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

*WORK PACKAGE 5
TASK 3*

*GOOD PRACTICES IN HEALTH
PROMOTION & PRIMARY
PREVENTION OF CHRONIC
DISEASES*

SUMMARY REPORT



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Associated Partners

The National Centre of Public Health and Analyses (Bulgaria); National Institute for Health Development (Estonia); Federal Centre for Health Education (Germany); Regional Health Authority of Attica (Greece); The Directorate of Health (Iceland); Health Service Executive, Institute of Public Health, European Institute of Women's Health (Ireland); Ministry of Health, Istituto Superiore di Sanita (Italy); Ministry of Health, Centre For Health Education and Disease Prevention (Lithuania); Directorate of Health (Norway); National Health Institute Dr. Ricardo Jorge, Directorate-General of Health, (Portugal); Ministry of Health, Social Services and Equality, Institute of Health Carlos III, Autonomous Communities and Public Health Authorities (Spain); National Institute for Public Health and Environment (Netherlands)

Collaborating Partners

Ministry of Health (Cyprus); The Platform for Better Oral Health in Europe (United Kingdom); The National Board of Health and Welfare (Sweden)

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Introduction

A major objective of CHRODIS-JA is to facilitate EU countries and regions exchange good practices in tackling chronic diseases by identifying and transferring effective interventions on health promotion and chronic disease prevention focusing on cardiovascular diseases including stroke and diabetes. Within this framework, major risk factors such as diet, physical inactivity, alcohol harm reduction and tobacco are addressed along with the wider social and economic determinants creating them. This is achieved by collecting experiences, interventions and plans by 38 organisations from 22 Member States, Norway and Iceland that will support identification and selection of potentially effective interventions for exchange or transfer to other settings.

Work package 5 (WP 5) '*Good practices in the field of health promotion and chronic disease prevention across the life cycle*' focuses on these objectives by promoting the exchange, scaling up and transfer of promising health promotion and primary prevention practices (i.e. interventions and/or policies) taking place in the partner countries. Outcomes will form a part of the 'Platform for Knowledge Exchange' (PKE), an up-to-date repository of good practices identified on the prevention of chronic disease of interest for stakeholders which is a key outcome of JA-CHRODIS.

Within the framework of WP 5 (Task 1), country reviews on existing policies and mechanisms in the area of health promotion and primary prevention in partner countries, also in relation to the identification of good practice, have been conducted, along with highlights on gaps and needs in this area <http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports/>. The overview showed that there is a strong need for further consistent investment in health promotion and primary prevention in order to reduce the burden of chronic diseases and make health systems more sustainable. It was also evident that, while there was a wide range of diversity across the health promotion and primary prevention landscapes in partner countries (e.g. structures, levels and types of policy development, implementation and monitoring/evaluation), the themes emerging in relation to gaps and needs were very similar.

All Partner Countries made reference to a lack of consistent funding at levels adequate to deal with the health promotion/primary prevention of chronic diseases. Furthermore, many countries have to cope with fewer resources due to the financial crisis. The dissemination of highly promising and evidence-based practices and approaches explored within the framework of JA-CHRODIS is expected to provide a useful basis to advocating for dedicated and sustained funding streams.

In considering the specific examples of good practice offered by Partner Countries, the need to establish robust and agreed criteria for what in fact constitutes 'good practice' was also evident. Existing procedures and criteria used to select and fund health promotion and prevention interventions within and between countries, appeared to have different emphasis. These differences highlight the need for a shared understanding of core health promotion concepts, in particular those based on already well defined and agreed frameworks such as the Ottawa Charter for Health Promotion and successive WHO declarations and charters. To facilitate a more effective cross- country exchange of information and

support, an expert panel within the framework of WP 5 (Task 2) have identified good practice criteria in relation to health promotion and primary prevention practices, which is presented in more detail in the next section.

The aim of the present report is to present the work of Task 3 of the WP5, which represents the effort to select and compile a series of detailed examples of good practices in health promotion and primary prevention of chronic diseases with a focus on cardiovascular diseases, stroke and type 2 diabetes, across Europe based on the criteria developed in Task 2. The JA-CHRODIS approach defines as a 'good practice' one that is worth disseminating because it is based on best available evidences, is associated with good outcomes and may inspire practices in different contexts. In the context of JA-CHRODIS, actions may mean policies, programmes, and clinical or public health interventions. Each Partner presented three or more highly promising or evidence-based examples with the collaboration of their relevant national Ministries, Institutes and civil-society institutions. Special attention was given to effective practices that have shown to have a positive impact on the health status of populations and groups, with a focus on vulnerable populations. Aspects of transferability and applicability have been also explored in a detailed description from the partners of the local context and structures where practices have been implemented. Within the current task, it is considered that appraisal of applicability and transferability could be enhanced by ensuring a thorough knowledge of the proposed health promotion and prevention practice/intervention and of its local setting and structures, since public health intervention depend very much on the context.

This mapping, validating and transferring of good practices that exist across the EU in relation to health promotion and primary prevention of chronic disease will further continue in Task 4, which involve the exchange and discussion of good practice examples in a Conference and will take place near the end of 2015, targeting key European stakeholders on the field (e.g. experts, policy makers and civil society representatives). This will enable further analysis of the practices from various perspectives, taking into account the wider social and political context and will serve to identify which projects could be scaled-up and transferred into another context and how this could be done in the most cost-effective way. WP 5 will conclude in 2016 with Task 5, in which a series of study visits to selected successful practice examples will take place for further exchange of experiences and knowledge transfer between the partners, who are implementing the best practices, and the partners interested in investigating whether the practice/project could be implemented in their specific context. The aim of the study visits will be to discuss core elements that need to be adapted to the situation of the new setting, if transferred and scaled-up.

Before proceeding to the next sections of the report we are highlighting some major issues in the field of health promotion and primary prevention, both in Europe and globally, in order to set the background for this report. For the sake of brevity, we are presenting them as points:

- The risk of chronic disease in adulthood is now understood to be associated with risk exposures across the life course. The framework of the present report therefore underlines the importance of a "whole of life" approach to prevention and health promotion. It is argued that a

comprehensive prevention strategy requires the systematic identification, prioritisation and application of cost-effective interventions for each stage of the life course.

- Important health improvement strategies may be delivered through common settings (e.g. schools, work places, primary health care). The importance and influence of the settings relevant to different life stages are therefore emphasised as key arenas for population health action on chronic disease.
- While important gains have been made in the prevention and control of chronic disease – for example, through the significant reduction in smoking rates – not all population groups have benefited equally from these improvements. Socio-economic inequalities are a major driver of the chronic disease epidemic. In most countries, people from poor or marginalised communities have a higher risk of chronic diseases because of material deprivation and psychosocial stress. Social determinants, such as education and income, influence vulnerability to chronic diseases and raise the risk of exposure to harmful products such as tobacco and unhealthy food and can limit access to health services. Joint cross-sectoral approaches are therefore essential to ensure that effective interventions provide health opportunities and lead to good health outcomes for all. “Closing the gap” in health inequalities requires approaches which more effectively respond to the needs and interconnected problems faced by many disadvantaged groups.
- Emotional health, social isolation and lack of quality social support are independently associated with onset and prognosis of coronary heart disease and are considered here of the same order of magnitude as standard risk factors such as smoking and high cholesterol.
- Health promotion measures should be considered in the context of improved resource allocation not cost savings. Cost-effectiveness should inform the policy process but not in isolation. Cost-effectiveness and societal value should be the underlying arguments for health promotion. Hence, the debate between disease prevention and health promotion should be about improving resource allocation - that is cost effectiveness and not cost reduction. Ultimately, health promotion efforts and activities reflect societal choices on how to live and what is valued; and these choices have long run implications.

Finally, we also should stress the findings of the recent OECD report ‘HEALTH AT A GLANCE 2015’ published in July 2015, in which most countries were found not to perform well for at least one or more indicators of risk factors to health, whether that is the proportion of their population smoking tobacco, overall alcohol consumption, or overweight and obesity problems among children and adults. Additionally, findings stress the fact that there has been mixed successes in improving risky behaviours. For example, while smoking rates have declined substantially in some countries, the percentage of the population who are obese continue to climb in most countries. This highlights the importance for countries to put a higher priority on health promotion and disease prevention to reduce modifiable risk factors to health.

