation of your example of good?

National and Local (municipality level). The policy/strategy is initiated and coordinated by the national JOGG foundation. The programs at local level are adapted to the needs of the municipalities and always supported by a city council member.

What are the main aim and the main objectives of your example of good practice?

Main aim is to reverse the increasing trend of young people (0-19 years) with overweight/obesity. The sub-aims are 1) To increase the amount of young people that achieve the recommended level of daily physical activity; 2) Reduce the intake of sugary drinks and increase the intake of water; 3) Increase the amount of young people that consume a healthy breakfast; 4) Increase the daily intake of fruit and vegetables and 5) Every setting (neighbourhood, school, home and health care) offers a healthy option, and promotes physical activity.

The objectives of the strategy at national level are:

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

Main objectives 2010-2014:

- Changing the increase of overweight and obesity among youth (0-19 years) into a decrease.
- Including 75 municipalities in the National JOGG movement

Main objectives 2015-2020

- Working on a healthy environment with structural attention for a healthy lifestyle and a healthy weight, reaching at least 1 million children and young people
- In 75 JOGG-municipalities there is a measureable increase in the number of children with a healthy weight

Please give a description of the problem the good practice wants to tackle:

The number of children with overweight is increasing In the Netherlands, one out of seven of the boys and one out of six of the girls have overweight. In some neighbourhoods, it's one out of three. Overweight and obesity in

children is a risk factor for developing overweight and NCDs in adulthood. Therefore, prevention of overweight is important at young age.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Overweight and obesity are a spearhead in the Dutch Health Policy. JOGG is embedded in the National Prevention Plan (Everything is health). One of the indicators to evaluate this policy plan is the amount of municipalities that implemented the JOGG-approach.

JOGG was also part of the Covenant on Healthy Weight, a joint initiative of 26 organizations in the Netherlands. This Covenant was initiated and supported by the Ministry of Health, Welfare, and Sports. In 2015 this covenant is discontinued and a special JOGG Foundation is set up which supported and finances by the Ministry of Health, Welfare and Sports.

Furthermore, JOGG is a pillar in the Partnership Overweight Netherlands. In the partnership, several stakeholders are collaborating to prevent overweight. Stakeholders include the Ministry of Health, Welfare and Sport, Health Care Insurance Board, Dutch Care Institute and the Netherlands Diabetes Federation. Local authorities who are taking part in JOGG approach are also involved. The JOGG approach at national level will be continued until at least 2020.

At local level Dutch municipalities have health policies in place. In these policies, they may focus on the prevention of overweight or obesity. Most of the Dutch municipalities have prevention of overweight as spearhead in their local policy document.

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Target group(s):

The target group of JOGG are children aged 0-19 years. Intermediary groups are: parents, teachers, educators, health professionals, sport coaches, dieticians, social workers, policy makers & private partners.

During implementation, did specific actions were taken to address the equity dimensions?

JOGG advises municipalities to target vulnerable groups in vulnerable environments. As such, at local level many activities are adapted in such a way that they best address the needs of groups with low SES or other ethnic background. To find out these needs social marketing techniques are used.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

During the development of the local activities the (intermediate) target group is involved to find out the demands and needs of the target group. To explore these needs and demands the principles of social marketing are used. Social marketing is an important part of the JOGG-approach.

Which vulnerable social groups were targeted?

The JOGG approach pays special attention to those who live in disadvantages areas and in these areas JOGG focuses on those who need the most such as children to -9 months until 4 years old.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, and using different strategies?

At local level, every setting (neighbourhood, school, home and health care) is included. At those settings, healthy options and physical activity is promoted.

School:

JOGG established a Charter for Healthy Food Supply at schools, to promote healthier food supply in school canteens. Charter parties are linked with schools in the JOGG municipalities. Moreover, the foundation connects the JOGG approach with the School Canteen Brigade and other national initiatives like the Healthy Schools program in these municipalities. Ambition – Realising a healthy school environment for all children and young people going to school. An environment with attention for a healthy lifestyle and a structural school policy on healthy nutrition, sports and physical activity is created.

Sports club:

Healthier Canteen Guidelines have been established to improve the food supply in sport canteens. To be effective, the JOGG foundation aims at extension and intensifying the realisation of Healthy Sport Canteens and uses the cooperation and infrastructure of the JOGG approach. Ambition – Creating a healthy environment in sport canteens, including structural attention for a healthier food supply.

Work:

Promote healthy lifestyles of youngsters who (almost) enter the labour market and adults surrounding them. Companies and organisations are encouraged to promote healthy lifestyles and to translate the ambition and objectives of JOGG to their own policy and actions. Ambition – Youngsters and adults work together in an environment with attention for vitality and a healthy lifestyle and with a structural policy on healthy supply of foods and drinks and increased physical activity and sports. This policy for vitality and healthy lifestyle is discussed and designed by employers and employees.

Besides these aspects, JOGG also addresses the direct environment of the youth by promoting infrastructural changes, safe neighbourhoods, more green and play areas in the municipalities.

Was an effective partnership in place?

At national level the JOGG movement is coordinated by the Foundation 'Jongeren Op Gezond Gewicht', based in The Hague. Former Dutch politician Paul Rosenmoller chairs the foundation and is the national JOGG ambassador, besides the Dutch prince Pieter-Christiaan van Oranje and dancer Juvat Westendorp.

At national and local level JOGG works together with partners from both the public and private sector (Social partners: Association of all Dutch healthcare insurers, Dutch Heart Foundation, Dutch association of Dieticians, Netherlands Olympic Committee* Netherlands Sport Federation, Association of all drinking water companies in the Netherlands, Royal Association for Physical Education, Branch Association for Supermarkets and Food Services in the Netherlands, Federation of the Dutch Food Industry, Association of Dutch Catering Organisations, Dutch council for Primary Education, Dutch council for Secondary Education, Dutch council for Intermediate Vocational Education. Private partners: Albert Heijn (leading food retailer in NL), Albron (food service organization), Zilveren Kruis Achmea (Health Care Insurance company), Friesland Campina (dairy company), Nutricia, Unilever; Knowledge partners: Nutrition Centre, National Institute for Public Health and the Environment, National Institute for Sport and Physical Exercise.

At local level, partners include: schools, municipals and municipal health services, council housing, general practitioners, dieticians and physiotherapists, supermarkets, religious institutions, social media, police, sports clubs, business and associations. At local level the parties vary but there is always a combination of public and private partners.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

JOGG is aligned with EPODE and is member of the EPODE international network.

At national level, JOGG was embedded in the Covenant on Healthy Weight, a joint initiative of 26 organizations in the Netherlands. From 2015, JOGG became a foundation. JOGG is also part of the National Prevention Plan and

JOGG is a pillar in the Partnership Overweight Netherlands. In the partnership, several stakeholders are collaborating to prevent overweight (see other question about alignment with national and local policy plans). At local level JOGG is always embedded in the health, social welfare and sports policy. The local governor signs the JOGG agreement and the local JOGG coordinator is appointed by the local government.

Was the intervention implemented equitably, i.e. proportional to needs?

JOGG advises municipalities to target vulnerable groups in vulnerable environments. As such, at local level many activities are adapted in such a way that they best address the needs of groups with low SES or other ethnic background (e.g. using social marketing principles).

Were potential burdens, including harm, of the intervention for the target population addressed?

Social exclusion and discrimination on weight were considered and JOGG professionals are made aware of the fact that their action may result in harmful effects. JOGG professionals work with interventions and programmes that take adverse effects into account.

At national level, the communication is in a positive manner.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

The local activities of JOGG are developed using the community-approach. Members of the (intermediate) target groups are involved during the development and implementation of the local activities.

Did the evaluation results achieve the stated goals and objectives?

At the moment, the overall progress of JOGG has been monitored in 5 municipalities:

- Zwolle: between 2009 and 2012 the percentage of primary school children with overweight decreased from 12.1% to 10.6%
- Utrecht: in the period 2010-2014 the percentage of primary school children with overweight in the JOGG neighbourhoods decreased from 25% to 22%
- Dordrecht: between 2012 and 2013 the percentage of primary school children with overweight in Dordrecht West decreased from 35.2% to 34.1%.
- Amsterdam: between 2011 and 2013 the percentage of primary school children with overweight at two JOGG schools in Nieuw West has decreased from 41.5% to 37.4%
- Rotterdam: in 2013 the percentage of primary school children with overweight in Rotterdam has stabilised.

For the evaluation of the local activities there is a progress and activity monitor. This implementation of this tool started at the end of 2013. The monitor registers the progress on the different pillars, reach of the municipalities. In 2016 the results will be presented of the all the 84 municipalities.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

For the monitoring and evaluation of JOGG a specific Evaluation Framework is developed (Koperen, et.al.2013). This framework is based on the CDC's evaluation framework. Process and outcome indicators are directed on the local team, advocacy, community capacity building and nutrition and physical activity interventions.

At national level: monitoring and evaluation is an important part of the logic model, the working plans and ambition documents. The part of the total activity budget varies on annual basis, but monitoring is one of the continuous activities.

The national JOGG foundation developed a progress and activity monitor to be used at local level. At local level, all municipalities address monitoring and evaluation in their action plans and most of them even design a specific

monitoring and evaluation plan. JOGG advises to allocate 15% of the total budget to evaluation of the approach. Activities are monitored constantly using the activity monitor. Questionnaires (including diet, intake of liquids, breakfast, physical (in)activity, environment) and BMI measurement at the start and after 3 years are used. Some municipalities choose to measure BMI on a yearly basis.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

The progress and activity monitor is developed for the process evaluation and serve as a standard tool for monitoring progress and evaluates local activities.

Monitoring takes place continuously, both at national and local level. Funds, human resources and material resources are allocated to monitor the implementation of JOGG.

Who did the evaluation?

Internal and external parties

Specifically, what has been measured / evaluated?

Process evaluation (respondents, method, participants satisfaction): At local level, the process is monitored twice a year, using the activity and progress monitor. The progress on the five pillars (political and governmental support; cooperation between the private and public sector; social marketing, scientific coaching and evaluation, linking prevention and health care), plus communication and local organization is monitored. At national level the program will be evaluated in 2016 on process (e.g. five pillars, communication and organization) and effects (behavioural changes and overweight).

Evaluation of the impacts/effects/outcome: The local youth health monitor is used to discover trends in health of the youth from 0-19 year. Every four years municipalities are obliged to monitor the health of the habitants of their municipality. This monitor is carried out by the regional Municipal Health Services. Municipalities are recommended to use the behavioural questionnaire which is developed for the evaluation of the behavioural effects of the local activities of JOGG. The behavioural questionnaire include questions on diet, intake of liquids, breakfast, physical (in)activity and environment) and BMI measurements at the start and after 3 years. On national level the program will be evaluated on effects by the National Institute of Public Health and Environment in 2116.

What are the main results/conclusions/recommendations from the evaluation?

JOGG municipalities Zwolle, Utrecht, Rotterdam, Dordrecht and Amsterdam are the first municipalities who have shown results for JOGG in the JOGG communities since the start in 2010.

- Zwolle: between 2009 and 2012 the percentage of primary school children with overweight decreased from 12.1% to 10.6%
- Utrecht: in the period 2010-2014 the percentage of primary school children with overweight in the JOGG neighbourhoods decreased from 25% to 22%
- Dordrecht: between 2012 and 2013 the percentage of primary school children with overweight in Dordrecht West decreased from 35.2% to 34.1%.
- Amsterdam: between 2011 and 2013 the percentage of primary school children with overweight at two JOGG schools in Nieuw West has decreased from 41.5% to 37.4%
- Rotterdam: in 2013 the percentage of primary school children with overweight in Rotterdam has stabilised.
- In the fall 2013, several JOGG municipalities presented their local JOGG approach and activities in the TV show Operatie NL Fit.

- In 2014, 10 JOGG municipalities continue their JOGG approach after the first 3-year period of cooperation.

35 of the 75 JOGG municipalities started with the thematic approach DrinkWater.

All JOGG municipalities have an online toolkit and inspiration kit of the thematic approach Physical Activity for Free at their own disposal. In October 2014, this second theme was introduced nationally at television via the Physical Activity for Free commercial.

Process evaluation: Besides, the 6 national private partners, about 120 partners are locally active. There are partners from the nutritional, sport, water, societal, financial and educational sectors.

In the context of the 5th pillar of JOGG, connecting prevention and health care, 8 municipalities started with the new lifestyle program Lifestyle Energy Fun & Friends, based on the MEND program. MEND is a community weight management program for children aged from 7-13 year. This program was shown to be effective in England.

Is the evaluation report available?

There are several local evaluation reports available in Dutch.

Was there a follow- or is any follow-up evaluation planned in the future?

The programme runs until at least 2020. Monitoring will continue yearly.

In 2014, 10 JOGG municipalities continued their JOGG approach after the first 3-year period of collaboration.

Who implemented the intervention:

The national JOGG foundation coordinates the JOGG approach.

In order to ensure high quality performance the local JOGG coordinators are trained by the national foundation. In the first six months, the local JOGG coordinators are coached by a trained JOGG coach who works with them locally.

Every municipality gets thorough support from the national foundation of up to a max of 40 days a year. All local coordinators and professionals have access to the online wiki platform on which they can find templates for their action plans, timelines, but also examples of other municipalities and instructions and inspiration on how to work on the five pillars.

What core activities are/have been implemented?

The national foundation focuses on:

- Advice on creating political and managerial support
- Training in the JOGG approach for locally involved parties
- Information on successful interventions and best practices
- Designing and providing municipalities with communication and information materials
- Directions on how to implement the JOGG approach
- Scientific research with which to measure the effects of the approach

At local level, the local JOGG coordinator plans various activities in relation to the five JOGG pillars. They focus on healthy schools, healthy sport canteens, healthy work, free physical activity and drink water.

The ambitions are described in comprehensiveness of the intervention or policy

Was the intervention designed and implemented in consultation with the target population?

The social marketing component of the approach ensures that both locally and at national level certain target groups, such as parents, professionals and children are consulted and involved in the design and implementation of activities, both at local and national level.

Did the intervention achieve meaningful participation among the intended target population?

JOGG has started with the local dissemination of the approach in 2010 in Zwolle. Currently, 84 municipalities (of the 393 municipalities) in the Netherlands are using the JOGG approach to promote a healthy weight among the youth. Within most JOGG municipalities the programme specifically focuses on the neighbourhoods that experience the greatest challenge in terms of socio-economic and health status.

The number of beneficiaries is estimated to be around 500,000 inhabitants

Did the intervention develop strengths, resources and autonomy in the target population(s)?

At local level, the community approach ensures working on the empowerment of the target group. Municipalities work with activities or interventions that strengthen skills and make youth more confident in controlling their lives and choices. At national level empowering by working on self-confidence and strengthening skills is a key value.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Locally, municipalities are strongly encouraged to perform a needs assessment and to involve all the relevant stakeholders/partners at municipal and neighbourhood level as well as to consult the target group. The output of such a need assessment varies across municipalities.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

The local activities are developed with the intermediate target groups such as teachers, management of schools, health, welfare professionals, sport foundations and private parties such as the local supermarket and companies. This involvement promotes the participation of the target group.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Municipalities commit to JOGG for at least 3 years and are obliged to pay a commitment fee (for which they get support from the national foundation). In addition, they appoint a local JOGG coordinator for at least 2 days a week. One requirement to start with JOGG is that the approach is adopted by the full council of the municipality and that they embed JOGG in their local policies. Also, the local municipalities are expected to continuously monitor and evaluate the effects, activities and progress of JOGG.

At national level a foundation is started for the JOGG program. The national JOGG foundation support local authorities and their local partners in their sustainable efforts to help the youth to live healthier. The ministry of Health, Welfare and Sports finances this foundation.

Is there a broad support for the intervention amongst those who implement it?

The number of municipalities that implement JOGG is rapidly increasing each year. It is aimed that each year 15 new municipalities join JOGG. From the start in 2010 until now there are already 84 municipalities who have adopted the JOGG-approach.

Is there a broad support for the intervention amongst the intended target populations?

At local level support of the target groups is ensured by the use of social marketing techniques and their support is measured in qualitative research.

At national level the satisfaction of the local JOGG participants with the support of the JOGG foundation and the needs are measured.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

There are several templates for the implementation of JOGG on local level such as a template for the ambition plan, financial plan and activity plan. At national level there is a financial report of the last 5 years.

[https://jongerenopgezondgewicht.nl/userfiles/CGG-JOGG%20financieel%20verslag%202010-2013%20A%20\(1\).pdf](https://jongerenopgezondgewicht.nl/userfiles/CGG-JOGG%20financieel%20verslag%202010-2013%20A%20(1).pdf)

Were sources of funding specified in regards to stability and commitment?

At national level the funding of JOGG consist of financial support of the Ministry of Health, Welfare and Sports, contribution of the municipalities (5000/10.000 euro per year) and financial contribution of private partners.

At local level the budget varies but every municipality invests in the commission of a JOGG-coordinator for three years.

Were organisational structures clearly defined and described?

Local level: during the planning phase of JOGG one of the first steps is to organize a stakeholder meeting in order to find out who want to commit to the approach. As a second step stakeholders can take place in the local organisation of JOGG (Steering group, partner group, working groups)

Possible local stakeholder: alderman, civil servants from various sectors (urban planning, healthcare, sports, economy), communication or social marketing specialist, general practitioner, dietician, care professionals, prevention workers, social workers, neighbourhood specialists, parents, teachers, day care providers, companies, children, media

National level: stakeholders form the backbone of JOGG throughout all steps of the approach. During the planning phase stakeholders were involved in defining the mission and structure of JOGG.

Stakeholders: Ministry of Health, Welfare and Sport, private companies, universities, expertise centres

There are several good practices of municipalities and templates in Dutch and can be used by the JOGG-coordinator.

Is the potential impact on the population targeted assessed?

Not of this program but is estimated in model studies that a decrease in the percentage of children with overweight will result in less chronic diseases and health gain.

Are there specific knowledge transfer strategies in place?

Commitment to JOGG requires 10.000 euro. In return, the national JOGG foundation supports municipalities at most 40 days a year. In addition, local JOGG coordinators are trained by the national foundation. In the first six months, the local JOGG coordinators are coached by a trained JOGG coach. Furthermore other strategies are: social media, newsletters, best practices, conferences, coaching, workshops, articles in (inter)national magazines and study books and the presentation of best practices and templates on the website

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

JOGG is already implemented in 84 municipalities. For further scaling up there need to be more financial resources and a different organization: more regional organization of the support of the JOGG-coordinators.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Political commitment: Healthy weight, as part of a healthy lifestyle is an important topic in local politics and adopted in relevant policy documents. Mayor and aldermen are familiar with, interested in and actively involved in the JOGG movement.
- Co-operation between the public and private sectors: Both public and private entities are closely involved with JOGG. For instance as part of the local project team they could generate ideas, provide communications resources, or contribute financially to JOGG's activities
- Social marketing: The essence of social marketing is to get to know your target group. Social marketing applies a "customer oriented" approach in order to create sustainable behaviour change. JOGG municipalities apply the principles of social marketing to their local situation.
- Scientific support and evaluation: The JOGG approach will be and is monitored and evaluated both in terms of process and outcome. JOGG municipalities use the most effective interventions and will measure the effects. The process will be evaluated and adjusted if necessary. BMI, health behaviour and the healthy environment of young people in JOGG communities will be monitored.
- Linking prevention and health care: In Dutch JOGG towns, (care)professionals identify overweight at an early stage. By linking preventive care with health care structures young people will receive the support they need.

What were, in your opinion, the main lessons to be learned?

On local level lessons learned are:

- To disseminate the norm for healthy behaviour a political and governmental support is essential. Governors can connect the different sectors within the municipality (and beyond) required for a comprehensive approach.
- Social marketing is a valuable addition to existing behavioural change strategies, where the focus is on seducing rather than banning. No there is more insight in how parents experience lunch at school and what the deeper motives are for mothers to let their child outside to play or not. That was the starting point for the target group.
- Public-Private Partnership (PPP): business brought knowledge, expertise, manpower and money in. These experiences have led to a clear vision and frameworks for PPS in the approach to healthy weight.
- Involvement of residents and organizations increases by involving them in the preparation and implementation of activities in their area.
- There is a need to take a long breath and remain active on different parts. Sports, healthy eating, social, education and business: an integrated approach is a condition.

On national level

- Next years there have to be more focus on embedding the activities in local policies and organizations
- Support for the implementation of the JOGG approach has to be organized at the regional level instead of national level. Because of the increase of the number of municipalities support on the national level is almost not possible anymore..
- More attention for the monitoring and evaluation at local and national level to have more insight in the results and to readjust the different components of the program
- Optimization of the different components of the JOGG-approach

Web page related to the intervention

www.jongerenopgezondgewicht.nl

References to the most important articles or reports on the intervention

Koperen, van M. e.a.(2014). Design of CIAO, a research program to support the development of an integrated approach to prevent overweight and obesity in the Netherlands. BMC Obesity 2014, 1:5
<http://www.biomedcentral.com/2052-9538/1/5>

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Dutch Obesity Intervention in Teenagers 'DOiT' Netherlands

Which 'life stage' for CVDs prevention targets the intervention?

Adolescence.

Short description of the intervention:

Target group: Adolescents attending the first two years of prevocational education (12 to 14 years old).

Aim: To prevent overweight among prevocational educational school children by improving energy-balance-related behaviours (EBRBs).

Design/method: The DOiT programme consists of 12 fixed theory lessons and four physical education lessons. The lessons in the first year are aimed at increasing awareness and knowledge of healthy behaviours, i.e. intake of sugar-containing beverages, high-energy snacks/sweets and breakfast, screen time and physical activity behaviour, such as active transport to school and sports participation and improvement of those behaviours. The lessons in the second year focus on increasing awareness and acting upon the influence of the obesogenic environments. The environmental component aims to raise awareness of the school environment, finding solutions to reduce negative influences within the environment and setting a plan for improvement. The parental component focuses on stimulation of social support of the parents and raising awareness of the availability and accessibility of healthy products and activities in the home environment. As part of the DOiT programme, all parents receive an information booklet in which the topics of the DOiT lessons are described. During the programme, adolescent receive homework assignments to complete with their parents. Optionally, at the end of the programme schools can organize a meeting for parents, where adolescents present what they learned.

Materials: The DOiT materials included a 'schoolbook' accompanied by separate worksheets, a student toolkit (pedometer, food/exercise diary and online computer-tailored advice) and a parental information booklet. DOiT is supported by an extensive teacher manual with a login for extra materials provided at the DOiT website.

Recruitment: Schools are actively recruited by sending a DOiT introductory package existing of an information letter with a factsheet, brochure and exemplary teachings materials. Additionally, different promotion activities, such as news items on different relevant websites and in digital mailings, presentations at national conferences and local meetings of different stakeholders, are executed in order to reach potential users. Health promotion professionals with the specialty on Health Schools are also actively contacted for their participation in recruitment of schools.

Frequency/duration/intensity: 2 year intervention programme. 12 fixed theory lessons (equally divided over two school years). Four physical education lessons (equally divided over two school years)

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

In 2002, the initial development of DOiT was formed using the Intervention Mapping (IM) protocol:

- Definition of the programme objectives, based on a thorough analysis of the health problem
- Selection of adequate theories and methods to realize behavioural change
- Design of intervention programme, as well as the selection, testing and production of the intervention materials and
- Evaluation in RCT design.

In 2009, adaptations to the DOiT programme were made and a 7-step implementation strategy was developed, again guided by the IM protocol in preparation of the nationwide dissemination at prevocational schools through the Netherlands. In short, childhood overweight is associated with many health risks. Since those health risks track into adulthood, prevention of overweight in youth is a major public health priority. The prevalence of overweight in 12-14 year old Dutch adolescents attending prevocational education is increasing rapidly (22% vs 13% for boys and 22% vs 16% for girls measured in 2011 compared with 2003).

The main theory underlying the DOiT programme is the self-regulation theory (Zimmermann, 2000). DOiT focuses on several behavioural determinants of EBRBs: knowledge, awareness, skills, social support, habit and self-efficacy. The initial 2002 version of DOiT included different theoretical methods and practical strategies translated into the DOiT materials to promote health EBRBs in 11 lessons incorporated in biology and physical education lessons during one school year. The environmental component included an advice to the school staff for changes in school canteens and financial support to provide additional physical activity options in the school setting.

From 2003 to 2005 the programme was evaluated in a cluster randomized controlled trial showing promising effects on adiposity measures and EBRBs. Using the RE-AIM framework, a process evaluation of DOiT was conducted. This process evaluation also provided suggestions for further adaptation to DOiT, preparing the programme for nationwide implementation.

From 2009, the programme was revised following the phases of the IM protocol. In the first phase (2009), interviews and focus groups were held making use of 1) the evaluation of its initial version; 2) updated literature study; 3) 14 semi-structured interviews with teachers; 4) seven focus groups with parents and 5) 12 focus groups with adolescents. In the second phase (2010) the adapted DOiT programme was implemented as part of a larger health promotion project in collaboration with the Municipal Health Service of Amsterdam. The RE-AIM framework was used to evaluate the process of implementation, including satisfaction with the adapted programme, suggestions for improvement and implications for further implementation. Next during 2011-2013, the programme was evaluated during nationwide dissemination in the Netherlands. 20 schools who bought the programme were followed during two school years. The process of implementation was evaluated as well as the effect compared to adolescents attending control schools.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Please see the answers on the individual components (objectives, methods & activities).

To which type of interventions does your example of good practice belong to?

Individual Intervention.

How is this example of good practice funded?

Schools can order the programme themselves or can receive funding via local supporting organizations (e.g. local sports organizations, municipal health services (GGD)). At the moment, the Dutch Ministry of Health, Welfare and Sports supports schools to promote healthy lifestyles. DOiT is one of the interventions that is supported by the Dutch government with financial support if schools are planning to implement the intervention DOiT.

What is/was the level of implementation of your example of good practice?

National. Since August 2011, the DOiT programme has been available for schools in the Netherlands. This implies that all schools in the Netherlands can select to buy the DOiT programme. All schools have free access to the implementation strategy and accompanying materials on the DOiT website. It is unknown how many schools have ordered the programme. From an implementation study it is known that 66 schools ordered the DOiT materials within the first year. Only 20 schools participated in the implementation evaluation, therefore, no data is available about use of the programme at the other 46 schools. Within the first 2 school years, more than 90 schools ordered the materials, reaching over 10,000 adolescents.

What are the main aim and the main objectives of your example of good practice?

DOiT focusses on five energy balance-related behaviours (EBRBs):

- 1) reducing intake of sugar-containing beverages (i.e. soft drinks and fruit juices);
- 2) reducing intake of high-energy snacks;
- 3) reducing screen time (i.e. TV viewing and computer use);
- 4) increasing levels of physical activity (i.e. active transport and sports participation)
- 5) daily and healthy breakfast consumptions

In school year one, six theory lessons in the class room aim to raise awareness and information processing with regards to EBRBs.

The parental components aim 1) to stimulate social support of the parents and 2) to raise awareness of the availability and accessibility of healthy products and activities in the home environment.

In the second school year, 6 theory lessons aims to 1) facilitate choice to improve behaviour and 2) raise awareness of the unhealthy environment, finding solutions and setting a plan for improvement of the environment.

The environmental component aims to raise awareness of the unhealthy environment, finding solutions and setting a plan for improvement of the environment.

For each EBRB specific performance and change objectives are formulated which were the bases for the development of the programme (Phase 1 of Intervention Mapping)

Please give a description of the problem the good practice example wants to tackle:

Childhood overweight is associated with many health risks. In the Netherlands, it has been shown that overweight measures of 12 to 14 year old Dutch adolescents attending prevocational education measured in 2011 compared with adolescents measured in 2003 have increased steeply (22% vs 13% for boys and 22% vs 16% for girls).

Adolescence is an important transition period in life course in which lifestyle is subject to important changes. Unfavourable behavioural patterns established during this period of life may be vital in the development of adult health behaviours.

The increase in the consumption of sugar-containing beverages has been suggested to play an important role in excessive weight gain and has shown to be associated with energy intake and body weight, and with weight gain and obesity. There is some evidence that avoiding consumption of sugar-containing beverages can play an important role in obesity prevention. It is estimated that 30-35% of total energy intake of Dutch adolescents is derived from snacks and sugar-containing beverages. Therefore, prevention of overweight and obesity should focus on the promotion of healthy dietary patterns.

Two important aspects of energy expenditure that contribute to excessive weight gain in adolescents are sedentary behaviour and declining levels of physical activity. It is estimated that 42% of the Dutch adolescents aged 12-17 years spend 10-19 hours per week watching television, while 34% spends 20 hours or more. Computer use has greatly increased in the last couple of years. This shows that an intervention should address both dietary habits and physical activity patterns during adolescents.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, the intervention is embedded within the governmental support programme 'Youth Impulse'. The aim of the National Programme is to improve collaboration between schools and health professionals and to improve the implementation of qualified Healthy School activities.

In this National Programme, funding is reserved for primary and secondary schools and vocational education. Schools can ask for 1) free tailor-made support to facilitate health promotion at schools 2) additional funding for health promotion programmes focussing on nutrition, alcohol or resilience training and 3) funding for working hours to prepare or execute health policy.

DOiT is one of the qualified interventions, which is presented in the Dutch best practice portal Loketgezondleven.nl that can be selected to acquire additional funding for health promotion programmes.

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Target group(s):

Adolescents aged 12 to 14 years attending prevocational education (low SES). Intermediate target groups are the parents of these adolescents, teachers and management of the schools

During implementation were specific actions taken to address the equity dimensions?

The intervention was adapted for adolescents attending prevocational education; also two different versions of the programme were developed to meet the different levels of prevocational education in the Netherlands. Also in the developmental process there were focus groups with adolescents and parents and interviews with teachers and experts to guarantee the intervention will meet the needs of the target group.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Funding is available for all secondary schools in the Netherlands through the support programme 'Youth Impulse'. A pilot study among teachers indicated that the programme was found to be too complex for the vocational adolescents' education level. Teachers suggested to develop two versions of DOiT, tailored to the different levels of prevocational education, ensuring feasibility for both tracks. The intervention can be implemented at any prevocational school in the Netherlands

Which vulnerable social groups were targeted?

Adolescents aged 12 to 14 years attending prevocational education (most likely low SES)

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

The intervention is conducted in school setting addressing the individual behaviour, involvement of parents and an environmental component. The environmental component aimed at raising awareness of the unhealthy environment, finding solutions and setting a plan for improvement of the environment. It focuses on physical activity facilities in and around school, healthy school canteen and (un)healthy food retail outlets around school.

Was an effective partnership in place?

Preferably, there is a partnership with the Municipal Health Service department of Health Promotion (specialists on healthy schools) and Child and Adolescent Health Care, prior to the implementation of the intervention.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

National level: Policy on overweight prevention has a specific focus on prevention of overweight and obesity in low SES adolescents and students at the prevocational level of education. Prevention of overweight and obesity is one the spearheads of the national prevention program.

Local level: Dutch municipalities have their own health policies in place. These health policies may focus on adolescents, low SES groups or on overweight. Most likely, the intervention will be implemented in municipalities that focus on those high-risk groups.

Most of the municipalities in the Netherlands have the prevention of overweight as one the spearheads of their local prevention program. This is encouraged by several national strategies such as JOGG (advice and finance to implement activities to prevent overweight and obesity) and Healthy School Canteens.

Was the intervention implemented equitably, i.e. proportional to needs?

All prevocational schools can implement the intervention, targeting all children between 12 and 14 years. And all schools can apply for financial support. A needs assessment was carried out to identify the needs of the target population. In the needs assessment the adolescents, parents, teachers and experts were interviewed in focus groups.

Were potential burdens, including harm, of the intervention for the target population addressed?

The lack of planning was experienced as hampering implementation and continuation of the programme at teachers' level. At individual level, no potential burdens were assessed.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

The process evaluation indicated that the majority of the adolescents who were exposed to the programme appreciated and used the DOiT materials and positively rated their experience with the programme activities. A majority of the teachers regarded the DOiT materials as suitable for prevocational education. Teachers reported that they would recommend DOiT to other schools, however only 33% of the teachers planned to continue using DOiT themselves after the 2 year implementation.

Did the evaluation results achieve the stated goals and objectives?

The process evaluation showed that the amount of implemented lessons decreased over time and only half of the delivered lessons were implemented according to the teacher manual. Teachers were satisfied with the DOiT lessons and teaching materials; adolescents were moderately satisfied with the DOiT materials and teaching materials; and one third of the schools wanted to continue using the DOiT programme after implementation. The effect evaluation is described below.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. The initial intervention, developed in 2002-2003 using the Intervention Mapping protocol, was evaluated on the process and the effect, described in a PhD thesis. In 2009, the intervention was adapted also with the Intervention Mapping protocol, and a pilot study was carried out. In 2010 and 2011, preparations were taken to scale up the intervention. From 2011 to 2013 the implementation and effect were evaluated and described in a PhD thesis.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

The lessons should preferably be delivered by biology, health care or physical education teachers at the schools. The manual is comprehensive and enables the teachers to implement the intervention. Schools were advised to appoint a DOiT coordinator. Furthermore, a contact person in the DOiT support office supported and advised implementers of DOiT throughout the school year.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

Specifically, what has been measured / evaluated?

In 2011-2013, the process evaluation was performed in 20 prevocational education schools in the Netherlands, including 110 teachers and 938 adolescents. The process evaluation showed that the amount of implemented lessons decreased over time (from 76% to 18%) and only half of the delivered lessons were implemented according to the teacher manual. Teachers were satisfied with the DOiT lessons and teaching materials; adolescents were moderately satisfied with the DOiT materials and teaching materials; and one third of the schools wanted to continue using the DOiT programme after implementation.

Evaluation of the impacts/effects/outcome: Cluster controlled implementation trials with 20 voluntary intervention schools (N=1002 adolescents) and 9 comparable control schools (N=484 adolescents). Adolescents' body height and weight, skinfold thickness and waist circumference were measures. Dietary and physical activity behaviours were measured by means of self-report. Data were collected at baseline and at 20-months follow-up.

Other: During interviews with DOiT coordinators and teachers after the first and second year, facilitators and barriers to the adoption, implementation and continuation of the DOiT programme were identified

What are the main results/conclusions/recommendations from the evaluation?

Implementation of the adapted programme did not lead to significant programme effects on any of the adiposity measures (BMI, waist circumference or skinfolds) or target behaviours at 20 months follow-up (consumption of sugar-containing beverages, high-energy snacks/sweets and intake of breakfast, screen time, active transport to school and sport participation). However, subgroup analysis showed that the programme resulted in significant beneficial effects on consumption of sugar-containing beverage in girls and breakfast consumption in boys.

Is the evaluation report available, preferably in English or at least an English summary?

Yes. The outcome of the effectiveness of the implementation is described in van Nassau et al, IJBNPA, 2014

Who implemented the intervention?

The intervention is implemented by the teachers at the prevocational schools during regular biology or physical education lessons. All teachers are qualified to teach at prevocational education level. The teachers are supported by the DOiT support office. They support and advise the implementers throughout the school year.

What core activities are/have been implemented?

To facilitate the implementation process, a 7-step implementation strategy with accompanying materials, such as teacher manual, is provided via the DOiT website.

Classroom component

- 12 theory lessons divided over two school years:
- Aiming at raising awareness and information processing with regard to energy-related behaviours
- Aiming at facilitation of choice to improve behaviour
- Aiming at raising awareness of the unhealthy environment, finding solutions and setting a plan for improvement of the environment

Physical education lessons: experiencing the effect of PA measured by pedometer and manual heart rate measurements. Repetition of experiencing the effect of PA measured by manual heart rate measurements. Learning about sport possibilities in the neighbourhood

Optional extra lessons: cultural differences: learning about the cultural differences in eating habits and being physically active; tasting, judging product by tasting, smelling and looking at unfamiliar snacks and soft drinks; cooking, preparing a healthy meal.

Environmental component: Aiming at raising awareness of the unhealthy environment, finding solutions and setting a plan for improvement of the environment. Focus on Physical activity facilities in and around school, healthy school canteen, (un)healthy food retail outlets around school

Parental component: Aiming at stimulating social support of the parents, aiming at raising awareness of the availability and accessibility of healthy products and activities in the home environment.

Was the intervention designed and implemented in consultation with the target population?

Prior to the intervention, a needs assessment was carried out among teachers, adolescents and the parents.

Did the intervention achieve meaningful participation among the intended target population?

Sixty six schools ordered the DOiT materials within the first year. Implementation of DOiT lessons decreased from 74 to 18% towards the end of the programme. Teachers delivered on average 56% of the lessons according to the teacher manual.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Process evaluation showed that the adolescents who were exposed to the programme appreciated and used the DOiT materials and positively rated their experience with the programme activities.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes, the needs assessment included a structures analysis of the main risk behaviours related to weight management and becoming overweight in youth. The methods of the needs assessment included evaluation of scientific literature, relevant national and international reports on obesity and obesity-related topics. Focus groups among adolescents were held, as well as interviews with teachers, experts in the field of physical activity, dietary behaviour and health promotion. This procedure led to the identification of risk behaviour from both sides of the energy balance: energy intake and energy expenditure.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Professionals of the Municipal Health Services and the local Sport Services are in place to recommend the intervention to the schools

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

The intervention owner is VU University Medical Centre in Amsterdam. From June 2013 onwards, the production and distribution process of the DOiT materials has been transferred to an educational publisher, enabling continued dissemination of the programme throughout the Netherlands. Future adaptations to the programme will occur in consultation with the researchers of the VU University Medical Centre in order to ensure the evidence-based core element and practical strategies of the programme. The publisher also maintains the website and is supporting the schools who are implementing the intervention. Schools can request funding from the government to implement DOiT.

Is there a broad support for the intervention amongst those who implement it?

A majority of the teachers regarded the DOiT materials as suitable for prevocational education. Teachers reported that they would recommend DOiT to other schools and planned to continue using DOiT themselves. Several schools selected DOiT as the health promotion activity they want to implement using the 'Youth Impulse' supporting funds.

Is there a broad support for the intervention amongst the intended target populations?

A process evaluation showed that the majority of the adolescents who were exposed to the programme appreciated and used the DOiT materials and positively rated their experience with the programme activities.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Teaching material is around 10 euro's per adolescent. Extra personal costs and time for the teachers is limited because DOiT is taught during existing lessons of biology, caretaking and physical education. The coordinator of the intervention in the school should have sufficient time, but the amount will depend per coordinator.

Were sources of funding specified in regards to stability and commitment?

Schools can apply for funding from the 'Youth Impulse'. But this funding is only available between 2014 and 2016.

Were organisational structures clearly defined and described?

DOiT support office was founded to guide and support the schools in their decision making, implementation and continuation with DOiT. Teachers are responsible to implement DOiT in the lessons. DOiT coordinator is a linking agent between the different implementing teachers within the school.

Is the potential impact on the population targeted assessed?

The intervention is potentially available to all prevocational schools. In the Netherlands, 330,600 adolescents attend prevocational education.

Are there specific knowledge transfer strategies in place?

The implementation and evaluation of the intervention is described in a PhD thesis, and several papers have been published (e.g. van Nassau et al, PHN, 2014; van Nassau et al BMC PH, 2013). The intervention is assessed as 'goed onderbouwd' and included as best practice in the database of the Centre for Healthy Living in the Netherlands. It is also presented in manual for Health Municipalities and Health Schools in a specific overview of interventions addressing prevention of overweight. In addition, the intervention is part of the 'Youth Impulse' support funding (see above). Therefore, it is expected that the intervention will be implemented on a larger scale.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Yes, the barriers and facilitators have been identified in a semi-structures interview guide with teachers and DOiT coordinators at implementing schools. The results are described extensively elsewhere (van Nassau et al, 2014).

Facilitators: Compatibility of the programme; Lay-out; Content; Potential for tailoring the programme

Barriers were mainly at school and teacher level. Complexity of the constant changes in school setting, as well as large teacher turnover were mentioned as most important barriers for implementation and sustainability.

Financial resources were not mentioned as barrier, probably because the intervention and materials were offered at a relatively low-cost.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Schools with more flexibility in the curricula, strongly motivated and committed teachers and a devoted DOiT coordinator are preconditions for success.

What were, in your opinion, the main lessons to be learned?

It is difficult to plan a 2-year programme in schools, due to teacher and student turnover.

Time constraints in schools are hindering implementation, therefore, the programme could benefit from identifying core components of the programme.

Web page related to the intervention

www.doitproject.com (in Dutch)

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Active School Flag Ireland

Which 'life stage' for CVDs prevention targets the intervention?

Infancy, Childhood & Adolescence .

Short description of the intervention:

Aim: The ASF is an initiative which aims to enhance levels of physical activity for children through developing a physically active and physically educated school community. Target group: School-going children between the ages of 5 and 18 years. It is open to all primary, post-primary, special needs education schools and YouthReach centres. **Design/Method:** Schools are recruited to the programme by invitation and once engaged with the programme they are supported on a programme of action planning and self-evaluation based on a 'whole school' approach. Schools are firstly required to review their current provision across the areas of physical education, physical activity and partnerships and commit to a number of improvements. The review areas including elements of planning and PE curriculum, professional development, schools PE resources, activity during break times, discretionary/cross-curricular and extra-curricular activity, inclusive physical activity and active travel.

Physical Education	Physical Activity	Partnerships
Planning and Curriculum	Activity during Break Times	Working with Pupils
Professional Development	Discretionary Time and Cross-Curricular Activities	Working with Parents
Resources	Extra-Curricular Activities	Working with the Local Community
	Inclusive Physical Activity	Working with National Agencies
	Active Travel	

Partnerships also form a defined focus of review including working with pupils, parents, the local community and national agencies. This work is supported by standardised ASF guidelines and review prompts which are periodically revised. Schools include an Active School Week as part of their annual school calendar. Schools are assessed by various means including an accreditation visit, completion of documentation and there are defined quality control mechanisms including an ASF screening committee. An overview of the programme can be viewed from this short presentation http://www.activeschoolflag.ie/files/ASF_Presentation_Slides.pdf

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes. The ASF mirrors well-evaluated 'active school' models operating in other countries. The evidence to support the design of the intervention is reflected in the published work 'Flying the Active Flag – physical activity promotion through self-evaluation in primary schools in Ireland' (a full reference is provided in the references section at the end of the form). This study explored the fit between the ASF design and the evidence from the literature on the

characteristics of successful programmes including the preferences of children. Supporting schools using a self-evaluation approach is a strategy with proven effectiveness in schools contexts including in Ireland (McNamara and O'Hara 2008; Schildkamp and Visscher, 2010; Schildkamp, Visser and Luyten, 2009). The ASF mirrors best practice guidelines internationally using a whole-school approach, which is considered as one of the seven best investments for physical activity. A pilot study was not conducted. The programme started with a small number of schools and adapted its work and priorities according to the early experiences.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, and methods?

The ASF initiative has a clear set of guidelines and tools to ensure a standardised approach to support changes in the physical activity policies, environments and opportunities within the school. The application documents can be viewed at <http://www.activeschoolflag.ie/home.html>.

Schools select from a menu of options in the context of their own local needs and priorities. Once committed to a set of actions these are linked with a defined set of indicators to monitor progress. Schools appoint a teacher as the Active School Flag coordinator to lead the process. Every school must also form an Active School Flag committee. Nominees from all areas of the school life are invited to take part – management, teachers, non-teaching staff members, pupils, parents and members of the community. Pupil voice is an extremely important aspect of the ASF process. As broad a range of pupils as possible are included on the committee, including those pupils that are not interested in sports. A record of all meetings is kept. In some schools ASF pupil committee members wear badges on the days when meetings are being held. The ASF committee meets with the accreditor during the accreditation meeting. A start and end date is applied to each individual improvement.

To which type of interventions does your example of good practice belong to?

The ASF is a nationwide initiative focussed on supporting the whole school approach to enhancing physical activity. The ASF mirrors other 'active school' models operating throughout Europe and internationally, for example the CDC Comprehensive School Physical Activity Program in the US.

How is this example of good practice funded?

National government – core funding comes from the Department of Education and Skills with additional sponsorship from the Department of Health under the Healthy Ireland Framework for Health and Wellbeing 2013-2025.

Non-governmental organisation - Elements of the programme are supported by Ireland Active and the Federation of Irish Sport.

What is/was the level of implementation of your example of good practice?

The ASF programme was launched in 2009 and 673 schools have received the ASF to date including 634 primary and 39 post primary schools. This represents around 19% of all primary schools and 5% of post-primary schools.

What are the main aim and the main objectives of your example of good practice?

The ASF is an initiative which aims to enhance levels of physical activity for children through developing a physically active and physically educated school community.

Please give a description of the problem the good practice example wants to tackle:

Inactive and sedentary lifestyles are a major concern among Europe's children and young people, and Ireland is no exception. Regular physical activity has many benefits including direct benefits during childhood to physical and mental health, weight control and child development. Children who are physically active are more likely to be active and less likely to be overweight in adulthood. Changes in the physical activity of children influence the public health of the population. It has been estimated that in Ireland, 9% of the burden of coronary heart disease and 11% of Type 2 diabetes can be attributed to physical inactivity.

Estimates of physical activity among children in Ireland: The Children's Sport Participation and Physical Activity survey 2009 estimated that 19% of primary school children and 12% of post primary school children achieve the target of 60 minutes of moderate to vigorous physical activity every day. The pan-European Health Behaviour in School-Aged Children Survey estimates that around one in four 11 to 15 year olds achieves the physical activity target and 54% watch more than 2 hours of TV every day.

Social and gender perspectives on physical activity: Similar to other European countries, girls were less active than boys and levels of physical activity increased with increasing socio-economic status.

Active play: 49% of children reported playing games outside with a parent within the last week

Active travel: It is estimated that 32% of primary children and 43% of post-primary children walk or cycle to or from school each day.

Physical education in school: Ireland scored a D- on the physical activity report card for children with just 35% of primary (5th and 6th Class) and 10% of post primary children receiving the recommended level of PE.

Extra-curricular school sport: 42% of primary and 57% of post-primary students reported participating in extra-curricular sport 2 or more times a week.

Overweight and obesity are a significant concern in Ireland, in keeping with most other European countries. In Ireland it has been estimated that one quarter of 9 years olds are overweight or obese. An infographic on childhood overweight and obesity in Ireland can be accessed here:

<http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/ChildhoodObesity/childhoodobesityinfographic.jpg>

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes.

- *Healthy Ireland – A Framework for Health and Wellbeing 2013- 2025 (Department of Health)*
- *A National Physical Activity Plan is expected to be published by the Department of Health later this year.*
- *In addition, the Active School Flag is aligned with priorities set out in government strategies on sports participation, active travel and the prevention of overweight and obesity.*

Implementation of your example of good practice is/was:

Periodic – as the programme is based in the school setting it occurs during term-time only and not in the summer months. The programme has been operating since 2009 and remains active.

Target group(s):

Children attending primary school
 Children attending post-primary school
 Early school leavers attending Youthreach centres

During implementation were specific actions taken to address the equity dimensions?

Yes. Particular attention is paid to the inclusion of children with additional needs such as disability and to the promotion of gender equitable programmes under the ' inclusive physical activity' strand. Partnership working with pupils, parents, the local community and national agencies ensure that priorities are based on local needs.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

In the early review phase when priorities are being considered, the school is prompted to consider the following:

INCLUSIVE PHYSICAL ACTIVITY

Inclusive Physical Activity refers to how the school caters for pupils of all abilities and interests including those with special needs, exceptional talent and disinterested pupils. Whole school physical activity events are also relevant to this review section.

How do you ensure that extra-curricular opportunities are accessible to all pupils?

How does your school ensure that pupils with special needs can play a full role in all physical activity opportunities?

How does your school encourage pupils with exceptional ability?

How does your school encourage children that are disinterested in sport to become more physically active?

Is Sports Day organised in an inclusive way, to maximise the physical activity opportunities for all?

Does your school organise accessible whole school recreational events such as hill walks etc.?

Does your school organise accessible physical activity fund raiser events?

Which vulnerable social groups were targeted?

Children living in social and economically disadvantaged circumstances; children with disabilities and special needs; as many schools in Ireland and all-girl or all-boy schools, the issue of gender participation can only be dealt with in certain ways.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

The design of the ASF seeks to address some of the obstacles faced by pupils in terms of physical activity and involvement in active travel and physical education in school.

The programme is rooted firmly in a whole school approach ensuring that many aspects of school life provide opportunity as well as support for physical activity as part of the school day.

Was an effective partnership in place?

The ASF works in partnership with schools and teachers. In addition the programme works in partnership with national bodies relating to the development of sports and the Health Service Executive. A list of partners involved with the programme is available here: <http://www.activeschoolflag.ie/professional-development-service-for-teachers.html>

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes. The programme is aligned with the Healthy Ireland Framework and the commitments made in current obesity policy. The policy is also aligned with government policy in respect of sports participation, active travel and social inclusion.

Was the intervention implemented equitably, i.e. proportional to needs

There are elements within the programme which ensure that focus is placed on inclusion of those pupils least likely to be physically active.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

The programme is operated with the direct involvement of pupils, parents and the local community. For example, in the review phase, during which priorities are discussed, the school considers the following prompts:

WORKING with PUPILS

Do pupils have a voice in terms of sports and physical activity provision in your school?

Has your school carried out pupil surveys on matters relating to physical education, physical activity, active travel, ASW etc.?

How are individual and team achievements celebrated within your school community?

Does your school have a Well Done Wall or Wall of Fame to acknowledge pupil achievements?

Does your school organise any form of Sports Awards? If so, what awards are given out?

What opportunities does the school offer pupils to display their physical activity skills?

WORKING with PARENTS

Do parents help out with the physical activity programmes?

Does your school participate in the HSE Be Active After School Activity Programme'?

How does the Parents' Association help to promote physical activity?

How does the Parents' Association support your school's efforts to provide sports equipment and/or to improve the sports facilities?

Does your school inform parents about local clubs and physical activity opportunities in their local area?

WORKING with the LOCAL COMMUNITY

What local facilities are used by your school?

Does your school allow local clubs to utilise its sports facilities?

Does your school have established links with local clubs and physical activity organisations?

Does your school have links with community groups such as the Special Olympics or Community Games?

Have local sports persons or teams been invited to your school to talk with the pupils?

Did the evaluation results achieve the stated goals and objectives?

The success of the programme is evident from a process evaluation of the experiences of participation by schools. More directly, the success of the initiative is evidenced by the ongoing growth and development of the programme which indicates a high level of acceptability and ownership by schools and the stakeholders at school level.

It has not yet been evaluated whether the programme has resulted in improvements in physical activity among the pupils. The proximal and process outcomes are positive but the effect of the programme on end-outcomes remains unclear. Preliminary data on physical activity based on pre- and post- assessments of children has been collected but the results are not yet available.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Findings from the self-evaluation process undertaken by the school led to reshaping of priorities at school level. Materials and resources have been periodically reviewed and improved to meet the needs of schools.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

There was a very clearly defined process in place to collect information on the work occurring in schools in terms of review and the establishment of school governance structures, the achievement of goals set by the school in any given year.

Specifically, what has been measured / evaluated?

See link 'Flying the Active Flag' – physical activity promotion through self-evaluation in primary schools in Ireland' published in Irish Educational Studies, Vol.31, September 2012
<http://www.tandfonline.com/doi/full/10.1080/03323315.2012.710066#abstract>

What are the main results/conclusions/recommendations from the evaluation?

The ASF is well accepted in schools and the self-evaluation process allows schools to cater a plan of action in the context of their local needs and assets. Schools placed physical activity in a more central position in school life as a consequence of involvement in the programme particularly in the areas of (1) alignment with curriculum structures (2) engagement with physical structures and (3) increase in organisational structures. Schools without indoor facilities were restricted in the breadth and frequency of curriculum delivery. For many schools, action planning placed an emphasis on fun and enjoyment, maximum participation and opportunities for achievement.

All schools included in the process evaluation type study prioritised changes to the playground environment as an area for development in their action plans. Schools were successful in implementing new organisational structures such as time-tables for shared equipment, zoning of spaces and activity rotas. Schools were also active in initiating more formal planning, greater provision and choice in co-curricular sport. The balance between competitive and non-competitive sports appeared to shift towards non-competitive sports in the main.

The central role of the teacher in co-curricular sport and other physical activity promotion programmes was evident. The presence of national governing body coaches was seen as an opportunity to upskill teachers. Many schools embraced the involvement of children and introduced innovative means to capture the views of pupils. Partnerships established through self-evaluation provided the potential for increasing the quantity and quality of physical activity promotion in schools. Leadership by the school was critical to the success of the programme. The self-evaluation approach requires little financial resource commitment and may represent good value for money. School's approaches to the self-evaluation reflect a multi-dimensional understanding of the purposes of, and approaches to, physical activity promotion within school communities.

In some schools, where there was a strong sporting tradition, they found it more challenging to focus on additional opportunities for children not involved in school teams. These practices were guided by school culture and maintained an adherence to competitive structures which may privilege a small number of pupils. The value placed by schools on competitive school representation needs to be accommodated within policy messages. Further research is required to examine if the actions identified during the self-evaluation process have become embedded in every day practice and are sustained within the school.

The quality and functioning of the partnerships established through ASF should be further explored with a view to supporting sustainable partnership for all parties. The long-term impact and sustainability of the initiative merits further investigation. Source of information: 'Flying the Active School Flag' – full reference available in references at the end of this form.

Is the evaluation report available, preferably in English or at least an English summary?

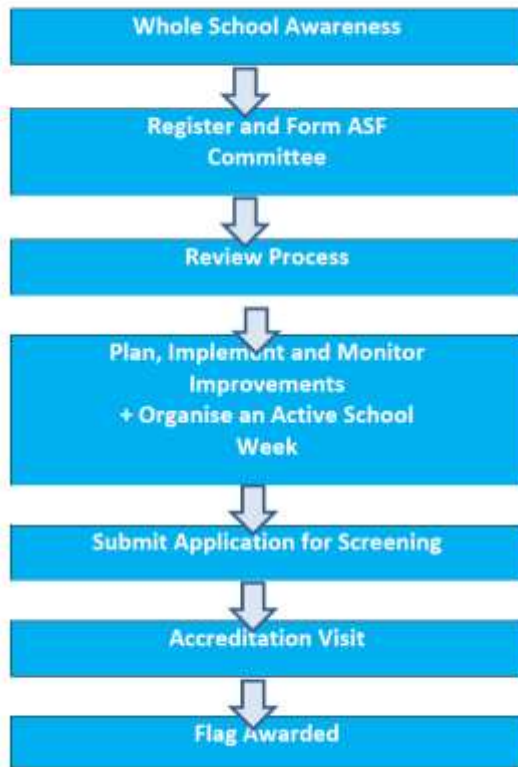
Elements of process evaluation are available at 'Flying the Active Flag' – physical activity promotion through self-evaluation in primary schools in Ireland' published in Irish Educational Studies, Vol.31, September 2012
<http://www.tandfonline.com/doi/full/10.1080/03323315.2012.710066#abstract>

Who implemented the intervention?

National Active School Flag Co-ordinator Within each school there is a school ASF co-ordinator and committee. Schools appoint a teacher as the Active School Flag coordinator to lead the process. Every school forms an Active School Flag committee. Nominees from all areas of the school life take part – management, teachers, non-teaching staff members, pupils, parents and members of the community.

What core activities are/have been implemented?

How to Achieve the Active School Flag



Was the intervention designed and implemented in consultation with the target population?

Yes, consultation with pupils, parents and other stakeholders is integral to the review and implementation processes.

Did the intervention achieve meaningful participation among the intended target population?

Around 670 schools have been awarded ASF.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

The ASF partners with a number of national organisations active in the area of sport, health and physical activity in addition to local sports partnerships. A listing of the supporting partners is on the website.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

The programme is core funded by the Department of Education and Skills..

Is there a broad support for the intervention amongst the intended target populations?

The involvement of pupils is a core element of the programme in all its phases

Were sources of funding specified in regards to stability and commitment?

The funding for the programme is €125,000 per annum from the Department of Education and Skills with additional sponsorship from Healthy Ireland.

Were organisational structures clearly defined and described?

The ASF adopts a clear application process and guidelines to quality assure the involvement of participant schools.

Is the potential impact on the population targeted assessed?

The impact of the programme on the physical activity levels of children has not yet been formally assessed but some data has been collected in this regard and is awaiting publication. The wider impacts of the programme on school culture, behaviours and attitudes and the social inclusion of pupils, parents and communities has not been formally assessed. Feedback has been provided by schools to the national co-ordinator but this has not been subjected to an external in-depth structured analysis, rather it has been used to guide the development of the programme.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

The budget for the programme is listed above. The cost to the school for processing the application is approximately €240.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- The Active School Flag has been successful as it is based on evidence of what works in supporting sustainable and meaningful change i.e. by adopting a whole school approach.
- ASF works because it fits with the model of self-evaluation already used by schools in other domains – the model is culturally acceptable to schools, easily understood and schools are supported with high quality resources and guidance.
- Leadership at national and school level
- Integrated local partnerships that mobilise and amplifying the reach and impact of the programme
- Co-ordination and integration with existing programmes, assets and lead agencies
- Commitment to core involvement with stakeholders from the outset and in all stages of the programme from review to selection of priorities through to implementation and monitoring, including pupils and parents.
- ASF respects the local context allowing schools the autonomy to define their own priorities within the programme and avoids a 'one size fits all' approach. Schools with more flexibility in the curricula, strongly motivated and committed teachers and a devoted DOiT coordinator are preconditions for success.

What were, in your opinion, the main lessons to be learned?

- Whole school approaches can be successful but careful attention to design is critical and schools can respond to reflection on the strengths and weaknesses of current practice.
- Physical activity approaches in school can embrace many aspects of physical activity including active travel and support for extra-curricular activity not just physical education.
- Important programmes such as this should be supported with adequate resources to ensure robust external evaluation on end outcomes as well as process outcomes. It is difficult to plan a 2-year programme in schools, due to teacher and student turnover. Time constraints in schools are hindering implementation, therefore, the programme could benefit from identifying core components of the programme.

Web page related to the intervention

Active School Flag website - <http://www.activeschoolflag.ie/home.html>

References

'Flying the Active Flag' – physical activity promotion through self-evaluation in primary schools in Ireland' published in Irish Educational Studies, Vol.31, September 2012
<http://www.tandfonline.com/doi/full/10.1080/03323315.2012.710066#abstract>
 Overview of research on Active School Flag experiences available at:
http://www.activeschoolflag.ie/files/MIC_Research-Active_School_Flag.pdf
 Children's Sport Participation and Physical Activity survey 2009
 The CDC Comprehensive School PA Program
<http://www.cdc.gov/healthyyouth/physicalactivity/cspap.htm>
 Harrington DM, Belton S, Coppinger T, et al. Results From Ireland's 2014 Report Card on Physical Activity in Children and Youth. J Phys Act Health. 2014; 11: S63-S68.
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 Schildkamp, K. and Visscher, A. (2009) Factors influencing the utilisation of a school self-evaluation instrument. Studies in Educational Evaluation 35, no. 4: 150-9.
 Schildkamp, K., Visscher, A and Luyten, H. (2010) The effects of the use of a school self-evaluation instrument. School Effectiveness and School Improvement 20, no. 1: 69-88.
 Growing Up in Ireland – Overweight and Obesity among 9 year olds in Ireland – short report based on data from the Growing Up in Ireland Longitudinal Survey in Ireland. Available at:
http://www.growingup.ie/fileadmin/user_upload/documents/Second_Child_Cohort_Reports/Growing_Up_in_Ireland_-_Overweight_and_Obesity_Among_9-Year-Olds_Executive_Summary.pdf

Other relevant documents:

Resources for schools interesting and involved in Active School Flag are available at:
<http://www.activeschoolflag.ie/physical-education.html>
 Links to professional development for teachers in the context of the programme available at:
<http://www.activeschoolflag.ie/professional-development-service-for-teachers.html>

Contact details of person for further information

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 Redmond's Hill Purdy's Lane
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National Network of Health Promoting Schools Lithuania

Title in original language:

Sveikatą stiprinančių mokyklų tinklas

Which 'life stage' for CVDs prevention targets the intervention?

The intervention targets the children and staff in schools and universities.

Short description of the intervention:

A 'health promoting school' is defined as 'a school that implements a structured and systematic plan for the health and well-being of all pupils and of teaching and non-teaching staff. This is characterized as a whole school approach (or 'whole of school approach'). The health promoting school is a health promotion program for children organized through formal and non-formal education. In Lithuania schools prepare, implement and self-evaluate 5-years duration programs. Requirements and criteria for programs are approved by the Health Promoting School Recognition committee (7 specialists from health and education fields). There are Health Promoting Schools in almost every municipality in Lithuania and every year to this network joins a growing number of the country's educational institutions. Lithuanian health promoting school network belongs to the Schools for Health in Europe network (SHE network). The health promoting school is a school where the whole community, with the partners, seek to strengthen the school community's health. In these schools, health topics have been integrated into the educational process - lessons and after-school activities. Health promoting schools conducts a long-term targeted and approved health promotion programs. Health promoting school includes various health areas:

- physical activity and physical education;
- a healthy diet;
- tobacco, alcohol and other psychoactive substance abuse prevention;
- accidents, injuries, stress prevention;
- violence, bullying prevention;
- preparation of family and sexuality education;
- communicable diseases;
- a culture of consumption.

Health promoting school community members participate in joint projects, competitions, training, conferences, actively share best practices. The SHE network demonstrates how networking at an international and national level can be effective and sustainable. Networking at a European level has stimulated the development of indicators for health promoting schools. Also, three European conferences were organised by the network, attracting a wide audience of researchers, policy makers, practitioners and schools. The most recent adopted the Vilnius (Lithuania) Resolution, which is a new tool for governments and schools to introduce school health promotion, intended to help put health promoting schools higher on the international and national educational and public health agendas. The Vilnius (Lithuania) Resolution was presented, discussed and adopted during the 3rd European conference. It marks the main outcomes of the conference as a next step in the development of school health promotion in Europe. For the first time, the work of students during a European conference was included, demonstrating their

active involvement and participation, which are part of the underlying principles of the health promoting school approach.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Over the last 20 years, 'health promoting schools' have shown evidence of improving the health and well-being of the whole school community. Most of the evidence on the effectiveness of health education and health promotion in schools is from work on specific health topics. The most positive evidence is found in the topics of mental health promotion in schools, healthy eating, sports and physical activity in schools and the weakest evidence is in the area of substance use. Successfully establishing health promoting schools within national educational systems takes time and requires the following: The more connected young people feel to their school, the greater their emotional well-being and educational attainment. Schools play an important part in improving the education, health and well-being of all young people and in the task of reducing health inequalities in Europe and across the world.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

The School Health Promoting Schools Recognition Procedure (Official Gazette. 2007, Nr.91-3656; 2010 NR.74-3758) approved by the Minister of Health and Minister of Education is intended for all schools wishing to become a Health Promoting School and schools belonging to the health promoting schools network. It provides the procedure of Health Promoting School recognition, the criteria for health promotion programs evaluation procedure, the certificate registration and issuance procedures.

To which type of interventions does your example of good practice belong to?

Policy/strategy

How is this example of good practice funded?

Institution of education, public health and/or research

What is/was the level of implementation of your example of good practice?

National

What are the main aim and the main objectives of your example of good practice?

The main aim is to improve pupils and school community health.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. In a National Child Welfare Policy Strategy and Pre-school education development program for 2011-2013

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes. All members of school community have equal access to education and health.

Which vulnerable social groups were targeted?

The children from poor families are educated in health promoting schools.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Each Health promoting school evaluates the interventions. There are two guides for schools how to evaluate the interventions.

Did the intervention achieve meaningful participation among the intended target population?

Yes, already there are 244 general education schools, 4 vocational training centres, 104 pre-school education institutions and 1 university in the National Network of Health Promoting Schools.

Communication details

ignas.keras@smlpc.lt

Croí MyAction- A Community Based Cardiovascular Disease Prevention Programme Ireland

Which 'life stage' for CVDs prevention targets the intervention?

Adulthood. This intervention is aimed at individuals and their partners/ family members at very high cardiovascular risk.

Short description of the intervention:

Croí MyAction is a 12-16 week intensive cardiovascular disease (CVD) prevention programme. This programme is a gold standard intensive risk factor management and lifestyle modification programme driven by specific protocols designed to achieve the latest ESC Guidelines (Perk et al., 2012). High-risk individuals defined as those with SCORE (Systematic Coronary Risk Evaluation) of $\geq 5\%$ or type-2 diabetes were referred to the programme through a series of pathways which include general practice and hospital departments such as cardiology, stroke, and endocrinology. Subsequently, the programme was expanded to include patients with stroke/TIA (Transient Ischemic Attack) and coronary heart disease (CHD). Established in 2009, this flagship community-based prevention model has reached over 1100 individuals.

The key components are: lifestyle modification (smoking cessation, healthy food choices, and physical activity); medical risk factor management (blood pressure, lipids, and glucose); and the prescription of cardio protective medication where appropriate. The programme is co-ordinated by a multidisciplinary team (MDT) which includes a nurse specialist, dietitian and a physiotherapist/exercise specialist supported by a physician. An important principle of the programme is involvement of the partner, as risk factors cluster in families due to shared lifestyles such as smoking and poor diet, and healthy lifestyle change is easier to achieve if the family changes together.

At initial assessment (IA), patients and partners are seen as couples, but individually assessed by each MDT member for: smoking habit (breath CO); diet (diet history, food habit questionnaire, and Mediterranean diet score); weight and height, Body Mass Index (BMI), and waist circumference; physical activity levels (7-day physical activity recall) and functional capacity (Chester Step test); psychosocial measures (anxiety, depression and quality of life); blood pressure (BP), fasting lipids, and glucose; and use of cardio protective medications. The 16-week programme includes individualised follow-up, a weekly educational workshop and supervised exercise session. There is also a weekly MDT meeting to review lifestyle, risk factor and therapeutic goals including medication prescription as appropriate. The programme is flexible, offering individuals the choice of attending during the day or in the evening.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The Croí MyAction programme was developed in response to the need to develop an effective model of prevention for individuals at high multifactorial risk. High risk approaches to cardiovascular disease prevention in Ireland have traditionally targeted those with established disease. However, there are many asymptomatic individuals with multiple risk factors whose risk is similar to those who have overt heart disease but go unrecognised. In Ireland, 2 studies, SLAN a National Health and Lifestyle Survey (Morgan et al, 2008) and 'Heart Smart' a West of Ireland

Community Based Prevention Programme, (Gibson 2008) both identified alarmingly high levels of CVD risk factors among our population over 40 years of age.

It is well established that up to 90% of CVD is preventable through modification of risk factors such as smoking, high blood pressure, high cholesterol, physical inactivity, and obesity (Yusuf et al, 2004). In response to the high levels of these risk factors in the Irish population, Croí, a registered Irish heart and stroke charity, established the provision of MyAction as the first cardiovascular prevention programme of its kind to be offered in Ireland.

The MyAction model was developed by Imperial College London and has its strong evidence base in the EUROACTION study (Wood et al, 2008), which demonstrated that an intensive nurse-led programme can achieve effective and substantial lowering of CVD risk factors in high risk groups of patients compared with usual care. This programme has been shown to be clinically effective, cost effective and cost saving. An economic analysis shows that every £1 invested in MyAction generates on average £6 in benefits over the lifetime of the patient (Matrix 2014).

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Please see above sections. To summarise, increased CVD risk patients and their family members/partners were invited to participate in a 16-week programme consisting of a professional multidisciplinary lifestyle intervention, with appropriate risk factor and therapeutic management in a community setting. Smoking, dietary habits, physical activity levels, waist circumference and body mass index, and medical risk factors were measured at initial assessment, at end of programme and at 1 year follow up.

How is this example of good practice funded?

Funding is by the non-governmental organisation (Croí, a registered Irish Heart and Stroke charity) with early support from the local publically funded health service. However, due to budget constraints this support was discontinued early in year 2, and since that time the programme has been funded entirely by Croí through its fundraising activities and philanthropic support.

What is/was the level of implementation of your example of good practice?

The Croí Myaction programme was implemented at a regional level in the West of Ireland in a community based setting.

What are the main aim and the main objectives of your example of good practice?

MyAction aims to:

- Provide an evidence based, high quality prevention programme which will reduce cardiovascular risk factors such as cholesterol, blood pressure, smoking, inactivity and central obesity in those most at risk
- Demonstrate the effectiveness of applying an integrated approach to cardiovascular health management in a community-based setting.

Please give a description of the problem the good practice example wants to tackle:

In Ireland, diseases of the circulatory system are the leading cause of death with high CVD mortality rates compared to European averages. The mortality rate caused by CVD is 25/100,000 per year in Ireland compared to 18/100,000 per year across the EU15 countries (DOHC, 2010). Risk factors for CVD are high with rising levels of obesity and diabetes, being observed in recent years (Morgan et al, 2008). It is predicted that by 2020, the number of adults with chronic diseases, such as diabetes, hypertension, coronary heart disease (CHD) and chronic obstructive pulmonary disease will increase by about 40% in Ireland (DOHC, 2013).

While risk factor management has improved, European-wide data suggest that usual care of high risk patients in general practice is suboptimal (Kotseva et al, 2010). Although many previous trials had demonstrated that control

of individual risk factors could improve outcomes, there was a need to develop a single integrated programme aimed at modifying multiple risk factors. The EUROACTION trial, conducted across 8 European countries demonstrated that a nurse led intensive programme resulted in effective and substantial lowering of CVD risk factors in a high risk group of patients (Wood et al, 2008). Following EUROACTION, the MyAction programme which is community based, was developed in Imperial College London in the UK (Connolly et al, 2011).

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. Croí MyAction is the first cardiovascular prevention programme of its kind in Ireland and is delivering to the recommendations of the National Cardiovascular Health Strategy (DOHC, 2010). The programme's unique principles and protocols align to the Healthy Ireland framework for improved health and wellbeing (DOHC, 2013).

Implementation of your example of good practice is/was:

Continuous (integrated in the system) – Croí MyAction is now 5 years in existence

Target group(s):

Croí MyAction adopts an integrated approach to care and targets high-risk individuals as defined by the European Guidelines on CVD prevention (Perk et al., 2012). High-risk individuals include patients with a: SCORE (Systematic Coronary Risk Evaluation) $\geq 5\%$, type-2 diabetes, stroke/TIA (Transient Ischemic Attack) are referred to the programme through a series of pathways which include general practice and hospital departments such as cardiology, stroke, and endocrinology.

During implementation, did specific actions were taken to address the equity dimensions?

To ensure that the programme was equitable, the programme was delivered in a community setting, easily accessible by public transport and with ample parking. It was provided free of charge, to ensure cost was not a barrier. A flexible approach to programme delivery was adopted whereby it was delivered at various times during the day and in the evening. All eligible referrals were invited to attend, regardless of religion, gender, or nationality, with patients from urban and rural locations being equally represented.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

The programme targeted both males and females equally, resulting in a 52.3% programme uptake by males. There was specific focus on recruiting individuals from the lower socioeconomic groups, which are known to be a high risk of CVD. This involved working in collaboration with relevant representative organisations and inviting groups to come and meet the MyAction multidisciplinary team, view the programme and the setting with the aim of encouraging uptake.

Which vulnerable social groups were targeted?

The programme targeted members of the Travelling community, the farming community, the homeless and those living in social isolation and in deprived areas of the region.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

The Croí MyAction programme adopts the settings-based approach to health promotion and is underpinned by values such as empowerment, public participation, equity and partnership. It is actively empowering people and communities through its individualised behavioural change approach to lifestyle modification. It is family-centred, actively involving patients' partners and other family members. By locating the programme in the heart of the

community it is more accessible to those who most need it, removing the barrier of having to attend the doctor's clinic or hospital.

The settings approach facilitates health promotion interventions to focus more on the broader determinants of health rather than simply addressing individual and/or population behavioural risk factors. In this context, the findings of the Croí MyAction programme have translated into a number of proposals which have been presented to the HSE (Health Service Executive) Department of Health, Minister for Health and other agencies with the aim of influencing and shaping National governance and policy around the delivery of CVD prevention. Overall, the Croí MyAction programme provides an integrated and cohesive mechanism for addressing multiple health issues and their determinants.

Was an effective partnership in place?

Partnership and cross sectional work is exemplified in the Croí MyAction programme at a number of levels. The programme is a collaboration between the voluntary sector – Croí, and an academic institution - Imperial College London, and through its unique integrated approach to prevention, is working in partnership with key stakeholders including, general practice, hospital departments, and community groups.

