

National Policy Approaches to Promoting Physical Activity: Seven Case Studies from Europe

Final Technical Report

Part 1: Main Results



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EXECUTIVE SUMMARY

Physical inactivity is an independent risk factor for non-communicable diseases (NCDs) and identified as the 4th leading risk factor for premature mortality. It is estimated that approximately 30% of the world's population do not meet the minimum recommended amount of physical activity to gain health benefits, prevent disease and promote wellbeing. It is well recognised that the factors that support and hinder efforts to increase levels of physical activity at the population level are complex and interconnected across multiple levels of influence.

Effective action to increase population levels of health-enhancing physical activity (HEPA) requires countries to develop a national policy framework to provide a clear direction and set of coherent strategic actions. This study aimed to identify and summarise examples of national policy approaches from a set of European countries and to compare and contrast the development process, content, and implementation.

The policy audit tool (PAT) was developed to provide a standardized instrument to assess national policy approaches to physical activity. A draft tool, based on earlier work, was developed and pilot-tested in seven volunteer countries (Finland, Italy, the Netherlands, Norway, Portugal, Slovenia and Switzerland). For each country a primary contact person was identified who led the country level data collection. Lead individuals were from diverse backgrounds and included: academics (n=2; Portugal and Switzerland); national or sub-national government officials (n=2; Italy, Norway) and representatives of a relevant national institute (n=3; Finland, the Netherlands, Slovenia). After several rounds of revisions, the final PAT comprises 27 items and collects information on: 1) government structure; 2) development and content of identified key policies across multiple sectors; 3) the experience of policy implementation at both the national and local level; and 4) a summary of the PAT completion process.

Country coordinators were advised to identify and review all available policy documents, programs and relevant activities from across multiple sectors and, where possible, to collaborate with colleagues from different agencies who have the necessary expertise and knowledge (both current and historical) for completion and finalization of the PAT. All countries completed the PAT using an iterative approach. On average, completion took approximately one year due to the data collection being undertaken concurrently with the development of the final PAT.

For the data analysis, items from the PAT were grouped into seven theme areas: 1) national policy and actions plans: what exists and the development process; 2) leadership, inter-sectoral partnerships, and policy implementation at the national and sub national level; 3) political commitment and funding; 4) HEPA recommendations, goals and targets, and surveillance systems; 5) communication and branding; 6) evidence and evaluation; and 7) successful programs, progress and challenges

1. National policy and actions plans: what exists and the development process

Five countries reported having specific physical activity policies, three of them solely on physical activity (Finland, Norway, and Slovenia). In two countries, HEPA was combined with sport and education (in the Netherlands) or healthy diet (in Switzerland). In Italy and Portugal, physical activity was incorporated within the broader public health policy.

Most countries identified some legislation relevant to HEPA and most common were in the areas of education, sport and health. The most frequently reported legislation was the education sector, with all countries reporting mandatory physical education in schools. Italy was the only country to report legislation on school buildings and the provision of sports facilities. Legislation within the health sector generally linked HEPA with the wider public health agenda to promote health and prevent disease. The level of detail on HEPA within these policy requirements varied.

HEPA related legislation and policy from the transport and environment sectors was reported by some, but not all, countries. Transport policies often stated requirements for non-motorized transport (cycling or walking), actions aimed at improving mobility, reducing carbon emissions, and addressing road safety. One example of legislation from the environment sector was the specification on free access to open space in Switzerland.

2. Leadership, inter-sectoral partnerships, and policy implementation at the national and sub national level

The Ministry of Health was most frequently identified by all countries as the provider of leadership and coordination of HEPA. Six countries (not Italy) reported either a clear partnership with at least one other ministry and in two countries the existence of a larger multi sector coordinating committee (Finland and Norway). All countries reported that policy implementation was delegated to the sub national jurisdictions (e.g. provincial, canton, or local level administrations). In many countries there was a requirement for regional and local area plans to be developed and to align closely with the national policy direction. However, the specifics of these and the process and success of local planning was not assessed in detail in this project.

All national policies and action plans were reported to emphasise the importance of cross-government action and working in partnership with stakeholders. Although recognised “in theory”, most countries reported that this was not effective across all levels of policy development and implementation. For example, collaboration was reported to be much stronger at the national level than at the regional and local levels in Finland. Conversely, Norway reported having strong partnership working at a regional and local level, but found it more challenging to establish strong links between the government and other national bodies such as the Health Directorate, the private sector and non-government organisations.

3. Political commitment and funding

The promotion and public endorsement of the importance of physical activity by senior politicians and leaders was reported to be present in several countries and this was viewed as a positive indication of increasing political support. However, it was also noted by several countries that during the time period of this project, there were indications that policy support was on the decline and this was associated with a decline in funding support. For example, in Norway the current HEPA policy expired in 2009 and no action to renew and update the policy was started until 2012 and is still not finished.

Funding is another indicator of government support although gaining information and data on government expenditure on physical activity is not easy. General information on funding was provided by all countries and more specific data indicating the scale of investment were provided by five countries that were able to access government sources. It is not surprising that the health and sports sectors were consistency identified

as major sources of funding. However there were examples across the countries of other government ministries and other non-government sources also contributing financial resources towards HEPA activities.

4. HEPA recommendations, goals and targets and surveillance systems

Six countries (excluding Italy) reported having national recommendations for children and adults, either developed through a national consultation process or by adopting international recommendations. Only the Netherlands reported specific recommendations for the older adult population. The recommendations on HEPA for each age group were broadly similar across countries and reflect the international consensus on the amount of physical activity necessary to benefit health. Several countries had tailored recommendations to specific health benefits and/or specific population groups (by gender, age, level of inactivity). Finland and Switzerland had stated recommendations on limiting sedentary behaviour.

Four countries (Netherlands, Portugal, Slovenia and Switzerland) reported specific national targets on HEPA, for example: *“to increase the proportion of young people (4-17 years) that meet recommended physical activity levels from 40% in 2005 to 50% by 2012”* (the Netherlands); and *“to stabilise and then increase by 1% per year the proportion of physically active people”* (Switzerland). Portugal reported having specific targets for different age categories (e.g., 15-24 years, 25-34 years, 35-44 years, etc) and also separate targets for males and females. Two countries had only simple statements of intent yet without a clear time bound target these countries cannot evaluate the success or failure of their national policy and actions. Three of the seven countries reported specific goals for reducing sedentary behaviour.

In addition to national targets for the prevalence of HEPA, other related goals were identified across different sectors including: education, healthcare, transport, sport, and environment. Examples of these other goals include: a requirement for every household to have 75m² of green space (the Netherlands); for 3% of residential areas to be allocated to a playground (the Netherlands); for the proportion of cycling trips to increase from 5% to 8% by 2019 (Norway); and for the knowledge of the benefits of HEPA to be increased among health professionals (Finland).

Only five of the seven countries reported having an established surveillance system. Two countries had a very long history of monitoring HEPA dating back to the 1970s (Finland and Slovenia) whilst in other countries this was a relatively recent development (Italy and the Netherlands). Surveillance systems varied from continual data collection with annual reporting (e.g., PASSI, Italy) to repeated surveys conducted and reported on a five year cycle (e.g., Swiss Health Survey). In Portugal, only one national survey had been conducted but plans were underway to develop an ongoing monitoring system.