In the present report, the countries’ good practice examples are summarised in Table 3 (i.e. Overview of Projects) where the reader can find their major characteristics in terms of aims, setting and implementation level. In the final section, the abstract of each project is presented with the aim to give a brief description of their core elements. For a comprehensive and detailed description of each project readers are referred to the Annex.

Methodology

The approach taken to assess and identify the good practice examples documented in this report involved multiple steps:

In the second semester of 2014 a joint collaboration between the task and work package leaders from Health Science Aragon (WP4, Spain), EuroHealthNet (WP5, Brussels) and BZgA (WP5, Germany) was established to conduct a review of existing approaches to good practice definition in Europe and beyond.

The collected information was obtained from two major domains:

1. The country reports which were developed in the first semester of the JA CHRODIS within WP5. The reports are based on questionnaires which aimed to gather information on if and how frameworks of good practice are designed in the partner countries. The reports as well as an executive overview can be obtained through the JA CHRODIS website:
<http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports/>
2. A literature review was conducted to include information on conceptual frameworks, assessment tools and procedures from sources outside the scope of the JA CHRODIS.

The complete list of sources can be obtained from WP4's delphi report available on the JA CHRODIS website: <http://www.chrodis.eu/our-work/04-knowledge-platform/wp04-activities/delphi-process/>

The collected information fed into a template for a questionnaire which served as the basis for an expert consultation in the form of a RAND modified Delphi methodology. A group of more than 25 European experts from the field of health promotion and primary prevention was convened to adapt and then complete the questionnaire during two online survey rounds, followed by a face to face meeting in Brussels in April 2014.

The final result is a list of ranked and weighted criteria for the identification of good practices in health promotion and prevention of chronic diseases (see TABLE 1). The final criteria represent common knowledge in health promotion, while the innovative aspect is the ranking and weight of the criteria.

TABLE 1: Final set of weighted criteria recommended for evaluating HPPP interventions

Priority group	Criteria name	Category description
1	Equity	In implementation, specific actions are taken to address the equity dimensions.
	Equity	In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).

2	Comprehensiveness of the intervention	The intervention has a comprehensive approach to health promotion addressing all relevant determinants, (e.g. including social determinants) and using different strategies (e.g. setting approach).
	Comprehensiveness of the intervention	An effective partnership is in place (e.g. multidisciplinary, inter-sector, multi-/ and alliances).
	Comprehensiveness of the intervention	The intervention is aligned with a policy plan at the local, national, institutional and international level.
	Description of the practice	The design is appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies.
	Description of the practice	The design describes the practice in terms of purpose, SMART objectives, methods (e.g. recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration)).
3	Ethical Considerations	The intervention is implemented equitably, i.e. proportional to needs.
	Ethical Considerations	Potential burdens, including harm, of the intervention for the target population are addressed.
	Ethical Considerations	The intervention's objectives and strategy are transparent to the target population and stakeholders involved.
	Evaluation	There is a defined and appropriate evaluation framework assessing structure, process and outcomes considering, e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome).
	Evaluation	Evaluation results achieve the stated goals and objectives.
	Evaluation	Information /monitoring systems are in place to regularly deliver data aligned with evaluation and reporting needs.
	Evaluation	The intervention is assessed for outcomes, intended or unintended
4	Empowerment and Participation	The intervention develops strengths, resources and autonomy in the target population(s) (e.g. assets-based, salutogenetic approach).
	Empowerment and Participation	The intervention achieves meaningful participation among the intended target population.
	Empowerment and Participation	The intervention is designed and implemented in consultation with the target population.
5	Target population	Target population/s are defined on the basis of needs assessment including strengths and other characteristics.
	Target population	The engagement of intermediaries/multipliers is used to promote the meaningful participation of the target population.
6	Sustainability	The continuation of the intervention is ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed.
	Sustainability	There is broad support for the intervention amongst those who implement it.

	Sustainability	There is broad support for the intervention amongst the intended target populations.
7	Governance and project management	The intervention includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.
	Governance and project management	Sources of funding are specified in regards to stability and commitment.
	Governance and project management	Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).
	Potential of scalability and transferability	Potential impact on the population targeted (if scaled up) is assessed.
	Potential of scalability and transferability	There is a specific knowledge transfer strategy in place (evidence into practice).
	Potential of scalability and transferability	An analysis of requirements for eventual scaling up such as foreseen barriers and facilitators (e.g. resources, organisational commitment, etc.) is available.

In the next step, partners involved in the identification process were provided with a questionnaire which was derived from two sources: The sections on general project information were taken with friendly approval from a good practice documentation template developed by the European Joint Action on Reducing Alcohol Related Harm (RARHA). These sections were complemented with questions that derived directly from the criteria which were developed during the Delphi process, resulting in a long and comprehensive questionnaire (see TABLE 2).

Due to the high standard that comes with the criteria and to not miss out on innovative approaches, partners were not strictly obliged to choose exclusively interventions which match the criteria and their priorities by 100%. Therefore, the resulting collection of good practice examples reflects the respective partners' decisions and none of the practices submitted for consideration were excluded from documentation in this report.

TABLE 2. Template for good practice examples in health promotion and primary prevention in chronic disease prevention

PART I: BASIC REQUIREMENTS

Before starting to fill in the questionnaire, please read carefully the following questions representing the basic requirements for inclusion of examples of good practices.

Does the intervention/policy belong to the field of health promotion or primary prevention of cardiovascular diseases (including stroke) and diabetes? (Health promotion is the process of enabling people to increase control over, and to improve, their health. It stresses empowerment, active participation, quality of life, and has always an equity focus. Primary prevention is directed towards preventing the initial occurrence of a disorder. The goal of primary prevention is to limit the incidence of

disease in the population by measures that eliminate or reduce causes or determinants of departures from good health, control exposure to risk, and promote factors that are protective of health. Disease prevention is sometimes used as a complementary term alongside health promotion (Disease prevention in this context is considered to be action which usually emanates from the health sector).

Is the intervention documented (e.g. online, in a report that is easily accessible, in a peer reviewed journal or grey literature? (Full documentation e.g., implementation procedures, resources, manuals, measurement of outcomes and processes)

Is the practice described in such detail that the approach and methodology are comprehensive, transferable, and also allow for some estimate of effectiveness?

ONLY IF YOU ANSWERED TWO OUT OF THESE THREE QUESTIONS WITH 'YES', PLEASE PROCEED WITH THE COMPLETION OF THIS QUESTIONNAIRE.

PART II: QUESTIONNAIRE

PRACTICE DESCRIPTION

Q1. Which 'life stage' for CVDs and/or diabetes prevention targets the intervention? (Choose one or more)

- Pregnancy/fetal development and the maternal environment
- Infancy and childhood
- Adolescence
- Adulthood
- Ageing

PLEASE, briefly describe

Q2. Name of the intervention in English and in original language:

Q3. Short description of the intervention (abstract): WHO, WHAT, WHERE, WHEN, HOW (Please give a short description of the aim of the intervention, the target group and the design/ method - sequence of activities, frequency, intensity, duration, recruitment method):

Q4. Was the design of the intervention appropriate and built upon relevant data, theory, context, evidence, previous practice including pilot studies? (Priority 2/7). PLEASE, briefly describe

Q5. Did the design thoroughly describe the practice in terms of purpose, SMART objectives, and methods? (e.g. recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration) (Priority 2/7). PLEASE, SPECIFY and briefly describe

Q6. To which type of interventions does your example of good practice belong to? (choose only one)

- Individual Intervention
- European or international project (i.e. implemented in several countries)
- Policy/strategy
- Other

PLEASE, briefly describe

Q7. How is this example of good practice funded? (it is possible to mark more than one answer)

- National/regional/local government

- European/international
- Institution of education, public health and/or research
- Non-governmental organization
- Private sector company/organization
- Other resources

PLEASE, briefly describe

Q8. 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)

PLEASE, briefly describe

Q9. What are the main aim and the main objectives of your example of good practice? PLEASE, briefly describe

Q10. Please give a description of the problem the good practice example wants to tackle (nature, size, spread and possible consequences of the problem):

Q11. Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

- Yes (please describe)
- No

Q12. Implementation of your example of good practice is/was: PLEASE, briefly describe