Was the intervention aligned with a policy plan at the local, national, institutional and international level? (Croí MyAction is the first cardiovascular prevention programme of its kind in Ireland and is delivering to the recommendations of the National Cardiovascular Health Strategy (DOHC,2010). It is contributing to the Healthy Ireland framework for improved health and wellbeing (DOHC,2013) and the Preventing Chronic Disease Framework (Jennings 2014). Furthermore, Croí MyAction aligns to the European Society of Cardiology's Prevention Guidelines (Perk et al., 2012), which endorses the nurse co-ordinated multidisciplinary approach to prevention.

Was the intervention implemented equitably, i.e. proportional to needs?

The Croí MyAction programme was implemented equitably. For example, it implements uniform rules for eligibility (i.e. inclusion and exclusion criteria) and is free to all participants regardless of their socio-economic status. The programme gives special attention to certain disadvantaged groups e.g. Travelling community and ensures the programme meets their individual needs. Croí MyAction is the first cardiovascular prevention programme of its kind in Ireland and is based in the Croí Heart & Stroke Centre in Galway. In this context, a roll-out of the programme nationally would ensure equal access to individuals from different geographic locations.

Were potential burdens, including harm, of the intervention for the target population addressed?

There was no potential burden/harm identified from this intervention.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

The intervention's objectives and strategy were transparent to the target population and stakeholders involved. Information on the intervention's objectives and strategy were disseminated via written and oral communications. Patients and other stakeholders received information packs on the programme outlining the intervention and goals.

Did the evaluation results achieve the stated goals and objectives?

Year on year this nurse-led, multidisciplinary programme has achieved outstanding and measurable improvements in cardiovascular health which have been widely published, including the European Journal of Preventive Cardiology (Gibson et. al 2014) and the British Journal of Cardiology (Gibson 2013).The evaluation results at five years are demonstrating that Croí MyAction is achieving its stated goals and objectives. Adherence to the

programme was high, with 530 (77%) participants and 258 (73.7%) partners having completed the programme, with 1-year data being obtained from 391 (86%) patients and 185 (60.7%) partners.

There were statistically significant improvements in both lifestyle (body mass index, waist circumference, physical activity, Mediterranean diet score, fish, fruit, and vegetable consumption, smoking cessation rates), psychosocial (anxiety and depression scales and quality of life indices), and medical risk factors (blood pressure, lipid and glycaemic targets) between baseline and end of programme, with these improvements being sustained at 1-year follow up. Precise details are available in peer reviewed journals and most recently in the 5 year report – see summary table below

A 5-year summary of the key programme outcomes has just been published and is available from

<http://www.nipc.ie/research.html>

5 YEARS OF POSITIVE PATIENT OUTCOMES A Report Prepared by the National Institute for Preventive Cardiology

Executive Summary

Croí has developed nationally recognised expertise in cardiovascular disease prevention, through the delivery of the European Society of Cardiology (ESC) endorsed MyAction Programme. The Croí MyAction Programme is a gold standard intensive risk factor management and lifestyle modification programme driven by specific protocols designed to achieve the latest ESC Guidelines. MyAction targets high risk individuals – i.e. those at high risk of heart attack, stroke, and diabetes – with a 12-16 week intervention and 3-year follow-up. Established in 2000, this flagship community-based prevention model has reached over 1,100 individuals. Right on time, this multi-disciplinary programme has achieved outstanding and measurable improvements in cardiovascular health which have been widely published, including the European Journal of Preventive Cardiology¹ and the British Journal of Cardiology². This report provides a 5-year summary of the key programme outcomes since its inception in 2000.

What has been achieved over a 5-year period?	Outcome	Impact on CVD Risk
	Smoking quit rate of 5.7%	50% reduction in CVD events ^{1*}
	Greater adherence to the cardio-protective Mediterranean Diet, with an increase in 4.3 units being observed	9% reduction in total mortality, CVD mortality and cancer ¹
	Improvement in physical activity targets from 1.0% to 5.0%	20-30% reduction in cardiovascular events ¹
	Improved average fitness of 1.0 METs	15-20% reduction in all-cause mortality ^{1,2*}
	Improvement in achievement of blood pressure targets from 55% to 73%, with a mean reduction of 8.6 mmHg (systolic) and 5.7 mmHg (diastolic) being observed	20% reduction in risk of CHD ^{1*} 35% reduction in risk of stroke ¹
	Improvement in achievement of cholesterol targets from 30% to 70%, with a mean reduction in Total Cholesterol of 11.75 mmol/L and LDL Cholesterol of 6.28 mmol/L being observed	15% reduction in CVD mortality and non-fatal myocardial infarction ^{1*}

CVD: cardiovascular disease; CHD: coronary heart disease; MET: metabolic equivalent

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

The intervention had a defined evaluation framework that involved conducting regular programme audits and monitoring of outcomes to ensure the programme was being delivered to an established protocol and guidelines. By assessing each aspect of the programme's performance against key performance indicators, this allowed for reshaping of the implementation plan accordingly. Details of tools used are described in Gibson (2014) and in the report <http://www.nipc.ie/research.html>

The intervention has been assessed for efficiency. A recent economic analysis demonstrates that Croí MyAction is cost-effective compared to usual care and represents an efficient use of resources; every €1 invested in Croí MyAction generates on average €8 in benefits. The Incremental Cost Effectiveness Ratio (ICER) was strongly dominant and a health care cost analysis in 617 participants generated €817,356 in savings. Benefits generated by the programme exceed its costs by €7,784 per participant. Moreover, an economic analysis of the same MyAction protocol applied to a culturally diverse and socially deprived population in London similarly found this integrated model of preventive care to be clinically-effective, cost-effective and cost-saving. The full report for the findings from the economic analysis of Croí MyAction can be found at: <http://www.nipc.ie/research.html>

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

On a yearly basis there was a formal analysis of outcomes to ensure the stated objectives were being met. These outcomes were compared to the MyAction programme in the UK and the EuroAction study (Wood et al, 2008), upon which the principles of the MyAction programme are based. An external audit, which examined each aspect of programme delivery including a professional competency assessment, was conducted by Imperial College London on an annual basis. There was an established protocol for data collection, with data being stored on a secure database hosted by Imperial College London.

Who did the evaluation?

In conjunction with an external party

Specifically, what has been measured / evaluated?

The process evaluation included monitoring of:

- Programme uptake and retention rates
- Outcomes which were based initially on the primary endpoints for lifestyle, risk factor, and therapeutic goals as recommended by the ESC 2007 Prevention Guidelines and more recently on the ESC 2012 Prevention Guidelines
- Participant feedback through completion of an anonymous evaluation form

Evaluation of outcomes took place at end of programme (16 weeks) and at 1 year follow up. Outcomes at each time frame were measured using standardised equipment, validated questionnaires and data collection tools. For example physical activity levels were assessed using the '7 day physical activity recall questionnaire' and a functional capacity test. Data collected was stored on a secure database hosted by Imperial College London.

What are the main results/conclusions/recommendations from the evaluation?

The programme is successfully recruiting individuals at high cardiovascular risk. Since Croí MyAction commenced in 2009 over 1,194 patients have been referred, with 71% (n=846) of these patients being eligible for the programme. As of January 2014 – 691 patients were invited to attend end of programme assessment, of which 77% attended (n=530), and 455 were invited to attend 1 year assessment of which 86% attended (n=391). As the programme only accepts patients at highest cardiovascular risk, those who are at low to moderate risk and do not meet the inclusion criteria (n=348) are sign-posted to other Croí health and lifestyle programmes

Results show statistically significant improvements in both lifestyle (body mass index, waist circumference, physical activity, Mediterranean diet score, fish, fruit, and vegetable consumption, smoking cessation rates), psychosocial (anxiety and depression scales and quality of life indices), and medical risk factors (blood pressure, lipid and glycaemic targets) between baseline and end of programme, with these improvements being sustained at 1-year follow up. For a full report on results please see a recently published five year report of patient outcomes which can be found at: <http://www.nipc.ie/research.html>

The following recommendations have been made as a result of conducting this evaluation:

- Croí MyAction has proven to be clinically effective, cost effective and cost saving and therefore should be considered as a chronic disease model of care.
- Manage CVD as a single family of diseases - Croí MyAction demonstrates the effectiveness of applying an integrated approach to CVD prevention and health service planners should therefore consider Croí MyAction as a chronic disease management model which could integrate the care of all those at high CVD risk (multiple risk factors, vascular disease, heart disease, TIA and type-2 diabetes).

- Promote healthy lifestyle as a focus of CVD preventive efforts - Recognising that cardiovascular risk is driven by poor dietary habits, physical inactivity and smoking, the focus of preventive efforts should be on promoting healthy lifestyle habits to address total cardiovascular risk. This requires the wider expertise of a team of multidisciplinary health care professionals including nursing, dietetics, physical activity, medicine and psychology.
- Train health care providers to address complex lifestyle behaviours - Addressing and managing complex lifestyle behaviours require expertise. Health care professionals should be trained and equipped with the skills to apply effective behavioural strategies in improving self-efficacy, promoting self-management and enhancing motivation.
- Deliver community-based CVD prevention programmes - CVD prevention programmes should be delivered in community settings that adopt flexible approaches in allowing easy access to those most at risk particularly vulnerable and deprived groups. This approach has proven to be very successful in the MyAction programme as demonstrated by the high uptake and retention rates.
- Promote early diagnosis and access to treatment for those at risk of CVD -Despite the global acceleration of CVD, many patients go undiagnosed and untreated. There is compelling evidence to show that even among those with established disease there are treatment gaps. There is a need to examine the wider role of other health care professionals such as pharmacists, nurses and patients organisations in the early identification of individuals at risk and to support general practice in ensuring that these patients are managed appropriately.
- Implement data monitoring and auditing of CVD risk factors on a national level in Ireland- Croí MyAction reports across a wide spectrum of CVD health outcomes. However there is a real need to develop intelligence in relation to data monitoring and auditing of CVD risk factor prevalence and management across the island of Ireland. Not only will this help assess progress in terms of achievement of best practice

Is the evaluation report available, preferably in English or at least an English summary?

A 5 year report of patient outcomes is available to download from <http://www.nipc.ie/research.html>

Outcomes have also been published in the European Journal of Preventive Cardiology, with the reference as follows: Gibson I , Flaherty G, Cormican S, Jones J, Kerins C, Walsh AM, Costello, C, Windle J, Connolly S, Crowley J. (2014) Translating guidelines to practice - findings from a multidisciplinary preventive cardiology programme in the west of Ireland, *European Journal of Preventive Cardiology* , Vol. 21 (3) 366-376.

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

The evaluation included a 1 year follow-up, recognising that long-term maintenance of lifestyle modification is key to the success of any prevention programme. There are also plans in place to apply for funding to assess the outcomes of Croí MyAction in a randomised control trial and to conduct further longitudinal follow up at 5 years.

Who implemented the intervention?

The intervention is being implemented by Croí, a registered Irish heart and stroke charity, with a strong commitment to prevention. In 2009, Croí commissioned the MyAction programme, developed by Imperial College London. MyAction is implemented by a multidisciplinary team which includes a nurse specialist, dietician, physiotherapist and a medical officer.

What core activities are/have been implemented?

To achieve the objectives of the intervention, the Croí MyAction programme is based on an established protocol, with defined outcomes and key performance indicators. All members of the multidisciplinary team receive standardised training and mentorship with built in competency assessments to ensure a quality assured programme is delivered. There are also standardised operational procedures in place to ensure quality and consistency in programme delivery.

Was the intervention designed and implemented in consultation with the target population?

The Croí MyAction programme was based on the evaluation of a pilot MyAction programme in the UK, where the target population played an active role in both the design and implementation of the programme. As part of the Croí MyAction programme, there is on-going evaluation and participant feedback, which has shaped the development of this programme.

Did the intervention achieve meaningful participation among the intended target population?

Croí MyAction is successfully recruiting patients at high cardiovascular risk. These patients presented with multiple cardiovascular risk factors, endorsing the programmes multidisciplinary specialist approach in tackling smoking, diet, physical activity, psychological and medical risk factors, within families all in one setting.

Since Croí MyAction commenced in 2009 over 1,194 patients have been referred, with 71% (n=846) of these patients being eligible for the programme. The programme employs specific evidence-based interventions that are known to increase uptake and retention and as result these rates have remained consistently high over the five year period. Central to this has been the delivery of the programme in the heart of the community, thus making it more accessible to those who most need it, removing the barrier of having to attend the doctor's clinic or hospital.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

The Croí MyAction programme is actively empowering people and communities through its individualised behavioural change approach to lifestyle modification. This behavioural change approach includes the use of motivational interviewing and brief intervention techniques along with SMART goal setting. To promote the concept of self-care all participants are given a personal record card to help track their progress. A family-centred, approach is adopted, recognising that families tend to share risk factors and people are more likely to succeed in behaviour change if the entire family are embracing change together.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

The target population were selected based on the population needs, which were determined by surveys on the prevalence of risk factors in Ireland (Morgan et al, 2008) along with National recommendations through our Cardiovascular Health Strategy (DOHC, 2010). The eligibility criteria for Croí MyAction were based on the European Guidelines and included patients >40 years of age at very high risk of CVD (SCORE $\geq 10\%$), patients with newly diagnosed type 2 diabetes with two other risk factors (smoking, hypertension, or dyslipidaemia) and ischaemic stroke and TIA patients. As it was not feasible to target all high risk, patients with known Coronary Heart Disease (CHD) were excluded if they previously attended a cardiac rehabilitation service.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Meaningful participation of the target population was achieved through a multifaceted approach to recruitment. This involved engaging with clinician's in developing a standardised referral pathway that was easy to use in everyday clinical practice. In consultation with key referral sources (General Practice and Hospital), an educational tool kit was developed to help clinicians identify the target population and utilisation of this tool kit was demonstrated at various continuous professional development meetings. By recognising the referral sources as key stakeholders from the outset and byinvolving them in developing the recruitment plan, this resulted in stronger engagement, with subsequent high referral rates being achieved. To target the population directly a recruitment strategy using social marketing, local media and promotional materials was established. Recognising that the target group included the socially disadvantaged, materials were designed to be culturally sensitive and appropriate to literacy levels.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, there is a strong commitment to support this programme by Croí. It has been incorporated into the organisation's strategic plan for the next 3 years and it is currently being funded through fundraising activities and philanthropic support. However to ensure its long terms stability, the programme has become embedded in a number of research activities and is the learning platform for a newly established MSc in Preventive Cardiology.

Is there a broad support for the intervention amongst those who implement it?

The multidisciplinary team who deliver this intervention are extremely committed and have been involved at all stages of programme development from programme planning, implementation and evaluation.

Is there a broad support for the intervention amongst the intended target populations?

There has been huge support for the Croí MyAction intervention among the target population and this is reflected in the high uptake rates at 88% and programme retention rates at 77%. An impressive 86% of participants return for follow-up at 1 year. These results compare favourably to other CVD prevention programmes e.g. cardiac rehabilitation where uptake rates average at 44% (NICE 2013).

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Croí MyAction is founded on a solid business case with clear resource requirements. There was a project management plan, which outlined budget, timescales and expected outcomes and this was essential to ensuring that the programme was delivered in a cost effective and efficient manner.

Were sources of funding specified in regards to stability and commitment?

Resource allocation was carefully planned in accordance with the business case. Initially there was a funding commitment for the delivery of a pilot Croí MyAction for 3 years from local health service public funds. However, due to budget constraints this funding was discontinued in year 2 and since then programme has been funded by Croí through its fundraising activities and philanthropic support. To ensure stability and commitment going forward the programme has been embedded in a number of research and education activities and forms part of the organisations strategic plan for the next 3 years.

Were organisational structures clearly defined and described?

The organisational structure is very clearly defined. There are regular update meetings between the team delivering the programme and the CEO. Progress reports are submitted on a monthly basis to the board of directors who have responsibility for the overall governance of the organisation. Clinical governance is provided by a Medical Director and each staff member has a clear job description outlining roles and responsibilities.

Is the potential impact on the population targeted assessed (if scaled up)?

This has been previously assessed as part of a PhD research project 3 years ago (available on request from contact – see end of document).

Are there specific knowledge transfer strategies in place (evidence into practice)?

Croí MyAction demonstrates that it is possible to implement the ESC prevention guidelines into everyday clinical practice, therefore transferring this knowledge, through building capacity is a key priority. In achieving this Croí has formed a unique academic collaboration with the National University of Ireland, Galway in establishing

postgraduate courses and a new entity known as the 'National Institute for Preventive Cardiology' (NIPC). The mission of the NIPC is to provide leadership through discovery, training and applied programmes (e.g. Croí MyAction) to prevent and control cardiovascular disease for all, promote healthier living, raise standards of preventive cardiology practice, and prepare leaders to advance preventive healthcare in Ireland. In addition, to promote the learning from Croí MyAction, the outcomes have been widely disseminated at multiple National, European and International health care professional conferences with over thirty oral/posters presentations being made.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Yes this readily available for both Ireland and the UK.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

There were a number of key factors that contributed to the success of Croí MyAction:

- The multidisciplinary approach adopted ensured patients had the opportunity to meet multiple specially trained health care professionals to help them address the complex behaviours that influence lifestyle change.
- The partnership and cross sectional work between the key stakeholders was essential to achieving successful integrated care.
- Having a project management plan, with established processes, timelines and targets ensured the programme was implemented in an effective way, resulting in positive patient outcomes and cost savings.
- Having an established programme protocol, based on evidence based guidelines, with defined outcomes and key performance indicators was critical to achieving the implementation of a high quality programme.
- The social interaction from the group based component of the programme was an important factor in contributing to the improvements in psychosocial and quality of life indices.
- As improvements in medical and lifestyle risk factors and psychosocial health were observed among both patients and partners, this reflects the importance of adopting a family based approach to prevention, as successful lifestyle change is more likely if the entire family are embracing lifestyle change together.
- Delivering the programme in the community ensured it accessibility to the target population, especially the lower socioeconomic groups.

What were, in your opinion, the main lessons to be learned?

- Translating best practice, evidence-based guidelines into everyday clinical practice is possible, however it is dependent on having a rigorous ongoing monitoring, reporting and evaluation system in place.
- In considering staff, it is critically important to have a highly motivated, skilled multidisciplinary team with built in administrative and programme management support.
- Identify potential barriers to implementation as early as possible, as these can impact on effective implementation.
- To widen the learning from this programme and in ensuring long-term sustainability, it is important to build the capacity of health care professionals through ongoing education, training and research.
- Adopting a protocol driven, evidence-based, outcome focused approach is essential to making learning transferable. The learning's from Croí MyAction have already led to the development of other community

based programmes which are addressing the increasing adverse lifestyle trends of obesity, physical inactivity and type 2 diabetes.

- Croí MyAction has proven to be clinically effective, cost effective and cost saving and thus should be considered as a chronic disease model of care.

Web page related to the intervention

<http://www.nipc.ie/research.html>

References to the most important articles or reports on the intervention

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“PUMP”, For a Million Steps Spain

Title in original language:

Por UN millón DE PASOs -“PUMP”

Which ‘life stage’ for CVDs prevention targets the intervention?

Any group of people can take part. However, population groups with certain specific profiles are taken into special consideration; for example: groups of people with CVD risks factors, sedentary groups, underprivileged people, people with disabilities or mentally ill, the elder.

Short description of the intervention:

WHO: Any institution, group or association of individuals can participate. They may register at the official platform, where all the needed information is explained, and accept the terms and conditions stated in the “Registration of Participation”. WHAT: Accept the challenge “would you be able to achieve a million steps in a month with the steps contributed by all the individual participants? WHERE: The group walks can take place anywhere. It doesn’t matter whether they are in urban areas or in the countryside. WHEN: Any time. They are self-programmed by each group. HOW: Accumulating, in a series of group-walks in a month, the number of steps aimed, by the contribution of all the participants (steps are registered using a pedometer).

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The intervention wholly adheres, follows and supports the WHO’s Global Strategy on Diet, Physical Activity and Health. Piloting of the intervention was carried out in 2008.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, and methods?

Both the intervention concept and its specific elements are very simple and easy to understand. Each stage of the practice is clearly described in the official platform and professional additional support is offered.

To which type of interventions does your example of good practice belong to?

Group intervention.

How is this example of good practice funded?

The Regional Ministry of Health provides the pedometers and any professional support needed. Its implementation is, in practice, extremely inexpensive –the cost of a pedometer for each group who registers. Health promotion technicians in each Health District throughout Andalusia consider providing support on the PUMP practice as one of their tasks, relevant for each District’s annual objectives.

What is/was the level of implementation of your example of good practice?

The practice has been implemented, since 2008, in ANDALUSIA (the Southern and most populated region of Spain). Each year, at the local level, nearly 150 municipalities and 100 associations participate, signifying more than 23000 individuals (almost 600 million steps altogether!).

What are the main aim and the main objectives of your example of good practice?

A sedentary life-style by means of promoting a group physical activity (walks) with a specific, measurable goal (to achieve 1 million steps). Since the achievement of the goal is not feasible in just a few walks, the group naturally adopts a repeated routine of walks. Moreover, the contribution of every single participant counts, so that makes the adherence to the practice is mutually encouraged. There is also a “step-treasurer”, a member who registers the steps the group makes in every walk; this makes the practice instantly be providing a result-feedback and reinforcement. This practice is, therefore, periodic, stimulating, self-managed and contains a strong social component. In fact, a “side-effect” of the practice –in reality another noteworthy objective– is the strengthening of THE community/social relations, inasmuch as by means of pursuing the common goal, social relations and a sense of group cohesiveness and efficacy are triggered.

Please give a description of the problem the good practice example wants to tackle:

By means of promoting a physical group activity (which also fosters social interactions), the practice aims to prevent/reduce risk factors associated to conditions such as CVD, obesity, Type 2 diabetes

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, the intervention is part of the Andalusian Plan for the Promotion of Physical Activity and Balanced Diets (“PAFAE”) and is closely linked to several Comprehensive Health Promotion Action Plans in the Government of Andalusia, such as the Comprehensive Action Plan on Diabetes and the Child Obesity Comprehensive Action Plan (“PIOBIN”). Above all, it is also fully aligned with the WHO Global Strategy on Diet, Physical Activity and Health.

Implementation of your example of good practice is/was:

Continuous (integrated in the system) . The intervention was launched in 2008 and is still ongoing.

Which vulnerable social groups were targeted?

Mental health groups, elderly groups, people with disabilities and people in distant areas.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, and using different strategies?

The practice encompasses many other health promotion activities, related to several Andalusian Comprehensive Health Promotion Action Plans being currently carried out by the Regional Ministry of Health (with the collaboration of the Health Care Centres, the municipalities, associations, health services in companies...)

Was an effective partnership in place?

The practice is aligning Public Health Institutions (such as Health Care Centres), Educational Institutions (such as schools), Municipalities (Community involvement) and even the Private Sector (health department of companies etc.).

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

As it was mentioned earlier, the practice is a substantial part of the Plan for the Promotion of Physical activity and balanced diets in Andalusia. It is also closely linked to several Comprehensive Health Promotion Action Plans currently ongoing with the support of the Government of Andalusia.

Was the intervention implemented equitably, i.e. proportional to needs?

The population signs up voluntarily to participate.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

As mentioned before, it is all clearly stated in the platform explaining the practice. Furthermore, participation in local presentations, workshops, conferences, media etc. is regularly done by the Health Promotion professionals (both from Health Districts and Health Care Centres).

Did the evaluation results achieve the stated goals and objectives?

As attested by the lofty number of “steps” achieved and also the high number of people participating every year, we can assume that (at the very least) the promotion of physical activity was successfully accomplished.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

The practice uses an on-line data system (password protected), which is able to provide process indicators such as: number of associations, participants, steps, age and territory...

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes. Apart from the on-line data system (link provided in previous question), an annual report includes the monitoring data for this and all the other Programs carried out in the Health Promotion Service of the General Secretariat of Public Health. Screen capture of the on-line data system and a chart summarising PUMP figures (from Health Promotion Service 2014 Report) follow.

The screenshot shows a web browser window with the URL www.pump.es/. The page has a blue header with navigation links: [Inicio](#), [Ayuda](#), [Contacto](#), [Sobre nosotros](#), [Ayuda](#). Below the header, there are two buttons: **Hacer la consulta** and **Descargar la información resultante de la consulta (formato EXCEL)**. The main content area displays a table with two columns: **Zona** and **Valores**. The table lists various metrics for different zones, including total activities, total participants, total steps, and total distance.

Zona	Valores
Total de actividades	300 actividades
Actividades al día	180 actividades
Actividades por semana	180 actividades
Total de participantes	47 162 participantes
Total de empresas participantes	38 190 empresas
Nº de mujeres participantes	32 381 mujeres
Total de hombres participantes	14 781 hombres
Nº de hombres en la zona	35 341 hombres
Resumen de personas en la zona	1 667 111 107 personas
Método de pago por participante	21 333 por participante
Resumen medio de las actividades	32 días
Actividades por grupos de edad	
17 años	103 actividades
17 años más	276 actividades
17 y más años	35 actividades
Todos los datos	21 actividades

Tabla 12: PUMP. 2014

PROVINCIA	MUNICIPIOS	ASOCIACIONES	MUJERES PARTICIPANTES	HOMBRES PARTICIPANTES	PASOS
Almería	18	7	684	353	61178896
Cádiz	18	30	2278	1765	89196671
Córdoba	18	4	725	266	35777589
Granada	20	3	226	186	6826734
Huelva	11	6	1150	866	30127062
Jaén	18	12	1125	744	37925149
Málaga	17	22	4118	3398	121112011
Sevilla	13	4	3340	1431	201586496
Andalucía	133	88	13646	9009	583730608

Fuente: Registro del PUMP

Who did the evaluation?

Internal and external parties

Specifically, what has been measured / evaluated?

Process evaluation: The on-line data system provides process indicators such as number of associations, number and age of participants (gender disaggregated), number of steps, number of days of activities, territory. The fact that many groups repeat participating in the practice is also an indirect indicator of satisfaction with it. Further qualitative information is frequently also gathered by the Health Promotion professionals, the association websites,

social media and or, informally, in the day of the “diploma ceremony” (when local health officials deliver a speech and a certificate of recognition –for having successfully accomplish the goal– is given to the participants). The practice have been awarded with a National Health System Good Practice Recognition (Spanish Ministry of Health, 2015), a prize in the Andalusian Health Programs Competition (2010) and in the NAOS Contest (Spanish strategy for nutrition, physical activity and prevention of obesity, 2010).

What are the main results/conclusions/recommendations from the evaluation?

The intervention is highly effective to involve people in physical activity. Its strong social component is an asset that enhances community involvement and social support. The practice may easily encompass other health promotion activities.

Is the evaluation report available, preferably in English or at least an English summary?

This is the very first document describing this practice in English.

Was there a follow-up or is any follow-up evaluation planned in the future?

The practice is continually ongoing.

Who implemented the intervention?

- Regional Ministry of Health
- Province Delegations
- Health Districts
- Health Care Centres
- Health Promotion Professionals
- Municipalities and companies health services
- Associations or groups of individuals

What core activities are/have been implemented?

The Regional Ministry of Health gives support to the general diffusion of the practice. Health Promotion Professionals provides direct personal support and help encompassing the practice in the framework of all the other health promotion activities.

Was the intervention designed and implemented in consultation with the target population?

The intervention is almost completely “self-catered” with health promotion professionals providing general additional support and guidance.

Did the intervention achieve meaningful participation among the intended target population?

YES, as mentioned earlier, the number of participants is very high every year.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

As mentioned before, the practice strong social component is an asset that enhances community involvement, social support and self-efficacy.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Due to the extremely inexpensive nature of the intervention, its continuation is well assured and even new modalities of the practice are arising (which includes certain appealing variants).

Are there specific knowledge transfer strategies in place?

There are experiences of other Spanish speaking countries having adopted the practice such as:

- Municipios de Buenos Aires (Argentina)
- Municipios de Posadas (Argentina)
- Centro Andaluz sociocultural y Deportivo de San Rafael (San Rafael. Mendoza. Argentina)
- Centro Andaluz General de Alvear (Mendoza. Argentina)
- Centro Cultural Andaluz en La Habana
- Colectivos de la Municipalidad de Buenos Aires

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

The practice simplicity, high transferability and possible adaptation to any local context make it easy an eventual scaling up. We can gather in an English document further details upon request.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Inexpensive.
- Easy to carry out
- Self-catered
- Strong social component and community support
- High impact in the media

What were, in your opinion, the main lessons to be learned?

The practice is SIMPLE, EFFECTIVE, FUN AND INEXPENSIVE!

Web page related to the intervention

www.juntadeandalucia.es/salud/porunmillondepasos

Facebook: [Por 1 millon de pasos](#)

Other relevant documents:

An English report gathering this type of documents will be provided in the future

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The DE-PLAN study “Diabetes in Europe – Prevention using Lifestyle, Physical Activity and Nutritional Intervention” in Greece

Short description of the intervention:

The DE-PLAN study (“Diabetes in Europe – Prevention using Lifestyle, Physical Activity and Nutritional Intervention”) is a large-scale diabetes prevention initiative, which aims to develop community-based type 2 diabetes prevention programmes for individuals at high risk across Europe. Led by the University of Helsinki, the project, realised in 17 countries, aimed at developing and testing models of efficient identification and site specific intervention of individuals at high risk of type 2 diabetes in the community. The whole European DE-PLAN study (whose Greek dietary part is reported here) aimed at implementing a lifestyle intervention programme to prevent T2DM within the national healthcare system of each participating country and by tailoring activities to the specific “real-life” local setting.

According to the general DE-PLAN protocol, each centre of the participating countries was allowed to follow any intervention strategy— group-based or individual-based consultation—with the objective of achieving better understanding of the disease risk from the participants and of building up motivation for an intention to change lifestyle. In the Greek site, group-based consultation interventions were chosen, as they were deemed to be more conveniently implemented, more cost-effective and efficacious from the participants’ standpoint. The previously validated Finnish Type 2 Diabetes Risk Score questionnaire was used to identify high-risk individuals for the development of T2DM. Identification of high-risk individuals through a questionnaire that requires minimal effort to complete is also a great advantage from a community standpoint, as it can be easily implemented in routine primary care.

The five prevention goals from the Finnish Diabetes Prevention Study comprised the core intervention goals of the sessions. In particular, the aim was to enable participants to make informed and reasonable changes with regard to their diet, namely (a) to reduce saturated fat and trans fatty acids consumption, (b) to decrease simple sugars and sweets intake, and, in order to increase the daily fibre intake, (c) to reduce consumption of refined cereals and (d) to eat at least 5 portions of fruits and vegetables per day.

In Greece two types of settings were generally used for the distribution of the questionnaires and implementation of the intervention procedure: primary-care settings and occupational settings (six centres from each type). The 1-year intervention programme consisted of six sessions (1 h each) held by a registered dietician at the area of the participants’ residence or work. Groups of 6–10 persons were constructed. In every session, information on healthy lifestyle, personal discussion and written material were provided, analysing the concept of the disease risk in general and the individual risk in particular. Although no formal exercise sessions took place, during all sessions, potential lifestyle changes regarding physical activity were discussed, aiming at 30–40 min, 5 times per week of moderate intensity aerobic exercise (i.e. brisk walking, light jogging, swimming). Participants were invited to express their ideas about how to incorporate small and frequent bouts of the aforementioned aerobic exercise in their daily programme.

The intervention strategy (six group sessions with a dieticians per year at the site of work or near the residence of the participants) was practical from a community standpoint and feasible in routine primary care. Social support was emphasised by the group setting and participants were also encouraged to involve their own social environment in the lifestyle changes.

These types of initiatives can also be expected to help reduce risk for other chronic conditions such as obesity, cancer and cardiovascular disease.

To which type of interventions does your example of good practice belong to?

European or international project (i.e. implemented in several countries)

How is this example of good practice funded?

European funding

What is/was the level of implementation of your example of good practice?

Local/urban

Did the intervention develop strengths, resources and autonomy in the target population(s)?

One particular goal was that all participants in the intervention group should obtain the necessary knowledge and understanding about how to influence their blood glucose level in everyday life. The education approach was based on the principles of empowerment, including participation and cooperation without assuming responsibility for the other person's performance, and accepting without judging the other's feelings and choices.

What are the main results/conclusions/recommendations from the evaluation?

This non-intensive intervention strategy (six group sessions with a dietitian per year at the site of work or near the residence of the participants) was found practical from a community standpoint and feasible in routine primary care. Weight reduction was modest beneficial effects were noted on glycaemic status.

At study end, participants reported decreased whole fat dairies and processed meats consumption sugars and refined cereals. Participants who improved their diet, decreased body, plasma triglycerides and 2-h post-load plasma glucose compared to those who had worsened their dietary habits. The implementation of a group-based, non-intensive dietary counselling proved to be practical and feasible in "real-world" community settings and was accompanied by favourable dietary changes and health benefits.

Cost-effectiveness will be assessed from the general DE-PLAN project

What were, in your opinion, the main lessons to be learned?

There has been a shift in preventive health care, from information and influence to empowerment, and more dialogue and participation. An important part of recent health promotion ideology is an increased emphasis on process as much as on results and on understanding the relationship between behaviour and health. This health promotion ideology reflects characteristics in the relationships between the provider and the recipient, and might entail cooperating and accepting without judging the other's performance, feelings and choices.

References to the most important articles or reports on the intervention

- Implementation and effectiveness of the first community lifestyle intervention programme to prevent Type 2 diabetes in Greece. The DE-PLAN study . Makrilakis et al. Diabet Med. 27, 459–465 (2010)
- Changes in dietary habits and their association with metabolic markers after a non-intensive, community-based lifestyle intervention to prevent type 2 diabetes, in Greece. The DEPLAN study. Kontogianni et al. Diabetes Res Clin Pract. 2012 Feb;95(2):207-14.

The study in other countries:

- The InnvaDiab-DE-PLAN study: a randomised controlled trial with a culturally adapted education programme

improved the risk profile for type 2 diabetes in Pakistani immigrant women. Telle-Hjellset et al., British Journal of Nutrition (2013), 109, 529–538

- Prevention of type 2 diabetes by lifestyle intervention in primary health care setting in Poland: Diabetes in Europe Prevention using Lifestyle, physical Activity and Nutritional intervention (DE-PLAN) project. Gilis-Januszewska et al., British Journal of Diabetes & Vascular Disease July/August 2011 vol. 11 no. 4 198-203

- Feasibility and effectiveness of the implementation of a primary prevention programme for type 2 diabetes in routine primary care practice: a phase IV cluster randomised clinical trial. Sanchez et al. BMC Family Practice 2012, 13:109

Contact details

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Workplace Health Promotion: Lombardy WHP Network Italy

Title in original language:

Promozione della salute nei luoghi di lavoro: il network Lombardo

Which 'life stage' for CVDs prevention targets the intervention?

Adulthood. The target of intervention are workers of all companies involved

Short description of the intervention:

The Lombardy Workplace Health Promotion Network involves 284 workplaces, employing 139.186 persons in November 2014. It is a public-private network, carried out by building partnerships and collaboration with all workplace main stakeholders: associations of enterprises, trade unions and the regional health system. The development of this Italian pilot project started in 2011 in Bergamo, by identifying and selecting good practices, and by experimenting the feasibility and effectiveness in two mid-sized companies before extending the project to other companies. A system of accreditation was later defined. Member companies should implement good practice activities over three years and 4 new activities every year to maintain the "Workplace Health Promotion Site"-logo. The areas of good practice are: nutrition, tobacco, physical activity, road safety, alcohol and substances, and well-being. The results are surprising in terms of network and adhesion. The WHP Network expanded on a regional scale during 2013 and is made up of companies ("Workplaces") which recognize the value of corporate social responsibility and undertake to be "environment conducive to health" systematizing, with the scientific support of Health Local Unit where necessary, actions (evidence-based) of different nature: informational (smoking cessation, healthy eating, etc.), organizational (canteens, snack vending machines, agreements with gyms, stairs health programmes, walking / biking from home to work, smoke-free environment, baby pit-stop, etc.) and collaboration with others in the local community (Associations, etc.).

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The particular aim of the Europe 2020 strategy is the target of 'achieving a 75% employment rate for 20–64 year olds throughout the EU'. There is a strong business case for investing in workplace health. The challenge for employers is to find a balance between meeting the targets for the business and the health needs of employees with chronic illness. Four main factors count for the majority of the burden of chronic non-communicable diseases: tobacco, poor diets, alcohol and lack of physical activity. There is evidence to support the use of health promotion activities in the workplace and there are potential benefits to be gained by employers investing in workplace programmes: reduced health care costs, saving on absence, stress reduction. A pilot study was carried out in Bergamo (with 94 companies involved and 21.000 workers)

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

The aims are SMART (specific, measurable, achievable, realistic and timed) :

- improvement in work organization and working environment

- encouragement for staff to take part in healthy activities
- promotion of healthy choices
- encouragement of personal development (empowerment)

The company interested in joining the Network must first of all check on following pre – requisites:

- Be in compliance with security contributions and insurance;
- Having drawn up the Risk Assessment as required by Legislative Decree 81/08, as amended and comply with the provisions on health and safety in the workplace;
- Being on compliance with environmental regulations (Legislative Decree 152/06, as amended).
- Complete the online registration and the ASL Health Promotion Service illustrate the programme or advise on how it should be developed
- Must not in the five previous years have received convictions related to the application of the Legislative Decree 231/2001 (Article 25 - f - manslaughter or grievous bodily harm committed in violation of the rules on health and safety at work or art 25 - environmental crimes).

Within 3 months from the date of joining, the company must carry out the following 2 steps:

- It has to organize for all employees a presentation of the programme
- It has to get employees to complete the first assessment questionnaire - available at the following link: https://www.surveymonkey.com/s/reteWHP_questionario_dipendenti
- The same questionnaire is to be completed again 12 months after the first survey and once again after 36 months.
- The company must complete a company questionnaire for the enhancement and/or reorientation of interventions already in place within the Company, and to observe and present changes/modifications on the medium-long term.
- It has to plan good activity (good practice) in 6 areas (promotion of healthy nutrition, tobacco control and smoking cessation, promotion of physical activity, road safety and sustainable mobility, prevention of alcohol and other addictions, personal and social welfare and work-life balance).

A year after the start up: accreditation of the worksite as a “Health Promoting Workplace” (the awarding of the WHP Network logo provided the company has implemented a minimum of 2 activities/good practices in 2 of the areas included in the programme).

At the end of the second year: in order to maintain accreditation, the company must have implemented a minimum of 2 activities/good practices in 4 areas of intervention.

At the end of the third year: the company should have implemented in all the 6 areas the minimum number of 2 activities/good practices.

At the end of every year the implementation of good practices will be reported by the company by entering relevant data into the online database.

The maintenance of the actions undertaken in the three years is a guarantee for a real structural change in the workplace. The annual planning (that can be changed during the year) is made online by 28 February each year.

To which type of interventions does your example of good practice belong to?

Policy/strategy. The programme “workplace health promotion, Lombardy WHP Network” is inserted in the Regional Prevention Plan for 2010-2013 and 2014-2018, in the National prevention Plan 2014-2018 and fits into the strategies of EUROPEAN INNOVATION PARTNERSHIP on Active and Healthy Ageing (EIP-AHA). Lombardy WHP Network is a member of the European Network for Workplace Health Promotion. (<http://www.enwhp.org>). The programme was conceived also around the concept of the UNI-ISO 26000 “Guide to Social Responsibility” according to the definition of sustainable development.

How is this example of good practice funded?

National/regional/local government. The programme is funded by Lombardy Region (it was part of Regional Prevention Plan 2010-2013 and now it is part of the Regional Prevention Plan for 2014-2018). The programme is linked to Territorial Networks of Conciliation, established in each province of Lombardy, to promote the adoption by businesses and public institutions in paths of social responsibility such as: good practice of conciliation life - work, improvement of organizational wellness, corporate welfare for the well-being of the employees and the link with health services in relation to prevention programs (screening, etc.)

What is/was the level of implementation of your example of good practice?

Regional. The programme is implemented in the whole Lombardy Region. The WHP programme was formalized through DDS n. 11861/2012 "health promotion in workplace: ASL suggestions for the development of effective and sustainable interventions". The programme is embedded in the National Prevention Plan 2014-2018 in order to test feasibility and scalability on national level

What are the main aim and the main objectives of your example of good practice?

The Workplace Health Promotion is the result of the joint efforts of employers, employees and society, with the aim of improving health and welfare in the workplace WHP addresses the following issues:

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

This programme involves accreditation as a "Health Promoting Company" for enterprises undertaking to introduce practices of proven effectiveness and which may be considered "Good Practices" in the field of health promotion and sustainable development. The objective of the WHP Network is not to award a "certificate of excellence" to just a few leading companies but rather to extend the Network to as many companies as possible in order to promote self-assessment and improvement as regards health promotion, welfare and sustainability.

Please give a description of the problem the good practice example wants to tackle:

The European Commission launched the Europe 2020 Strategy in March 2010 to address the economic crisis which has had a detrimental effect on growth and social development. The strategy has several aims including the promotion of a smart, sustainable and inclusive economy which will be delivered through high level targets. The particular section of the Europe 2020 strategy is the target of 'achieving a 75% employment rate for 20–64 year olds throughout the EU'.

The workplace directly affects people's health because it is where people spend a lot of their time. It is the perfect setting to promote a healthy lifestyle and contribute to improved health among the workers of a company. Faced with labour shortages and a high percentage of workers suffering from health problems and chronic illnesses, there is a good case for investing in workplace health. There is a strong business case for investing in workplace health. The challenge for employers is to find a balance between meeting the targets for the business and the health needs of employees with chronic illness. Four main factors account for the majority of the burden of chronic non-communicable diseases: tobacco, poor diets, alcohol and lack of physical activity. These factors are associated with lifestyle issues which could be altered by behavioural changes and/or, the influence of workplace health promotion initiatives (*The Chronic Disease Alliance. (2010) A unified prevention approach. Position paper for the EU Commissioner of Health and Welfare. www.idf.org/webdata/docs/idf-europe/Chronic-disease-alliance-Final.pdf*). There is much evidence to support the use of health promotion activities in the workplace and there are potential benefits to be gained by employers investing in workplace programmes: reduced health care costs, saving on absence, stress reduction (*Effectiveness and economic benefits of workplace health promotion and prevention. Summary of the scientific evidence 2000–2006, www.iga-info.de/fileadmin/Veroeffentlichungen/iga-Reporte_Projektberichte/iga-Report_13e_effectiveness_workplace_prevention.pdf*). Taking care of the health of

workers through a broad public health approach means to create the conditions for a healthy and active aging and prevent chronicity (expanded chronic care model). Today's workplace is defined by the imbalance between intellectual overload and physically undemanding tasks. This over- and under-utilisation is associated with long-term illnesses such as depression, burn-out or musculoskeletal disorder, and should trigger an intervention to prevent chronic illness developing. It is important to create a mandatory, systematic and robust way to manage workplace health and to provide professional support to those at risk of chronic diseases.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The programme is embedded in the National Prevention Plan 2014-2018 and in Lombardy's Regional Prevention Plan from 2009-2013 to 2014-2018

Implementation of your example of good practice is/was:

Continuous (integrated in the system). The programme is embedded in the annual system assigning the objectives to the general managers of local health authorities and hospitals. (Determination for the management of the regional social health services year 2015)

Target group(s):

All company workers are involved (young adults, adults, male and female). There are positive implications in workers family lifestyles. Since 2015 special attention will be given to the engagement of blue collars that at present are less involved than white collars

During implementation, did specific actions were taken to address the equity dimensions?

This is a setting based community programme and all company workers are involved. Since 2015 special attention will be given at the involvement of blue collar workers that at present are less than white collar

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

The programme involves all workers (male and female, from local or urban areas, with different socioeconomic status)

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, (e.g.. including social determinants) and using different strategies (e.g.. setting approach)?

Yes, the intervention aims to address subjects' health behaviours that are clearly related to social, environmental and interpersonal determinants.

Was an effective partnership in place?

An effective partnership is in place (between the regional health system, private enterprises and public associations) and it is based on a corporate social responsibility. It spread actions "recommended and/or proven" that facilitate the adoption of a healthy lifestyle in all the staff of the organization, with repercussion on families and on the local community. It's oriented on organizational and economic criteria

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The programme "workplace health promotion, Lombardy WHP Network" is inserted in the National Prevention plan 2014-2018, in the Regional Prevention Plan for 2010-2013 and 2014-2018 and fits into the strategies of

EUROPEAN INNOVATION PARTNERSHIP on Active and Healthy Ageing (EIP -AHA). Lombardy WHP Network is a member of the European Network for Workplace Health Promotion. (<http://www.enwhp.org>). The programme was conceived also around the concept of the UNI-ISO 26000 “Guide to Social Responsibility” according to the definition of sustainable development.

Was the intervention implemented equitably, i.e. proportional to needs?

Yes, every company can choose the level of implementation proportional to its specific needs

Were potential burdens, including harm, of the intervention for the target population addressed?

There aren't potential burdens or harms because the implemented activities are evidence based and may be considered “Good Practices” in the field of health promotion and sustainable development.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, the company directly chooses the strategies and applies them. The company has to organize for all employees a presentation of the programme. There is a manual available that describe pre-requisites, aims, process and strategy

Did the evaluation results achieve the stated goals and objectives?

At the end of 2014 we can count the adherence of 284 companies to the network and a total of 139,186 employees are involved. From 2013 to 2014 the regional increase was equal to 103% in relation to the number of companies and 132% in relation to the number of employees

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

1. The programme was evaluated by expert health promotion peer reviewers using the national good practice assessment form, before to be adopted at regional level (http://www.dors.it/alleg/bp/201412/griglia_naz_en.pdf)
2. Every year the companies declare what actions (good practice) have been implemented and what they will intend to do
3. To plan the more consistent actions in the business context and to assess the improvements achieved, it is important “in the start” to measure the actual situation with respect to the behaviours (determinants of health and risk factors) of the workers in the organizational business aspects.

To this end, within 3 months from the enrolment, it is expected to:

- distribute an anonymous questionnaire to all employees for the evaluation of their lifestyle (the data are not yet available)
- complete a “company” questionnaire for the development and/or the re-orientation of actions already in place within the Company and to observe and present changes/modifications on the medium-long term.

Both instruments are used again at 36 months from the first distribution

4. One year impact in Bergamo province was evaluated (Med Lav 2015; 106, 3: 159-171)

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes: At the end of each year, the Companies through the regional online database have to:

- certify, the implementation of the best practices (i.e. actual actions to facilitate the ability of workers to adopt healthy behaviours in Company) and

- report their problems and needs

Specifically, what has been measured / evaluated?

Process evaluation: The programme was evaluated by expert health promotion peer reviewers using the national good practice assessment form, before to be adopted at regional level (www.dors.it/alleg/bp/201412/griglia_naz_en.pdf) every year the companies declare what actions (good practice) have been implemented and what will intend to do within 3 months from the enrolment, the company:

- distribute an anonymous questionnaire to all employees for the evaluation of their lifestyle
- complete a “company” questionnaire for the development and/or the re-orientation of actions already in place within the Company and to observe and present changes/modifications on the medium-long term. Both instruments are used again at 36 months from the first distribution.

Evaluation of the impacts/effects/outcome:

1) At the end of 2014 we can count the adherence of 284 companies to the network and a total of 139,186 employees are involved. From 2013 to 2014 the regional increase was equal to 103% in relation to the number of companies and 132% in relation to the number of employees.

2) One year impact in Bergamo province was evaluated (Med Lav 2015; 106, 3: 159-171)

A controlled non-randomized, before-after evaluation was carried out. Data were collected through anonymous questionnaires before (t0) and after participation in a 12-month health promotion programme (t1). The “control” group consisted of workers in companies participating in the programme who had not yet undertaken any interventions in the theme areas covered by the assessment. Results: In the workers participating in the programme, positive early effects (after 12 months) were related to intake of food providing protection (fruit and vegetables) and increased rates of smoking cessation. The effects were more evident in males and in white collars. The physical activity and alcohol consumption trends went in the desired direction and with more effects than in the non-participating group, but without statistical significance. In the short term, no evident changes in events of road injury risk or in the quality of personal relationships were seen, probably due to the small size of the sample involved in these study areas. The results, although within the methodological limitations of the study, showed that after 12 months there was a reduction in some important risk factors for chronic diseases in workers participating in the programme, particularly for fruit and vegetable intake and smoking cessation. It will be important to monitor the effects of the programme on other risk factors in the medium and long term, and also the impact of employment status and gender so as to adjust the programme interventions accordingly. Cooperation with occupational/authorized physicians with use of their data collected from health surveillance, together with a limited set of general risk factor indicators, would be a desirable development for further studies.

3) At the end of each year the Companies certify, through the regional online database, the implementation of the best practices (i.e.. actual actions developed in order to facilitate the ability of workers to adopt healthy behaviours).

Below some results:

Company sector distribution: 32% of the companies are from the health sector, 11% from the metal sector, 11% chemical industries, other sectors are classified with a percentage from 1% to 3% each, while the percentage of the non-classified sectors is 21% total.

Table 2 describes the activation of six areas covered by the program WHP and the number of involved employees: it is reported that more than one company every 2 activated the nutrition area

Among the practices, 129 companies activated the nutrition area (45% of the total number of companies registered at the WHP program, including those who have not activated the feeding area) and started an information campaign. 111 activated a reorganization of their workplace canteens.

Tab 2: ACTIONS	company	n° lavoratori
NUTRITION AREA	161 (57%)	82478 (59%)
NO SMOKING AREA	64 (23%)	37117 (27%)

PHISYCAL ACTIVITY AREA	100 (35%)	32272 (23%)
ROAD SAFETY AREA	32 (11%)	12937 (9%)
ALCOHOL AND SUBSTANCES AREA	26 (9%)	5984 (4%)
WELL BEING AREA	83 (29%)	39969 (29%)

Among the practices activated in the No Smoking area the most frequent actions are 2.5 and 2.6 (15%) (TABLE 3)

Table 3. NO SMOKING AREA	company
2.1: STOP SMOKING CLASS	26 (9%)
2.2: COMPETITION "STOP AND WIN"	2 (1%)
2.3: SMOKING FREE COMPANY POLICY	32 (11%)
2.4: MINIMAL ADVICE BY THE OCCUPATIONAL DOCTOR	40 (14%)
2.5: SMOKING ASSESSMENT BY THE OCCUPATIONAL DOCTOR	42 (15%)
2.6: NO SMOKING ADVICE	43 (15%)
2.7: ACCESS TO A NO SMOKING MEDICAL SPECIALIST	10 (4%)
2.8: SMS/MAIL SERVICE	6 (2%)
2.9: OTHER ACTIVITIES (APPROVED BY THE LOCAL HEALTH UNIT)	23 (8%)

Among the practices activated in the Physical Activity area the most frequent action is 3.5 (30%) (TABLE 4)

TAB 4 PHYSICAL ACTIVITY AREA	company
3.1: POSSIBILITY OF PHYSICAL ACTIVITIES IN THE WORKINGPLACE	36 (13%)
3.2: BYCICLE USE PROMOTION	23 (8%)
3.3: SPECIAL AGREEMENTS/INCENTIVES	58 (20%)
3.4: DISTRIBUTION OF PEDOMETER	28 (10%)
3.5: INTERNAL INFORMATION CAMPAIGN	84 (30%)
3.6: INTERNAL SPORTING EVENTS	48 (17%)
3.7: COMPANY WALKING GROUP	25 (9%)
3.8: COMPANY INIZIATIVES DIFFERENT FROM THE PREVIOUS	40 (14%)
2.9: OTHER COMPANY INIZIATIVES VALIDATED BY THE LOCAL HEALTH ENTITY	36 (13%)

What are the main results/conclusions/recommendations from the evaluation?

The main result is:

- participation and involvement of the companies in the region (103% increase in the subscriptions to the network from 2013 to 2014)
- maintenance of the actions undertaken in the three years is a guarantee of a real structural change in the work environment
- best practices are evidence based activities (continuous updating of the catalogue of evidence-based actions by the Local Health Units) so they are proved to be effective in other contexts
- evidence-based actions are of different natures: informational (smoking cessation, healthy eating, etc.), organizational (canteens, snack vending machines, agreements with gyms, health Programmes stairs, walking / biking from home to work, smoke-free environment , baby pit stop, etc.) and collaboration with others in the local community (Associations, etc.).
- a one year impact estimation was conducted in Bergamo province (with 94 companies and 21.000 workers) and showed that after 12 months there was a reduction in some important risk factors for chronic diseases (particularly for fruit and vegetable intake and smoking cessation). It will be important to monitor the effects of the programme on other risk factors in the medium and long term, and also the impact of employment status and gender so as to adjust the programme interventions accordingly. Cooperation with occupational/authorized physicians with use of their data collected from health surveillance, together with a limited set of general risk factor indicators, would be a desirable development for further studies.

- take care of the health of workers through a broad public health approach allows to set the conditions for a healthy and active aging and prevent chronicity (according to the logic of the Expanded chronic care model)
- however, the evaluation of initiatives to change lifestyle (especially the changes in diet and physical activity) needs a long time work and an appropriate Follow Up.

Is the evaluation report available, preferably in English or at least an English summary?

“One year impact estimation of a workplace health promotion programme in Bergamo province» Med Lav 2015; 106, 3: 159-171. The document regarding process evaluation is in press. The efficacy of proposed actions in the specific setting (workplace) is no more tested because the actions are evidence based

Was there a follow-up or is any follow-up evaluation planned in the future?

There is an annual Follow Up Process (every 28 February the company must send their own data, declare the good practice to be implemented in the year, and declare their problems and needs)

Who implemented the intervention?

The Workplace Health Promotion is the result of the joint efforts of employers, employees and society. The company directly chooses the strategies and applies them. The Local Health Unit supports by moving towards evidence based interventions. The Lombardy region collect, verify the data, and support the entire process

What core activities are/have been?

- The program manual is published in Italian and in English (it describes the entire process and collect certified “good practice” to implement)
- A online regional system was created to collect data and share information within the WORKPLACE NETWORK
- Lombardy WHP Network joined the European Network for Workplace Health Promotion. (<http://www.enwhp.org>).
- The programme was conceived around the concept of the UNI-ISO 26000 “Guide to Social Responsibility” according to the definition of sustainable development.
- the WHP Network logo was created
- the strategic conditions to support the process were created (through DDS n. 11861/2012 “health promotion in workplace: ASL suggestions for the development of effective and sustainable interventions”)

Did the intervention achieve meaningful participation among the intended target population?

The intervention involves all company workers and indirectly acts also their families

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes, the intervention aims to support the healthy choices of the workers and their family and to empower them

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes. This is a workplace programme and it is based and organized on the setting specific needs and characteristics

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes, The Workplace Health Promotion is the result of the joint efforts of employers, employees and society.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, the programme is embedded in the National Prevention Plan 2014-2018 and in Lombardy's Regional Prevention Plan 2019-2013 and 2014-2018. The programme is embedded in the annual system that assigns the objectives to the general managers of local health authorities and hospitals. (Determination for the management of the regional social health services year 2015)

Is there a broad support for the intervention amongst those who implement it?

Yes. The company choose to join the Network and give a broad support to the process. The Lombardy Region supports and appreciates the involved companies.

Is there a broad support for the intervention amongst the intended target populations?

The company workers participate in a satisfactory way to all the proposed activities. They are not able to support directly the intervention

Were sources of funding specified in regards to stability and commitment?

No, there aren't specified sources of funding because the programme is a "system action" (it is embedded in an annual system that assign the objectives to the general managers of local health authorities and hospitals. "Determination for the management of the regional social health services")

Were organisational structures clearly defined and described?

Yes.

A) The company interested in joining the Network must first of all check on the following prerequisites:

- Be in compliance with security contributions and insurance;
- Having drawn up the Risk Assessment as required by Legislative Decree 81/08, as amended and comply with the provisions on health and safety in the workplace;
- Being on compliance with environmental regulations (Legislative Decree 152/06, as amended).
- The company must not in the five previous years have received convictions related to the application of the Legislative Decree 231/2001

Then the company must follow the procedure described in the Network Manual

B) The Prevention Department of Local Health Unit update, through the scientific literature, the list of evidence based good practice

C) The Lombardy Region supports the involved companies, analyses the annual online data and maintains alliances

Is the potential impact on the population targeted assessed?

At the moment there are data from a pilot study in Bergamo with promising results. A controlled non-randomized, before-after evaluation was carried out. Data were collected through anonymous questionnaires before (t0) and after participation in a 12-month health promotion programme (t1). The "control" group consisted in workers of companies participating in the programme who had not yet undertaken any interventions in the theme areas covered by the assessment.) The programme is embedded in the National Prevention Plan 2014-2018 in order to test feasibility and scalability on national level

Are there specific knowledge transfer strategies in place (evidence into practice)?

The knowledge transfer strategies are:

- a presentation of the programme to all employees by the company
- the manual describing process and strategy
- local journal articles
- scientific publications

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Not yet. The programme is embedded in the National Prevention Plan 2014-2018 in order to test feasibility and scalability on national level

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The preconditions of success are:

- to coordinate at regional level for the maintenance of the intersectoral network (health, private enterprise and public associations)

- the corporate social responsibility
- to ensure an organizational and economic process
- to continue to update the catalogue of recommended and/or proven efficacy actions (made by the ASL)
- to support all the participating companies

What were, in your opinion, the main lessons to be learned?

INTERSECTORAL PARTNERSHIP AND ALLIANCES: The program has a strong intersectoral character, the interest groups involved are, in particular: Confindustria Lombardia, Assolombarda, Sodalitas Foundation and Directions Strategic Health Authorities Subjects or units that manage social and socio-medical offers, public institutions, other Non Profit Organizations (with particular reference to social promotion associations and sports, voluntary organizations), national associations representing municipalities and provinces in Lombardy, trade unions, professional associations, scientific societies, universities.

IMPACT: The spread of registered actions that facilitate the adoption of healthy lifestyles and the empowerment of workers and, indirectly, their families contributes to improve the health of the population; it promotes healthy aging and prevents chronic diseases. The chosen interventions and strategies influence multiple levels of the organization including the individual employee and the organization as a whole. The evidence based actions are continuously updated according to the literature data. The one year Bergamo impact evaluation showed that after 12 months there was a reduction in some important risk factors for chronic diseases in workers participating in the programme, particularly for fruit and vegetable intake and smoking cessation. It will be important to monitor the effects of the programme on other risk factors in the medium and long term, and also the impact of employment status and gender so as to adjust the programme interventions accordingly.

SETTING: the workplace is a privileged setting for health promotion interventions. On average, Italians working full-time spend one-third of their day, five days per week at the workplace.

SUSTAINABILITY: The increased subscriptions to the network and the participation of companies over time have shown the organizational and economic sustainability of the programme

Web page related to the intervention

<http://retewhplombardia.org>

<http://www.promozionesalute.regione.lombardia.it>

References to the most important articles or reports on the intervention

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- M. CREMASCHINI, R. MORETTI, G. BREMBILLA, MARINELLA VALOTI, F. SARNATARO, P. SPADA, GRAZIELLA MOLOGNI et al. «One year impact estimation of a workplace health promotion programme in Bergamo province». Med Lav 2015; 106, 3: 159-171
- Pavan A, Pirola ME, Bonfanti M, Coppola L, Macchi L. “La promozione della salute nei luoghi di lavoro: valutazione di evidenze di efficacia e raccomandazioni metodologiche” in La Medicina del Lavoro Med Lav 2009; 100 (Suppl 1): 3-5
- Bodo R., Cereda D., Meschiari A., Rotta E., Pirrone L., Coppola L. “Protocollo di Intesa Regione Lombardia– Fondazione Sodalitas per l’attivazione e sostegno di percorsi intersettoriali di promozione della salute” . in Scardetta P, Cattaneo C, Lana S, De Mei B (Ed.). III Manifestazione nazionale del programma Guadagnare Salute. Costruire insieme la salute. Programmi ed interventi di promozione della salute tra intersettorialità, sostenibilità ed efficacia. Orvieto, 22-23 ottobre 2014. Riassunti. Roma: Istituto Superiore di Sanità; 2014 (ISTISAN Congressi 14/C5)

Other relevant documents:

<http://retewhplombardia.org>
http://www.surveymonkey.com/s/iscrizione_reteWHP
http://www.surveymonkey.com/s/reteWHP_questionario_dipendenti
<http://www.surveymonkey.com/s/WHPpianificazione>
http://www.surveymonkey.com/s/reteWHP_rendicontazione
<http://retewhplombardia.org/manuale/>
<http://retewhplombardia.org/strumenti/>
<http://retewhplombardia.org/e-health/>

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Health Promotion for Adults with Intellectual Disabilities: A Multi-Component Intervention in Community Residences Sweden

Title in original language:

Hälsofrämjande gruppbostad

Short description of the intervention:

The risk of ill-health is increased in people with intellectual disabilities (ID), partly due to physical inactivity and an unbalanced diet. Caregivers at community residences face a dilemma when trying to support healthy behaviours without violating autonomy. The intervention aimed to promote healthy behaviours i.e. promote physical activity and healthy diet among people with mild to moderate ID living in community residences in Stockholm County. The intervention was based on Social Cognitive Theory and involved activities both to strengthen the individual and to influence the social and physical context, through three components: 1) Appointment of a health ambassador in each residence and network meetings; 2) a 10 session study circle for caregivers; and 3) a 10 session health course for residents. The programme took 12 to 16 months to complete and was designed to be compatible with ordinary work routines in community residences. The intervention started with an information meeting explaining the programme intended for to all caregivers and managers of the residences. A health ambassador was appointed in each residence who attended network meetings to improve health promotion competence. The role of the ambassadors was to inspire colleagues. The study circle for the caregivers intended to increase knowledge in nutrition, physical activity and health. During each 90 minute session the staff discussed a theme related to health and how to change work routines. Adults with mild to moderate ID living in community residences were eligible for inclusion and were included if at least three individuals in each residence agreed to participate. Recruitment took place between May 2009 and February 2010.

To which type of interventions does your example of good practice belong to?

Individual Intervention targeting both residents and staff.

How is this example of good practice funded?

Regional government and public health research

What is/was the level of implementation of your example of good practice?

Regional, the intervention was conducted in several municipalities in Stockholm County.

What are the main aim and the main objectives of your example of good practice?

Improve dietary habits and physical activity for adults with mild to moderate intellectual disability as well as staff work routines by targeting both residents and staff.

Please give a description of the problem the good practice example want to tackle (nature, size, spread and possible consequences of the problem):

The prevalence of ID globally is around 1 %, and the prevalence is higher among men and in low-income countries. In 2012 approximately 64 000 Swedish residents, or 0.7 % of the Swedish population, received support according to the LSS law , The Act concerning Support and Services for Persons with Certain Functional Impairments. People with intellectual disabilities have higher risk of poor health and self-rated health is 10 times more likely to be low compared to the general population. This can partly be explained by the disability per se, but one third of ill-health is attributed to level of education, lacking cash margins, sedentary leisure time, obesity, discrimination, and social participation. Thus, in theory health could be improved by targeting these factors. Increased vulnerability to poor health, behavioural risk factors and limited health literacy identifies the need for specific health interventions for people with ID.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

People with ID are a vulnerable group and are prioritized both in the national public health policy and in various regional policies in Stockholm County e.g. the action plan against overweight and obesity.

Implementation of your example of good practice is/was:

Periodic. A manual and an evaluation plan have been made freely available, and several municipalities in Sweden have started to implement the programme.

Who implements/implemented the intervention?

The intervention was developed and evaluated by researchers at Karolinska Institutet and the Centre for Epidemiology and Community Medicine (CES) in Stockholm County Council. It is designed to be implemented by local staff in residences and in the municipality, based on a manual.

What core activities are/have been?

- An introductory information meeting explaining the intervention and preparing the staff and managers.
- Development of educational materials on nutrition, physical activity and health for health ambassadors.
- Coaching of health ambassadors by the research team during the intervention period by telephone and e-mail.
- Newsletters sent by mail.
- Four network meetings for the health ambassadors.
- One day training of leaders of the health course for residents.
- Study circle developed for the caregivers (without presence of the research team), including a booklet containing easy-to-read information on 10 health topics, suggested discussion questions for each topic, and guidance how to agree on new work routines.
- A 10 session study circle for residents including several aspects of health developed by an adult education organisation (Studieförbundet Vuxenskolan), who's employees also acted as course leaders.

Who did the evaluation?

Internal and external parties

What has been measured / evaluated?

Process evaluation: Qualitative data were collected to identify barriers and facilitators of the implantation of the health course for residents by 1) education notes from course leaders; 2) observation during course sessions; and

3) group discussions with course leaders. To study the implementation process of the whole programme, interviews were conducted with managers and health ambassadors after the intervention period.

Evaluation of the impacts/effects/outcome: The intervention was evaluated in a cluster-randomised controlled trial including 30 residences (16 intervention, 14 controls) and 130 individuals. Measurements took place at baseline, after 12-16 months and 1 year after completion of the study. Outcome variables were measured at baseline, at completion (after 12-16 months) and at 1 year follow-up. Individual outcomes were physical activity (pedometry); dietary quality (photography of meals); BMI and waist circumference was measured, resident satisfaction with life by questionnaire. Work routines were studied through questionnaire including 26 items within three domains; 1) general health-promoting work; 2) food and meals; and 3) physical activity. The items covered work routines as well as aspects related to knowledge among staff, role modelling, food supply and opportunities for physical activity.

Intervention fidelity was assessed by participation of residents and caregivers in core activities such as: 1) network meetings for health ambassadors; 2) the study circle for caregivers; and 3) the health course for residents.

What are the main results/conclusions/recommendations from the evaluation?

A significant intervention effect was found for physical activity, with an average increase of 1608 steps per day among participants in the intervention group compared to control. No other significant effects were found for other individual measures, but a desirable trend was observed for BMI and waist circumference. Satisfaction with life did not change. Work routines improved significantly in the intervention group.

The qualitative studies found that it is important to support motivation for change among managers and caregivers throughout the implementation process, and to support the residents during the health course, and in their social and physical environment.

Higher effectiveness could probably be obtained by improving implementation strategies to increase fidelity. Further studies are needed to improve diet of residents and meal work routines.

Is the evaluation report available, preferably in English or at least an English summary?

Report in Swedish: http://dok.sls.se/CES/FHG/Jamlik_halsa/Rapporter/halsofarmande-gruppbostad-slutrapport.2013_5.2013.pdf; Doctoral thesis: <https://openarchive.ki.se/xmlui/handle/10616/42084>

Was there a follow-up or is any follow-up evaluation planned in the future?

8 out of 14 intervention residences participated at the 1 year follow-up. The significant effects found for work routines were sustained at follow-up. However, no significant effects on individual level persisted.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

There is both an objective and perceived (by staff in residences) need for health promotion among this target group, resulting in a positive attitude by local authorities. The intervention had a flexible and participatory approach and was designed to fit existing work routines. Easy-to-read materials

What are the main lessons to be learned?

This health promoting intervention has shown that the programme was well received probably due to the high degree of participation of staff in development and implementation. Work routines and physical activity can be improved and this has implication for health among persons with intellectual disabilities. It seems to be more difficult to improve dietary habits and also more difficult to evaluate.

Web page related to the intervention

In Swedish <http://folkhalsoguiden.se/gruppbostad/>

References to the most important articles or reports on the intervention

[Barriers and facilitators in health education for adults with intellectual disabilities--a qualitative study](#)
Bergstrom H, Elinder LS, Wihlman U; *Health education research* 2014;29(2):259-71

[A multi-component universal intervention to improve diet and physical activity among adults with intellectual disabilities in community residences: a cluster randomised controlled trial](#); Bergstrom H, Hagstromer M, Hagberg J, Elinder LS; *Research in developmental disabilities* 2013;34(11):3847-57

[Psychometric evaluation of a scale to assess satisfaction with life among people with intellectual disabilities living in community residences](#); Bergstrom H, Hochwalder J, Kottorp A, Elinder LSQ; *Journal of intellectual disability research : JIDR* 2013;57(3):250-6

[Validation of personal digital photography to assess dietary quality among people with intellectual disabilities](#)
Elinder LS, Brunosson A, Bergstrom H, Hagstromer M, Patterson E; *Journal of intellectual disability research : JIDR* 2012;56(2):221-6

[The role of staff in health promotion in community residences for people with intellectual disabilities: variation in views among managers and caregivers](#); Bergstrom H, Wihlman U; *Journal of intellectual disabilities : JOID* 2011;15(3):167-76

[Promoting a healthy diet and physical activity in adults with intellectual disabilities living in community residences: design and evaluation of a cluster-randomized intervention](#); Elinder LS, Bergstrom H, Hagberg J, Wihlman U, Hagstromer M; *BMC public health* 2010;10():761-

Other relevant documents:

In Swedish <http://folkhalsoguiden.se/gruppbostad/>

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Smoking reduction in psychiatric inpatients Greece

Short description of the intervention:

Smoking is more prevalent in psychiatric patients than in the general population. This finding is closely associated with the diagnosis of schizophrenia. Several studies have shown that after correcting for possible confounders, such as demographic and socioeconomic status, alcohol and antipsychotic use, or institutionalization, higher rates of smoking are still found in schizophrenia across cultures and countries. However, health care settings do not often aim or are equipped to help patients to quit smoking, thus missing out an opportunity to support patients at risk because of smoking complications. The present intervention aimed to help patients admitted to a non-smoking psychiatric ward to reduce the amount of cigarettes they smoke and cope with smoking cessation.

A prospective naturalistic study of smoking avoidance measures was conducted in the 2nd Department of Psychiatry of Attikon University Hospital in Athens. Regarding diagnosis, patients with schizophrenia smoke significantly more than patients suffering from mood disorders. The patients' smoking habits were monitored before admission, during their hospitalization and at discharge. Contrary to the current practice in many Greek psychiatric wards, it was decided that this new psychiatric unit would not tolerate smoking. Certain measures were applied in order to prevent patients from smoking: it was not allowed for anyone to smoke in the patients' bedrooms or anywhere else inside the clinic; smoking was only allowed in the yard and the nursing staff was always aware of who was smoking; as a nursing aim, the nursing staff tried to help patients avoid some cigarettes a day if possible. The patients were not offered any kind of medication (nicotine gums or patches) in order to reduce smoking. The number of cigarettes consumed daily was controlled by the nursing staff. The patients were informed that their smoking habits during their hospitalization were going to be recorded and used for research purposes. The study was approved by the Ethics Committee of the "Attikon" Hospital.

The nursing staff advised all tobacco users to reduce or quit smoking, assessed readiness and if the patient was willing to do it, and provided resources and assistance. The nursing staff assisted every smoker to a) remove tobacco products from his/her environment and monitor their use; b) get support from family and friends; c) review past reduction/quit attempts; d) anticipate challenges, including nicotine withdrawal, stress and mood states, particularly during the critical first few weeks; and e) identify reasons and benefits of reducing/quitting. If the patient was unwilling to reduce/quit at this time, the nursing staff helped to motivate the patient by identifying reasons for smoking cessation in a supportive manner, focusing on a) the indication why reducing/quitting was personally relevant, b) the positive and negative consequences, and c) the identification of potential benefits and potential barriers, and build patient's confidence about reducing/quitting. Furthermore, the nursing staff followed an agreed protocol allowing drinking coffee to the patients who smoked twice a day only (i.e. in the morning and in the afternoon). This was done in order to help patients tolerate the dependence symptoms more easily and use cigarettes in an organized way. Coffee was substituted by fruit juices and chewing gums, thus breaking the habit of drinking coffee and smoking cigarettes and avoiding situations that could lead to smoking. Subsequently, the patient was encouraged and helped to explore alternative coping strategies (relaxation, exercise and creative pursuits). Additionally, nursing staff were always available to maintain a sustained contact reducing smoking using cognitive communication approaches.

Before the patient's discharge, the nursing staff discussed the patient's progress and experiences so far and checked his/her attitude towards smoking. Results showed that with this simple intervention, most of the smokers (83.5%) managed to reduce their cigarette consumption per day. Female inpatients benefited more than males from the intervention. Staff generally anticipated more smoking-related problems than actually occurred. The study showed that when the medical and nursing staff made consistent yet simple efforts in order to help patients, their

smoking was substantially curtailed. Findings indicate that seriously mentally ill psychiatric inpatients despite negative preconceptions and stereotypes are able to reduce their smoking easily without side effects with minimal intervention.