5. Communication and use of ‘branding’ to promote HEPA

Public education on lifestyle risk factors has been a cornerstone of health promotion. Community wide campaigns can raise awareness and knowledge of the health benefits of active living, provide motivation and prompt behaviour change, and promote opportunities and programs. Most countries reported some experience with national mass media (or large scale) communication campaigns but, in general, these were linked to specific HEPA initiatives and were not an overarching or ‘unifying’ campaign on HEPA. However, there was one example from the Netherlands where the *“30 minutes moving”* message is used consistently across, and to link, all interventions. In contrast, Finland reported that many different providers promoted different activities and each had their own communication campaign.

6. Evidence and evaluation

All countries reported the use of the best available evidence in policy development, however they also acknowledged that achieving this in practice was a challenge. Only one country (the Netherlands) reported an established processes for developing evidence based policy. In this country, the Netherlands Institute for Sport and Physical Activity (NISB), a government funded agency, provided a central role ensuring that the relevant scientific evidence was taken into consideration. Other countries reported a general intent to use scientific evidence but no specific details of the process or mechanisms by which this was achieved. In general, most countries reported that the use of evidence varied considerably.

All countries reported recognition of the need to undertake evaluation of national policy and actions however limited supporting information was provided. In general, the practice of evaluation was described as weak. Only one country (Norway) reported undertaking a formal independent (external) evaluation of their national HEPA policy. In other countries, evaluation was reported to be more commonly undertaken at the specific program level and, even then, described as inconsistent. In some countries no evaluation was reported at all or it was planned but did not take place. For example, Portugal reported the planned evaluation of 'Mexa-se' but this did not actually eventuate. In contrast, and alarmingly, there were examples of HEPA programs being abolished despite demonstrating positive evaluation results.

7. Successful programs, progress, and challenges

Countries were asked to identify three areas of greatest progress and three remaining challenges in promoting physical activity. Areas of progress included: an increase in political commitment towards HEPA promotion (Finland, the Netherlands, and Slovenia); growing interest in HEPA from both the media and the public (Switzerland); the development of national HEPA recommendations (Switzerland); the development of stronger professional networks and collaborations, particularly across multiple-sectors (Finland, Italy, the Netherlands, Slovenia, Switzerland); advances in national surveillance on HEPA (Italy, Norway, Portugal); and more HEPA programs for specific population groups for example migrant youths (the Netherlands) and people with disabilities (Norway).

Remaining challenges most often identified lack of financial resources. Portugal reported a lack of funding for HEPA, Norway reported a lack of consensus on the allocation of funds for HEPA, and Switzerland reported the need for better mechanisms, including funding and structures, for the promotion of HEPA. Other challenges included: the development and management of inter-sectoral partnerships, particularly in relation to allocating clear roles and responsibilities (Slovenia, Switzerland); ensuring equity in physical activity provision for low socio-economic groups (the Netherlands); and programme evaluation (Portugal, Slovenia).

Summary

Bringing together all the key components to form a strong national policy framework directed toward increasing population levels of HEPA is not simple. For some time physical activity has been the 'Cinderella' of risk factors – widely recognized and largely ignored. The UN political declaration and WHO Global Action Plan for NCD prevention both provide strong endorsement of the need to increase levels of physical activity. It is however clear that achieving this goal will require a whole systems approach. Although progress is evident in this set of seven countries, there remained much more to do and scope for better implementation. It is estimated that less than one quarter of all countries have any national policy or action

plan addressing HEPA and most countries struggle to secure the political commitment, necessary resources and level of policy implementation needed to achieve the desired success.

This project has shown that an in-depth policy audit and cross country comparison can highlight similarities and differences in progress, challenges and accomplishments. The results reveal new ideas and opportunities for other countries. The sharing of good examples of comprehensive HEPA policy and actions plans between countries is beneficial and should be supported. Furthermore, global advocacy efforts and international support is needed for those countries developing their first HEPA policy. Global and regional networks and partnerships should be leveraged to assist in these efforts to create more active populations.

ABBREVIATIONS

DPAS	The World Health Organization's Global Strategy on Diet, Physical Activity and Health
EU	European Union
GAP	Global Action Plan for the prevention and treatment of NCDs: 2013-2020
HEPA	Health Enhancing Physical Activity
NCDs	Non-communicable Diseases
NGO	Nongovernmental Organization
PAT	Policy Audit Tool
UN	United Nations
WHO	World Health Organization

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INTRODUCTION

Physical inactivity is an independent risk factor for NCDs (1-4) and identified as the 4th leading risk factor for premature mortality.(5) It is estimated(6) that approximately 30% of the world's population do not meet the minimum recommended amount of physical activity to gain health benefits, prevent disease, and promote wellbeing.(5)

For over a decade, and particularly since the publication of the Global Strategy on Diet, Physical Activity and Health (DPAS), (5) there have been recurrent calls for countries to develop a national policy approach to physical activity. (6,7) a strong policy framework for health-enhancing physical activity (HEPA) is necessary to define a plan for coherent multi-level action, to foster partnerships across sectors, to secure political commitment and gain recognition as a priority policy area.(7)

It is well recognised that the factors that support and hinder efforts to increase levels of physical activity at the population level are complex and interconnected across multiple levels of influence.(8) Therefore it follows, that single solutions or programs focussed solely at the individual level are unlikely to have sufficient impact for population wide change. Increasing physical activity in adults and young people requires large scale, culturally adapted, actions across multiple sectors.(4, 9, 10)

With increasing recognition of this need, there is a demand for better evidence on what policy level actions are required to support physical activity. This has stimulated interest in learning from how other countries are progressing in terms of policy development and implementation. This growing interest in learning and sharing experiences on policy actions provided the basis for this project.

Prior to the commencement of this project in 2009, there had been remarkably few articles on national physical activity policy analysis and, those that did exist, were limited either to an analysis of a single policy document or provided a very detailed and comprehensive assessment but from only one or two countries.(6, 11-13) Due to this gap in information, an international collaborative project was commenced to capture the policy context relating to promoting and supporting health enhancing physical activity (HEPA) in a set of countries in Europe. In particular, the project aimed to identify the factors that support or hinder national efforts to increase physical activity within countries and compare progress and challenges between the participating countries. It was envisaged that the findings from both the process of conducting a national policy appraisal and the results from each country would provide useful insights to assist other counties in further developing their own HEPA policy agenda.

PROJECT AIM

This project had three aims:

1. To develop and pilot test a data collection tool to capture information on national policy approaches to increasing population levels of physical activity;
2. To collate a set of case studies on the current national policy context for physical activity from a sample of European countries; and
3. To compare and contrast the current status of physical activity policy within this set of countries.

METHODS

This project was undertaken within the framework of the European Network for the Promotion of Health Enhancing Physical Activity (HEPA Europe). As such, the term *health enhancing physical activity* was adopted, and shortened to “HEPA” throughout this report. This project was undertaken during 2009-2012, and involved seven volunteer institutions from seven different countries.

Development of the Policy Audit Tool (PAT)

At the commencement of this project in 2009, no suitable tool was available to capture information on national HEPA related policies in a standard format. Therefore, a data collection instrument was developed to ensure that similar and relevant information was identified from each country.

The development of the Policy Audit Tool (PAT) commenced with a review of published and grey literature on national and cross national policy on physical activity. This identified seven relevant studies (6, 12, 14-17) including the World health Organisations’ Global Strategy on Diet, Physical Activity and Health.(9) This set of documents was reviewed and internally cross referenced to identify a core set of criteria reflecting ‘good practice’ in policy development and implementation. A final set of 17 elements were selected for inclusion in the PAT (see Appendix 1). A first draft of the PAT was developed and structured using a ‘question and answer’ format to collect information on each of the 17 policy elements.