- Continuous (integrated in the system)
- Periodic:
- Single - How long did it last?
 - Less than one year
 - One year
 - From one to two years
 - More than two years

Q13. Target group(s) (it is possible to specify more than one target group): PLEASE, briefly describe

EQUITY

Q14. In design, did relevant dimensions of equity were adequately taken into consideration and targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups)? (Priority 1/7). PLEASE, briefly describe

Q15. During implementation, did specific actions were taken to address the equity dimensions? (Priority 1/7). PLEASE, briefly describe

Q16. Which vulnerable social groups were targeted? PLEASE, briefly describe

COMPREHENSIVENESS

Q17. 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)? (Priority 2/7). PLEASE, briefly describe

Q18. Was an effective partnership in place? (e.g. multidisciplinary, intersectoral, alliances)(Priority 2/7). PLEASE, briefly describe

Q19. Was the intervention aligned with a policy plan at the local, national, institutional and international level? (Priority 2/7). PLEASE, briefly describe

ETHICAL CONSIDERATIONS

Q20. Was the intervention implemented equitably, i.e. proportional to needs? (Priority 3/7). PLEASE, briefly describe

Q21. Were potential burdens, including harm, of the intervention for the target population addressed? (Priority 3/7). PLEASE, briefly describe

Q22. Were the intervention's objectives and strategy transparent to the target population and stakeholders involved? (Priority 3/7). PLEASE, briefly describe

EVALUATION

Q23. Did the evaluation results achieve the stated goals and objectives? (Priority 3/7). PLEASE briefly describe

Q24. Did the intervention have a defined and appropriate evaluation framework assessing structure, processes and outcomes? e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome). (Priority 3/7). PLEASE, briefly describe

Q25. Did the intervention have any information /monitoring systems in place to regularly deliver data aligned with evaluation and reporting needs? (Priority 3/7). PLEASE, briefly describe

Q26. Who did the evaluation?

- An external party
- An internal party (representatives of the intervention, own organisation)
- Both – internal and external parties

Q27. Specifically, what has been measured / evaluated? PLEASE, briefly describe

- Process evaluation (respondents, method, participants satisfaction) (please describe)
- Evaluation of the impacts/effects/outcome (please describe the design)
- Other (please add and describe)

Q28. What were the main results/conclusions/recommendations from the evaluation? PLEASE, briefly describe

Q29. Is the evaluation report available, preferably in English or at least an English summary? (if yes, please provide link/reference/document)

Q30. Was there a follow-up or is any follow-up evaluation planned in the future? PLEASE, briefly describe

EMPOWERMENT AND PARTICIPATION

Q31. Who implemented the intervention? (an individual or a team or an organization or a network of organisations, describe professional background of the team, etc.) PLEASE, briefly describe

Q32. What core activities are/have been implemented? (i.e. the activities that have been implemented in order to achieve the objectives of the intervention, such as for example training sessions, events, material published) PLEASE, briefly describe

Q33. Was the intervention designed and implemented in consultation with the target population? (Priority 4/7). PLEASE, briefly describe

Q34. Did the intervention achieve meaningful participation among the intended target population? (Priority 4/7). PLEASE, briefly describe

Q35. Did the intervention develop strengths, resources and autonomy in the target population(s)? (e.g. assets-based, salutogenetic approach) (Priority 4/7). PLEASE, briefly describe

TARGET POPULATION

Q36. Was the target population/s defined on the basis of needs assessment including strengths and other characteristics? (Priority 5/7). PLEASE, briefly describe

Q37. Was the engagement of intermediaries/multipliers used to promote the meaningful participation of the target population? (Priority 5/7). PLEASE, briefly describe

SUSTAINABILITY

Q38. Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources and/or mainstreamed? (Priority 6/7). PLEASE, briefly describe

Q39. Is there a broad support for the intervention amongst those who implement it? (Priority 6/7). PLEASE, briefly describe

Q40. Is there a broad support for the intervention amongst the intended target populations? (Priority 6/7). PLEASE, briefly describe

GOVERNANCE AND PROJECT MANAGEMENT

Q41. Did the intervention include an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks? (Priority 7/7). PLEASE, briefly describe

Q42. Were sources of funding specified in regards to stability and commitment? (Priority 7/7). PLEASE, briefly describe

Q43. Were organisational structures clearly defined and described? (i.e. responsibility assignments, flows of communication and work and accountabilities) (Priority 7/7). PLEASE, briefly describe

POTENTIAL OF SCALABILITY AND TRANSFERABILITY

Q44. Is the potential impact on the population targeted assessed (if scaled up)? (Priority 7/7). PLEASE, briefly describe

Q45. Are there specific knowledge transfer strategies in place (evidence into practice)? (Priority 7/7). PLEASE, briefly describe

Q46. Is there available an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators? (e.g. resources, organisational commitment, etc.). (Priority 7/7). PLEASE, briefly describe

ADDITIONAL INFORMATION

Q47. What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

Q48. What were, in your opinion, the main lessons to be learned?

Q49. Communication details

- Web page related to the intervention
- References (with possible links) to the most important articles or reports on the intervention
- Other relevant documents (implementation manuals, training manuals, posters, videos or other tools available for use or adaptation, etc.):
- Contact details of person who may be contacted for further information

Overview of Good Practice Examples

Name of the practice	Country	Target group(s) and goal (s)	Type of practice and setting	Major characteristics	ANNEX
			Pre-natal environment, early childhood, childhood and adolescence		
An Intervention for Obese Pregnant Women - Sweden	Sweden	Pregnant women; Control of weight gain	Individual project; Maternity health services (e.g. Mother Health Care centres)	Physical activity & diet counselling; Midwives' training	Page 4.
ToyBox Intervention - Greece	Greece	Preschool children Prevention of overweight/obesity	European project; Preschool/ kindergarten	Teachers' training; Parental involvement; Supportive environmental modifications	Page 7.
School Fruit Scheme Strategy for the 2010–2013 school years - Lithuania	Lithuania	Primary school children; Increase of fruits and vegetables consumption	National Strategy; Primary Schools	Distribution of free fruits and vegetables at school; Teachers' training; School awareness-raising activities	Page 13.
Promotion of Fruit and Vegetable Consumption among Schoolchildren, 'PROGREENS' - Bulgaria	Bulgaria	School children (11-12 years of age); Improve diet and specifically fruit and vegetables consumption	European project; Secondary Schools	Health education activities; Teachers' training; Parental involvement; Development of guidelines for key stakeholders on fruit and vegetables consumption	Page 18.
'Let's Take on Childhood Obesity' – The Childhood Overweight and	Ireland	Parents of children aged 2-12 years; Overweight/obesity prevention	National project; Community	Public health campaign; Health education materials through various channels	Page 24.

Obesity on the Island of Ireland campaign - Ireland					
The Icelandic National Curriculum Guides for Preschools, Compulsory Schools and Upper Secondary Schools: Health and Wellbeing One of Six Fundamental Pillars of Education - Iceland	Iceland	Pre-school and school children (2-19 years of age); Improve physical, mental and social health	National School Policy Schools and community	Whole school' approach; National Curriculum Guides; Health Education – Health Literacy; Teachers' training	Page 38.
Young People at a Healthy Weight 'JOGG' - Netherlands	Netherlands	Children (1-19 years of age), Parents and the Community; Overweight/obesity prevention	National project; Community	Community approach; Targets on neighbourhoods; Advocacy and social marketing; Local intervention activities;	Page 43.
Dutch Obesity Intervention in Teenagers 'DOIT'- Netherlands	Netherlands	Adolescents (12-14 years of age); Overweight/obesity prevention	National project; Schools	Health education lessons on diet and physical activity; Awareness raising activities for the school environment; Parental component; Teacher training	Page 54.
Active School Flag - Ireland	Ireland	School children of all ages (incl. special needs education schools and	National project; Schools and community	'Whole school' approach; Physical Education curriculum; Local partnerships;	Page 63.