Relevant documents:

Smoking reduction in psychiatric inpatients is feasible: results from a 12-month prospective study. Michopoulos et al. Annals of General Psychiatry (2015) 14:4 - DOI 10.1186/s12991-015-0043-5

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Groningen Active Ageing Strategy Netherlands

Title in original language:

Sociaal Vitaal

Which 'life stage' for CVDs prevention targets the intervention?

Ageing. Target group: Older population (men and women): sedentary, frail older adults in deprived areas. The recruitment phase was tailored to include this vulnerable group.

Short description of the intervention:

Sociaal Vitaal is an intervention programme for community-dwelling, sedentary frail older adults in deprived areas. The aim of the intervention is to promote 'healthy ageing' in the target population. Focus is on 1) increasing the physical activity of elderly; 2) develop resilience to cope with ageing and 3) increase social skills to make contact with others. The intervention consists of the recruitment of participants, screening of participants for physical inactivity, loneliness and lack of resilience. The elderly will be recruited by volunteers through home-to-home visits. Elderly that are interested in the project will be screened by a fitness test in combination with a questionnaire that measures loneliness and resilience. The project consists of a 1) multifaceted exercise programme in their own neighbourhood where participants will be supported to meet the Dutch Norm on Physical Activity; 2) a resilience training focussing on coping with fear, gaining of self-confidence, setting boundaries and getting grip on emotions and own behaviour; 3) social skills training focussing on an increased insight in the social interactions and to improve social skills to make and maintain social contacts; 4) education of several health and social topics, adapted to the participants needs, which will help to increase health literacy. The various projects are integrated. All practitioners received specific training for the intervention. To improve and maintain health behaviour, participants receive self-management training for 6 months after the intervention. This training focusses on how to implement the lessons learned during the intervention in daily practice. The following 18 months are used to implement and sustain the intervention by align with local policy plans and support the groups to be self-sufficient.

A local project group, formed prior to the intervention, will define the neighbourhood of the intervention, the target population and the involvement of all relevant partners. Selection of the neighbourhood (deprived area) is done by a demographic scan of the municipality the intervention will be implemented.

A protocol is available in which the intervention is explained step-by-step. The health promotion material, letters to participants, recruitment protocol, screening protocol and outline of the trainings are described in a comprehensive protocol (in Dutch). Training is available for practitioners of the exercise class. Instructions and training for the social skills and resilience training are also available.

Frequency/duration/intensity of training: Social skills training: 4 sessions of 45 minutes; Exercise class: 60 minutes weekly; Resilience training: 12 sessions 45 minutes

The intervention will last for 9 months. After the intervention, a continuation phase takes place of 24 months. During this period, participants receive a self-management training. In 5 meetings participants are trained to recruit new members for their own activity group in their own neighbourhood and to organize and manage this group by themselves, Also in these 5 meetings they are encouraged to join other activities in their neighbourhood.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The conceptual model assumes that low socio-economic status and ageing adversely affect the health literacy, lifestyle and resilience of sedentary frail older adults in deprived areas. This leads to physical frailty and psycho-social frailty and subsequently leading to health and adverse quality of life.

For the conceptual model, the following theories are used: the Health-Related Fitness and Physical Activity" model (Toronto model : Bouchard & Shephard, 1994), the evolution-biological play theory (Bult, 1994), the Reserve Capacity Model (Matthews et al., 2008; Meyers, 2009), the Resilience theory (Windle et al., 2008; Hildon et al., 2010 and the Ecological Model to promote healthy behaviour (Sallis et al., 2008)

Furthermore, a cross-sectional analysis of the relationship between quality-of-life, social functioning, depressive symptoms, self-efficacy, physical functioning and socio-economic status (SES) in community dwelling elderly was carried out prior to the intervention. The path analysis indicated an indirect effect of SES on the Quality of Life by social functioning, depressive symptoms and self-efficacy in the target population.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Please see the answers on the individual components (objectives, methods & activities)

To which type of interventions does your example of good practice belong to?

Individual Intervention

How is this example of good practice funded?

National/regional/local government.

What is/was the level of implementation of your example of good practice?

National - Local (municipality level). The intervention is implemented locally, but with support on a national level. All regional sport organizations have adopted this intervention and are willing to implement the intervention in the municipalities.

What are the main aim and the main objectives of your example of good practice?

The main aim of the intervention is to promote healthy ageing in community-dwelling, sedentary, frail older adults in deprived areas by specific objectives:

- 1) Promote physical activity levels (1.1), enjoy physical activity (1.2) and an increase physical functioning (1.4). The effects will be measured with validated and standardized tools, as described below. An increase in leg strength and aerobic endurance by 10% is expected. The effects will be assessed 24 months after the intervention. It is expected that 75% of the participants will maintain physically active.
 - 2) An increase of resilience by learning to cope with physical and mental frailty. The effects will be measured using the Groningen Ageing Resilience Questionnaire (GARI), as described below. It measures three dimensions of resilience. It is expected that two dimensions (self-efficacy and adaptive coping mechanisms) will increase by 7.5%.
 - 3) An increase in social skills and social networking to make contacts, maintain new contacts and improve the quality of old friends. A 10% increase in self-confidence to make new friends and a 7.5% increase in social networking size is expected.
 - 4) An increase in knowledge on several aspects of healthy living: physical exercise, smoking, alcohol use, nutrition and relaxation. An increase in knowledge on those topics will be 15%.
- Pilot studies have shown that the expected changes are feasible.

Please give a description of the problem the good practice example wants to tackle:

Elderly with a low socio-economic status are more likely to have unhealthy lifestyle characteristics, such as low levels of physical activity, unhealthy dietary habits, smoking and excessive alcohol intake compared to elderly with

a high socio-economic status. Moreover, low SES elderly are more likely to experience physical and psychological problems, leading to frailty. Those persons have a higher risk of developing non-communicable diseases such as diabetes, depression, dementia and multi-morbidity.

In the Netherlands there are 2.56 million elderly aged 60 to 85 years, of which 15% (384,000) has a low level of education. It is estimated that 76,800 elderly suffer from frailty due to low levels of physical activity, lack of mental resilience and loneliness. Health forecasts (2014) predict that in 2060 636,000 elderly will have a low SES status. This will lead to increased health care expenses.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The intervention is embedded within the Government Programme on Sport and Physical Activity Close to Home ("Sport in de buurt"). One of the actions is to grant money for sport and exercise projects for sedentary or low participation groups (Sport Impulse). Sport clubs, fitness centres or other sport providers develop or implement activity programs for sedentary or low participation groups. The main requirement is that they work together with local neighbourhood partners, and must be aimed at one of three target groups, amongst others sedentary people. The maximum grant period is two years. After that, the activity should continue without governmental funding. Sociaal Vitaal is one of the interventions that is selected as a best practice to be implemented by sport providers in the different municipalities.

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

During implementation were specific actions taken to address the equity dimensions?

The intervention focuses on sedentary, frail older adults in deprived areas. The recruitment phase was tailored to include this vulnerable group. Also the training material was adapted to the target group. Furthermore, in the continuation phase there was specific attention to the sustainability of the intervention and the empowerment of the target group.

In design, did relevant dimensions of equity were adequately taken into consideration?

Yes, in the Netherlands, national funding is available for sedentary people through the Sport Impulse (Part of the Policy programme Sport and Physical Activity Close to Home). Also, specific attention should be paid to decrease health inequalities due to SES. This intervention is specifically focusing on frail, older subjects living in deprived areas. A disadvantage is that only subjects fluent in Dutch meet the inclusion criteria of the intervention (the training material is only available in Dutch). Therefore, certain ethnic minorities could not participate in the project. At the moment, the intervention is adapted to suit the need of inclusion of participants, not fluent in Dutch. The training material will be translated and the activities will be adapted to those ethnic minorities.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, and using different strategies?

Yes, the intervention has a multidimensional approach, that it addresses three different health determinants (health literacy, lifestyle factors and resilience and social skills) and is performed in deprived areas (community approach).

Was an effective partnership in place (e.g.. multidisciplinary, inter-sector, multi-/ and alliances)?

Prior to the intervention, a multidisciplinary team is formed (from sports, welfare and the municipality). For more details on this team, please see the question on the implementation of the programme.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

National level: The Dutch Policy programme “Sport and Physical Activity close to home” aims to make it easier for people to adapt an active and healthy lifestyle, by providing sport facilities close to home. Sport Impuls grants are specified to set up activity programmes for sedentary or low participation groups. The only aim is that they should work together with local neighbourhood partners. Two years after implementation, the activity should continue without government funding.

Local level: Dutch municipalities have their own health policies in place. These health policies may focus on elderly, low SES groups or on subjects with health inequalities. Most likely, the intervention will be implemented in municipalities that focus on those high-risk groups.

Was the intervention implemented equitably, i.e. proportional to needs?

Specific attention was paid to include a vulnerable group of elderly (lonely, sedentary low-SES elderly) in the recruitment phase. Elderly wanting to participate but not meeting the inclusion criteria (e.g. physically active) were referred to other interventions. A needs assessment was carried out to identify the needs of the target population.

Were potential burdens, including harm, of the intervention for the target population addressed?

A protocol was developed at the physical performance test that when a subject had a score above a certain limit, they were referred to a doctor. Certain subjects had to get permission of their GP or physician to participate in the project. The procedure was explained to the potential participants prior to the test.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

An evaluation of three pilot projects showed that the intervention matched the needs of the elderly with a low socio-economic status. The intervention has been implemented by several municipalities, thereby meeting the needs of the stakeholders. All regional sport organizations have adopted the intervention and have decided to implement the intervention in their region. It is anticipated that from 2016 20 projects will be implemented each year.

Did the evaluation results achieve the stated goals and objectives?

At the moment, the effectiveness of the intervention is evaluated in 2 pilot studies, 16 months and 9 months after the intervention. The following conclusions were drawn:

1. 25% of the initial target population was reached;
2. Participation in the project resulted in an increased fitness, increased self-efficacy and improved social skills for social networking (not quantified).

A process evaluation showed that the project met the need and living situation of elderly with a low-socio-economic status.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

The outcome of the intervention will be evaluated by an effect evaluation, results are expected in 2015. Effects of the pilot study show effects on the outcome measures. This outcome has been evaluated by a pre-experimental design, without control group. For more information on the outcome measures, please go to other questions on evaluation.

The process of the pilot study has been evaluated. In this process evaluation, the reach, success factors, evaluation of participants, trainers and coordinators are evaluated. In addition, points for improvements have been formulated and have been taken in account during the development and implementation of the intervention.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Quality control is conducted by the owner of the intervention (GALM), and focusses on the following aspects:

- Screening of locally executed projects, implementation of the trainers, execution of the programme according to the protocols and modules
- Make use of the fitness protocol and evaluation of the effects on fitness by comparing pre and post intervention measures
- Evaluation of experiences of participants per intervention, trainers and municipalities and other institutions
- Evaluation of effects

Who did the evaluation?

An internal party (representatives of the intervention, own organisation): GALM

Specifically, what has been measured / evaluated?

Process evaluation (respondents, method, participants satisfaction): In the process evaluation the focus was on the reach, success factors, evaluation of participants, trainers and coordinators are evaluated. In addition, points for improvements have been formulated. Results were based on interviews with the target group and intermediate groups. There were three pilots (N=19, N=30 and N=104). Findings are:

- new people are found (not known by welfare organizations)
- people are more assertive
- less depressed
- people have fun and the social aspects of the intervention are appreciated
- more positive thinking

Evaluation of the impacts/effects/outcome (please describe the design): A scientific research study was developed to assess the effect of the intervention on physical fitness, resilience, social skills and social networking and quality of life. The outcome of the evaluation of an RCT is expected in 2015.

In the pilot phase, the effect of the intervention has been evaluated using a pre-experimental design. The physical functioning was measured with two validated and standardized performance-based tests:

1. *Leg strength* was assessed using the 30-second Sit-To-Stand test the number of complete sit-to-stand tests in 30 seconds without using arms was counted
2. *Aerobic endurance* was assessed by using the Two Minute Step Test. During this test, the participant marched in place for 2 minutes while lifting the knees. The total number of times the knee was lifted was counted.

Resilience was measure using the GARI tool. This tool was specifically developed for the intervention (van Abbema et al, 2015). Social Networking was assessed using the Lubben Social Network Scale, which is a 6-item scale where higher scores indicate a more extensive social network.

What are the main results/conclusions/recommendations from the evaluation?

At the moment, the effectiveness of the intervention has been evaluated in 2 pilot studies, 16 months and 9 months after the intervention. The following conclusions were drawn.

1. 25% of the initial target population was reached

2. Participation in the intervention resulted in an increased fitness, increased self-efficacy and improved skills for social networking.

Is the evaluation report available, preferably in English or at least an English summary?

A PhD student (2011-2014) will evaluate the implementation of Sociaal Vitaal. Results will be published soon.

Was there a follow-up or is any follow-up evaluation planned in the future?

A PhD student will evaluate the implementation of Sociaal Vitaal from 2011-2014. This is done by a randomized-controlled trial

Who implemented the intervention?

Stichting GALM is the owner of the intervention and takes care for national implementation. To implement Sociaal Vitaal, a local project group will be formed, in which the local municipality (policy, financial support, supply of addresses), local social welfare council (volunteers, implementation and coordination of intervention), local physiotherapists (implementation of physical activity training in neighbourhood), residence association (implementation in neighbourhood) and, if needed local mental health care services are represented.

The volunteers recruit potential participants by home visits after providing information on the importance of the program and the procedure of the intervention. The regional Sport Organization recruits the trainers of the Sociaal Vitaal groups and trains the volunteers, is responsible for the recruitment of participants, execution of the fitness tests, and coordinates the preparation and implementation of the project. Stichting GALM supports the project by providing the protocols, organizing the training for the trainers and promote the self-management training for the groups. They are also responsible for the monitoring of the progress of the intervention. The exercise component of the intervention will be executed by specifically trained and certified teachers. Stichting GALM coordinates the training of the practitioners (mostly physiotherapists). Health promotion activities will be carried out by physiotherapists, the general practitioner, the pharmacist, the dietician, the notary or a civil servant of the municipality. The intervention will be carried out in a community centre in the neighbourhood.

What core activities are/have been implemented?

The total duration of the intervention is 38 months, and consists of three phases.

- The preparation phase is 5 months, the implementation phase takes 9 months and the continuation phase is 24 months.

Preparation phase:

- Creating of support for the intervention and forming a working group of all collaborating partners
- Selection of eligible neighbourhoods
- Recruitment and training of volunteers for the home-visits and the fitness test (preferably other elderly). Protocols are available that describe 1) the profile of the volunteer; 2) training for the fitness test and 3) a protocol to conduct the fitness test.
- Preparation of a protocol of the project, containing a time schedule, work division and a budget

Implementation phase:

- Recruitment of participants
- Conducting a fitness test (sit-to-stand test, aerobic endurance and grip test), measuring blood pressure and BMI, as well as a questionnaire on loneliness, resilience and income)

Implementation of the 'Sociaal Vitaal' intervention:

- multifaceted exercise class, resilience training and social skills training and certain health promotion classes on diet, smoking, physical activity, alcohol use and overweight. The exercise class is the basis of the intervention. The resilience training and social skills training are based on physical exercises, thereby adapted the intervention to the experience of the target population.

The project is executed weekly (with holiday breaks). In total, 43 training classes are provided. Every other week the exercise class is combined with the resilience training (2 blocks of 6 classes) and the social skills training (4 classes). Monitoring of the project takes place by questionnaires and execution of fitness tests, prior and after termination of the intervention.

Continuation phase:

The continuation phase lasts 24 months. During this phase, the groups are assisted to sustain their activities. Furthermore, a self-management training is provided aiming to 1) create social cohesion among the participations; 2) to learn skills to implement physical activity and social skills as daily routines 3) to teach resilience training and practice with goal setting to improve healthy ageing and 4) stimulate groups to be active in their own neighbourhood.

This self-management training will be taught 4 times (half yearly).

Was the intervention designed and implemented in consultation with the target population?

Prior to the development of the intervention, a needs assessment was performed among elderly with a low socio-economic status. It was concluded that elderly needed support to improve their healthy lifestyle. Furthermore, it was concluded that elderly needed support to improve the assertiveness and learn to maintain friendships.

Did the intervention achieve meaningful participation among the intended target population?

Evaluation have shown that the positive response rate is 6% (60 people of 1000 invited to participate). Half of subjects with a positive response will meet the inclusion criteria.

Did the intervention develop strengths, resources and autonomy in the target population?

Process evaluation showed that the intervention increased the self-efficacy among the participants.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

A needs assessment was performed among the target population. The target population was identified based on the conceptual model.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Volunteers were engaged to recruit the participants. The volunteers came from the same neighbourhood and were also older adults (peer group approach).

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

The intervention owner is GALM. They maintain and update the protocols of the intervention. However, the first year of the funding is under responsibility of local municipalities. There are many funding sources that local governments can use for funding (e.g. Sport Impuls). The second and third year of the intervention are considered a transition phase, in which the participants will be taught to be an independent group. They will be supported to find additional funding (e.g. organizing fairs). After three years, they should be independent.

Is there a broad support for the intervention amongst those who implement it?

The intervention is currently implemented in many municipalities. The process evaluation showed that health workers could reach new participants that were not known prior to the intervention, due to the innovative and

active way of recruitment the participants. All the regional sport organizations have adopted this intervention and are planning to implement it in the municipalities of their region.

Is there a broad support for the intervention amongst the intended target populations?

A needs assessment was carried out, and the process evaluation showed that participants enjoyed the intervention.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

A worksheet is available with the hours needed, specified per each phase of the intervention and for each activity. There is also an estimation of the required budget available.

Were sources of funding specified in regards to stability and commitment?

No, sources of funding were only specified for the implementation of the intervention.

Were organisational structures clearly defined and described?

Please see the organization structure described above.

Are there specific knowledge transfer strategies in place (evidence into practice)?

The intervention is currently evaluated by a PhD student.

The intervention is assessed as theoretically sound and included as best practice in the database of the Centre for Healthy Living in the Netherlands. In addition, the intervention is part of the Sport Impuls (see above). Municipalities can apply for a grant to implement the intervention. Therefore, it is expected that this intervention will be implemented on a broader scale.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Foreseen barriers are infrastructure that is needed, and the education and training of the practitioners. However, there are activities to provide a training at vocational education.

Money to implement the intervention is also a barrier. However, for the next two years, every municipality can apply for the implementation of this intervention in their deprived areas because of Sport Impulse.

However, facilitators are that there is an increasing group of subjects that meet the inclusion criteria for the intervention.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The process evaluation identified several success factors for the intervention:

- Municipality with sufficient support and budget to implement Sociaal Vitaal;
- A consultant that supports the municipality with the development and implementation of Sociaal Vitaal;
- Trained staff, such as volunteers, and physiotherapists
- Availability of health promoters/GP, dieticians etc.
- An appropriate inside training facility

What were, in your opinion, the main lessons to be learned?

- Deviation of the protocol, especially during recruitment, will lead to the inclusion of the wrong target population

- Counselling and teaching frail elderly with a low socio-economic status requires specific skills of the trainers (empathy and patience), and thus supervision of the trainers is important for the success of the intervention.
- Another intervention should be tailored to low SES elderly that are not fluent in Dutch. In practice, it appeared that many potential candidates could not participate because they could not speak Dutch.

Other relevant documents:

At the moment, training material is only available in Dutch.

Bielderma A, Greef de MHG, Krijnen WP, Schans van der CP. (2014),. Relationship between socio-economic status and quality of life in older adults: a path analysis. Quality of Life Research , DOI 10.1007/s11136-014-0898-

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Health Promotion for People Belonging to the Cardiovascular Disease Risk Group 'hereinafter – Program' Lithuania

Title in original language:

Širdies ir kraujagyslių ligų rizikos grupės asmenų sveikatos stiprinimas 'hereinafter – Program'

Which 'life stage' for CVDs prevention targets the intervention?

Adults. It is a program for 40-55 years men and 50-65 years women who belongs to cardiovascular disease risk group (obesity, smoking etc.) and also participate in Screening and prevention program for people at high risk for cardiovascular disease (secondary prevention).

Short description of the intervention:

The Program was approved by the Ministry of Health Minister Order in 22th of September 2014. Order No. V-979 "For approval of cardiovascular disease risk persons health promotion procedure description" (hereinafter - Description). The primary health care physician informs the person about opportunity to participate in a Program. If a person agrees to participate in the Program the physician fills and hands him a sheet of health indicators status and includes that person to the Program list. At least once a month the list is being sent to the Municipal public health bureau by the physician. Municipal public health bureau, in accordance with lists, organizes the Program. For example Vilnius Public Health Bureau in cooperation with primary health care institutions carried out the Program since September 2014. Two-month long program involved two groups of 18 people (hereinafter – Vilnius group), belonging to cardiovascular disease risk group, for example, those who have the most common cardiovascular risk factors such as high blood pressure, high cholesterol, type II diabetes, overweight or obesity and smoking.

How is this example of good practice funded?

National/regional/local government.

What is/was the level of implementation of your example of good practice?

The Program is implemented in all Public Health Bureaus in the municipalities.

What are the main aim and the main objectives of your example of good practice?

The goal – using the integration of primary health care facilities and municipal public health bureaus ongoing health activities, effectively strengthen the persons health, introduce them with cardiovascular disease risk factors and healthy lifestyle principles, teach how to change lifestyle, manage stress, choose the healthy diet and physical activity and reduce the cardiovascular diseases risk factors.

Implementation of your example of good practice is/was:

Continuous (integrated in the system).

Did the evaluation results achieve the stated goals and objectives?

Yes, nearly all participants in Vilnius group noted an improvement of their overall well-being, increased physical activity, consumption of fresh vegetables and fruit, reduced-fat, sugary and salty food after the Program. Participants' body weight decreased by an average of 1.45 kg (range from 0.4 kg to 2.6 kg), BMI decreased by an average of 0.52 (range from 0.1 to 0.9), waist circumference decreased by an average of 2.5 cm (range from 0 cm to 8 cm) during the Program. Two months after the program positive changes were observed in high-density lipoprotein (HDL) and glucose levels in the blood.

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

The evaluating will be continued.

What core activities are/have been implemented?

In Vilnius group: The specialists explained about the most important cardiovascular risk factors and their correction and prevention, the main cardiovascular diseases and their symptoms during the training. The dietician taught about the importance of healthy eating, presented the general dietary recommendations, taught how to read and understand food labels. It was also emphasized high salt intake negative influence on blood pressure. Each participant had a unique opportunity to consult with nutritionists; also individual nutrition plans were scheduled for each participant. The importance of Physical activity in the prevention of cardiovascular was set not only by lectures, but in practice too: each participant had the opportunity to exercise weekly with physical therapist. Physical therapist arranged physical activity plan for each one, taking into account the human individual characteristics and an assessment of the physical capacity of every individual and consulted during the entire Program. The psychologist taught stress management techniques, moreover, free psychological counselling was provided.

Contact details of person who may be contacted for further information

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Multimodal Training Intervention: an Approach to Successful Ageing Iceland

Title in original language:

Fjölpætt heilsurækt – Leið að farsælli öldrun

Short description of the intervention:

Mr. Janus Gudlaugsson, Doctor of Philosophy in Sport and Health Science at the University of Iceland. This intervention was a part of his thesis for a doctoral degree at the University of Iceland from 2007 – 2014. The doctoral defence was 22nd of September 2014. Multimodal training interventions (6-MTI) are of special interest for older individuals, because of their high rate of disability, functional dependence and use of healthcare resources.

The aim of this study was to examine the effects of a 6-month multimodal training intervention (6-MTI), and nutrition and health counselling on different variables, such as on functional fitness (FF), body composition (BC) and cardio metabolic risk factors (CMRF). The aim was also to evaluate at 6- and 12-month follow-ups the effects and sustainability of a 6-MTI. Furthermore, the aim was to investigate the effects on the different sexes and to see whether they were different between older males and females. Another goal was to examine the 6-MTI effect and long-term effects on participants, who were divided into three different age groups. Finally, the aim was to evaluate whether the applied 6-MTI design and methodology could form a sustainable strategy for developing and maintaining the health of older age groups with regard to international recommendations.

The participants were healthy older individuals, 71–90 years old, selected from the population-based Age, Gene/Environment Susceptibility – (AGES) Reykjavik Study that had been screened depending on their health and physical performance. Ninety-two of the 325 older individuals (>70 years), along with 25 spouses, accepted the invitation. The main reasons for not participate in the study were that the study was conducted over too long and binding period, participants showed a lack of interest or participants suffered illness.

This study was a randomized controlled, cross-over design. After enrolment and baseline assessment the participants (n=117) were randomized into an immediate training intervention group (n=56) and a delayed intervention group (n=61). The trial was conducted in three 6-month phases after the baseline assessment. The immediate intervention group participated in a 6-MTI, while the delayed intervention group served as a control group. After the first 6 months of the study the baseline measurements were repeated, and the crossover took place. The delayed intervention group now received comparable training intervention for 6 months as the immediate intervention group received before, which from that time-point did not receive any further intervention from the research staff. After the second 6-MTI, the baseline measurements were repeated in both groups. The delayed intervention group did not receive any further intervention. An additional 6-month follow-up was done and the measurements were repeated for the fourth time. At this time point the research was formally closed.

The intervention consisted of a 6-MTI with an emphasis on daily endurance training (ET) and twice-a-week resistance training (RT). This was supported by three lectures on nutrition and four on health-related topics.

The ET consisted of daily walking over the intervention phase. The duration of the training session increased progressively through the 6-month training period. During the first week, the participants trained for 20 minutes at each session, and then the duration was increased systematically over the training period. The average duration per day was estimated at around 30 minutes. In the first and last eight weeks, a health instructor was on site twice a week, but in weeks 9–18, only once a week. The training took place outdoors on a 400-meter running track, except for four weeks during the winter period when the training was indoors. Other endurance training sessions were self-administered with participants following a training plan from the program.

The RT took place twice-a-week in a fitness centre. It was individualized and always under the guidance of health instructors. The RT consisted of 12 exercises for all major muscle groups. The exercises for the lower body included leg press, leg extensions and calf raises. Exercises for the upper body included bench press, chest cross, shoulder press, pull downs, biceps curls, triceps extensions, and exercises for abdominal muscles and the back. The focus was on strength-endurance training for the first 3 months but for the latter 3 months it was on strength-power. The participations had 7 lectures, 3 on nutrition and 4 on healthy ageing, endurance, strength, and how to train. Some municipalities in Iceland are exploring the possibility to implement this method, adapted to their situation.

To which type of interventions does your example of good practice belong to?

Individual Intervention.

How is this example of good practice funded?

The research project was funded by following institutions, organizations and companies:

- The Icelandic Centre for Research – RANNÍS (Rannsóknamiðstöð Íslands – RANNÍS)
- The Fitness Centre World Class Laugar (World Class Laugar heilsurækt)
- The Sport Fund at the Ministry of Education, Science and Culture (Íþróttasjóður)
- The Capital Area Commune Association (Samband sveitarfélga á höfuðborgarsvæðinu)
- The Football Association of Iceland (Knattspyrnusamband Íslands)
- The Physiotherapy Máttur in Árborg (Máttur Sjúkrapjálfun, Selfossi)
- The Commune Árborg (Sveitarfélagið Árborg)
- The General and Transport Workers' Union – Hlíf (Verkamannafélagið Hlíf, Hafnarfirði)
- The Older Fishermen's Home Hrafnista – DAS (Hrafnista – DAS)
- The Kiwanis Club Eldborg in Hafnarfjörður (Kiwanisklúbburinn Eldborg, Hafnarfirði)
- The Oddfellow Order in Iceland (Oddfellowreglan á Íslandi)
- The Directorate of Health in Iceland (Embætti landlæknis)
- The School and Leisure Department, City of Reykjavik (Íþrótt- og tómstundasvið Reykjavíkurborgar).

What is/was the level of implementation of your example of good practice?

The results of the research have been well received and caught the attention of both national and local authorities who are interested in implementing the method. According to the author, one of the main benefits of this multimodal training intervention is that the ideology can be adapted for single individuals or a group of older people, in small or large communities.

What are the main aim and the main objectives of your example of good practice?

The aim was to examine the effects of a 6-month multimodal training intervention (6-MTI) and nutrition and health counselling on different variables, such as functional performance, strength, endurance, body composition and metabolic risk factors. The aim was also to evaluate at 6- and 12-month follow-ups the effects and sustainability of a 6-MTI. Furthermore, the aim was to investigate if the effects on the different sexes and to see whether they were different between older males and females. Another goal was to examine the 6-MTI effect and long-term effects on participants, who were divided into three different age groups. Finally, the aim was to evaluate whether the applied 6-MTI design and methodology could form a sustainable strategy for developing and maintaining the health of older age groups with regard to international recommendations.

Please give a description of the problem the good practice example wants to tackle:

Results from a recently published study in Iceland (2011), showed that 33% of older adults engaged in no leisure time activity, 73% were eating fewer than five portions of fruit and vegetables daily, 24% were obese, and 8% were

currently smoking. 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%. This underlines the importance of establishing specific health intervention efforts in communities in order to address preventable health risks among older adults and at the same time promote Physical activity, including appropriate training, and good nutrition among older adults.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

No, but the results of the research have been well received and caught the attention of both national and local authorities who are exploring the possibility of implementation.

Implementation of your example of good practice is/was:

The trial was conducted in three 6-month phases after the baseline assessment (see Description). A 5 year follow-up has just been made (November 2014).

Target groups:

The target group was 117 healthy men and women from 71 – 90 years old. The participants were healthy older individuals, 71–90 years old, selected from the population-based Age, Gene/Environment Susceptibility – (AGES) Reykjavik Study that had been screened depending on their health and physical performance. Ninety-two of the 325 older individuals (>70 years), along with 25 spouses, accepted the invitation.

Who implements/implemented the intervention?

The administrator of the implementation was Dr. Janus Gudlaugsson (Ph.D.) and five master's students did take part in the research team during the design phase, measurements or intervention. They have all now finished their Master degree via this research. This was done under control of Mr. Gudlaugsson's PhD Committee:

Supervisor, Professor Erlingur Jóhannsson, and assistance Supervisor Professor Sigurbjörn Árni Arngrímsson both at the Centre for Sport and Health Sciences, the University of Iceland. Professor Vilmundur Guðnason from the Icelandic Heart Association, and Professor Pálmi Jónsson, Landspítali – University Hospital, Iceland. Other specialized persons were Dr Thor Aspelund, Icelandic Heart Association, associate Professor Anna Sigridur Olafsdottir at the Centre for Sport and Health Sciences, the University of Iceland

What core activities are/have been implemented?

The intervention consisted of a 6-month multimodal training with an emphasis on daily endurance training (ET) and twice-a-week resistance training (RT). This was supported by three lectures on nutrition and four on health-related topics. The ET consisted of daily walking over the intervention phase. The duration of the training session increased progressively through the 6-month training period. During the first week, the participants trained for 20 minutes at each session, and then the duration was increased systematically over the training period. The average duration per day was estimated at around 30 minutes. In the first and last eight weeks, a health instructor was on site twice a week, but in weeks 9–18, only once a week. The training took place outdoors on a 400-meter running track, except for four weeks during the winter period when the training was indoors. Other endurance training sessions were self-administered with participants following a training plan from the program. The RT took place twice-a-week in a fitness centre. It was individualized and always under the guidance of health instructors. The RT consisted of 12 exercises for all major muscle groups. The exercises for the lower body included leg press, leg extensions and calf raises. Exercises for the upper body included bench press, chest cross, shoulder press, pull downs, biceps curls, triceps extensions, and exercises for abdominal muscles and the back. The focus was on strength-endurance training for the first 3 months but for the latter 3 months it was on strength-power. The participants received 7 lectures, 3 on nutrition and 4 on healthy ageing, endurance, strength, and how to train. The delayed intervention

group had the same intervention as the immediate intervention group, in addition: Hands-on teaching in kitchen and two personal interviews.

Who did the evaluation?

Both internal and external parties.

What has been measured / evaluated?

Process evaluation (respondents, method, participants satisfaction) (please describe): Data regarding the participants satisfaction was gathered but haven't been processed.

Evaluation of the impacts/effects/outcome (please describe the design): The primary measurements were: daily activity assessed with Actigraph accelerometers and a standardized questionnaire. Body mass index (BMI) was calculated as body mass (kg) divided by height squared (m²). Physical performance was measured with the SPPB-test and mobility and balance was measured by the 8-foot up-and-go test. Maximal isometric muscle strength of the thigh and hand was measured in an adjustable dynamometer chair and endurance performance was measured using the 6-minute walk test (6MW). Quality of life was measured with standardized questionnaire. Whole-body composition was measured using Dual energy X-ray absorptiometry, iDXA software, and blood analysis was done at the Icelandic Heart Association using standard protocols.

Functional fitness, body composition and cardio metabolic risk factors were measured. The results from physical performance tests for the whole group, male or female separated or different age groups, showed remarkable changes. This concerns the main results in the SPPB-test except balance which had a ceiling effect. The results from the dynamic balance 8-foot up-and-go test were similar. In both these tests the results were maintained for at least one year after the 6-MTI.

An improvement after the 6-MTI was seen in the strength tests for hand and thigh and also in the 6MW endurance test. The positive changes were maintained in the endurance test at 6 and 12 months follow-up but the strength went back to baseline. Changes in body composition, such as weight, BMI and fat-mass were for the better at the end of the 6-MTI. These changes were not all maintained in the follow-up phases. An increase was seen in total lean mass by the immediate intervention group, but in their control phase, 6 months after the 6-MTI, the total lean mass decreased back to baseline and the total fat mass increased at the same time. A decrease was seen in the cardio metabolic risk factors, waist circumference, systolic and diastolic blood pressure, after the 6-MTI by the immediate intervention group. The same results were seen for the delayed intervention group in their intervention period. Most of these changes were maintained at the 6-month follow-up, where the blood pressure kept on decreasing.

What are the main results/conclusions/recommendations from the evaluation?

The main results concerning PA at baseline showed that most of the participants did little PA according to international guidelines. About 60% was physically active for 15 minutes or less each time they walked, which is far from the international recommendation. Seventy percent of the participants walked three days or less each week and about 10% participated in RT. Six months after the 6-MTI about 35% walked 16 to 30 minutes every time they walked, and 35% walked longer than 30 minutes when they walked. About 50% had four or more walking days in every week at this time-point and 40% said they walked 2–3 days a week. About 40% of the participants had two or more resistance-training days 6 months after the 6-MTI, but about 60% did not do any kind of RT. One year after the intervention the status was similar, both in endurance and RT participation. The results from physical performance tests for the whole group, male or female separated or different age groups, showed remarkable changes. This concerns the main results in the SPPB-test except balance which had a ceiling effect. The results from the dynamic balance 8-foot up-and-go test were similar. In both these tests the results were maintained for at least one year after the 6-MTI. An improvement after the 6-MTI was seen in the strength tests for hand and thigh and also in the 6MW endurance test. The positive changes were maintained in the endurance test at 6 and 12 months

follow-up but the strength went back to baseline. Changes in body composition, such as weight, BMI and fat-mass were for the better at the end of the 6-MTI. These changes were not all maintained in the follow-up phases. An increase was seen in total lean mass by the immediate intervention group, but in their control phase, 6 months after the 6-MTI, the total lean mass decreased back to baseline and the total fat mass increased at the same time. A decrease was seen in the cardio metabolic risk factors, waist circumference, systolic and diastolic blood pressure, after the 6-MTI by the immediate intervention group. The same results were seen for the delayed intervention group in their intervention period. Most of these changes were maintained at the 6-month follow-up, where the blood pressure kept on decreasing.

Is the evaluation report available, preferably in English or at least an English summary?

- Mr. Gudlaugssons' Doctoral thesis (Abstract in English), see <http://skemman.is/item/view/1946/19892;jsessionid=4DE8511776A7D1A94E1F1C7D92AFD9A3>
- Three scientific papers from the research:
 1. Gudlaugsson et al. (2012). Effects of a 6-month multimodal training intervention on retention of functional fitness in older adults: A randomized-controlled cross-over design. *International Journal of Behavioral Nutrition and Physical Activity*, 9:107. <http://www.ijbnpa.org/content/9/1/107>
 2. Gudlaugsson et al. (2013). Effects of exercise training and nutrition counselling on body composition and cardio metabolic factors in old individuals. *European Geriatric Medicine*, 4, 431–437. [http://www.europeangeriatricmedicine.com/article/S1878-7649\(13\)00892-9/abstract](http://www.europeangeriatricmedicine.com/article/S1878-7649(13)00892-9/abstract)
 3. Guðlaugsson et al. (2013). The effects of 6 months' multimodal training on functional performance, strength, endurance, and body mass index of older individuals. Are the benefits of training similar among women and men? *Læknablaðið (The Icelandic Medical Journal)*, 99; 331–337. <http://www.laeknabladid.is/tolublod/2013/0708/nr/4910>

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

1. The first follow-up was 6-month after the intervention. June 2009 (the immediate intervention group) and December 2009 (the delayed intervention group)
2. The second follow-up was 12-month after the intervention. December 2009 (the immediate intervention group)
3. The third follow-up was 6 and a ½ year after the intervention. November 2014 (both groups)

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The study design and plan contained the before mentioned elements. In addition, the seven lectures about health and nutrition designed to further strengthen the possibilities of developing sustainable strategies after the 6-month multimodal training intervention and to influence physical activity and other lifestyle behaviour of the participants. The cooperation with the Icelandic Heart Association, who assisted to contact the participant's, the participant's themselves who were positive and encouraging, cooperation with World Class, health and fitness centre who offered free facilities and all the master's students who helped with the research.

What are the main lessons to be learned?

The results of this thesis emphasize the need for continued development of interventions for this age group to support older individuals in keeping up their activity of daily living as long as possible. The results are positive as shown in the published papers, but several of the findings highlight the need for longer term programs. An assessment of the cost-effectiveness of such a measure and other expenses is beyond the scope of this discussion

and in the thesis, but the results nevertheless demonstrate that this type of simple program seems to be effective. A financial or economic analysis would be an interesting area for future research.

Web page related to the intervention

In progress.

References (to the most important articles or reports on the intervention)

- Mr. Gudlaugssons' Doctoral thesis (Abstract in English), see <http://skemman.is/item/view/1946/19892;jsessionid=4DE8511776A7D1A94E1F1C7D92AFD9A3>
- Three scientific papers from the research:
 1. Gudlaugsson et al. (2012). Effects of a 6-month multimodal training intervention on retention of functional fitness in older adults: A randomized-controlled cross-over design. *International Journal of Behavioral Nutrition and Physical Activity*, 9:107. <http://www.ijbnpa.org/content/9/1/107>
 2. Gudlaugsson et al. (2013). Effects of exercise training and nutrition counselling on body composition and cardio metabolic factors in old individuals. *European Geriatric Medicine*, 4, 431–437. [http://www.europeangeriatricmedicine.com/article/S1878-7649\(13\)00892-9/abstract](http://www.europeangeriatricmedicine.com/article/S1878-7649(13)00892-9/abstract)
 3. Guðlaugsson et al. (2013). The effects of 6 months' multimodal training on functional performance, strength, endurance, and body mass index of older individuals. Are the benefits of training similar among women and men? *Læknablaðið (The Icelandic Medical Journal)*, 99; 331–337. <http://www.laeknabladid.is/tolublod/2013/0708/nr/4910>

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Sörmlands Health Program for 40, 50 and 60 Year Olds Sweden

Title in original language:

Sörmlands Hälsoprogram för 40, 50 och 60 åringar

Target groups:

All inhabitants of the county Sörmlands the year they turn 40, 50 and 60 years.

Short description of the intervention:

All Sörmlanders who turns 40, 50 or 60 years will get an invitation sent home with an offer to participate in Sörmlands health programs during the year. To participate in the health program is free of charge. The program includes two visits to the healthcare centre, which includes blood sugar and blood lipid tests, measurement of blood pressure, height, weight, and waist measurements and calculating the Body Mass Index (BMI), a health survey and a conversation about health. The main aim is to prevent common non communicable diseases such as cardiovascular disease, type 2 diabetes and to strengthen public health.

To which type of interventions does your example of good practice belong to?

Individual intervention.

How is this example of good practice funded?

National/regional/local government. County of Sörmland.

What is/was the level of implementation of your example of good?

Local (municipality level). County of Sörmland, about 270 000 inhabitants.

Please give a description of the problem the good practice example want to tackle:

We want to increase the participation to 70% (from 53%) and reach groups with poor socioeconomic and less healthy lifestyle and habits (food, physical activity, alcohol and tobacco).

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. Sörmlands health program is based on previous initialised health program in the County of Västerbotten. There is a national network for similar programs in the Swedish HPH (health promoting hospitals).

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Who implements/implemented the intervention?

Trained nurses who work with the health program is undergoing training in the health program and the communication methodology used in health talks/communication, motivational interviewing, MI

What core activities are/have been implemented?

The staff participate in on-line training regarding Sörmlands health programs (hand on/manual), they get basic and advanced training in motivational interviewing and then tutoring once a year. This fall they will get an on-line based knowledge and fact education on physiological aspects of how lifestyles affect the development of cardiovascular diseases.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

What has been measured / evaluated?

Process evaluation and evaluation of the impacts/effects/outcome: ongoing process.

What are the main results/conclusions/recommendations from the evaluation?

Ongoing process. This first year will give us a baseline. We are working with the result right now.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

We have received good support from the county council of Västerbotten and Västernorrland (above others). The national network has also constituted an important support for the development of the program. Important for increased participation and utilization of excellence in various fields have been engaging relevant professions (nurses, system, communication device etc.)

What are the main lessons to be learned?

It is important to create anchoring, participation and a common goal to work. In order to build a sustainable and stable software requires time and commitment from many different activities concerned.

Web page related to the intervention

<http://www.1177.se/Sormland/Tema/Halsa/Livsstil---att-andra-en-vana/Sormlands-halsoprogram/>

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A Sustainable, Active, Primary Prevention Strategy for Cardiovascular Diseases in Italy for Adults 50+ 'Projects Cuore and Cardio 50' Italy

Title in original language:

Programma organizzato di screening del rischio cardiovascolare finalizzato alla prevenzione attiva nei soggetti cinquantenni- "Projects Cuore and Cardio 50"

Which 'life stage' for CVDs prevention targets the intervention?

Adulthood (50 years old subjects, males and females)

Short description of the intervention:

Aims:

- 1) To implement a national cardiovascular register
- 2) To describe risk factor distributions (health examination survey)
- 3) To estimate the cardiovascular risk of the Italian population and to implement the evaluation of cardiovascular risks in clinical practice
- 4) To evaluate through active call- , parameters and lifestyle of an asymptomatic population
- 5) To implement the primary prevention programme (counselling on smoking cessation, healthy diet, physical activity)

Target group: Asymptomatic men and women, aged 50 years, resident of the Local Health Authority involved, were invited to join a cardiovascular disease prevention programme through active call.

Design/methods: The Model, tested in two preventive studies in Veneto (*Epidemiol Prev* 2014; 38(1): 38-45,) forecast that the Screening Centre (SC) of the Prevention Department, in collaboration with GPs and Sanitary District, is in charge of the organization of the entire programme. The SC prepares the list of residents and the GPs apply and define the criteria for exclusion and select eligible subjects. Selected subjects are called for a visit (with eventual recall in case of non-response)

Group A: no behavioural risk factors, regular parameters; Group B: behavioural risk factors and regular parameters; Group C: new hypertension and new hyperglycaemia subjects independent from behavioural risk factors; Group D: not eligible subjects

Based on the interview results and the patient's health conditions, the Health Operator does motivational counselling and proposes specific preventive interventions. The health courses are organised with GPs, local authorities, cultural and voluntary associations and consist in: no smoking groups, walking groups, nutritional groups and individual nutritional counselling. All participants are evaluated through a lifestyle questionnaire. Parameters such as blood pressure (BP), glycaemia, waist circumference and body mass index are collected and recorded with a specific program (cuore.exe) that allows a preventive health balance and divide subjects into different risk groups. In addition to cuore.exe, a calculation of physical activity has been proved to be one of the best prevention factors in CVDs. A model to compare/ integrate screening results with those of the ISS risk chart is to be prepared.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Scientific evidence has reinforced the importance of preventive interventions designed to prevent or delay the onset of CVD through the adoption of healthy lifestyles. In particular a correct diet, regular physical activities and elimination of smoking. This is true not only for groups of people with high cardiovascular risk, but also at population level, implementing interventions aimed to all those at risk in order to reduce or control CVD. Taking into consideration the population in all age groups is an approach to promote a healthy and active aging which is a priority of public health in the European Region as part of the new policy of the European reference for the health and well-being, Health 2020. To quit smoking, increased physical activity and improving the levels of education, along with early detection and treatment of diabetes and hypertension reducing levels of obesity, may be a contribution also to the prevention of the cognitive functions of the elderly, also in relation to Alzheimer's disease. The model was tested in two pilot studies in Veneto (Epidemiol Prev 2014; 38(1): 38-45,) with satisfactory results

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, and methods?

The aims are SMART (specific, measurable, achievable, realistic and timed)

- 1) To implement a national cardiovascular register
- 2) To describe risk factor distributions (health examination survey)
- 3) To estimate the cardiovascular risk of the Italian population and to implement the evaluation of cardiovascular risks in clinical practice
- 4) To evaluate through active call parameters and lifestyle of an asymptomatic population
- 5) To implement the primary prevention programme (counselling on smoking cessation, healthy diet, physical activity)

Methods: Asymptomatic men and women, aged 50 years, residents of the Local Health Authority involved, were invited to join a cardiovascular disease prevention programme through active call by the Screening Centre of the Prevention Department, in collaboration with GPs and the Sanitary District.

All participants are evaluated through an administered lifestyle questionnaire and physical parameters are collected and recorded to divide the subjects into different risk groups.

Based on the interview results and the patient's health conditions, the Health Operator does motivational counselling and proposes specific preventive interventions. Specific interventions are standardized. The subjects with unhealthy lifestyles (class B) were invited for health counselling and reassessed after 6 months and 1 year.

To which type of interventions does your example of good practice belong to?

Policy/strategy. The National Prevention Plan 2014-2018 intend to test the feasibility and to start the program in all regions by 2018 (Development of programs / interventions, aimed at encouraging the adoption of active lifestyles in the population) and therefore this goal has been dismissed in the Regional Prevention Plans. The risk evaluation is developed at national level; the primary prevention programmes, at the moment, are active at regional level (12/20 regions involved).

How is this example of good practice funded?

National/regional/local government. The programme is funded by CCM (National Centre for Disease Prevention and Control). Its task is to liaise between the Ministry of Health on one hand, and regional governments on the other with regards to surveillance, prevention and prompt response to emergencies. An effective partnership is in place: the health courses are organised with the collaboration of GPs, local authorities, cultural and voluntary associations.

What is/was the level of implementation of your example of good practice?

Regional. This programme is now implemented in 12 Italian Regions and it is inserted in their Regional Prevention Plan strategies. The aims are to extend the primary prevention intervention at national level.

What are the main aim and the main objectives of your example of good practice?

- 1) To implement a national cardiovascular register (<http://www.cuore.iss.it/valutazione/valutazione.asp>)
- 2) To describe risk factor distributions (health examination survey) (www.cuore.iss.it/fattori/popolazione.asp)
- 3) To estimate the cardiovascular risk of the Italian population and to implement the evaluation of cardiovascular risks in clinical practice
- 4) To evaluate through active call, parameters and lifestyle, of an asymptomatic population
- 5) To implement a structured primary prevention program (counselling on smoking cessation, healthy diet, physical activity)

Please give a description of the problem the good practice example wants to tackle:

In Europe and in Italy, CVD represent a problem of public health, both in terms of mortality (in Italy 31.2% x 100.00 residents), morbidity and disability (in Europe cardiovascular diseases DALYs=17.4)

Scientific evidence has reinforced the importance of preventive interventions designed to prevent or delay the onset of CVD through the adoption of healthy lifestyles; in particular a correct diet, regular physical activities and elimination of smoking. This is true not only for groups of people with high cardiovascular risk, but also at population level, implementing interventions aimed to all those at risk in order to reduce or control CVD.

In addition, the WHO points out that the change of some risk factors at population level can lead to substantial changes in the risk profiles. A fundamental element for prevention is the identification of those at risk. Due to the weight of the epidemiological data cited above, there is a low public perception of the risk for CVD and a lack of information on predisposing factors.

In the Italian National Health Service (NHS) there are many experiences of active programs of population, such as vaccination or cancer screening; based on the positive results obtained from these programs we can assume that, with suitable modifications, the same organizational model can also be applied to the prevention of CVD

Taking into consideration the population in all age groups is an approach to promote a healthy and active aging which also is a priority of public health in the European Region as part of the new policy of the European reference for the health and well-being, Health 2020. To quit smoking, increased physical activity and improving the levels of education, along with early detection and treatment of diabetes and hypertension reducing levels of obesity, may be a contribution also to the prevention of the cognitive functions of the elderly, also in relation to Alzheimer's disease.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. At National level the project focused on the delivery of a "risk map" through GPs. With the active call by the Departments of Prevention it is intended to activate a way of integrated care between different levels of care (Prevention Department, MMG-District Hospital) regarding the contrast of the modifiable risk factors (poor diet, smoking, sedentary lifestyle) and to increase the knowledge and perception of cardiovascular risk in the general population. The National Prevention Plan 2014-2018 intend to test the feasibility and to start the program in all regions by 2018 (Development of programs / interventions, aimed at encouraging the adoption of active lifestyles in the population) and this goal has been included in the Regional Prevention Plans.

Implementation of your example of good practice is/was:

Periodic: the cardiovascular register and the population risk assessment is active from 1998. The active prevention programme is part of the project POPAC (an extensive Programme for Active Cardiovascular Prevention), that started in January 2009 and is still being implemented. The objective is to make it become an action system.

Target group(s):

Asymptomatic men and women, with the age of 50 years, residents of the Local Health Authority involved, were invited to join a cardiovascular disease prevention programme. This programme aims to develop resources and empowerment in the target population.

During implementation, did specific actions were taken to address the equity dimensions?

This is a community programme, there aren't specific objective for vulnerable social groups

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

This is a community intervention: all 50 years old residents of the Local Health Unit are invited. The Local Health Units are distributed in both rural and urban areas and cover the whole regional territory.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, and using different strategies?

Yes, the intervention aims to address subjects' health behaviours that are clearly related to social, environmental and interpersonal determinants.

Was an effective partnership in place?

An effective partnership is in place between the Prevention Department, District-GPs, hospitals, local authorities, cultural and voluntary associations. With the active call by the Departments of Prevention it is intended to activate a mode of integrated care between different levels of care (Prevention Department, MMG-District Hospital), regarding the contrast of the modifiable risk factors. . The results of the preliminary study carried out in Veneto confirm the feasibility of the program

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The intervention is aligned with The National Prevention Plan 2014-2018 (that intend to test the feasibility and to start the program in all regions by 2018) and therefore this goal has been included in the Regional Prevention Plans.

Was the intervention implemented equitably, i.e. proportional to needs?

Yes, because it is addressed to a specific population segment (50 years old subjects)

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, the intervention's objectives and strategy are clearly described to the target population, to GPs and to the whole community

Did the evaluation results achieve the stated goals and objectives?

We have only preliminary results, but the preventive studies have reached satisfactory results

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

Specifically, what has been measured / evaluated?

Process evaluation: The process evaluation measures

- number of active call respondents
- number of FU respondents
- number of activated counselling sessions
- list of proposed activities for risk factors control (e.g. walking group...)
- number of working groups interdisciplinary meetings
- participants satisfaction

Complete data are not yet available.

Evaluation of the impacts/effects/outcome:

- All participants are evaluated through a lifestyle questionnaire. Parameters such as blood pressure (BP), glycaemia, waist circumference and body mass index are collected and recorded with a specific program (cuore.exe) that allows a preventive health balance and to divide subjects into different risk groups.
- Glycaemia: the use of a glucose stick through three types of determinations: fasting, postprandial, random.
- Cholesterol: was carried out on only a small percentage of patients as the use of a stick was not considered reliable, it was reported on the data sheet the value of cholesterol of those persons who at the time of the visit brought recent exams with them (not older than 3 months).
- Nutrition: two parameters were considered, fish consumption and the consumption of fruit and vegetables.
- Physical activity: measurement and evaluation of physical activity was performed by using an algorithm according to the international physical activity questionnaire IPAQ.
- Complete data are not yet available; we have only the data for the Veneto region.

What are the main results/conclusions/recommendations from the evaluation?

The results suggest that a preventive program based on the active call of the population by the Department of Prevention could be an effective tool to identify asymptomatic individuals with unknown hypertension and/or hyperglycaemia and to offer lifestyle interventions to lower the risk of cardiovascular diseases. A peculiarity of the project is the organizational aspect, it is a network between National Health Service structures (SSN) and staff, local health authorities and voluntary services. The Prevention Department works closely with GPs, offering programs of health promotion, prevention and address the hypertensive and/or hyperglycaemic subjects in suitable clinical studies.

The following data refer to the Veneto Region. We have not yet data regarding the extension of the programme to the 12 Italian regions involved.. The adherence to the project is rather high (60.8%, 17.004 subjects), given that it requires the availability of time to access the centre where the interviews and counselling are taking place. According to the data collected, the female population gives greater attention to their health and prevention initiatives (51,2% vs 48.8%). 44,5 % of the population did not adhere to the project and this high percentage requires subsequently targeted studies in order to identify the reasons. The program highlights an interesting fact in the analysis of the classes: only 24% of the respondents are class-A (no risk factors), 56% are class B while class C, basically characterized by subjects with hypertension and/or hyperglycaemia, result in 12% of the population. The model, therefore, proposes the theme on the medicine initiative introduced in the last national plan of prevention. The program allows identifying in an early stage subjects with hypertension and/or high values of blood sugar, that otherwise would have come to the attention of GPs in a later stage. 6% of the contacted subjects are not eligible (class D): this could be the result of a misclassification in the selection process or a non-completeness of the database of MMG. This underlines the need for personal contacts and interviews for a more accurate framing. Regarding to the lifestyles observed, 33, 4% had a sedentary lifestyle, 20% were smokers and 50% were overweight. The subjects with unhealthy lifestyles were invited for health counselling and reassessed after 6 months and 1 year. The follow up (FU) evaluation shows that there has been a statistically significant improvement

of physical activities, BMI, and the number of smokers decreased. However, the evaluation of initiatives to change lifestyle (especially the changes in diet and physical activity) needs a long time of work and an appropriate FU.

Is the evaluation report available, preferably in English or at least an English summary?

A partial evaluation report (only Veneto region) is available in Italian (with English summary)

- Ferro A, Cinquetti S, Moro A et al. Preventing cardiovascular diseases through a screening modelling applicable to wide population group: Results from the first phase of the project. Epidemiol prev 2014; 38(1): 38-45)

Was there a follow-up or is any follow-up evaluation planned in the future?

The subjects with unhealthy lifestyles (class B) were invited for health counselling and reassessed after 6 months and 1 year. The FU adhesion was 50%. The FU evaluation shows that there has been a statistically significant improvement of physical activities, BMI, the number of smokers decreased. However, the evaluation of initiatives to change lifestyles (especially the changes in diet and physical activity) needs a long time of work and an appropriate follow-up.

Who implemented the intervention?

The project “Cuore” was conducted at a national level by the Istituto Superiore di Sanità. The Cardio 50 Project involves 12 Italian Regions, coordinated by the CCMR-Veneto. An effective partnership is in place between the Prevention Department, District-GPs, Hospitals, local authorities, cultural and voluntary associations. The working group is composed by: Screening Centre Operators, General Practitioners, Health Operators and cultural and voluntary associations (only for walking group organization)

What core activities are/have been implemented?

The program of screening of cardiovascular risk is divided as follows:

1. Pre-evaluation by general practitioners (GPs) to sort the lists according to the criteria for exclusion (history of cardiovascular and cerebrovascular events, diabetes, hypertension, severe neoplastic diseases, long-term care , institutionalization);
2. Active call of the subjects by the Screening Centre of the Local Health Unit
3. Screening visit performed by a Health Assistant/Nurse Professional (or other health staff duly formed), at the Department of Prevention or in other regional offices;
4. The classification of the subject in risk groups
5. Proposal of specific interventions for the risk groups. Participants receive
 - counselling,
 - informative materials on lifestyles
 - are invited to health promotion initiatives (individually or in groups) in relation to the personal risk factors.

Did the intervention achieve meaningful participation among the intended target population?

The intervention is based on the participation of the population (the subjects are invited to the screening visit, to the different interventions and to the follow up)

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes, the intervention increases health related knowledge and empowerment of the subjects and their family

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes. 50 years old people are a high risk population for cardiovascular diseases and are a strategic target for behavioural risk factor intervention. Taking into consideration the 50 years old population can help to promote a healthy and active aging which is a priority of public health in the European Region (Health 2020)

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes, General Practitioners and cultural and voluntary association members act as key intermediaries

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, the intervention is inserted in the National Prevention Plan 2014-2018 and in the Regional Prevention Plans of the involved Regions.

Is there a broad support for the intervention amongst those who implement it?

Yes. There is support among GPs, local authorities, cultural and voluntary associations

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

The intervention use Local Health Units and GPs resources, that are “system resources” (National Health System)

Were organisational structures clearly defined and described?

Yes.

1. the Screening Centre prepares the list of residents
2. pre-evaluation by general practitioners (GPs) to sort the lists according to the criteria for exclusion
3. active call of the subjects by the Screening Centre of the Local Health Unit
4. screening visit performed by a Health Assistant/Nurse Professional (or other health staff duly formed), at the Department of Prevention or in other regional offices;
5. specific interventions for the risk groups, organized by Local Health Unit with the collaboration of GPs, local authorities, cultural and voluntary associations.

Is the potential impact on the population targeted assessed?

The test of scalability is currently underway in both the project cardio 50 that in the National Prevention Plan

Are there specific knowledge transfer strategies in place?

The knowledge transfer strategy is the website CUORE with national and local journal articles, informative materials on lifestyle

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The pre-condition for success are the organizational aspects:

- it is a network between SSN structures and staff, local authorities and voluntary services.
- The Prevention Department works closely with GPs, offering programs of health promotion and prevention and address the hypertensive and/or hyperglycaemic subjects in suitable clinical studies.
- The working group must be a multidisciplinary group with GPs, health operators and staff from the Screening centre

What were, in your opinion, the main lessons to be learned?

The results confirm that a preventive program based on an active call of the population by the Department of Prevention could be an effective tool to identify asymptomatic individuals with unknown hypertension and/or hyperglycaemia and to offer lifestyle interventions to lower the risk of cardiovascular diseases. In summary, the data available today offer positive results to extend the model and at the same time invite to proceed with further investigation.

Web page related to the intervention

<http://www.cuore.iss.it>

References to the most important articles or reports on the intervention

- Palmieri L, Donfrancesco C, Giampaoli S et al. Favorable cardiovascular risk profile and 10-year coronary heart disease incidence in women and men: results from the Progetto CUORE. Eur J Cardiovasc Prev Rehabil 2006;13(4):562-70.
- Ferro A, Cinquetti S, Moro A et al. Preventing cardiovascular diseases through a screening modelling applicable to wide population group: Results from the first phase of the project. Epidemiol prev 2014; 38(1): 38-45

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Diabetes Counselling on Wheels: Early Detection and Counselling on Diabetes for Citizens of Turkish Origin and the Rural Population Germany

Title in original language:

Diabetesberatung auf Rädern – Früherkennung und Beratung zum Thema Diabetes für türkischstämmige Bürgerinnen und Bürger und die ländliche Bevölkerung

Which 'life stage (s)' for CVDs prevention targets the intervention?

The intervention is not directed towards a specific age group. However, it is focussed on older people, as many relatives of the first generation of immigrants, for example, are less well provided for in terms of healthcare than the rest of the population, due to language and cultural barriers. In addition, it is often difficult for the older rural population to obtain easy access to specialist medical care, as a result of the shortage of (specialist) doctors. The average age of the participants with a Turkish migration background is currently around 52 years. The participants from rural regions are on average 66 years old (data as of: 11.06.2015).

What is the level of implementation of your example of good practice?

Local level. The North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe is planning the respective assignment locations in co-operation with the Verband der Diabetes-Beratungs- und Schulungsberufe Deutschland e. V. (VDBD) [Association of the diabetes counselling and training professions in Germany] and its local representatives. The selected towns and regions have a high proportion of migrants, and the rural regions are characterised by poor provision of healthcare services.

To which type of interventions does your example of good practice belong?

Individual intervention. The diabetes counselling is directed towards migrants of Turkish origin and the rural population. The diabetes counselling is intended to instruct them about diabetes mellitus and to inform them locally, to diagnose as yet undetected diabetes cases at an early stage and to refer newly diagnosed cases to suitable specialist contact persons locally. The counselling will be given in the form of individual conversations.

Short description of the intervention:

The project "Diabetes Counselling on Wheels – early detection and counselling on the subject of diabetes for citizens of Turkish origin and the rural population" will be carried out in co-operation with the Deutsche Diabetes-Hilfe e. V. [German Diabetes Aid], the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe Menschen mit Diabetes [German Diabetes Aid - People with Diabetes] (DDH-M) and the Institute of Medical Sociology (IMS) at Hamburg-Eppendorf University Hospital.

The goal of the project is to instruct people with (a Turkish) migration background and people in structurally weak, rural regions (two target groups) about diabetes mellitus and to inform them locally, to diagnose as yet undetected diabetes cases at an early stage and to refer newly diagnosed cases to suitable specialist contact persons locally. Already affected or endangered persons who have not taken up the standard prevention services on offer are to be reached through a low-threshold approach.

The Diabetes-Info-Mobile has already been in operation in North Rhine Westphalia since 2003. The pilot project "Diabetes Counselling on Wheels – early detection and counselling on the subject of diabetes for citizens of Turkish origin and the rural population" and thus counselling throughout Germany started in August 2014. The assignments take place on the one hand in selected towns and regions with a high proportion of people with a Turkish migration background, on the other hand in structurally weak, rural regions.

There were 20 assignments in 2014. A further 32 assignments are planned in 2015.

The project is planned to last four years. Of primary importance are the personal counselling by intercultural experienced diabetes counsellors with the aid of the FINDRISK questionnaire (determination of the diabetes risk), a blood glucose measurement as required, as well as information material appropriate to the target group.

The accompanying quasi-experimental interventional study without a control group will be carried out by the Institute of Medical Sociology at Hamburg-Eppendorf University Hospital. The study will include the collection of qualitative and quantitative data. As a basic rule, all interested persons will have free access to the Diabetes Counselling on Wheels. For participation in the study, the following inclusion criteria were defined:

- a sufficient command of the German, Turkish or English language
- written consent
- identification as a diabetes risk patient
- provision of contact data by the participant

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The majority of migrants living in Germany have a Turkish immigrant origin. Investigations have shown an increased prevalence of diabetes among people with a Turkish migration background. In order, for example, to overcome cultural differences and language barriers to achieve a greater uptake and orientation of preventive services, the provision of culture-sensitive migrant-orientated diabetes care is required. In addition, rural regions are often characterised by a shortage of specialist doctors, so that elderly people have difficulty obtaining access to specialist medical care. Accordingly, in line with the national health goal, the project places "Diabetes" in the area of primary prevention and is directed towards persons with increased risk.

The Diabetes-Info-Mobile can build on the experience gained with Diabetes Counselling on Wheels since 2003.

There will be a coordination of the measuring instruments used between those responsible for the project in practice and the accompanying scientific team.

Additional variables and tests concerning the data collection routines have been taken from the project of the German Federal Ministry for Education and Research "Health competence of diabetics of Turkish origin".

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods)?

The concept contains a clear goal (including target group), a structured approach (planning/conduct) and an accompanying scientific evaluation (process and outcome evaluation).

For detailed information, see short description and question: "Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?"

How is this example of good practice funded?

A part of the project is financed from donations that have been raised by diabetesDE – Deutsche Diabetes-Hilfe. In addition, diabetesDE – Deutsche Diabetes-Hilfe, the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe and the Institute of Medical Sociology at Hamburg-Eppendorf University Hospital will provide funding of their own. Additionally, a part of the funding will be provided by the German Federal Ministry of Health (BMG). The PNPAS is funded by Ministry of Health.

What are the main aim and the main objectives of your example of good practice?

The main aim of the project is to reach the two target groups and to instruct and sensitise them for the subject of diabetes mellitus, as well as to motivate risk patients to consult further diagnostics by (specialist) doctors. The main objectives of the evaluation are to show the extent to which the target group has been reached and the proportion of participants who consult a doctor.

Please give a description of the problem the good practice example aims to tackle:

The onset of diabetes mellitus type 2 can be delayed or even prevented with the aid of preventive, behaviour-orientated measures. The project is directed towards instructing people with an increased risk of diabetes and referring them to a (specialist) doctor as required. Previous scientific investigations have shown that the social situation and health are closely correlated. For example, people in a vulnerable social status are more likely to suffer from chronic diseases. The measures of the project are directed towards people with a Turkish migration background, especially those in a vulnerable social status and / or a low degree of integration, as well as people living in rural areas, who often have difficulties to obtain specialist medical care as a result of the regional circumstances.

The project is directed towards an increased participation of the target group, which otherwise is not reached by preventive measures. The evaluation will determine the degree to which the target group is reached and the extent to which (specialist) medical care is taken up and any change in behaviour following the counselling. The quantitative evaluation with regard to the effect of the intervention is innovative in this context.

Implementation of your example of good practice is/was:

For more than two years. The mobile diabetes counselling, initiated by the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe, has established in the state of North Rhine Westphalia since 2003. The pilot project "Diabetes Counselling on Wheels – early detection and counselling on the subject of diabetes for citizens of Turkish origin and the rural population" is planned to last four years. With the aid of the results obtained from the pilot project, the aim is to sustain the project on a regular basis.

Target group(s):

There are two target groups:

- (older) individuals with a (Turkish) migration background, in particular in a vulnerable social status and a low degree of integration
- (older) individuals in structurally weak, rural regions

During implementation, have specific actions been taken to address the equity dimensions?

The project concept aims to reach out to those population groups that otherwise struggle to gain access to preventive care services as a result of various different barriers (cultural differences, language barriers, gaps in care in rural regions). In order to reach the target groups, the measures will be carried out by following a seeking-out approach. The assignments of the "Diabetes Counselling on Wheels" will take place in selected settings, such as weekly markets, shopping centres, mosques and urban festivals. In order to break down language and cultural barriers in the uptake of preventive measures, the use of a Turkish-speaking diabetes counsellor as well as appropriate information material in Turkish is planned.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

A primary goal is to reach the target groups (elderly) people with a (Turkish) migration background, especially those with a vulnerable social status and a low degree of integration, (elderly) people in structurally weak, rural regions). Cultural differences and language barriers were taken into account in the interest of the uptake and alignment of the preventive counselling. Accordingly, a low-threshold mode of operation has been chosen in the form of a seeking-out approach.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

The measures involved in the project are attributable to the field of primary prevention. With the aid of risk-factor screening of persons suffering from or at risk of developing diabetes, prevention and health promotion are to be strengthened. The organisation and the course of the counselling will follow specified procedures. The FINDRISK questionnaire and, if necessary, a blood glucose test will be carried out. In addition, the information material used will be orientated towards the target group's structure. A seeking-out approach was selected as a suitable way of gaining access to "population groups that are difficult to reach". The counselling will be carried out in the sense of a low-threshold mode of operation. The assignments will take place in the living environment of the target groups and will be carried out by interculturally experienced diabetes counsellors. In the sense of the setting approach, they will be conducted in co-operation with the Verbund der Diabetes-Beratungs- und Schulungsberufe in Deutschland e. V. (VDBD) (organisation of the assignment days locally, distribution of flyers/handouts in local pharmacies), local specialist practices, district health offices, integration officers at the respective assignment location, and a specialist employee of Turkish origin resident in the local area in each case.

Was an effective partnership in place (e.g.. multidisciplinary, inter-sector, multi-/ and alliances)?

The co-operation of the various different organisations enables a coordinated viewpoint from the perspective of doctors, counsellors and patients. Main actors are:

- diabetesDE – Deutsche Diabetes-Hilfe e. V. (coordination and promotion)
- the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe (will provide the Diabetes-Info-Mobile and carry out the assignments)
- Institute of Medical Sociology at Hamburg-Eppendorf University Hospital (scientific evaluation)

Other actors involved are:

- Verbund der Diabetes-Beratungs- und Schulungsberufe in Deutschland e. V. (VDBD) (organisation of the assignment days locally, distribution of flyers / handouts in local pharmacies)
- local specialist practices, district health offices, integration officers at the respective assignment location
- a specialist employee of Turkish origin who resides in the respective local area

Was the intervention implemented equitably, i.e. proportional to needs?

The project is directed towards,

- (older) individuals with a (Turkish) migration background, especially those with a vulnerable social status and a low degree of integration
- (older) individuals in structurally weak, rural regions.

The counselling will be provided by Turkish-speaking culture-sensitive diabetes counsellors. The information material used will also be orientated towards the target group in question. Regional representatives of the migrants of Turkish origin will provide support in the planning and preparation of the individual assignments and in part will take on the role of a multiplier. The extent to which the approach is appropriate to the target groups and the project can be extended will be investigated as part of the evaluation.

Were potential burdens, including harm, of the intervention for the target population addressed?

Yes. Older (Turkish) migrants show an increased risk of diabetes and are often not reached by preventive care services. In addition, rural regions are often characterised by a shortage of specialist doctors, so that older people have difficulties to access specialist medical care. With the aid of mobile diabetes counselling, the aim is to reach out to the hard to access target groups with a low-threshold approach.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes. Information is provided about the project and the assignment locations transparently under http://www.diabetesde.org/ueber_uns/aktionen_von_und_mit_diabetesde/diabetes_auf_raedern/. Participation is free of charge and voluntary for the participants. Prerequisite is that they have full legal capacity and have given their written consent. The declarations of consent are available with identical contents in German as well as bilingually in German-Turkish and German-English. The participants will receive a blank copy of the declaration of consent. In order to ensure a quality-assured manageability of the organisation and conduct of the mobile diabetes counselling, a continuous coordination between the main actors will take place.

Did the evaluation results achieve the stated goals and objectives?

The evaluation has not yet been completed. The evaluation will be conducted from 2014 to 2018. As qualitative elements of the evaluation, the information material will be subject to a user test and the experiences of the counsellors will be documented. Within the context of evaluation under the conditions of daily practice, various different quantitative data (sociodemographics, education, clinical/biometric data, health behaviour and lifestyle components) will be collected during the counselling. Three months after the counselling, the participants will be interviewed by telephone. The referral of risk patients to (specialist) medical treatment is defined as the primary outcome. Secondary outcomes are possible behavioural changes in diet and exercise.

The following statements can be made regarding reaching the target groups at present (status: 11.06.2015):

Table 1: Age-group distribution in %

	Total number of participants (N=221)	Turkish migration background (n=116)	Rural population (n=105)
Younger than 35 years	6.3	8.6	3.8
35-44 years	12.7	22.4	1.9
45-54 years	19.9	30.2	8.6
55-64 years	23.5	21.6	25.7
Older than 64 years	37.6	17.2	60.0

Table 2: Average age (mean (standard deviation))

	Total number of participants (N=221)	Turkish migration background (n=116)	Rural population (n=105)
Average age in years	57.55 (17.0)	51.69 (12.6)	65.83 (13.4)

Does the intervention provide a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. The project involves a quasi-experimental interventional study without a control group, which is being conducted under the direction of the scientific Institute of Medical Sociology at Hamburg-Eppendorf University Hospital. The evaluation is being conducted under the conditions of routine practice. Accordingly, the data input is carried out directly during the counselling in the Diabetes-Info-Mobile. The following data are collected:

Process evaluation: (observation of a scientific assistant in the form of a non-participatory observation, planned six times):

- User test of the information material for the subgroup of the people of Turkish origin (Is the information material appropriate to the needs and to the target group?)
- Experiences of the diabetes counsellors (e.g. local conditions, organisation)
- Observation and documentation of the population with regard to interest or disinterest, gaining of interest, etc. (observational evaluation)
- Expert interviews with all of those involved in the project "Diabetes Counselling on Wheels" with regard to barriers and beneficial framework conditions, as well as with a focus on transfer potentials
- Sociodemographics and education: reading, as appropriate writing, numerical competence, German proficiency, nationality, origin, language, social support (family, household), school qualification or number of years of schooling
- Clinical/biometric data: height, weight, waist measurement, blood glucose, HbA1c, cholesterol, triglycerides, HDL, LDL, secondary diseases, other diseases
- Health behaviour and lifestyle components: FINDRISK, diet, exercise, smoking, alcohol consumption, visits to the doctor

Three months after the counselling in the Diabetes-Info-Mobile, the study participants will be briefly interviewed on the telephone by a (Turkish-speaking) diabetes counsellor, in order to ensure a uniform standard. The interview guideline was developed and coordinated jointly by the parties responsible for the project. The brief interview contains questions on the following areas:

- Visit to the doctor? Family doctor or specialist doctor? Suspected diagnosis confirmed? Accompanying and secondary diseases?
- Further measures and examinations initiated? (e.g. ophthalmological examination, diabetes education, etc.)
- Change in diet and exercise?