Recruitment of case study countries

In November 2009 invitations to participate in a cross country ‘policy’ project were sent to national experts from the HEPA Europe working group on national approaches to physical activity promotion. Experts from seven countries elected to take part (Finland, Italy, the Netherlands, Norway, Portugal, Slovenia and Switzerland). This set represents a group of countries with varying history in the promotion of physical activity and at different stages of policy development and implementation. The seven countries also reflect diversity in terms of current estimates of the prevalence of physical inactivity. Data from the WHO 2010 Global Status Report on NCDs(1) showed that across the case study countries the Netherlands is the most active with 20% of adults failing to meet recommended physical activity levels. In contrast, Italy and Portugal are the least active, with over 50% of adults being classified as insufficiently active.(1)

Pilot testing of the PAT

Pilot testing of the tool was undertaken in the seven participating countries. In each country there was a main contact person who was willing to lead and coordinate the policy audit work. Coordinators were from a variety of institutions, namely: academic (n=2; Portugal, Switzerland); national or sub-national government official (n=3; Italy, Norway, Slovenia) or representative of a relevant national institute (n=2; Finland, the Netherlands). An iterative approach was used which involved 3 phases of PAT completion, each of which was followed by an opportunity to share experiences. The experiences and feedback from the countries was used to inform revisions to the PAT. Full details on the development of the PAT have been published elsewhere.(18)

This work resulted in the final PAT, which comprises 27 items, structured into 4 sections:

Section 1 Country Context

Captured a brief overview of the government structure within the country and an orientation to the key Ministries and the relationship between central government and regional/local government;

Section 2 Policy Framework

Captured relevant key policy documents (recent past and present) and their respective action plans (where available) from across all relevant sectors, including health, sport, transport, education, and environment, as well as any other sector which could be nominated by the respondents;

Section 3 Policy Implementation

Sought information on policy leadership (national and local), the level of collaboration and community involvement, as well as examples of both successful and less successful actions. This breadth of information was meant to inform readers on both the development process and key learning related to policy implementation.

Section 4 Method of Completion / Collaborations

Sought a brief summary of the steps taken to complete the PAT and an overview of those involved in the process within the country.

Protocols for Country Completion of the PAT

Country leads were requested to coordinate the process of identifying and reviewing all available policy documents from across multiple sectors to capture the current status of physical activity policy in their respective countries. The leads were advised to collaborate with other colleagues and representatives from different agencies within their country who may have appropriate historical and current knowledge and expertise. This process would serve to provide wider input as well as support and assistance. As the context within each country would vary, no further specific methods were outlined. Although all the countries followed these broad guidelines, there were differences in the approach taken and in the level of success in engaging other stakeholders and obtaining the relevant information. Details of the methods and who was involved in each country is provided in Appendix 2.

Throughout the data collection period, project coordination and, where needed, technical assistance, was provided by the core project team (authors FB, KM and SK) through regular phone conferences and email communication. Individually tailored feedback was provided on each case study with the aim of improving clarity and breadth of the information provided. Once all seven PAT case studies were completed, they were reviewed by the core project team to ensure each question had been adequately completed in a similar way by all countries.

The full PAT case study for each country is included in Part 2 of this document. The final reports varied in length, ranging from 16 to 37 pages. In order to provide a shorter version of the results and a summary of

the HEPA policy context in each country, a two page summary version was developed. The summary was created by shortlisting the key areas of interest and developing an exemplar for one country (Switzerland) as a demonstration. After a review and revision, the final format was agreed and used as a template by the other six countries. The summary reports are provided in Part A of the results.

All case studies were compiled between January 2010 and October 2011. The exact timelines for completion of the PAT are shown on the full country case studies in Part 2. All results reflect the political situation surrounding HEPA promotion in these countries at that time that the PAT was completed.

Please note: Any developments or changes in HEPA policy which have occurred subsequently (since approximately October 2011) are not included in this report.

Data Analysis for Cross Country Comparison

The core project team (FB, KM, SK) led the cross country analyses using data provided in the final country reports from each of the seven countries. The aims of these analyses were:

1. To summarise the policy context across seven countries;
2. To identify and compare similarities and differences between HEPA policy development, content, and implementation between countries;
3. To identify what lessons can be learned about the current context of policy and national level action aimed at physical activity promotion across countries; and
4. To critique the PAT as a tool for appraising policy development, content, and implementation.

A multi-stepped approach was undertaken for these analyses and the first step included getting familiar with each country report and extracting their responses to each question to create a set of “pooled data” tables. During this stage the text responses from each country were not edited and were retained in their original ‘raw’ form exactly the same as in the country specific reports. The second step involved assessing how best to group the questions and responses to form a manageable set of coherent themes. This process resulted in seven themes, each comprising between two to five question items from the PAT. The grouping of items into themes served two key functions: 1) to help the reader navigate the large body of information and results; and 2) to facilitate the comparative analysis between countries on sub-sets of related topics.

Analysis of each theme was assigned to one of the core project team (FB, KM, SK) who led the data extraction of key findings and drafted a set of discussion points. Each theme was then reviewed by the other members of the project team and any differences in opinion or interpretation were discussed. Subsequently, summary tables of results were developed (where appropriate in tabular format) to facilitate reading and to provide an accessible overview of the information for a wider readership.

These seven themes reflect key areas of interest as shown below:

- Theme 1:** National policy and actions plans: what exists and the development process
- Theme 2:** Leadership, inter-sectoral partnerships, and policy implementation at the national and sub-national level
- Theme 3:** Political commitment and funding
- Theme 4:** HEPA recommendations, goals and targets, and surveillance systems
- Theme 5:** Communication and branding
- Theme 6:** Evidence and evaluation
- Theme 7:** Successful programs, progress, and challenges

All results were collated and circulated to the country leads for comment. In addition, a face to face meeting was held in Zurich (June 2012) to review and discuss the cross-country analysis and interpretation. Between August 2012 and August 2013 the core project team (FB, KM, SK) compiled the technical report. This was circulated to the country leads in September 2013 to confirm the completeness and accuracy. The project timelines and steps are summarised in Appendix 3.

RESULTS

The results are presented in two parts.

Part A includes the summary case studies from each country. These summaries provide a brief overview of the HEPA policy context in each country and were derived from the full country case studies.

Part B of the results focuses on the cross-country comparison. This involved identifying similarities and differences between the national approaches to HEPA in each of the case study countries in order to inform an appraisal of the progress, development, and current context of HEPA promotion in these countries.

Copies of the full country reports (“case studies”) are available in Part 2 of this Technical Report , prepared as a standalone document due to its length.

Part A: Two page summary of national policy

The following section includes the two-page summary case studies from each of the seven countries.

Finland

Background

In Finland, the laws concerning physical activity are handled by government. The proposals of the laws are given by government and accepted by parliament. In addition, the government can give governmental resolutions (like resolution on directions for development of health-enhancing physical activity) which are not laws, but policy papers. In the Finnish structure, the local authorities/local government in towns and rural district communes have strong independence concerning how much local money is invested in physical activity. Although Finnish national government is strongly committed to enhancement of physical activity, the current situation varies somewhat on the local level.

Policy development and documents

In June 2008 the Finnish government published a resolution concerning the development of health enhancing physical activity and diet. This document contains specific population targets and proposes the main ways to enhance HEPA and healthy diet. This is this is the main political paper on HEPA currently, providing the political and government strategy for physical activity in Finland.