		Youth centres); Improve physical activity		Teachers training	
National Network of Health Promoting Schools - Lithuania	Lithuania	School children; Various health topics	National project; Schools	Health education lessons; Whole school' approach European dimension (Health Promoting Schools Network)	Page 73.
Adulthood & Aging					
Croí MyAction, a Community Based Cardiovascular Disease Prevention Programme - Ireland	Ireland	High – risk adults; Prevention of cardiovascular disease	National programme ; Health care services	Life style behaviour modification (smoking, diet, physical activity); Family-centred; Multidisciplinary health care team; Coordination of treatment if necessary; Community orientation	Page 76.
“PUMP” - For a Million Steps - Spain	Spain	Adults & Seniors Promote physical activity	National programme; Community	Local group walks; Social support Children can be included; Community Networking	Page 88.
The DE-PLAN study in Greece – Greece	Greece	High – risk adults; Prevention of Diabetes	European project; Primary care services; Workplaces	Life style behaviour modification (diet, physical activity); Nurses' training; Group-based consultations	Page 94.
The Lombardy Workplace Health Promotion Network -Italy	Italy	Adults (employees); Improve health (diet, smoking, physical activity, road safety, alcohol etc.)	National project; Workplaces	European dimension (European Workplace Health Promotion Network); Advocacy; Supportive organizational and environmental measures at workplaces	Page 97.
Health Promotion	Sweden	Adults with intellectual	Individual Intervention;	Caregivers' training;	Page 108.

for Adults with Intellectual Disabilities: a Multi-Component Intervention in Community Residences - Sweden		disabilities Improve healthy behaviours, i.e. physical activity and healthy diet	Community residences	Health education sessions with residences; Strong focus on social health, as well	
Smoking reduction in psychiatric inpatients - Greece	Greece	Psychiatric adult patients; Smoking cessation	Individual Intervention; Psychiatric hospitals/ institutions	Nurses' training; Motivational counselling; Supportive environmental measures	Page 112.
Groningen Active Ageing Strategy - The Netherlands	The Netherlands	Seniors; Improve physical activity and social life	Individual Intervention; Community	Focus on sedentary frail older adults; Community exercise programme; Social skills and resilience building; Health education sessions; Social support	Page 114.
Health Promotion for People Belonging to the Cardiovascular Disease Risk Group 'Hereinafter – Program' - Lithuania	Lithuania	High – risk Adults (40-55 year old men and 50-65 year old women) Prevention of cardiovascular disease	Individual Intervention; Primary health care	Life style behaviour modification (e.g. diet, smoking, stress); Community oriented	Page 123.
Multimodal Training Intervention: an Approach to Successful Ageing - Iceland	Iceland	Seniors (71–90 years old); Improve physical wellbeing	Individual Intervention; Community	Nutrition and health counselling; Exercise training; Daily walking outdoors; Partner support component;	Page 125.
Sörmlands Health Program for 40, 50 and 60 Year Olds -	Sweden	Adults (40, 50 or 60 years old) Prevention of	Individual intervention; Health care service;	Medical Screening; Health education and counselling; Nurses' training;	Page 131.

Sweden		cardiovascular disease and diabetes		Community oriented	
A Sustainable, Active, Primary Prevention Strategy for Cardiovascular Diseases in Italy for Adults 50+ 'Projects Cuore and Cardio 50' -Italy	Italy	Adults (50 years old and above) Cardiovascular disease prevention	Individual intervention; Primary Health care Services	Health interviews; Active call; Physical activity promotion and diet; Health education courses and counselling; Community oriented	Page 133.
Diabetes Counselling on Wheels: Early Detection and Counselling on Diabetes for Citizens of Turkish Origin and the Rural Population - Germany	Germany	Adults of Turkish immigrant origin; Adults in rural regions; Prevention of diabetes	Individual Intervention; Primary health care services	Focus on older adults; Mobile health care units; Diabetes prevention and management counselling; Culturally sensitive service; Community oriented	Page 141.
Diabetes Prevention and Screening in Vulnerable Populations of the Metropolitan Lisbon Area - Portugal	Portugal	Adults; Diabetes prevention	Individual intervention; Community	Focus on vulnerable urban populations; Mobile health care units; A screening/diagnosis component; Advocacy; Health education and self-management sessions; Health professionals' training	Page 152.
"Healthy and active ageing" - Germany	Germany	Older adults (60 years old and above); Promotion of physical, emotional and social wellbeing	National strategy: Community	Focus on health aging (physical activity, diet, mental health, substance abuse etc.); Focus on key stakeholders; Multidisciplinary approach;	Page 157.

				Services coordination and networking; Health education;	
			All life cycles		
CINDI / Countrywide Integrated Non-Communicable Disease Intervention - Bulgaria	Bulgaria	Adults (25-64 years old); Children (14-18 years old); Prevention of non-communicable diseases	National programme; Community Level	Based on an international model; Focus on smoking, alcohol abuse, physical inactivity and unhealthy nutrition. Collaborative interventions; Population health education; Development of guidelines;	Page 163.
NHS Smoking Cessation Services - United Kingdom	United Kingdom	All age groups Smoking cessation	National programme; Primary Health Care Services	Stop smoking support health services; Media campaign and websites; Key stakeholders' training; Guidelines' development; Emphasis on pregnant women, young people and low socioeconomic groups;	Page 170.
Up-to-date health - Running and Walking Centre in Tondela, 'CMMCTnd' - Portugal	Portugal	Adults and seniors; Improve physical activity; Improve social life	Individual intervention; Community Level	Health care services collaboration; Local physical exercise activities; Awareness-raising events; Networking; Focus on seniors in rural locations	Page 176.
The Keyhole for Healthier Food - Norway	Norway	All age groups; Improve diet	Individual Intervention; Population level	Labelling scheme on food products; European approach; Advocacy strategy aiming the food industry; Special focus on families; Health Campaigns;	Page 183.
National Programme for the Promotion of	Portugal	All age groups; Improve diet	National policy; Population level	Health education activities; Intersectoral collaboration;	Page 188.

Healthy Eating, 'PNPAS' – Portugal				Collaboration with the food industry/ catering/ advertisement sectors etc. Key stakeholders' training	
Healthy Kinzigtal - Germany	Germany	All age groups; Improve health care treatment and preventive services	Individual intervention and local strategy; Community level	Long-term integrated health care services; Strong focus on prevention; Collaboration between health and social care and community services; Multidisciplinary health care services;	Page 196.
Gaining Health: Making Healthy Choices Easier - Italy	Italy	All age groups Prevention of chronic diseases	National Strategy; Population level	Intersectoral collaboration; Regulatory actions; Advocacy; Environmental targets; Health Awareness activities; Key stakeholders' training;	Page 214.
The Prevention and Health Promotion Strategy of the Spanish NHS: Framework for Addressing Chronic Disease in the Spanish NHS - Spain	Spain	All age groups; Prevention of chronic diseases	National Policy; Primary Health Care	Focus on children (younger than 15 years old and adults 50 years old and above); Intersectoral collaboration; Focus on prevention (diet; smoking; physical activity, alcohol, emotional wellbeing); Community interventions	Page 228.
Total Ban on Smoking in Indoor and Some Outdoor Public Places - Bulgaria	Bulgaria	All age groups; Smoke-free legislation	National Policy; Population level	Whole-of-government approach; Environmental targets (taxation, tobacco control policies etc.) smoking cessation services; public health campaigns; advocacy;	Page 238.
Healthy Life Centre - Norway	Norway	High risk adults Prevention of chronic	Individual intervention; Community	Interdisciplinary team working; Counselling sessions;	Page 245.

		diseases		Health professionals' training Focus on diet, physical activity, smoking, alcohol, sleep, mental health); Local activities;	
Active Vallecas - Spain	Spain	All age groups; Improve physical activity	Local-regional Intervention	Promotion of active lifestyle through physical activity programmes; Focus on child obesity and adults with risk factors, inclusion and opportunities for employment in sports for vulnerable populations; Intersectoral collaboration	Page 250.
Norwegian Public Health Act - Norway	Norway	All age groups; Improve public Health	National Policy; Population level	Development of public Health plans; Collaboration of key stakeholders; Focus on health inequities; Focus on living conditions;	Page 260.
The Welfare Watch-Iceland	Iceland	All age groups; Reduce impact of economic crisis on health	National Strategy; Population level	Focus on families; Focus on individuals in poverty; Coordination of policy and actions; Focus on living conditions; Intersectoral collaboration	Page 266.
Well London Programme - United Kingdom	United Kingdom	All age groups; Improve healthy living	Individual Intervention; Community	Community mobilisation; Focus on poor urban areas; Multicultural activities; Social support; Focus on volunteers; Focus on diet, physical activity and mental health;	Page 274.
'Tobacco Free	Ireland	All age groups;	Policy/Strategy;	Whole-of-government approach;	Page 279.