Does the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

It is planned that the input of the data (see one question back) will be done by the diabetes counsellors directly on location via an entry mask with a laptop or possibly a tablet computer with a touch screen. Data analysis will be conducted by their Medical Institute for Sociology.

Who conducted the evaluation?

Both, internal and external parties.

Specifically, what has been measured/evaluated?

Process evaluation (respondents, method, participants' satisfaction)

- User test of the information material for the subgroup of the people of Turkish origin (Is the information material appropriate to the needs and to the target group?)
- Experiences of the diabetes counsellors (e.g. local conditions, organisation)
- Observation and documentation of the population with regard to interest or disinterest, gaining of interest, etc. (observational evaluation)
- Expert interviews with all of those involved in the project "Diabetes Counselling on Wheels" with regard to barriers and beneficial framework conditions, as well as with a focus on transfer potentials.

Evaluation of the impacts/effects/outcome:

- Sociodemographics and education: Questions will be asked about reading, as appropriate writing, numerical competence, German proficiency, nationality, origin, language, social support (family, household), school qualification or number of years of schooling.

- Clinical/biometric data: Questions will be asked about height, weight, waist measurement, blood glucose, HbA1c, cholesterol, triglycerides, HDL, LDL, secondary diseases, other diseases.
- Health behaviour and lifestyle components: FINDRISK, diet, exercise, smoking, alcohol consumption, visits to the doctor

Three months after the counselling in the Diabetes-Info-Mobile, the study participants will be briefly interviewed on the telephone by a (Turkish-speaking) diabetes counsellor, in order to ensure a uniform standard. The brief interview contains questions on the following areas:

- Visit to the doctor? Family doctor or specialist doctor? Suspected diagnosis confirmed? Accompanying and secondary diseases?
- Further measures and examinations initiated? (e.g. ophthalmological examination, diabetes education, etc.)
- Change in diet and exercise?

What are the main results/conclusions/recommendations from the evaluation?

Since the evaluation has not yet been completed, only the objectives of the evaluation can be mentioned here.

A primary objective is to determine the extent to which the target group could be reached and what proportion of the participants who received counselling subsequently consulted a doctor.

A further objective of the evaluation is to identify the proportion of the target group that shows abnormal parameters without a known diagnosis.

A process evaluation is also being conducted, which assumes an important role for the transferability of this project. Here, promoting and inhibiting factors in the planning and implementation will be documented, which may be of existential importance for a possible continuation as well as for an extension.

Is the evaluation report available?

No, not yet, but a compilation of the findings in a manual or guideline is planned.

Who implemented the intervention?

diabetesDE - Deutsche Diabetes-Hilfe unites all people with diabetes and all professional groups such as doctors, diabetes counsellors and researchers, in order to campaign for better prevention, care and research in the fight against diabetes. Thus, early detection of diabetes mellitus as well as good care are one of the main objectives of the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe. Consequently, a Diabetes-Info-Mobile has been in operation flexibly at different places in North Rhine Westphalia since 2003. The counselling is provided by interculturally experienced diabetes counsellors.

The Institute of Medical Sociology at Hamburg-Eppendorf University Hospital offers counselling for communal, state and federal authorities, social service providers (above all health insurance funds) and other institutions of the healthcare system, as well as patient and self-help organisations. This is provided in the form of expert opinions, expert reports, contract research, advisory board work and advanced training courses. A key focus here is "Patient orientation and self-help".

What core activities are/have been implemented?

Ten assignments were carried out to reach the target group of people with a (Turkish) migration background (Cologne-Mülheim, Cologne-Nippes, Cologne-Chorweiler, Solingen, Gelsenkirchen, Dortmund, Gießen twice, Duisburg-Marxloh, Kerpen) and 10 assignments to reach the target group of the "rural population" (Monschau, Simmerath, Siegen, Erndtebrück, Freudenberg, Bitburg, Daun, Roetgen, Wittlich, Gerolstein). A further 32 assignments are planned in 2015, 14 assignments having been carried out to date (northern Germany).

The planned assignments of the Diabetes Counselling on Wheels can be seen under <http://nrw.menschen-mit-diabetes.de/diabetes-info-mobil/termine>

Was the intervention designed and implemented in consultation with the target population?

In general, the interests of people with diabetes were represented in the form of the self-help organisation of the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe as a project partner. In the sense of participation, a conceptual involvement of the target group was not intended during the planning or implementation phase. In spite of this, representatives of the diabetes and migrants working group of the Deutsche Diabetes Gesellschaft [German Diabetes Society], for example, were also involved in the planning phase, and regional representatives of the migrants of Turkish origin were also happy to support the planning and preparation of the individual assignments and repeatedly took on the role of a multiplier.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

The goal of the project is to inform and guide people with (a Turkish) migration background and people in structurally weak, rural regions (two target groups) about diabetes mellitus and to inform them locally, to diagnose as yet undetected diabetes cases at an early stage and to refer newly diagnosed cases locally to physicians. Statements about the achievement of the goals cannot be made until the final evaluation has been carried out.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

The project is based on experience gained by the mobile diabetes counselling in North Rhine Westphalia. The Diabetes-Info-Mobile has already been in operation in the target group of people with a migration background. The projects conducted to date have neither been accompanied scientifically, nor have they been aligned conceptually to the needs of this target group thus far. On the basis of existing investigations, the target group of people with a (Turkish) migration background was chosen, as this group shows an increased risk of diabetes mellitus and, in parallel, is often not reached by preventive care services. As regards the rural population, this group is often affected by a shortage of (specialist) medical care, and preventive counselling can also be provided in structurally weak regions with the aid of the Diabetes-Info-Mobile.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Beside a general address on location, the citizens of Turkish origin will be specifically addressed in their native language. In addition, the Verband der Diabetes-Beratungs- und Schulungsberufe in Deutschland e.V. will make contact with a specialist employee of Turkish origin resident in the local area in each case. In order to better reach the target groups, the assignments will take place in the living environments of the target groups. As a whole, experience has shown a very good acceptance of the Diabetes-Info-Mobile.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

The North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe initiated the Diabetes-Info-Mobile together with the Landesverband der Betriebskrankenkassen NRW [State Association of the Company Health Insurance Funds of North Rhine Westphalia] in 2003. The pilot project "Diabetes Counselling on Wheels – early detection and counselling on the subject of diabetes for citizens of Turkish origin and the rural population" is initially limited to the project period of 2014-2018. After completion of the pilot project, an evaluation is to be carried out with the aim to show whether the approach of the project is suitable for achieving the stated objectives. Only if the success of the project can be demonstrated by the evaluation, the decision on a continuation of the project, a possible extension to other population groups (e.g. migrants of Arabian or Russian origin) or other indications (certain forms of cancer or cardiovascular diseases), or also a transfer into financing by another sponsor can be made.

Is there a broad support for the intervention amongst those who implement it?

The North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe has had a Diabetes-Info-Mobile in operation since 2003. The state association has been an independent association since 1975, representing the interests of all people with diabetes in the state of North Rhine Westphalia on a state level. The state association will continue to campaign for better prevention, care and research in the fight against diabetes in the future.

Is there a broad support for the intervention amongst the intended target populations?

In the planning and implementation of the project, people with diabetes participated from the very beginning through the North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe. This self-help organisation and also the Federal Association of the Deutsche Diabetes-Hilfe, as a Germany-wide representation of the interests of those affected and their relatives support the project "Diabetes Counselling on Wheels". The more closely defined target groups of the project, i.e. people with a Turkish migration background and people living in rural regions, have also repeatedly commented positively about the assignments of the Diabetes-Info-Mobile. Regional representatives of the migrants of Turkish origin have also gladly provided their support in planning and preparation of the individual assignments and have repeatedly taken on the role of a multiplier.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

A financial plan was drawn up for the project, including a total calculation of the organisation, production of materials and conduct of the assignments. Practical application and scientific supervision were differentiated in the calculation. For the implementation of the project, the calculation contains the following items to be taken into account:

- Procurement and equipment of the vehicle
- Operational costs: staff costs, petrol, wherein terror of the vehicle, etc.
- Overnight costs for one specialist employee
- Production of materials: flyers and questionnaires
- Follow-up telephone calls
- Organisation: organisational and staff costs for preparation and follow-up analysis, contact the local institutions, advertising
- Scientific supervision: staff costs, travelling expenses, ethics committee approval

Approximately half of the costs to be incurred can be borne by the diabetesDE- Deutsche Diabetes-Hilfe (donations) and the Institute for Medical Sociology (own funds). In order to conduct the project and evaluate it in the planned scope, a project application was made to the German Federal Ministry of Health (BMG) and approved accordingly. The original estimation of the resources required (staff, material and budget) was well founded and was based on experience values from previous projects. Nevertheless, the project "Diabetes Counselling on Wheels " differs from previous projects in certain points, so that it only became clear over the course of the pilot project where there is a potential for optimisation. All of the partners sit down together and consult with each other at regular intervals to evaluate the processes and continuously optimise them.

Were sources of funding specified in regards to stability and commitment?

The project is funded from two main sources: donations acquired by diabetesDE, and from funding granted by the MoH (BMG). Since the funding of the BMG represents a deficit financing, which is subject to renewed approval from year to year, the stability of the project is only ensured to a limited degree, even if the BMG has signalled that financing is envisaged for the entire project period.

Were organisational structures clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities)?

The responsibilities are clearly defined and a continuous exchange between the project partners takes place.

Main actors (responsibilities):

- diabetesDE – Deutsche Diabetes-Hilfe e.V. (coordination and promotion)
- The North Rhine Westphalian Association of the Deutsche Diabetes-Hilfe – Menschen mit Diabetes (DDH-M) (will provide the Diabetes-Info-Mobile and carry out the assignments)
- Institute of Medical Sociology at Hamburg-Eppendorf University Hospital (scientific evaluation)

Other actors involved:

- Verbund der Diabetes-Beratungs- und Schulungsberufe in Deutschland e.V. (VDBD) (organisation of the assignment days locally, distribution of flyers / handouts in local pharmacies)
- local specialist practices , district health offices, integration officers at the respective assignment location (promotion)
- a specialist employee of Turkish origin resident in the local area in each case (consultation, promotion)

Is the potential impact on the target population assessed (if scaled up) ?

The evaluation will be conducted from 2014 to 2018.

Are there specific knowledge transfer strategies in place (evidence into practice)?

The final evaluation is designed to show whether the approach of the project is suitable for achieving the stated objectives. If the project is successful, a compilation of the findings in a manual or guideline is planned, in order to facilitate continuation or a possible extension to other population groups (e.g. migrants of Arabian or Russian origin) or other indications (certain types of cancer or cardiovascular diseases).

Is there an analysis of requirements available for eventual scaling up such as foreseen barriers and facilitators?

Yes. Beside the quantitative evaluation, a process evaluation will be conducted. The aim of the process evaluation is to identify promoting and inhibiting factors. These findings can be used for a continuation or for the transfer to other indications and population groups. A compilation of the results in a manual or guideline is planned.

An analysis of the prerequisites for an extension of the project will be compiled within the context of the scientific supervision upon completion of the project, but is currently not available.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The most important pre-condition for the success of the project was the co-operation of the three project partners that are jointly conducting the project "Diabetes Counselling on Wheels". Each of the three partners brings specialised knowledge into the project and can fall back on experience in a wide range of different tasks:

- The North Rhine Westphalian Association of the DDH-M has been operating a Diabetes-Info-Mobile for several years, is providing the vehicle with its tailor-made equipment, and for many years has been working together with diabetes councillors who themselves in turn have experience in mobile counselling and the use of the laboratory equipment. As an association, with this focus on prevention and healthcare promotion, the North Rhine Westphalian Association of the DDH-M goes far beyond the objective of pure self-help projects. In the assignments before the start of the project and other small projects, the North Rhine Westphalian Association has already been able to collect experience with the target group of the migrants.

- The Institute of Medical Sociology at Hamburg-Eppendorf University Hospital contributes comprehensive expertise in the scientific support of projects on diabetes education and in dealing with the target group of migrants, and has become established in Germany as an important contact for self-help as regards scientific questions.
- diabetesDE – Deutsche Diabetes-Hilfe has a broad network in the diabetes scene as an umbrella organisation and contributes comprehensive experience in public relations work as well as project management.

The interplay of the involved partners and their complementary fields of scientific knowledge and specialist experience were key factors to implement the project in its present form.

What were, in your opinion, the main lessons to be learned?

A key finding from the course of the project thus far is that it is absolutely necessary to clarify in advance how well all the actors are prepared for the project in all its facets (addressing the target group, project management, documentation). As inhibitory factors in implementation have already been identified, one goal is to draw up a concept upon conclusion of the project. Thus, the problems, but also the approaches found to solving them, as well as the findings/experience gained will be documented for future projects.

In addition, already in the first year of the project, it became clear that the project could not have been implemented with staff working on a strictly voluntary basis. Since the project "Diabetes Counselling on Wheels" provides a service, namely preventive work for others, the long-term establishment of the project urgently requires a more solid financial base, above all to cover overhead costs.

Web page related to the intervention

http://www.diabetesde.org/ueber_uns/spendenprojekte/unsere_projekte/diabetes_beratung_auf_raedern/

References to the most important articles or reports on the intervention:

<http://www.zdf.de/volle-kanne/praxis-taeglich-unterwegs-mit-dem-diabetesmobil-fuer-migranten-36420494.html>

<http://nrw.menschen-mit-diabetes.de/diabetes-info-mobil/praevention-zahlt-sich-aus>

http://www.diabetes-online.de/aktiv_gesund_leben/a/1710382

<http://www.aerzteblatt.de/nachrichten/59813/Diabetesberatung-auf-Raedern-will-Hemmschwellen-abbauen-und-Sprachbarrieren-ueberwinden>

<http://www.gesundheitsstadt-berlin.de/mobile-diabetes-beratung-tourt-durch-den-nordosten-6469/>

Videos:

<https://www.youtube.com/watch?t=56&v=x6ogS7J9hBQ>

<https://www.youtube.com/watch?v=d211ZjEyonM>

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Intervention on Diabetes Prevention and Screening in Vulnerable Populations of the Metropolitan Lisbon Area Portugal

Title in original language:

Projecto de Intervenção para a Prevenção e Rastreio da Diabetes em Populações Vulneráveis da Grande Lisboa

Which 'life stage (s)' for Diabetes and CVDs prevention targets the intervention?

Adulthood and Ageing. The chosen intervention was implemented among the 18+ years old population of several low socioeconomic neighbourhoods in the Metropolitan Lisbon area.

To which type of interventions does your example of good practice belong to?

Individual intervention. Individuals were targeted for their professional category (healthcare and social care professionals), for their socioeconomic status, and for their diabetes risk status.

What is the level of implementation of your example of good practice?

Regional. The intervention was implemented in the Lisbon Metropolitan Area (estimated general population: 2.8 million people). It was implemented between 2008 and 2014 (four years).

Short description of the intervention:

The intervention was developed to address the needs of vulnerable urban populations, with concomitant reduced access to healthcare, in regards to diabetes prevention and screening/diagnosis. It was implemented in collaboration with municipalities and local social partners of the Metropolitan Lisbon Area, between 2008 and 2014. Implemented activities included training sessions about diabetes prevention and management for both healthcare and social care professionals, sessions about diabetes prevention and healthy lifestyles promotion for the adult population, and diabetes risk screening sessions also for the general population.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Intervention was based on previous knowledge on diabetes risk stratification. The main tool used, the FINDRISK questionnaire, was validated in several European countries.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

The objectives and intervention content were clearly drawn in the design phase but, due to implementation difficulties in the real-life scenario, recruitment and locations were chosen already during project roll-out.

How is this example of good practice funded?

Funding was provided by a national governmental agency (DGS, the General Directorate of Health), a private foundation (Ernesto Roma Foundation), and a private patient association (APDP – Diabetes Portugal).

What are the main aim and the main objectives of your example of good practice?

Main aim: Address the hypothesis that low socioeconomic populations are at an increased risk to develop diabetes. Main objectives: To promote health in vulnerable communities in the Lisbon Metropolitan Area; to promote equity in the access to healthcare; to implement diabetes prevention; to screen vulnerable populations for diabetes risk; to establish partnerships to consolidate the ability to act on vulnerable communities; to contribute for the actions advocated by the National Plan on Diabetes.

Please give a description of the problem the good practice example wants to tackle:

Especially with the recent economic crisis, low socioeconomic status population has increased and access to healthcare has worsened. By 2013, 27.5% of the general population were at risk of poverty or social exclusion. Likewise, economic restrictions are also reported to impinge negatively on nutritional choices and sedentary behaviours. This has clear impact on negative health outcomes, namely on diabetes incidence. Additional consequences include undiagnosed diabetes and complications.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The intervention is fully aligned to the National Plan for Diabetes.

Target group:

Adult population located at low socioeconomic neighbourhoods in the Lisbon Metropolitan Area. Also, healthcare and social care professionals that cover the mentioned neighbourhoods.

During implementation, did specific actions were taken to address the equity dimensions?

Yes. Actions were articulated with municipalities and partners in Lisboa, Amadora, Loures, Odivelas, Oeiras and Sintra, to identify areas with low socioeconomic status and lower access to healthcare services.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes, as stated above.

Which vulnerable social groups were targeted?

Low socioeconomic status adults. Migrants were also specifically targeted.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

Yes. The intervention targeted both at-risk adults and healthcare and social care professionals.

Was an effective partnership in place?

Yes, partnerships were established with municipalities, healthcare providers, and social associations.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes, it was aligned with the National Plan for Diabetes. Likewise, it was aligned with Ernesto Roma Foundation and APDP – Diabetes Portugal stated institutional missions.

Were potential burdens, including harm, of the intervention for the target population addressed?

Yes, with the exception of people identified at-risk of diabetes being invited for further voluntary screening, namely by performing an OGTT (oral glucose tolerance test), at the APDP clinic, which is located in downtown Lisbon, distant to some of the intervention areas. Travel expenses could not be covered by the project, so had to be incurred by the participants.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes. Information was disseminated in oral and written form.

Did the evaluation results achieve the stated goals and objectives?

It was concluded that initial estimates were too ambitious in terms of recruitment of participants.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes, information gathered through questionnaires was used to streamline processes. Cost/outcome studies were not performed.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes, reporting was performed each 6 months to the funding body.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

Specifically, what has been measured / evaluated?

Process evaluation: respondents and participants in the training/education sessions. Basic analysis of statistics. Evaluation of the impacts/ outcome: Diabetes risk profile distribution and referral acceptance of people identified as of high-risk. Using FINDRISK questionnaire to the vulnerable population and performing OGTT (oral glucose tolerance test) to people identified as at high-risk.

What are the main results/conclusions/recommendations from the evaluation?

While the distribution of diabetes risk assessment in the studied low socioeconomic population was similar to that observed in the general population, the high-risk profile was shifted to a lower age. This supports the notion that diabetes incidence happens earlier in this vulnerable population.

Is the evaluation report available?

Yes, but only in Portuguese. "Projecto de intervenção para a prevenção e rastreio da diabetes" (2014) Ed. Fundação Ernesto Roma.

Who implemented the intervention?

The intervention was implemented by a team of nutritionists and diabetes educators from the Ernesto Roma Foundation. Support for the OGTT was given by healthcare personnel at APDP.

What core activities are/have been implemented?

For the general population, were implemented actions of diabetes risk screening and diabetes prevention education. People at risk were further invited to participate in screening for diabetes diagnosis. Training sessions were implemented for healthcare and social care professionals.

Did the intervention achieve meaningful participation among the intended target population?

Yes, although participation was lower than initially anticipated.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes, the target populations were chosen based on previous needs assessment conducted by questionnaires to professionals and national epidemiological studies.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes, population participation was promoted through associations that develop assistential work within the targeted communities.

Is there a broad support for the intervention amongst those who implement it?

Yes, feedback from the partners was positive. And several partners maintained collaboration in subsequent projects regarding diabetes prevention.

Is there a broad support for the intervention amongst the intended target populations?

Yes, the target population expressed appreciation for the project objectives and actions.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes, this was fully submitted before intervention to obtain approval and funding.

Were sources of funding specified in regards to stability and commitment?

Yes. Funding was provided by a governmental agency (DGS). Additional funding was provided by Ernesto Roma Foundation and APDP, in accordance with their stated institutional missions.

Were organisational structures clearly defined and described?

Yes. There existed a dedicated core team that assured actions development and institutional communication within the partnership, as well as externally.

Is the potential impact on the population targeted assessed (if scaled up) ?

Yes, the potential to detect undiagnosed diabetes and at-risk individuals was assessed and validated through the implementation of the FINDRISK and the OGTT.

Are there specific knowledge transfer strategies in place (evidence into practice)?

Yes, the intervention demonstrated locally several assumptions for the target population. It also revealed barriers and facilitators for the scale-up of diabetes prevention actions.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

No, published materials only include the description of the model to be replicated.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Conditions for success included that the targeted population had lower access to healthcare and a preoccupation regarding diabetes, and hence valued the intervention. The fact that it was free of charge and conducted through a mobile unit, going directly to the communities, was also highly valued. The involvement of DGS and APDP, national reference institutions in diabetes care, was likewise a condition for success.

What were, in your opinion, the main lessons to be learned?

Several lessons were learned from this intervention, especially those related to streamlining processes (the need for a detailed needs and barriers assessment to provide an adequate estimate of participants; the prior engagement of partners with direct intervention in the field, the development of strategies to engage healthy participants who are less sensitive to health issues). Also the conclusion that, in these interventions, all services must be deployable within the target community.

Web page related to the intervention:

<http://fundacaoernestoroma.org/projecto-de-prevencao-e-rastreio-da-diabetes-em-bairros-vulneraveis-de-lisboa>

Other relevant documents:

Booklet “Projecto de intervenção para a prevenção e rastreio da diabetes” (2014) Ed. Fundação Ernesto Roma.

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“Healthy and active ageing” Germany

Name of the intervention in original language:

“Gesund und aktiv aelter werden”

Which ‘life stage’ for CVDs prevention targets the intervention?

Ageing

Short description of the intervention:

The described intervention is a strategy on active and healthy ageing, developed, organized and coordinated by the Federal Centre for Health Education (BZgA), Germany. Its aims are: the preservation and support of physical, psychological, and cognitive skills; the preservation and support of an active, autonomous, socially integrated and self-responsible healthy lifestyle; to prolong the life time until need for care

Target group: population of 60 years and older; ‘the young old’ and older people without major health problems; individuals with age-related morbidities / disabilities and/or in need of care; long term care recipients; relatives of older people; the general population; institutions, collaboration partners, stakeholders, multipliers/intermediaries.

Target areas and topics: The strategy was implemented in 2012 and follows an integrated, multidisciplinary approach. It aims to serve as an umbrella to facilitate the networking and collaboration of governmental, non-governmental, academic and private stakeholders in jointly defined key topics of healthy ageing, such as

- physical activity (incl. fall prevention)
- healthy diet
- mental health (incl. depression and dementia)
- substance abuse (alcohol, tobacco, pharmaceuticals)
- Disseminate information on major diseases, risk factors, prevention opportunities and early diagnosis
- Integration, activation and participation of the target group

The first module to be developed was “physical activity” for which two activity programs are conceptualized, developed and evaluated.

Actors:

The activities in the aforementioned areas are planned and coordinated by the Federal Centre for Health Education (BZgA) and accompanied by an interdisciplinary scientific advisory board under supervision of the Ministry of Health. Cooperation partners are among others the German National Association of Senior Citizens’ Organisations (BAGSO), German Olympic Sports Confederation (DOSB), German Gymnastics Federation (DTB), German Sport University Cologne (DSHS), German Adult Education Association (DVV), German Association of the Blind and Visually Impaired (DBSV), German Association of Family Physicians and General Practitioners (DHÄV), German Hiking Association (DWV), several universities and others.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The concept was developed with the consideration of the available scientific literature on healthy ageing in Germany and internationally. This included scientific evidence from various governmental and non-governmental

sources. The literature basis was complemented by expert workshops, the inclusion of experiences from model projects as well as the results of the national Good Practice criteria development process.

How is this example of good practice funded?

Public funding with contributions of the Association of German Private Healthcare Insurers and engagement of cooperation partners

What is/was the level of implementation of your example of good practice (it is possible to mark more than one answer)?

National, Regional, Local (municipality level)

What are the main aim and the main objectives of your example of good practice?

- The preservation and support of physical, psychic, and cognitive skills
- The preservation and support of an active, autonomous, socially integrated and self-responsible healthy lifestyle.
- To prolong the life time until need for care

Please give a description of the problem the good practice example wants to:

About 17 million people are currently living in Germany above the age of 65 years. This age group will grow to an estimated 24 million people by the mid 2030ies, with the strongest growth in the age group above 80 years. More than 50% of these individuals are in good health and express a high quality of life in surveys (63% of the people in the age group 70 to 85 years). However, this does not reflect the whole picture as physical handicaps are part of many people's everyday life.

In the age group between 70 and 85 years:

- 85% experience difficulties in the execution of strenuous tasks
- 55% experience difficulties while bending over, knee down or stooping
- 44% experience difficulties when lifting and carrying shopping bags
- 33% experience difficulties during longer walks
- 28% experience difficulties when climbing stairs
- 18% report difficulties with bathing or dressing

The major somatic disease burden is represented by cardiovascular diseases, musculoskeletal diseases, falls, diabetes, and malign neoplasms. Multimorbidity is on the rise with more than 75% of the people above the age of 75 years having two different conditions in need for therapy.

Dementia and mental disorders, in particular depression, play a key role in the morbidity of older people and in the development of the need for care. Individuals with dementia and their relatives often face taboos, which foster stronger retreats from societal participation and activities.

More than half of the population above 80 years is in need for care, from which about 2/3 are taken care of in their homes.

Physical inactivity is one of the key health risks which leads to an increase in mortality and supports the development and progress of obesity and associated diseases with a high risk for the subsequent loss of autonomy and need for care.

There is sound scientific evidence on the trainability of individuals up to a higher age with a big potential for health promotion and prevention approaches. This accounts in particular for strengthened every-day life's activity in the age group over 70 years.

Institutions of long-term care have just recently come to focus as settings for health promotion and prevention approaches. International interventional studies have shown promising effects with increased mobility, strengths, autonomy, and quality of life. This prevention potential is to this point only used by a low number of older people due to barriers in the implementation in this setting.

The strategy "healthy and active ageing" aims to provide a comprehensive approach to tackle the multiple dimensions that come with the heterogeneity of the target age group.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

The strategy is aligned with the Federal government's demographic strategy¹, with the national initiative to promote healthy diets and physical activity *INFORM*² and the national health target process *Gesundheitsziele.de* as part of the national health target "healthy ageing"³.

Implementation of your example of good practice is/was:

Continuous (integrated in the system), established in 2011/2012 and ongoing

Target group(s):

People over 60 years, including senior populations with men and women living by themselves, frail populations and people in need for care. A special focus is on socially vulnerable older people.

During implementation, did specific actions were taken to address the equity dimensions?

Data on health inequities were taken into account during the conceptualization and implementation. A collaboration with the nation-wide "Cooperation Network 'Equity in Health'" was established.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes. The concept of the strategy was developed on the basis of demographic data with a differentiated perspective on:

- Age – Dynamic of the future increase in people over the age of 65
- Gender – Increasing life expectancy for both sexes, with an increasing share of women in the older age groups
- Demographic development – Taking into account societal questions on generational justice
- Migration background – about 10% of the target group
- Socioeconomic status – Household structures change with age towards a higher share of small (1 / 2 person) households
- Differences of rural and urban areas
- Specific milestones in the life cycle, e.g. transition into retirement age

Which vulnerable social groups were targeted?

- Individuals in early retirement due to occupational disability

¹ http://www.bmi.bund.de/EN/Topics/Society-Constitution/Demography/demography_node.html

² <https://www.in-form.de/profiportal/in-form-initiative/internationales/in-form-english-version.html>

³ http://health-targets.de/cgi-bin/render.cgi?__cms_page=national_health_targets

- Individuals with a migration background
- Individuals in low socioeconomic circumstances
- Older people in need for care living in chronic care homes

Was an effective partnership in place?

The building of a strong network and partnerships is the key purpose of the strategy. It involves governmental as well as non-governmental institutions and actors from various fields of healthy ageing. The development, implementation and conceptualization of the work is accompanied by an interdisciplinary scientific advisory committee (Fachbeirat).

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The strategy was aligned with the (non-governmental) health target process, the national demography strategy of the federal government as well as with the national (governmental) strategy “InForm” on the prevention of malnutrition, lack of physical activity, obesity and associated diseases.

Was the intervention implemented equitably, i.e. proportional to needs?

The prioritization of the topics within the strategy was based on the following criteria:

- Commonness of the targeted condition (incidence/prevalence)
- Medical relevance (severity of disease)
- Prevention potential

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, through printed materials, internet, conferences and expert workshops.

Evaluation:

Evaluation of the strategy was/is being conducted in the following areas:

- Documentation and analysis of the results produced by the regional conferences
- Pre-testing and evaluation of all target-group related Materials (brochures, expertises, and web site modules) through focus groups and target group interviews. Main focus is to assess the feasibility, target group specificity and strength of the effect of the materials. Furthermore the evaluation should allow to re-adjust ongoing developing processes in the strategy.
- Evaluation of the activity programs “every day’s training program for older people” and “Moving worlds - The Luebeck Model”

Did the evaluation results achieve the stated goals and objectives?

Up to now yes, but evaluation is ongoing according to the public health action cycle.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Currently planned

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

A series of scientific expertises and one study focusing the target group of people over 65 years were published over the course of the strategy.

Who did the evaluation?

Both – internal and external parties

Specifically, what has been measured / evaluated?

- Process evaluation (respondents, method, participants satisfaction) (please describe Materials, e.g. brochures, programs, logos, etc.)
- Evaluation of the impacts/effects/outcome (please describe the design)
Yes, in regards to two sub-programmes to promote physical activity among older people (currently planned)

Who implemented the intervention?

The implementation followed a multi-step procedure, while the coordination was conducted by BZgA. In the building phase of the implementation (2012/2013), an interdisciplinary scientific advisory committee was constituted, expertises were commissioned, a comprehensive concept was developed as well as regional conferences were organized. A web portal was built as the main networking and information hub (www.gesund-aktiv-aelter-werden.de/).

What core activities are/have been implemented?

- Joint organization of a series of workshops on the national as well as regional levels.
- Organization of conferences with the aim to connect stakeholders in healthy ageing.
- Targeted dissemination under the support of partners of health information through topic-specific media kits and information material for multipliers/intermediaries as well as the target group(s), e.g. leaflets, brochures, posters, CD-ROMs, etc.
- Definition of entryways to the target group(s) and network building with relevant partners and structures like physicians, adult education centres, sports clubs, and/or commercial stakeholders (dance studios, fitness studios, etc.).
- Strengthening of the community level and its actors including the support for civil engagement and participation through improved network and capacity building.
- Initial approaches to network building was conducted in different model regions with the aim to develop transferable guidelines.

Was the intervention designed and implemented in consultation with the target population?

The intervention was mainly designed and implemented with representatives and umbrella organisations of target groups, e.g. the German National Association of Senior Citizens' Organisations (BAGSO), Federal Fall Prevention Initiative (part of the European network ProFouND), the German Association of the Blind and Visually Impaired (DBSV), and different sports associations/federations.

Did the intervention achieve meaningful participation among the intended target population?

The target population is involved in the conceptualization and implementation through e.g. focus group testing of materials and participation in the regional conferences.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

This is one of the goals of the strategy.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Target populations were defined on the basis of demographic data and based on needs. The described strategy is primarily targeted to multipliers / intermediaries but includes elements like the development of an everyday training programme which addresses the target group directly.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, as the strategy is coordinated and led by a public governmental body (BZgA).

Were sources of funding specified in regards to stability and commitment?

Yes, through the annual project planning framework of BZgA, where one specific unit is in charge of the strategy.

Were organisational structures clearly defined and described?

Yes. A mapping of potential partners has been conducted in the preparation. Tasks and responsibilities of partners are defined.

Are there specific knowledge transfer strategies in place (evidence into practice)?

Yes, e.g. advanced education and training , adult education, and information materials (print and digital media).

What were , in your opinion, the main lessons to be learned?

- Synergies used through cooperation and networking
- Collaboration at eye-level between stakeholders through participation
- Inclusion and participation of the target group
- Thorough analysis and compliance with the structural and legal conditions

Web page related to the intervention

<http://www.gesund-aktiv-aelter-werden.de/>

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CINDI / Countrywide Integrated Non-Communicable Disease Intervention Bulgaria

Title in original language:

СИНДИ /Интервенционна програма за интегрирана профилактика на хронични незаразни болести

Which 'life stage' for CVDs prevention targets the intervention?

Adulthood - The life stage targeted is population of working age (25-64), including groups at high risk for certain diseases, CINDI programmes also involves a child component, which includes students (14-18), teachers, and parents.

Short description of the intervention:

The aim of CINDI program is to improve health by reducing mortality and morbidity from the major non-communicable diseases through integrated collaborative interventions that prevent diseases and promote health.

Target group - population of working age (25-64), including groups at high risk for certain diseases; Target group of child component of the program - students (14-18), teachers, and parents.

CINDI Bulgaria is a national program with 9 demonstration zones and corresponds to the national health policy. CINDI approves disease prevention through the existing health structure, with the active participation of the society and individuals. There are specific goals and objectives, based on accurate epidemiological framework, which is constantly monitored. Bulgaria is included in the CINDI Program in 1985 under the collaboration of the Ministry of Health and WHO within 5 zones. However, after the conduction of a survey in the 5 demonstration zones, the activities are suspended because of the socio-political changes within the country. Ten years later, in 1995, Ministry of Health Bulgaria joins again the CINDI network. In the period of 1996 - 1998 the program starts in 8 demonstration zones with total population of about 700 000 individuals. Intervention measures for health promotion and risk factors reduction for the most common chronic non-communicable diseases developed in zones after 2000. For the period 2000 - 2010 there were conducted 4 monitoring, assessing behaviour change of the population's health. A database was developed. Monitoring showed positive changes on population level since the start of the programme. In 2004 the child component of the program was introduced – "Healthy Children in Healthy Families". It was implemented in 7 zones and is also currently operating on a local level.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes. There have been used the Cindy Protocol and the experience of countries participating in the network program. Before its launching pilot studies were conducted in the demonstration zones on the basis of which priorities and future actions were identified.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes. Objectives, tasks and activities under the program are scheduled in details. Target groups, places of intervention, management of the program and its funding have been defined.

To which type of interventions does your example of good practice belong to?

CINDI includes more than 30 countries in Europe and Canada, including Bulgaria. For each country, the program is of national importance, as is realized in demonstration zones, and for the development is responsible the relevant Ministry of Health.

How is this example of good practice funded?

On national level the program is funded by the Ministry of Health. On local level – by Community and NGO.

What is/was the level of implementation of your example of good practice?

On national level - Ministry of Health and NCPHA. On local level – Community, Regional health inspections.

What are the main aim and the main objectives of your example of good practice?

The main objective of CINDI is to improve health by reducing mortality and morbidity from major non-communicable diseases (cardiovascular, cancer, injuries, chronic respiratory diseases and others) through integrated collaborative interventions that prevent diseases and promote health. CINDI aims to reduce the risk of non-communicable diseases by reducing common risk factors, such as smoking, alcohol abuse, physical inactivity and unhealthy nutrition.

Please give a description of the problem the good practice example wants to tackle:

Chronic non-communicable diseases in Bulgaria are responsible for over 80% of all deaths. The main cause of NCD is the diseases of the circulatory system - 67.5%, followed by malignant neoplasms with 16.4% and others. These diseases are the result of common risk factors - smoking, alcohol abuse, unhealthy nutrition and low physical activity. Within CINDI program, numerous educational and training activities on a population and local level have been done with the aim to reduce the level of the main risk factors for the occurrence of chronic non-communicable diseases.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, CINDI is part of national and regional health policy.

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Target group(s):

Target group - population of working age (25-64), including groups at high risk for certain diseases; Target group of child component of the program - students (14-18), teachers, and parents.

During implementation, did specific actions were taken to address the equity dimensions?

Yes. The target groups for interventions under the program are: population at the working age (25-64 years), incl. groups at high risk for certain diseases, unorganized population, children and students at the age of 14-18 years. Through media and other mass information media, and organized meetings with various institutions and organizations involved in the program, awareness of the population about goals, objectives, participants, etc. under the program was created.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes. The evaluation of the program is based on monitoring data, which includes mandatory evaluation indicators (age-sex composition of the population, level of education, factors associated with lifestyle; biological risk factors,

etc.); recommended (marital status, occupation, etc.); selective (diet of the population; environmental factors - home, work, family, etc.).

Which vulnerable social groups were targeted?

Ethnic minorities and disabled people. Health education activities in CINDI zones are directed to specific groups (ethnic minorities). They are free medical examinations, consultations and trainings on healthy nutrition, physical activity, hygiene, etc. Special emphasis is given to disabled people. For blind people and people with residual vision are provided clubs with exercise bike, treadmill and steppe. Information-consultative health centre for health education activities was created. There are also support groups for people with chronic non-communicable diseases and others.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

Yes. The main strategies of the program are directed to: health education of the population to control the main risk factors for NCDs and health; building capacity among medical specialists and program partners; participation of communities and institutions in program activities; development of guiding principles and guidelines of good practice of the professionals and partners, and information materials to the population, etc.

Was an effective partnership in place?

Yes. The program involves many partners - Municipality and the Municipal Council; Regional Health Inspections, Regional Health Insurance Fund, hospitals, medical and diagnostic consultative centres, dispensaries, media, NGOs, schools and kindergartens, companies, unions, clubs, youth homes, pharmaceutical companies, police, traders, manufacturers, etc.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The program activities are consistent with national health policy, but also with the policy of CINDI programme.

Was the intervention implemented equitably, i.e. proportional to needs?

Yes, so far as it was possible, given the financial resources that was available to the program.

Were potential burdens, including harm, of the intervention for the target population addressed?

Yes. Population and institutions involved in the program as well as organizations were informed on the objectives, tasks and activities set out therein.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes. There have been actively used the media and other mass information media, and also a number of meetings were organized with various institutions and organizations dealing with issues of public health.

Did the evaluation results achieve the stated goals and objectives?

Yes. The conducted four monitorings established positive changes in population's behaviour on health.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. To monitor the process of implementation of the program activities and their effectiveness it has been used a Manual for monitoring and evaluation of the results developed by WHO experts to the countries participating in CINDI programme. The collection of all data is carried out by standardized procedures described in particular documents

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Four monitorings have been conducted to assess the process of changing the population's behaviour on health - 2000, 2002, 2004 and 2007. There is also a database. Reports that identify priority areas and future intervention activities are prepared, too.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation).

Specifically, what has been measured / evaluated?

Process evaluation: Four monitoring procedures were implemented with the aim to evaluate behaviour change of population's health – in 2000, 2002, 2004, and 2007. A database was developed. The results from the monitoring demonstrated positive changes on a national level.

Evaluation of the impacts/effects/outcome (please describe the design): The evaluation of the activities and the results from the implementation of the program are carried out on the basis of data monitoring on the lifestyle and the level of risk factors. The components of the evaluation include: relevance, adaptability, degree of performance, efficiency, productivity of research, impact.

What are the main results/conclusions/recommendations from the evaluation?

For the 10-year program period, the main positive changes at a population level are:

- It has decreased the number of individuals who are carriers of two, three and four health risk: smoking, high cholesterol, hypertension, obesity;
- It has decreased by 6.2 points the proportion of men with hypertension, and 10 points - in women;
- It has reduced by 0.2 mmol/l the average of cholesterol, population levels of triglycerides - below 1.7 mmol/l;
- Increased proportion of people with normal weight, slightly increased share of these with obesity, reduced the proportion of overweight individuals;
- There are positive changes in nutrition: almost every second individual consumes fish and chicken twice a week; reduced consumption of salt; increased consumption of fresh fruits and vegetables;
- Physical activity is increased but not yet sufficient to achieve a preventive effect;
- Smoking among men has decreased by 10 points, among women - increased by 3 points (a fact specific to the countries in Europe).
- Alcohol abuse is reduced by 4 points for men, for women - unchanged;
- Mortality rates from major diseases, the objective of the program, have reduced.

Is the evaluation report available, preferably in English or at least an English summary?

Vasilevski, N., G. Tzolova, P. Dimitrov, A. Manolova. Surveillance of risk factors for non-communicable diseases among population aged 25-64 within the zones of CINDI Program – Bulgaria`2007. Bulgarian Journal of Public

Health, Vol II, № 3, 2010, page 1-34. It is available free on the website of National Centre of Public Health and Analyses (<http://ncpha.government.bg>).

Was there a follow-up or is any follow-up evaluation planned in the future?

The changes in Bulgaria in recent years have closed down a number of prevention programs in 2010, including CINDI, despite the positive results that CINDI has achieved. But, however, the experience of CINDI was used to create the National Program for Prevention of Chronic Non-communicable Diseases 2014 - 2020.

Who implemented the intervention?

The implementation of the programme is done on a central and local level. A team (the National Centre of Public health and Analyses) is responsible for its implementation, guided by the programmes's director. On a local level, the activities are implemented by local coordinators (individuals from the National Health Inspectorates), programme boards and working groups, in which medical and non-medical experts are involved.

What core activities are/have been implemented?

Huge education and training activities at a population and high-risk level are done annually: campaigns; world theme days and holidays, focused on changing the behaviour of population health; TV and radio shows; publications in newspapers; conferences, lectures, seminars, trainings, consultations; health education materials, etc.

Was the intervention designed and implemented in consultation with the target population?

Yes. Surveys have been periodically conducted among the population to assess the implemented program activities. Through the media the program and its achievements have been promoted before each survey the populations are acquainted with its objectives and design, etc.

Did the intervention achieve meaningful participation among the intended target population?

Yes, the population in the demonstration areas is actively involved in conducted events under the program.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

To the possible extent, given the socio-economic situation of the country over the recent years.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes. Both for the population of 25-64 years, given the incidence of NCDs in the country, and students of 14-18 years, when risk factors for these diseases were formed.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

The program has multiple partners, but mainly the activities are realized by teams in CINDI demonstration zones.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes. The program is funded by the municipalities and the activities are carried out by teams of CINDI, together with their partners.

Is there a broad support for the intervention amongst those who implement it?

Yes. Program activities are carried out with the support of many institutions and organizations, both at central and local level.

Is there a broad support for the intervention amongst the intended target populations?

Yes. The population actively participates in program activities and results of the studies show a positive change in population's behaviour on health.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes. Programme councils are established to plan, organize and report the resources (human and financial) necessary for the program activities.

Were sources of funding specified in regards to stability and commitment?

Yes. The program is implemented at the local level and relies on local funding during the first years of support from the Ministry of Health. The municipal council provides funds annually by presented preliminary cost assessments. Other sources of funding are also used.

Were organisational structures clearly defined and described?

The management is carried out at central and local level, with clearly defined responsibilities and tasks. There are Programs councils, working groups on issues, Public health coalitions.

Is the potential impact on the population targeted assessed (if scaled up) ?

The program has set clear goals for the prevention of NCDs and risk factors leading to their occurrence as well as a deadline for achieving them.

Are there specific knowledge transfer strategies in place (evidence into practice)?

There have been used various methods and approaches to increase the knowledge of the population, using good practices implemented and generating results in the other countries participating in the program.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

The evaluation of the program is based on monitoring data. The components of the evaluation include: relevance, adaptability, level of performance, effectiveness, research productivity, impact, efficiency (comparison of resources invested (inputs) - financial, human, etc. with the results obtained)

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The results are due to the policy of the program and the numerous professionally conducted intervention measures within CINDI zones. The success of the program is linked with the great efforts of the National Centre of Public Health and Analyses, the Regional Health Inspections and the structures of the program, the participation of

municipalities, public health coalitions, NGOs and others, and also the support of the Ministry of Health, i.e. the engagement and collaboration of many partners.

What were, in your opinion, the main lessons to be learned?

CINDI has proven effective international model programme for the prevention of chronic non-communicable diseases. The program combines activities for disease prevention and health promotion, in line with the new public health achievements of medicine. CINDI-Bulgaria managed to achieve positive results in the zones, with positive changes in the risk factors of health, with changes in the indicators of the health status of the population, which appear to be significantly higher results than the funds invested in the programme.

References to the most important articles or reports on the intervention

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- Tzolova, G., M. Nikolova. Analysis of the survey data for carriage of risk factors for health among children aged 14-18 years - program "Healthy children in healthy families", municipality of Ruse, RHI, 2013.
- Dimitrov, P., G. Tzolova, A. Manolova E. Teolova, A. Koteva. Overcoming health inequalities in the municipality of Lovech - Bulgaria through promotion of health throughout life. S., 2014.

Other relevant documents:

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NHS Smoking Cessation Services United Kingdom

Which 'life stage' for CVDs prevention targets the intervention?

All, with particular emphasis on pregnant women, those under 20 years of age, manual workers and people with low income.

Short description of the intervention:

Since the publication in 1999, of the White Paper *Smoking Kills*, the UK Government has demonstrated a strong commitment to reducing smoking prevalence through the implementation of an advertising ban, raising tax on tobacco to increase its price, a ban on smoking in workplaces and enclosed public places and the creation of a network of smoking cessation services. NHS stop smoking services represents a unique national initiative to provide support for smokers who are motivated to quit. The service provision framework employed by smoking cessation clinics was originally based on the Maudsley model, an evidence-based approach to treating dependent smokers. This approach entails regular meetings (in a group or on an individual basis) with a trained adviser using structured, withdrawal-orientated behavioural therapy combined with smoking cessation medications such as nicotine replacement therapy (NRT), bupropion or varenicline. Since the establishment of the services, the Department of Health (DH) in England has required local monitoring of the effectiveness of the smoking cessation services in all parts of the country. This involves regular reporting of the number of people setting a quit date and the number of 4-week quitters. This monitoring data provides an overview of the volume of clients treated by the services (over 2 million between 2003 and 2007) but has a number of limitations, not least the fact that it relies on self-reporting rather than carbon monoxide monitoring.

In addition to routine monitoring, the DH commissioned a national evaluation of NHS stop smoking services in England between 2001 and 2004. As part of the process of developing smoking cessation guidance in England, the National Institute for Health and Clinical Excellence (NICE) commissioned a systematic review of existing evidence. The review aimed to analyse available evidence on the effectiveness of intensive NHS treatments for smoking cessation and to consider the differential impact on different sub-populations. The review reported findings on the effectiveness of cessation interventions in clinical as opposed to research settings to provide evidence from "real-world" settings.

The NHS smoking cessation services continue to function. In terms of the questions asked by CHRODIS:

The aim of the intervention is to stop tobacco smokers from smoking. The target group is theoretically people of all ages, who smoke tobacco, but there is particular emphasis on pregnant women, those under 20 years of age, manual workers and people with low income. The design is the use of trained smoking cessation counsellors who work with groups or individuals. Recruitment is either by self-referral or by referral from any NHS clinician (General Medical Practitioners, General Dental Practitioners, Pharmacists, Health Visitors, etc.).

[This summary is taken from the introduction to a systematic review of the effectiveness of NHS smoking cessation services (Bauld et al. 2011)].

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes, it was developed in the light of previous practice and has developed over the last 15 years

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes its outcomes are **Measurable** in terms of the numbers who have stopped smoking. The numbers in the UK have decreased during the last 15 years so the intervention has been **Attainable**. The results indicate that it has been **Realistic**. It has also been **Timely**.

To which type of interventions does your example of good practice belong to?

Policy/strategy. In 1999, the UK Government published a White Paper *Smoking Kills*. It has subsequently introduced a range of measures to reduce smoking prevalence including: an advertising ban, taxing tobacco heavily, banning smoking in workplaces and enclosed public places and developing a national network of smoking cessation services, which provide group and one-to-one counselling.

How is this example of good practice funded?

The changes in legislation were part of the work of Parliament and were funded by the Parliamentary and Civil Service Budgets. The Smoking Cessation Service is funded by the NHS.

What is/was the level of implementation of your example of good practice?

Legislative changes were at a national level. The Smoking Cessation Service is a central initiative implemented at a local level throughout the country.

What are the main aim and the main objectives of your example of good practice?

- To reduce the numbers of smokers
- To assist those who wish to stop smoking to achieve this goal

Please give a description of the problem the good practice example want to tackle:

A Health Development Agency report published in 2004, suggested that cigarette smoking was the leading cause of preventable death in England and was responsible for an estimated 86,500 deaths per year. Parrot & Godfrey (2004) estimated that smoking cost the NHS between approximately € 2 billion annually.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, as previously described it is part of a long-term Government initiative that was developed after the publication of the White Paper *Smoking Kills*. It is embedded at national and local levels

Implementation of your example of good practice is/was:

It has been and is continuous over the last 15 years

During implementation, did specific actions were taken to address the equity dimensions?

The legislation that has been passed covers the entire population. The smoking cessation service is available to the entire population of the country. It costs nothing to those who use it.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes, the new laws and smoking cessation service have been designed to target all members of the community irrespective of gender, ethnicity, place of residence, etc.)

Which vulnerable social groups were targeted?

All groups but with particular emphasis on pregnant women, those under 20 years of age, manual workers and people with low income. Referral to the Smoking Cessation Service can be made by any clinician (doctors, dentists, pharmacists, nurses, etc.) or directly by smokers themselves. By definition, it is therefore necessary for members of vulnerable social groups to make contact with clinicians. As most health care services are provided free at the point of delivery, there is no financial barrier to accessing care and the Smoking Cessation Service.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, (e.g.. including social determinants) and using different strategies (e.g.. setting approach)?

Smoking cessation counsellors are trained to advise smokers in a manner appropriate to their individual backgrounds and will tailor their advice accordingly i.e. use different strategies as required

Was an effective partnership in place?

Yes, over the last decade, all clinicians in England have been made aware of the Smoking Cessation scheme and encouraged to refer their patients who smoke.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes, as previously explained the intervention was a direct result of a Government White Paper

Was the intervention implemented equitably, i.e. proportional to needs?

Yes, any smoker can be referred to a Smoking Cessation counsellor or contact the service direct.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, it should be obvious to all stakeholders and those referred to smoking cessation counsellors that smoking is detrimental to health

Did the evaluation results achieve the stated goals and objectives?

The evaluation is ongoing. Smoking Cessation counsellors have to report the numbers who they advice and the outcomes of their advice and annual statistics are published (see the list of references at the end of this report). In addition, a systematic review of *The effectiveness of NHS smoking cessation services* (Bauld et al. 2010) has been published . Further evaluations have also been performed, including one into cost effectiveness of the service (Stephens 2001).

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes, apart from structured reports to the NHS by every smoking cessation counsellor by 2007 the results of numerous studies which evaluated the intervention had been published. Since then further studies have been published

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes. The percentage of the population who smoke and the numbers who quit smoking each year after contacting the NHS smoking cessation service are monitored. As mentioned earlier, all smoking cessation counsellors are required to submit reports of the numbers of smokers referred to them and the outcomes. These reports are monitored and, over the years, the information received has been fed back to the counsellors to help them revise their practice as necessary.

Specifically, what has been measured / evaluated?

The evaluations have been both external, usually by teams from academic institutions and internal via the data fed back to the NHS from the smoking cessation counsellors. Data have been collected on: numbers referred, their gender, age, ethnicity, etc., the numbers who have stopped smoking at various time-points after counselling, whether or not they were also prescribed nicotine substitutes, their satisfaction with the service, how many failed to attend for individual or group counselling, etc.

Evaluation of the impacts/effects/outcome:

- Via periodic structured reports from the smoking cessation counsellors.
- Via some Randomised Controlled Trials
- Via a systematic review

Other. In 2008, the National Institute for Health and Clinical Excellence (NICE) published guidance on smoking cessation services. Four of the seven recommended treatments that have been proven to be effective, either separately or combined are provided by the smoking cessation service and are:

- individual behavioural counselling
- group behaviour therapy
- self-help materials
- telephone counselling

What are the main results/conclusions/recommendations from the evaluation?

The main result has been a decline in the numbers of smokers in the UK. The conclusions are that the changes in legislation and the smoking cessation service have been effective in reducing the number of smokers in the UK. The recommendations include those on proven effective treatments from NICE, that the service should continue and that it should continue to be monitored by the NHS for the Government.

Is the evaluation report available, preferably in English or at least an English summary?

- Bauld I., Bell K., McCullough I., Richardson I., Greaves L. (2010) The effectiveness of NHS smoking cessation services: a systematic review. *Journal of Public Health*; 32: 71-82.
- National Institute for Health and Clinical Excellence (2008) Smoking cessation services - Guidance (guidelines ph10) at www.nice.org.uk/ph10 accessed on 9 June 2015
- Statistics on NHS Stop Smoking Services, England - April 2013 - March 2014 at www.hscic.gov.uk/catalogue/PUB14610 accessed on 9 June 2015.

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

As previously described, the service is continuously monitored by the NHS

Who implemented the intervention?

The smoking cessation service was planned centrally by administrators, psychologists and clinicians and is run by administrators and trained counsellors who may or may not have a clinical background such as nursing. Referral to the service is from clinicians working in the NHS.

What core activities are/have been implemented?

- A media campaign to publicise the service
- Training sessions and events for clinicians to raise their awareness of the service
- Training for the counsellors
- Numerous websites and publications

Did the intervention achieve meaningful participation among the intended target population?

Yes, the latest data for the year April 2013 to March 2014 report that during this period 586,337 people set a quit smoking date with the NHS stop smoking services and 300,539 (%1%) successfully quit.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Pregnant women, those under 20 years of age and manual workers were identified as those with a greater need.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes. The referring clinicians can be described as intermediaries

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, the service is funded by the NHS and an early evaluation (Stephens 2001) indicated that it was very costs effective. It has continued and institutional ownership guarantees its funding and human resources.

Is there a broad support for the intervention amongst those who implement it?

Yes, the smoking counsellors are dedicated to their task, especially those who were previously smokers themselves.

Is there a broad support for the intervention amongst the intended target populations?

Yes, Stephens (2001) found a 48% success rate after one month. In the year April 2013 - March 2014, 586,337 people set a date to stop smoking through the NHS Stop Smoking Service of whom 51% succeeded in stopping smoking.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

In spite of economic pressures, the funding has been forthcoming from the NHS for 15 years so it seems reasonable to conclude that the estimation has been adequate.

Were sources of funding specified in regards to stability and commitment?

See the answer to the previous question

Were organisational structures clearly defined and described?

Yes, these were planned centrally and implemented locally

Is the potential impact on the population targeted assessed (if scaled up) ?

Yes, the monitoring reports sent by the smoking cessation counsellors give an ongoing national picture of past and present impact on the targeted population.

Are there specific knowledge transfer strategies in place (evidence into practice)?

The results of external evaluations and the internal monitoring are fed back to the funders, administrators and counsellors

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

As the counselling service provides national coverage and universal availability, it is difficult to see how it can be scaled up.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Strong policy from the Government and sufficient funds.
- Recognition from the population of the nature of the problems caused by smoking

What were, in your opinion, the main lessons to be learned?

As nicotine is such an addictive substance, the need to offer long-term, supportive and easily available help to those who wish to stop smoking and to continue to provide this service in the long-term.

Web page related to the intervention

There are numerous web-pages - Google NHS Stop Smoking Services

References (with possible links) to the most important articles or reports on the intervention

- Bauld I., Bell K., McCullough I., Richardson I., Greaves L. (2010) The effectiveness of NHS smoking cessation services: a systematic review. *Journal of Public Health*; 32: 71-82.
- National Institute for Health and Clinical Excellence (2008) Smoking cessation services - Guidance (guidelines ph10) at www.nice.org.uk/ph10 accessed on 9 June 2015
- Statistics on NHS Stop Smoking Services, England - April 2013 - March 2014 at www.hscic.gov.uk/catalogue/PUB14610 accessed on 9 June 2015.
- Stephens J. (2001) Costs effectiveness of NHS smoking cessation services. London, King's College www.ash.org.uk accessed via Google on 9 June 2015

Other relevant documents:

Google NHS Smoking Cessation Services

Contact details for further information

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Up-to-date health - Running and Walking Centre in Tondela, 'CMMCTnd' Portugal

Title in original language:

Saúde em Dia - Centro de Marcha e Corrida de Tondela (CMMCTnd)

Which 'life stage' for CVDs prevention targets the intervention?

The intervention "Saúde em Dia - Centro de Marcha e Corrida de Tondela" (CMMCTnd) CMMCTnd is focused on the senior population of the Municipality of Tondela, but it also includes adults.

What is the level of implementation of the intervention?

Local. The intervention has been implemented in the Municipality of Tondela.

To which type of interventions does your example of good practice belong to?

Individual intervention.

Short description of the intervention:

The intervention CMMCTnd targets adults, especially the senior population, of the Municipality of Tondela, Portugal. The main goal of CMMCTnd is to reduce the sedentary lifestyle and the isolation of the target population, through activities promoting healthy and active ageing. The main operational objectives of CMMCTnd are: to disseminate the practice of technically oriented physical exercise; to establish partnerships with the health sector, identifying beneficiaries from medical appointments and introducing them to physical exercise activities in the presence of a Sports Technician; to assess and monitor the health parameters; and to register physical performance and health of participants. Besides these main objectives, this program also enabled a better occupation plan of the local sporting facilities, the stimulation of the associativism and the creation of job opportunities for sports technicians.

The project comprises sessions of exercise (2-3 times a week), in public spaces dedicated for fitness, walking, jogging, swimming, among others. Some activities are also oriented to the promotion of cognition and include cultural events, allowing the establishment of partnerships with local institutions. The intervention also includes the presence of a Sports technician at the Health Unit Centres that orients the beneficiaries from the diabetic medical appointments towards an exercise programme in CMMCTnd. In addition, the presence of three nurses at the CMMCTnd allows the diagnosis and the monitoring of the beneficiaries, registering potential useful information for the general practitioner or the Sports technician in the "Exercise and Physical Health Bulletin". There is also collaboration with one nutritionist (training and monitoring healthy eating habits) and one psychologist (working in psychomotricity and cognitive development areas).

What are the main aim and the main objectives of your example of good practice?

The main goal is to fight sedentary lifestyle, isolation, and loneliness of the elderly population in the municipality of Tondela. This is accomplished through activities promoting healthy and active ageing. The main objectives are to provide a platform of health promotion through the practice of regular physical exercise activities, supported and monitored by specialized staff (Physical Education professional), and to provide space for counselling, information and study of questions related with health and physical exercise. The specific objectives of CMMCTnd are:

- to evaluate the physical condition of the beneficiaries of the programme and to perform the diagnosis using several test batteries (e.g. Fullerton Advanced Balance Scale and Senior Fitness Test) and physiological parameters (e.g. glycaemia, cholesterol, and body index mass);
- to promote and develop institutional capacities to recommend to the adequate health services;
- to establish partnerships with the Health Units in order to adjust the physical exercises to the needs of the beneficiaries;
- to register the physical exercise performance of the beneficiaries, providing the health professionals (general practitioner) with complementary data for clinical monitoring;
- to provide technical support to the beneficiaries, whether or not practicing physical exercise;
- to allow research projects implementation with groups of citizens, in partnerships with Universities and Health Institutions.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes. According to the Resolution of the European Parliament, dated February 6th, 2013, about the European Innovation Partnership for the Active and Healthy Ageing, there is an urgent need to increase the levels of physical exercise of the elderly population, promoting healthy and active ageing, since lack of regular physical exercise leads to several health problems, which constitute the fourth most common death risk factor. In addition, in 2007, a study was performed to evaluate the sports habits of the population of the Municipality of Tondela, and it was concluded that almost 41% of people with more than 40 years-old were not practicing physical exercise, pointing the lack of offer in the Municipality as the major cause for the registered lack of physical activity.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes. Participants become aware of the programme through dissemination activities of local associations and by the Professor of Physical Education (weekly present at the Health Units Centre). The physical exercise sessions are held in various locations in the Municipality, from January to December, 2-3 sessions per week, lasting 60 minutes each session. The activities consist of training of physical capacities as a mean to prevent decline of physical and cognitive functions. The physical performance and health indicators are evaluated by a team of nurses that registers the performance in the "Exercise and Physical Health Bulletin". These records are forwarded by the participant to the general practitioner. This communication channel allows a more sustained evaluation of the progress of the participant, taking into account possible diseases. Single sessions (workshops) in the areas of health and physical exercise complement the practical part with theoretical knowledge on the importance and influence of these vital factors in the quality of life of citizens. The main objective of the intervention is to promote healthy lifestyles fighting physical inactivity, isolation and loneliness, which tend to increase in our society.

What core activities are/have been implemented?

In general, physical exercise activities are scheduled regularly (2-3 times per week) and there are training sessions (workshops) on nutrition issues, physical exercise and diabetes prevention. The individual performances (physical exercise and health status) are registered in the booklet ("Exercise and Physical Health Bulletin"), joining information from/to doctors, nurses and sports technicians.

Please give a description of the problem the good practice example want to tackle:

In 2007, a study was performed to evaluate the sports habits of the population of the Municipality of Tondela. The data presented in the “Sports Letter” registered that almost 41% of people with more than 40 years-old were not practicing physical exercise, pointing lack of offer as the major cause. In order to find solutions to reduce this index and to satisfy the targeted population, it was created an “anti-sedentary lifestyle” program, along with the institutional partners. Besides the main objective, this program also enables a better occupation plan of the local sporting facilities, the creation of partnerships and job opportunities for Physical Exercise technicians.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes, the target populations were chosen based on previous needs identified on a diagnosis analysis of the Municipality of Tondela.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes. In addition to the local health institutions through general practitioners refer beneficiaries (especially those with conditions susceptible to improve with regular physical exercise), we engage associative institutions that, through its members, locally organize activities to promote the advantages of the intervention (organized walking groups, free screenings of blood glucose levels, and body mass index, etc.). In addition, there were several awareness-raising events, including generalized diagnosis to the population (free screening of cardiovascular risk; evaluation of physical performance - overall strength, flexibility, etc. and assessing, in collaboration with the Faculty of Sport Sciences and Physical Education, University of Coimbra and Sports School of the University of Porto). The organization of workshops and information sessions on health, exercise and nutrition, with the support of experts in the respective fields, promoted the awareness of potential beneficiaries.

During implementation, did specific actions were taken to address the equity dimensions?

Yes. The programme is open to all population of the Municipality of Tondela interested in participate, with a special attention to the senior population, particularly the citizens living in more rural, isolated locations.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes. The programme was designed taking into account that there are senior citizens living in rural isolated areas, and some with physical disabilities. The activities are planned in accordance the attendees.

Which vulnerable social groups were targeted?

The programme encloses all population of the Municipality of Tondela, particularly the senior population. This means that there are persons with low income and low education, and some may have a physical disability, and live isolated.

Is the intervention embedded in a broader national/regional/ local policy or action plan?

Yes. This intervention has the support and is being promoted by the Municipality of Tondela. It is aligned with the Portuguese Plan of Walking and Running (framed by the Portuguese Institute of Sports, Portuguese Athletics Federation and Faculty of Sport of the University of Porto).

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

Yes. The intervention was designed taking into consideration the senior population of the Municipality of Tondela, knowing that this group of people usually lives isolated, and has low income and low socio-economic conditions.

Was an effective partnership in place?

Yes. CMMCTnd has established partnerships with the Health Care Units, private sector and with private charity institutions.

Who implemented the intervention?

The programme involves the Municipality of Tondela, the partner institutions (Health Units of Tondela, local associations and parish councils, Fresenius Kabi-Labesfal, among others). Direct involvement of health professionals (medical doctors and 3 nurses) with 21 Physical Education professionals (graduated in Physical Education), acting synergistically with nutrition specialists (training and monitoring healthy eating habits) and 1 Psychologist (working in psychomotricity and cognitive development areas).

Was the intervention designed and implemented in consultation with the target population?

The population of the Municipality of Tondela responded to a questionnaire identifying that one of the reasons to explain the high levels of inactivity was the lack of offer.

Did the intervention achieve meaningful participation among the intended target population?

Yes. In 2013 there were 1387 attending the activities and in 2014 there were 1420 beneficiaries participating in the 65 local projects.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes. The questionnaire in 2014 showed that the beneficiaries feel healthier, more mobility, more strength and energy, since their participation in the project. The results also show the importance of acquaintanceship with others, reducing isolation and loneliness of senior people, promoting their integration in the activities of the society.

Was the intervention implemented equitably, i.e. proportional to needs?

The intervention has been implemented fairly, without gender discrimination, age or vulnerable social groups.

Were potential burdens, including harm, of the intervention for the target population addressed?

The beneficiaries of CMMCTnd are monitored by nurses and physical exercise is performed in the presence of specialized staff.

Was the objective/strategy transparent to the target population/stakeholders involved?

Yes. The Municipality of Tondela is a public institution; therefore it follows the transparency guidelines to public institutions. In addition, the information is available to the target population and partner institutions upon request.

How is this example of good practice funded?

CMMCTnd is funded by Regional government (Municipality of Tondela – 80%) and the other institutions coordinating local projects (20%).

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes. The activities/local projects to be implemented annually by the CMMCTnd are identified, in order to allocate the needed human resources, material and budget.

Were sources of funding specified in regards to stability and commitment?

Yes. The intervention is funded by the Municipality of Tondela and by other institutions coordinating the local projects.

Were organisational structures clearly defined and described?

Yes. The intervention is managed by the councillor for Sport of the Municipality of Tondela, working in collaboration with his team.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. We use the following validated instruments, among others :

- The Short Form (36) Health Survey on health status;
- Senior Fitness Test (Rikli and Jones, 1999);
- Fullerton Advanced Balance (FAB) Scale;

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes. The intervention is evaluated annually.

Who did/does the evaluation?

Both internal and external parties

Specifically, what has been measured/evaluated?

Internal process evaluation: questionnaires to the beneficiaries & informal interviews. Satisfaction survey to the participants/beneficiaries - Results from the survey (2014): from the 234 respondents, 191 answered that it was "very important", citing the following main reasons: "I have more mobility"; "I feel healthier" and "I feel happier."
External process evaluation: Intervention recognized (2014) as having "High potential for Social Entrepreneurship" certified by the project "Map of Innovation and Social Entrepreneurship in Portugal" (based in ES+ methodology, which was developed by researchers at the IES in collaboration with INSEAD, ISCTE, the Universidade Católica do Porto and a doctoral student from the University of Lancaster).

What are the main results/conclusions/recommendations from the evaluation?

Taking into consideration the clear benefits of promoting regular physical exercise activities and reducing socio-economic exclusion, in addition to the positive feedback of the beneficiaries, it is recommended that this program should be extended.

Did the evaluation results achieve the stated goals and objectives?

Yes. The target population (senior population of the Municipality of Tondela) has been actively participating in the project, thus increasing the levels of physical exercise. In addition, it is contributing to reduce the isolation of some citizens.

Is the evaluation report available?

Yes, but only in Portuguese.

Was there a follow-up or is any follow-up evaluation planned in the future?

The intervention is evaluated annually.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes. The CMMCTnd is promoted by the Municipality of Tondela and it is aligned with the National Plan of Walking and Running.

Is there a broad support for the intervention amongst those who implement it?

Yes. All partners are committed with CMMCTnd. Indeed, the partnership with the Health Care Units has been extended, supporting the favourable feedback of the institutions involved.

Is there a broad support for the intervention amongst the intended target populations?

Yes. As seen in the "Satisfaction survey" on the participants/beneficiaries.

Is the potential impact on the population targeted assessed (if scaled up)?

Yes. The physical conditions and health status of the population enrolled in the project are assessed by specialized staff (nurses and Physical Education professional).

Are there specific knowledge transfer strategies in place (evidence into practice)?

The initiatives/activities taking place at CMMCTnd can be performed by other national institutions and can be adapted in other countries.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators? (e.g.. resources, organisational commitment, etc.).

Yes. In this context there is a commitment with the Parish Councils, Associative institutions and health care units.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- 1) Human Resources. Qualified personnel in the area of physical exercise and health (specialized staff in Physical Exercise, nurses and medical doctors).
- 2) Material Resources. Existence or acquisition of materials and sports equipment, such as cardio-frequency meters, ropes, dumbbells, etc., and for health status assessment (equipment for blood glucose quantification, lancets and strips, sphygmomanometers, bio-impedance scales, etc.).
- 3) Financial Resources. Financial contribution for technical, material and logistical support.
- 4) Partnerships (Establishment of a network of institutional partners). Involvement of Health Care Facilities; Parish councils; local authorities; Companies; schools and universities.
- 5) Target population. Target the more sedentary groups (elderly, people with diagnosed conditions; patients referred by the general practitioner/other doctor, requiring regular physical exercise).

What were, in your opinion, the main lessons to be learned?

1. Finding that the strategy to improve health, autonomy, personal independence and quality of life of citizens of the Municipality of Tondela was achieved;

2. The promotion of factors that lead to social life and to fight isolation and loneliness, promoting the creation of healthy life styles;
3. The recognition that partnerships between institutions, local (local authorities, health authorities, sport, cultural and social associations, private sector and others) are important, leading to the establishment of a "network of common interests" in the promotion of health and wellbeing of our citizens;
4. Recognizing that important association between physical exercise and health as fundamental and complementary contributions to improve health and the quality of life;
5. The value and importance of promoting active and healthy ageing;
6. Knowing that the senior population is satisfied, which is perceived as a significant improve of their condition, autonomy and personal independence, and especially their health status (physical and psychological);
7. The privilege of receiving public recognition from prestigious Institutions, such as Universities, Health Care Units.

Web page related to the intervention

<http://www.cm-tondela.pt/index.php/servicos/desporto/programa-saude-em-dia/centro-municipal-de-marcha-e-corrida>

References to the most important articles or reports on the intervention

Master thesis (2012) "The practice of physical activity and recreation as informal education agents"

Master thesis (2013) "The impact of an exercise program for 16 weeks in health status, physical performance and quality of life of type 2 diabetes patients of Tondela"

Other relevant documents (implementation manuals, training manuals, posters, videos or other tools available for use or adaptation, etc.):

https://www.youtube.com/watch?v=RRqeZEzy8S8&list=PLXaHwIYRoo_eq5VuADFQ-CYfnfIHApSX8

www.facebook.com/marchaecorridatondela

<http://www.cm-tondela.pt/index.php/servicos/desporto/programa-saude-em-dia/instrumentos-de-avaliacao>

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The Keyhole for Healthier Food Norway

Title in original language:

Nøkkelhullet

Target groups:

General population. Specific target groups are families with children.

Short description of the intervention

The Keyhole (Nøkkelhullet) is a voluntary Nordic label for food. Compared to other foods of the same type, products with the Keyhole comply with one or more of these requirements: more whole grain, less saturated fat, less salt and less sugar. The Directorate of Health's dietary advice recommends a varied diet with plenty of vegetables, fruit and berries, whole grains and fish, and limited amounts of processed meat, red meat, salt and sugar. Energy balance is also important. The aim of the Keyhole is to help make the right choices when doing grocery shopping and also to stimulate the food industry to develop products containing less fat, healthier fats, less salt and sugar and more fibre, full grain, vegetables and fruits.