National recommendations

In January 2008 national physical activity recommendations were published for children and young people, advising 1-2 hours of physical exercise daily for 7-18 years of age. Also, in 2008 the UKK Institute updated and modified the physical activity pie for adults and older adults, recommending aerobic physical activity for 2 hours and 30 minutes a week at a moderate intensity or 1 hour and 15 minutes a week at a vigorous intensity (an equivalent combination of both is also possible). However, the pie is not official government policy.

National goals and performance indicators

The 2008 HEPA resolution does not contain clear targets for prevalence but states an intention to increase the number of people exercising enough for their health and decrease the number of people who do not exercise at all.

National action plans outlining a clear implementation strategy

The 2008 Governmental Resolution on HEPA has an action plan or a work plan developed by the Advisory Committee. This lists what actions have taken place at the local level over the past year. This work plan also lists, for every area, the actions and targets for the future on what should be done to enhance the situation. The planning frame is usually four years.

Communication and branding

In Finland there is not one over-arching communication strategy but different operators active in HEPA promotion have their own communication strategy. At the national level Finland has had a TV series as well as general mass media campaigns on health, which included physical activity. There is also a national website containing information on physical activity. The interventions to promote physical activity in Finland are not linked by one common brand/slogan.

Evidence of political commitment

Political commitment is excellent at the governmental level. The topic is frequently included in official speeches and the key politicians are very engaged in HEPA promotion. Many organisations and associations active in physical activity have the key politicians on the board. As an example, the Prime Minister was the chairperson of Young Finland Association (physical activity in children and adolescents) and the Minister of Health is the chairperson of Finnish Sport for All Association. However, at the local (communal) level, there is great variation in the level of commitment of local officials and key politicians in HEPA promotion.

Coordination and stewardship for HEPA promotion

The government has delegated the coordination role to the HEPA Advisory Committee. The Committee has delegates from governmental organisations, local authorities, and non-governmental organisations (NGOs).

Surveillance or health monitoring system

The National Institute of Health and Welfare is mainly responsible for surveillance and health monitoring. For adults, surveillance data is captured via the annual Health Behaviour and Health among the Finnish Adult Population (AVTK) postal survey (since 1978). In this survey there are several questions concerning physical activity (leisure time physical activity, work commuting physical activity, physical activity in work). There are plans to also include objective measurement of physical activity in a sub-sample of participants. A similar postal survey is conducted in older adults every second year (since 1991) and the FINRISK survey is conducted every fifth year (since 1972). For children and young people, there are two national surveys which contain some questions about physical activity and Finland also takes part in the International Health Behaviour in School-aged Children (HBSC) survey.

Evaluation of policy implementation

The evaluation of physical activity policy implementation is done on three level:

1. The National Institute of Health and Welfare (former National Public Health Institute) is mainly responsible for overall evaluation of HEPA, healthy diet, and obesity. Every year a postal survey is done and physical activity is one of the lifestyle factors asked in the questionnaire. In addition, every fifth year a survey containing measurements is done in Finland.
2. The Governmental political program “Health Enhancement” contains an evaluation part where also physical activity is involved. The evaluation is mainly based on the measurements done by the National Institute of Health and Welfare.
3. Every greater national project in the field of physical activity will also have their own project oriented evaluation. Financiers usually expect independent evaluation to be done in every project. The evaluation is usually external conducted by research institutes, universities, or private firms working in this field.

Main successes and challenges

Successes include strong political commitment, gradual increases in funding for physical activity and the strengthening of the HEPA network. Challenges include westernised lifestyles, diversity in how physical activity is handled at the local level, and objective physical activity and physical fitness measurement at the population level.

Italy

Background

Italy has a constitutionally-based organisational system of regionalism, composed of 19 Regions and two Autonomous Provinces (local government). Usually, the national level has the competence to develop general strategies and goals on a subject, the Regions develop the general rules for the implementation, and municipalities and schools carry out the implementation.

Policy development and documents

Health: In 2004, the Gaining Health Programme was launched as a combined effort of nine ministries and in agreement with the Independent Regional and Provincial Governments, focussing on the four main NCD risk factors, including the promotion of physical activity. The programme is implemented through the National and Regional Prevention Plans, and a specific national project on physical activity.

Sport: The Italian National Olympic Committee (CONI) is responsible for the development and management of sports activities in Italy.

Education: Several protocols exist on sport infrastructure and the provision of sport and physical activity in schools. A key law is Decree 18/12/1975 which includes technical regulations on school buildings, with indications of environmental criteria for the practice of physical activity.

Environment: This is an under-developed area in Italy; however, in 2010 the Ministry of Environment launched a call for projects on the reduction of CO₂ emissions by promoting bike sharing.

Transport: No information received.

National recommendations

Italy does not have official national recommendations on physical activity levels. However, the national surveillance systems use the international physical activity recommendations as cut-off points for what constitutes a “sufficient” level of physical activity.

National goals and performance indicators

There is no national goal for physical activity. However, the National Health Plan 2010 – 2012 defined a goal to contain the prevalence of obesity under 10%, with a combination of initiatives that combine physical activity promotion and healthy diet.

National action plans outlining a clear implementation strategy

The National Prevention Plans are implementation tools of the Gaining Health program. With the First National Prevention Plan 2005-2009, the National Health System for the first time addressed the prevention of NCDs. The new National Prevention Plan (PNP) 2010 – 2012 called for the adoption of Regional Health Prevention Plans. The Italian Centre for Disease Control and Prevention (CCM) provides Regional Governments with technical assistance, assessment, and certification of the results obtained. As part of the “Gaining Health” program, a 3-year national project on physical activity promotion was carried out from 2007-2010, involving 6 Regions (“Promoting Physical Activity - Actions for a Healthy Life”).

Communication and branding

Communication is an essential element in the “Gaining Health” Programme, which includes an information campaign for the general public addressing healthy choices, a specific programme in collaboration with schools, and specific plans for each action. Several logos and slogans were in use, for example “Diamoci una Mossa”, in forma con il movimento (Let’s move! Fitness through physical activity), an intervention to enhance PA in primary schools.

Evidence of political commitment

While the inclusion of obesity reduction and promotion of a healthy lifestyle as a public health priority in the National Prevention Plan (PNP) 2010 – 2012 and the adoption of the Gaining Health Programme represent important political commitments, by 2010 political commitment towards implementation had decreased and the CCM funds for Health Promotion had been significantly cut.

Coordination and stewardship for HEPA promotion

At the national level, stewardship for HEPA promotion is with the Ministry of Health, General Directorate of Prevention, Healthy Lifestyle Unit and Public Health and Innovation Department. Considering the increasing decentralization of decision making at the sub-national levels, it has a key role to ensure coordination and the establishment of solid links between national and local, as well as public and private institutions.

Surveillance or health monitoring system

Italy has recently established a surveillance system with continuous data collection in adults since 2007, based on the Behavioural Risk Factor Surveillance System (BRFSS) model (PASSI - Progressi delle Aziende Sanitarie per la Salute in Italia). Since 2011 this survey also includes elderly, and since 2008 a biannual survey has been conducted in children (Okkio alla salute). In 2010 Italy also participated in the HBSC survey.

Evaluation of policy implementation

The CCM is responsible for the evaluation (and consequential funding) of regional, multi-regional or national projects. Local programs are required to conform to strict project management protocols, including evaluation protocols, in order to receive funding.

Main successes and challenges

Examples of greatest progress in recent years include: the establishment of a systematic surveillance system on risk factors; a “cultural revolution” in network and project management (with health promotion embedded within the National Health Service); and the preventive approach of the gaining Health Programme. Remaining challenges include: the lack of a central co-ordination between different institutions that deal with the subject; the lack of collaboration between institutions; and differences between the northern and southern regions of the country in access to services and facilities.