Ireland' - Ireland		Smoke-free legislation	Population health approach	Environmental targets (taxation, tobacco control policies etc.) smoking cessation services; public health campaigns; advocacy;	
NICE Public Health Guidance on the Prevention of Cardiovascular Disease at a Population Level - United Kingdom	United Kingdom	All age groups Prevention of cardiovascular disease	Strategy; Population health approach	Development of public health guidelines; Public health campaigns; Focus on smoking cessation, prevention and tobacco control, physical activity, obesity, hypertension, maternal and child nutrition and alcohol misuse; Awareness/training of key stakeholders	Page 289.
Community Food Initiatives - Ireland	Ireland	All age groups Improve diet	Individual intervention; Community	Community development approach; Focus on families; Focus on low income communities; School and community activities; Training of key stakeholders	Page 293.

Abstracts

Pre-natal environment, Early childhood, Childhood & Adolescence

An Intervention for Obese Pregnant Women - Sweden

The intervention targets obese pregnant women with the aim to control pregnancy weight gain. The intervention on its pilot study included meetings 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. The project is now implemented in all parts of Stockholm and there are education courses plans for different parts of Sweden that have been interested of the project. Funding is obtained from Stockholm's läns Landsting, the regional government. Material is available at internet for all Mother Health Care centres. The project was feasible and well tolerated by the pregnant women and the midwives enjoyed working with the project. All participants were satisfied or very satisfied with the project. About 1/3 of the mothers reach the goal of maximum weight gain 6 kg and 2/3 gain maximum 10 kg.

ToyBox Intervention - Greece

The ToyBox-intervention (<http://www.toybox-study.eu>) 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). Main aim is to prevent overweight/obesity in early childhood. 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. The implementation of the ToyBox-intervention was conducted at four levels. *Level 1.* Teachers conducted permanent environmental changes in the classroom/kindergarten, in order to create a supportive environment (i.e. rearrangements of the classroom/kindergarten to create free space). *Level 2.* Teachers promoted the four targeted EBRBs within each day (e.g. reminding every day children to drink water regularly and do short movement breaks, arranging a daily break for the whole class to eat healthy snacks and performing two physical education sessions per week). *Level 3.* Teachers implemented interactive classroom activities. *Level 4.* Parents/caregivers were encouraged and advised via simple and friendly to read material and 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. The ToyBox-intervention resulted to favourable changes of energy balance related behaviours for the children in the intervention group



compared to the control group. The results of the process evaluation showed that the intervention was well-received from the targeted audience. The cost-effectiveness study will be published shortly.

School Fruit Scheme Strategy for the 2010–2013 school years - Lithuania

The aim of the Strategy was to instil an awareness of the health benefits of eating fruit and vegetables in children. 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 School Fruit Scheme Strategy for the 2010–2013 school years set up the budget of the programme, target groups, accompanying awareness measures and distributes the products. Fruit and vegetables (i.e. carrots, apples, pears, bananas and citrus fruit) were distributed, free of charge, three times per week to pupils in early and primary education (years 1 to 4) at Lithuanian general schools wishing to participate in the School Fruit Scheme. Each child received one portion per day. At least two thirds of the overall quantity distributed to schoolchildren were products grown in Lithuania. 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. Such additional accompanying measures may consist of: children's excursions to fruit or vegetable farms to familiarise 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 informational publications); training for teachers on promoting 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. In school years 2009-2010, 171 schools took part in the program and 21,222 products were distributed to children. In school years 2012-2013, 1365 schools and nurseries participated in the program and 192,454 products were distributed to children. The funds for the implementation were allocated from the European Agricultural Guarantee Fund and the Lithuanian State budget.

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

The aim of the intervention (<http://www.progreens.org/>) is to educate children on healthy diet and specifically on fruit consumption. The intervention was developed within the European Union's 7th Framework Programme, funded by the European Commission and included 11 Member States. The main objectives were: 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. The expected results were: estimates of the fruit and vegetable consumption in different European countries; information concerning important psychosocial and socio-demographic determinants of fruit and vegetable consumption among school children in different European countries; a set of intervention strategies tailored to be appropriate and effective in promoting fruit and vegetable consumption among school children; an increased consumption of fruit and vegetables among the participating target group; a set

of recommendations for national and international authorities, commercial and professional groups on best-practices for assessment and promotion of 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 a survey was conducted in 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. The results informed the development of educational materials for students, guidelines and training for teachers, a shop visit brochure, informational materials for the parents, a poster project school activity. In October 2009, the start of the intervention was implemented within 6 schools in the capital. The intervention was characterized by a highly effective partnership, including school representatives, healthcare professionals and contacts with branch organizations of producers.

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

'Let's Take on Childhood Obesity' is a public health campaign on childhood obesity aimed at parents of children aged 2-12 years, on the island of Ireland. The Childhood Overweight and Obesity on the island of Ireland campaign is a 3 year campaign and was launched in October 2013 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) in partnership with the Health Service Executive and Healthy Ireland Framework in the Republic of Ireland and the 'Fitter Futures for All' Implementation Plan in Northern Ireland.

The campaign urges parents to make practical changes to everyday lifestyle habits which would make a big difference to their children's future health. The aim of the campaign was to halt the rise in both overweight and obesity levels in children by 2015, 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. It specifically addressed: a) Sugary drinks, b) Treat foods, c) Portion sizes, d) Physical activity, d) Screen time and e) Sleep.

Campaign channels included television and radio advertisements, social and digital advertising through the means of infographics, vox-pops and how-to-videos from health experts which were all hosted on the Safefood website. Free family booklets were distributed through crèches, health centres, GP surgeries, libraries and by public health nurses and available on the Safefood and partner websites (<http://www.safefood.eu/Childhood-Obesity/Welcome.aspx>). The message about childhood obesity was promoted through the Safefood website and the social media channels of Facebook and twitter. External sites, including the partner pages were used to distribute the information to a wider audience.

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

The National Curriculum Guide is a policy framework for Icelandic schools across educational levels: children in pre-schools (2-5 years), compulsory schools (6-15 years) and upper secondary schools (mainly 16-19 years). In

2011, new National Curriculum Guides for pre-, compulsory and upper secondary schools were published in Iceland by the Ministry of Education, Science and Culture. In that policy a milestone was made by defining “health and wellbeing” as one of the six fundamental pillars of education, thereby confirming the importance of health and wellbeing for education and vice versa. The policy describes the role of education in schools according to Icelandic laws and regulations, the objectives and organization of school operations and the requirements and rights of everyone in the school community. Six fundamental pillars have been developed within this framework that forms the essence of the educational policy in Iceland. In addition to “health and wellbeing”, the other pillars are “literacy”, “sustainability”, “democracy and human rights”, “equality” and “creativity”. The main health factors that are to be encouraged are: positive self-image, physical activity, nutrition, rest, mental wellbeing, positive communication, security, hygiene, sexual health and understanding of one’s own feelings and those of others. The National Curriculum Guide and particularly the pillar “health and wellbeing” is an important foundation for the Health Promoting School projects. The well-established Health Promoting School project likewise provides an important support for schools to implement the pillar “health and wellbeing” in all their work. The number of Health Promoting 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.

Young People at a Healthy Weight ‘JOGG’ - Netherlands

JOGG is a movement which encourages all people in a city, town or neighbourhood to make healthy food and exercise an easy and attractive lifestyle option for young people. It focuses on children and adolescents themselves, along with their parents and the direct environment. The main aim is to reverse the increasing trend of young people (0-19 years) 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.

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. 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 on how to measure the effects of the approach

Activities at the local level: Each city has its own JOGG-coordinator who plans various activities in relation to the 5 JOGG pillars. These activities differ between the municipalities implementing the JOGG approach. It ranges from drinking water activities at kindergarten to creating playgrounds. Municipalities commit to JOGG for at least 3 years. 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. JOGG has started with the local dissemination of the approach in 2010 in Zwolle. Currently, 84 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.