The Keyhole symbol has been used as a common Nordic labelling scheme on food products in Norway, Denmark and Sweden since 2009. Which food product groups that can be labelled with the Keyhole symbol (link) and the criteria the products must meet, are determined by Norwegian, Swedish, Danish and Icelandic authorities. In Norway, the Directorate of Health and the Norwegian Food Safety Authority are responsible for the labelling scheme. Using the Keyhole symbol is voluntary, and it is the manufacturers' responsibility to follow the set of criteria set by the authorities. The Norwegian Food Safety Authority is responsible for monitoring compliance with the regulations regarding use of the label. Stricter criteria were introduced on 1 March 2015. By 1 September 2016, all products labelled with the Keyhole must meet the new criteria.

The Keyhole is a Swedish-registered trademark owned by Livsmedelsverket in Sweden.

The Keyhole is found on the packaging of the food products. Breads, meats and cheeses which are not pre-packaged are also labelled. All fresh fish, fruit, berries, vegetables and potatoes are natural Keyhole products, even though they are not labelled. All grocery stores in Norway sell products with the Keyhole. The Keyhole is also found on some food products at venues such as kiosks and petrol stations.

The Keyhole is for everyone. Food with the Keyhole is for all healthy people – adults, teenagers and children.

What does the Keyhole symbol on a food product mean? There are a total of 33 food product groups which can use the Keyhole. Within each product group, different criteria are considered (fibre, fat, sugar and salt). For example, a Keyhole-labelled breakfast cereal will contain more fibre and less sugar than a breakfast cereal without the symbol. In meat products, the proportion of saturated fats and salt is considered most important, while Keyhole-labelled bread on the other hand must meet the criteria for fibre, fat, sugar and salt. In certain food groups there are also requirements for the content of vegetables, fruit, berries and whole grain. In certain product groups, such as soda, candy and chocolate, cakes and biscuits, no products can be labelled with the Keyhole symbol. For more information on which criteria that apply to the various food product groups, read more here: Keyhole Regulations.

To which type of interventions does your example of good practice belong to?

This is a European project. The Keyhole symbol has been used as a common Nordic labelling scheme on food products in Norway, Denmark and Sweden since 2009. Iceland and Lithuania are also part of the cooperation.

How is this example of good practice funded?

National government and private sector. Using the Keyhole symbol is voluntary, and it is the manufacturers' responsibility to follow the set of criteria set by the authorities.

What is/was the level of implementation of your example of good practice?

National

What are the main aim and the main objectives of your example of good practice?

The Keyhole is a voluntary Nordic label for food. The aim is to make healthy choices easier for people. Compared to other foods of the same type, products with the Keyhole comply with one or more of these requirements: more whole grain, less saturated fat, less salt and less sugar.

It is also an aim to stimulate the food industry to develop products containing less fat, healthier fats, less salt and sugar and more fibre, full grain, vegetables and fruits.

Please give a description of the problem the good practice example wants to tackle:

The keyhole is meant to help people make healthier food choices. The aim is to prevent obesity and non-communicable diseases (NCD), such as diabetes, cancer and cardiovascular disease.

Approximately 30% of the total number of deaths in Norway, happen prematurely if the limit is set to before 75 years of age (2009: 12033 deaths, 29% of all deaths). In total, cardiovascular disease, cancer, chronic lung diseases and diabetes account for well over half of these deaths (64% among men and 70% among women). More men than women die prematurely of non-communicable diseases. From 1980 to 2009 there has been a decline in premature mortality from both cardiovascular diseases (70%) and cancer (18% for men and 12% for women). Looking at all deaths before 75 years age summed up (numbers from 2009, both sexes combined), 40% died of cancer, 20% of cardiovascular disease, 4% of chronic lung diseases and 2% of diabetes. Lung cancer is the numerically dominant cause of premature deaths from cancer, followed by colon cancer and breast cancer. This picture confirms that WHO's goal of reducing premature mortality from non-communicable diseases is highly relevant in Norway.

(<https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/308/Reduksjon-i-ikke-smittsomme-sykdommer-nasjonal-oppfølging-av-WHOs-mal-IS-0373.pdf>)

Overweight and obesity is a problem in Norway, as it is in the rest of Europe. Norwegian researchers followed body mass index (BMI) and waist circumference (WC) in a large adult population in Norway (n = 90 000) from 1984–1986 (HUNT1) through 1995–1997 (HUNT2) to 2006–2008 (HUNT3) to study whether this is occurring

in Norway. Height and weight were measured with standardized and identical methods in all three surveys; WC was also measured in HUNT2 and HUNT3. In the three surveys, mean BMI increased from 25.3 to 26.5 and 27.5 kg m⁻² in men and from 25.1 to 26.2 and 26.9 kg m⁻² in women. Increase in prevalence of obesity (BMI 30 kg m⁻²) was greater in men (from 7.7 to 14.4 and 22.1%) compared with women (from 13.3 to 18.3 and 23.1%) (ref Midthjell K et al. Trends in overweight and obesity over 22 years in a large adult population: the HUNT Study, Norway. Clinical obesity; 2013). Foods labelled with the keyhole have less fat and sugar and more dietary fibre than alternative food items in the same category. Thus the keyhole may contribute to the prevention of obesity. Prevention of obesity may, in turn, reduce the incidence/prevalence of diabetes, cancer and cardiovascular disease. Implementing a labelling system to make healthier choices easier is a follow-up to the government's "Action plan for an improved diet among the population (2007 - 2011) - Recipe for healthier eating".

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. Implementing a labelling system to make healthier choices easier is a follow-up to the government's "Action plan for an improved diet among the population (2007 - 2011) - Recipe for healthier eating". NCD strategy to help

Norway reach the goal of the WHO of reducing premature death from non-communicable diseases by 25% by the year 2025.

www.regjeringen.no/contentassets/e62aa5018afa4557ac5e9f5e7800891f/ncd_strategy_060913.pdf

The Keyhole is part of the new white paper on public health (Mestring og muligheter) (2014-2015).

Implementation of your example of good practice is/was:

Continuous

Vulnerable social groups:

Ethnic minorities. In 20011 the Directorate conducted a mass media campaign on keyhole labelling and collaborated with a smaller television channel (utrop TV) on providing dietary inputs and recommendations to minority populations. The keyhole labelling initiative is being monitored in different social groups by level of education, marketing legislation and targeted materials. This monitoring exercise seems to be promising in terms of the potential health impact of tackling social inequalities in diet. (Evaluation of the Norwegian Nutrition Policy with focus on the Action Plan on Nutrition (2007-2011)

http://www.euro.who.int/_data/assets/pdf_file/0003/192882/Evaluation-of-the-Norwegian-nutrition-policy-with-a-focus-on-the-Action-Plan-on-Nutrition-20072011.pdf

Who implements/implemented the intervention?

The criteria the products must meet are determined by Norwegian, Swedish, Danish and Icelandic authorities. In Norway, the Directorate of Health and the Norwegian Food Safety Authority are responsible for the labelling scheme. Using the Keyhole symbol is voluntary, and it is the manufacturers' responsibility to follow the set of criteria set by the authorities.

What core activities are/have been implemented?

Campaigns: Three consumer-oriented mass media campaigns were carried out during the period 2009-2011 to inform the population about the keyhole labelling system. A home page was created, along with materials for consumers (folders in 12 languages) and for the food industry and education sectors. In just two years the keyhole became the best known and most used logo in the grocery trade. There is a new campaign running in 2015. In 2011 the Directorate conducted a mass media campaign on keyhole labelling and collaborated with a smaller television channel (utrop TV) on providing dietary inputs and recommendations to minority populations. By December 2014 approximately 2000 keyhole-labelled products were available, in addition to fruits, vegetables, berries and fresh fish that could also be labelled with the logo.

A population survey was conducted in January 2012 of awareness and knowledge about the keyhole among consumers.

As a direct communication tool to increase knowledge and skills for consumers, the Cookbook for all was published in September 2007. The book was given free to all pupils in lower secondary schools and to student teachers. Municipalities could buy the book at cost of production for training purposes (for example, language courses for immigrants or Good Food courses). The book was updated with the keyhole labelling scheme and new dietary advice and was made available in bookshops for the general public. It was mentioned by the informants as a success story for staff working in schools.

- Information leaflet, translated into 14 different languages:
http://www.nokkelhullsmerket.no/helse_og_undervisning/#/article_257
- Educational materials for schools:
http://www.nokkelhullsmerket.no/helse_og_undervisning/#/article_318
- Four new films 2015:

Breakfast: <https://www.youtube.com/watch?v=p7nzdrHWV2A&feature=youtu.be>
 Lunch: <http://youtu.be/Pi2mDPU7RdM>
 Dinner: <http://youtu.be/eYb4nLW3ReA>
 Facts: https://www.youtube.com/watch?v=owV_twaCR3o
 Webpage: <https://helsenorge.no/kosthold-og-ernaring/nokkelhullet>

Who did the evaluation?

Both – internal and external parties. The WHO Regional Office for Europe conducted an evaluation of the Norwegian Action Plan on Nutrition (2007–2011) in 2012. The evaluation was commissioned by the Directorate of Health of the Norwegian Ministry of Health and Care Services under the terms of the framework agreement between the Regional Office and the Directorate of Health. The overall aim of the assignment was to provide an independent evaluation of the Action Plan on Nutrition and an assessment of the possible options for the future in terms of policy recommendations. Assessment of the impact of the Keyhole and the activities to promote it, was part of the evaluation.

What has been measured / evaluated?

It has not been done an external evaluation to measure effect on changes in food intake, but every year a survey is done to measure the proportion of the population with knowledge about the Keyhole (n=1000) and every other year a larger Spisefakta-survey (n=5000) also measuring the knowledge about the Keyhole. The results of these show that 30% take into account the Keyhole label when they go grocery shopping. There are no differences as far as socioeconomic status goes

(helsedirektoratet.no/Documents/Kosthold%20og%20ern%C3%A6ring/Forbrukerunders%C3%B8kelse_n%C3%B8kkelhullet_2011-2015.pdf)

The University of Oslo has made a report on the effect of exchanging relevant products for keyhole certified products. This is not an evaluation of the keyhole, but an evaluation of the health effects of exchanging products for more healthy alternatives.

(helsedirektoratet.no/Documents/Kosthold%20og%20ern%C3%A6ring/Effektberegning_nokkelhullet_UiO.pdf)

Results: When the usual non - keyhole-labelled foods eaten in Norkost 3 (a semi-quantitative food frequency questionnaire in different age groups) was replaced with keyhole-labelled foods were both intake of total fat, saturated fat and energy reduced, while the intake of dietary fiber increased. The reduction in the intake of total fat, saturated fat and energy were respectively 11.4 g / day (13.0 % reduction), 8.9 g / day (26.5 % reduction) and 403 kJ / day (4.3 % reduction). Replacement of milk and cheese to Keyhole labelled varieties contributed to the greatest reduction in intake of total fat and energy. Replacement of milk and cheese contributed equally as replacement of margarine and butter to the reduction in intake of saturated fat. Intake of dietary fiber increased by 4.7 g / day (19.3 % increases) and it was the exploitation of grain products that contributed to the largest increase.

What are the main results/conclusions/recommendations from the evaluation?

A population survey in January 2012 of awareness and knowledge about the keyhole among consumers aged over 18 years, showed continued positive progress: 98% knew or had heard about the logo: 85% knew that the logo represented a healthier choice; many knew that the logo represented less fat, sugar and salt and more dietary fibre; 60% trusted the scheme; and 50% thought that it made it easier to choose healthier foods.

The keyhole labelling initiative is being monitored in different social groups by level of education, marketing legislation and targeted materials. This monitoring exercise seems to be promising in terms of the potential health impact of tackling social inequalities in diet.

Is the evaluation report available, preferably in English or at least an English summary?

Evaluation of the Norwegian Nutrition Policy with focus on the Action Plan on Nutrition (2007-2011) (www.euro.who.int/_data/assets/pdf_file/0003/192882/Evaluation-of-the-Norwegian-nutrition-policy-with-a-focus-on-the-Action-Plan-on-Nutrition-20072011.pdf)

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Nordic cooperation
- Government sanctioned and endorsed by public authorities/ grounded on governmental authoritative foundation
- Professional and scientific foundation
- Additional information

Web page related to the intervention

www.nokkelhullsmerket.no/frontpage_en/article418.ece

References to the most important articles or reports on the intervention

Evaluation of the Norwegian Nutrition Policy with focus on the Action Plan on Nutrition (2007-2011) www.euro.who.int/_data/assets/pdf_file/0003/192882/Evaluation-of-the-Norwegian-nutrition-policy-with-a-focus-on-the-Action-Plan-on-Nutrition-20072011.pdf

Other relevant documents (implementation manuals, training manuals, posters, videos or other tools available for use or adaptation, etc.): www.nokkelhullsmerket.no/frontpage_en/article418.ece

Contact details for further information

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Henriette Øien

'PNPAS' National Programme for the Promotion of Healthy Eating Portugal

Title in original language:

Programa Nacional para a Promoção da Alimentação Saudável - PNPAS

Which 'life stage (s)' for CVDs prevention targets the intervention?

The National Programme for the Promotion of Healthy Eating (PNPAS) cover all life cycles.

What is the level of implementation of your example of good practice?

The implementation of the PNPAS is on the national level in collaboration with local and regional health administration on the operationalization and supervision of the different strategies and structures. Also, the coordination with educational institutions and municipalities is devised.

To which type of interventions does your example of good practice belong to?

National Policy. The PNPAS is a concerted and cross-cutting set of actions to ensure and encourage access to and consumption of certain types of food with the objective of improving the nutritional status and health of its population.

Short description of the intervention:

The PNAPS is a national policy for healthy eating (national programme), i.e., a concerted and cross-cutting set of actions to ensure and encourage access to and consumption of certain types of food with the objective of improving the nutritional status and health of its population. This programme was designed and coordinated by Directorate-General for Health. The PNPAS has five general goals:

- To increase the knowledge about food consumption by Portuguese population, its determinants and consequences.
- To modify the availability of certain foods, namely in schools, workplaces and public spaces.
- To inform and empower the population in general, especially the most disadvantaged groups, on how to purchase, cook and store healthy foods.
- To identify and promote cross-cutting actions to encourage the consumption of good nutritional quality foods in coordination and integrated with other public and private sectors, namely in the areas of agriculture, sports, environment, education, social security and municipalities.
- To improve the qualification and mode of action of the different professionals who, through their activity, may influence knowledge, attitudes and behaviours in the food area.

To reach the five general goals, the PNPAS proposes a set of activities distributed over six main areas:

- The systematic collection and aggregation of indicators of nutritional status, food consumption and its determinants over the life cycle, the assessment of food insecurity situations, and the assessment, monitoring and dissemination of best practices with the goal of promoting healthy eating habits or eating habits that protect from disease at the national level.
- The change in the offer of certain foods (with high sugar, salt and fat content), by controlling their supply and sales in schools, health and social support institutions and in the workplace, and by encouraging a greater availability of other foods like water, fresh fruit and vegetables, and the encouragement to actions of nutritional

reformulation of food products through a coordinated action with the food industry and the catering sector, or also through other activities that may influence food availability, taking into account the latest scientific knowledge and consensus.

c) The increase in food and nutrition literacy, the empowerment of citizens from different socioeconomic and age groups, particularly the most disadvantaged ones, towards healthy choices and eating practices, and the encouragement of best practices on labelling, advertising and marketing of food products.

d) The identification and promotion of cross-sectional actions with other sectors of society, namely agriculture, sports, environment, education, municipalities and social security, should allow, inter alia, promoting the adoption of a Mediterranean eating pattern, likely to encourage the consumption of foods of vegetable origin, seasonal, national, using packaging or means of transport that reduce the emission of pollutants, developing electronic tools that enable planning healthy, easy-to-use and affordable menus with price information for individuals and families, and developing a network at municipal level for monitoring best practices and projects in the area of the promotion of healthy eating for citizens.

e) The improvement of education, qualification and mode of action of different professionals who can influence quality eating habits, namely at the level of the health sector, schools, municipalities, the tourism and catering sector or social security.

f) The improvement of the intervention and coordination methods of professionals and structures dealing with the phenomenon of obesity.

The PNPAS coordinates its strategies with different partners of the sector, from food producers to consumers, represented on its Advisory Board, with the technical support of its Scientific Council and taking into account the different international guidelines at this level, namely those from European Commission, the World Health Organization and the European Food Safety Authority.

The PNPAS considers particularly relevant the collaboration of local and regional health structures in the operation and supervision of the different strategies and structures and also in the coordination with educational institutions and municipalities. The implementation procedures are organized in five areas:

- Projects and partnerships - intersectoral work;
- Information, collecting and monitoring of data about Portuguese context;
- Professionals - Improve qualifications and practices;
- Empowerment of citizenship;
- Changing food availability and modify the environment

The PNPAS has a national scope; is integrated in the activities of Directorate-General of Health, but has a schedule for four years.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The design of programme was based on international documents namely the Adelaide Statement (1988); the International Conference on Nutrition (Rome, 1992). More recently, and at European level, food and nutrition were considered key elements in the definition of goals, strategies and recommendations found in various documents produced both by the World Health Organization (WHO) and by the European Commission (EC). Examples of this are the “Global strategy on diet, physical activity and health” (WHO, 2004), “WHO European Action Plan for Food and Nutrition Policy 2007-2012” (WHO European Region, 2008), European Charter on counteracting obesity (WHO European Region, 2006), “The Challenge of obesity in the WHO European Region and the strategies for response” (WHO European Region, 2007) and the White Paper on “A Strategy for Europe on Nutrition, Overweight and Obesity related health issues” (Commission of the European Communities, 2007). In these strategic documents, it is possible to observe the need to modify eating and physical activity behaviours in European societies, in the mid- to short-term, especially since despite the efforts made so far, the growth of chronic diseases continues, now affecting more than a third of the European population, and globally it is estimated that 60% of premature deaths are caused by these diseases. In that sense, in 2008 the WHO developed a global action plan for chronic diseases –

WHO 2008-2008 – Action Plan for the Global Strategy for the Prevention and Control of Non Communicable Diseases (WHO, 2008), where inadequate eating was presented as one of the four main risk factors for chronic diseases. Moreover the design of programme was based on recent data of high prevalence of obesity in Portuguese society (about 1 million obese adults and 3.5 million pre-obese) and its association with social features and economic, and socially vulnerable population groups. In this context they seem to be more exposed to situations of disease and insecurity food. The PNPAS take into account obesity as an expression of inadequate food intake and insufficient energy expenditure by the Portuguese population. Particular attention should be paid to this disease, particularly as regards its treatment, due to its specificity, high prevalence in population and ability to influence the onset and course of other chronic non-communicable diseases. For the first time, data on food insecurity began to be systematically collected at national level for the adult population. Although the programme is still in its initial phase, it will allow a better understanding the situation on most vulnerable groups facing the risk situation and will guide the best strategic intervention. Another evidence is the frequent underestimation or underreporting cases of overweight and obesity in information health services systems, which makes difficult the correct diagnosis situation and the specific monitoring of these patients.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Please, see the description of intervention above.

How is this example of good practice funded?

The PNPAS is funded by Ministry of Health.

What are the main aim and the main objectives of your example of good practice?

The PNPAS aims to improve the nutritional status of the population, encouraging physical and economic availability of foods which constitute a healthy eating pattern and creating the conditions for the population to value, enjoy and eat them, integrating them into their daily routines. An adequate food consumption and the consequential improvement of the nutritional status of citizens has a direct impact on the prevention and control of the most prevalent diseases at national level (cardiovascular diseases, cancer, diabetes, obesity...), but should also enable, simultaneously, the economic growth and competitiveness of the country in other sectors such as those related to agriculture, environment, tourism, employment or professional qualification.

The programme allow the provision of foods which promote health and well-being for the entire population, being able to create citizens capable of making informed decisions about healthy foods and cooking practices, encourage the production of foods that are healthy and at the same time are able to boost employment, a balanced spatial planning and local economies, encourage local consumptions and production methods that reduce impacts on the environment, reduce inequities in demand and access to foods that constitute a healthy eating pattern and improve the qualification of those professionals that can influence the food consumption of the population. The PNPAS has into account obesity as an expression of inadequate food intake and insufficient energy expenditure by the Portuguese population. Particular attention should be paid to this disease, particularly as regards its treatment, due to its specificity, high prevalence in population and ability to influence the onset and course of other chronic non-communicable diseases. The PNPAS has five general goals:

- a) To increase the knowledge about food consumption by Portuguese population, its determinants and consequences.
- b) To modify the availability of certain foods, namely in schools, workplaces and public spaces.
- c) To inform and empower the population in general, especially the most disadvantaged groups, on how to purchase, cook and store healthy foods.

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

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

Please give a description of the problem the good practice example want to tackle:

An adequate food consumption and the consequential improvement of the nutritional status of citizens has a direct impact on the prevention and control of the most prevalent diseases at national level (cardiovascular diseases, cancer, diabetes, obesity...), but should also enable, simultaneously, the economic growth and competitiveness of the country in other sectors such as those related to agriculture, environment, tourism, employment or professional qualification. Recently, food and nutrition were considered key elements in the definition of goals, strategies and recommendations. The international documents (WHO, European Union) refers that it's possible to modify eating and physical activity behaviours as a measure to minimize the growth of chronic diseases, now affecting more than a third of the European population, and globally it is estimated that 60% of premature deaths are caused by these diseases.

The PNPAS is intent to contribute to involve different sectors of society in the search for solutions to improve the food supply and consumption. Multisectoral and cross-cutting strategies are needed in all government sectors, the private sector, civil society, professional networks, media and organisations at all levels (national, regional and local). Also, the PNPAS is aimed to contribute to the reduction of asymmetries in the access to good nutritional quality food and to the reduction of diseases influenced by food intake in more vulnerable populations. The PNPAS seek to increase the information and knowledge about obesity and eating behaviour in Portuguese population. It is estimated that, in Portugal, occurs a high prevalence of obesity (about 1 million obese adults and 3.5 million pre-obese) and this problem it's associated with social and economic features, namely in the vulnerable groups.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The PNPAS is articulated with National Health Plan 2012-2016.

Implementation of your example of good practice is/was:

A continuous implementation during 2012-2016.

Target group(s) (it is possible to specify more than one target group):

The PNPAS is targeted to adult population, but in some actions has a focus in childhood and adolescence or in older people.

During implementation, did specific actions were taken to address the equity dimensions?

Yes. In some activities, the PNPAS has focus in the most vulnerable groups, namely low income and education groups, as well as unemployed people. Also, the PNPAS is aimed to reduce inequities in demand and access to foods that constitute a healthy eating pattern and improve the qualification of those professionals that can influence the food consumption of the population.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Some activities are addressed to focus in vulnerable groups, namely low income, low education level and so one. Moreover, the PNPAS has specific activities for schools, particularly inserted schools in problem areas. The PNPAS addressed low income and education groups, as well as unemployed people. Some activities are addressed to children and adolescents on the brink of social exclusion and poverty.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

Yes. The PNPAS addressed some social determinants, namely education level and occupational status. The intervention is based upon a setting approach, including schools, workplaces, catering and nutrition industry (bakeries).

Was an effective partnership in place?

The PNPAS coordinates its strategies with different partners of the sector, from food producers to consumers, represented on its Advisory Board, with the technical support of its Scientific Council and taking into account the different international guidelines at this level, namely those from European Commission, the World Health Organization and the European Food Safety Authority. Also, the PNPAS has particular relevant collaboration with local and regional health administration, schools and municipalities.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The PNPAS is aligned with National Health Plan 2012-2016 and with international organizations, such as European Commission, the World Health Organization and the European Food Safety Authority. Examples of some documents: "Global strategy on diet, physical activity and health" (WHO, 2004), "WHO European Action Plan for Food and Nutrition Policy 2007-2012" (WHO European Region, 2008), European Charter on counteracting obesity (WHO European Region, 2006), "The Challenge of obesity in the WHO European Region and the strategies for response" (WHO European Region, 2007) and the White Paper on "A Strategy for Europe on Nutrition, Overweight and Obesity related health issues" (Commission of the European Communities, 2007); Action Plan for the Global Strategy for the Prevention and Control of Non Communicable Diseases (WHO, 2008); "First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control".

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, all target groups in the intervention's know the objectives.

Did the evaluation results achieve the stated goals and objectives?

The PNPAS is in course from 2012 to 2016. In this sense, it has not a final evaluation. However, the monitoring of the 2013 and 2014 shows that the indicators are reaching their targets. The monitoring and some evidence show a need for information about nutritional status, food and nutritional literacy campaigns, specifically to healthcare professional and older populations. Moreover, further regular monitoring of nutritional status and appropriate intervention according to the needs diagnosed has been considered relevant.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

The PNPAS includes some indicators and targets to monitor progress in the strategies implemented, helping to define best practices for the promotion of healthy eating. Some impact indicators and targets of the proposed strategies are:

- Controlling the prevalence of overweight and obesity in child and school-age population, limiting growth to zero by 2016.
- Increasing by 5% the number of school-age children who eat the recommended amount of fruits and vegetables on a daily basis.

- Increasing by 5% the number of school-age children who eat a proper breakfast on a daily basis.
- Increasing by 5% the number of consumers who use the nutritional label before purchasing food products.
- Increasing by 10% the number of municipalities that regularly receive information about healthy eating.
- Reducing by 10% the average amount of salt present in the main food contributors to salt intake by the population.

These targets are used for public accountability and are released and updated regularly on the web site of Directorate-General of Health in <http://www.geosaude.dgs.pt/websig/v5/portal2/public/index.php?par=geosaude>

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

The results of the monitoring has been translated in annual reports and the indicators are updated regularly on the web site of Directorate-General of Health in <http://www.geosaude.dgs.pt/websig/v5/portal2/public/index.php?par=geosaude>

Who did the evaluation? The monitoring has developed by an internal directorate, Directorate of Analysis and Information - Directorate-General of Health.

Specifically, what has been measured / evaluated?

Some impact indicators of the proposed strategies are:

- Controlling the prevalence of overweight and obesity in child and school-age population, limiting growth to zero by 2016.
- Increasing by 5% the number of school-age children who eat the recommended amount of fruits and vegetables on a daily basis.
- Increasing by 5% the number of school-age children who eat a proper breakfast on a daily basis.
- Increasing by 5% the number of consumers who use the nutritional label before purchasing food products.
- Increasing by 10% the number of municipalities that regularly receive information about healthy eating.
- Reducing by 10% the average amount of salt present in the main food contributors to salt intake by the population.

What are the main results/conclusions/recommendations from the evaluation (please describe)?

As mentioned above, the PNPAS is in course between 2012-2016. In this sense, it has not a final evaluation. However, the monitoring of the 2013 and 2014 shows that the indicators are reaching their targets. The monitoring and some evidence show a need for information about nutritional status, food and nutritional literacy campaigns, specifically to healthcare professional and older populations. Moreover, further regular monitoring of nutritional status and appropriate intervention according to the needs diagnosed has been considered relevant.

Is the evaluation report available?

The report is online in <http://www.alimentacaosaudavel.dgs.pt/numeros-e-factos/relatorio-anual-pnpas/>
Unfortunately, the report is available only in Portuguese language.

Was there a follow-up or is any follow-up evaluation planned in the future?

Yes, the PNPAS has planned annual reports and a final report.

Who implemented the intervention?

The PNPAS implements the interventions with a multidisciplinary approach based in networks of organizations. Specifically, the PNPAS considers relevant the collaboration of local and regional health structures in the operation and supervision of the different strategies and structures and also in the coordination with educational institutions and municipalities. The professionals come from the different backgrounds as such as: Health professionals (nurses; psychologist, nutritionists, general doctors); teachers; social workers; food engineers and so on.

What core activities are/have been?

The PNPAS has been produced diverse material for information and literacy for different target groups (manuals about food); campaigns for media; blog (<http://nutrimento.pt/>); events. The PNPAS develop the book "Smart Food" which won of Nutrition Awards 2013, in the Mobilization Initiative category.

<http://www.alimentacaosaudavel.dgs.pt/en/projects-and-partnerships/projects-at-national-level/>

This book gave rise to a site that promotes interaction with citizens: <http://www.alimentacaointeligente.dgs.pt/index.html>

Was the intervention designed and implemented in consultation with the target population?

Before the activities have been implemented was made a situation diagnosis.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes. The interventions defined by PNPAS has intended to increase in food and nutrition literacy, the empowerment of citizens from different socioeconomic and age groups, particularly the most disadvantaged ones, towards healthy choices and eating practices, and the encouragement of best practices on labelling, advertising and marketing of food products.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes. The interventions defined by PNPAS are designed with basis on diagnosis analysis.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes. The PNPAS is a national policy, with an annual budget defined by the Government (Ministry of Health).

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes. The PNPAS defines annually the activity plan, identifying the resources needed to implement them.

Were sources of funding specified in regards to stability and commitment?

Yes. The PNPAS is funding by Ministry of Health.

Were organisational structures clearly defined and described?

The PNPAS has a governance structure composed by a National Director, an advisory board and a scientific council.

Are there specific knowledge transfer strategies in place (evidence into practice)?

The strategies defined by PNPAS can be applied in the national context and can be adapted to the others countries.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Multisectoral and cross-cutting strategies with all government sectors, the private sector, civil society, professional networks, media and organisations at all levels (national, regional and local) are very relevant for the success of the PNPAS.

What were, in your opinion, the main lessons to be learned?

We believe that the main lesson are related with capacity to develop multisectoral intervention, involving different Ministries and private sector.

Web page related to the intervention

<http://www.alimentacaosaudavel.dgs.pt/>

<http://www.alimentacao inteligente.dgs.pt/index.html>

<http://nutrimento.pt/>

References to the most important articles or reports on the intervention

<http://www.alimentacaosaudavel.dgs.pt/en/food-and-health/library-and-resources/links-uteis/>

Other relevant documents):

<http://www.alimentacaosaudavel.dgs.pt/en/legislation/>

Contact details for further information

Professor Pedro Graça (PhD), pedrograca@dgs.pt

Healthy Kinzigtal Germany

Title in original language:

Gesundes Kinzigtal – GmbH

Which 'life stage' for CVDs prevention targets the intervention?

All age groups are addressed. It is an overall concept for the integrated care of a region.

What is the level of implementation of the intervention?

The local level. "Healthy Kinzigtal" has been implemented in the small region of "Kinzigtal", which is located in Baden-Württemberg and consists of several small towns. In these, 32,000 people live who are insured by the AOK or the Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (formerly LKK) and can thus become members of Healthy Kinzigtal. Various German regions have already shown their interest in Healthy Kinzigtal and, at the end of 2014, a Dutch counterpart of OptiMedis AG was founded, OptiMedis Nederland BV., with the aim of founding comparable projects in the Netherlands.

To which type of interventions does your example of good practice belong to?

Individual intervention and policy/strategy. The objective is to optimise the healthcare and prevention of an entire region. Numerous individual projects and services can be derived from the overall concept of Gesundes Kinzigtal GmbH. The integrated care model in Kinzigtal is one of the few models in Germany with a population based integrated care approach. Healthy Kinzigtal has a holistic public health approach, enabling health and social care professionals and other partners involved to offer a comprehensive package of services to people across indications and health service sectors.

Short description of the intervention:

In 2005, the Medizinische Qualitätsnetz Ärzteinitiative Kinzigtal e. V. – MQNK [Medical Quality Network Doctors' Initiative Kinzigtal] (consisting of 35 general practitioners and medical specialists, 1 psychotherapist and 4 hospital doctors), together with the health science-orientated management and investment company OptiMedis AG, Hamburg, founded the management company Gesundes Kinzigtal GmbH [Healthy Kinzigtal], with the aim to optimise healthcare in the Kinzigtal region.

The integrated regional care model "Healthy Kinzigtal" is pursuing the idea of integrated care orientated towards amplifying the health benefits for the population concerned: to this end, doctors and psychotherapists, physiotherapists, clinics and hospitals, nursing services, clubs and societies, fitness centres and health insurance funds are co-operating closely with a regional management company and its prevention and care management programmes. Gesundes Kinzigtal GmbH is a company that was jointly founded by the Medizinische Qualitätsnetz Ärzteinitiative Kinzigtal (MQNK) e.V. and OptiMedis AG, a management and investment company specialised in integrated care. Based on the triple aim concept of Berwick et al., it has set the following aims: improvement of the health status of the population, better healthcare provision as experienced by the individual and this under efficient use of resources (cost effectiveness).

"Healthy Kinzigtal" derives its strength from the higher healthcare efficiency it achieves. In other words, the actual costs for people insured in the Kinzigtal region should be lower than the average costs on a national level. If this is accomplished, "Gesundes Kinzigtal GmbH" receives a proportion of the "health dividend" achieved. This has been successfully achieved every year since the beginning of the intervention in 2006.

Three main goals ("Triple Aim") are pursued:

- to support and strengthen the health of the population
- to enable the individual to experience better healthcare provision
- to improve the cost effectiveness of healthcare provision

The prevention and healthcare services provided by Healthy Kinzigtal are based on close co-operation across specialist and professional fields between service providers from the healthcare system, on the one hand. Depending on the service and aim, experts from other sectors (sector-wide) are also involved, such as clinics, pharmacists, nutritionists, physiotherapists, social workers and health coaches, and nursing specialists. On the other hand, Healthy Kinzigtal is currently working together with 38 clubs and societies in the region, several fitness studios, six companies and the local authorities of the region.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Gesundes Kinzigtal GmbH is based on a long-term integrated care contract with the AOK Baden-Württemberg [a public health insurance fund] and the Sozialversicherung für Landwirtschaft, Forsten und Gartenbau [Social insurance for agriculture, forestry and horticulture] (formerly LKK). After completion of the first ten years, the contract is to be continued indefinitely with both partner funds from 2016 onwards. Integrated care, as offered by Gesundes Kinzigtal GmbH, overcomes the barriers present in the gesetzliche Krankenversicherung (GKV) [German statutory health insurance], e.g. between the outpatient and inpatient sectors. Among other things as a result of the separation of the two care systems, patients sometimes experience uncoordinated treatment courses. On top of this, additional expenditure may be incurred without any additional health benefit being achieved. This problem area was the starting point for the project "Healthy Kinzigtal".

A further starting point for "Healthy Kinzigtal" was a provision of the best possible care, taking cost effectiveness into consideration. Based on a critical analysis of the existing healthcare system, an alternative model was brought into being: the economic yield is not generated by the number of services provided, but by the health benefit achieved for the population of the region; what is decisive is the development of the delta of the healthcare costs of the health insurance funds involved for all insured persons of the region compared with the revenues of the health insurance funds for these persons (allocations from the central health fund in accordance with the composition of the population). This delta is compared with the time prior to the intervention. To this extent, the economic driver for the service provider and the sponsoring company consists in the development of lower healthcare costs (e.g. fewer dysfunctions requiring inpatient treatment) than develop typically for Germany. Investments in the improvement of the health of the population, whether it be through medical or social activities, through health education, exercise campaigns or programmes for vulnerable and chronically ill population groups, should thus become worthwhile measures. It should be of decisive importance to invest as precisely and as inexpensively as possible in primary and above all secondary prevention to achieve a long-term benefit. A major prerequisite for this was the long (ten-year) term of the contract between Gesundes Kinzigtal GmbH and the health insurance funds. The long-term orientation of the agreed contract provides an incentive to invest in the sustainability of the health benefit and not only to pursue a short-sighted cost lowering policy. (cf. Hildebrandt H., Schmitt G., Roth M., & Stunder B. (2011). Integrierte regionale Versorgung in der Praxis: Ein Werkstattbericht aus dem "Gesunden Kinzigtal". In: ZEFQ 105: 585-89)

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods (e.g. recruitment, location of intervention, concrete activities, and timeframe)?

For the support and implementation of its tasks and goals, the management company maintains its own administrative office with around 18 full-time positions, which cover a broad profile of qualifications (public health, political economics, business economics, sports science, nursing, home care, occupational therapy, medical and commercial assistance staff). The preparation work for this project took around three years.

All activities are planned and supported by the management company. The following is an overview of the health and prevention programmes implemented in the Kinzigtal region, among other things for diabetics and patients with heart failure:

- Strong heart - Targeted against a weak heart (heart failure)
- Healthy weight - Now I'm going to do something about it (metabolic syndrome, including diabetes)
- Good prospects - Care services for children
- In balance - Getting to grips with my blood pressure
- Strong muscles - Solid bones
- Staying mobile - Treating rheumatism at an early stage
- Strong support - My healthy back
- Better mood - Getting to grips with depression
- ÄrztePlusPflege - DoctorsPlusCare
- Good counselling - Help, advice and support in critical times
- Psycho Acute
- Disease management programmes (DMP)
- Smoke-free Kinzigtal, including RiO – smoke-free into the operating theatre
- Social service
- Liberating sounds - In tune with music

In addition, there are numerous co-operation partners from the non-medical field, e.g. local authorities, sports clubs, cultural societies, and companies. For example, Healthy Kinzigtal is co-operating with 38 sports clubs in the region. On the one hand, the members of Healthy Kinzigtal receive discounts at numerous clubs. On the other, physical exercise courses offered by the clubs are building blocks of the above-mentioned health and prevention programmes. Thus, as a part of the programme "Healthy weight", there is a sports course for people who are overweight. This is organised by the Hausach gymnastics club. Or within the context of company health management, e.g. behavioural prevention takes place in the form of lectures, courses on back exercises or on dietary advice directly in the employees' working environment. Otherwise, it would be more difficult to reach them for prevention.

These programmes are developed according to the following schedule. Here is an example of the orientation of the programmes in accordance with the needs of the target groups, taking the example of patients with diabetes:

Intervention diabetes



OpMind AG

2

How is this example of good practice funded?

The initial funding of approximately 4 million euros was provided by the AOK Baden-Württemberg (statutory health insurance fund). These funds were used for establishing the management, the quality assurance, the scientific support and the network itself. The phase of the initial funding in the Kinzigital ended on 1 July 2007.

Since this time, Gesundes Kinzigital GmbH has been financed on the basis of savings contracting, also referred to as a cost-savings agreement, which was agreed with the two health insurance funds AOK Baden-Württemberg and Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (formerly LKK). Only if the healthcare is organised just as well as before the foundation, a higher patient satisfaction of the members has been achieved and a structured procedure has been implemented, does Gesundes Kinzigital GmbH receive payment – in other words a share of the saved expenditures of the two health insurance funds. Further financial building blocks are project and third-party funds – in 2013, these were e.g. funds from a research project on quality indicators for the Kassenärztliche Bundesvereinigung [Association of Statutory Health Insurance Physicians], funds from a project for the Bundesministerium für Bildung und Forschung [German Ministry of Education and Research] and various prize monies.

What are the main aim and the main objectives of your example of good practice?

Three main goals ("Triple Aim") are pursued:

- to support and strengthen the health of the population
- to enable the individual to experience better healthcare provision
- to improve the cost effectiveness of healthcare provision

The three objectives are not to be achieved independently of each other, but influence each other mutually. The aim is to achieve a balance of these three objectives.

The primary objective is to reduce the morbidity load for the population, above all in relation to chronic diseases, by means of prevention, health promotion and empowerment ("health literacy"). Thus, e.g. osteoporosis, heart attacks or strokes, as well as secondary diseases related to diabetes, can be avoided or delayed by exercise training, dietary counselling or help in stopping smoking. An additional objective is to achieve a better interface organisation within and between the outpatient and inpatient sectors, i.e. an efficient co-operation of the service partners both within a sector and beyond sector limits (optimised treatment chain).

Please give a description of the problem the good practice example want to tackle (nature, size, spread and possible consequences of the problem):

Integrated care, as offered by Gesundes Kinzigital GmbH, is aimed at overcoming the barriers present in the gesetzliche Krankenversicherung (GKV), e.g. between the outpatient and inpatient sectors. Among other things as a result of the separation of the two care systems, patients sometimes experience uncoordinated treatment courses. On top of this, additional expenditure may be incurred without any additional health benefit being achieved. Legislation now encourages service providers and health insurance funds to risk more co-operation and integration. This is the starting point for Gesundes Kinzigital GmbH.

Contrary to the interest in maximising performance in the sense of microeconomic yield optimisation, this new form of care pursues a maximisation of health results and a long-term relative reduction of costs. Contrary to the interest in medicalisation, the focus is to be directed towards supporting the self-management capabilities of the people concerned and the promotion of health. In addition, interest is focused on a targeted sustainable investment in prevention and healthcare optimisation for the regional population.

Since Gesundes Kinzigital GmbH has contractually agreed with the health insurance funds to receive the pseudonymised routine data of the health insurance funds for the population in the Kinzigital region, data evaluations can be conducted by Gesundes Kinzigital GmbH and OptiMedis AG, as can be seen in the figures.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. Healthy Kinzigtal is a strategy for a region, taking a network of doctors and building up a regional health network that also comprises actors that do not originate from the healthcare system as stakeholder groups or client/service recipients, e.g. local authorities, schools, sports clubs and cultural societies, companies. Together with two health insurance funds and various different service and co-operation partners, integrated care is organised and provided for the Kinzigtal region.

The management company OptiMedis AG is in the process of building up further regions in Germany along the lines of Healthy Kinzigtal and, to this end, is in contact with around 30 doctor and healthcare networks and hospitals and associations.

The implementation of your example of good practice is/was:

Continuous. The contract started at the end of 2005. The contract was initially limited to 10 years. From 2016, the contract with the two health insurance funds is to be extended indefinitely.

Target group(s):

The target group of Healthy Kinzigtal is the entire population of the Kinzigtal region who are insured by the statutory health insurance funds AOK BW or SVLFG BW, regardless of age or need for care. However, persons insured by other health insurance funds also have the opportunity to participate in Healthy Kinzigtal, but under different preconditions.

During implementation, did specific actions were taken to address the equity dimensions?

One focus of the model "Healthy Kinzigtal" is directed at preventive measures for people with multi-morbid diseases. Although this vulnerable group does not represent an exclusive target group, there are specific services for multi-morbid people. For example, doctors are given advanced training in the optimisation of medication in multi-morbid or elderly people. In addition, training programmes held in the Kinzigtal healthcare academy are aimed at helping multi-morbid patients to adopt appropriate coping strategies.

Further subprojects and services (e.g. Smoke-free Kinzigtal, AGiL – Active promotion of healthcare for the elderly in Kinzigtal, promotion of healthcare for Muslims and other migrants) are directed towards specific vulnerable target groups. As service partners, general practitioners were included who enjoy a high standing particularly among people in a difficult social situation.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

See previous question. On average, people insured by the AOK or SVLFG (from which the participants of Healthy Kinzigtal are recruited) have a lower social status and a lower level of education and show a higher rate of morbidity than people insured by other health insurance funds. cf. Project ICARE4EU Case report Healthy Kinzigtal Germany http://www.icare4eu.org/pdf/Gesundes_Kinzigtal.pdf

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants, (e.g.. including social determinants) and using different strategies (e.g.. setting approach)?

Healthy Kinzigtal's integrated care is one of the few population-based integrated care approaches in Germany, organising care across all health service sectors and indications. The comprehensive approach of Healthy Kinzigtal originates from the conceptual approach of addressing four problems of today's form of healthcare provision.

1. Contrary to the parcellation of the responsibility for healthcare that prevails today (explained by sectoral financing), a new regional level of responsibility was created, which, due to an integrated care contract, generates an economic interest in an optimisation of the overall healthcare provision across all sectors.

2. Contrary to today's interest in maximising performance in the sense of microeconomic yield optimisation, this new level of responsibility is interested in a maximisation of health results and a long-term relative reduction of costs.

3. Contrary to today's interest in medicalisation in the provision of services, this new regional level of responsibility directs the focus towards supporting the self-management capabilities of the people concerned and the promotion of health

4. Contrary to today's care, which tends to be orientated towards short-term effects, this new regional level of responsibility is interested in a targeted sustainable investment in prevention and healthcare optimisation for the regional population, based on the long-term contractual agreement which will be open-ended as of 2016. (cf. Hildebrandt H., Schmitt G., Roth M., & Stunder B. (2011). Integrierte regionale Versorgung in der Praxis: Ein Werkstattbericht aus dem "Gesunden Kinzigtal". In: ZEFQ 105: 585-89)

The respective settings will be integrated into the services of Healthy Kinzigtal, e.g. sports clubs, companies, schools or nursing homes. For example, there are 38 co-operations with sports clubs in the region. On the one hand, the members of Healthy Kinzigtal receive reduced rates at numerous clubs. On the other, physical exercise courses offered by the clubs are building blocks of individual health and prevention programmes (see below). Thus, as a part of the programme "Healthy weight", there is a sports course for people who are overweight. This is organised by the Hausach gymnastics club. This is organised by the Hausach gymnastics club. Or within the context of company health management, e.g. behavioural prevention takes place in the form of lectures, courses on back exercises or on dietary advice directly in the employees' working environment. Otherwise, it would be more difficult to reach them for prevention.

Healthy Kinzigtal is currently offering a large number of health and prevention programmes for specific risk groups and on specific clinical pictures:

- Strong heart - Targeted against heart failure
- Healthy weight - Now I'm going to do something about it
- Good prospects - Care services for children
- In balance - Getting to grips with my blood pressure
- Strong muscles - Solid bones
- Staying mobile - Treating rheumatism at an early stage
- Strong support - My healthy back
- Better mood - Getting to grips with depression
- ÄrztePlusPflege - DoctorsPlusCare
- Good counselling - Help, advice and support in critical times
- Psycho Acute
- Disease management programmes (DMP)
- Smoke-free Kinzigtal, including RiO – smoke-free into the operating theatre
- Social service
- Liberating sounds - In tune with music
- ÄrztePlusPflege - DoctorsPlusCare
- Good counselling - Help, advice and support in critical times
- Psycho Acute
- Disease management programmes (DMP)
- Smoke-free Kinzigtal, including RiO – smoke-free into the operating theatre
- Social service
- Liberating sounds - In tune with music

The comprehensive character of the programme Healthy Kinzigtal becomes particularly clear through the wide variety of different modules offered (in chronological order).

Overview of the modules carried out (from: http://www.icare4eu.org/pdf/Gesundes_Kinzigtal.pdf)

2006	<ul style="list-style-type: none"> • Chronic heart failure management • Diabetes mellitus type II management (Disease Management Programme, DMP) • Breast cancer management (DMP) • Shared decision-making training
2007	<ul style="list-style-type: none"> • Lifestyle intervention for patients with metabolic syndrome • Quit smoking programme (smoke-free Kinzigtal) • Active health promotion for elderly • Intervention by psychotherapists/psychiatrists in case of acute personal crisis • Coronary heart disease management (DMP) • Start of electronic integration of all physicians (central patient record)
2008	<ul style="list-style-type: none"> • Prevention of osteoporosis/ osteoporotic features • Social case management for patients facing problems with finding appropriate information and management for their complex social situation • Asthma management • COPD management
2009	<ul style="list-style-type: none"> • Medical care for the elderly in nursing homes • 'Healthy Kinzigtal gets moving' initiatives • Patient academy classes initiative
2010	<ul style="list-style-type: none"> • Start of planning health and fitness training centres • Better management of major depression • Start of central electronic patient records
2011	<ul style="list-style-type: none"> • Physical exercises and treatment for patient with back pain • Early detection of treatment of rheumatic disorders • Hypertension and prevention of renal diseases • Improving medication adherence of elderly patients by distributing unit dose blisters
2012	<ul style="list-style-type: none"> • Health promotion programmes for unemployed • Reduction of antibiotic medication for various indications • Music therapy for patients with chronic pain problems • Start of a new approach to the development of a central electronic patient record connecting all physicians
2013	<ul style="list-style-type: none"> • Educational campaign for incontinence and pelvic floor training • Health promotion/health management for small and medium-sized companies and their employees • Coaching high cost patients with complex psycho-social needs (enlargement of the social coaching programme) • Start "Selbstbestimmt&Sicher", a programme supporting elderly and sick patients by using monitoring devices to detect falls and to ensure their safety in their own apartment or house (to reduce unnecessary nursing home stays and hospitalisation) – an EC funded project on "ambient assisted living" • Start of the new central electronic patient record connecting all physicians (CGM-net) • Start "Gesundheitsakademie Kinzigtal [health academy Kinzigtal+]" – a training and education institute mainly for health care professionals
2014	<ul style="list-style-type: none"> • Reduction of delirium stages for patients in hospitals: to reduce the number of anxiety and complications after a surgery (GK in collaboration with the hospital staff) • Smoke free intervention before a surgery together with GP's and hospitals –

	supporting patients to stay free of smoking 4 weeks prior to elective surgery and offering smoke free training <ul style="list-style-type: none"> • "Beyond Silos" – EC-funded project to connect the ICT-systems of the central electronic patient record of the physicians with the ICT-system of social care • Screening interventions for the population with a migration background and their specific health needs
2015	<ul style="list-style-type: none"> • Start of the construction of a training and education centre "Gesundheitswelt Kinzigital *world of health+" • Start of "Gesunde Betriebe im Kinzigital *Healthy companies in Kinzigital+" – a network of small and medium sized companies dedicated to improve the health of their employees and families • Implementation of a version 2.0 of several programmes having already started in earlier years (after evaluation and redesigning the outlays of the programmes)

Was an effective partnership in place?

When Healthy Kinzigital was founded, there was already an existing network of doctors, the Medizinisches Qualitätsnetz – Ärzteinitiative Kinzigital e.V., with an intersectoral composition of general practitioners, medical specialists, hospital doctors and psychotherapists. Over the course of time, the network of providers was enlarged by further partners, such as hospitals, nursing homes, outpatient nursing services, psychosocial counselling centres, physiotherapists, and pharmacists. Sports clubs, cultural societies and fitness centres have also become co-operation partners. In addition, Gesundes Kinzigital GmbH is currently collaborating with welfare organisations in several research projects (EU projects "Smart Care" and "Beyond Silos", BMBF project "Selbstbestimmt und sicher" ["Self-determined and safe"]).

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

In 2000, integrated care was taken up in the Sozialgesetzbuch V (GKV) [German Social Welfare Code], according to which networks of doctors and management companies were permitted to conclude contracts directly with health insurance funds. The Gesundheitsmodernisierungsgesetz (GMG) [Health Modernisation Act] of 2004 also envisaged an initial funding for integrated care (nationally) for the years 2004 to 2008. These framework conditions were the basis for the integrated care model Healthy Kinzigital. The contract with the AOK Baden-Württemberg was signed in 2005, which was followed a year later by today's Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (formerly LKK). (Regional level)

Was the intervention implemented equitably, i.e. proportional to needs?

Several routes are available for identifying the needs for an intervention (e.g. a health programme): Either possible regional need is expressed from routine practice, e.g. by doctors, e.g. regarding a specific clinical picture. This suspected need is then recognised on the basis of statistical and scientific analyses as being relevant for the population or a subgroup, or not. Or the need may be identified on the basis of a "desk analysis" and then discussed with the practitioners and patients. The process of determining needs and intervention planning ideally looks like this:



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This process of statistical and scientific analysis in interaction with the practitioners (general practitioners and medical specialists, among others) as well as the people concerned (patients) guarantees that the interventions are appropriately planned and implemented in the healthcare process.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Upon signature of the contract with the AOK, a patients' advisory committee was established, which, in the first six months (when insured persons could not yet enrol = development phase), was made up of representatives of regional clubs and societies, self-help and social institutions in co-operation with the health insurance funds. The proposed interventions were presented to the patients' representatives and then, in response to their feedback, varied as appropriate or chronologically brought forward or put back. Since the second year of the contract, the patients' advisory committee has been elected at members' meetings and is closely involved in intervention planning. Most recently, the five-member committee was, e.g. included in the planning of an approach for "health literacy" and self-management promotion for chronically ill people.

Since patients and doctors jointly agree on goals that are to be achieved, the patient is integrated in the decision making and agreement seeking processes from the very start of the programme:

Patients who enrol in the care model "Healthy Kinzigtal" can select a doctor or psychotherapist who will coordinate the treatment for them as a doctor of their trust. According to the salutogenetic principle, the patients are asked upon enrolment about what health goals they consider to be realistic and their experiences with overcoming limitations. In addition, an extended check-up examination is performed in order to ultimately jointly elaborate the individual development potential and appropriate treatment goals. To this end, the participating doctors were trained in the shared-decision-making (SDM) method. In order to achieve these (target) agreements between the doctor and patient, among other things the health programmes developed for the participants by Gesundes Kinzigtal GmbH are utilised. As a result of the specific selection of programmes offered, above all patients suffering from chronic diseases felt addressed to begin with, but the circle of members has swelled in the meantime due to the extension of services offered. The overall medical concept is orientated along the "Chronic Care Model" (CCM),

which combines a targeted activation and increase in the competence of the patient with regard to their illness with an organisational development process in the doctors' practices, a competence development for the specialist medical staff and an influence on the surrounding environment.

Did the evaluation results achieve the stated goals and objectives?

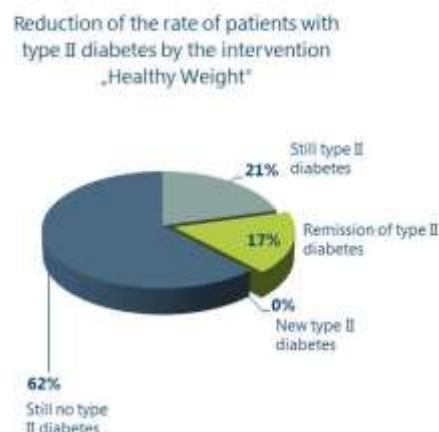
Healthy Kinzigtal is being evaluated externally and internally via a mix of diverse quantitative and qualitative methods. The evaluation results achieved the three main goals ("Triple aim"):

Population health (health status of the population): The majority of the quality indicators examined by the external scientific evaluation (PMV Forschungsgruppe der Universität zu Köln [PMV Research Group at the University of Cologne]) show positive developments. For example, the prevalence of patients with fractures among all insurants with osteoporosis. In 2011, this prevalence was approximately 26% in the "Kinzigtal" population (≥ 20 years old), compared with 33% in the control group. Further, the PMV research group has analysed the process quality among insurants with chronic CHD. The proportion with cardiologic examinations among the patients with chronic CHD was markedly higher in the group of IV-insurants (40.9%) than in the group of non-IV-insurants (34.3%). (cf. Köster, I, Ihle, P, Schubert I (2015): Evaluation report 2004-2011 for Gesundes Kinzigtal GmbH, AOK data, Cologne).

The following two figures show the results regarding prevention in diabetes development.

Prevention of the progression of type II diabetes (Intervention: „Healthy Weight“)

- 62% of the participating individuals were patients without type II diabetes at the start of the program and all of them kept that status
- The other 38% were patients with type II diabetes at the start of the intervention, but 17% recovered from this status and became non-diabetic patients
- This means that for four out of ten patients a remission of the disease could be observed (HbA1c < 5,7%)!



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Patient experience (individual experience of healthcare): To the question "Would you recommend becoming a member of Healthy Kinzigtal to your friends or relatives?" A total of 92.1% of those questioned answered with "Yes, for sure" or "Yes, probably". 24% of those questioned further stated that they now live "more healthily" than before enrolment in the Integrated Care System Healthy Kinzigtal (ICSGK). In the sub-group of questioned insurants who had objective agreements with their doctors, 45.4% gave this answer.

Cost effectiveness: For both participating statutory health insurers, cost savings relative to the normally expected costs for the ICSGK population concerned are observable in every year. For example: In the eighth year of intervention (2013), the cost savings amount to a total of 4.65 million € for the AOK Baden-Württemberg. This represents a contribution margin of 148€ per insurant (31,156 insurants concerned).

(cf. Hildebrandt, H., Pimperl, A., Schulte, T., Hermann, C., Riedel, H., Schubert, I., Köster, I., Siegel, A., Wetzel, M. (2015): Triple-Aim-Evaluation in der Integrierten Versorgung Healthy Kinzigtal – Gesundheitszustand, Versorgungserleben und Wirtschaftlichkeit. Bundesgesundheitsblatt – Gesundheitsforschung – Gesundheitsschutz, 4-5)

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. The project is being evaluated over its entire duration. The Evaluationskoordinierungsstelle Integrierte Versorgung Gesundes Kinzigtal (EKIV, www.ekiv.org [Evaluation Coordination Agency Integrated Care Healthy Kinzigtal]) has been contracted to perform the evaluation. The coordination agency was set up at the beginning of the intervention in Kinzigtal at the Department of Medical Sociology of the University of Freiburg. The evaluation is carried out under the inclusion of specialist scientific societies and organisations in the field of healthcare research. There are annual work reports and research reports for specific individual services. (cf. "Evaluation" section).

The EKIV coordinates, among other things, an evaluation model concerning an oversupply, undersupply or inappropriate supply of care in Healthy Kinzigtal. Further evaluation modules are concerned with the implementation of Shared Decision Making (SDM), coaching of the officials responsible for the integrated care and the process evaluation from the viewpoint of the service providers (COPE). Since 2012, the members of Healthy Kinzigtal have been polled (GEKIM). In addition, individual programmes of Healthy Kinzigtal are regularly evaluated.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes. For the ongoing management, standardised feedback reports for care providers, the network management, the project management team and other stakeholders of the integrated care system have been implemented. A set of indicators was created that is constantly evolving and giving relevant information and was specifically established for this purpose (cf. Annex 3). These reports have been developed under strong involvement of all relevant stakeholders and are produced and distributed quarterly via an online platform. The network management and physician reports currently include about thirty indicators providing information about different components of care, presented in a framework referring to the Donabedian Model with the three categories of "structure", "process" and "outcomes". The software used to view the reports allows an overview with high information density but also provides detailed analysis for each indicator (Pimperl *et al.*, 2015).

Third quarter of 2013**Quality indicators and key figures**

Your practice
(practice 8)

Ø-LP-
GP's

Ø-NLP-
GP's

Min /
Max GP

3. Outcomes: Which impacts have interventions on medical and financial outcomes and patient satisfaction?

3.1 Economical outcomes	Allocation (Morbi-RSA) per patient		1,021,11	914,19	834,46	1,115,86
	- Total costs per patient		826,54	917,89	841,14	668,74
	= Contribution margin per patient		194,56	-3,70	-6,68	215,30
3.2 Health outcomes	Hospital cases per 1.000 patients (risk-adj.)		68,01	91,39	93,99	59,41
	Decedents % (risk-adj. mortality)		0,00 %	0,43 %	0,32 %	0,00 %
	Patients with osteoporosis & fracture %		1,8 %	1,3 %	1,3 %	0,0 %
3.3 Patient satisfaction	Impression of practice very good - exc. %		66,7%	61,0%		83,3%
	Med. treatment very good - exc. %		52,8%	53,0%		79,2%
	Recommendation likely - certain %		85,2%	84,6%		95,6%

2. Process - What must we excel at?

2.1 Diagnostic quality	Unspecified diagnoses %		26,3 %	27,7 %	34,3 %	17,0 %
	Suspected diagnoses %		1,8 %	1,4 %	1,6 %	0,8 %
2.2 Utilization	Patients >= 35 with health-check-up %		9,1 %	8,0 %	7,8 %	12,8 %
	Patients incapable of working %		27,2 %	25,3 %	26,8 %	18,1 %
	Length of incapacity for work		2,71	2,48	2,74	1,76
2.3 Improvement of Medication	Generic quota		92,2 %	88,5 %	87,0 %	92,2 %
	Pat. with heart-fail. & guideline prescr. %		72,7 %	71,5 %	68,8 %	84,6 %
	Patients >= 65 with pot. inad. med. (PRISCUS) %		14,4 %	11,6 %	11,2 %	5,6 %
	Patients >= 65 with inad. med. (FORTA D) %		10,2 %	9,0 %	9,9 %	5,5 %

1. Structur - What is the target population? Where can we

1.1 Patient structure	1.1.1 Age, gender, etc.	Ø-Number of patients		481,0	480,9	326,1	934,0
		Ø-Age		57,68	55,31	52,96	54,2
		Female %		57,6 %	56,3 %	55,7 %	67,8 %
		Patients capable of work %		53,6 %	58,1 %	59,2 %	75,7 %
		Patients dependent on care %		8,7 %	8,3 %	7,7 %	4,2 %
1.1.2 Morbidity		Ø-Charlson-comorbidity-score		2,15	1,37	1,26	0,75
		Regional GP-risk-score (Ø = 1,00)		1,16	1,04	0,95	0,81
1.1.3 Enrollment		Participants Integrated Care %		86,5 %	58,5 %	10,7 %	86,5 %
		Participants Disease Management Programs %		71,0 %	54,9 %	34,4 %	80,1 %
1.2 Learning & innovation		Participation in quality circles (Ø = 1,00)		1,50	1,00	-	4,00

Who did the evaluation?

Internal evaluation is performed by the contractual partners AOK Baden-Württemberg and SVLFG BW, as well as OptiMedis AG. Externally, the evaluation is coordinated by the EKIV and carried out by research institutions (cf. www.ekiv.org)

Specifically, what has been measured/evaluated?

Process evaluation: The evaluation project with the title "Identification and reduction of oversupply, undersupply or inappropriate supply of care – Care evaluation on the basis of routine data from the statutory health insurance" has the central aim of describing the relative development of the quality of care in the Kinzigtal region in longitudinal comparison, especially for selected common diseases (coronary heart disease, heart failure, dementia, diabetes, hypertension, etc.) on the basis of indices. For this purpose, pseudonymised routine data from the statutory health insurance for individuals insured by the AOK Baden-Württemberg and the Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (formerly LKK) for the years 2004-2011 were available. The evaluation follows the design of a quasi-experimental controlled study. Prevalences, indices and quality indicators that were determined for the interventional group are compared with data from a sample representative for the whole of Baden-Württemberg (AOK and SVLFG, the control group). Both groups comprised persons over the age of 20 years.

Evaluation of the impacts/effects: The quality of the medical outcomes, the health-economic effects (cost effectiveness), patient satisfaction and professional satisfaction of the participating doctors are measured. Central questions are the extent to which a quality improvement and a stronger patient activation can be achieved, which indicators can validly measure health outcomes in patients in medical practices, whether the project can be implemented in standard care, whether it is more cost effective than standard care without sacrificing quality, and whether the communication and specialist co-operation of the healthcare providers are improved.

The incidence of a fracture secondary to osteoporosis was documented as 26 % in the "Kinzigital" population in 2011. In the comparative population, this proportion was 33 % (quasi-experimental control study). A quasi-experimental cohort study conducted since 2012 suggests that the intervention leads to a lower mortality: in the first four years after intervention, the mortality rate is 14 percent lower in 5,411 "IV-insurants" from Healthy Kinzigital investigated than in the "non-IV-insurants".

Satisfaction of the insurants and patients with the IV Healthy Kinzigital is the subject of the GeKiM study (Healthy Kinzigital – member survey). The GeKiM study is designed as a trend study. The first wave of the survey took place in 2012, further surveys are to be conducted at two-year intervals. 3,030 members received a standardised questionnaire. A total of 717 (23.6 %) completed this questionnaire. 92.1 % of the participants stated that they would recommend IV Healthy Kinzigital "definitely" or "probably". In addition, 24 % of those surveyed said that they now "live more healthily".

As regards the costs, a positive result compared with the reference population can be attested across all years in both health insurance funds. In the eighth year (2013), a contribution margin plus of 4.65 million euros was achieved by the AOK Baden-Württemberg. For individuals insured by the AOK BW, an improved contribution margin of 148 euros per head is thus achieved.

What are the main results/conclusions/recommendations from the evaluation?

Beside the above-mentioned results on the quality and cost effectiveness of the integrated care in the Kinzigital region, both the high "patient satisfaction" and the satisfaction of the service partners of Healthy Kinzigital with the IVGK are particularly prominent in the evaluation. One quarter of the participants surveyed state a change towards a healthy lifestyle. The majority of evaluated indicators on care quality point towards a very positive development. Among the service partners, almost 95% stated that they would both become a member in Healthy Kinzigital again and recommend membership to their colleagues. As a whole, the Evaluations-Koordinierungsstelle Integrierte Versorgung (EKIV) draw a positive interim conclusion concerning care in the Kinzigital region: In many areas, signs of a relatively high quality of care can be identified, which frequently increased – also in comparison with the rest of Baden-Württemberg – in the period 2004-08. Much more rarely, there are indications of an (absolute or comparative) deterioration in the quality of care. The EKIV considers the evaluation of the integrated care model Healthy Kinzigital to be suitable for providing practice-relevant answers to important questions on the development of future healthcare provision in Germany.

Is the evaluation report available?

See: www.optimedis.com, www.gesundes-kinzigital.com, www.ekiv.org English newsletter

In German:

http://www.ekiv.org/pdf/EKIV-Evaluationsbericht_2010_Kurzfassung_fin_2011-02-24.pdf

http://www.ekiv.org/pdf/EKIV-Evaluationsbericht_2011_Kurzfassung_FINAL_2012-06-30.pdf

<http://optimedis.de/files/Publikationen/Studien-und-Berichte/2014/Mortalitaetsstudie-2014/Mortalitaetsstudie-2014.pdf>

http://optimedis.de/images/.docs/aktuelles/121026_drei_dimensionen.pdf

Was there a follow-up or is any follow-up evaluation planned in the future?

For Gesundes Kinzigtal GmbH, the constant evaluation of the results is an integral part of its corporate culture. Thus, among other things, the routine data from the statutory health insurance are used for a continuous evaluation, e.g. on oversupply, undersupply and inappropriate supply or for individual health programmes. Also surveys, e.g. on satisfaction of the members, are conducted at two-year intervals.

Who implemented the intervention?

Gesundes Kinzigtal GmbH was founded in 2005 by the Hamburg Company OptiMedis AG and the medical network "Medizinisches Qualitätsnetz – Ärzteinitiative Kinzigtal". The medical network brings its medical expertise to Gesundes Kinzigtal GmbH; OptiMedis AG its health science and management expertise. The director of OptiMedis AG is at the same time the managing director of Gesundes Kinzigtal GmbH and has a professional background in pharmaceuticals and public health, as well as articles for the WHO on health promotion and healthy cities / health promoting hospitals.

What core activities are/have been implemented?

1. Care and prevention programmes for the prevention of health risks, for improvement of the health status and quality of life of vulnerable groups of individuals.
2. Case management for supporting individual patients in health-related and social problem situations.
3. Patient activation by means of numerous different services in the form of lectures, courses on various different health topics.
4. Corporate health management for prevention of health risks in the corporate context.
5. Practice management for the supervision and support of partner practices.
6. Information and communication technology (ICT): use of integrated information and communication technology, among other things electronic patient files, for better coordination in the care of patients.

Was the intervention designed and implemented in consultation with the target population?

The integrated care model Healthy Kinzigtal was initially planned with the doctors of the region and in part with the AOK Baden-Württemberg. Upon signature of the contract with the AOK, a patients' advisory committee was established, which, in the first six months (when insured persons could not yet enrol = development phase), was made up of representatives of regional clubs and societies, self-help and social institutions in co-operation with the health insurance funds. The proposed interventions were presented to the patients' representatives and then, in response to their feedback, varied as appropriate or chronologically brought forward or put back. Since the second year of the contract, the patients' advisory committee has been elected at members' meetings and is closely involved in intervention planning. Most recently, the five-member committee was, e.g. included in the planning of an approach for "health literacy" and self-management promotion for chronically ill people.

Did the intervention achieve meaningful participation among the intended target population?

The programmes of Healthy Kinzigtal are based on a patient-orientated approach. In order to integrate patients as comprehensively as possible, various different aspects are taken into account. On the one hand, treatment plans are individually agreed with each member/patient. On the other hand, doctors and patients jointly agree the goals to be achieved (target agreement), so that the self-management of the patient and the "shared-decision making" are strengthened and improved.

In addition, there is a patients' advisory committee, which functions as a mediator between patients and the company or its service partners and involves the patients in the development of the programmes. In the case of concrete problems, an ombudswoman meets with the persons concerned in order to find a solution. In addition, there is a right to have a say in the make-up of the care, e.g. through members' meetings. Every two years, the participants are asked how satisfied they are with the care in the Kinzigtal region.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Since 2013 a health academy has been established, which enables not only medical staff but also interested people who live in the Kinzigtal region to inform themselves about health-relevant subjects. In addition, in order to improve the doctor-patient interaction in the IVGK, courses are offered for patients and practitioners for the further development of communicative and causative competences or target agreements, which risk patients develop jointly with the doctor of their trust.

Also through the target agreements between doctors and patients, in which the goals to be achieved are specified, the self-management of the patients and the "shared-decision making" are strengthened and improved. Thus, results of a patient survey conducted in 2014 show that patients who had made such a target agreement with their doctor, e.g. were more successful in taking up a healthy lifestyle than patients without a target agreement. Nevertheless, many patients remain reluctant about taking on more responsibility and empowerment with regard to their health. Patients are mostly not used to such an equal footed relationship with their doctor. Such a change and development requires time and Healthy Kinzigtal wants to promote and facilitate this process step-by-step.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Fundamentally, the project is directed towards the entire population of the Kinzigtal region. Since Healthy Kinzigtal was founded in order to create "better organised healthcare provision" in the Kinzigtal, it was and remains absolutely necessary to examine the target population of the Kinzigtal region for their concerns and needs. Among other things, this is illustrated by the fact that insurants with disproportionately high morbidity values were preferentially motivated to enrol in Healthy Kinzigtal. In addition, success was achieved in motivating above all elderly insurants and pensioners to enrol. These insurants were subsequently offered special prevention and hospital management programmes. All other specific services of Healthy Kinzigtal were tailored towards the respective target groups.

For the objective of Healthy Kinzigtal to achieve a reduction in morbidity above all in relation to chronic diseases thanks to a targeted promotion of preventive services, it is prerequisite for the needs of the target population of the Kinzigtal region to be determined.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

On the one hand there are the service partners from medicine and therapy, on the other partners with whom Healthy Kinzigtal works as a company. These include sports clubs and cultural societies, fitness centres, companies from the region, schools and many other partners. Apart from this, Healthy Kinzigtal co-operates project-wise with various different pharmacies in the region. In order to promote healthcare provision on a political level and in society as a whole, Healthy Kinzigtal is currently involved in several EU and other projects.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

It is planned that the AOK Baden-Württemberg and the Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG) will continue the contract for an unlimited period from 2016 onwards. In addition, Healthy Kinzigtal is in discussion with other health insurance funds and insurance companies, concerning opening up the services of Healthy Kinzigtal to people insured by other health insurance funds.

In addition, Gesundes Kinzigtal GmbH is consolidating its activities. For example, in the expansion of medical care and in the training of young doctors, with which the medical and therapeutic care in the Kinzigtal region will also be ensured in the long run. At the end of 2015, the "Gesundheitswelt Kinzigtal" ["Kinzigtal World of Health"] will open in Hausach under the ownership of Gesundes Kinzigtal GmbH. The *World of Health* comprises among other things a

training centre with special exercise and fitness offers for people with appropriate risks or diseases, as well as the health academy, in which lectures for the population or advanced training courses for service providers are offered.

Is there a broad support for the intervention amongst those who implement it?

Healthy Kinzigtal and its company have been in existence for almost 10 years. A large network of service and corporation partners supports the integrated care of the patients. An evaluation project ("Process evaluation from the viewpoint of the Healthy Kinzigtal service providers") has surveyed the satisfaction of the Healthy Kinzigtal service partners with the IVGK project and their affiliation to the IVGK since 2008. In 2010, 94% of the responding service partners stated that they would "become a member of Healthy Kinzigtal again" if they had the choice, and also 94% of the responders would "recommend membership to others".

Is there a broad support for the intervention amongst the intended target populations?

Since 2006, the membership figures of Healthy Kinzigtal have continuously increased. It started with 875 members in 2006. At the end of 2013, 9,806 people had decided to become members of Healthy Kinzigtal. Further, a survey on patient satisfaction (GEKIM) shows that more than 90% of the currently enrolled insureds "would definitely or probably enrol again if they were given the choice".

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

Yes, in a very comprehensive form for a total period of 10 years. The measures are orientated towards the formulated goals: improvement of the health status of the population, better healthcare provision as experienced by the individual, efficient use of resources (cost effectiveness). These goals are orientated towards the "triple aim" approach of Berwick.

Were sources of funding specified in regards to stability and commitment?

The initial funding of approximately 4 million euros was provided by the AOK Baden-Württemberg. These funds were used for establishing the management, the quality assurance, the scientific support and the network itself. The phase of the initial funding in the Kinzigtal ended on 1 July 2007. Since this time, Healthy Kinzigtal has financed itself solely from the success of its work. The financing is based on savings contracting, also referred to as a cost-savings agreement, which was agreed with the two health insurance funds AOK Baden-Württemberg and Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (formerly LKK). Only if the healthcare is organised just as well as before the foundation, a higher patient satisfaction of the members has been achieved and a structured procedure has been implemented, does Gesundes Kinzigtal GmbH receive payment – in other words a share of the saved expenditures of the two health insurance funds.