The Netherlands

Background

On a national level the Ministry of Health, Welfare and Sport (VWS) is responsible for sport, physical activity and health policy, although they link with other ministries where relevant. In the Netherlands there is a decentralized system of government. National government provides policy and the framework for sports and physical activity, but the municipalities themselves decide to what extent they follow national policy and provide for and support sports infrastructure, programs, and activities. There is no law that obliges municipalities to undertake action in this field. On a national level two NGO's support provincial and local sports and physical activity promotion, NOC*NSF (National Sports Federation), and NISB (Netherlands Institute for Sport and Physical Activity).

Policy development and documents

Sport: Sport is the area of greatest policy development in the Netherlands with a succession of policy documents including: *Time for Sport*, 2005; *Together for Sport*, 2006; *The power of Sport*, 2008; and *Excellence at Every Level* (2009).

Transport: A key document is the *Dutch Bicycle Master Plan, 1999*. However, other broader documents include the *Mobility Policy and the Spatial Planning Policy*.

Education: The Sport, Physical Activity and Education Policy, *Beleidskader Sport Bewegen en Onderwijs* (2008), describes the amount of hours for physical education in schools.

Health: The main policy papers are *Opting for a healthy life, Public Health policy in the Netherlands 2007-2010* (2006) and *Being Healthy and Staying Healthy: A Vision of Health and Prevention* (2007).

Environment: A key document is *Agenda for a living countryside: multi-year program for a living countryside* (2007-2013) which has a strong focus on walking.

National recommendations

In the Netherlands the national physical activity recommendations are:

- Adults: minimum 30 minutes moderate intensity activity per day, at least 5 days a week OR 3 times a week 20 minutes vigorous intensity physical activity
- Youth: 60 minutes moderate intensity activity, each day of the week
- Elderly: 30 minutes moderate intensity activity per day, at least 5 days a week

National goals and performance indicators

The most recent objectives, which were set out in 'The Power of Sport' (2008) stated that in 2012, at least 70% of adults (18+) will do the recommended amount of exercise (2005, 63%), at least 50% of young people (aged 4-17) will do the recommended amount of exercise (2005, 40%), and no more than 5% of adults in the Netherlands will be inactive (2005, 6%).

National action plans outlining a clear implementation strategy

Together for Sport, 2006 outlines the implementation strategy of the policy paper *Time for Sport*, for the years 2006-2010. The strategy consists of various programs related to physical activity and health and

importantly the *National Action Plan Sport and Physical activity (NASB; 2008-2014)*. This action plan is targeting people who are not sufficiently active compared to the norm of physical activity.

Communication and branding

In the Netherlands the slogan is '30 minutes moving'. The National Campaign is organised by the NISB (NGO). This campaign has several actions like: climbing stairs week, a bus 'what to eat and how to move' which drives around, and a website for consumers. NISB also executes a number of other campaigns together with partners, such as the cycling campaign 'Heel Nederland fietst' (the whole of Netherlands is cycling).

Evidence of political commitment

Although not a top priority of the State policy, there is substantial political commitment for physical activity. In all recent relevant documents physical activity has been mentioned. In the sport policy documents physical activity is one of the key issues. The budgets to promote physical activity have risen in recent years and an extensive budget is being spent on the combined life style intervention *Beweegkuur* (physical activity and healthy nutrition promotion). In addition, The Minister and State Secretary are promoting sports and physical activity in speeches and videos.

Coordination and stewardship for HEPA promotion

There is not one organisation in the Netherlands providing overall stewardship and coordination for HEPA promotion. Instead, there is a culture that relevant stakeholders work together and, depending on the topic, some are more 'in the lead'.

Surveillance or health monitoring system

The annual National Survey on Injuries and Physical Activity in the Netherlands (IPAN) measures the physical activity behaviour of the Dutch population. The IPAN is a continuous survey amongst a representative sample of 10,000 Dutch inhabitants (4 years and older). Every two years a report is published with the results.

Evaluation of policy implementation

In general there is not one way of evaluating processes, results, and effects of policy implementation. Sometimes there are specific guidelines for evaluation and sometimes independent organisations are being asked for evaluation of the more extended programs. The evaluation of the National Action Plan Sports and Physical Activity is broadly divided into two parts: 1) The outcome evaluation of the action plans of local governments; and 2) The evaluation of the coordination of implementation.

Main successes and challenges

The three greatest successes in HEPA promotion in the Netherlands are: the promotion of physical activity within health; better integration of physical activity within education; and increased participation in sport among migrant youths. Remaining challenges include: inter-sectoral collaboration in general; relations with the spatial planning sector, in particular; and HEPA promotion among low socio-economic groups.

Norway

Background

The Storting is the Norwegian Parliament. In Norway 17 ministries are represented in the Government. The Ministry of Health and Care Services has the overall responsibility for government policy on health and care services, as well as physical activity. The majority of the 17 ministries have a responsibility for public health work in general and physical activity in particular.

Policy development and documents

Environment: The environment sector is a key area of policy with regards to HEPA promotion in Norway.

The Outdoor Recreation Act established the universal right of free access to and passage through uncultivated land in the countryside. *The Planning and Building Act* (2009) is important for urban development and design of our physical surroundings, and the *White Paper No.39 Outdoor recreation (Friluftsliv) - A way to better the quality of life* (2001) intends to facilitate engagement in outdoor activities close to where people live. In addition, the *Government's Environmental Policy and the State of the Environment in Norway* (2005) describes the policy on outdoor recreation, securing recreational areas and covering environmental issues related to physical activity such as active transportation.

Transport: The *White Paper No. 16 National Transport Plan* (2009) includes a National Cycling Strategy.

Sport: *White Paper No. 14 to the Storting (1999) Sport in a State of Change - About the State's relationship to sport and physical*, focuses on strengthening voluntary local work for sport, and on increasing engagement in sport, particularly among children and young people.

Working Life: The *Working Environment Act* (2006) outlines employers' obligations with regard to physical activity.

Health: Two key documents emphasise the important role of prevention in healthcare, *The Parliament White Paper No.16 Prescription for a healthier Norway* (2003), and the *White Paper No. 47 The Coordination Reform Proper treatment – at the right place and right time* (2009).

Inter-sectoral work: *The Action Plan on Physical Activity 2005–2009 - Working together for physical activity* (2004) was an important document in promoting inter-sectoral action and showing how different sectors influence physical activity. The plan was the result of collaboration between eight ministries and contained 108 measures to increase the physical activity.

National recommendations

The first Norwegian recommendations for physical activity were published in 2000 and were updated in 2004. Children and adolescents should be active a minimum of 60 minutes of physical activity every day. Adults and older adults are recommended to take at least 30 minutes of moderate and/or vigorous physical activity every day. The activity can probably be divided into shorter intervals of physical activity during the course of the day.

National goals and performance indicators

There are no clear indicators. In *The Action Plan on Physical Activity 2005-2009* only broad targets were mentioned including an increase in the number of children and youth who are physically active for at least 60 minutes per day and an increase in the number of adults and elderly people who are moderately physically active for at least 30 minutes per day.

National action plans outlining a clear implementation strategy

The Action Plan on Physical Activity 2005-2009 was a national mobilisation intended to promote improved public health through increased physical activity. The Action Plan aims to increase and strengthened factors that promote physical activity in the population and reduce factors that lead to physical inactivity. Increased physical activity will be attained through a total strategy that includes measures in diverse areas of society – in kindergartens, in schools, at work, in transport, in the local environment, and in leisure. This initiative requires cooperation between different sectors and levels of administration.