Dutch Obesity Intervention in Teenagers 'DOiT' - Netherlands

The aim the DOiT programme is to prevent overweight among prevocational educational school children by improving energy-balance-related behaviours (EBRBs): reducing intake of sugar-containing beverages (i.e. soft drinks and fruit juices); reducing intake of high-energy snacks; reducing screen time (i.e. TV viewing and computer use); increasing levels of physical activity (i.e. active transport and sports participation); daily and healthy breakfast consumptions. The target group is adolescents attending the first two years of prevocational education (12 to 14 years old). 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, adolescents 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. The intervention is implemented by the teachers at the prevocational schools during regular biology or physical education lessons, supported by the DOiT support office. DOiT is supported by an extensive teacher manual with a login for extra materials provided at the DOiT website. 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. Within the first 2 school years, more than 90 schools ordered the materials, reaching over 10,000 adolescents. 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.

Active School Flag - Ireland

The Active School Flag (ASF) is an initiative which aims to enhance levels of physical activity for children through developing a physically active and physically educated school community. The ASF mirrors well-evaluated 'active school' models operating in other countries. It is open to all *primary, post-primary, special needs education schools and YouthReach centres*. 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 include 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. 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.

ASF was launched in 2009 and 510 schools have received the ASF to date (2015). The assessment provides useful information on the ways in which schools conceptualised the issue of physical activity and achieved change within their own local contexts, resources and organisational structures, including the establishment of several innovative and beneficial partnerships in the local community. The ASF self-evaluation and improvement model resulted in schools improving their physical activity provision and had real capacity to increase physical activity in primary schools. This programme represents an important element of the national approach to physical activity in the school setting. There is an impressive level of school participation which suggests significant 'reach' and the growth of the ASF over time indicates a high level of acceptability among the school sector. The whole school approach is comprehensive in its consideration of physical activity and the focus on issues of inclusion and partnership may be of particular relevance to addressing inequalities in physical activity and in sustaining physical activity.

National Network of Health Promoting Schools - Lithuania

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 and every year a growing number of the country's educational

institutions join the network. 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. The Lithuanian health promoting school network belongs to the Schools for Health in Europe network (SHE network). In these schools, health topics have been integrated into the educational process - lessons and after-school activities. Health promoting schools conduct a long-term targeted and approved health promotion programs in various health areas: physical activity and physical education; healthy diet; tobacco, alcohol and other psychoactive substance abuse prevention; accidents, injuries, stress prevention; violence, bullying prevention; family and sexuality education; communicable diseases; the culture of consumption. 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 marked 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.

Adulthood & Aging

Croí MyAction, a Community Based Cardiovascular Disease Prevention Programme - Ireland

Croí MyAction is a 12-16 week intensive cardiovascular disease prevention programme. It is aimed at individuals and their partners/ family members at very high cardiovascular risk. It was developed in response to the need of an effective model of prevention for individuals at high multifactorial risk. The programme is a gold standard intensive risk factor management and lifestyle modification programme driven by specific protocols designed to achieve the latest ESC Guidelines. 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. 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 which includes a nurse specialist, a 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. The 16-week programme includes individualised follow-up, a weekly educational workshop and supervised exercise session. There is also a weekly 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. The Croi MyAction model was first developed by Imperial College London and has its strong evidence base in the EUROACTION study 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. The 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 to people and communities through its individualised behavioural change approach to lifestyle modification. It is family-centred, actively involving 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. This programme has been shown to be clinically effective, cost effective and cost saving. A recent economic analysis demonstrates that is cost-effective compared to usual care and represents an efficient use of resources.

"PUMP" - For a Million Steps - Spain

The programme "For a Million Steps" is an effective intervention to promote physical activity. The goal is to promote group walks with the slogan 'Accept the challenge "would you be able to achieve a million steps in a month with the steps contributed by all the individual participants?" Any institution, group or (formal or informal) association of individuals can freely participate (many are from local governments, health care centres, schools, nursing houses, workplaces etc.). They may register at the official platform, where all the needed information is explained. The group walks can take place anywhere (e.g. urban areas or countryside) at any time; they are self-programmed by each group. It has a strong social component that enhances community involvement and social support and the practice may easily encompass other health promotion activities. It has been implemented since 2008 in Andalusia, Spain, and it is still ongoing. Each year, at the local level, nearly 150 municipalities and 100 associations participate, signifying more than 23000 individuals. The Regional Ministry of Health gives support to the general diffusion of the practice. Local health promotion professionals also provide direct personal support and help encompassing the practice in the framework of all the other health promotion activities. Due to the inexpensive nature of the intervention, its continuation is well assured and even new modalities of the practice are arising. The practice simplicity, high transferability and possible adaptation to any local context make easy an eventual scaling up.

The DE-PLAN study in Greece – Greece

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 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. 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 the 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. Social support was emphasised by the group setting and participants were also encouraged to involve their own social environment in the lifestyle changes. At study end, participants reported decreased whole fat dairies and processed meats consumption of 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. These types of initiatives can also be expected to help reduce risk for other chronic conditions such as obesity, cancer and cardiovascular disease.

The Lombardy Workplace Health Promotion Network -Italy

The Lombardy Workplace Health Promotion Network (WHP) 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 four new activities every year to maintain the "*Workplace Health Promotion Site*"- logo. The areas of good practice are: nutrition, tobacco, physical activity, road safety, alcohol and substances, and well-being. The results were surprising in terms of network and adhesion. The WHP Network expanded on a regional scale during 2013 and is made up of companies ("Workplaces") which recognize the value of corporate social responsibility and undertake to be an "environment conducive to health" systematizing, with the scientific support of Health Local Unit where necessary, evidence-based actions of different nature: informational (smoking cessation, healthy eating, etc.), organizational (canteens, snack vending machines, agreements with gyms, stairs health programmes, walking /

biking from home to work, smoke-free environment, baby pit-stop, etc.) and collaboration with others in the local community (Associations, etc.).

The “Lombardy WHP Network” programme is 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). 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. 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.

Health Promotion for Adults with Intellectual Disabilities: a Multi-Component Intervention in Community Residences - Sweden

The risk of ill-health is increased in people with intellectual disabilities (ID), partly due to physical inactivity and an unbalanced diet. The intervention aimed to promote healthy behaviours, i.e. physical activity and healthy diet among people with mild to moderate ID living in community residences in Stockholm County, as well as staff work routines by targeting both residents and staff. The intervention is based on the 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.

The intervention was developed and evaluated by researchers at Karolinska Institutet and the Centre for Epidemiology and Community Medicine in Stockholm County Council. It is designed to be implemented by local staff in residences and in the municipality, based on a manual. 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. Work routines improved significantly in the intervention group.

Smoking reduction in psychiatric inpatients - Greece

The 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. 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. Subsequently, the patient was encouraged and helped to explore alternative coping strategies (e.g. relaxation, exercise and creative pursuits). Additionally, nursing staff were always available to maintain a sustained contact 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 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.

Groningen Active Ageing Strategy - The Netherlands

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. The intervention consists of the recruitment of participants, screening of participants for physical inactivity, loneliness and lack of resilience. The elderly are recruited by volunteers through home-to-home visits. Elderly that are interested in the project are 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 focusing 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 help to increase health literacy. The intervention lasts for 9 months. After the intervention, a continuation phase takes place for 24 months. During this period, participants receive self-management training. This training focuses on how to implement the lessons learned during the intervention in daily practice. 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.

They are also encouraged to join other activities in their neighbourhood. The following 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, defines the neighbourhood of the intervention (deprived area), the target population and the involvement of all relevant partners. 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. The effectiveness of the intervention was evaluated in 2 pilot studies, 16 months and 9 months after the intervention. The following conclusions were drawn: 25% of the initial target population was reached; participation in the project resulted in an increased fitness, increased self-efficacy and improved social skills for social networking. A process evaluation showed that the project met the needs and living situation of elderly with a low-socio-economic status. The outcome of the intervention will be evaluated by an effect evaluation; results are expected in 2015.