Were organisational structures clearly defined and described?

The team of the administrative office of Healthy Kinzigtal organises and plans the integrated care in the Kinzigtal region. More than 200 people are directly and indirectly involved in the optimisation of the healthcare in the region: general practitioners, medical specialists and hospital doctors, psychotherapists, physiotherapists, nursing services, the specialist medical staff of the practices, pharmacists, numerous clubs and societies, institutions – as well as people who are working in the administrative office on co-operation with all of those concerned. More than 20 people are currently employed in the administrative office – both full- and part-time. They include specialists for business and political economics, health economics, health science and health management, sports science, administration, public relations, marketing and media work, information technology and practice management.

The work of the administrative office is distributed over several supporting pillars. In accordance with the approach of the integrated care model Healthy Kinzigtal, the four departments networking & supply, administration & research, health management, as well as communication & information work across sectors. Each department has a departmental head, which form the management circle together with the managing director. They set the course for the company and are supported by the medical advisory committee in medical questions and by the patient's advisory committee in questions of member involvement.

Is the potential impact on the population targeted assessed (if scaled up)?

There is a continuous scientific evaluation of the services offered by Healthy Kinzigtal. For this purpose, the management company of Healthy Kinzigtal and the participating health insurance funds have set up a coordination agency at the University of Freiburg. The scientific research shows that the care in Kinzigtal has improved in numerous clinical pictures compared with the care provided to date. The survey of patient satisfaction also shows that more than 90% of the currently enrolled insureds "would definitely or probably enrol again if they were given the choice".

Are there specific knowledge transfer strategies in place (evidence into practice)?

The transferability of the shared-savings model on a national level is limited as the delta of costs savings would decrease accordingly (long-term perspective), although an estimated 25% of all regions in Germany would have to implement a comparable model of integrated care to realise this potential threat. The perspective of extra funding from potential savings served as a powerful incentive for stakeholders to participate, which has contributed to the success of the programme. A national rollout of the Healthy Kinzigtal model would require a new funding method. However, the shared savings model can play a role in transitioning towards a more integrated delivery system and contribute to a cultural change. The programme's transferability has not been evaluated yet, but a pre-existing physician network would be helpful for the implementation within another region. Nevertheless a similar programme is planned to be implemented in Billstedt-Horn, a part of the city of Hamburg that has a population with a low social status. Further programme expansions are being negotiated in the Saarland, Baden-Württemberg and Berlin; implementation is planned for 2016.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

There are deliberations and also initial discussions about extending the programme Healthy Kinzigtal to other federal states in Germany. In general, there are potential hurdles in the fact that, on the one hand, nursing care insurance is not included in Healthy Kinzigtal, although this would be advantageous for a comprehensive integrated care. On the other hand, health insurance funds receive less risk structure compensation the healthier a person is, which may have a deterrent effect for them.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Of benefit at the start of the intervention in 2006 was undoubtedly the statutory initial funding for integrated care projects (2004 to 2008) and further the Alliance of medicine (represented by the doctors' network), health-science and management know-how (represented by OptiMedis) and cost bearers (represented by the AOK Baden-Württemberg). The most important factors for the success of the intervention are:

- Assumption of the responsibility for organisation by a professional management company
- Care programmes with health-promoting and secondary preventive elements, extending across specialist fields, professions and in part sectors
- Continuous data analysis, controlling and evaluation for constant optimisation of the intervention
- Therapeutic alliance of doctors and patients through diverse measures; the patients become co-producers of their health (shared decision making)

- New incentive structures for promotion of quality instead of quantity through an innovative financing model.
- Mutual acquaintance and trust of the actors involved in the intervention, e.g. the doctors, nursing, physiotherapy, hospital.

What were, in your opinion, the main lessons to be learned?

- "There is no free lunch": Interventions like those in the Kinzigtal region initially require investments in the care processes and structures.
- The actors involved, e.g. doctors, must also have a sense of responsibility among each other, and the area covered by the intervention should only be as big as allows mutual acquaintance and trust. Therefore, a regional context is beneficial and necessary.
- Interventions need time and patience. Therefore, we plead for contract terms of at least 6 to 10 years.
- Since services follow money, incentive systems must be designed in integrated care in such a way that the recovery and health of the patients – and not simply an increase in services – is remunerated.

Web page related to the intervention

<http://www.gesundes-kinzigtal.de/>

References (with possible links) to the most important articles or reports on the intervention:

<http://publications.jrc.ec.europa.eu/repository/bitstream/JRC93763/jrc93763.pdf>

<http://www.who.int/servicedeliverysafety/areas/people-centred-care/evidence-overview/en/>

http://www.kingsfund.org.uk/publications/population-health-systems?goback=.gde_5095119_member_5976047907332202497

http://www.icare4eu.org/pdf/Gesundes_Kinzigtal.pdf

<http://www.ncbi.nlm.nih.gov/pubmed/25201659>

http://www.gesundes-kinzigtal.de/media/documents/EKIV-Evaluationsbericht_2011_GESAMT_FINAL_2012-06-30.pdf

Other relevant documents:

http://www.icare4eu.org/pdf/Gesundes_Kinzigtal.pdf

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Gaining Health: Making Healthy Choices Easier Italy

Title in original language:

Guadagnare salute: rendere facili le scelte salutary

Which 'life stage' for CVDs prevention targets the intervention?

The Program "Gaining health: making healthy choices easier" is a national Government strategy, according to the principles of the "Health in All Policies". The program promotes health and equity in health throughout the course of life. This means not only to ensure a good start to every child (with prevention interventions before pregnancy, protection of maternity and new families and protection interventions, promotion and support of breastfeeding), but also to prevent unhealthy behaviours that often are established during childhood and adolescence, to ensure education for all, to reduce the risk of chronic diseases in adults, to get to a healthy and active aging. Interventions of the program are therefore targeted to the citizens in all ages, in the contexts of life and work, according to the "life course" approach.

Short description of the intervention:

The Program "Gaining health: making healthy choices easier" is a national Government strategy based on the "Health in all policies" aimed to promote cross-sector actions, facilitate behaviours with positive impact on people's health and prevent NCDs, acting on the main modifiable common risk factors (tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity.)

The specific areas of the program are:

GAINING HEALTH by making a healthier diet easier (diet)

GAINING HEALTH by making it easier to move and do physical activity (physical activity)

GAINING HEALTH by making it easier to quit smoking (fight against smoking)

GAINING HEALTH by making it easier to prevent alcohol abuse (fight against alcohol abuse)

The program develops a "life course" approach and intersectorial policies for preventing non communicable diseases with the aim to:

- tackle health inequalities,
- support food choices nutritionally correct,
- promote an active lifestyle
- guide policies to build urban environments that encourage physical activity.

The Strategy is in line with the WHO and EU policies. In developing the national strategy, the Ministry of Health plays a leading role by advocating, inspiring and guiding the multisectoral action. In fact, the MoH signs several "Memoranda of understanding" with other Ministries, other public and private sectors, in order to achieve specific objectives.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Non communicable diseases represent an issue which needs a global response as they cause premature deaths, affect development and pose social challenges in most countries worldwide. The global scenario regarding non communicable diseases confirms the absolute need to adopt strategies and programmes that set clear priorities and identify major health problems. Italy has given priority to contrast risk factors and enhance positive determinants with major investments in prevention and intersectoral interventions that involve many public

institutions and civil society and has adopted a “long-term” and “multicomponent” strategy. The reduction of the impact on the population of cancer, cardiovascular diseases, diabetes and chronic respiratory diseases can be achieved through the development and strengthening of policies and programmes promoting healthy lifestyles and preventing chronic conditions, with special emphasis on “health determinants”, and through the implementation of appropriate “cross-sector” policies at the national, regional and local level. In fact, these chronic diseases have in common risk factors such as tobacco use, harmful use of alcohol, unhealthy diet, overweight and/or obesity, and physical inactivity, and they are strictly related to unhealthy individual behaviour and to the economic, social and environmental context in which people live and work.

Development of the Italian NCD strategy: In autumn 2006, the Italian Ministry of Health started the development of a national strategy to address the growing burden of chronic diseases and to promote healthy lifestyles. To launch the development process, in October 2006, the Ministry of Health held a stakeholders meeting with representatives of the ministries dealing with economy, development, education, transport, agriculture, environment, and sport, as well as of trade unions, the National Institute of Health, the National Institute of Nutrition, municipalities, local government and various associations. This was followed by various working meetings during which the strategy was elaborated and, in May 2007, it was adopted by a decree of the Prime Minister. The strategy is called “Guadagnare salute: rendere facili le scelte salutari” [“Gaining health: making healthy choices easier”] and builds on and link to the national prevention plan, which was adopted by an agreement between the national and regional levels in 2005. The strategy was named after, and refers to the work being carried out under Gaining Health: the European strategy for the prevention and control of non-communicable diseases adopted by the WHO Regional Committee for Europe in 2006. That Strategy takes also into account the approach of the WHO Framework Convention on Tobacco Control (2003).

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

This program aims to fight risk factors in a coordinated way, with an approach not just including health aspects but which encompasses environmental, social and economic implications, and requires all involved stakeholders (central and regional governments, local agencies and the private sectors) to share objectives.

To act effectively against NCDs and tackle health inequalities, Gaining Health plays a role of stewardship, orienting regional planning and realizes actions aimed to:

- “System governance” (inter-sectoral agreements, surveillance systems on the determinants and monitoring of the actions)
- Capacity building (training at a distance, to support the transfer of best practices, sharing of tools, meetings)
- Communication, Information, education

The strategy:

- promotes people “empowerment” towards healthy choices
- supports interventions to create environmental conditions that facilitate healthy behaviours.

The definition of reciprocal responsibilities, through widely coordinated planning and activation of comprehensive actions and interventions on the various determinants, increases effectiveness and optimizes the use of resources. The actions of advocacy include the active involvement of sectors outside the health system, both government and civil society (Ministries, municipalities, professional associations and unions, consumer associations, food industry, mass media, etc.), as recommended by the European Union (EU) and the World Health Organization (WHO).

To which type of interventions does your example of good practice belong to?

Policy/strategy. National and local government, with the leadership of the Health system, acts through:

- information, which can increase awareness
- regulatory actions, included in intersectoral strategies to change the living environment
- allocation of specific resources to support exemplary actions

Harmful behaviours create diseases which are a burden on the healthcare and social welfare systems, but are not caused by these systems.

Gaining Health policies aims to (for example):

- encourage movement and physical exercise (public transport and urban green spaces)
- encourage fruit and vegetable intake
- reduce the concentration of salt, sugars and fats in foods
- reduce the amount of high calories food in the diet
- discourage smoking as much as possible
- reduce alcohol abuse

These policies are implemented by the intervention of various Ministries, the Italian Regions, the Public Healthcare System, the Municipalities as well as by agreements with producers and distributors and other involved subjects.

How is this example of good practice funded?

National/regional/local government. The program has not a specific budget. The activities of the program are partially funded by the Centre for Diseases Prevention and Control (CCM) of the MoH and by the National Prevention Plans (2010-2012 and new 2014-2018) that develop at Regional level the intersectoral approach of “Gaining Health”, implementing actions in specific health areas and promoting the involvement of other sectors, with the leadership of the Local Health Services.

Moreover, each subject (public or private) can contribute, as a stakeholder, to the implementation of “Gaining health,” putting into place their specific and/or sectorial actions (for example food industries and food distributors have financed activities to promote healthy foods or to reformulate foods, particularly salt reduction in bread and frozen meals). This contributes to prevent intervention fragmentation, dispersion of human and economic resources, and gives continuity to the actions promoted by the various co-interested sources.

What is/was the level of implementation of your example of good practice?

- National
- Regional
- Local (municipality level)

The strategy is implemented with the intervention of various Ministries, The Regions, the Municipalities, the Public Healthcare System, the education sector, as well as with agreements with producers and distributors and other public/private involved subjects

What are the main aim and the main objectives of your example of good practice?

The main aim is the reduction of the impact on the population of cancer, cardiovascular diseases, diabetes and chronic respiratory diseases, that have in common risk factors such as tobacco use, harmful use of alcohol, unhealthy diet, overweight and/or obesity, and physical inactivity, as related to unhealthy individual behaviour and to the economic, social and environmental context in which people live and work.

This can be achieved through:

- the development and strengthening of policies and programmes promoting healthy lifestyles and preventing chronic conditions, with special emphasis on “health determinants”
- through the implementation of appropriate “cross-sector” policies at the national, regional and local levels. To act effectively against NCDs and tackle health inequalities, the strategy promotes people “empowerment” towards healthy choices and support interventions to create environmental conditions that facilitate healthy behaviours. It also include the definition of reciprocal responsibilities, through widely coordinated planning and activation of comprehensive actions and interventions on the various determinants, in order to increase effectiveness and optimize the use of resources, including communication, regulatory interventions and actions aimed at the community and individuals.

Actions include not only information and education activities, promoted by the health sector, but also advocacy and active involvement of sectors outside the health system, both government and civil society (Ministries, municipalities, professional associations and unions, consumer associations, food industry, mass media, etc.), as recommended by the European Union (EU) and the World Health Organization (WHO).

Please give a description of the problem the good practice example want to tackle:

According to the World Health Organization, chronic diseases in Europe cause 86% of deaths and 77% of the loss of years spent in good health (cardiovascular diseases, cancer, diabetes mellitus, chronic respiratory diseases, mental health problems and musculoskeletal disorders). The European Region of the WHO has the highest burden of Non-Communicable Chronic Diseases in the world. Almost three fourths of deaths in the Region are caused by cardiovascular diseases and cancer and three main groups – namely, cardiovascular diseases, cancer and mental illnesses – represent more than half the burden of disease (measured in “DALYs, i.e. disability-adjusted life years”).

In Italy about 250.000 new cases of cancer are diagnosed each year and the number of new cases is increasing, even if in general, deaths caused by cancer are tending to decrease; there are however geographic differences between the various Italian regions as regards death rates, incidence and prevalence rates. The expected increase in the years ahead, due to the higher average age of the population and increase of the global population, will add to the current significant epidemiological, social and economic burden. It is indeed estimated that in 2050 more than 2 billion people globally will be over 60 years of age.

A negative impact of this phenomenon is the increased disability caused by non-communicable chronic diseases and the number of persons with reduced independence, unhealthy lifestyle choices, poor social inclusion and reduced participation in active life. Given that the incidence of most forms of cancer tends to increase with age, the prevalence of this disease will increase significantly in the future. The progressive ageing of the population therefore forces the Governments of Industrialised Countries to implement appropriate and innovative strategies to mitigate the negative effects not only on individuals, but also on the social and economic system.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The Program “Gaining health” is a national strategy approved by the Government that in line with the principles of the “Health in All Policies” develops intersectorial actions to promote health and to make healthy lifestyles and healthy life environments easier for people. The program involves different stakeholders and a lot of partners, such as Ministries, Regions, Public Health Services, and also Food Industry, Consumers Associations, Trade Unions, etc.

The National Health Service develops the objectives of the strategy with the actions of the National Prevention Plan at regional and local level. It is embedded in the European strategy “gaining health” approved in Copenhagen on 12 September 2006 by the WHO Regional Committee for Europe

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Target group(s):

The program accompanies the citizens in all ages, in places of life and work with a “life course” approach. Moreover, the program has developed considerable attention to the involvement of multiple “key figures” to share a vision and a common language, in order to enhance knowledge and skills of communication-relational, essential for the promotion of healthy lifestyles at the individual and collective. The main “intermediate” targets are, in fact, health care providers (operators of prevention services, the general practitioners, paediatricians, pharmacists.), but also stakeholders such as teachers, administrators, associations, citizens themselves. They are involved in training activities with the objectives to:

- Update on the requirements and the available knowledge about the health impact of the main risk factors of chronic diseases
- Knowledge of communication as a means of promoting health
- Use of tools to support interventions for health promotion.

During implementation, did specific actions were taken to address the equity dimensions?

For its universalistic approach and policies, the program provides the contrast of inequality in every action. For example, the early years are a key determinant of health. Give every child the best start in life is crucial to reduce health inequalities across the life course, and other social and economic inequalities throughout life. In this sense, GS supports parenting skills, to form moms and dads more carefully regarding the health of their children through several activities and projects. Parents well aware and informed, in fact, can increase the health of their children through simple actions and healthy lifestyles: take folic acid before pregnancy, do not drink alcoholic beverages during pregnancy and no smoking during pregnancy and in presence of children, during breastfeeding, put babies to sleep on their back, protect babies in the car and at home, make all the recommended vaccinations, read them a book. (see the thematic website www.genitoripiu.it; www.mammeliberedalfumo.org). Moreover, to achieve some of the goals of Gaining Health the Ministry of Health and the Ministry for Youth and Sports signed on September 19th, 2007 a Memorandum of Understanding to develop actions to reduce inequalities and social exclusion for vulnerable groups of citizens, promoting the movement in all stages of life and the inclusion in practice of sports of disabled persons, or with mental distress or illness.

The Memoranda of Understanding between the Ministry of Health and the “Italian union sport for all” (UISP) and the Italian Olympic Committee” (CONI) also provide the inclusion of vulnerable people (elder, disabled persons, or mentally ill patients, prisoners, etc.) in sport and physical activities. According to this memoranda several projects have been activated in the last years, co-funded by the Ministries and the Associations involved. The new Memorandum of Understanding between the Ministry of Education, University and Research and the Ministry of Health “for the protection of the right to health, the study and inclusion” signed in April 2015, aims to strengthen the inter-institutional collaboration, to improve coordinate and facilitate the activities concerning the integration of measures for the protection and promotion of health and wellbeing of children, pupils and students, as well as for school inclusion in cases of disability and specific developmental disorders.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes, because “Gaining health” is an ethical program to reduce health inequalities, to promote better social conditions, to protect vulnerable people (children, old people and poor people) and to make healthy choices easier for people. The risk factors distribution varies greatly within the Italian population; they are most widespread in the lower socio-economic classes, who have a much higher mortality and morbidity than individuals in a more advantageous social and economic position. Another important discriminating factor is the significant gradient between northern and southern Italy. As regards, for example, obesity/overweight, Southern Italian Regions have a higher prevalence than those in the North, both in adult and in children. The excess of weight is a condition most common in low educational and social levels and covers both men and women.

Which vulnerable social groups were targeted?

Targeted vulnerable social groups:

- children,
- old people
- poor people
- migrants

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

Yes, the program aims to address health behaviour, that are clearly related to social, environmental and interpersonal determinants, through interventions for health promotion with a multi component (cross determinants of health), life cycle (life course) and settings (schools, workplaces, communities, health service) and cross-sector (education policy, social, urban planning, transport, agriculture, etc.) approach, with the involvement (empowerment of communities) of all levels.

Was an effective partnership in place?

The Program promote an intersectoral approach, involving different stakeholders and a lot of partners, such as Ministries, Regions, Public Health Services, and also Food Industries, Consumers Associations, Trade Unions, etc. In particular Gaining Health has developed a strong partnership between the health and education sectors. Indeed, schools and the families are the places where all individuals, from the earliest years of life, can receive help and guidance for the development of their behaviour; at school, children do not only receive educational contents but they are also formed as persons and citizens. In this connection educational interventions are being carried out both at school and in other contexts, concerning some of the main areas (healthy diet, physical activity, smoking and drug addiction, oral hygiene), which use the teaching and information materials produced on the basis of the data collected through the monitoring systems. In developing the national strategy, the Ministry of Health playing a leading role by advocating, inspiring and guiding the multisectoral action, has signed several “Memoranda of understanding” with other Ministries, public and private sectors, in order to achieve specific objectives to promote and facilitate healthy lifestyles. In order to promote the traditional Mediterranean diet, rich in fresh fruit and vegetables, for its positive health effects and to provide concrete responses in terms of healthy nutrition and lifestyles, the Ministry of Health has created and maintains a constant and constructive dialogue with the food industry which has the opportunity of taking on an active role in improving people’s health, in meeting the emerging demand of citizens for the acquisition and maintenance of healthy lifestyles as well as in playing a role as “health promoter”. As a consequence, in Italy some food production and distribution companies have volunteered to take initiatives aimed at improving the nutritional quality of some of their products, at progressively reducing the serving sizes, and at eliminating less healthy products from automatic dispensers in school settings. The Ministry of Health is also working with Food Industry to increase the availability of foods with reduced content of salt. Therefore, since 2009, thanks to some Memoranda of Understanding signed between the Ministry of Health, the Food Industry and the National Craft Bakers Associations, bread and bakery products, some frozen foods and some kind of fresh “pasta” have been gradually marketed with a 5 to 15% reduction in their salt content. However our most recent monitoring data show that salt intake of Italian population is double of the recommended level of less than 5 grams per person per day.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The Italian strategy is based on two main programs, strongly inter linked: the Program “Gaining health: making healthy choices easier” and the “National Prevention Plan”. The key instrument of the Ministry of Health in the field of prevention, since 2005, is represented by the National Prevention Plan (NPP) that identified the prevention of non-communicable diseases (NCDs) as a priority for the Italian Health System. It is a strategic document which, at national level, sets targets and tools that are then adopted, at local level, with regional plans.

The NPP 2014-2018 outlines actions for health promotion and prevention, aimed to accompany the citizens at all stages of life, both in living and working settings. This strategic choice refers to the belief that an investment in prevention interventions, provided they are based on scientific evidence, is a winning choice, able to help ensuring, in medium and long term, the sustainability of the National Health System.

The structure of the new NPP, according to a highly innovative approach, is characterized by a transversal approach, with the definition of macro-objectives, the identification of risk factors and health determinants, the

definition of key objectives and the identification of key indicators (and related standards). The NPP will find its declination in the specific regional and local contexts through Regional Prevention Plans.

As regards, in particular, to prevention of NCDs, the NPP 14-18, according to the objectives of the WHO-Europe Action Plan 2012-2016 and in continuity with the previous NPP, in order to reduce morbidity, mortality and premature disability linked to NCDs, and to limit the inequalities caused by social and economic conditions that affect health, has chosen an approach that includes both population and individual strategies. This approach is based mainly on population strategies aimed at spreading and facilitate the choice of healthy lifestyles, implementing the objectives of the National Programme "Gaining Health. However, if you were in the presence of subjects already with behavioural or intermediate risk factors, the strategic choice is to spread the techniques of motivational counselling, addressing the subjects to community (e.g. walking groups, groups for quitting smoking) or therapeutic (e.g.. physical activity prescription) programs.

Was the intervention implemented equitably, i.e. proportional to needs?

Yes, because it is addressed to the whole community with specific interventions for children, old and poor people and migrants

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, the intervention's objectives and strategy are clearly described to the whole community

Did the evaluation results achieve the stated goals and objectives?

It is a complex and articulated process and the results in terms of health of the population must be evaluated in the long term, but there are encouraging signs: the surveillance of the population begin to show improvements on some key determinants (e.g. childhood and adolescents obesity). The strategy of "Gaining health" has been implemented by all the Italian Regions as part of the Regional plans of prevention; for the realization of the interventions, specific training activities were also activated, involving more than 6000 operators.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Projects financed by the CCM and those promoted by the Regions in the Plans of Prevention have a structured assessment system, with process indicators and results and related standards. Some activities are planning an evaluation cost effective to test its transferability and reproducibility. Many initiatives are still in progress (such as initiatives to reduce salt in the diet) and will be evaluated over the long term.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Some process indicators:

- Number of agreements signed with Ministries, Associations of the food chain, the Food Industry, Sports associations, etc.
- Data from national surveillance systems: OKkio alla Salute -Keep an eye on Health- involves every two years more than 40,000 children and parents and 2,500 schools in all the Italian Regions. (It collects data on weight, eating habits, exercise and sedentary lifestyle of children of the third primary class, and about some aspects of the school environment).Italy also participates to the international HBSC (Health Behavior in School-aged Children - health-related behaviours in children of school age), involving every four years, a sample of students aged 11, 13 and 15 from all the Italia Regions. (The survey represents our national instrument for monitoring the factors and processes that may determine the effects on the health of

adolescents, because since 2010 the survey has been realized in all the Italian Regions, including a sample of more than 60.000 students). Regarding adults and older persons, since 2008, the surveillance systems named *PASSI (Steps) System "Health Progresses by the Local Health Units in Italy"* and - *PASSI d'Argento [Silver Steps System]* gather information on risk factors, people's perception of health, and the delivery of health services to people 18-69 years old and over 70 (<http://www.epicentro.iss.it/passi/> - *PASSI System*; <http://www.epicentro.iss.it/passi-argento/default.asp> - *PASSI d'Argento [Silver Steps System]*).

- Information System "Pro.Sa." for the identification and cataloging of "best practices" between the programs / projects related to Gaining Health
- Number of requests of the "logo" of "Gaining Health" to identify initiatives / projects/ publications promoted by the Ministry of Health and / or other Ministries or to other public and private institutions or associations for projects/ initiatives/ activities, consistent with the objectives of the program.

Who did the evaluation?

Both – internal and external parties

Specifically, what has been measured / evaluated?

Process evaluation instruments:

- National Platform on diet, physical activity and smoking". To implement the strategy and develop policies that promote the health and act on the causes of inequalities in health, the establishment, within the Ministry of Health, of a "National Platform on diet, physical activity and smoking," made possible to share with the representatives of Central administrations involved, the Italian Regions the Association of Italian Municipalities, the National Institute of Health, the Associations of General Practitioners, Pharmacists and of Paediatricians, the specific objective of Gaining Health.
- Memoranda of Understanding and other agreements. For the development of cross-sectoral objectives the Ministry of health signed the Memoranda of Understanding with the Ministry of Education, the Ministry of Agriculture, the Prime Minister's Office (Department of Youth and Sports) to activate, on issues such as the promotion of healthy diet and the Mediterranean diet, physical activity and sport, the contrast to alcohol and tobacco smoke, fruitful cooperation. Other agreements were signed with associations of the food chain, the Food Industry, sports associations, which gave specific undertakings such as the reformulation of food products, the realization of initiatives of information and promotion of physical activity and sport.
- Use of Logo Gaining Health (The smiling heart). To allow, an immediate identification of initiatives consistent with the strategy and objectives of the program, the Ministry of health created and recorded a "Logo Gaining health", the use of which has been granted over the years on the basis of specific rules in order to prevent misuse. The logo has been attributed to initiatives / projects/ publications promoted by the Ministry of Health and / or other Ministries or to other public and private institutions or associations for projects/ initiatives/ activities consistent with the objectives of the program.
- Surveillance systems data. As provided by the strategy, health education initiatives have been supported by a lifestyle surveillance systems, aimed at monitoring certain health aspects of children and school-attending adolescents, an instrument of the health and school systems shared with the Regions and Ministry of Education. The Italian surveillance system OKkio alla Salute (Keep an eye on Health), promoted by the Ministry of Health since 2008, involves every two years more than 40,000 children and parents and 2,500 schools in all the Italian Regions. It collects data on weight, eating habits, exercise and sedentary lifestyle of children of the third primary class, and about some aspects of the school environment. Information is collected with a national standardized methodology, to ensure reproducibility and comparability, with four questionnaires for children, parents, teachers and school administrators. Italy also participates to the international HBSC (Health Behaviour in School-aged Children - health-related behaviours in children of school age), promoted by the Regional Office of the World Health Organization for Europe, involving every four years, a sample of students aged 11, 13 and 15 from all the Italia Regions. The survey represents our

national instrument for monitoring the factors and processes that may determine the effects on the health of adolescents, because since 2010 the survey has been realized in all the Italian Regions, including a sample of more than 60.000 students.

- Regarding adults and older persons, since 2008, the surveillance systems named PASSI (Steps) System “Health Progresses by the Local Health Units in Italy” and - PASSI d’Argento [Silver Steps System] gather information on risk factors, people’s perception of health, and the delivery of health services to people 18-69 years old and over 70 (<http://www.epicentro.iss.it/passi/> - PASSI System; <http://www.epicentro.iss.it/passi-argento/default.asp> - PASSI d’Argento [Silver Steps System]). PASSI is conducted by participating local health units (LHU), which use a common questionnaire and methodology. Each month, LHU staff conducts telephone interviews of a random sample of resident adults 18-69 years of age. Data are transmitted to the national coordinating centre, where they are cleaned, managed, and made available for local, regional, and national analysis. Training, data analysis and communications are centrally supervised, and data quality is routinely monitored.

Evaluation of the impacts/effects/outcome:

The area of Smoking Prevention. In this area main objectives of the strategy has been implemented and evaluated, through surveillance systems and some specific projects promoted by the CCM, the National Centre for Disease Prevention and Control established by the Ministry of Health as structure for coordination with the Regions in order to enable public health interventions (primary prevention, promotion of healthy lifestyles and screening, addressing health emergencies, etc.).

Moreover, improving Gaining Health, after the smoking ban entered in force since 2005, Italy introduced other norms to extend the ban. In particular, the need to strengthen the protection of the health of non-smokers, especially children, has led to raising children under 18 years, the ban on the sale of cigarettes (conversion law November 8, 2012, n. 189 of Decree Law of 13 September 2012); with the LAW November 8, 2013, n. 128 (Conversion into law of the Decree-Law 12 September 2013 n. 104, on urgent measures in education, universities and research) smoking prohibition was extended to outdoor areas belonging to the schools. The law introduced a change in the law 3/2003.

- Regarding the objective of PROTECTING FROM SECOND HAND SMOKE, it has been assured support to the law protecting against second hand smoke (Law 3/2003) by improving their application and monitoring compliance with the ban, for the purposes of active health promotion. Since 2007, on a mandate from the Ministry of Health, the Health and Safety Unit of the Italian Police (Carabinieri per la Sanità) carried out over 30,000 random controls throughout Italy, in many different types of venues where the smoking ban is in effect (metro and train stations, hospitals, doctors’ offices, museums and libraries, airports, post offices, betting parlours, discos, malls, arcades, restaurants, pubs, and pizzerias), which showed that overall compliance is high. In the last two years vending machines and smoking rooms have been also controlled.

Since 2008, the Italian adults surveillance systems “STEPS” (in Italian called PASSI) have been evaluating the perception of population on respect of the ban in public place and workplace respectively. The positive opinion is increasing from 87% in 2008 to 89% and more in 2013. In particular, in the period 2010-2013, the perception of the rule of law on the prohibition of smoking in public places and the workplace seems quite high: 89% of adults surveyed reported that the smoking ban in public places frequented by them in the 30 days preceding the interview, it is always or almost always respected; 91% of respondents, working in closed states that the smoking ban is respected in the workplace. People who applied the ban in their home are increasing too (from 71,6% in 2008 to 78,3% in 2012). The Centre for disease Prevention (CCM) of the Ministry of Health funded the project “Local health districts prevention programme in support of Law 3/2003”, in 2008 to evaluate the compliance with the law in public and private workplaces, and the involvement of the Prevention departments of the Local Health Units in an active vigilance role on the appropriate application of the law as public health tool. The project involved ten Italian Regions coordinated by the Veneto Region, and also developed two operational guidebooks, “Towards a smoke-free school” and

“Towards a smoke-free workplace”, which combined the indications provided by the Veneto regional administration with those from other Regions. The Ministry of Health also financed in 2014 a project to evaluate the application of the “new” smoking ban at schools, involving 12 Italian Regions. As reported by the head teachers (school managers) of the 237 schools participating, the smoking ban “indoors” is respected by teachers and non-teaching staff in 90% of cases, while among students is respected only by 68% of them. The ban in outdoor areas belonging to the schools is respected by the 61% of teachers, 55% of non-teaching staff and 37% of students. Regarding the use of the electronic cigarettes, the ban is always respected in 94% of cases between teachers and non-teaching staff and in 87% between the students. The head teacher or his deputy has rarely had to ask to stop smoking in open spaces. Regarding the objective of PREVENTING YOUNG PEOPLE FROM STARTING TO SMOKE, the Ministry of health, with a CCM project, has promoted an educational campaign targeted to young people, using old and new media (social network, websites). <https://www.youtube.com/watch?v=VKM8VwgkEKY>

The Campaign, realized with the coordination of the ISS, has provided a “pre” and “post”, evaluation through questionnaires, conducted by an external independent company. Moreover, tanks to projects promoted by the CCM and to the National Prevention Plan 2010-2012 educational programs have been developed in schools, based on experiences already present in Italy and validated in terms of effectiveness. Other projects have been developed in workplaces, according to the principles of the Workplace health promotion of the WHO (for example, see the page: <http://retewhplombardia.org/>).

A CCM project for the development of a network on evidence based prevention produced the “Guidelines for smoking prevention”, as tool for health professionals and other professionals involved in prevention in different sectors. (http://www.snlg-iss.it/cms/files/LG_Prev_Fumo_B.pdf).

Regarding the objective of HELPING SMOKERS TO QUIT, the CCM supported projects to promote the training of GPs, other health and not health professionals for the use of the “minimal advise” technique and on non-smoking counselling. Moreover, the ISS update on the website information for citizens about the activity of public and/or private services to quit smoking (Centri Antifumo) with data on staff, methods of treatment approach (<http://www.iss.it/fumo/index.php?lang=1&anno=2015&tipo=20>).

In 2008, in agreement with the Youth Department, the Ministry of Health/CCM activated a “pilot” national project for the promotion of Physical activity and walking. The project was coordinated by Veneto - Verona local Health Unit - and involves the Regions Piemonte, Marche, Emilia Romagna, Lazio, Puglia with the aims to increase activities of ordinary life (walking, cycling). Physical activity is oriented towards the prevention of chronic diseases and helps social integration of persons with disabilities. A program aimed to encourage urban mobility, create safe routes for primary school children walking to school and to promote physical activity also in senior citizens and in disabled and people with mental ill, in cooperation with Regions, local health services and sport organizations.

The main actions were to establish a network of Regional representatives and Prevention departments of Local health units, to activate local networks of Associations for the promotion of PA (Municipalities, Schools, health workers, other private and public authorities), to create at a local level walking groups for elderly people and activities for children (“Pedibus” and other initiatives), to extend among PA participants basic nutritional information and to extend among workers (public health professionals, general practitioners, prevention technicians, municipal operators, voluntary associations) scientific knowledge on PA promotion and on urban interventions able to influence lifestyles (http://prevenzione.ulss20.verona.it/attmotoria_nazionale.html).

Another project, promoted by the CCM of the Ministry of Health was aimed to evaluate the behaviour changes in children after an activity to promote PA and fresh fruit/vegetables consumption at school (Go with the fruit!). The Regions participants were: Tuscany (co-ordinator), Apulia, Campania, Marche and Sicily. The main objectives are to make easier the access to F&V and, in general, the healthy choices and to evaluate the behaviour changes (increase of school children who eat, at least, one portion of fruit and one portion of vegetable a day). In ten intervention primary schools of each Region fresh fruit will be distributed,

free of charge, three days a week for three months and teachers will start a specific educational program. Questionnaire on F&V consumption will be administered before the intervention, at the end and four months later. In other ten control schools of each Region only the questionnaire will be administered three times without intervention. The students involved will be on the whole Regions 2.000 (1.000 interventions; 1.000 controls).

The communication plan has been supplemented with distance learning modules for health professionals and not, involved in implementing or enhancing the knowledge on the thematic areas of Gaining Health, making available details on lifestyles and on the contrast to chronic diseases. (<http://www.creps-siena.eu/e-vai-con-la-frutta.html>)

Other

The National surveillance systems provide useful information for all the stakeholders (decision-makers, administrators, health workers, citizens) and monitor the trends of behavioural risk factors and of the actions being implemented, tracking them over time, and hence allow comparisons with other Countries. Such systems provide data on nutrition and on the behaviour of children in primary schools ("OKkio alla salute" - Keep an Eye on Health), while data on lifestyles of children between the ages of 11 and 15 are being gathered through the international HBSC (Health Behaviour in School-aged Children) study, and the Global Youth Tobacco Survey (GYTS), promoted by WHO and by CDC-USA.

As regards adults, the national Behavioural Risk Factor Surveillance System (named PASSI) gathers crucial information about risk factors, the people's perception of health and the delivery of health services to people aged between 18 and 69 and to the over 70 population.

Topics explored are: quality of life, smoking habits, physical activity, diet, alcohol consumption, driving behaviours, cardiovascular risk factors, cancer screenings, vaccinations, mental health, domestic accidents, socio-demographic aspects. Monthly telephone interviews are conducted by personnel of the Local Health Units to a random sample of the resident general population.

The various projects launched by the school and by the regions, many of which are included in the database, measured the behaviours chosen as target.

Is the evaluation report available?

Articles/documents, related to the evaluation process:

[In Italy the prevalence of sedentary habits among children is decreasing](#) - No abstract available.

[Unhealthy eating habits among children aged 8-9 are still common in Italy](#) -No abstract available.

[Sociodemographic variation in childhood overweight and obesity in Italy in 2014](#) -No abstract available

[Italy 2014: childhood obesity is decreasing](#)

[High sodium and low potassium intake among Italian children: relationship with age, body mass and blood pressure.](#)

[Smoking habits among Italian adolescents: what has changed in the last decade?](#)

[Compliance with the smoking ban in Italy 8 years after its application.](#)

[Adherence to the Mediterranean diet in Italian school children \(The ZOOM8 Study\).](#)

[Excess dietary sodium and inadequate potassium intake by hypertensive patients in Italy: results of the MINISAL-SIIA study program.](#)

[Excess dietary sodium and inadequate potassium intake in Italy: results of the MINISAL study.](#)

[Population based strategy for dietary salt intake reduction: Italian initiatives in the European framework.](#)

[Surveillance system OKkio alla SALUTE: the role of primary school in the promotion of healthy life style. Results of 2008.](#)

<http://www.epicentro.iss.it/passi/rapporto2012/R2012Indice.asp>

<http://www.epicentro.iss.it/passi/rapporto2013/R2013Indice.asp>

<http://www.epicentro.iss.it/passi/dati/attivita.asp>

<http://www.epicentro.iss.it/passi/dati/sovrappeso.asp>

<http://www.epicentro.iss.it/passi/dati/frutta.asp>

<http://www.epicentro.iss.it/passi/dati/alcol.asp>

<http://www.epicentro.iss.it/passi/dati/fumo.asp>

<http://www.iss.it/binary/publ/cont/0931.pdf>

Who implemented the intervention?

The Program “Gaining health: making healthy choices easier” is a national Government strategy. In developing the national strategy, the Ministry of Health plays a leading role by advocating, inspiring and guiding the multisectoral action. In fact, the MoH signs several “Memoranda of understanding” with other Ministries, other public and private sectors, in order to achieve specific objectives.

What core activities are/have been implemented?

For example, the CCM national project “PinC” (Programma nazionale di informazione e comunicazione a sostegno degli obiettivi di Guadagnare Salute, i.e. National Information and Communication Programme for the support of the objectives of Guadagnare Salute) was coordinated by the ISS (national centre of epidemiology, surveillance and health promotion Cnesps) in collaboration with Regions, to promote communication and education initiatives. PinC aims to activate awareness and empowerment processes for individual and collective choices of healthy lifestyles, with a set of information and communication activities to support the objectives of Gaining Health. According to its general goal, the first specific objective of PinC is to empower the collaborating network between institutions and projects related to the Programme Gaining Health and to the general health promotion, to integrate and increase the value of different activities within sharing goals and messages among involved actors. Thereby one achievement of PinC is to identify existing projects, initiatives and inter-sector agreements in support of the Programme Gaining Health and the national prevention Plan for common areas of activity and to create a network for adding value and integrating different communication actions, goal sharing among all involved figures. Other two specific objectives were to plan a strategy for developing messages upon a solid evidence, for general population and specific audiences and to perform editorial products and training activities for public health professionals or not, to increase their core competences in health promotion. It is used a communicative type based on a “participating approach”: interactive exchange, listening, dialogue and integration among all partners to facilitate activities promoting healthy lifestyles. The communication strategy aims to reach targets capillary, at regional and local levels, with different and combined communication tools. Information about risk factors, recommendations and support are given to citizens for making healthy lifestyles easy. The central activity of the project PinC was:

- a communication plan to make individual and social responsibility aware of choices for healthy lifestyles and to validate an effective communication model, usable in the overall Italian context
- a blended learning plan for health care and non-health to consolidate role and competences of health promoters.

The communication plan focused on the implementation of measures of communication and information targeted at health professionals and non-medical, to the citizens and, in particular, to target teenagers and women. The activities included the production and distribution of publications, such as videos, booklets, technical reports, brochures and posters, as well as the development of a multimedia campaign with the use of tools such as press, national and local radio, websites, social network, etc., the realization of three national events organized in collaboration with Ministry of Health and all Italian Regions.

Was the intervention designed and implemented in consultation with the target population?

The strategy wasn’t designed in consultation with target population but was developed with various stakeholders: Ministries, The Regions, the Municipalities, the Public Healthcare System, the education sector, as well as with agreements with producers and distributors and other public/private involved subjects.

Did the intervention achieve meaningful participation among the intended target population?

The strategy achieves participation among Ministries, National Health System, school system and other public and private sectors

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes, the intervention increases health related knowledge and empowerment of the whole community

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

The Program develops a "life course" approach, according to the principles of the "Health in All Policies". So the program accompanies the citizen in all ages, in places of life and work with a "life course" approach.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, the intervention is inserted in the National Prevention Plan 2014-2018. Furthermore, the National Centre for Prevention and Disease Control (CCM) promotes the program "Gaining health" through a number of projects, consistent with the four thematic areas. Some of these projects, are "transversal" to the four specific risk factors addressed by the program.

Is there a broad support for the intervention amongst those who implement it?

Yes. There is a broader support of the Ministries involved, the Regions, the Municipalities, the Public Healthcare System, the education sector, as well as with agreements with producers and distributors and other public/private involved subjects

Are there specific knowledge transfer strategies in place (evidence into practice)?

The communication is an integrated component of the program Gaining Health, as a fundamental tool of information and knowledge for people (both citizens and health professionals). Communication plays a vital role in ensuring community empowerment. Participatory approaches in communication that encourage discussion and debate result in increased knowledge and awareness, and a higher level of critical thinking. Critical thinking enables communities to understand the interplay of forces operating on their lives, and helps them take their own decisions. Keyword for the communication on lifestyles is therefore to motivate the individual to change, to bring the citizens to take healthy attitudes and behaviours, for also promoting a healthy environment.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- intersectoral approach
- networking at national and local level
- "cross-cut" actions on risk factors

What were, in your opinion, the main lessons to be learned?

The "Health in all policies" is the framework of the program "Gaining Health". According to a vision characterized by:

- whole -government approach
- whole -society approach

It is necessary to continue to strengthen the cross-sectoral approach, to promote policies to reach groups at higher risk, such as those socially and economically disadvantaged, to reduce health disparities and effectively meet the real needs of people.

Web page related to the intervention

http://www.salute.gov.it/portale/temi/p2_4.jsp?lingua=italiano&tema=Prevenzione&area=stiliVita
<http://www.guadagnaresalute.it>
<http://www.epicentro.iss.it/okkioallasalute/>
<http://www.epicentro.iss.it/passi/>
<http://www.hbsc.unito.it/it/>
<https://www.google.it/search?q=guadagnare+salute&biw=1280&bih=887&tbm=isch&tbo=u&source=univ&sa=X&ei=LBqIVef9Iov5>

References to the most important articles or reports on the intervention

I Manifestazione nazionale del programma Guadagnare Salute Guadagnare Salute: i progressi delle aziende sanitarie per la salute in Italia, Napoli 24-25 settembre <http://www.epicentro.iss.it/gs-napoli2009/default.asp>
 II Manifestazione nazionale del programma Guadagnare Salute Le sfide della promozione della salute dalla sorveglianza agli interventi sul territorio, Venezia, 21-22 giugno 2012
<http://www.guadagnaresalute.it/convegni/venezias2012Bilancio.asp>
 III Manifestazione nazionale del programma Guadagnare Salute Costruire insieme la salute. Programmi ed interventi di promozione della salute tra intersectorialità, sostenibilità ed efficacia Orvieto, 22-23 ottobre 2014 http://www.iss.it/binary/publ/cont/Guadagnare_salute.pdf

Other relevant documents:

<http://www.guadagnaresalute.it/Orvieto/video.asp>

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The Prevention and Health Promotion Strategy of the Spanish NHS: Framework for Addressing Chronic Disease in the Spanish NHS Spain

Title in original language:

Estrategia de Promoción de la Salud y Prevención en el Sistema Nacional de Salud. En el marco del abordaje de la cronicidad en el SNS

Which 'life stage' for CVDs prevention targets the intervention?

The Strategy has a life-cycle approach, starting on the pregnancy. In the first stage (2014-2020), two populations have been prioritised for action: children (younger than 15, including fetal development) and those aged 50 years and older.

Short description of the intervention:

The Prevention and Health Promotion Strategy of the Spanish NHS proposes the progressive development of interventions aimed at improving health and preventing diseases, injuries and disability. It is an initiative developed within the framework of the Plan for the Implementation of the Strategy for Addressing Chronic Disease across the Spanish National Health System (NHS).

The major causes for the burden of disease, both at a global level and in our environment, have common determinants and risk factors; tackling them in a cooperative and holistic way improves the impact of the actions for promotion and prevention as well as their efficiency.

Strategies to improve health and prevent diseases are based on effectiveness and five important approaches needed to achieve the best results: a life-cycle approach, employing specific approaches for specific environments, a population approach, a positive approach and holistic approach.

Vision: The vision of this Strategy is to promote a society where individuals, families and communities are able to achieve their maximum potential regarding development, health, wellbeing and autonomy, and where working for health is assumed as a task shared by everyone.

Mission: Facilitating a common framework for health promotion and primary prevention in the cycle of life, harmonising its integration in the portfolio of services of the National Health System and getting other sectors of society actively involved, promoting participation of individuals and population in order to raise their autonomy and capacity to have a greater control over their own health.

General objective:

- promoting the populations' health and wellbeing by fostering healthy environments and lifestyles and strengthening safety in order to prevent injuries.
- Increasing life expectancy in good health by two years, for those born in Spain has been set out as a quantifiable global objective for 2020.

This Strategy represents an opportunity to integrate and coordinate the efforts for health promotion and prevention among all levels, sectors and actors involved. It also means a new driver in the re-orientation of the National Health System, which is a demand of our environment and a recommendation that has been repeated by international organisations such as the WHO and the European Union. Health is a high priority for society and it requires a joint response, coordinated and integrated by effective interventions and maintained over time.

Strategic lines: Strategic lines tackled are: Strengthening public health, territorial coordination and governance, health equity, re-orientation of health services, intersectorality in health, health empowerment, healthy and safe environments and community participation and action.

A Three-dimensional course of action: This Strategy is developed in a three-dimensional course of action: by populations, environments and factor to address.

In the first stage, two populations have been prioritised for action: children (younger than 15) and those aged 50 years and older. In the interventions addressed to prevention and health promotion, it is important to act in an inclusive way. Not only addressing the main health/risk factors and their interactions all together, but also the different life environments of each population. Therefore, for the population aged younger than 15, priority environments for intervention have been identified, in addition to the healthcare, education and community environment. In the population aged over 50 years, the healthcare and community approaches are addressed.

The factors addressed in this Strategy are the most important in tackling chronic diseases: healthy eating, physical activity, tobacco consumption and risk of alcohol consumption, in addition to emotional wellbeing and a safe environment for preventing non-intentional injuries.

Specific Objectives: In the first stage of this Strategy, the specific objectives are:

1. To encourage healthy life-styles as well as safe environments and behaviours among children through the coordination of holistic interventions in the health care, family, community and education fields.
2. Encourage healthy life-styles during pregnancy and breast-feeding.
3. Encourage emotional wellbeing among children.
4. Encourage active and healthy aging in the population aged over 50 years old, through the comprehensive integration of healthy life-styles and safe behaviours in a coordinated manner between healthcare and family-community fields.
5. Prevent functional impairment and promote health and emotional wellbeing in the population aged over 70 years old, fostering the coordination of comprehensive interventions in the health care, social services and community fields.

Selected interventions for action

The interventions are:

- Comprehensive counselling about life styles in Primary Healthcare, linked to community resources in child population
- Comprehensive counselling about life styles during pregnancy and breast-feeding
- The positive parenthood programme, for promoting emotional wellbeing among the child population
- Comprehensive counselling about life styles in Primary Healthcare linked to community resources in the over-50 age group of the population.
- The frailty screening and multi-factor attention for the elderly, which will lead to plans of preventive intervention and individualised monitoring in line with the action plans by the European Innovation Partnership for Active and Healthy Ageing (EIP-AHA).

Hence, within this Strategy, progress will be made in the comprehensive health intervention. Primary Healthcare interventions will be reinforced as well as health promotion; these interventions in Primary Healthcare will be strengthened on a global basis. Community interventions and their coordination within different environments (healthcare, social, education and community fields) will be fostered, always on the basis of the guiding principles of integrity, scientific evidence, cohesion, participation, evaluation, health in all policies and equity.

Implementation: Throughout the process of the effective implementation of the Strategy, this are the main lines of actions in place:

- The operational development of comprehensive interventions that will go into detail in the common and replicable aspects related to the best identified practices in order to ease their globalisation and will promote an effective coordination among the Public Health and Primary Healthcare structures to ensure equity in their implementation.

- The design of professional training plan focused on the methodology of change and the education on healthy life styles which include brief counselling, intensive individual/group education and community education. The capacity-building activities will be based fundamentally on on-line methodology.
- The training of the population through the design of a web platform related to healthy life styles.
- The creation of partnerships, which includes a Plan for local development for which bilateral work has already been put in place. One of the key elements of this Plan will be the creation of on-line maps bringing together community resources for prevention and health promotion at a local level. In relation to the joint work in the education environment, the aim is to universally reinforce interventions in a harmonised way in two specific fields: Physical activity and healthy eating, and emotional health and wellbeing. It also includes joint work with the sports sectors in two lines of action: the operational development of training programmes for physical activity for health, aimed at healthcare, education and community professionals; and support for all those interventions in the strategy using physical activity as an instrument to improve health.

This action among sectors allows the strengthening of public health and the guiding principle "health in all policies".

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

For the elaboration of this Strategy, a participative methodology has been employed, based on the implication of the professional sectors related to health as well as the health care administrations at both a national and regional level. The starting point was the identification of good practices in health promotion and primary prevention, established in the Autonomous Communities. After a strict process of evaluation, prioritisation, integration and planning; based on its importance and feasibility, this methodology allowed us to identify the best available practices to be universalised throughout the entire NHS and integrate them on the comprehensive interventions selected for action.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

The Strategy is well described in terms of purpose and objectives, and briefly describes the comprehensive interventions selected for action. Also establishes the implementation needs and evaluation framework, as well as a timeframe for implementation. Nonetheless, during the implementation process one of the first actions accomplished have been the operational development of comprehensive interventions that will go into detail in the common and replicable aspects related to the best identified practices in order to ease their globalisation and will promote an effective coordination among the Public Health and Primary Healthcare structures to ensure equity in their implementation. The concrete activities, timeframe and evaluation of each comprehensive intervention are there described.

To which type of interventions does your example of good practice belong to?

Policy/strategy. The Prevention and Health Promotion Strategy of the Spanish NHS proposes the progressive development of interventions aimed at improving health and preventing diseases, injuries and disability. It was approved by the Inter-territorial Council of the National Health System on 18 December 2013 for its universal implementation among the Spanish NHS.

How is this example of good practice funded?

National/regional/local government, as part of the activities on the Spanish NHS

What is/was the level of implementation of your example of good?

It's implemented at all levels, national, regional and local, depending on the intervention or action.

What are the main aim and the main objectives of your example of good practice?

The general objective is to promote the populations' health and wellbeing by fostering healthy environments and lifestyles and strengthening safety in order to prevent injuries. Increasing life expectancy in good health by two years, for those born in Spain has been set out as a quantifiable global objective for 2020. In the first stage of this Strategy (2014-2020), the specific objectives are:

- To encourage healthy life-styles as well as safe environments and behaviours among children through the coordination of holistic interventions in the health care, family, community and education fields.
- Encourage healthy life-styles during pregnancy and breast-feeding.
- Encourage emotional wellbeing among children.
- Encourage active and healthy aging in the population aged over 50 years old, through the comprehensive integration of healthy life-styles and safe behaviours in a coordinated manner between healthcare and family-community fields.
- Prevent functional impairment and promote health and emotional wellbeing in the population aged over 70 years old, fostering the coordination of comprehensive interventions in the health care, social services and community fields.

Please give a description of the problem the good practice example wants to tackle:

Spain has achieved one of the highest life expectancy rates in the world (82.1 years) however other countries in the region have the advantage of more of their life expectancy being lived in good health (in Spain, 61.5 years old among men and 59.4 years old among women). Since the last century, modern societies are facing two interrelated challenges, the demographic and the epidemiological transition. This means a change from the transmissible diseases to non-communicable diseases, as the life expectancy rises in the population. Chronic health conditions stand for 86% of deaths and 77% of the disease burden in the WHO European region. They are the main cause of preventable mortality and morbidity. Even if mortality due to these diseases has a progressive decline, their disease burden is on the rise. In Spain, they stand for 89.2% of the total disease burden measured in years of life adjusted by the disability-adjusted life year (DALY).

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

The Prevention and Health Promotion Strategy of the Spanish NHS proposes the progressive development of interventions aimed at improving health and preventing diseases, injuries and disability. It is an initiative developed within the framework of the Plan for the Implementation of the Strategy for Addressing Chronic Disease across the Spanish National Health System (NHS).

Implementation of your example of good practice is/was:

Continuous (integrated in the system)

Target groups:

For the first stage of the Strategy, two populations are prioritized:

- People under 15 years old, including the pregnancy.
- People 50 years or older

During implementation, did specific actions were taken to address the equity dimensions?

Equity is one of the guiding principles, so this perspective is integrated as a cross-cutting aspect on the whole Strategy. In the implementation process, equity is being address through the following actions:

- Adapting the interventions during its operational development, depending on the different needs of each population group. To do so, a brief tool has been adapted from the “methodological guide for the integration of equity on Strategies, programs and activities on health” already published (please see: <http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent Guia2012/Methodological Guide Equity SPAs.htm>)
- To reach an effective equity on health and improve effectiveness of the interventions, the works will be conducted with an intersectorial approach.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

All relevant dimensions of equity are considered both at the designing phase and at the implementation.

Which vulnerable social groups were targeted?

Equity is one of the guiding principles, so this perspective is integrated as a cross-cutting aspect on the whole Strategy, tailored by each population group needs. During the implementation phase, different groups will be targeted depending on each action, and will be identified by the tool already mentioned.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

One of the main features of the Strategy is its comprehensive and holistic approach. It takes in consideration the three main aspects of health: physical, emotional and social health. At the same time, it has a comprehensive approach of the risk factors considered, since they tend to act jointly. The factors addressed in this Strategy are the most important in tackling chronic diseases: healthy eating, physical activity, tobacco consumption and risk of alcohol consumption, in addition to emotional wellbeing and a safe environment for preventing non-intentional injuries.

Was an effective partnership in place?

The creation of partnerships is a central line of action of the Strategy, which includes a Plan for local development for which bilateral work has already been put in place. One of the key elements of this Plan will be the creation of on-line maps bringing together community resources for prevention and health promotion at a local level. In relation to the joint work in the education environment, the aim is to universally reinforce interventions in a harmonised way in two specific fields: Physical activity and healthy eating, and emotional health and wellbeing. It also includes joint work with the sports sectors in two lines of action: the operational development of training programmes for physical activity for health, aimed at healthcare, education and community professionals; and support for all those interventions in the strategy using physical activity as an instrument to improve health. This action among sectors allows the strengthening of public health and the guiding principle "health in all policies" that is one of the strategic lines of action of the whole Strategy.

Was the intervention implemented equitably, i.e. proportional to needs?

Equity is one of the guiding principles, so this perspective is integrated as a cross-cutting aspect on the whole Strategy. In the implementation process, equity is being address through the following actions:

- Adapting the interventions during its operational development, depending on the different needs of each population group. To do so, a brief tool has been adapted from the “methodological guide for the integration of equity on Strategies, programs and activities on health” already published (please see: <http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent Guia2012/Methodological Guide Equity SPAs.htm>).

- To reach an effective equity on health and improve effectiveness of the interventions, the works will be conducted with an intersectorial approach.

Were potential burdens, including harm, of the intervention for the target population addressed?

Yes, this aspect is incorporated in the adapted equity tool to be used during the implementation phase.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes. There was an external and public consultation process regarding the Strategy which took place on March 2014. It had the aim to facilitate public participation and focused on detecting, among the different actors, essential aspects for improving regarding the implementation phase.

Did the evaluation results achieve the stated goals and objectives?

Monitoring Strategy is conceived as a continuous process. Every two years an assessment and monitoring report, which raises an analysis and improvement measures will be made. Also an overall evaluation of the Strategy will be made at the end of the first phase 2014-2020.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. To proceed with the monitoring and evaluation, a number of general indicators of impact on health and lifestyles are established. All indicators are disaggregated, provided the source permits, by age group, sex, socioeconomic status and geographical units. Furthermore, unless otherwise specified, figures refer to calendar year periods. There are indicators relating to the final impact on health and lifestyles of the Strategy and a first group of structural and process indicators.

Summary table of impact indicators.

INDICATORS	SOURCES
Healthy life expectancy	
Healthy life expectancy at age 65 .	Spanish National Health Survey
Perceived health status	
% population aged over 65 with negative assessment of their health status.	Spanish National Health Survey and European Health Survey
Functional decline	
% population aged over 65 with limitations for the activities of daily life. Global and by specific dimensions (physical/ mental/ both).	Spanish National Health Survey and European Health Survey
Falls	
Rate of hospitalisations due to hip fracture	Basic Minimum Data Set on hospital discharges
The number of elderly individuals (65 or older) who died as a result of injury	Deaths according to cause of death Spanish National Statistical Institute

Impact of interventions	
% population experiencing improved result (significant change) in the initial performance test 6 months after the counselling-intervention.	Primary healthcare Information systems
% population at high risk of falls that suffers any fall after the intervention.	Primary healthcare Information systems

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Monitoring Strategy is conceived as a continuous process. Every two years an assessment and monitoring report, which raises an analysis and improvement measures will be made. Also an overall evaluation of the Strategy will be made at the end of the first phase 2014-2020.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

Specifically, what has been measured / evaluated?

Process evaluation: Monitoring Strategy is conceived as a continuous process. Every two years an assessment and monitoring report, which raises an analysis and improvement measures will be made. Also an overall evaluation of the Strategy will be made at the end of the first phase 2014-2020.

Evaluation of the impacts/effects/outcome :To proceed with the monitoring and evaluation, a number of general indicators of impact on health and lifestyles are established. All indicators are disaggregated, provided the source permits, by age group, sex, socioeconomic status and geographical units. Furthermore, unless otherwise specified, figures refer to calendar year periods. There are indicators relating to the final impact on health and lifestyles of the Strategy and a first group of structural and process indicators.

What are the main results/conclusions/recommendations from the evaluation?

First evaluation is planned in 2016

Is the evaluation report available?

First evaluation is planned in 2016 and its results will be publicly available at the Strategy web site: <http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/estrategiaPromocionPrevision.htm>

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

Monitoring Strategy is conceived as a continuous process. Every two years an assessment and monitoring report, which raises an analysis and improvement measures will be made. Also an overall evaluation of the Strategy will be made at the end of the first phase 2014-2020.

Who implemented the intervention?

The whole Spanish NHS structure is involved on the implementation. It's implemented at all levels, national, regional and local, depending on the intervention or action.

What core activities are/have been implemented?

Throughout the process of the effective implementation of the Strategy, these are the main lines of actions in place:

- The operational development of comprehensive interventions that will go into detail in the common and replicable aspects related to the best identified practices in order to ease their globalisation and will promote an effective coordination among the Public Health and Primary Healthcare structures to ensure equity in their implementation.
- The design of professional training plan focused on the methodology of change and the education on healthy life styles which include brief counselling, intensive individual/group education and community education. The capacity-building activities will be based fundamentally on on-line methodology.
- The training of the population through the design of a web platform related to healthy life styles.
- The creation of partnerships, which includes a Plan for local development for which bilateral work has already been put in place. One of the key elements of this Plan will be the creation of on-line maps bringing together community resources for prevention and health promotion at a local level. In relation to the joint work in the education environment, the aim is to universally reinforce interventions in a harmonised way in two specific fields: Physical activity and healthy eating, and emotional health and wellbeing. It also includes joint work with the sports sectors in two lines of action: the operational development of training programmes for physical activity for health, aimed at healthcare, education and community professionals; and support for all those interventions in the strategy using physical activity as an instrument to improve health.

Was the intervention designed and implemented in consultation with the target population?

Yes. For the elaboration of this Strategy, a participative methodology has been employed, based on the implication of the professional sectors related to health as well as the health care administrations at both a national and regional level. The starting point was the identification of good practices in health promotion and primary prevention, established in the Autonomous Communities. After a strict process of evaluation, prioritisation, integration and planning; based on its importance and feasibility, this methodology allowed us to identify the best available practices to be universalised throughout the entire NHS and integrate them on the comprehensive interventions selected for action.

There was an external and public consultation process regarding the Strategy which took place on March 2014. It had the aim to facilitate public participation and focused on detecting, among the different actors, essential aspects for improving regarding the implementation phase.

Did the intervention achieve meaningful participation among the intended target population?

Yes. There is a continuous participation of Regions through the Institutional committee of the Strategy and its diverse working groups for implementation. Also the participation on each line of action is meaningful, for example on the public consultation phase, or the professional training plan in place, offered to all the NHS primary care professionals free of charge.

Did the intervention develop strengths, resources and autonomy in the target populations?

Yes. That is a main perspective of all the interventions under implementation, especially regarding the Plan for local development and is on-line map of local salutogenetic resource.

Was the target populations defined on the basis of needs assessment including strengths and other characteristics?

Yes. That is explained on the situation analysis developed as part of the designing phase of the Strategy.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes. As part of the designing and implementation process the scientific societies most related to the interventions prioritised were and are nowadays involved.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, as said previously, the Strategy was approved by the Inter-territorial Council of the National Health System on 18 December 2013 and is being implemented on the whole Spanish NHS system.

Is there a broad support for the intervention amongst those who implement it?

Yes. There is a continuous participation of Regions through the Institutional committee of the Strategy and its diverse working groups for implementation.

Is there a broad support for the intervention amongst the intended target populations?

Yes. There is a continuous participation of Regions through the Institutional committee of the Strategy and its diverse working groups for implementation. Also the participation on each line of action is meaningful, for example on the public consultation phase, or the professional training plan in place, offered to all the NHS primary care professionals free of charge.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

The Strategy is being implemented as part of the routine preventive services of the Spanish NHS.

Were sources of funding specified in regards to stability and commitment?

The Strategy is being implemented as part of the routine preventive services of the Spanish NHS.

Were organisational structures clearly defined and described?

Yes. The Strategy is organised on a series of committees and working groups, coordinated by the Directorate General for Public Health at the Spanish MoH.

Is the potential impact on the population targeted assessed?

Yes. As part of the monitoring and evaluation, a number of general indicators of impact on health and lifestyles are established.

Are there specific knowledge transfer strategies in place?

Yes. A professional training plan is in place, focused on the methodology of change and the education on healthy life styles which include brief counselling, intensive individual/group education and community education. The capacity-building activities are based on on-line methodology and free of charge.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Yes. This is part of the works done as part of the operational development of the comprehensive interventions selected for action, as well as part of the “plan for local development”.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

A strong leadership, political commitment, intersectorial approach and good coordination.

What were, in your opinion, the main lessons to be learned?

The need for a strong leadership and a good coordination, with a special attention to public health and primary healthcare coordination. Also, the need to enhance coordination between regional health authorities to reach a universal implementation of the actions. Another important aspect is the need for a strong evidence on health promotion issues, taking into consideration this evidence has unique characteristics and it is not possible to assume the parameters used in the evidence based clinical medicine.

Web page related to the intervention

<http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/estrategiaPromocionyPrevencion.htm>

References

<http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/estrategiaPromocionyPrevencion.htm>

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Total Ban on Smoking in Indoor and Some Outdoor Public Places Bulgaria

Which 'life stage' for CVDs prevention targets the intervention?

The complete ban on smoking in indoor and some outdoor public places is associated with every person's right to live in a smoke-free environment. The policy is shaped to target every age group from the population (including pregnancy/fetal development; infancy and childhood, adolescence, adulthood and ageing).

Short description of the intervention:

The purpose of the ban on smoking in indoor and some outdoor public places is to protect public health. This ban on one hand protects the health of non-smokers who are exposed to tobacco smoke in indoor and some outdoor public places, and on the other hand protects smokers themselves from excessive use of tobacco and tobacco products. The policy is directed towards the whole population. After many discussions, information campaigns, meetings with various organizations, debates in Parliament, etc., on May 17, 2012 the National Assembly passed amendments to the Law of Health, which introduced a total ban on smoking in indoor and some outdoor public places from June 1, 2012. The ban of smoking includes: adjacent terrain and sidewalks of nurseries, kindergartens, schools, student dormitories and places where social services are provided for children playgrounds, open public spaces, which are organized activities for children and students, sports venues cinemas and theaters summer - at sports and cultural events. The Ministry of Health and its regional structures in the country - 28 Regional health inspectorates - carry out state health control, to limit smoking in indoor and some outdoor public places, on compliance with the requirements of Art. 56 and Art. 56a of the Law of Health. In order to enhance the efficiency and increase the range of public facilities and according to the working hours of dining and entertainment, the checks are carried out during weekdays, weekends and holidays. It also carries out daily checks on extended hours (after 17:00) and night checks (after 22:00). Overtime checks are carried out jointly with the employees of the Ministry of Interior.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

The policy was drawn upon the Framework Convention on Tobacco Control of the World Health Organization and the Recommendation of the Council of the European Union. From February 2010, debates started and the first statement on the complete prohibition was introduced by the Law of Health, which at the beginning had to come into force on 1 June 2010.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes. Objectives and tasks were scheduled in details as well as targets and management and funding.

To which type of interventions does your example of good practice belong to?

Policy/strategy.

How is this example of good practice funded?

National/regional/local government. On a national level, the policy is funded by the government, but in relation to its associated activities, it is supported by different institutions, NGOs, by the private sector and any other interested stakeholder.

What is/was the level of implementation of your example of good practice?

National.

What are the main aim and the main objectives of your example of good practice?

The main objective of the policy is to provide health protection of the nation by ensuring smoke-free environment in indoor public place, indoor workplaces, public transportation and some outdoor public places. Smoke-free legislation aims to provide ground for positive impact on health.

Please give a description of the problem the good practice example wants to tackle:

On the global scale tobacco smoking is one of the leading preventable causes of morbidity and mortality. Tobacco smoking is a substantiated cause for developing cancer, cardiovascular and respiratory diseases and inflicts more problems than alcohol use, drug use, high blood pressure, high cholesterol and obesity. In order to tackle the associated negative health consequences caused by tobacco smoking and second-hand tobacco smoking, Bulgaria ratified the following: Framework Convention on Tobacco Control WHO; Recommendation of the Council of the European Union. Nevertheless, partial ban on smoking was initially introduced as a more liberal regime in June 2010. Experience of the application of this legislation shows that the partial smoking ban through regulation of certain areas, divided by partitions, ventilation systems or facilities for smokers and non-smokers does not contribute to better health and is an ineffective method for protection from the harmful effects of tobacco smoke. Therefore, the total ban on smoking in indoor and some outdoor public places was introduced in June 1, 2012.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes and as a national policy, it is embedded in every regional/local plan. All 28 Regional Health Inspectorates take measures for the performance of continuous and effective public health control in compliance with the ban on smoking.

Implementation of your example of good practice is/was:

Continuous (integrated in the system).

Target group(s):

The policy is a population-based one, involving all age groups and people of different socio-economic status.

During implementation, did specific actions were taken to address the equity dimensions?

The policy is directed towards the whole nation.

Was an effective partnership in place?

Yes, the policy was supported by all governmental structures, NGOs and other public and private, and international organization. Example: In each RHI there is a Consultancy Office for smoking cessation. These offices provide advice by trained experts (doctors, psychologists, etc.) for quitting smoking, for spirometric measurements of carbon monoxide in the exhaled air and the amount of carboxyhemoglobin in the blood of passive and active smokers. With the aim to provide smoking cessation assistance have been introduced: a national telephone line for smoking cessation (0700 10 32); a website (www.aznepusha.bg) which has up-to-date information on the topic;

collaboration between the MoH and scientific associations in the country who support the policy of the Ministry of Health on prevention of smoking-induced health risks and healthy lifestyle.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes, it was aligned with the Framework Convention on Tobacco Control WHO and the Recommendation of the Council of the EU. Currently, the National Programme for the Prevention of Chronic Non-Communicable Diseases 2014-2020 includes a number of activities related to smoking control to prevent smoking initiation, to reduce health risks of tobacco use and second-hand smoke exposure.

Did the evaluation results achieve the stated goals and objectives?

Yes. Further monitoring established slow positive changes in population's behaviour related to tobacco smoking (about 2% reduction).

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Tobacco-induced diseases are monitored through the National Programme for the Prevention of Chronic Non-Communicable Diseases 2014-2020, which first results are to be analysed and published by the end of the year. Tobacco use and SHS are also monitored within the frame of the Global Youth Tobacco Survey (GYTS), conducted in 2002, 2008 and 2015 (in progress), which is designed to enhance the capacity of countries to monitor tobacco use among youth (representative national sample of students between 13-15 years) and to guide the implementation and evaluation of tobacco prevention and control programmes.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation).

Specifically, what has been measured / evaluated?

Process evaluation (respondents, method, and participants' satisfaction): The evaluation of the Total Ban on Smoking includes compliance with the ban; population's opinion on the total ban, reduction of people who smoke; SHS; reduction in the number of tobacco-induced diseases and all negative health consequences associated with tobacco use.

Evaluation of the impacts/effects/outcome: According to a survey conducted after the introduction on the ban by the National Centre for Public Opinion Research, almost 61% of the people supported the complete ban on smoking. More often the total ban was supported by women, people over the age of 59 (76%) - highly educated, with higher socio-economic status, and from rural areas. . Against the total ban were more often men, people aged between 40 and 49 years and residents of smaller towns. High levels of support of the total ban were registered among people who never smoked (86%) and among former smokers - 75%. Two-thirds of smokers opposed the ban, but one third supported it. Additionally, 3% of respondents indicated that they had stopped smoking after the introduction of the smoking ban in enclosed public places.

Health behaviour associated with tobacco use as well as other negative health consequences associated with tobacco use will be analysed till the end of the year. Currently, data analyses from the survey within the National Programme for the Prevention of Chronic Non-Communicable Diseases 2014-2020 is conducted, which will illustrate the impact of the Total Ban on Smoking on the population. Additionally, data analyses from the GYTS (currently processing) will also lead to the evaluation of the impact and effects of the Ban.

What are the main results/conclusions/recommendations from the evaluation (please describe)?

The policy has the potential to build awareness of the harm of smoking and to further support smoke-free legislation in encouraging cessation and discouraging uptake of smoking.

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

Yes, the survey within CINDI (Countrywide Integrated Non-communicable Disease Intervention) had four monitoring phases (in 2000, 2002, 2004, and 2007), assessing the process of changing population's behaviour on health, including tobacco use. Now, we expect the results from the survey within the framework of the National Programme for the Prevention of Chronic Non-Communicable Diseases 2014-2020, which includes corresponding information from initial CINDI survey, allowing information for comparative purposes on smoking, SHS and tobacco-induced diseases. Additionally, a follow-up is planned in 5 years. The survey within the framework of GYTS also provides information for monitoring on tobacco use and SHS from 2002 and 2008, which is also comparable with the currently emerging results from the GYTS data analysis.

Who implemented the intervention?