Communication and branding

There was a communication strategy in *The Action Plan on Physical Activity 2005-2009*. The target groups of the strategy were decision makers and professionals in various sectors, NGOs and the media. The slogan for the whole communication campaign was: “Better health in 1-2-30”.

Evidence of political commitment

Physical activity is put on the political agenda and mentioned in a lot of strategies. But it is difficult to assess political commitment to the promotion of physical activity in Norway, because the answer one receives depends on whom one asks. While some are satisfied with the current political commitment to increasing the level of physical activity in the country, others are far from being so.

Coordination and stewardship for HEPA promotion

The Action Plan on Physical Activity (2005-2009) had an inter-ministerial coordination group that followed the work, with meetings twice a year. The Ministry of Health and Care Services had overall responsibility for physical activity and chaired the group.

Surveillance or health monitoring system

In Norway, there is no national public health surveillance system that annually monitors the level of physical activity in the population. In *The Action Plan for Physical Activity 2005-2009*, it was intended to develop a system to monitor the level of physical activity among the Norwegian public. During the implementation of the Action Plan, two comprehensive surveys of the level of physical activity were carried out using accelerometer and questionnaires.

Evaluation of policy implementation

The Action Plan on Physical Activity 2005-2009 has been evaluated. The objective of the evaluation was to establish a foundation of knowledge on which to continue developing the work to improve public health through increased physical activity in the population.

Main successes and challenges

Areas of greatest success include: greater PA provision, and particularly outdoor recreation, for people with disabilities; mandatory physical education in schools; and objective measurement of physical activity. Remaining challenges include: changes in urban planning and infrastructure to create environments which are conducive to physical activity; and up skilling professionals across a range of sectors in physical activity promotion.

Portugal

Background

Portugal has been a democratic republic since the ratification of the Constitution of 1976 - the main law which governs all others. There are four organs of sovereignty: the President (Head of State - moderating power, with some executive power), the Assembly of the Republic (Parliament - the legislative power), the Government (executive power) and the courts (judicial). In Portugal a semi-presidential regime is in force. Some ministries are responsible for health, physical activity, sports and recreation: Ministry of the Presidency (the Minister of the Presidency is supported by the Secretary of State for Youth and Sports); Ministry of Public Works, Transports and Communications; Ministry of Environment and Spatial Planning; Ministry of Health; and Ministry of Education.

Policy development and documents

The main law which governs all others is the Constitution of the Portuguese Republic - April 2nd, 1976.

Other key documents across relevant sectors are:

Health: The most important is the *National Health Plan 2004 – 2010* which includes several programs aimed at promoting physical activity and healthy lifestyles. Other relevant documents include the *National Program for Prevention and Control of Diabetes*, the *National Program to Combat Obesity*, the *National Program for Prevention of Cardiovascular Diseases*, and the *National Program for the Health of Older Persons*.

Education: The *Law No. 46/86 of 14 October - Law of the Education* establishes the framework for the education system, where physical education is compulsory for all children from primary through to secondary education and school sport is an extra-curricular activity offered by all schools.

Transport, environment and spatial planning: The *Regional Operational Programs (2007-2013)* is a financial instrument of regional policy. It includes activities in the field of pedestrian and bike paths.

Sport: The *Law No. 5 / 2007 of January 16 - Law on Physical Activity and Sport* sets out the basis for development policies in physical activity and sport. The Portuguese Sports Institute (PSI) (*Decree-Law No. 169/2007 of 3 May*) is the most important organization responsible to assist the design, implementation and evaluation of public policy in sport.

National recommendations

The country has no official national recommendations for physical activity levels, adopting the international recommendations (edited by the Sports Institute of Portugal, in July 2009): *“a minimum of 60 minutes of daily physical activity of moderate intensity, for children and youth, and a minimum of 30 minutes daily moderate physical activity for adults, including seniors.”*

National goals and performance indicators

It is intended by the National Health Plan 2004-2010 to reduce the prevalence of individuals who spend most of their free time with sedentary activities:

- Persons aged 15-24 years: from 45.5% to 15% in males and 64.2% to 16% in females
- Individuals of 35-44 years: from 67.5% to 34% in males and 77% to 39% in females
- Individuals 55-64 years: from 70% to 35% in males and 83.2% to 42% in females
- Individuals of 65-74 years: from 75.5% to 38% in males and from 87% to 44% in females

However, the plan provides no details of how these ambitious targets will be achieved or evaluated.

National action plans outlining a clear implementation strategy (<- point 8 in full template)

There are a range of action plans including: The National Plan Ecotrail; the National Health Plan 2004-2010 and the Integrated Plan of Regional Planning – Alentejo. In addition the government has identified specific HEPA programmes including Project 'Ciclória' and the National Program of Walking and Running.

Communication and branding

Portugal has no communication campaigns addressing physical activity. But "Move yourself" the slogan from an extinct PSI Program (Mexa-se), is still adopted by the local public administration in developing programs to promote physical activity.

Evidence of political commitment

The Prime Minister appears frequently in the media carrying out his usual physical activity, even during official visits to various countries.

Coordination and stewardship for HEPA promotion

There is not one single institution providing overall stewardship, different bodies are responsible for partial aspects.

Surveillance or health monitoring system

In 2008/09 Portugal carried out its first national study of prevalence of physical activity and fitness levels. Current developments are hoped to form the basis of an ongoing surveillance system but this is not yet confirmed.

Evaluation of policy implementation

There is a Steering Committee of the National Health Plan, coordinated by the High Commissioner of Health. The committee meets quarterly and is responsible for monitoring the evolution of the indicators associated with the goals of the Plan. Although some other plans mentioned evaluation intentions, there is no information available about the processes. For example, the Mexa-se Program included in its main document the evaluation process, nevertheless it was abolished and replaced by the Program for Walking and Running without any evaluation.

Main successes and challenges

Examples of an area or issue of greatest progress in recent years include: the completion of the first prevalence study on physical activity and fitness levels of the Portuguese population; the inclusion of physical activity indicators in the national health programs; and the creation of large events such as Lisbon and Oporto bike tours, and mini-marathons, that involves thousands of participants including public figures and politicians. Issues that remain more difficult to address include: the lack of funding for HEPA initiatives; inter-sectoral coordination; and evaluation of the effectiveness of national programmes.

Slovenia

Background

The Republic of Slovenia is a parliamentary representative democratic republic since 25 June 1991, and became a European Union (EU) member on 1 May 2004. National authorities such as a Slovenian Parliament and Government are responsible for execution of all adopted national (and when appropriate also regional) documents. There are two ministries that are responsible for physical activity; the Ministry of Health is responsible for health and (health enhancing) physical activity documents, while the Ministry of Education, Science, Culture and Sport (Previous Ministry of Education and Sport) is responsible for documents regarding sport and recreation. Local authorities (municipalities) are responsible for all adopted local (and when appropriate also regional) documents regarding health, physical activity, sport, and recreation.

Policy development and Documents

Education: Physical Education is a compulsory subject at all education levels from kindergarten to university.

Sport: The most important national document for sport & recreation is the *National Programme of Sport in the Republic of Slovenia, 2000-2010* which is based on the Law of Sport of the Republic of Slovenia 1998.

Health: The most important PA document is *National Health Enhancing PA Programme 2007-2012*.

Workplace and Social Sector: An important document is the *Resolution on National Programme of Safety and Health at Work, 2003* which is based on the Occupational Health and Safety Act (1999).