Health Promotion for People Belonging to the Cardiovascular Disease Risk Group 'Hereinafter – Program' - Lithuania

The Program 'hereinafter' was approved by the Ministry of Health Minister Order in 2014. It is a program for 40-55 year old men and 50-65 year old women who belongs to cardiovascular disease risk group (obesity, smoking etc.) and also participate in the screening and prevention program for people at high risk for cardiovascular disease (secondary prevention). Using the integration of primary health care facilities and municipal public health bureaus ongoing health activities, effectively strengthen the people's health, introduce them with cardiovascular disease risk factors and healthy lifestyle principles, teach how to change lifestyle, manage stress, choose a healthy diet and physical activity and reduce the cardiovascular diseases risk factors. Each participant has 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 plans 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. A psychologist taught stress management techniques, moreover, free psychological counselling was provided. 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. Evaluation showed that 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.

Multimodal Training Intervention: an Approach to Successful Ageing - Iceland

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 research study was to examine the effects of a 6-month multimodal training intervention (6-MTI), nutrition and health counselling on different variables, such as on functional fitness (FF), body composition (BC) and cardio metabolic risk factors (CMRF). The main aim was also to evaluate at 6- and 12-month follow-ups the effects and sustainability of a 6-MTI and additionally, 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. 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. 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. Several of the findings though highlighted the need for longer term programs. 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.

Sörmlands Health Program for 40, 50 and 60 Year Olds -Sweden

Within the framework of the Sörmlands health program, all inhabitants of the county Sörmlands who turn 40, 50 or 60 years get a home invitation with an offer to participate free of charge in local health programs during the year. The main aim is to prevent common non communicable diseases such as cardiovascular disease, type 2 diabetes and to strengthen public health. 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. Participating nurses are undergoing training in the health program and the communication methodology used in health talks/communication as well as training in motivational interviewing. The Sörmlands health program is based on previous initialised health program in the County of Västerbotten and supported by the National Health Promoting Hospitals Network.

A Sustainable, Active, Primary Prevention Strategy for Cardiovascular Diseases in Italy for Adults 50+ 'Projects Cuore and Cardio 50' –Italy

The main aims and objectives of the Projects Cuore and Cardio 50 -now implemented in 12 Italian Regions and inserted in their Regional Prevention Plan strategies – are: to implement a national cardiovascular register; to describe risk factor distributions (health examination survey); to estimate the cardiovascular risk of the Italian population and to implement the evaluation of cardiovascular risks in clinical practice; to evaluate through active call- , parameters and lifestyle of an asymptomatic population ; to implement the primary prevention programme (counselling on smoking cessation, healthy diet, physical activity).

The *target group* is 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. 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. 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.

The programme is funded by 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. 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.

Diabetes Counselling on Wheels: Early Detection and Counselling on Diabetes for Citizens of Turkish Origin and the Rural Population - Germany

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. The goal of the Diabetes Counselling on Wheels 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 at-risk 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 selected towns and regions have a high proportion of migrants, and the rural regions are characterised by poor provision of healthcare services. 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 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 co-operation of the various different organisations enables a coordinated viewpoint from the perspective of doctors, counsellors and patients.

The project is directed towards an increased participation of the target group, which otherwise is not reached by preventive measures. The evaluation – in progress (2014 to 2018) - 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 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. With the aid of the results obtained from the pilot project, the aim is to sustain the project on a regular basis.

Diabetes Prevention and Screening in Vulnerable Populations of the Metropolitan Lisbon Area - Portugal

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. Main objectives were: 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. 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. 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). 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. The fact that the service was free of charge and conducted through a mobile unit, going directly to the communities, was highly valued. The involvement of DGS and APDP, national reference institutions in diabetes care, was likewise a condition for success.

“Healthy and active ageing” - Germany

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 groups: 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. 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 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.

All life cycles

CINDI / Countrywide Integrated Non-Communicable Disease Intervention - Bulgaria

The aim of CINDI program is to improve health by reducing mortality and morbidity from the major non-communicable diseases (cardiovascular, cancer, injuries, chronic respiratory diseases and others) through integrated collaborative interventions that prevent diseases and promote health. The CINDI programme 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.

CINDI Bulgaria is a national program with nine demonstration zones and corresponds to the national health policy. The target group is the population of working age (25-64), including groups at high risk for certain diseases. It also includes a child component - students (14-18), teachers, and parents. 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 was first included in the CINDI Program in 1985 under the collaboration of the Ministry of Health and the WHO within five zones. 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 four monitorings, assessing behaviour change of the population's health. 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 seven zones and is also currently operating on a local level. On national level the program is funded by the Ministry of 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. The main strategies are: 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. The program involves many partners - Municipality and the Municipal Council; Regional Health Inspections, Regional Health Insurance Fund, hospitals, medical and diagnostic consultative centres, media, NGOs, schools and kindergartens, companies, unions, clubs, youth homes, pharmaceutical companies, police, traders, manufacturers, etc.

NHS Smoking Cessation Services - United Kingdom

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 services target all age groups, with particular emphasis on pregnant women, those under 20 years of age, manual workers and people with low income. Recruitment is either by self-referral or by referral from any NHS clinician (General Medical

Practitioners, General Dental Practitioners, Pharmacists, Health Visitors, etc.). 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. 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. Additional activities include: media campaigns 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.

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. The service is funded by the NHS and an early evaluation indicated that it was very cost effective. It has continued and institutional ownership guarantees its funding and human resources.

Up-to-date health - Running and Walking Centre in Tondela, 'CMMCTnd' - Portugal

The intervention CMMCTnd targets adults, especially the senior population, of the Municipality of Tondela. The main goal of CMMCTnd is to reduce the sedentary lifestyle and isolation of the target population in the Municipality of Tondela, 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 with 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 collaboration and the creation of job opportunities for sports technicians.

The project is developed by conducting local sessions of exercise (2-3 times a week), in spaces dedicated for fitness, walking, jogging, swimming, among others. Some projects also develop areas of cognition and cultural activities, allowing the establishment of partnerships with local health. This allowed the presence of a Sports technician at the Health Unit Centres that orients the beneficiaries from the diabetic CMMCTnd medical appointments towards an exercise programme in CMMCTnd. In addition, the presence of three nurses 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).

In addition to the local health institutions, associative institutions are engaged, and through its members, locally organise activities to promote 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). 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 2013 there were 1387 attending the activities and in 2014 there were 1420 beneficiaries participating in the 65 local projects. The questionnaire in 2014 showed that the beneficiaries feel healthier, more mobility, more strength and energy. The results also show the importance of reducing isolation and loneliness of senior people, promoting their integration in the activities of the society.

The Keyhole for Healthier Food - Norway

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 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. For more information on which criteria that apply to the various food product groups, read more here: [Keyhole Regulations](#). 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. For more information on which criteria that apply to the various food product groups, read more here: [Keyhole Regulations](#).

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.

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.

National Programme for the Promotion of Healthy Eating, 'PNPAS' – Portugal

The PNAPS is a national policy for healthy eating, 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 with the collaboration of other public and private sectors, namely in the areas of agriculture, sports, environment, education, social security and municipalities; to improve the qualification and mode of action of the different professionals who, through their activity, may influence knowledge, attitudes and behaviours in the food area. To reach the five general goals, the PNPAS proposes a set of activities:

- a) the systematic collection of indicators on nutritional status, food consumption and its determinants, the assessment of food insecurity situations, and the dissemination of best practices
- b) the change in the 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, through a coordinated action with the food industry and the catering sector or also through other activities
- c) the increase in food and nutrition literacy, particularly the most disadvantaged ones, towards healthy choices and eating practices, and the encouragement of best practices on labelling, advertising and marketing of food products.
- d) the identification and promotion of cross-sectional actions with other sectors of society, namely agriculture, sports, environment, education, municipalities and social security likely to encourage the consumption of foods of vegetable origin, seasonal, national, using packaging or means of transport, developing electronic tools that enable planning healthy, easy-to-use and affordable menus with price information, and developing a network at municipal level for monitoring best practices for the promotion of healthy eating for citizens.
- e) the improvement of education, qualification and mode of action of different professionals who can influence quality eating habits, namely at the level of the health sector, schools, municipalities, the tourism and catering sector or social security.

The PNPAS is in course between 2012-2016. 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 interventions according to the needs diagnosed has been considered relevant.