Ministry of Health and its regional structures in the country (28 Regional Health Inspectorates) carry out state health control to ban smoking in indoor and some outdoor public places, on compliance with the requirements of Art. 56 and Art. 56a of the Law of Health. In order to enhance the efficiency and increase the range of public facilities and according to the working hours of dining and entertainment, the checks are carried out during weekdays, weekends and holidays. It also carries out daily checks on extended hours (after 17:00) and night checks (after 22:00). Overtime checks are carried out jointly with the employees of the Ministry of Interior and sometimes with volunteers. The control over the implementation of existing legislation is carried out systematically and consistently without prior notification, and focused - after signals about established violations. Healthcare professionals from the RHIs in the country take all measures for the performance of continuous and effective control to exclude non-compliance provisions of the Law of Health. In carrying out the public health control, state healthcare professionals have the right to issue prescriptions for non-compliance of smoking in facility and establish acts of administrative violations. Signals from citizens and NGOs are received in the Ministry of Health for violating the ban on smoking in public places. Each signal is sent for check to the RHI on the territory the infringement has been established. MoH periodically prepares and sends indicative letters to the RHIs in order to improve the effectiveness of control activities. Regardless of the changing environment (political, public, social, etc.), Ministry of Health, supported by the representatives of NGOs, proposed new texts in the Law of Health to increase penalties for violators of the ban on smoking in public places and for more precise interpretation of existing legislation.

What core activities are/have been implemented

Ministry of Health has implemented a number of joint activities and initiatives with non-governmental organizations, with some of which has signed an Agreement for cooperation in the implementation of existing legislation to restrict tobacco smoking. The purpose of the Agreement is:

- Raising awareness of the citizens for the effective enforcement of prohibitions and restrictions on smoking;
- Participation of trained volunteers in inspections performed by state health inspectors;
- Reception of signals for violations by citizens of the smoking ban and sending the signals to the corresponding RHI.

In 2013 the Council of Ministers adopted National Program for the Prevention of Chronic Non-communicable Diseases 2014-2020. The program includes a number of activities in the restriction of smoking to prevent smoking initiation, reducing health risks of tobacco use and second-hand smoking. MoH and RHIs perform range of activities: conducting national informative campaigns, preparation of information materials - leaflets, audio and video clips

(<http://www.mh.government.bg/ForThePacient.aspx?pageid=462&home=true&categoryid=4368&articleid=4778>), press conferences, seminars, trainings, competitions etc. Annually are held national campaigns linked with May 31st World No Tobacco Day and International No Tobacco Day. Other annual campaigns are:

- the International Children's Drawing Contest "No to smoking" in cooperation with the Italian League for the Fight against Cancer and the National Centre for Public Health and Analysis. The competition is for children aged 5 to 11 years, with the goal is children with their drawings to call on their parents to quit smoking;
- National Competition "The Healthy Former Smoker" for the "European ex-smoker". The aim is to encourage current smokers to overcome tobacco dependence and become ex-smokers.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Yes, as the total ban on smoking aims to improve the health of the whole population thus, targeting all age groups.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes. The Ban on Smoking has multiple partners across different sectors.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Yes, the policy is funded by the government and is fully protected by law. Different activities are constantly conducted by the RHIs and different NGOs.

Is there a broad support for the intervention amongst those who implement it?

Overall there is a board support. However, recently one of the opposition parties proposed to Parliament to relax the total ban on indoor smoking in public spaces with a motion submitted to the Health Commission in Parliament. The Health Minister said that neither the Health Ministry, nor the government would support any relaxation to the total ban on indoor smoking. Apart from the political situation, the activities related to the Ban on Smoking are carried out with the support and collaboration of different governmental and non-governmental organizations, both nationally and locally.

Is there a broad support for the intervention amongst the intended target populations?

According to the National Centre for Public Opinion Research, more than 60% of the people support the total ban on smoking.

Were sources of funding specified in regards to stability and commitment?

Yes, the Ban is funded by the governmental budget, guaranteeing the financial stability and commitment.

Were organizational structures clearly defined and described?

Yes. The Ministry of Health together with the National Centre of Public Health and Analyses, other ministries and governmental structures had the assigned responsibilities. The 28 RHIs worked on a regional and local level to ensure the implementation of the tasks. There is strong collaboration between different ministries in the application of the Ban.

Is the potential impact on the population targeted assessed (if scaled up)?

By the end of the year data analyses from the National Programme for the Prevention of Chronic Non-Communicable Diseases 2014-2020 survey and the GYTS will allow to measure the potential impact on the population targeted.

Are there specific knowledge transfer strategies in place (evidence into practice)?

Yes. The Ban is constructed through evidence-based information and further results from the surveys in progress will lead to the formulation of new transfer strategies into practice.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

The most important barriers concerning the Ban are associated first with the gaps in the normative texts allowing violations to be dropped too easily and illogically in court and second, the lack of a specific definition of "indoor place", which is used for violating the Ban. There were some difficulties in meeting the requirements for ban on smoking in public places: a lack of motivation and confidence of smokers about the purpose of smoking ban, aimed at preventing health risks of tobacco use and passive smoking. The issue of ban of smoking has been politicized in order to achieve political advantages. In 2013, lawmakers filed to the 42th National Assembly proposals for repeal of the current ban on smoking. Ministry of Health managed to defend its position for health protection and maintaining the ban on smoking, in order to ensure an environment free of tobacco smoke. The proposal was not accepted, the total ban on smoking in public places remains.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

The pre-condition were that Bulgaria ratified the Framework Convention on Tobacco Control of the World Health Organization, which entered into force for the Republic of Bulgaria on February 5, 2006. In 2009 the National Assembly adopted amendments to the Law of Health (SG. 41 of June 2, 2009) which introduced a total ban on smoking in indoor public places, indoor workplaces and public transport. Changes were to take effect from June 1, 2010. Another pre-condition is the Recommendation on smoke-free environments by the Council of the European Union, adopted as a guideline on protection from exposure to tobacco smoke, taken in conjunction with Article 8 of the Framework Convention on Tobacco Control, became an Annex to the Recommendation. These two documents set the start and the pre-condition to the success of the Ban.

What were, in your opinion, the main lessons to be learned?

The main lessons to be learned are related with the potential to build awareness of the harm of smoking and to support smoke-free legislation. Such effects will shape more favourable attitudes and social norms about quitting, which in turn can increase smokers' intention to quit. Moreover, laws regulations and administrative provisions of the country concerning the manufacture, presentation and sale of tobacco products have to be taken in more depth in order to facilitate the upcoming amendments in labelling and packaging, health warnings.

Web page related to the intervention

- <http://webcache.googleusercontent.com/search?q=cache:0Zijr9Y64EoJ:www.mh.government.bg/Articles.aspx%3Fflang%3Ddbg-BG%26pageid%3D380%26currentPage%3D3%26categoryid%3D1058+&cd=1&hl=bg&ct=clnk&gl=bg>
- <http://dv.parliament.bg/DVWeb/showMaterialDV.jsp?idMat=64775>

References (with possible links) to the most important articles or reports on the intervention

<http://webcache.googleusercontent.com/search?q=cache:ht8iL-bYOHEJ:www.mh.government.bg/DownloadHandler.ashx%3Fid%3D6244+&cd=1&hl=bg&ct=clnk&gl=bg>

Other relevant documents:

Audio and video materials:

- http://webcache.googleusercontent.com/search?q=cache:IJqLJgN_KcJ:www.mh.government.bg/ForThePatient.aspx%3Fpageid%3D462%26home%3Dtrue%26categoryid%3D4368+&cd=1&hl=bg&ct=clnk&gl=bg
- <http://www.mh.government.bg/bg/informaciya-za-grazhdani/zdravosloven-nachin-na-zhivot/informirani-i-zdravi/nacionalna-kampaniya-sreshu-tyutyunopusheneto/>

Printed materials: <http://www.riokoz-vt.com/NEPUSHACHI.PDF>

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Healthy life centre Norway

Title in original language:

Frisklivssentral

Target groups:

General population. People with, or in high risk of disease, who need support in health behaviour change and in coping with health problems and chronic diseases. Equity in health services is a goal and The Healthy life centres reaches out to vulnerable groups with low socioeconomic status.

Short description of the intervention:

A Healthy Life Centre (HLC) is an interdisciplinary primary health care service which offers effective, knowledge-based programs and methods for people with, or in high risk of disease, who need support in health behaviour change and in coping with health problems and chronic diseases. The HLC is part of the public health care service in the municipality. HLC programs have a patient oriented approach and aim at strengthening the individual's control of his or her own health (empowerment). As a minimum HLCs offer various exercise groups, and individually or group based counselling or courses for increased physical activity, healthy nutrition and tobacco cessation. Many HLCs also offer counselling, support and education on issues related to mental health, sleep and alcohol. Counselling is based on Motivational Interviewing (MI). In the municipality, the HLCHLC functions as a resource-, knowledge- and contact centre for behaviour change, health promotion and disease prevention. When contacting the HLC, either on their own or by referral, participants get a consultation to examine their needs and motivations. The participant is then enrolled in a 12-week program. During the program, they can get an individual consultation if needed. The duration of the program may be prolonged. Cooperation with other municipal health care services, hospitals, Non-Governmental Organizations (NGOs), private and public organizations and local authorities is of vital importance in order to provide continuous and integrated health care and help people to establish independent and lasting health enhancing habits. A key task for the HLC is to guide the participants into suitable and feasible local programs and activities that they can continue with on their own after participation in the HLC. The HLCs should provide a good overview of such programs. The service must follow law regulations regarding municipal health care services. All personnel providing health care at the HLC, is regarded as health-personnel. Their practice must follow the regulations in the health personnel act.

To which type of interventions does your example of good practice belong to?

Individual intervention. Interventions directed towards individuals, but also education towards broader groups, ex diabetics, and exercise/physical activity groups for the community.

How is this example of good practice funded?

National/regional/local government.

What is/was the level of implementation of your example of good practice?

Local (municipality level).

What are the main aim and the main objectives of your example of good practice?

The main aim of the Healthy Life Centre (HLC) is health promotion and prevention. They offer effective, knowledge-based programs and methods for people with, or in high risk of disease, who need support in health behaviour change and in coping with health problems and chronic diseases.

Please give a description of the problem the good practice example wants to tackle:

The aim is to prevent obesity and non-communicable diseases (NCD), such as diabetes, cancer and cardiovascular disease and to help the local communities with a model they can use to organize their work on individual health behaviour change and prevention. Status in Norway: Approximately 30% of the total number of deaths in Norway happens prematurely if the limit is set to before 75 years of age (2009: 12033 deaths, 29% of all deaths). In total, cardiovascular disease, cancer, chronic lung diseases and diabetes account for well over half of these deaths (64% among men and 70% among women). More men than women die prematurely of non-communicable diseases. From 1980 to 2009 there has been a decline in premature mortality from both cardiovascular diseases (70%) and cancer (18% for men and 12% for women). Looking at all deaths before 75 years age summed up (numbers from 2009, both sexes combined), 40% died of cancer, 20% of cardiovascular disease, 4% of chronic lung diseases and 2% of diabetes. Lung cancer is the numerically dominant cause of premature deaths from cancer, followed by colon cancer and breast cancer. This picture confirms that WHO's goal of reducing premature mortality from non-communicable diseases is highly relevant in Norway.

(<https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/308/Reduksjon-i-ikke-smittsomme-sykdommer-nasjonal-oppfølging-av-WHOs-mal-IS-0373.pdf>) Overweight and obesity is a problem in Norway, as it is in the rest of Europe. Norwegian researchers followed body mass index (BMI) and waist circumference (WC) in a large adult population in Norway (n = 90 000) from 1984–1986 (HUNT1) through 1995–1997 (HUNT2) to 2006–2008 (HUNT3) to study whether this is occurring in Norway. Height and weight were measured with standardized and identical methods in all three surveys; WC was also measured in HUNT2 and HUNT3. In the three surveys, mean BMI increased from 25.3 to 26.5 and 27.5 kg m⁻² in men and from 25.1 to 26.2 and 26.9 kg m⁻² in women. Increase in prevalence of obesity (BMI 30 kg m⁻²) was greater in men (from 7.7 to 14.4 and 22.1%) compared with women (from 13.3 to 18.3 and 23.1%). (ref Midthjell K et al. *Trends in overweight and obesity over 22 years in a large adult population: the HUNT Study, Norway. Clinical obesity; 2013*)

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Embedded in a variety of official documents. White paper on public health (Meld St 19 (2014-2015 Mestring og Muligheter). Also embedded in 'The Coordination Reform'; the Summary in English: Report No. 47 (2008–2009) to the Storting [Parliament] The Coordination Reform: Proper treatment – at the right place and right time St.meld. nr. 47 (2008–2009) www.regjeringen.no/en/dep/hod/documents.html?id=313901

Also "Guide for establishment and management to healthy life centre" (so far only available in Norwegian, a revised version is planned to be translated to English in 2016)

Implementation of your example of good practice is/was:

Continuous (integrated in the system).

Who implements/implemented the intervention?

The employees at healthy life centres are employed by the municipality. They have a broad range of professions, among others: physiotherapists, dietitian, educators, nurses and ergotherapists. Different professions work together in a team and they cooperate with other community health services, NGOs, private companies and hospitals. Some of the healthy life centres do also cooperate with universities and colleges.

What core activities are/have been implemented?

History:

- 2015: More than 220 municipals have HLC, and the number is continuously increasing
- 2013: Health White Paper emphasizes the need to strengthen the municipal health services efforts in supporting health behaviour change. More and more municipalities establish HLC. Growing international interest in this kind of healthcare
- 2013: A new edition of "Guidelines for municipal Healthy Life Centres." HLC is referred to as a preventive health care service.
- 2012: New law on public health and a new law on health services. All municipalities are recommended to establish Healthy Life Centre.
- 2011: The Norwegian Directorate of Health publishes " Guidelines for municipal Healthy Life Centres", largely based on the results from the project in Troms, Oppland, Buskerud, Vest- Agder og Nordland. A Health service reform that emphasizes the need for strengthening prevention in health services is launched by the minister of health at a Healthy Life Centre.
- 2008: The number of municipals with HLCs has increased to 42.
- 2004: The Norwegian Directorate of Health signed a project in cooperation with the regions of Troms, Oppland, Buskerud, Vest-Agder and Nordland, that aimed to develop and try out different models for referral and follow-up measures for behaviour change support.
- (physical activity, diet and smoking cessation)
- 2003: Green prescription is launched – a new tariff doctors can use in follow up patients with type 2 diabetes and high blood pressure. Doctors report the need for a service to which they can refer patients.
- 1996: The first Healthy Life Centre is established in Modum municipality.
- 1984: The Municipality of Vinje provides behaviour change support (physical activity) in public health service.

Who did the evaluation?

An external party.

What has been measured / evaluated?

There has been done research/evaluation of both effect and implementation and organization/the model for healthy life centres. An article review the exciting reports is being produced (expected to be done this year, in Norwegian only). In Norway, 'frisklivssentraler' – 'healthy living centres' have been introduced to support change of behaviours that have significance for health. The Norwegian knowledge centre has made a systematic review to answer questions about effects of organised follow-up on change of health behaviours (physical activity, diet, use of tobacco and alcohol). The review included studies of interventions corresponding to those given in Norwegian 'frisklivssentraler' – 'healthy living centres' during one period of organised follow-up (3 months), all together, 23 randomised controlled studies from literature searches were included (finished in June 2012) <http://www.kunnskapssenteret.no/en/publications/effects-of-organised-follow-up-of-behaviour-that-may-increase-risk-of-disease-in-adults> .

What are the main results/conclusions/recommendations from the evaluation?

Evaluations have shown that HLCs recruit people who do not on their own seek or participate in other services such as fitness centres. The HLCs therefore plays an important role in reducing social differences in health behaviour and health. Participants in HLCs need help to find appropriate services, build motivation and to create strategies for maintaining sustainable coping and behaviour change. General practitioners who refer patients to HLCs are of the opinion that the HLCs offer good services. Studies indicate that participation in the programs can lead to improved physical fitness, weight loss and improved self-perceived health and quality of life, as well as maintaining health behaviour change one year after the follow-up. A systematic review 6 who included 23 randomized controlled studies of interventions corresponding to those given in HLC's, meant to answer questions about effects of

organized follow-up on change of health behaviours (physical activity, diet, use of tobacco and alcohol) over a period of organized follow-up (3 months). Based on the summary of the findings and assessment of the quality of the documentation, the following conclusions were drawn:

- Referral to a local centre and follow-up, and training on one's own with follow up probably increase physical activity in the intervention period and in the short term (3 months after the intervention period).
- We lack documentation of sufficient quality about interventions to conclude about change of diet and physical activity.
- Self-help materials and follow-up may increase abstinence from smoking during the intervention period.
- Referral to a nurse may increase the number of persons who abstain from smoking 6 months after starting the intervention.
- We did not find studies of interventions to reduce alcohol use that met our inclusion criteria.

Studies have shown that behaviour change interventions are profitable/cost-efficient. For example it is estimated that for each person who does not smoke, who avoids overweight and is regularly physically active, the welfare benefit/gain/reward will be at NOK 7.5-12.5 million. Another example is that dietary and exercise changes can be equally efficient as treatment with insulin in type 2 diabetics, while it may be less expensive than the drug therapy. More knowledge about the impact of the services offered by the HLCs is needed. A three year national effect study on Healthy Life Centres is therefore planned from the autumn of 2015. The Norwegian directorate of health has published a guide for the establishment, management and quality of the HLC. The guide will be updated in 2015 and later translated to English.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Economy and endorsements by public authorities: national grants to stimulate establishing of healthy life centres, and local municipalities embedding the healthy life centres in the municipal plans and budgets; a national guide for establishment and management of the services and to ensure the quality of the services; Easy accessible services.

What are the main lessons to be learned?

The services are helpful in providing support for long-term behavioural changes in the fields of physical activity, nutrition and smoking cessation and coping with health problems and chronic diseases. The healthy life centres recruit vulnerable social groups and people who do not seek or participate in other services such as fitness centres on their own. The services are still in the establishing phase. The number of municipalities with a healthy life centre has tripled in the past six years. But still only half of the Norwegian municipalities (428 all together) have a healthy life centre and there are huge differences in the political priorities in the communities.

Web page related to the intervention

<https://helsedirektoratet.no/folkehelse/frisklivssentraler>

Other relevant documents:

Here are some documents and links to documents, and also a power point presentation, that might help to give a broader picture of the healthy life centre program, research that the service is based on etc. Unfortunately, most of it is written in Norwegian. <http://helsedirektoratet.no/publikasjoner/veileder-for-kommunale-frisklivssentraler-etablering-og-organisering-/Sider/default.aspx>

Some research:

- HIST/NTNU (2011): http://www.innherred-samkommune.no/prosjekt/frisklivssentraler/dok/kunnskapsoversikt_2011_150411.pdf
- Møreforskning (2009): <http://helsedirektoratet.no/folkehelse/frisklivssentraler/Documents/ein-resept-a-ga-for-kortversjon.pdf>
- Blom (2008): <http://www.tromsfylke.no/LinkClick.aspx?fileticket=-z091RfIWV4%3D&tabid=710>

- Helgerud og Eithun (2010): Se vedlegg
- Kallings (2008): <http://diss.kib.ki.se/2008/978-91-7409-111-3/thesis.pdf>
- Kallings (2010): Se vedlegg.
- Eriksson M, Westborg C.J, Eliason M.C.E. A randomised trial of lifestyle intervention in primary healthcare for the modification of cardiovascular risk factors. The Björknäs study. Scandinavian Journal of Public Health 2006; 34: 453-461.
- Erfarenheter av Fysisk aktivitet på Recept –FaR. 2003:53. Stockholm. Statens folkhälsoinstitut.
- Fysisk aktivitet på recept (FaR) i Östergötland 2005. Rapport 2006:11. Linköping.
- Folkhälsovetenskapligt centrum i Östergötland
- Rapport nr. 181. Stockholm. Statens beredning för medicinsk utvärdering. Fysisk aktivitet som behandling.
- Motion og kost på recept i Københavns kommune. 2007.Syddansk universitetsforlag, Odense.
- Motion på recept. Erfaringer og anbefalinger.2007. Sund by nettverket.
- Kunnskapssenteret (2012): <http://www.kunnskapssenteret.no/publikasjoner/effekter-av-organisert-oppf%C3%B8lgning-p%C3%A5-atferd-som-%C3%B8ker-risiko-for-sykdom-hos-voksne>
- <http://helsedirektoratet.no/folkehelse/frisklivssentraler/Documents/evalueringsrapport-oppf%C3%B8lgningssystemer-til-gronn-resept-2008-2004.pdf>
- <http://www.helsedirektoratet.no/folkehelse/frisklivssentraler/Documents/erfaringer-og-resultater-fra-moro-prosjektet.pdf>
- <http://www.sbu.se/sv/Publicerat/Gul/Metoder-for-att-framja-fysisk-aktivitet/>
- <http://www.sbu.se/sv/Publicerat/Gul/Metoder-for-rokavvanjning/>

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ACTIVE VALLECAS SPAIN

Title in original language:

Vallecas Activa

Which 'life stage' for CVDs prevention targets the intervention?

All life stages.

Short description of the intervention:

Vallecas Activa takes place in Entrevías (one of the most disadvantaged neighbourhoods in Madrid), situated in the district Puente de Vallecas. This programme currently integrates five projects, each in different levels of development:

1. Health pilot project:

General objective: to promote an active lifestyle in the population of the surroundings of the Municipal Sports Centre, in collaboration with Madrid's Municipal Health Centres and Primary Healthcare Centres and hospitals of Madrid's Regional Health Service.

WHO: Health professionals (of the Primary Healthcare Centres of the Madrid's Regional Health Service and Madrid's Municipal Health Centres) prescribe a programme for lifestyle change to people with diagnosed risk factors.

WHAT: Physical Activity programme run by sports professionals of the Municipal Sports Centre of Entrevías (City Council of Madrid) and adapted to the population's health situation, plus a health education programme, run and coordinated by health professionals of the participating health centres. It has different health programmes, depending on the target population:

- "Healthy Habits": with the aim of changing physical activity and eating habits of patients with diabetes risk, cardiovascular risk or adult obesity.
- "Families + Active": with the aim of treating children with overweight or obesity with a family perspective, combining health education for parents and physical activity for children, by age groups.
- "Exercise, moms and babies": combined programme of health education, parenting support and breastfeeding promotion and a physical activity programme with postpartum recovery exercises, hipopressive exercises, pelvic floor recovery and early child stimulation.
- "Healthy Walks": tackling sedentary behaviour with organized healthy walks, as a way of including social commitment and social reinforcement as improvement tools of programme adherence.

WHERE: The programme is located in the Municipal Sports Centre of Entrevías. The health centres involved are: CS José María Llanos, CS Entrevías, CS Vicente Soldevilla, CS Ángela Uriarte, CS Buenos Aires, CMS Puente de Vallecas, CS Alcalá de Guadaira and Hospital Infanta Leonor.

WHEN: the people selected by the health professionals are given a "Sports Prescription" to subscribe to the programme.

HOW: the user commits to assist to 66 physical activity sessions and 8 health education workshops (approximately 9 months). The price of the programme has been reduced from the standard rate. In case of 2 unjustified absences, the participant is unsubscribed.

2. Education pilot project:

General objective: to identify children in school age with health risks related to their physical condition. To recognize child obesity as a vulnerable situation of a minor, and to activate a protocol of minor protection.

WHO: teachers identify children that may be developing obesity with a simple test (BMI calculation).

WHAT: teachers learn how to recognize child obesity as a vulnerable situation of a minor, and to activate a coordinated protocol with the health system to protect the minor.

WHERE: tests are conducted in Physical Education classes of the schools of the surroundings of the Entrevías Sports Centre (IES Arcipreste de Hita, Escuela Profesional 1º de Mayo, CC Cumbre Oxford, CEIP Francisco Ruano, CEIP García Morente, CEIP Giner de los Ríos. CC Liceo Cónsul, CEIP Padre Mariana, CC Santa Rafaela María, CEIP José María de Pereda, CEIP Manuel Núñez de arenas, CC Santo Ángel.)

WHEN: tests are conducted at the beginning and the end of the school year.

HOW: when the test is positive, parents are informed so they can go to the paediatrician and/or social services. If the diagnosis is confirmed, the child can be offered one of the lifestyle change programmes of the Entrevías Sports Centre

3. Social Inclusion pilot project

General objective: to ease the access to sport practice for people in vulnerable situations recognized by Social Services, and who cannot access to sport activities because of different reasons (economic, social, cultural, etc.).

WHO: social workers, during their social intervention, when they diagnose people in vulnerable situations

WHAT: give access to regular sport activities of the Entrevías Sports Centre to people in vulnerable situations

WHERE: in the Social Services Centres of the district Puente de Vallecas (Centro de Servicios Sociales Pablo Neruda, Centro de Servicios Sociales San Diego, Centro de Servicios Sociales Ramón Pérez de Ayala, Centro de Servicios Sociales Entrevías) and in the Entrevías Sports Centre.

WHEN: to subscribe to this initiative is mandatory to fulfil the social inclusion criteria and to have the “social prescription” issued by the Social Services Centre.

HOW: the Sports Centre will reserve at least 2 places per activity group for this initiative, with reduced prices. Sports professionals will send a three-month report to the social worker, with the social evolution of the user. To disseminate the project, 3 health education workshops have been carried out for all people receiving the Integration Minimum Income.

4. Employment and training pilot project

General objective: to give a training and employment option in Sports to people in unemployment and vulnerable situations, recognized by Social Services.

WHO: Madrid’s Basketball Federation, Social Services, Entrevías Sports Centre and unemployed people.

WHAT: to train unemployed people for becoming referees and sport monitors.

WHERE: Entrevías Sports Centre.

WHEN: on the dates of the training courses for referees and basketball monitors.

HOW: the sports federation commits to give a certain number of scholarships without cost to people recognized in vulnerable situations by social services that fulfil the established access criteria and find in Sports a solution for their unemployment. Those people who pass the course are offered to collaborate as referees or monitors as a paid job within the programmes of Madrid’s City Council and the Basketball Federation.

5. Professional motivation pilot project

General objective: to improve the coordination between professionals, to raise their motivation and to improve their health.

WHO: health professionals, social workers, assistants, sport professionals and any other person involved in the development of Vallecas Activa programme.

WHAT: to jointly conduct a sport activity, supervised and continuous, 2 days per week

WHERE: Entrevías Sports Centre

WHEN: on the schedule of lower occupation (15:00-16:00 h)

HOW: applying to the activity

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies

Active Vallecas is methodologically based on the recommendations on community intervention of the Programme of Community Activities of Primary Care of the Spanish Society of Family and Community Medicine (SEMFyC) and the model of health and physical activity promotion of the Madrid Society of Nursing in Primary Care (SEMAP) and the Federation of Associations of Community Nursing in Primary Care (FAECAP).

The project integrates different programmes from different institutional levels:

- “Planes de Barrio” (Neighbourhoods plans) – Madrid City Council.
- Programme ALAS (Health, Eating and Physical Activity) and resources of the Gente+Saludable (People+Healthy) Strategy - Madrid City Council.
- Programme Active Families (child obesity and sedentarism) - Madrid Society of Nursing in Primary Care (SEMAP)
- Programmes of supervised physical activities in the Municipal Sports Centres of Madrid City Council.
- Programme “Walking in Madrid” – Sports General Directorate, Madrid City Council.
- The study “How are habits are formed: Modelling habit formation in the real world”, London University. (Eur. J. Soc. Psychol. 40, 998–1009 (2010). DOI: 10.1002/ejsp.674).
- The Project “Active School” – Region of Castilla La Mancha.
- Programmes of Reintegration – Social Services, Madrid City Council
- Initiatives of the civil society networks and sports clubs of Vallecas.
- NAOS Strategy – Ministry of Health, Social Services and Equality.
- Strategy of Health Promotion and Prevention of the National Health Service - Ministry of Health, Social Services and Equality

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods

The programmes describe the objectives, admission criteria, follow up, schedule, duration of the programme, frequency of sessions (sport activity and health education), design of the sessions, duration of sessions, number of participants per group, age, length of time spent in the programme, incompatibility situations, attendance commitments and protocol of selection by health professionals and social workers.

To which type of interventions does your example of good practice belong to?

Active Vallecas is a community and interdisciplinary intervention project, with the joint participation of all the professional categories of the primary healthcare sector with professionals of Sports Science, Education and Social Services. This coordination of different public institutions and professional sectors allows offering a quality improvement of public services to give the most adequate response to citizens’ needs.

How is this example of good practice funded?

Regional and local government: this project does not imply an additional economic commitment

What is/was the level of implementation of your example of good practice?

Active Vallecas is an initiative of local-regional collaboration, between Education and Health, which are of regional level, and Sports and Social Services, which are of local level.

What are the main aim and the main objectives of your example of good practice?

- General Aim: to improve the efficiency of the public resources that work for the citizens’ wellbeing
- Objective of the Health pilot project: to promote an active lifestyle in the population of the surroundings of the Municipal Sports Centre, in collaboration with Madrid’s Municipal Health Centres and Primary Healthcare Centres and hospitals of Madrid’s Regional Health Service.

- Objective of the Education pilot project: to identify children in school age with health risks related to their physical condition. To recognize child obesity as a vulnerable situation of a minor, and to activate a protocol of minor protection.
- Objective of the Social Inclusion pilot project: to ease the access to sport practice for people in vulnerable situations recognized by Social Services, and who cannot access to sport activities because of different reasons (economic, social, cultural, etc.).
- Objective of the Employment and training pilot project: to give a training and employment option in Sports to people in unemployment or vulnerable situations, recognized by Social Services.
- Objective of the Professional motivation pilot project: to improve the coordination between professionals involved in the project, to raise their motivation and to improve their health.

Please give a description of the problem the good practice example wants to tackle:

The WHO estimates that physical inactivity is the 4th main mortality risk factor, causing 1.9 million deaths globally, and being responsible of 10% to 16% cases of breast cancer, colorectal cancer and diabetes mellitus, and approximately 22% of cases of ischemic heart disease.

Improving people's health depends, among other aspects, in healthier lifestyles. These lifestyles, apart from the importance of having good quality information, have the environment in which people live as a key factor and can influence on people developing their potential with their maximum quality of life. The concept of health as wellbeing requires a global view of all institutions, beyond the health sector, to transform reality and reduce social, human and economic costs of diseases associated with sedentarism and poverty. Cooperation between institutions is a necessary condition to raise this aim.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

The project has been developed independently, but it is aligned with local, regional, national and international strategies.

Implementation of your example of good practice is/was:

Continuous and integrated in the system. For this to happen, coordination is needed for the programme preparation, to approve the prices of the activities, to establish inclusion criteria, prescription, etc. Currently, integration is one of the aspects where improvements are taking place.

Target group(s):

Target groups are described in the Short Description of the intervention. There are selected based on the needs detected by professionals from the health sector, social services and education sector. Also, these professionals will have a coordination tool with the Sport Services, to propose new sport programmes to tackle detected problems. A proposal questionnaire will be hosted in their computer system that they will be able to email to the corresponding Sports centre.

During implementation, did specific actions were taken to address the equity dimensions?

Health pilot project: actions have been made to reduce the gap of socioeconomic inequalities by offering lower prices to access the sports centre and the activities for the most disadvantaged people, and also a gender adaption of the activities.

Education pilot project: coordination between education, social services and municipal sport services has been established in order to help teachers in their work with families with Integration Minimum Income when vulnerable situations due to child obesity are identified. To accomplish this, it has been added a new obligation in the Individualized Integration Programme (a commitment contract signed by the beneficiaries of the Integration

Minimum Income): the obligation of following the health check-ups of their sons and daughters, according to the public health system, and the obligation of attending the “Families + Active” programme (child obesity programme in sports centres) after the paediatrician refers to. Social Services pilot project: to establish the price of the access to the sports programme, social services will inform of the monthly per capita rate in their “Social Prescription”. A progressive price system has been established, which is accessible for beneficiaries of the Integration Minimum Income to people in the poverty line.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

Yes, the project has positive discrimination for population with an exceeded risk due to their health status or social condition. The project works on unemployment, education level, vulnerability, integration of all ethnicities, as well as other aspects, with the aim of improving the social and territorial balance through a social intervention in a disadvantaged neighbourhood.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

The project has a global view to transform reality and to reduce human, social and economic costs of diseases associated to sedentary behaviour and poverty, combining a population strategy with an individual high risk strategy.

Was an effective partnership in place?

A multidisciplinary approach and an intersectoral approach are two of the strong points of this project, between professionals of health, education, social services and sports sectors.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes, the project is aligned with these strategies, among others:

European strategies:

- Health 2020

National strategies:

- NAOS Strategy – Ministry of Health, Social Services and Equality.

- Strategy of Health Promotion and Prevention of the National Health Service - Ministry of Health, Social Services and Equality

Regional strategies:

- Strategy for Chronic Patients – Region of Madrid

Local strategies:

- Strategy Gente + Saludable (People + Healthy) – City Council of Madrid

- Sports Strategic Plan - City Council of Madrid

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, the intervention's aims and strategy were designed by the different involved actors and shared with the target population. The design is based in 7 motivation rules:

- Set an objective: in our programs the objectives are mutually decided with the professional that makes the diagnosis and establishes the inclusion criteria (GP, social worker, etc.).

- Finish what you start: the attendance commitment to the programme is mandatory to be maintained in the programme.
- Socialize with people with similar interests: the activities are conducted in groups of people with similar interests, in a healthy and funny environment where it is easy to create new friendships.
- Learn to learn: we respect the different phases of learning development of each person. Due to this, that is why, although the activity is done in groups, each person individually counts his/her 66 sessions until they end of the program, and receives a different prescription in each learning phase. All physical activity programmes are complemented with a health education programme.
- Align your natural talent with your interest: the project generates spaces for the involved professionals to develop their natural talent performing their chosen profession with passion. This is transmitted in the value chain of the experience we create for the citizens.
- Increase knowledge of what inspires you: the physical activity programmes are complemented with a health education programme, related cultural activities and complementary information in consultation, with the aim of arousing their interest.
- Take a risk: we differentiate between faults and failures. Mistakes are part of learning and development. We find motivation in not giving up generating healthy habits.

Did the evaluation results achieve the stated goals and objectives?

Yes, obtained results (participation, adherence, questionnaires, and improvement in health indexes) confirm that we are achieving the established aims for each project.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes, there are available reports of subscription, occupation, permanence time, number of attendances, health tests, questionnaires, interviews, etc.

Who did the evaluation?

An internal party (representatives of the intervention, own organisation)

Specifically, what has been measured / evaluated?

Process evaluation. There are available reports of subscription, occupation, permanence time, number of attendances, health tests, questionnaires, interviews to users and professionals, etc. The questionnaires study the following aspects:

- Information about the programme obtained in the Health Centre.
- Prices of the programme
- Sport activity
- Schedules
- Sport facilities
- Health Education workshops
- If his/her aims have been achieved
- General Assessment of the programme
- If he/she knew the sport resources before this programme.

Evaluation of the impacts/effects/outcome :

- Health pilot project: It has been conducted since February 2013 until now. 230 people (2013-2014) and 441 people (2014-2015) have subscribed, referred from 8 health centres. The average adherence (follow up of the physical activity weekly sessions) has been 78%. The results of physical fitness and health have been positive, and also the satisfaction. 86% of people interviewed did not know the Sports Centre before, and 63% had not used any of the Municipal Sports Centres of Madrid before.
- Education pilot project: It has been conducted since the school year 2014-2015. 14 schools have been involved. Currently we are conducting the analysis of the number of children that have needed paediatric follow up after school's identification.
- Social Services pilot Project: It has been conducted since April 2013 until now. 17 people (2013-2014) and 91 people (2014-2015) have subscribed, referred from 4 Social Services Centres. The percentage of activity renewal is 86%. This year the 595 holders of the Integration Minimum Income of Entrevías's Social Services Centre have participated (this means 1858 potential beneficiaries, as it is a programme that influences all family).
- Employment and training pilot Project: It began on September 2014. Scholarships have been given by the Basketball Federation, so that people selected by Social Services can study a course on Sports Referee. 14 people have done the course, 2 people have finished it and are working as referees.
- Professional motivation pilot project: It began on April 2013 and it programs a supervised activity, 2 hours per week, on the schedule of lower occupation of the Sports Centre (15:00-16:00) for all professionals involved in the programme. Currently 10 people have subscribed.

What are the main results/conclusions/recommendations from the evaluation?

- It is important to transfer the experience to other Sports Centres, Health Centres, schools and Social Services Centres, since the proximity criteria of the resources is essential. Of the 8 Health Centres and 4 Social Services Centres that refer to the Sports Centre, the majority of the subscriptions come from the closest ones, making the distance a barrier.
- The permanence percentage in the programme is very high. Coordination between the different services multiplies the health results and improves the efficiency of the resources.

Is the evaluation report available?

Links to download presentations:

<http://www.congresofagde.com/Ponencias/Ponencia%20Oscar%20Sanchez.pdf>

http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/docs/Presentacion_OscarSanchez.pdf

Was there a follow-up or is any follow-up evaluation planned in the future?

We continue using the follow up tools developed until now, and for the season 2015-2016 the University Complutense of Madrid is designing a research on this project.

Who implemented the intervention?

The Project is implemented by a group of people with different professions and different institutions (doctors, nurses, social workers, teachers, sport technicians and managers)

What core activities are/have been implemented?

To coordinate team working, a document of principles declaration was agreed, with the mission, vision, values, organization chart, distribution of functions, norms, etc.

For the development of the programmes: there were elaborated materials for the health education sessions and physical activity sessions, referral prescription, follow up card, tests.

For communication: videos of the programmes, logos, design for presentations.

For management: control of subscription and follow up, attendances, questionnaires.

Was the intervention designed and implemented in consultation with the target population?

Yes, the General Assembly is the maximum governing body of the project. The users of the programmes are part of the General Assembly and can attend to take part in the decisions that affect the project.

Did the intervention achieve meaningful participation among the intended target population?

Yes, participation of the target population has been very active, through the General Assembly. Also, the project was presented to other existing formal participation structures as the Health councils.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Vallecas Activa Project is an example of user's empowerment and participation. Due to the preoccupation with the continuity of the programme for 2015-2016, users have organized themselves and have collected more than 3,500 signatures to ask for its continuity to the different institutions and platforms.

The programmes developed in Vallecas Activa are programmes of habits changing for the citizens to become active leaders of their wellbeing. In this sense, the programmes have a specific length and the aim is that, once the programme is finished, the citizen is autonomous on his/her wellbeing care.

The users are self-organizing to continue the activity once they have finished it.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Before the actions were developed, a needs assessment and situation analysis was conducted in the population of Vallecas, carrying out interviews to the target population. Also, opinion from the participating professionals was obtained, by semi-structured interviews.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Possible collaborating agents were identified and were added to the project, in order to gain value with their contribution.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

The continuity and sustainability of the project is due to the support received and the commitment of the involved agents, since the economic funding needed does not imply deficit for the participating institutions. Currently we are working on expanding the project to the rest of the city of Madrid, elaborating an agreement between Madrid City Council and the Region of Madrid.

Is there a broad support for the intervention amongst those who implement it?

Currently the support and willingness necessary to continue the project in Vallecas are present, and to activate this initiative in other districts of the City of Madrid.

Is there a broad support for the intervention amongst the intended target populations?

Already answered in the last question of Empowerment and Participation section.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

It was conducted an analysis of available resources, activity volume of each resource, previous coordination between institutions and economic cost or benefit that the project would imply for each public service involved, were it was stated that health projects do not need much money, but passion of the people who want to start them.

Were sources of funding specified in regards to stability and commitment?

No, but a more efficient management of the existing resources was accomplished.

Were organisational structures clearly defined and described?

To coordinate team working, a document of principles declaration was agreed, with the mission, vision, values, organization chart, distribution of functions, norms, etc.

Is the potential impact on the population targeted assessed?

Yes, the experience is easily transferred and could benefit a high number of potential people. The huge volume of attention of diseases associated with sedentarism and chronicity put on risk the viability of the current health and wellbeing system. In this sense, Vallecás Activa is an example that it is possible to change reality and make public resources more efficient.

Are there specific knowledge transfer strategies in place (evidence into practice)?

Currently it is being transferred to other districts of Madrid, with all the “know how” of Vallecás Activa project.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

We have designed a draft of an agreement for the City of Madrid where all these aspects are stated.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Connection of proactive and motivated people
- Available resources
- Ability for conflict resolution
- Coordinating team multidisciplinary and with experience in project management.
- Simplicity in innovation
- Support of people with government responsibilities.

What were, in your opinion, the main lessons to be learned?

Major health promotion projects do not need much money, but passion of the people who want to start them.

Relevant documents:

News published:

<http://www.madriario.es/distrito/varios/-distritos/vallecás-activa/416798>

http://madridpress.com/not/179685/el_plan_deportivo_vallecás_activa_se_extendera_a_otros_distritos/

<http://www.abc.es/agencias/noticia.asp?noticia=1702290>
<http://www.eldigitaldeasturias.com/noticias/vallecas-activa-el-deporte-como-terapia-social-en-madrid/>
http://www.eldistrito.es/frontend/eldistrito/seccion.php?id_seccion=230
<http://www.madrid.es/portales/munimadrid/es/Inicio/Ayuntamiento/Medios-de-Comunicacion/Notas-de-prensa/Deporte-como-terapia-social?vgnextfmt=default&vgnextoid=7b4047283d149410VgnVCM1000000b205a0aRCRD&vgnnextchannel=6091317d3d2a7010VgnVCM100000dc0ca8c0RCRD>
<http://www.expansion.com/blogs/re-imaginando/2014/11/08/hacer-mas-que-decir.html>
<http://www.fbm.es/arbitros/46-arbitros/4769-proyecto-formacion-y-empleo-vallecas-activa-fbm>
http://www.madrid.org/cs/Satellite?c=CM_Actualidad_FA&cid=1354386787648&language=es&pagename=ComunidadMadrid%2FEstructura
<http://www.laquincena.es/noticias/comunidad-madrid/2014111666029/enfermeras-sermas-lideran-actividad-promocion-actividad-fisica-salud-vallecas>
http://www.telecinco.es/informativos/sociedad/Enfermeras-Sermas-alimentacion-saludable-Vallecas_0_1893675102.html
<https://newhub.shafaqna.com/ES/ES/7027874>
<http://www.ciudades-saludables.com/>
<http://mapeandoporcarabanchelalto.blogspot.com.es/>
<http://www.grupoppmadrid.es/patricia-lazaro-presento-del-proyecto-vallecas-activa/>
http://www.madridsalud.es/noticias/noticia670_2015.php
<http://vallecasdigital.com/vallecas-activa-apuesta-del-distrito-para-el-dia-del-deporte/>
http://www.madrid.org/cs/Satellite?c=CM_Actualidad_FA&cid=1354486575376&destacado=si&idConsejeria=1109266187266&idListConsj=1109265444710&idOrganismo=1142439320383&language=es&pagename=ComunidadMadrid%2FEstructura&sm=1109266100996

Congresses and Meetings:

https://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/Jornada_Implementacion_Estrategia.htm
http://www.recs.es/descargas/Jornada_Estrategia_Salud_20141017.pdf
 III World Congress on Public Health Nutrition <http://www.nutrition2014.org/>
 XVI Encuentro del PACAP el 21 de noviembre 2014
 IV Congreso colombiano del Deporte
 Master en investigación de actividad física y deporte. UCLM
http://www.naos.aesan.msssi.gob.es/naos/estrategia/premios/ganadores/ganadores_2014.html
 Congreso Nacional de Gestores deportivos “Deporte Cuestión de estado”
<http://www.congresofagde.com/programa/>

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Norwegian Public Health Act

Norway

Title in original language:

Folkehelseoven

Which 'life stage' for CVDs prevention targets the intervention?

All age groups. This being a national law, it reaches all groups, but the goal is to tackle inequity in health and therefor vulnerable groups (which groups may vary among municipalities) are at special focus.

Short description of the intervention:

The new Public Health Act was introduced in Norway 1 January 2012. The purpose of this Act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries. The Act establishes a new foundation for strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. The Act provides a broad basis for the coordination of public health work horizontally across various sectors and actors and vertically between authorities at local, regional and national level. Only by integrating health and its social determinants as an aspect of all social and welfare development through intersectoral action, can good and equitable public health be achieved.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

This is a comprehensive law and the work leading up to the law took all different aspects into consideration.

To which type of interventions does your example of good practice belong to ?

Policy/strategy.

How is this example of good practice funded?

National/regional/local government.

What is/was the level of implementation of your example of good practice?

National and Local (municipality level).

What are the main aim and the main objectives of your example of good practice?

This Act shall ensure that municipalities, county authorities and central government health authorities implement measures and coordinate their activities in the area of public health work. Promotion of participation and collaboration with stakeholders such as voluntary sector is an important aspect of good public health work. Central government health authorities have a duty to support the public health work of the municipalities among others by making available information and data to monitor public health and health determinants at local level. The Act aims to facilitate long-term, systematic public health work. One of the main features of the Act is that it places responsibility for public health work is as a whole-of-government and a whole-of-municipality responsibility rather

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

The Act builds on a broad determinant perspective on public health work. Overview of public health and health determinants constitutes the starting point for evidence based public health work. Based on a local assessment of the public health challenges, public health policy development must be an integrated part of ordinary societal and spatial planning and administration processes in counties and municipalities and in other social development strategies. Instead of detailed requirements, the Act prescribes procedural requirements that will provide the municipalities and counties with a foundation for systematic and long-term public health work across the sectors, based on the municipalities' own planning and administration systems. The municipality shall implement the measures that are necessary for meeting the municipality's public health challenges. This may, for example, encompass measures relating to childhood environments and living conditions, such as housing, education, employment and income, physical and social environments, physical activity, nutrition, injuries and accidents, tobacco use, alcohol use and use of other psychoactive substances https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/1234.pdf.

Please give a description of the problem the good practice example wants to tackle:

Even though Norway is an egalitarian society, there are social inequalities in health, and the Public health Act was introduced among other purposes, to tackle this and ensure that municipalities, county authorities and central government health authorities implement measures and coordinate their activities in the area of public health in a proper and sufficient manner. To reach results in the public health field, it is important to have long-term plans and the act was introduced to facilitate long-term, systematic public health work.

Implementation of your example of good practice is/was:

Continuous (integrated in the system).

During implementation, did specific actions were taken to address the equity dimensions?

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

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

The law is stating that this should be taken into consideration in all aspects of public health. Determinants of health constitute the starting point for evidence based public health work. The municipal health profiles (http://www.fhi.no/eway/default.aspx?pid=240&trg=MainContent_6898&Main_6664=6898:0:25,9032:1:0:0:::0:0&MainContent_6898=6706:0:25,9056:1:0:0:::0:0) are created for the municipalities to recognize, follow the development and be able to reach out to groups in need.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

Yes, the municipality shall implement the measures that are necessary for meeting the municipality's public health challenges. This may, for example, encompass measures relating to childhood environments and living conditions, such as housing, education, employment and income, physical and social environments, physical activity, nutrition, injuries and accidents, tobacco use, alcohol use and use of other psychoactive substances.

Was an effective partnership in place?

Yes, this act makes the municipality as a whole and at the highest level responsible for public health and health promotion and thereby giving responsibility to all sectors, not just the health sector.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

The municipal public health profiles are designed to give each municipality insight in their populations of special needs and the Public Health Act requires the municipalities to act on these specific challenges

§ 5 Overview of public health and health determinants in the municipality: The municipality shall have sufficient overview of the population's health and the positive and negative factors that may influence this. This overview shall be based i.e. on: information that the central government health authorities and county authorities make available in accordance with Sections 20 and 25; knowledge from the municipal health and care services, cf. Health and Care Services Act Section 3-3; and knowledge of factors and development trends in the environment and local community that may influence the health of the population. This overview shall be in writing and identify the public health challenges in the municipality, including an assessment of the impact and the causal factors. The municipality shall in particular pay attention to development trends that may create or maintain social or health-related problems, or social inequalities in health. The Ministry may prescribe, by regulations, detailed provisions relating to the requirements for the municipality's overview. Entry into force 1 January 2012, cf. Section 34.

§ 6 Goals and planning. The overview in accordance with Section 5, second paragraph shall be included as a basis for work on the municipality's planning strategy. A discussion of the municipality's public health challenges should be included in the strategy, cf. Section 10-1 of the Planning and Building Act. In its work on the municipal master plan pursuant to Chapter 11 of the Planning and Building Act, the municipality shall define the overall goals and strategies for public health that are appropriate for meeting the challenges facing the municipality based on the overview in accordance with Section 5, second paragraph.

Were potential burdens, including harm, of the intervention for the target population addressed?

Yes, the law, the profiles and the public health plans (in those municipalities which have developed such plan) are all accessible for everyone.

Did the evaluation results achieve the stated goals and objectives?

This is a law and it has not been through an evaluation like an intervention would have. But research has been done on the implementation and we will link to written qualitative project reports and master theses on the subject:

- Master's thesis on "Implementation of the Public Health Act in a Norwegian municipality with regard to Health in All Policies and Health Inequity"
<https://bora.uib.no/bitstream/handle/1956/8217/120877258.pdf?sequence=1>
- Project reports "Use of Norwegian Municipal Public Health Profiles and Data Bank: A qualitative study"
- <http://brage.bibsys.no/xmlui/bitstream/id/244968/Folkehelseprofilen%20og%20Kommunehelsen%20HELSE.pdf>
- DETERMINANTS IN NORWEGIAN LOCAL GOVERNMENT HEALTH PROMOTION _ INSTITUTIONAL PERSPECTIVES, Marit K. Helgesen and Hege Hofstad: <http://www.emeraldinsight.com/doi/abs/10.1108/S0275-495920140000032019>

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

The counties (19 all together) have the responsibility for supervising the municipalities' adherence to the law. The Ministry of Health and Care services will conduct inspections with both counties and municipalities to check if they

have executed according to the Act and the health overview standards (Norwegian Board of Health Supervision, available at <http://www.helsetilsynet.no/no/Tilsyn/Tilsynsomrader/Tilsyn-pa-folkehelseomradet/>)

§ 31 Supervisory authority for the Public Health Act . The county governor shall supervise the legality of the municipality's and county authority's fulfilment of the duties imposed in or pursuant to Sections 4 to 9, 20, 21, and 27 to 30 of this Act. The rules in Chapter 10 A of the Local Government Act apply to the supervisory activities in accordance with the first paragraph.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

There is a big program run by the Public health institute (www.fhi.no) on public health profiles for all regions and municipalities to feed statistics to the municipalities for them to be able to tailor the interventions in their community. Public health profiles:

http://www.fhi.no/eway/default.aspx?pid=240&trg=MainContent_6898&Main_6664=6898:0:25,9032:1:0:0:::0:0&MainContent_6898=6706:0:25,9056:1:0:0:::0:0

What are the main results/conclusions/recommendations from the evaluation?

“This present study reveals that the participants do not consider the health sector to be the most important sector in the health promotion work. It also deviates from these studies with regard to the broad and partly extensive participation from all sectors. This corresponds with the basic idea of HiAP and the importance of SDH and the policy behind the Public Health Act. The participants regard the Public Health Act as a helpful tool for systematic, inter-sectoral health promotion work in the municipality.” (p 72 Implementation of the Public Health Act in a Norwegian municipality with regard to Health in All Policies and Health Inequity” <https://bora.uib.no/bitstream/handle/1956/8217/120877258.pdf?sequence=1>)

Is the evaluation report available, preferably in English or at least an English summary?

- Master’s thesis on “Implementation of the Public Health Act in a Norwegian municipality with regard to Health in All Policies and Health Inequity”
- <https://bora.uib.no/bitstream/handle/1956/8217/120877258.pdf?sequence=1>
- Project reports “Use of Norwegian Municipal Public Health Profiles and Data Bank: A qualitative study”
- <http://brage.bibsys.no/xmlui/bitstream/id/244968/Folkehelseprofiler%20og%20Kommunehelsa%20HELY.pdf>

Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

To follow the Public health act all municipalities are to organize their public health work towards the goal of health in all policies (HiP) and some decide to make their own public health plans. The municipalities are required to keep track of the status of health among their inhabitants. The national institute of public health is making yearly reports on county and municipal level (the public health profiles: http://www.fhi.no/eway/default.aspx?pid=240&trg=MainContent_6898&Main_6664=6898:0:25,9032:1:0:0:::0:0&MainContent_6898=6706:0:25,9056:1:0:0:::0:0)

Who implemented the intervention?

The law is to be implemented by all municipalities thru the way the organize their primary health care, but also thru health in all policies, with public health and inequity in health as an aspect of all public interventions and plans.

What core activities are/have been implemented?

The 428 Norwegian municipalities are required to monitor the health status of their inhabitants and the determinants for health (Ibid. §1, §4, §5). In fulfilment of §5, the National Institute of Public Health annually distributes a suite of processed statistics from central registries to support the municipalities. To coordinate any municipalities have hired Public Health Coordinators. Web page for the public health profiles: http://www.fhi.no/eway/default.aspx?pid=240&trg=MainContent_6898&Main_6664=6898:0:25,9032:1:0:0::0:0&MainContent_6898=6706:0:25,9056:1:0:0::0:0

Was the intervention designed and implemented in consultation with the target population?

The plans to be made to follow the Act are to be executed in the municipalities and require cooperation from multiple sectors.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

The target population for each municipality and their different actions are continuously developed and the National Institute of public health gives a yearly report on the public health situation in each county/municipality.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Continuation is ensured in this being a law.

Is there a broad support for the intervention amongst those who implement it?

It is mandatory for the municipalities to follow, execute and support the Public Act.

Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks?

When the act was introduced, the funding for the municipalities was raised, but not specified towards actions to execute the intentions of the law. The intention of the act is not to raise costs, but for the municipalities to organize their public health work, in all sectors, in a different manner and use a more systematic approach.

Were sources of funding specified in regards to stability and commitment?

See answer to the last question.

Were organisational structures clearly defined and described?

This is specified in the act:

§ 30 Internal control: The municipality and county authority shall establish an internal control system to ensure that the requirements stipulated in or pursuant to this Act are observed. The municipalities' supervision of activities and property in accordance with Section 9 shall be documented in particular, including equal treatment and the independence of the supervision.

Is the potential impact on the population targeted assessed (if scaled up)?

This is already a national law and implemented at highest level.

Web page related to the intervention

The Norwegian public health act, official document:

https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/123.pdf

References to the most important articles or reports on the intervention

The Norwegian public health act, official document:

https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/123.pdf

Short version/presentation:

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

Other relevant documents:

<http://brage.bibsys.no/xmlui/bitstream/id/244968/Folkehelseprofiler%20og%20Kommunehelsa%20HELY.pdf>

http://www.fhi.no/eway/default.aspx?pid=240&trg=MainContent_6898&Main_6664=6898:0:25,9032:1:0:0:::0:0&MainContent_6898=6706:0:25,9056:1:0:0:::0:0

The Public Health Act, adopted in 2012 imposes Norwegian government to implement health in all policies and reduce social inequity in health. The act is important for implementing health promotion in a long term perspective as a cross- sectoral assignment. Responding to the knowledge gap the research project SODEMIFA was established in 2013. This report is project report is produced by the research project: "Implementation of the Public Health Act in a Norwegian municipality with regard to Health in all Policies and Health Inequity": <https://bora.uib.no/handle/1956/8217>

Contact details of person who may be contacted for further information

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The Welfare Watch Iceland

Title in original language:

Velferðarvaktin

Short description of the intervention:

The Welfare Watch was established in accordance with a cabinet resolution in 2009 as a response to the economic crisis and it was re-established in 2014. The Minister of Social Affairs and Social Security appointed the Welfare Watch, a Steering Committee, with the main role to monitor systematically the social and financial consequences of the economic situation for families and individuals in Iceland and to propose measures to help households and in particular vulnerable groups. Originally the Welfare Watch had representatives from 19 stakeholders, among others from six ministries, Social Partners, NGOs, Union of Local Authorities, The City of Reykjavik, the Directorate of Health, the Directorate of Labor and the Council of Equal rights of man and women. In 2014 the Welfare Watch expanded and is now a platform with 35 stakeholders represented from all sectors and levels of the society. The Welfare Watch is a governmental enterprise, with chairman and an employee provided by the Ministry of Welfare. Other stakeholders do not get special payment for their participation but donate the time of their representatives to the work (is considered a part of their daily work). The Welfare Watch established the Social Indicators which have been published every year since 2012. The Social Indicators are a collection of indicators regarding democracy and activities, standard of living and welfare, health and social cohesion. The Welfare Watch has frequent meetings and has smaller working task groups. Several proposals and reports have been delivered by the Welfare Watch. Social gradient in health is a fact in Iceland, like in other European countries. The report Review of the social determinants and the health divide in the WHO European Region informed the development of Health 2020, the European Policy framework for health and well-being. The report emphasises that without improvements in all the social determinants of health, there will be no significant reductions in health inequities. Health 2020's ultimate goal is to achieve health equity by reducing the socially determined inequities in the WHO European Region. The key to success is engagement of stakeholders across sectors and levels, like is facilitated by the work of the Welfare Watch.

To which type of interventions does your example of good practice belong to?

Policy/strategy. The Welfare Watch is a national level platform, involving key stakeholders from all sectors and levels, providing important data and insight in general, informing policy and actions.

How is this example of good practice funded?

National/regional/local government; Institution of education, public health and/or research; Non-governmental organization; and other resources. The Welfare Watch is a governmental enterprise, with chairman and an employee provided by the Ministry of Welfare. Other stakeholders contribute the time of their representatives to the work.

What is/was the level of implementation of your example of good practice?

National; (No regional level in Iceland); Local (municipality level); and other. Most of the recommendations published by the Welfare Watch are aimed at the government although in some cases they focus on the local level (i.e. recommending that the municipalities guaranty that every child gets school lunch in primary school).

What are the main aim and the main objectives of your example of good practice?

Originally it was to monitor the social and financial consequences of the economic situation for families and individuals and propose measures to help households. In 2014 the objectives where narrowed to focus on families with children and those living in severe poverty. In January 2015 proposals regarding these groups were published and introduced to the Minister of Social Affairs and Housing. The main themes were:

1. Child benefits and child social insurance
2. Criteria for the minimum subsistence
3. The Housing situation
4. Basic service
5. Case coordinators
6. Cooperation with NGO,s and a project fund

In Icelandic: http://www.velferdarraduneyti.is/media/rit-og-skyrslur-2015/Skyrsla_Velferdarvaktar_Jan2015.pdf

Please give a description of the problem the good practice example wants to:

Originally the main aim was to monitor the effect of the economic crises to be able to give guidance to the government on where actions where most needed. Now it is the situation of families with children and those living in severe poverty. After the crises, many families have struggled with housing and employment. The Welfare Watch tries to keep monitoring the situation and watch that difficult situations do not get worse. Example could be young people who drop out of school and are inactive and young single mothers.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. The Welfare Watch was established and is operating on ministry level. In the group there are amongst others representatives from several ministries.

Implementation of your example of good practice is/was:

Continuous (integrated in the system).

Target groups:

General population; Children; Adolescents; Young adults; Adults; Older population; Pregnant women; Women; Men; Families; Other. The focus since 2014 has been on families with children and those living in severe poverty. All the target groups mentioned above can fall under those criteria.

Vulnerable social groups:

Ethnic minorities; Migrants; Disabled people; Low income groups; Low education groups; Unemployed; Uninsured groups; Homeless; and Isolated older people.

Who implements/implemented the intervention?

The Welfare Watch is led by the ministry of Welfare, with a chairperson and an employee. The 36 entities that have their representative in the watch are from different kind of public bodies in the field of health, education and social affairs. Furthermore there are representatives from non-public entities such as the Red Cross, the

Home and School Association, Unicef etc. Most representatives have a professional background of some sort [See Annex I].

What core activities are/have been implemented?

A report regarding the work of the Welfare Watch in 2009 is available in English, see: http://eng.velferdarraduneyti.is/media/velferdarvakt09/29042010The-Welfare-Watch_Report-to-the-Althingi.pdf

Evaluation report for the Welfare-Watch's work from 2009-2014 will be available soon in English [See Annex II, Summary for the report].

Who did the evaluation?

An external party.

What has been measured / evaluated?

Process evaluation (respondents, method, participants' satisfaction) (please describe): The Social Science Research Institute at the University of Iceland recently evaluated the Welfare Watch. Many methods were used, questionnaires answered by the working groups in the Welfare Watch, collaborating partners and the general public. Individual interviews with ministers and people from the Steering Committee of the Welfare Watch. Focus groups among those in the working groups of the Welfare Watch and a content analysis.

In Icelandic: http://www.velferdarraduneyti.is/media/velferdarvakt09/Velferdarvaktin_Lokautgafa_150315.pdf

Evaluation report for the Welfare-Watch's work from 2009-2014 will be available soon in English [See Annex II, Summary for the report].

Evaluation of the impacts/effects/outcome (please describe the design): Analyses of progress reports from the working groups and interim reports from the steering committee to the government revealed that the steering committee utilised the work performed by the working groups to propose improvements. The working groups formulated most of their proposals in 2009 – the first year of Welfare Watch operations – and the steering committee passed on most proposals to the government that same year. The steering committee focused on the issues of unemployed people, bolstering labour-market measures, household debt issues, and education issues, to name but a few. Information on the website of the Icelandic national parliament (hereinafter "Althingi") for 2009–13 was looked at in order to ascertain what had happened to the various proposals put by the steering committee to the government. Several plans and legal acts entering into force in the early years of the financial crisis closely resemble proposals made by the Welfare Watch. Examples of this are various labour-market measures for young people not covered within the unemployment insurance system and measures for people struggling with mortgage payments.

The Social Indicators have been published annually since 2012. Social indicators, numerous publications in English: <http://www.statice.is/Pages/1377>

Health, social affairs and justice, numerous publications English: <http://www.statice.is/pages/1384>

The Social Indicators Examples of Published material in English:

- Social indicators: The quality of children's lives (2015): <http://www.statice.is/Pages/452?itemid=7b3410f1-c16d-4cf6-835d-dd3cfa38d7b9>
- Social indicators: Children and poverty: <http://www.statice.is/Pages/452?itemid=7cf65dd1-13d4-4705-98a7-4e8ee2ba7ae5>
- Social indicators: Material deprivation 2004-2013 (2014): <http://www.statice.is/Pages/452?itemid=110ec029-f96f-4d99-b3da-caefbc433e33>
- Social indicators: Tenants renting at market rates (2014):

<http://www.statice.is/Pages/452?itemid=e6efd001-4f80-49bf-be39-2b32038f6e29>.

Other (please add and describe): ‘Report of the Independent Expert on the effects of foreign debt and other related international financial obligations of States on full enjoyment of all human rights, particularly economic, social and cultural rights, Juan Pablo Bohoslavsky’ – Addendum, Mission to Iceland (8-15 December 2014):

Page 11, paragraph nr. 34: “One of the new innovative bodies formed in early 2009 was Welfare Watch, an independent consultative body which today includes more than 35 representatives, from key ministries, municipalities, social partners and civil society, many also working at grass root level. The aim was to monitor the social impact of the crisis, provide advice to State institutions and coordinate targeted interventions on the ground. Welfare Watch managed to spread the message that during the crisis the weakest in society should be protected. The watchdog submitted several reports with recommendations, including a report that was submitted to Parliament. Welfare Watch is expected to submit in 2015 additional recommendations on how to address and guarantee the rights of persons suffering multiple forms of deprivation to the Government and the Independent Expert hopes that their expert advice will be duly considered by Icelandic authorities.”

Page 20, paragraph nr. 69: “Welfare Watch should explicitly be mentioned as an innovative response to a financial crisis. The body can be credited for having improved collaboration between Government departments, local authorities and civil society in tackling the social impact of the crisis and for enhancing citizens’ participation. Its work resulted in improved social monitoring and targeted interventions by authorities and welfare organisations. Welfare Watch also helped to spread the message within public authorities and society at large that nobody should be left behind as a consequence of the banking collapse.” The report online:

http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session28/Documents/A_HRC_28_59_Add.1_AUV.doc .

What are the main results/conclusions/recommendations from the evaluation?

To structure the work further. Have an employee who can work with all the sub-groups to stop possible duplication of work. Many of the proposals from the Welfare Watch were realized or used in some way by the government, i.e. free dental care for children from low income families and much lower cost for all children under 18 in a 5 year period [See Annex II].

Is the evaluation report available, preferably in English or at least an English summary?

A report regarding the work of the Welfare Watch in 2009:

http://eng.velferdarraduneyti.is/media/velferdarvakt09/29042010The-Welfare-Watch_Report-to-the-Althingi.pdf

English report that evaluated the Welfare-Watch’s work from 2009-2014 will be available soon in English [See Annex II].

The previously mentioned Report of the Independent Expert on the effects of foreign debt and other related international financial obligations of States on full enjoyment of all human rights, particularly economic, social and cultural rights, Juan Pablo Bohoslavsky – Addendum, Mission to Iceland (8-15 December 2014):

http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session28/Documents/A_HRC_28_59_Add.1_AUV.doc.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Among other things pre-conditions for success could be:

- The Welfare Watch is a governmental level platform, with representatives from four ministries, Ministry of Welfare (Health, Social Affairs and Housing), Ministry of Finance and Economic Affairs, Ministry of Education and Culture and Ministry of the Interior and numerous governmental institutes. (See Annex I)
- Participation of other, key stakeholders, cross sectors and levels. (See Annex I)

- The utilization of data (The Social Indicators) to inform policy and practice, focusing on vulnerable groups.

What are the main lessons to be learned?

In 2014 Iceland had the presidency for the Nordic Council of Ministers and established a 3 year project based on the Welfare Watch, called the Nordic Welfare Watch. The project is divided into three separate projects: 1) The Nordic Welfare Watch – in response to crises; 2) Welfare consequences of financial crises; and 3) Nordic welfare indicators. Further information in English: <http://eng.velferdarraduneyti.is/nordicwelfarewatch/>

Web page related to the intervention

- The Welfare Watch, In Icelandic <http://www.velferdarraduneyti.is/velferdarvaktin/>
- The Nordic Welfare Watch, in English: <http://eng.velferdarraduneyti.is/nordicwelfarewatch/>

References (with possible links) to the most important articles or reports on the intervention

- Prosperity, The fight against poverty in Iceland:
http://www.velferdarraduneyti.is/media/Rit_2013/Prosperity-the-fight-against-poverty-in-Iceland-1406-C.pdf
- *The Welfare Watch - report to Althingi:
http://eng.velferdarraduneyti.is/media/velferdarvakt09/29042010The-Welfare-Watch_Report-to-the-Althingi.pdf
- The Well-being Watch, Task Force on Basic Services – Report on Basic Services and Streamlining Measures in Times of Recession:
<http://www.velferdarraduneyti.is/media/velferdarvakt09/Report-on-Basic-Services-and-Streamlining-Measures.pdf>
- Interim Report by the collaborative group monitoring welfare in the Suðurnes region:
<http://www.velferdarraduneyti.is/media/rit-og-skyrslur2012/InterimReportEnglishFeb2012.pdf>
- *The Bohoslavsky report:
http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session28/Documents/A_HRC_28_59_Add.1_AUV.doc

Contact details of person who may be contacted for further information

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Annex I (of 'Welfare Watch' Programme - Iceland)

Participants in the first Welfare Watch from 2009-2014 Steering Committee: Ministry of Social Affairs and Social Insurance Icelandic Confederation of Labour Association of Academics (BHM) Federation of State and Municipal Employees (BSRB) SA – Business Iceland Evangelical Lutheran Church of Iceland	Participants in the current Welfare Watch 2014- Ministry of Welfare – Siv Fríðleifsdóttir Chairwoman Icelandic Family Therapy Association Icelandic Family Help Centre The Debtors' Ombudsman Association of Academics (BHM) Faculty of Social Work – University of Iceland Women of Multicultural Ethnicity Network in Iceland
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Ministry of Justice Ministry of Education Ministry of Commerce Ministry of Finance Ministry of Health The Teachers Union Icelandic Red Cross Reykjavik Municipality Icelandic Association of Local Authorities (Labour market) Later additions: The Organization of Disabled in Iceland National Association of Intellectual disabilities Directorate of Labour Directorate of Health The Gender Equality Council The Debtors' Ombudsman National association of older citizens Icelandic Human Rights Centre Also more representatives joined specific working groups formed by the Steering Committee	The Office of the Ombudsman for Children Ministry of the Interior Reykjavik Municipality Federation of State and Municipal Employees (BSRB) The Organization of Disabled in Iceland The Ministry of Education and Culture Icelandic Association of Local Authorities Rights Keepers for the disabled (rettindagaeslumenn) VIRK – Vocational Rehabilitation Fund Directorate of Labour The Icelandic Mental Health Alliance National association of older citizens The National Parents Association SA – Business Iceland Unicef – Iceland Safe the Children Iceland Icelandic Human Rights Centre National Association of Intellectual disabilities Sjonarholl – Counselling Centre Directorate of Health Icelandic Confederation of Labour The Women's' Shelter The Social Insurance Administration The Centre for Gender Equality Ministry of Finance and Economic Affairs Icelandic Church Aid The Primary Health Care of the Capital Area The Homes Association The Teachers Union Red Cross Iceland
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Annex II (of 'Welfare Watch' Programme - Iceland)

Summary from the evaluation report on the first Welfare Watch (2009-2013), soon to be published online

The financial crisis in the autumn of 2008 created a new playing field in Icelandic society. Many people lost their jobs, and the Icelandic economy fell into deep recession. One of the government's responses to the financial crisis was to set up the Welfare Watch, which was in operation from early 2009 to December 2013. This assessment report discusses the organisation, implementation and outcome of the proposals made in the course of this first Welfare Watch.

The work of the Welfare Watch has been assessed by means of interviews, questionnaires and content analysis. Data was collected in the autumn of 2014. Interviews were held with the Head of the Welfare Watch, one of the project's workers and three other representatives from the steering committee. The various ministers in office during the lifetime of the Welfare Watch were also interviewed. Discussions were held in two focus groups amongst working-group representatives who had participated in Welfare Watch activities. The project was then assessed by means of three questionnaires sent to representatives of Welfare Watch working groups, staff in agencies involved in the project and the general public. Finally, the content of reports, minutes and other material connected to the Welfare Watch was analysed in order to gain insight into the organisation of the project and the proposals generated.

The Welfare Watch was set up and mandated by Asta Ragnheidur Johannesdottir, then Minister for Social Affairs and Social Security. The Minister entrusted the then-Head of the Welfare Service, Lara Bjornsdottir, with the task of running the Welfare Watch and recruited Ingibjorg Broddadottir, who at that time worked as an expert in the Employment and Equality Office, to work on the project. The Director of the Icelandic Federation of Skilled Construction and Industrial Workers, Thorbjorn Gudmundsson, was also brought in to work on the project. This group decided jointly on the composition of the Welfare Watch's steering committee.

The steering committee was made up of representatives from ministries, stakeholders, Reykjavik City Council, the Association of Icelandic Local Authorities and the third sector (NGOs). From the interviews with ministers and members of the steering committee, it emerged that people were generally satisfied with how successfully a broad group of people with varying knowledge and experience had been put together. The steering committee set up working groups to deal with the various projects that it deemed urgent to tackle. Each working group was headed by a chairman who also sat on the Welfare Watch steering committee. These chairmen had the task of calling upon

people with expert knowledge in the specific fields dealt with in each group. Each working group had the task of assessing the consequences of the financial crisis on the group in question and proposing improvements for the use of the steering committee in its interim reports to the government.

When the Welfare Watch was set up, it was given the task of monitoring the social and financial repercussions of the financial crisis on individuals and families and proposing improvements. The Welfare Watch's mandate was renewed during the term of office of Guðbjartur Hannesson. The commission letter he issued stated that the steering committee must keep both the government and public fully informed and act independently. A survey among the members of Welfare Watch working groups contained questions on how well the Welfare Watch had fulfilled its role. A large majority, i.e. 84%, felt that the social and financial consequences of the economic crisis had been well monitored, but fewer considered that proposing improvements had been successful. The role of the Welfare Watch was also discussed in interviews with ministers and members of the steering committee. These discussions included what people understood regarding the Welfare Watch's independence. Respondents agreed that the Welfare Watch had been independent in the sense that the group decided for itself what issues were discussed and how these issues were discussed. Some, however, felt that a working group appointed by the government could hardly be considered independent.

The Welfare Watch handled projects of various types. Meetings were held on the situation in Icelandic society in both the steering committee and working groups, and the steering committee of the Welfare Watch also issued conclusions, recommendations and challenges; wrote five progress reports containing recommendations for the government; had audits done; and organised meetings and forums. These projects were more often than not aimed at children, families with children and young people. Respondents from the steering committee agreed that urging municipal councils to ensure school-meal provision was one of the most important recommendations the committee had issued and that the number of schools offering children free porridge in the morning had risen considerably. The recommendation to ensure children's dental health was also considered to have been effective.