Environment: The most important documents are the *Spatial Development Strategy of the Republic of Slovenia, 2004* and the regulations that were the basis for the Spatial Planning Act (2002) and the new Spatial Planning Act (2007).

Transport: All of the documents in the transport sector are based on traffic legislation such as the Road Traffic Safety Act (2004) and the Law Amending the Road Traffic Safety Act (2010). The most important policy document is the *Resolution on the Transport Policy of the Republic of Slovenia 2006*, which is a very important document for walking and cycling.

Development and Tourism: The most important document within the development and tourism sector is *Slovenia's Development Strategy 2007-2013*. On the basis of Slovenia's Development Strategy two subsequent documents were created: Development Plan and Policies of Slovene Tourism 2007-2011 and Tourism Policy for the year 2009 with Policies for 2010.

National recommendations

Slovenia has official national physical activity guidelines/ recommendations for adults only. For other groups there are some technical/ professional guidelines but no official ones. Therefore, when concerning physical activity for children, adolescent and seniors, Slovenia follows the WHO Physical Activity Guidelines and the American College of Sports Medicine (ACSM) physical activity Recommendations.

National goals and performance indicators

The National HEPA Programme 2007 - 2012 states only a broad intention to encourage all forms of regular physical activity. One of the most important goals related to physical activity level change comes from the National Programme of Sport, 2000-2010 and is to increase the number of sporty active people by 2.5 % annually and to increase by 1% annually the sporty active levels of currently non-active citizens.

National actions plans outlining a clear implementation strategy

The detailed Action Plan for the National HEPA Programme involves almost all target groups and settings and includes different organizations from public, private sector and others, who should work jointly together in order to achieve National HEPA Programme goals.

Communication and branding

The National HEPA Programme includes promotional activities for physical activity and health aimed at increasing public awareness of the health benefits of physical activity.

Evidence of political commitment

All described policy documents were adopted by Slovenian government or National Assembly, which means that the state is obliged to implement them and mostly also review them at the end. The same applies to documents adopted by regional authorities/Regional Development Agencies (Regional Development Councils) and local authorities/Municipalities (Municipal Councils). Physical activity and sports are occasionally mentioned in political speeches and some important politicians are actively engaged in physical activity and sports. However, from the public health point of view, physical activity is still not as high on the political agenda as it could be.

Coordination and stewardship for HEPA promotion

There are always multiple sectors/ministries that are involved in the preparation and implementation of specific policy document but always one sector/ministry is assigned overall responsibility for the leadership and coordination of policy.

Surveillance or health monitoring system

Slovenia has established a surveillance and monitoring system for physical characteristics and motor abilities of primary and secondary school children. The system is coordinated by Ministry of Education and Sport in collaboration with the Faculty of Sport at the University of Ljubljana. Slovenia also executes surveys on health and physical activity habits among both youth and adult populations, although these surveys do not constitute an official established surveillance system.

Evaluation of policy implementation

The evaluation of the *National Programme of Sport in the Republic of Slovenia 2000-2010*, is conducted by the local community council at the local level and overseen by the Government on the national level. The Government reports each year to the Parliament (National Assembly). The National HEPA Programme also includes a specific strategy for evaluation.

Main successes and challenges

Main successes include the development and adoption of the National HEPA Programme and the establishment of an inter-sectoral working group responsible for the development of the National HEPA Action Plan. Main challenges include: evaluation and monitoring of the implementation of the National HEPA Programme; maintaining suitable coordination and work motivation among interdisciplinary partners; and maintaining consistency in HEPA activities independently of political changes.

Switzerland

Background

Switzerland has a federalist structure where most political responsibilities, including for health and education, lie with the communities and with the cantons. The federal administration has a mainly subsidiary role, except for some specifically defined topics such as defence or external policy. For historic reasons that is also the case for sports promotion.

Policy development and documents

Environment: The Freedom to Roam (1907) is a very important historic key element both for the environment and for transport. A more recent development is the Federal CO₂ Law (1999).

Sport: The Federal Law on the Promotion of Gymnastics and Sport (1972) is the most important basis. The Concept of the Federal Council for a Sports Policy in Switzerland (2000) followed.

Transport: The Freedom to Roam (1907) and the Federal Law on Walking and Hiking Paths (1985) are very important historic elements. Even though the Mission statement on human powered mobility (2002) has not been finalized, it has strongly guided further developments in this area, including the Federal CO₂ Law (1999).

Health: The Federal Health Insurance Law (1996) was an important step, defining among other things, the role of the foundation “Health Promotion Switzerland”. The National environment and health action plan (2001-2007) had a key role in bringing together the different sectors but has had limited concrete impact and has been discontinued. The Health objectives for Switzerland (2002) were probably less important in terms of direct impact, but they are one of the pillars of the upcoming prevention law. The National Programme on Diet and Physical Activity (2008-2012) is the latest development in this sector.

National recommendations

National recommendations for health-enhancing physical activity were issued for adults in 1999 and for children in 2006. They are based on the international recommendations (at least half an hour of moderate intensity activities a day for adults, at least an hour a day for children and adolescents).

National goals and performance indicators

The *Sustainable Development Strategy* states a goal to increase of the proportion of physically active transport stages within the modal split of overall mobility. However, no specific targets are defined. The *Concept of the Federal Council for a Sports Policy in Switzerland* defined the increase of physically active people in Switzerland. For the years 2003 to 2006 the target was stated of first stabilizing and then increasing by 1% per year the proportion of physically active people in Switzerland. No more specific targets were stated for 2007 to 2010. In addition, the *Mission statement on human powered mobility* (which exists only as a draft so far) has one target on increasing physically active transport by 15% within 10 years.

National action plans outlining a clear implementation strategy

The “Concept of the Federal Council for a Sports Policy in Switzerland” has had two “packages of measures”, one from 2003 to 2006 and one from 2007 to 2010. However, the National Programme on Diet and Physical Activity 2008-2012 has no action plan. The federal laws mentioned above do not have action plans, but ordinances defining the ways in which the corresponding financial means are being used.

Communication and branding

Switzerland has had different communication campaigns addressing physical activity. Some brands such as the “Youth+Sport” are known by the vast majority of the Swiss population and have an excellent reputation; others have been used by different actors more recently and have not been evaluated yet for brand recognition.

Evidence of political commitment

The national programme Youth and Sport has had very strong political support on different political levels since the 1970s. The *Concept of the Federal Council for a Sports Policy in Switzerland* has had strong political support during its development in the late 1990s, but only limited additional resources have materialised. The political support for the *National Programme on Diet and Physical Activity* and the (first ever) national prevention law will become clear in the upcoming discussions of the law in the federal parliament. At the same time, there is growing interest and support for all aspects of physical activity promotion at the level of cities and cantons.

Coordination and stewardship for HEPA promotion

There is not one single institution providing overall stewardship, different bodies are responsible for partial aspects. Some activities have been delegated outside of government, e.g. to the Foundation Health Promotion Switzerland.

Surveillance or health monitoring system

There is no standardized surveillance system for physical activity but three monitoring systems contain information on physical activity: the “observatory sport and physical activity Switzerland”, the MONET indicator system on sustainable development, and the Monitoring System on Nutrition and Physical Activity, MOSEB.

Evaluation of policy implementation

The “Concept of the Federal Council for a Sports Policy in Switzerland” had some evaluation of its first package of measures. There are no specific plans for the current second package of measures. The “observatory sport and physical activity Switzerland” (www.sportobs.ch) contains a whole series of sport policy indicators. In addition, the strategy of Health Promotion Switzerland for a healthy body weight is being evaluated by different monitoring and evaluation projects, and an evaluation of the “National Programme on Diet and Physical Activity” is planned for 2011.