Healthy Kinzigal - Germany

Gesundes Kinzigal (Healthy Kinzigal) was founded in 2005 by the Hamburg Company OptiMedis AG and the medical network "Medizinisches Qualitätsnetz – Ärzteinitiative Kinzigal". Healthy Kinzigal 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]. After completion of the first ten years, the contract is to be continued indefinitely with both partner funds from 2016 onwards. In addition, Healthy Kinzigal is in discussion with other health insurance funds and insurance companies, concerning opening up its services to people insured by other health insurance funds. Integrated care, as offered by Gesundes Kinzigal 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 Kinzigal". A further starting point for "Healthy Kinzigal" was a provision of the best possible care, taking cost effectiveness into consideration.

The objective of the strategy is to optimise the healthcare and prevention of an entire region. 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"). Three main goals 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. Healthy Kinzigal 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. Numerous individual projects and services can be derived from the overall concept of Gesundes Kinzigal GmbH. The integrated care model in Kinzigal is one of the few models in Germany with a population based integrated care approach. All age groups are addressed.

The prevention and healthcare services provided by Healthy Kinzigal 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. Healthy Kinzigal is also currently working together with 38 clubs and societies in the region, several fitness studios, six companies and the local authorities of the region. *Core activities are:*

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.

Since 2006, the membership figures of Healthy Kinzigal 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 Kinzigal. Further, a survey on patient satisfaction shows that more than 90% of the currently enrolled insured persons "would definitely or probably enrol again if they were given the choice".

Gaining Health: Making Healthy Choices Easier - Italy

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. 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. In developing the national strategy, the Ministry of Health (MoH) plays a leading role by advocating, inspiring and guiding the multisectoral action. MoH signs several “Memoranda of understanding” with other Ministries, other public and private sectors, in order to achieve specific objectives. These policies are implemented by the intervention of various Ministries, Italian Regions, Public Healthcare System, Municipalities as well as by agreements with producers and distributors and other involved subjects. 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. 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

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. 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. The main “intermediate” targets are health care providers 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; knowledge of communication as a means of promoting health; use of tools to support interventions for health promotion.

The Prevention and Health Promotion Strategy of the Spanish NHS: Framework for Addressing Chronic Disease in the Spanish NHS - Spain

The Prevention and Health Promotion Strategy of the Spanish NHS: ‘Framework for Addressing Chronic Disease in the Spanish NHS’ – Spain 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 Strategy has a life-cycle approach, starting on from 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. 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.

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.

Between healthcare and family-community fields. 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). The main lines of actions in place: the operational development of comprehensive interventions; the design of professional training; 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. 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.

Total Ban on Smoking in Indoor and Some Outdoor Public Places - Bulgaria

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: rooms with separate jobs , 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 carried 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.

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 assistance for smoking cessation have been introduced: National telephone line for smoking cessation 0700 10 32; 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. By the end of the year data analyses will allow to measure the potential impact on the population targeted.

Healthy Life Centre - Norway

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.

Evaluations have shown that HLCs recruit people who do not on their own seek or participate in other services such as fitness centres. 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 three year national effect study on Healthy Life Centres is 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.

Active Vallecas - Spain

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. 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: the general objective is 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. Health professionals prescribe a programme for lifestyle change to people with diagnosed risk factors plus a health education programme, run and coordinated by health professionals of the participating health centres.
2. Education pilot project: the general objective is to identify children in school age with health risks related to their physical condition. WHO: teachers identify children that may be developing obesity with a simple test (BMI calculation). Tests are conducted in Physical Education classes of the schools of the surroundings of the Entrevías Sports Centre. When the test is positive, parents are encouraged to visit the paediatrician and/or a 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: the general objective is to ease the access to sport practice for people in vulnerable situations recognized by Social Services Centres of the district Puente de Vallecas, and who cannot access to sport activities because of different reasons (economic, social, cultural, etc.). Eligible groups are given access to regular sport activities of the Entrevías Sports Centre to people in vulnerable situations. To subscribe to this initiative is mandatory in order to fulfil the social inclusion criteria and to have the "social prescription" issued by the Social Services Centre. The Entrevías 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: the general objective is to give a training and employment option in Sports (e.g. as referees and sport monitors) to people in unemployment and vulnerable situations, recognized by Social Services. Madrid's Basketball 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: the general objective is to improve the coordination between professionals, to raise their motivation and to improve their health. Health professionals, social workers, assistants, sport professionals and any other person involved in the development of Vallecas Activa programme, jointly conduct a sport activity, supervised and continuous, 2 days per week.

Norwegian Public Health Act - Norway

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

Each municipality 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. The counties (19 altogether) 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. Evaluation showed 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."

The Welfare Watch- Iceland

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 WelfareWatch.

Originally, the main aim was to monitor the social and financial consequences of the economic situation for families and individuals and propose measures to help households. In 2014 the objectives were 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: child benefits and child social insurance; criteria for the minimum subsistence; the Housing situation; basic service; case coordinators; cooperation with NGO,s and a project fund. Evaluation report for the Welfare-Watch's work from 2009-2014 will be available soon. 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. An English report that evaluated the Welfare-Watch's work from 2009-2014 will be available soon in English.

Well London Programme - United Kingdom

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 in delivery of better services. Its aim is to improve all these areas. Each project recruits teams of volunteers from deprived areas who receive training in outreach and health promotion and then go out into their communities to signpost local residents to services and activities that promote health and wellbeing. Phase 1 ran from 2007 to 2011 and included a suite of 14 projects aimed at building community capacity and cohesion it focused on physical activity, healthy eating, mental wellbeing, local environments, arts and culture. Its collective aim was to improve health and wellbeing. Over 47000 people took part in phase 1. It was evaluated in 2011/2012 and was found to have had very positive impacts in improving diet and physical activities. The programme has been designed following community research carried out by the University of East London, which identified a need to provide local residents with skills to increase opportunities for volunteering to work in their communities to improve health and wellbeing and raising awareness around health issues. Relevant data showed that the residents in the areas targeted had worse than average health (for London). The project was based on the social marketing theory which recognises that a peer-to-peer approach is often effective in motivating people to take up activities and make lifestyle changes. There are a wide variety of activities to achieve the aims of the project. They included such activities as helping people to grow their own healthy food, to buy healthy food at low cost and cook it, physical activities, reaching out to hard to reach

groups, etc. The Well London Phase 1 evaluation is freely available online as are the plans for the phase 2 evaluation (www.info@welllondon.org.uk). 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.

'Tobacco Free Ireland' - Ireland

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. 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 in its presidency in 2012. Ireland has committed to the introduction of standardised packaging of tobacco products and legislation relating to smoking in cars when children are present is also approved, awaiting implementation. 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 the development of licensing systems relating to the sale of tobacco. 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. The tobacco control programme deliver 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 Irish government has consistently continues to action its commitment to rigorously defend legal challenges to tobacco control legislation developed in the context of Tobacco Free Ireland in the courts.

NICE Public Health Guidance on the Prevention of Cardiovascular Disease at a Population Level - United Kingdom

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 etc. The guidance has been promoted widely and can be accessed freely from the NICE website <http://www.nice.org.uk/guidance>.

Community Food Initiatives - Ireland

Community Food Initiatives (CFIs) - funded by *Safefood* and managed by *Healthy Food for All* - aim 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. Overall, CFIs promote good health by making it easier for people to make healthy food choices. The CFI programme consists of ten Community Food Initiatives based in areas of socio-economic disadvantage across the island of Ireland. The aim of the 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. The programme also supports and encourages all ten community projects involved, through shared learning, training and collaboration.

The Objectives of the CFI Programme are to: fund ten community-based food initiatives across the island of Ireland, over a three-year period (2013–2015); provide technical support, collective training and facilitate networking; Encourage projects to consider long term sustainability from the start of the programme; promote shared learning among CFIs on the island; identify policy and best practice lessons and increase awareness of the programme among key stakeholders. A summary of the key findings from the first year evaluation report is outlined below and can be accessed on <http://www.safefood.eu/Publications/Research-reports/Evaluation-of-year-one-of-the-Community-Food-Initi.aspx>. In year one, the CFIs engaged with more than 12,000 persons in activities related to healthy eating, growing food and cooking skills. 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. Priorities for the future: prioritise healthy eating/food activities – develop meal planning, budgeting and shopping skills; volunteerism – continue to sustain, recruit and organise volunteers and work to achieve results; promote shared learning among CFI's on the island of Ireland outside of organised networking events; encourage long term sustainability planning – including a social enterprise approach; continue to identify policy and best practice lessons and increase key stakeholder awareness.