The defined role of the Welfare Watch was to act as analysts and advisors. In two cases, however, the Welfare Watch was actually responsible for implementing projects. One of these two projects was to set up social indicators – respondents from the steering committee felt this to be one of the most important of the Welfare Watch's projects. These social indicators provide a collection of statistical data in one place, enabling the public and the government to follow developments and changes in society and compare the situation of various groups to that in other countries. The other project was to set up the Sudurnes Watch. The results of the Sudurnes Watch include fostering co-operation between the police, social services and child protection services in the field of domestic violence.

Meetings of the Welfare Watch steering committee were used to discuss the activities of the working groups, to present the work performed at the workplaces of the group's members and to gain insight and expertise from individuals outside the Welfare Watch. The role of the Welfare Watch chairman was to convene the group and oversee its activities. They did not, however, set the group specific tasks, as the members of the steering committee would generally reach their own conclusions as to which matters needed attention at any given time. Interviews with members of the steering committee included discussions of how the group's meetings had been used. Respondents appreciated how often the Welfare Watch met, particularly in the early stages of the financial crisis when many matters were pressing. There were, however, some instances of excessively long agendas and meetings. Some indicated that excessively long meetings could get in the way of members' other activities and prevent material presented by attendees from being utilised as it should. There were high levels of satisfaction with the work of the chairman, who was considered to possess a good deal of knowledge and experience.

Assessing the work of the Welfare Watch included assessing working methods and management within the working groups. The replies given by respondents suggest that working methods were similar to those present in the steering committee. The chair ran and convened the group, but in every other respect, things were done by teamwork, with the group deciding collectively what material was worth examining. From focus group discussions, it emerged that, in some cases, the division of tasks within working groups was unclear. A questionnaire answered by members of the working groups showed that 57% of respondents were satisfied with how tasks were divided within their groups, while 13% were unsatisfied.

Interviews with members of the steering committee revealed that, while heated debates on individual matters were frequent, the group had worked together well. A majority of working-group questionnaire respondents (78%) indicated that they were satisfied with the level of communication with others in the working group. Respondents from Welfare Watch working groups did, however, consider that more co-operation was needed between the steering committee and the working groups. It was considered important to strengthen the ties between the members of the working groups and the steering committee to ensure that the members of the working groups gained a better understanding of what was expected of them. Information was requested on the results of the work carried out in the working groups.

Analyses of progress reports from the working groups and interim reports from the steering committee to the government revealed that the steering committee utilised the work performed by the working groups to propose improvements. The working groups formulated most of their proposals in 2009 – the first year of Welfare Watch operations – and the steering committee passed on most proposals to the government that same year. The steering committee focused on the issues of unemployed people, bolstering labour-market measures, household debt issues, and education issues, to name but a few. Information on the website of the Icelandic national parliament (hereinafter "Althingi") for 2009–13 was looked at in order to ascertain what had happened to the various proposals put by the steering committee to the government. Several plans and legal acts entering into force in the early years of the financial crisis closely resemble proposals made by the Welfare Watch. Examples of this are various labour-market measures for young people not covered within the unemployment insurance system and measures for people struggling with mortgage payments.

Interviewees considered the Welfare Watch to have had a significant effect on welfare in Iceland at the beginning of the financial crisis. This was also the case for individuals external to Welfare Watch. Surveys among the general public and the staff in public bodies represented in the Welfare Watch revealed that half of those who had heard of the Welfare Watch considered it to have been very important for Icelandic society in the early years of the financial crisis. One aspect of the importance of the Welfare Watch was the various reports containing proposed improvements used by the government to prioritise tasks. One respondent indicated that the work of the Welfare Watch may have contributed to fewer cutbacks being made in welfare than in other areas. Note was also made of the fact that, although not all the Welfare Watch's proposals had been implemented, its work had an indirect impact on welfare in Iceland by raising awareness about issues requiring attention. Increased debate subsequently led to entities other than the government taking on such issues.

Through the Welfare Watch, various public bodies and organisations worked together on welfare issues, and representatives of the Welfare Watch felt they had learnt a great deal from their participation in this cross-discipline project. Respondents agreed that co-operation on a broad basis had played a crucial role in efforts to improve the situation of people in Iceland. A large majority of working-group members expressed pride at having taken part in Welfare Watch working groups.

Well London Programme United Kingdom

Which 'life stage' for CVDs prevention targets the intervention?

All life stages.

Short description of the intervention:

The Well London Programme started in 2007 and has run since then. It has been funded by the national lottery and consists of a series of programmes run in 20 of London's most deprived areas. It was devised in the context of the Mayor of London's health inequalities strategy and was led by an alliance of representatives covering major development priorities for London. The Well London delivery team contributes to policy objectives such as improving wellbeing and equality, capacity building and participation as delivery of better services. Its aim is to improve all these areas. Each project recruits teams of volunteers from deprived areas who receive training in outreach and health promotion and then go out into their communities to signpost local residents to services and activities that promote health and wellbeing. Phase 1 ran from 2007 to 2011 and included a suite of 14 projects aimed at building community capacity and cohesion it focused on physical activity, healthy eating, mental wellbeing, local environments, arts and culture. Its collective aim was to improve health and wellbeing. Over 47000 people took part in phase 1. It was evaluated in 2011/2012 and was found to have had very positive impacts in improving diet and physical activities. The results of the evaluation have informed the development of Phase 2 of the programme which has run from 2012 to 2015 and is being evaluated.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes, the programme has been designed following community research carried out by the University of East London, which identified a need to provide local residents with skills to increase opportunities for volunteering to work in their communities to improve health and wellbeing and raising awareness around health issues. Relevant data showed that the residents in the areas targeted had worse than average health (for London). The project was based on the social marketing theory which recognises that a peer-to-peer approach is often effective in motivating people to take up activities and make lifestyle changes. In some ways Phase 1 was a pilot for the programme.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes. Initially, 15 volunteers with existing relationships within their communities were trained to reach out and empower local people. Volunteers went out twice per week for 4 hours per day on promoting activities and talking to and befriending residents. The recruitment of volunteers from the local community meant that those who were not usually reached by services or involved in projects were more likely to be reached and engaged.

To which type of interventions does your example of good practice belong to?

It is a community based approach.

How is this example of good practice funded?

The National Lottery fund is a non-governmental organisation.

What is/was the level of implementation of your example of good practice?

Regional and local.

What are the main aim and the main objectives of your example of good practice?

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

Please give a description of the problem the good practice example wants to tackle:

Lack of exercise and poor diet leading to obesity and its consequences. The prevalence of obesity in the UK population is one of the highest in Europe and it is higher in the poor communities that are targeted by the Well London project. Type 2 diabetes and cardiovascular diseases are more prevalent in these poor communities. Due to a number of barriers the targeted groups often did not seek health care and preventive advice until they had advanced problems.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, within the Mayor of London's health inequalities strategy.

Implementation of your example of good practice is/was:

Continuous. It started in 2007 and continues to run.

Target group(s):

In general, the entire population of the most deprived parts of London.

During implementation, did specific actions were taken to address the equity dimensions?

Yes one of the aims is and was to reduce inequalities.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted

Yes, socio-economically deprived groups were targeted in poor urban areas and the volunteers worked in their own ethnic groups.

Which vulnerable social groups were targeted?

All those who were not engaging with local services

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants,?

Yes, there were and are a wide variety of activities to achieve the aims of the project. They included such activities as helping people to grow their own healthy food, to buy healthy food at low cost and cook it, physical activities, reaching out to hard to reach groups, etc.

Was an effective partnership in place?

Yes the programme involves local volunteers, health and social workers and local politicians and it was supported by multiple organisations listed on page 16 of this template.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes, with the Mayor of London's health inequalities strategy.

Was the intervention implemented equitably, i.e. proportional to needs?

Yes, no one took part unless they wished to.

Were potential burdens, including harm, of the intervention for the target population addressed?

Given the nature of the project it is difficult to see how there could be harm to anyone involved.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

Yes, they were well publicised and described in the media, on the project website and by the volunteers.

Did the evaluation results achieve the stated goals and objectives?

Yes, see the Well London Phase 1 evaluation which is freely available online and the plans for the phase 2 evaluation.

Did the intervention a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. The evaluation was based on the Medical Research Council's guidelines for evaluating complex interventions and aimed to capture evidence of impact on the participants' health behaviours and wellbeing and on the local environment. Its results informed the development of Phase 2 of the project.

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

There was constant feedback from the volunteer community workers.

Who did the evaluation?

Both – internal and external parties.

Specifically, what has been measured / evaluated?

While project and programme evaluations focused on those delivering or participating in the Well London activities, a controlled trial sought to assess its wider impact. It sought to assess the wider impact on the population of within target areas. It examined the effects of the programme on healthy eating, physical activity and mental wellbeing, as well as on social factors such as community cohesion.

Evaluation of the impacts/effects/outcome (please describe the design): Data from adults were collected by household surveys before and after the intervention in target areas. Matched areas from the same borough acted as controls. For a full description please download the report of the Phase 1 evaluation from www.info@welllondon.org.uk

What are the main results/conclusions/recommendations from the evaluation?

The scale and complexity of the Well London programme mark it out as a nationally and internationally significant initiative applying a community development approach in neglected urban areas. It is generating learning and evidence not only to support its integration locally but also to inform wider policy and practice in a field of growing importance.

Is the evaluation report available?

Yes, it is on the Well London website: www.info@welllondon.org.uk

Was there a follow-up or is any follow-up evaluation planned in the future?

An evaluation of Phase 2 of the programme is underway. For details, visit the Well London website www.info@welllondon.org.uk.

Who implemented the intervention?

The Well London Delivery Team coordinated by City Gateway. Each of the multiple interventions had its own team for example one which involved the establishment of a food co-operative included the development manager of a local school, a community dietitian, a social worker, a teacher and volunteers. The project was supported by a number of organizations.

What core activities are/have been implemented?

Training sessions, multiple events, website, published evaluations.

Was the intervention designed and implemented in consultation with the target population?

Yes, the first volunteers went out in to the community seeking out people who had not previously engaged and fed back to the development team.

Did the intervention achieve meaningful participation among the intended target population?

Yes, 47000 participated in Phase 1 of the project.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes, it empowered local residents through a series of different activities.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

Prior to the project, the University of East London had identified needs in the local community.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

Yes, the use of volunteers from the communities involved was key to the success of the project.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

The project started in 2007 and continues. It has been funded by the Big Lottery Wellbeing Fund and is hosted by the Greater London Authority. In the UK no funding is guaranteed to go on forever but as far as I am aware there are no plans to stop the funding.

Is there a broad support for the intervention amongst those who implement it?

Yes, the programme is delivered by the Well London Alliance which is a partnership between the Arts Council England, Central YMCA, Groundwork London, the London Sustainability Exchange, South: London and Maudsley NHS Foundation Trust and the University of East London. It was originally led by the London Health Commission and hosted by the Greater London Authority.

Is there a broad support for the intervention amongst the intended target populations?

Yes, the Phase 1 evaluation indicates that this is the case.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

A realistic assessment of the problems prior to the commencement of the programme; Adequate funding; A well-coordinated and enthusiastic team; Use of well-motivated and enthusiastic volunteers to reach out to the communities in which they lived.

What were, in your opinion, the main lessons to be learned?

Local people respond well to health advice if it is delivered by their peers who can understand their culture and environment rather than by well-meaning but sometimes "distant" health and social workers.

Web page related to the intervention

www.info@welllondon.org.uk

References to the most important articles or reports on the intervention

- Well London Phase 1 Evaluation at www.info@welllondon.org.uk (accessed on 3 May 2015).
- Philips G et al. Well London Phase 1. Results among adults of a cluster randomised trial of community engagement to improving health behaviours and mental wellbeing in deprived inner city neighbourhoods. *J Epidemiol Community Health* 2014. doi:10.1136/jech-2013-202505 (epub ahead of print).
- Philips G et al. Measures of exposure to the Well London phase 1 intervention and their association with health, wellbeing and social outcomes. *J Epidemiol Community Health* 2014. doi:10.1136/jech-2013-202507 (epub ahead of print).
- Derges J et al. Well London and the benefits of participation, results of a qualitative study nested in a cluster randomised controlled trial. *BMJ Open* (In press).

Contact person for further information

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'Tobacco Free Ireland' Ireland

Which 'life stage' for CVDs prevention targets the intervention?

The intervention relates to a population-wide comprehensive tobacco control programme that targets the general population and features particular elements targeting smokers (in the context of supporting smoking cessation).

Short description of the intervention:

Tobacco smoking remains a highly significant cause of premature death, illness and disability across Europe in the JA- CHRODIS priority areas of cardiovascular disease and stroke. In addition, smoking is a major contributor to premature mortality, illness and disability for those at risk of Type 2 diabetes and those with diagnosed diabetes.

There is a consensus view, from international experts and the learnt experience of the implementation of tobacco control measures in many European countries, that tobacco control policies are most successful where they are comprehensive in nature and include strong commitments to regulation on the sale of tobacco products, denormalisation and high level, far-reaching supports for smoking cessation.

The Irish tobacco control programme is being proposed as a national policy 'intervention' which demonstrates many of the known elements of successful tobacco control, is putting those elements into real action and is demonstrating tangible results for smoking prevalence and engagement with smokers on smoking cessation. The policy is being proposed as a model of good practice as a comprehensive government-led approach, a key element of success in addressing embedded negative health behaviours and in the prevention of chronic diseases. Ireland was the first country in Europe to implement the smoke-free legislation in workplaces and was pivotal in negotiating and supporting the recent EU Tobacco Products Directive during its presidency of the European Union in 2012. The Tobacco Free Ireland policy was published in 2013, the first policy published in the context of the Healthy Ireland Framework for Health and Wellbeing 2013-2025. The policy includes commitments that - Policy implementation be guided by a clearly articulated action plan

- A whole-of-government approach be taken with all government officials, employees of state agencies and members of any government branch responsible for setting and implementing tobacco control policies and for protecting those policies against tobacco industries interests. The main areas of action relate to
- the protection of children and denormalisation of smoking
- legislative compliance and regulation of the retail environment
- monitoring of tobacco use and prevalence
- protecting people from tobacco smoke
- offering help to quit tobacco use
- warning about the dangers of tobacco
- raising taxes on tobacco products
- building national and international partnerships

The commitments made in Tobacco Free Ireland go further than many other European countries, particularly in the context of promotion and expansion of smoke-free campuses and features a number of significant legislative and regulatory measures. In addition, Ireland has committed to introduce standardised packaging of tobacco products, in line with considerable evidence supporting this measure as a means to deter young people from taking up smoking and to stimulate and support quit attempts (see references). The tobacco control programme delivers specific actions in the context of the World Health Organisation MPOWER model, including a far-reaching, evaluated and comprehensive national smoking cessation awareness and support programme and an accredited national brief intervention training programme for smoking cessation.

The Health Service Executive are implementing a national Tobacco Free Campus Policy. The Irish government has consistently actioned its commitment to rigorously defend legal challenges to tobacco control legislation developed in the context of Tobacco Free Ireland in the courts.

The Irish government has consistently actioned its commitment to rigorously defend legal challenges to tobacco control legislation developed in the context of Tobacco Free Ireland in the courts. A high level action plan for Tobacco Free Ireland was published in March 2015. An annual report on implementation is expected to be published later this year, which provides an update on progress up to end 2014. The following sections detail some of the findings from our national data sources on the implementation of the programme and its effects.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Tobacco Free Ireland was developed by a Tobacco Policy Review Group. The policy was informed by a stakeholder workshop as well as through a thorough consideration of the international evidence-base. The report of the Tobacco Policy Review Group includes an assessment of national data on smoking prevalence and behaviours as well as an appraisal of the context of relevant European and international policies, Council recommendations and directives.

All initiatives within the implementation are evaluated with a view to maximising the denormalisation of smoking. Raising taxes on tobacco products and introduction of standardised packaging are strongly supported by the international evidence base. With this evidence in mind, many elements of the Tobacco Free Ireland policy can be considered to deliver a positive equity impact. For example, please view the TV advertisements from this perspective (<https://www.youtube.com/playlist?list=PLEBA5026888903B15>).

The design and implementation of the QUIT smoking cessation marketing campaign was based upon an appraisal of local research, expert participation and best international evidence with a firm commitment to reach those most likely to smoke, in particular lower socio-economic groups. International evidence shows that campaigns that combine why to quit and how to quit messages and adopt a hard-hitting emotive tone are likely to be most successful. A review of HSE social marketing campaigns for the period 2006-2009 pointed to the need for greater integration and engagement between mass media campaign activity and service delivery channels.

The national standards for cessation support was informed by NICE guidance, the New Zealand smoking cessation guidelines (2007) and the UK NHS programmes.

The Tobacco Free Ireland policy has a research and evaluation strand which supports the ongoing quality improvement of the various initiatives under the policy including the expansion of smoke-free places and the development of the smoking cessation mass media campaigns and support services.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

The objectives and actions of the tobacco control programme are clearly detailed in the Tobacco Free Ireland policy document and the allied action plan which includes specific, measurable, achievable, relevant and time bound commitments to implementation of the various elements of the policy.

The action plan for the implementation of the policy was published in March 2015. An annual report detailing progress with implementation is expected by end 2015. Links to all these documents are provided at the end of this form.

What is/was the level of implementation of your example of good practice?

National policy level initiatives in the area of regulation, legislation and monitoring. Regional and local level initiatives in the areas of enforcement and delivery of smoking cessation support and support for development of smoke-free spaces. The intervention is a national tobacco control programme linked with the Healthy Ireland Framework for Health and Wellbeing 2013-2025.

What are the main aim and the main objectives of your example of good practice?

The Tobacco Free Ireland policy and allied tobacco control programme aims to create an Ireland that is tobacco-free by 2025. This would mean that less than 5% of the Irish population would smoke by 2025. Ireland is the first country in Europe to propose a target of less than 10% for smoking prevalence.

The Irish government intends to achieve this goal through the implementation of an evidence-based, comprehensive, ambitious and integrated set of measures which will ultimately reduce the number of people starting to smoke and increase the numbers of people successfully quitting smoking.

Please give a description of the problem the good practice example wants to tackle::

Tobacco use is the leading cause of preventable death in Ireland. Each year at least 5,200 people die from diseases caused by tobacco use, representing around 19% of all deaths. Around 30% of those smoking-related deaths are attributable to circulatory diseases including cardiovascular disease and stroke. It has been estimated that smoking is the cause of up to 2,500 strokes and 500 stroke-related deaths a year in Ireland. Irish health expenditure on smoking-related diseases was approximately €500million in 2009.

Smoking is a leading risk factor for premature mortality in the WHO European Region, causing about 1.6 million deaths a year. Smoking-related deaths account for a large proportion of the gender gap in mortality found in European countries (typically 40 to 60%). Smoking is also highly significant in terms of health inequalities in the occurrence of, and disability from, cardiovascular disease and stroke.

Results from the next national health survey in Ireland (the first Healthy Ireland Survey) are expected later this year. However, data from a monthly telephone survey of persons aged 16 and over indicate that the overall prevalence of smoking in Ireland in 2014 was 19.5%. Smoking rates were highest among young adults (18-34 years) and over one third of all smokers were regular smokers (11-20 cigarettes per day). The highest smoking rates were in the lowest socio-economic groups. 54.1% of smokers are male. On average 12.7 cigarettes are smoked per day by regular smokers. While this data indicates that smoking prevalence among children and adults in Ireland compares favourably with many other European countries, the prevalence of smoking remains highly significant in terms of the implications for Ireland's population level risk of cardiovascular disease and stroke. According to the Health Behaviour in School-Age Children survey, in 2010, 11.9% of children aged 10 to 17 were current smokers.

Tobacco use is a significant issue in all European countries, with wide inequalities in tobacco-related harm both within and across European states.

During implementation, did specific actions were taken to address the equity dimensions?

The Tobacco Free Ireland policy acknowledges the extent of socio-economic inequality in smoking prevalence and tobacco-related harms.

The World Health Organization guidance for addressing inequities in tobacco-related harm emphasises the importance of (a) monitoring the impact of tobacco control policies on different socio-economic groups in all routine tobacco prevalence surveys (b) ensuring NRT and smoking cessation support are affordable and accessible to low income groups (c) ensuring enforcement on smoke-free legislation in low income workplaces (d) use of mass media campaigns that use TV rather than print, are intensive in exposure, use messages targeted at disadvantaged groups and use emotive personal stories (e) restrict sale of tobacco to minors, especially in deprived neighbourhoods (f) require large pictorial warnings on tobacco products (g) delivery smoking cessation in a broad range of settings and offer specialist services to high-need groups, use smoking cessation and SMS to reach young disadvantaged people

Similarly, the European Commission Report to the Consumers Health and Food Executive Agency examined best practice in actions on tobacco to reduce health inequalities. This concluded that (a) increases in the prices of tobacco have the largest potential for reducing inequalities due to smoking (b) legislative-based expansion of smoke-free places show potential in reducing inequalities in smoking (c) mass media campaigns have a neutral or

slightly negative equity impact but campaigns that are emotive, graphic and based on personal testimony have more impact among those in the lowest socio-economic groups (d) the provision of comprehensive tobacco cessation services targeted at disadvantaged communities shows positive equity impact.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

The Tobacco Free Ireland policy is committed to addressing inequalities and this has been integral to the design of the policy and its implementation. The principal elements of the policy which relate to addressing inequalities include the commitment to raise tobacco prices through taxation (including particular price rises for roll your own tobacco), additional measures to address illicit tobacco, the specific social marketing design of the mass media campaign, the commitment to address cost barriers in accessing Nicotine Replacement Therapy and the development of free at point of access standardised smoking cessation support. Please view the round of TV ads here in consideration of the elements known to succeed in relation to mass media and lower socio-economic groups, <https://www.youtube.com/playlist?list=PLEBA5026888903B15>. The campaign has won two awards for advertising effectiveness at the ADFX 2014 Irish Advertising Awards.

Which vulnerable social groups were targeted?

- Smokers
- Lower socio-economic groups
- Children
- Patients and health care workers (smoke-free health care campuses)
- Pregnant women and persons with mental health issues (through focussed skills training for health service providers).

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

Tobacco Free Ireland is a comprehensive approach encompassing broad cross-government policy, regulatory and legislative measures as well as fostering co-ordinated regional and local action in terms of smoking cessation. The expansion of smoke-free spaces in a variety of settings including hospitals, health care facilities, playgrounds, beaches and universities/schools uses a settings based approach to denormalise smoking.

Communities and health promotion/environmental health personnel are empowered to initiate and support the development of smoke-free spaces not just through a national policy mandate but also through the availability of defined toolkits and resources.

The HSE launched the new QUIT service in late 2014 with a new support team of counsellors available over the phone, by email, live web-chat, SMS text or via Twitter or Facebook. The QUIT service also has a new interactive website and online QUITplan offering a standardised treatment programme over 12 months. Smokers considering a quit attempt are provided not just with advice to quit but with practical support to empower them to take control over their own health as well as empathy and personal support. The QUIT campaign and allied smoking cessation services provide choice to the smoker in selecting an approach suited to their individual circumstances and preferences, the opportunity to progress their quit journey through face-to-face, telephone or online support. Smokers can also choose to engage with the support of other smokers and ex-smokers through the facebook group and other social media. All services are free at point of access and highly accessible.

While the policy makes no specific reference to addressing the social determinants of health, the targeted approach to reduce smoking among economically disadvantaged communities is significant in terms of social determinants of health – the social and economic cost of smoking is high in disadvantaged communities and a major contributor to poverty and deprivation, in particular child poverty. By tackling smoking in disadvantaged communities there is a direct benefit not just to health but to income and opportunities.

Was an effective partnership in place?

A critical element of the success of the policy is the partnership approach employed. There are defined high level partnerships across government departments and between those tasked with leading on implementation lead agencies in the community and voluntary, advocacy and clinical leadership sectors. For example, the Irish Cancer Society, Irish Heart Foundation, Irish College of General Practitioners and others have joined with the mass media campaign to ensure maximal impact.

The HSE Tobacco Control Partners Group meets regularly to share and discuss the implementation of the policy with statutory and non-statutory stakeholders.

Was the intervention implemented equitably, i.e. proportional to needs?

The European Commission Report to the Consumers Health and Food Executive Agency examined best practice in actions on tobacco to reduce health inequalities. This concluded that (a) increases in the prices of tobacco have the largest potential for reducing inequalities due to smoking (b) legislative-based expansion of smoke-free places show potential in reducing inequalities in smoking (c) mass media campaigns have a neutral or slightly negative equity impact but campaigns that are emotive, graphic and based on personal testimony have more impact among those in the lowest socio-economic groups (d) the provision of comprehensive tobacco cessation services targeted at disadvantaged communities shows positive equity impact. With this evidence in mind, many elements of the Tobacco Free Ireland policy can be considered to deliver a positive equity impact. See also responses to previous questions.

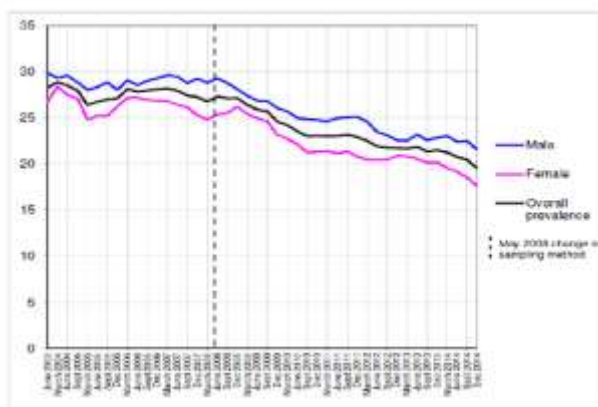
Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

The policy and its action plan are publicly available documents. An annual report on implementation will be made available in due course. Progress with implementation is discussed regularly with a range of relevant stakeholders through the meetings of the HSE Tobacco Control Partners Group.

Did the evaluation results achieve the stated goals and objectives?

Smoking prevalence: Data on smoking prevalence from the first Healthy Ireland Survey will be available later this year. Based on data from a monthly telephone survey and using moving averages among those aged 16 and older, overall smoking prevalence in Ireland has declined from 28.3% to 19.5% between 2003 and 2014. In the first year of the Tobacco Free Ireland policy, the overall prevalence of smoking fell from 21.5% in 2013 to 19.5% in 2014 – this equates to 70,000 fewer smokers in 2014 compared to 2013.

Smoking in Ireland 2014 – Synopsis of Key Patterns:
Cigarette Smoking Prevalence by Gender (12 month moving average)



Data from the most recent wave of the Health Behaviour in School-age Children Survey is expected later this year. Smoking among children is declining. The proportion of children aged 10 to 17 reporting that they had ever smoked fell from 36% to 27% between 2006 and 2010. Between 2002 and 2010, the proportion of children who ever tried a cigarette reporting that they first tried a cigarette under the age of 13 has declined. In 2010, 11.9% of children age 10 to 17 were current smokers.

Smoking cessation: Since the QUIT campaign started in 2011, it has been estimated that over 600,000 quit attempts were made in Ireland, more than double the level of quits before the campaign started. Since 2011, the average uptake of online support services has more than doubled, with calls to the national smokers quit line remaining steady. In 2014, the HSE undertook work to improve integration between the QUIT media campaign and HSE smoking cessation services with the establishment of the HSE QUIT team. An integrated one-stop model QUIT service was developed in 2014. Early results show significant increases in service activity from the campaign activity. (See report for full detail <http://www.lenus.ie/hse/handle/10147/312193>).

The conversion rate (converting contacts made into quit attempts) has also seen positive trends in recent years (See report <http://www.lenus.ie/hse/handle/10147/312193>).

An evaluation of the Brief Intervention for Smoking Cessation Training Programme was completed in 2014.

National standards for smoking cessation support have been published and an online course was delivered to staff in 2014.

Specific training in relation to smoking cessation in the context of mental ill-health and pregnancy were developed in 2014, with speciality online modules produced. The uptake of the training is under evaluation.

Expansion of smoke-free spaces and denormalisation of smoking: The Department of Health is a smoke-free campus. All Health Service Executive acute hospitals have implemented the HSE Tobacco Free Campus Policy. Around two thirds of primary care sites have implemented the policy. The HSE has committed to implement policy in line with the European Network of Smoke Free Health Services standards. An audit of a sample of tobacco-free campuses was conducted in 2014. The development of smoke-free spaces will be expanded through integration with the Healthy Ireland Healthy Workplace Policy. Work is underway in partnership with a range of stakeholders on the development of smoke-free schools and third-level education settings, parks and beaches and playgrounds. 4 out of 5 local authorities have implemented or agreed to implement a smoke-free playground policy.

The National Environmental Health Service Tobacco Control Inspection Programme continues to rigorously monitor the enforcement of smoke-free legislation and operate test purchasing of tobacco products to minors. The Protection of Children's Health (Tobacco Smoke in Mechanically Propelled Vehicles) Bill 2014 is underway to progress the legislation. This legislation will prohibit smoking in cars when children are present.

Did the intervention have a defined and appropriate evaluation framework assessing structure, processes and outcomes?

The policy is accompanied by a defined Tobacco Free Ireland Action Plan and an annual report on progress with implementation will be made available later this year. A number of evaluations are in place across the various elements of the programme including

- Audit of tobacco –free campuses
- Evaluation of brief intervention training
- Ongoing monitoring and evaluation of the QUIT campaign and allied services.
- Audit of smoking behaviour among HSE staff.

Specifically, what has been measured / evaluated?

- . Process evaluation
 - Audit of tobacco –free campuses
 - Evaluation of brief intervention training
 - Ongoing monitoring and evaluation of the QUIT campaign and allied services.
- . Evaluation of the impacts/effects/outcome The policy is accompanied by a defined Tobacco Free Ireland Action Plan and an annual report on progress with implementation will be made available later this year.

What are the main results/conclusions/recommendations from the evaluation?

There is not yet a formal review or evaluation report on the Tobacco Free Ireland policy and its allied programme. The policy was published in 2013 and will conclude in 2025, at which stage the success of the policy in meeting its aim of a smoking prevalence of less than 5% can be assessed. In the interim, the Irish government continues to produce annual reports of progress on smoking prevalence and periodic updates on the achievement of policy actions. Please see answers to previous questions for further details.

Who implemented the intervention?

Department of Health, Tobacco and Alcohol Control Unit (TACU) in partnership with the HSE national tobacco control office and division and wider stakeholders.

What core activities are/have been implemented?

- Development of legislation to regulate the appeal, affordability and accessibility of tobacco products to minors.
- Expansion of smoke-free spaces.
- Training of health service providers.
- Development of tools and guidelines to support evidence based practice.
- Development and refinement of smoking cessation support services and mass media campaigns (QUIT).
- The HSE launched a new free QUIT support service on 30th December 2014, with a new support team of counsellors (i.e.. the QUIT Team) available over the phone, by email, live web-chat, SMS text or via Twitter or Facebook. The QUIT service also has a brand new interactive website and online QUIT plan.

Quitters can also order a QUIT kit on quit.ie which includes the QUIT booklet guide to quitting, a money box for saving the cash not spent on cigarettes, a wristband and pencil, a wallet card and post-it pack. QUIT Support service is evidence-based and offers quitters a standard smoking cessation support programme, where they will be tracked and supported for 12 months. The QUIT support service offers the standard treatment programme to quitters and comprised of 7 contacts with the client as follows:

The first consultation is approximately 20 minutes, which can be scheduled for any convenient time, where the quitters smoking habits, triggers and reasons to quit are analysed. If the smoker is ready to quit, they set a quit date. The QUIT team schedule calls for the quit date and once a week for the first 4 weeks with follow up calls at 3 months and 12 months. Quitters can call, text or use Facebook to contact the QUIT team between scheduled calls to get support when and how they need it, and will usually speak to the same advisor throughout the process. QUIT support via Website www.QUIT.ie. The QUIT.ie website has been completely redesigned and updated to match the new QUIT support service. The site is mobile and tablet friendly, and for users who prefer to QUIT without one-to-one support, offers an independent QUIT plan, with daily email and SMS support, an option to LIVE CHAT with an advisor if needed. Quitters can log in at any time to check on their progress, how much money they've saved, how far they've come and find answers to common questions.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

The HSE launched the new QUIT service in late 2014 with a new support team of counsellors available over the phone, by email, live web-chat, SMS text or via Twitter or Facebook. The QUIT service also has a new interactive website and online QUITplan offering a standardised treatment programme over 12 months. Smokers considering a quit attempt are provided not just with advice to quit but with practical support to empower them to take control over their own health as well as empathy and personal support. The QUIT campaign and allied smoking cessation services provide choice to the smoker in selecting an approach suited to their individual circumstances and preferences, the opportunity to progress their quit journey through face-to-face, telephone or online support. Smokers can also choose to engage with the support of other smokers and ex-smokers through the facebook group and other social media. All services are free at point of access and highly accessible.

Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population?

The policy is based on robust high level partnership across government departments and across sectors. For further detail, see response on partnership.

Are there specific knowledge transfer strategies in place (evidence into practice)?

- Political support and leadership
- Leadership and commitment within the senior civil service and across government departments
- Excellence in evidence-informed programme design and implementation
- Persistence
- Partnership with key stakeholders in many disciplines and sectors
- Integration of audit and evaluation into key elements of the programme.

What were, in your opinion, the main lessons to be learned?

Smoking remains a most significant contributor to chronic disease in Europe. It's time for greater action across Europe and there are valuable lessons from the Irish experience.

Web page related to the intervention

Tobacco Free Ireland policy and related information

<http://health.gov.ie/healthy-ireland/tobacco/>

Tobacco Free Ireland Action Plan

<http://health.gov.ie/blog/publications/tobacco-free-ireland-action-plan/>

Quit website – portal to smoking cessation information, support and referral

<https://www.quit.ie/>

HSE tobacco free campuses initiative <http://www.hse.ie/tobaccofreecampus>

HSE National standard for smoking cessation programmes

<http://www.hse.ie/eng/about/Who/TobaccoControl/cessation/>

National Tobacco Control Office <http://www.ntco.ie/>

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Other relevant documents:

Toolkit of resources for tobacco-free campuses including information for staff and patients guidance for managers, 'Yes but No Butt' DVD etc. <http://www.hse.ie/tobaccofreecampus>

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NICE Public Health Guidance on the Prevention of Cardiovascular Disease at a Population Level United Kingdom

Which 'life stage' for CVDs prevention targets the intervention?

All life stages.

Short description of the intervention:

The United Kingdom's Department of Health asked the National Institute for Health and Care Excellence (NICE) to produce public health guidance on the prevention of cardiovascular disease (CVD) at population level. The resulting guidance was published in 2010 and is for the government, the NHS, local authorities, industry and all those whose actions influence the population's cardiovascular health, including health commissioners, managers and practitioners working in local authorities, the wider public and voluntary and community sectors. The guidance complements NICE guidance on smoking cessation and prevention and tobacco control, physical activity, obesity, hypertension, maternal and child nutrition and alcohol misuse. The aim of the guidance is to encourage patients, policy makers and managers in all sectors and healthcare practitioners to be aware of the risk factors for CVD and to minimise them to prevent the condition from arising.

The target groups are: Ministers, the relevant government officials and policy makers at all levels in the Departments of Health, Business, Culture, Media and Sport, Education, Environment, Food and Rural Affairs, Transport, the Advertising and Food Standards Agencies, the Medical Research Council, Caterers, Food and Drink Producers and Retailers, Farmers, Marketing and Media Industry and Non-governmental agencies such as the British Heart Foundation, Diabetes UK and the Stroke Association.

The guidance has 21 recommendations, each with actions. The topics are:

Salt content of food

Saturated Fats

Trans fats

Marketing and Promotion aimed at children and young people

Commercial interests

Product labelling

Health impact assessment

Common agricultural policy

Physically active travel

Public sector catering

Take-aways and other food outlets

Monitoring

Regional CVD prevention programmes - good practice principles

Regional CVD prevention programmes - preparation

Regional CVD prevention programmes - programme development

Regional CVD prevention programmes - resources

Regional CVD prevention programmes - leadership

Regional CVD prevention programmes - evaluation

Children and young people

Public sector food provision

Physical activity

Health impact assessments of regional and local plans and policies

They have heightened the awareness of all groups involved to the risk factors for CVD and the actions to be taken to avoid them.

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Yes, the guidance was developed by an invited expert committee, who reviewed all the relevant literature and drafted the guidance in the light of the best available evidence.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

As guidance, recommendations for good practice are set out and the groups who should follow them are specified. However, although the guidance has influenced food producers to reduce the salt, saturated fat and trans fat content of processed food and advertisers to modify marketing and promotion aimed at children and young people, no specific timeframe was set.

To which type of interventions does your example of good practice belong to?

Individual intervention and policy/strategy because the guidance is aimed at the whole population, policy makers and food producers and advertisers.

How is this example of good practice funded?

The production of the guidance was funded by national government. Its implementation is funded by all the groups listed above.

What are the main aim and the main objectives of your example of good practice?

To prevent CVD, by raising the awareness of the groups listed earlier in this description, to the risk factors and offering guidance on how to avoid or limit them.

Please give a description of the problem the good practice example wants to tackle:

In England in 2007, CVD led to the deaths of nearly 159,000 people (34% of all deaths in England). Premature deaths in people under 75 years of age are preventable. CVD accounted for 40,000 premature deaths in England in 2007. The British Heart Foundation (BHF) has estimated that about 111,000 people, in the UK, have a stroke for the first time each year. In 2009, the BHF also estimated that in 2008, in the UK, there were 96,000 new cases of angina, 113,000 heart attacks and 68,000 new cases of heart failure. Premature death rates from CVD appear to be up to six times higher among lower socioeconomic groups (O'Flaherty et al. 2009). The consequences are unnecessary premature deaths, poor quality of life for those who survive and a high financial cost, which nine years ago in the UK was estimated to be about £30 billion annually (Luengo-Fernandez et al. 2006).

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes, within the Health Department (Ministry) overall plan to prevent disease

Implementation of your example of good practice is/was:

Continuous in that the guidance has been in place since 2010

Target group(s) :

In general, the entire population but more specifically:

Ministers and officials in the following government departments (ministries):

Health

Business, Innovations and Skills

Culture, Media and Sport

Education

Environment, Food and Rural Affairs

Transport

The Treasury

Food Standards Agency

NICE

National Research Bodies such as the Medical Research Council

Other bodies including:

Caterers

Food and Drink producers

Food and drink retailers

The Marketing and Media Industry

Farmers

The whole population

During implementation, did specific actions were taken to address the equity dimensions?

Yes, the far higher prevalence of CVD in the lower socio-economic groups and the need to improve equity with regard to CVD was highlighted.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants?

Yes, there were and are recommendations on 21 topics related to the prevention of CVD such as salt content of food, lack of exercise, etc. The actions for each recommendation used different strategies, tailored to the recommendation.

Was an effective partnership in place?

Yes, all the government departments have to work in partnership and the Department for the Environment, Food and Rural Affairs and the Food Standards Agency have been and are in regular contact with representatives of food producers, retailers and advertisers.

Was the intervention aligned with a policy plan at the local, national, institutional and international level?

Yes within government policy nationally and locally.

Who implemented the intervention?

The guidance was developed by a committee of experts convened by NICE. The committee consisted of individuals with specialist knowledge of risk factors for CVD

What core activities are/have been implemented?

The guidance was promoted widely and can be accessed freely from the NICE website www.nice.org.uk/guidance

Is the potential impact on the population targeted assessed (if scaled up)?

Yes, by considering the annual mortality rates for CVD, the number of premature deaths for CVD and any changes in the proportion of those from lower socio-economic groups suffering from CVD.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Wide publicity so that all members of the population were and are aware of the risk factors for CVD

What were in your opinion, the main lessons to be learned?

The need to include all parties with an interest in the development of the recommendations and of continuous publicity for them

Web page related to the intervention

www.nice.org.uk/guidance

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The Community Food Initiative Programme Ireland

Which 'life stage' for CVDs prevention targets the intervention?

- Childhood, adolescence, adulthood and ageing.
- The focus of the Community Food Initiative (CFI) Programme is on adults who are responsible for food shopping and meal preparation for their family and/or children.
- The target audience for the CFI has a low level of income.

Short description of the intervention:

The Community Food Initiative (CFI) Programme aims to promote greater access and availability of healthy and safe food in low-income areas through a programme of local projects using a community development approach, across the island of Ireland. The programme also aims to positively influence the eating habits of families in low income communities by addressing the barriers to having a healthy diet and supporting greater access to affordable and healthy food at a local level. The programme supports and encourages the involvement of ten individual community projects, through shared learning, training and collaboration. Crucially evidence from the programme is used to identify best practice and inform policy change. A detailed outline of the ten CFI projects can be found on <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/Community-Food-Initiative-year-1-report-appendix-B.pdf>. This is a three-year (2013-2015) programme funded by Safefood and is managed by Healthy Food For All. SafeFood, is an all-island implementation body set up under the British-Irish Agreement with a general remit to promote awareness and knowledge of food safety and nutrition issues on the island of Ireland. Healthy Food for All is an all-island charity combating Food Poverty by promoting access, availability and affordability of healthy food for low-income groups <http://healthyfoodforall.com/>. The programme builds upon the key learnings and experiences from an initial Demonstration Programme of CFIs 2010–2012. The demonstration programme provided funding, technical support, collective training and facilitated networking of seven CFI's between 2010 and 2012 <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/safefood-Community-Food-Initiatives-2010%e2%80%932012-Evaluation.pdf>.

The Objectives of the CFI Programme are to:

1. Fund ten community-based food initiatives across the island of Ireland, over a three year period (2013–2015)
2. Provide technical support, collective training and facilitate networking
3. Encourage projects to consider long term sustainability from the start of the programme
4. Promote shared learning among CFIs on the island
5. Identify policy and best practice lessons and increase awareness of the programme among key stakeholders.

Key features of the CFI programme included:

- on-going support was provided i.e. a programme approach was used, as distinct from the provision of money only i.e. a grant scheme. Support included technical advice, training, regular networking opportunities and on-going evaluation.
- the selection process sought projects that were hosted in an established organisation with a proven track record in managing grants and projects. This allowed an immediate focus on developing the CFI itself rather than the organisation.
- all projects were located in communities of socio-economic disadvantage.
- a development worker from Healthy Food for All provided the technical support, and facilitated collective training and networking between projects. They also co-ordinated the programme and assisted in raising awareness of the programme on IOI.

- three networking meetings were held each year to make training, sharing learning amongst the CFIs and site visits possible.

Target audience: A broad range of participants engaged in CFI projects, from children to older people. The host organisations were very important in promoting CFI's through their other services, and their client groups determined who was most likely to engage with their CFI. There was no clear pattern in one gender engaging overall with CFIs to any differing degree. CFIs which had difficulty engaging males or females found targeting with gender specific activities useful, e.g. women's gardening groups and men only groups. In year one, more than 12,000 persons took part in an activity organised by a CFI and people from marginalised backgrounds were introduced to the benefits of healthy eating.

Key Success Factors of CFI's:

- There is a transfer and sharing of best practice, knowledge, and learning across the 10 community food initiatives. This allows learning from local projects to inform and influence policy in relation to community food programmes.
- The community development approach to the CFI enables recognition of issues at local level and identification of appropriate solutions by the local community. Skills are transferred from those participating in CFI's to other community members and families.
- CFI's encourages community and family cohesion.
- The CFI uses a targeted approach to reach low income groups
- Participants reported improved levels of health and well-being, better mood, more motivation to do other things (e.g. go walking).

Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies?

Based on the success of previous Demonstration Programme safefood committed funding for this current Community Food Initiative Programme 2013-15. The Demonstration Programme achieved what it set out to achieve and the evaluation found that CFIs are a worthwhile and valuable approach to tackling food poverty at a community level with every programme CFI reporting making a difference to food poverty at a local level.

Based on the findings from the evaluation, the following recommendations were made for future funding of CFIs in the current programme, all of which are being adhered to:

Approach:

- CFIs are supported financially through a programme approach of technical training and shared learning.
- A designated Development Worker, co-ordinates and manages the programme, which is essential to its success.

Types of CFIs funded:

- We chose those that are part of an established community development 'host' organisation.
- We ensured more commonality between CFIs under the programme to ensure that learning can be harnessed fully by choosing community-wide projects.
- We prioritised those that have the potential to integrate their activities with existing local resources such as peer-led training programmes, local authority land and schools.
- We considered the potential of projects to develop food skills more broadly than food growing skills through their associated activities. Food gardens are excellent at engaging communities with food and improving access and availability of foods, but CFIs have greater potential to build further broader food-related skills. These can range from budgeting, shopping, storing, preparing and cooking healthy and safe meals.

Process:

- We endeavoured to ensure that the training and networking commitments of the programme approach were fully understood by CFI co-ordinators from the outset.
- We simplified the application process and provided clarity on what is and what is not eligible for funding.
- We keep the financial reporting process as simple and straightforward as possible.

Where possible we allow adequate flexibility in budgets to facilitate CFIs in developing and adapting to local needs.

- We made evaluation needs for the CFIs simple and clear from the outset.
- We keep training practical, relevant and accessible as possible, considering the emerging needs of all the projects.
- We have encourage CFIs to think about long-term sustainability and resource from the outset, e.g. building local partnerships, developing steering groups, developing a strong volunteer base.

Increasing awareness about the programme and influencing policy

- We have endeavoured to ensure more scope to share learning among community organisations from this programme.
- We make the learning of the Programmes available to statutory and voluntary organisations to influence policy and practice.

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods?

Yes, there were clear aims and objectives at the outset, even though all 10 projects are very diverse, all have a common aim of promoting healthy eating among participants and ultimately the wider community. The recruitment process into the programme was rigorous and adhered to strict eligibility criteria for this three-year programme, which was based on the learnings and the recommendations from the evaluation of the previous Demonstration Programme.

For example:

- We chose projects that are part of an established community development 'host' organisation.
- We ensured more commonality between CFIs under the programme to ensure that learning can be harnessed fully by choosing community-wide projects.
- We prioritised those that have the potential to integrate their activities with existing local resources such as peer-led training programmes, local authority land and schools.
- We considered the potential of projects to develop food skills more broadly than food growing skills through their associated activities. Food gardens are excellent at engaging communities with food and improving access and availability of foods, but CFIs have greater potential to build
- Further broader food-related skills. These can range from budgeting, shopping, storing, preparing and cooking healthy and safe meals

To which type of interventions does your example of good practice belong to?

Individual Intervention

How is this example of good practice funded?

National funding provided by SafeFood, See more at: <http://www.safefood.eu/Utility/About-s.aspx#sthash.OlwWCuBK.dpuf>

What is/was the level of implementation of your example of good practice?

Local

What are the main aim and the main objectives of your example of good practice?

The Community Food Initiative's Programme aims to promote greater access and availability of healthy and safe food in low-income areas through a programme of local projects using a community development approach, across the island of Ireland. The Objectives are to:

1. Fund ten community-based food initiatives across the island of Ireland, over a three-year period (2013–2015)

2. Provide technical support, collective training and facilitate networking
3. Encourage projects to consider long term sustainability from the start of the programme
4. Promote shared learning among CFIs on the island
5. Identify policy and best practice lessons and increase awareness of the programme among key stakeholders

Please give a description of the problem the good practice example wants to tackle:

The numbers of people experiencing food poverty increased from 450,000 in 2010 to 600,000 in the Republic of Ireland in 2013 (Social Inclusion Monitor, 2015). Food poverty is associated with low income, deprivation, labour market inactivity and households with large numbers of children. Certain household types are more vulnerable to food poverty, with almost one-third (30%) of lone-parent households food poor in 2013, an increase from 23% in 2010 (ESRI, 2015). Unemployed households are the most likely to be food poor. Food poverty is defined as the “inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation” (Friel & Conlon, 2004). Not only does it have a negative impact on an individual’s health, it also adversely impacts on an individual’s social engagement. Low-income households consume less nutritionally balanced diets and suffer from higher rates of diet-related chronic diseases such as diabetes, heart disease, obesity and certain cancers at a younger age. These factors have long-term implications for demands on the health system and to the State, with safefood estimating the cost of obesity alone at €1.13 billion (safefood, 2012).

This Community Food Initiative (CFI) Programme is a three-year funded programme by SafeFood and managed by Healthy Food for All. The overall Programme is a combination of 10 Community Food Initiatives (CFIs) based in areas of socio-economic disadvantage across the island of Ireland. Underpinning this project is the conviction that CFIs represent a practical way in which barriers to healthy eating can be addressed at local level. The Community Food Initiative (CFI) programme follows on from an earlier Demonstration Programme of CFIs, which ran for three years, from 2010 to 2012.² The aim of the CFI Programme is to promote greater access and availability of healthy and safe food in low-income areas through a programme of local projects using a community development approach.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

Yes. Food poverty is linked to a number of critical public policy issues, notably welfare adequacy, health inequalities, low educational attainment and constraints on social participation. Food prices in Ireland remain above the European average. The cost of food varies depending on access to different food outlets. Lack of access to multiple or discount supermarkets means food costs are significantly higher if bought in a local convenience store.

- 11.7% of children live in consistent poverty (Social Inclusion Monitor, 2015)
- 37.3% of children live in households experiencing basic deprivation (Social Inclusion Monitor, 2015)
- 1 in 4 children are living in jobless households (ESRI 2012)
- 1 in 5 children (21%) are going to school or to bed hungry because there is not enough food in the home (HBSC 2012)
- 1 in 6 children never have breakfast on weekdays (HBSC 2012)
- Families with older children would have to spend 59% of Child Income Support on food alone in order to meet the recommended dietary requirements for a teenage child (VPSJ, The Cost of a Child, 2012)
- It is up to ten times cheaper to provide calories in the form of unhealthy foods that are high in fat, salt and sugar than it is in the form of protective foods such as fruit and vegetables and other important foods such as lean meat and fish (Healthy Food for All, 2009)

Implementation of your example of good practice is/was:

Single. The Community Food Initiative (CFI) Programme 2013-15 is a specific three-year funded programme. As per learning from the evaluation of the previous Demonstration Programme 2010-12, from the outset the CFIs involved have been encouraged and supported to consider long-term sustainability, through for example specific training

and networking events. Three-year funding gives them the chance to be at a stage of development which is anticipated will lever additional funding from local agencies and organisations. It is also anticipated that after three years the CFI will have evidenced its many benefits to the community and that the host organisation could absorb some of the minimal costs of running it. All of the funded CFIs are and/or have expressed that they are determined to keep going beyond the current funding stream as they all recognise the many benefits to their communities. Management of the CFI Programme has also encouraged a strong partnership approach and local ownership from the outset to help ensure its long-term sustainability.

Target group(s):

The target audience is specifically families and young people experiencing food poverty in low-income areas. However, due to the broad remit of the host community organisations, the CFIs encourage participation of all low-income community members and have been very successful if engaging even hard-to-reach marginalised groups such as men and the migrant population.

During implementation, did specific actions were taken to address the equity dimensions?

All CFIs were chosen as part of community-run organisations in low-income areas on the island of Ireland. Therefore many different dimensions of equity were taken into consideration by way of the fact that the host organisations only work in disadvantaged, targeted areas. The target audience is specifically families and young people experiencing food poverty in low-income areas in both rural and urban areas. However, due to the broad remit of the host community organisations, the CFIs encourage participation of all low-income community members and have been very successful if engaging even hard-to-reach marginalised groups such as men and the migrant population.

In design, did relevant dimensions of equity were adequately taken into consideration and targeted?

All CFIs were very deliberately chosen as part of community-run organisations in low income areas on the island of Ireland. Therefore many different dimensions of equity were taken into consideration by way of the fact that the host organisations only work in disadvantaged areas. For this programme the target audience is specifically families and young people experiencing food poverty in low-income areas. However, due to the broad remit of the host community organisations, the CFIs encourage participation of all low income community members and have been very successful if engaging even hard-to-reach marginalised groups such as men and the migrant population. Nobody is excluded.

Which vulnerable social groups were targeted?

For this programme the target audience is specifically families and young people experiencing food poverty in low-income areas. However, due to the broad remit of the host community organisations, the CFIs encourage participation of all low-income community members.

Did the intervention have a comprehensive approach to health promotion addressing all relevant determinants and using different strategies?

The Community Food Initiative Programme 2013-15 supports low-income communities in tackling food poverty issues locally. The programme adopts a community development approach through various activities that address barriers disadvantaged communities face in accessing a healthy diet. This helps promote and improve the health of local people and all CFIs have self-reported improvements in the overall wellbeing of the people who engage with the CFI.

Was an effective partnership in place?

The Community Food Initiative (CFI) Programme 2013-15 is a specific three-year funded programme based on the learnings from the evaluation of the previous Demonstration Programme 2010-12. The programme is a successful partnership between SafeFood, the funding provider and Healthy Food For All who manages and supports the programme operationally at local level. A key success factor in this programme was the establishment of a dedicated Development worker who plays a key role in supporting CFI's to set up the necessary infrastructure for their gardens and establish administrative structures. The host organization ensures the accountability of the project and its ongoing support. The local community partake in the healthy food related activities and ownership is encouraged at local level by, for example, encouraging establishment of a steering group to ensure long-term sustainability of the CFI. Local partners (e.g. local authorities) are engaged with to ensure sharing of valuable resources and information at local level. From the outset the CFIs involved have been encouraged and supported to consider long-term sustainability, through for example a strong partnership approach locally to help ensure its long-term sustainability. All CFIs were very deliberately chosen as part of community-run, well established organisations with a proven track-record in low-income areas on the island of Ireland.

Was the intervention implemented equitably, i.e. proportional to needs?

Yes. The Community Food Initiative Programme 2013-15 supports low-income communities in tackling food poverty issues locally. The programme adopts a community development approach through various activities that address barriers disadvantaged communities face in accessing a healthy diet. This helps promote and improve the health of local people and nobody in the community is excluded. All CFIs were very deliberately chosen as part of community-run, well-established organisations with a proven track record in low-income areas on the island of Ireland.

Were potential burdens, including harm, of the intervention for the target population addressed?

All CFIs were very deliberately chosen as part of community-run, well-established organisations with a proven track-record in low-income areas on the island of Ireland. The Community Food Initiative Programme 2013-15 supports low-income communities in tackling food poverty issues locally. The programme adopts a community development approach through various activities that help local people address the barriers they face in accessing a healthy diet. No 'harm' was anticipated.

Were the intervention's objectives and strategy transparent to the target population and stakeholders involved?

The host organisations have always encouraged the participation of local people by explaining what the Community Food Initiative activities will entail and what the intended outcomes will be. Ultimately each host organization is encouraging local ownership.

Did the evaluation results achieve the stated goals and objectives?

Yes, the evaluation results suggest that the objectives of the programme were successfully addressed in the first year of the programme, with some more work to be done in years two and three. These results can be found in the Report on the Evaluation of the Community Food Initiative Programme (2013-2014) at <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx> All five objectives have been successfully addressed in year one, with further development required in years two and three.

1. Ten CFI projects were established across the island of Ireland.
2. Technical support and training has been provided and three all-island networking events took place.
3. Long-term project sustainability is now a growing focus for CFIs.

4. Shared learning and networking has been developed among the projects.
5. Stakeholder awareness has been encouraged through promotion, building the evidence base and networking.

Did the intervention have a defined and appropriate evaluation framework assessing structure, processes and outcomes?

Yes. Findings from the evaluation of the initial demonstration programme of CFI's 2010 – 2012 provided a testing ground for the future funding and support of CFI's and led to improvements in the current CFI programme 2013-2015. The Evaluation of the Community Food Initiative Programme 2013-2015 is based on an analysis of quarterly questionnaires/reports collected from each of the ten CFI's between July 2013 and March 2014. The questionnaire can be found at <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/CFI-Appendix-A.pdf>. The methodology used in the evaluation is detailed at <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>

Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs?

Yes. The Evaluation of the Community Food Initiative Programme 2013-2015 is based on an analysis of quarterly questionnaires/reports collected from each of the ten CFI's between July 2013 and March 2014. The questionnaire can be found at <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/CFI-Appendix-A.pdf>

Specifically, what has been measured / evaluated?

The following is a list of the key data collected and measured/evaluated. Details can be found at <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-oneof-the-Community-Food-Initi.aspx>

1. Programme reach – number of individuals who took part in a CFI activity
2. Participation in regular on-going activities
3. Profile of participants
4. Main challenges, successes and 'learnings' from the first year of the programme
5. Achievement of CFI programme objectives

Reach of the CFI Programme: In year one, the CFIs engaged with more than 12,000 persons in activities related to healthy eating, growing food and cooking skills (Table 1). Many individuals engaged in activities from time to time e.g. school or community events while a smaller number of individuals regularly took part in core activities such as gardening and cooking. Projects varied and some had an association with local schools. While participants were initially mostly female, a more mixed group developed throughout the year but there was still low participation from teenagers and the elderly. The evaluation found that there is a need for greater emphasis on participation in food skills activities such as meal planning, budgeting and shopping skills.

Table 1: Total engagement in CFI activities in year one

Number of individuals that took part in CFI Activities	
Overall reach of all CFI activities	12,117*
Healthy eating	3,299
Gardening/Growing	3,273
Cooking skills	1,515
Planning/Budgeting/Shopping	373
Other activity such as physical activity, food and healthy living seminars/demonstrations, community meals, open or fun days, foraging and networking	3,717

*number of individuals who took part in an activity organised by a CFI, 60 individuals took part in more than one activity and are, therefore, counted twice, most participants (74%) took part in only one activity during any given month.

Programme achievements and successes: All five objectives have been successfully addressed in year one, with further development required in years two and three. (see section 5.1, above). Year One project objectives achieved include:

1. Community gardens were established
2. Administrative structures/budgets met
3. Positive engagement with and response from local community/schools
4. Training courses were well attended with positive feedback from participants.

Other successes reported by the 10 projects included the volunteer contribution to the project (n=3), reaching marginalised groups (n=2), networking and sharing of knowledge in local community (n=2), bringing people together (n=2), providing practical life skills in growing and cooking (n=2), increasing consumption of healthy food (n=2), introducing people to the joys of physical exercise (n=1), the hosting of special events that got people interested in healthy eating (n=1), and beginning to address food poverty (n=1).

What are the main results/conclusions/recommendations from the evaluation?

The main results from Year One of the current Community Food Initiative (2013-2015) are outlined in section 5. 6 above and a detailed conclusion can be found at <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>. The main conclusion arising from the current CFI programme 2013-2015, is that CFI's are a worthwhile and valuable approach to tackling food poverty at a community level. Some of the main conclusions and future priorities are as follows:

Reach: Overall, it can be concluded that the current community food initiative programme demonstrates its ability to reach and engage with a very large number of individuals (n= 12,000) in activities related to healthy eating. In particular, a substantial number of people, including people from marginalised and disadvantaged communities, took part in a CFI activity and have been introduced to the benefits of healthy eating. These projects have engaged with their local communities, and feedback on their training courses and once-off events has been positive.

Infrastructure: Each of the projects has set up the necessary infrastructure for their gardens and established administrative structures. However, some administrative difficulties were identified by the Development Worker relating to the completion of reports by some CFIs. This will need to be resolved by the projects concerned so that they do not worsen and threaten the good relationship that clearly exists between the Development Worker and all the projects.

Designated Development Worker: A designated development worker was an essential resource to provide technical support, training and networking and learning opportunities among CFI's. In Year one, the development worker supported the 10 CFIs in a number of ways, including establishing and maintaining good relationships with the 10 CFIs, visiting each CFI site, organising three networking events and encouraging the CFIs to share with each

other, and identifying and organising the training needs that reflect the emerging needs of the 10 projects and the programme.

Engaging target groups: Maintaining and growing participant numbers for some projects was challenging, especially those from the most disadvantaged communities.

Sustainability: Recognising the need for a long term sustainability plan for the project is a requirement in moving forward. CFIs have begun to consider the implications of sustainability for their projects by, for example, investigating additional funding opportunities, recruiting volunteers and considering ways in which their CFI brand may be sustained when the programme has run its course.

Shared learning: Most shared learning occurs at the networking events and when projects visit each other. Learning is also shared through an online forum, Mango Apps. The Development Worker believes that networking is a very powerful forum for the projects to build relationships and share learning and encourages projects to visit other sites so that they can gain a different perspective on their project. Half of the CFIs said they were satisfied with the shared learning to date, while the others were somewhat dissatisfied. A key feature in Year two and three will be promoting shared learning among CFI's outside of the organised networking events.

Identifying policy and best practice lessons and increase awareness of among key stakeholders in Ireland: A substantial amount of evidence was gathered during Year one which will be used for promotion and advocacy purposes when dealing with government departments and others involved in policy development.

Prioritise healthy eating/food activities: Most emphasis by the CFIs in Year one has been on the establishment of the community garden and gardening skills. More emphasis in future will be on developing meal planning, budgeting and food shopping skills.

Is the evaluation report available, preferably in English or at least an English summary?

Yes the evaluation report is available in English at <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>. Also available in English are:

1. A summary of the evaluation report.
2. The questionnaire/report used in the evaluation.
3. A detailed outline of each of the Ten CFI projects.

Who implemented the intervention?

Safefood fund and Healthy Food for All (HFfA) manage the CFI programme. The Community Food Initiative host organization ensures the accountability of the project and its ongoing support. The local community partake in the healthy food related activities and ownership is encouraged at local level by, for example, encouraging establishment of a steering group to ensure long-term sustainability of the CFI. Local partners (e.g. local authorities) are engaged with to ensure sharing of valuable resources and information at local level. A designated Development worker plays a key role in co-ordinating and managing the programme.

What core activities are/have been implemented?

- Site visits by the Healthy Food for All (HFfA) programme manager to participating host organisations are a crucial way to develop strong links with the CFIs and build a database of learning to share and link to policy messages.
- Three Networking Events are hosted each year for programme projects to share learning and challenges. Networking events also offer a training dimension based on the emerging needs of the projects and the programme. For example, some of the networking events to date have been on sustainability and community engagement.
- The HFfA programme manager presents on the CFIs at various fora and conferences and attends external events to input on learnings from the programmes.
- The Development Worker also updates the HFfA quarterly newsletter and the annual report to reflect CFI Programme activities. Quarterly evaluation reports and half-yearly financial reports are also coordinated by the

programme manager and HfFA run National Conferences where learning from the programme is shared with a wider stakeholder audience. The Development worker also uses evidence from the programme to make submissions to the Government Departments recommending key actions to support the future development of CFIs nationally.

Safefood is responsible to share learning and outcomes www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx

Was the intervention designed and implemented in consultation with the target population?

Yes. The host organisations are well established and have proven track records of successful engagement in their local communities. They have always encouraged the participation of local people by explaining what the Community Food Initiative activities will entail and what the intended outcomes will be and by asking them what they would like in their own communities to tackle these issues. Each host organization encourages local ownership to ensure long-term sustainability of the projects.

Did the intervention achieve meaningful participation among the intended target population?

Yes. The CFIs have proven very successful in engaging local people in healthy food related activities. The current programme concentrates on accessing families and young people but nobody is excluded from participation. The CFIs have proven to successfully engage hard-to-reach groups such as men, Traveller and migrant communities. Host organisation report local people requesting additional healthy food related activities and they are often inspired to start up other groups such as walking groups. Everybody can relate to food and it is integral to the experience of poverty. Everybody who partakes realises that they have valuable skills to share and their new-found confidence helps them share their learning with others in their community, which encourages the participation of more community and family members.

Did the intervention develop strengths, resources and autonomy in the target population(s)?

Yes. The CFIs have proven very successful in developing the skills and strengths of local people in healthy food related activities. The current programme concentrates on accessing families and young people but nobody is excluded from participation. The CFIs have proven to successfully engage hard-to-reach groups such as men, Traveller and migrant communities. Host organisation report local people requesting additional healthy food related activities and they are often inspired to start up other groups such as walking groups. Everybody can relate to food and it is integral to the experience of poverty. Everybody who partakes realises that they have valuable skills to share and their newfound confidence helps them share their learning with others in their community, which encourages the participation of more community and family members. Often people go on to further education in, for example, horticulture and cookery classes as a direct result of being involved in the CFI. Host organisations encourage local ownership by established steering groups for the CFIs and a strong volunteer base. This helps ensure the long-term sustainability of the CFI.

Was the target population/s defined on the basis of needs assessment including strengths and other characteristics?

With high food costs and recessionary times in Ireland low-income families struggle to put food on the table and can be disproportionately affected by food poverty. Access to the target population(s) is through established community organisations in low-income areas who have the trust and relationships built with local people.

Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed?

Implementing a three year CFI programme aimed to allow CFI's the time to develop and become sustainable through a variety of measures, including a strong partnership approach and encouraging local ownership. Some CFI's have begun to consider implications of sustainability for their projects by for example, investigating additional funding opportunities, recruiting volunteers and considering ways in which their CFI brand may be sustained when the programme has run its course. However with funding cuts and challenges faced by all organisations at community level, this is not ensured. Mainstreaming is being encouraged at national level through using the evidence from the programme to inform policy inputs at government level.

The reality for the sustainability of many community initiatives is that they are reliant on at least some level of funding. To support CFIs with on-going funding, the initial Demonstration programme highlighted that integration of a CFI into other activities of a host organisation and a strong volunteer base are greatly beneficial to long-term sustainability. Other important lessons for best practice for supporting CFIs in the future can be found in the Recommendations section, page 20, of the Report on the Demonstration Programme of Community Food Initiatives 2010-2012, see <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/safefood-Community-Food-Initiatives-2010%e2%80%932012-Evaluation.pdf>

Is there a broad support for the intervention amongst those who implement it?

Yes. All host organisations are (and were in advance of getting funding) very supportive of their CFI and the work of Healthy Food for All and Safefood. All CFIs self-report a marked increase in the overall wellbeing of their target communities through their healthy food related activity and all recognise the many benefits of running a Community Food Initiative.

Healthy Food for All very much support the intervention and recognise CFIs as viable ways at local level to help tackle food poverty issues and the many barriers people on low-incomes face in accessing a healthy diet. Safefood are very supportive of the intervention and have funded two three-year programmes to date.

Is there a broad support for the intervention amongst the intended target populations?

Yes. All host organisations are (and were in advance of getting funding) very supportive of their CFI and the work of Healthy Food for All and Safefood. All CFIs self-report a marked increase in the overall wellbeing of their target communities through their healthy food related activity. Participants are keen to continue the work and courses are well attended and often encourage the development of additional activities, e.g. community gardening and healthy eating courses can lead to walking groups being established.

Were sources of funding specified in regards to stability and commitment?

Yes. The eligibility criteria for success in getting funding and being part of the programme of shared learning was clearly outlined and specified in advance of signing of contracts and drawing down of first tranche of funding. All organisations chosen are well established and have a proven track record of sustainability and accountability.

Were organisational structures clearly defined and described?

Yes. Key senior members of staff were identified in each organisation to regularly link in with the Healthy Food for All (HFfA) managers of the programme. These staff members were also required to attend the networking and training opportunities to ensure the continued sharing of learning throughout all projects and for the duration of the three-year programme.

Is the potential impact on the population targeted assessed (if scaled up) ?

While there has been no formal assessment on the potential impacts on the target population if scaled up, the evaluation results following the first year of the programme are very encouraging, particularly in relation to the

very large reach and engagement of more than 12,000 persons in activities related to healthy eating, growing food and cooking skills. Findings from the first year evaluation can be found on <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>

Are there specific knowledge transfer strategies in place (evidence into practice)?

All information is shared on various social media forums, website, Facebook, Twitter. Visit <http://www.safefood.eu/> for details. Healthy Food for All (HFfA) partners with other national organisations to share the evidence garnered from working with CFIs to promote the work and advocate on their behalf. All evidence and learning informs pre-budget submissions and statement of strategy to the Government.

Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators?

Key learnings and recommendations for the future funding and development of Community Food Initiatives can be found in the following reports: Report Demonstration of Community Food Initiatives 2010-2012 at <http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/safefood-Community-Food-Initiatives-2010%e2%80%932012-Evaluation.pdf> & http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/K8336-SAFEFOOD_CFI-EVALUATION-REPORT_A4.pdf

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

- Using the recommendations from the evaluation of the previous Demonstration Programme led to improvements in the current CFI programme.
- Working with well-established and respected community organisations in the local low-income Areas
- Adopting a strong community development approach.
- Having a designated development worker to co-ordinate and manage the programme.
- Offering networking and training opportunities that resonated with the emerging needs of the projects and the programme.
- Networking, communication and sharing the information and learning with other CFIs and stakeholders. To learn and share any learnings with others.

What were, in your opinion, the main lessons to be learned?

- The programme shows evidence that Community Food Initiatives work at local level to help tackle the issues of food poverty.
- All projects self-report improvements in the well-being of their communities by having a CFI locally.
- All projects are very keen to continue their CFI beyond the current funding stream.
- All CFIs have exceeded their original expectations.
- Many of the CFIs have experience challenges due to funding cuts.
- It is important to be flexible and facilitate community member's needs – no 'one size fits all' approach
- Actively promote the project in the local community.
- Encourage community ownership – let locals shape the project.
- Continue to develop skills – long term planning, time management and project prioritisation.
- Encourage long term sustainability planning – including a social enterprise approach.
- Continue to identify policy and best practice lessons and increase key stakeholder awareness.

References to the most important articles or reports on the intervention:

- Evaluation of the Community Food Initiative Programme 2013-2015. (SafeFood, 2014). <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>
- Demonstration Programme of Community Food Initiatives 2010-2012. (SafeFood, 2013). <http://www.safefood.eu/Publications/Research-reports/Demonstration-Programme-of-Community-Food-Initiati.aspx>
- Department of Social Protection (2015), Social Inclusion Monitor 2013, Dublin: Department of Social Protection.. www.welfare.ie or www.socialinclusion.ie . Accessed 24th June, 2015
- ESRI (2015) All-Island Food Poverty Network Belfast 21th April, (2015) Presentation by Bertrand Maître The Impact of the Republic of Ireland Food Poverty Indicator. <http://www.safefood.eu/SafeFood/files/7d/7d19abbc-f3d6-40dd-b022-79326d5d0aea.pdf> Accessed 24th June, 2015
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- SafeFood (2012). The cost of overweight and obesity on the Island of Ireland. <https://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/Final-Exec-Summary-The-Economic-Cost-of-Obesity.pdf>
- Department of Health and National University of Ireland, Galway (2012). The Irish Health Behaviour in School-aged Children (HBSC) Study 2010. http://www.nuigalway.ie/hbsc/documents/nat_rep_hbsc_2010.pdf Accessed 24th June, 2015
- Mac Mahon B, Weld G, Thornton R & Collins M (2012). The Cost Of A Child. A consensual budget standards study examining the direct cost of a child across childhood. A Vincentian Partnership for Social Justice research report <http://www.budgeting.ie/images/stories/Publications/cost%20of%20a%20child%20-%20full%20report.pdf>
- Healthy Food For All (2009). Policy Briefing, October (2009). The affordability of healthy eating for low-income households. http://healthyfoodforall.com/wpcontent/uploads/2013/10/2009-10-20_AffordabilityOfHealthyEating.pdf. Accessed 24th June, 2015

Other relevant documents:

- <http://healthyfoodforall.com/about/hffa-programmes/cfi-programme-2013-2015/>
- <http://www.safefood.eu/Home.aspx>
- <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>
- <http://www.safefood.eu/Publications/Research-reports/Demonstration-Programme-of-Community-Food-Initiati.aspx>
- <http://healthyfoodforall.com/topic/community-news/>
- <http://healthyfoodforall.com/community/community-case-study/>

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Promotion of Fruit and Vegetable Consumption among Schoolchildren, 'PROGREENS'	Bulgaria	Page 18.
Total Ban on Smoking in Indoor and Some Outdoor Public Places	Bulgaria	Page 238.
Diabetes Counselling on Wheels: Early Detection and Counselling on Diabetes for Citizens of Turkish Origin and the Rural Population	Germany	Page 141.
"Healthy and active ageing"	Germany	Page 157.
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The Welfare Watch	Iceland	Page 266.
The Icelandic National Curriculum Guides for Preschools, Compulsory Schools and Upper Secondary Schools: Health and Wellbeing One of Six Fundamental Pillars of Education	Iceland	Page 38.
'Let's Take on Childhood Obesity' – The Childhood Overweight and Obesity on the Island of Ireland campaign	Ireland	Page 24.
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A Sustainable, Active, Primary Prevention Strategy for Cardiovascular Diseases in Italy for Adults 50+ 'Projects Cuore and Cardio 50'	Italy	Page 133.
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