Main successes and challenges

Examples of greatest progress include: the extension of the Youth and Sport programme to 5 to 10 year olds in 2008; the consensus on recommendations and principles of physical activity and health; growing interest in the topic in the media and in the public; and growing involvement and number of actions by other sectors. Areas or issues which remain a challenge include: clarification of roles and joint actions by national institutions; mechanism (funding, structures) for supporting action and change; and a monitoring system on physical activity for all age groups.

Part B: Results from the cross country comparison

The final PAT comprised 27 questions capturing information across a large number of criteria. Seven themes were identified for this set of analyses. The results for each of the seven themes are presented in sequence in the remainder of this chapter. Under each theme, summary tables are presented (where data were appropriate for tabular format) alongside narrative summary points. Blank spaces on the tables indicate that either no relevant policy exists or that none was reported on the PAT. Each section concludes with a discussion of the key findings and a set of recommendations for possible adaptation and improvements to the PAT.

- Theme 1: National policy and actions plans: what exists and the development process
- Theme 2: Leadership, inter-sectoral partnerships, and policy implementation at the national and sub national level
- Theme 3: Political commitment and funding
- Theme 4: HEPA recommendations, goals and targets, and surveillance systems
- Theme 5: Communication and branding
- Theme 6: Evidence and evaluation
- Theme 7: Successful programs, progress, and challenges

1. National policy and actions plans: what exists and the development process

Introduction

A key goal of the PAT was to identify what national policies, strategies, and action plans exist in each country that include, or are relevant to, physical activity. These could be a standalone physical activity specific policy or other policies covering a wider set of issues, which include actions that contribute towards the HEPA agenda. This could include policy documents from within the health sector but it was also deemed particularly important to search for, and assess policies in, other key areas outside of the health sector such as sport, education, transport, and environment. However, the search within each country was not limited to only these fields and this appraisal could extend to including legislation as well recent past government policy documents. Although it was deemed beyond the scope of the current project to undertake a complete historical audit of all policy documents, countries were invited (and suggested themselves) to include recent past policy if it was particularly important and useful for understanding the current and future policy context.

This section presents results from the PAT items that address six key issues:

- i. What policy documents and action plans exist within each of the seven countries?
- ii. What level of integration of physical activity in other policy areas is evident within each of the seven countries?
- iii. What evidence is there that the policy development process used a consultative approach?

- iv. To what extent were international documents used to guide policy development?
- v. What are the similarities and differences in the breadth of settings and populations covered by the key policy documents across the seven countries?
- vi. What are examples of specific physical activity actions included in key policy documents?

Results

i.) What policy documents and action plans exist within each of the seven countries? (Q2 and Q8)

Question 2 and Question 8 of the PAT attempted to capture the key policy documents within each country which outline the government's, and in some cases non-government agencies', intentions and strategies towards increasing national levels of physical activity. Question 2 specifically requested details of the "key policy documents" while question 8 asked for details of the "related action plan(s) which outline an implementation strategy". One complication in attempting to capture and audit key documents was that the names (titles) of documents varied greatly between and within countries; that is, documents can be called 'policy', 'action plan', and/or 'strategy' and the use of these terms varied across the seven countries. In addition, regardless of the name, these documents varied in the level of detail provided. This practical issue presented some difficulty for the participating countries and their efforts to review the relevant documents and provide their responses to the PAT questions. To accommodate the variability in the names and content of documents called 'policy', 'strategy' and 'action plan', this analysis drew together the country responses from both Question 2 and 8 and, by doing so, also resolved the omission and the duplication that occurred within country responses due to the confusion or differences in the names of documents. A summary of the existence of legislation, policy or other documents (such as reports, guidance documents, or specific programme plans) in each country is summarised in Table 1. Further details on the relevant documents in each country are included in Appendix 4.

Table 1 Types of documents across different sectors, by country

Country	PA specific			Health			Sport			Education			Transport			Environment			
	L	P	O	L	P	O	L	P	O	L	P	O	L	P	O	L	P	O	
Finland	✓		✓		✓	✓	✓		✓	✓		✓		✓					
Italy				✓	✓	✓	✓			✓								✓	
The Netherlands		✓		✓	✓			✓	✓	✓	✓			✓				✓	✓
Norway		✓		✓	✓			✓	✓	✓			✓	✓				✓	✓
Portugal			✓		✓		✓	✓		✓								✓	✓
Slovenia		✓		✓	✓		✓	✓		✓			✓	✓				✓	✓
Switzerland		✓		✓	✓		✓	✓		✓			✓	✓				✓	✓

L= Legislation; P=Policy; O=Other relevant documents

Key findings: Legislation

- Two countries (Italy and Portugal) reported that the Constitution was a key legislative document with relevance to HEPA promotion.
- Most countries reported relevant legislation in the areas of health (n=5; Italy, the Netherlands, Norway, Slovenia, Switzerland) and sport (n=5; Finland, Italy, Portugal, Slovenia, Switzerland).
- Examples of legislation in the health sector included the Public Health Act (the Netherlands), laws on public healthcare (the Netherlands, Slovenia), Health Services Acts (Norway, Slovenia) and Health Insurance Laws (the Netherlands, Slovenia, Switzerland).
- Italy reported a large number of examples of legislation in the health sector, such as Laws and Decrees which govern the creation of the Italian Centre for Disease Control and Prevention (CCM), the National Platform on Nutrition, Physical Activity and Diet, and the Gaining Health Program, a national initiative.
- In the sports sector, examples of legislation covered the creation of the National Olympic Committee (Italy), the establishment of a National Sports Institute (Portugal), the endorsement of physical activity guidelines (Portugal), the delivery of national sports programs (Slovenia), and funding for sport (Switzerland).
- In Switzerland, the Federal Law on the Promotion of Gymnastics and Sport is also legislation that covers the provision of physical education. Notably, Switzerland was the only country where sport and physical education are covered within one law.
- All seven countries reported some examples of legislation within the education sector. All countries reported legislation addressing the provision of physical education curriculum.
- Three countries had legislation for Kindergarten (Finland, Norway, Slovenia), three countries had primary school curriculum (Portugal, Slovenia and Switzerland) and 5 countries had legislation addressing the secondary school curriculum (Italy, the Netherlands, Portugal, Slovenia, Switzerland).
- Slovenia was the only country with legislation covering all ages from kindergarten through to secondary school physical education (PE) curriculum.
- Legislation addressing PE requirements was usually expressed as a total duration (e.g. two hours per week); in Portugal a breakdown of how the activity should be divided across the week was also provided (e.g. 135 minutes per week as one 45 minute session and one 90 minute session).
- Italy did not report legislation on the duration for physical education, however it was the only country to report having legislation related to school buildings. The education law (decree law 18/12/1975) includes the requirement that every school building must have a sports hall and also states the maximal distance which is allowed between a pupil's home and their school.
- Four countries (Norway, Portugal, Slovenia, Switzerland) reported legislation relevant to physical activity from the environment sector. Switzerland, in particular, reported a long history of legislation dating back to the legislation on "Freedom to Roam" from 1907.
- Legislation related to transport and the environment was reported separately in three countries (Norway, Slovenia, Switzerland) although there were often high levels of integration between these sectors. For example, in Switzerland the Federal CO₂ Law which is an environmental policy places

strong emphasis on the importance of shifting travel behaviour from motorised to active modes of transport. Similarly, the Resolution on the Transport Policy of the Republic of Slovenia, published by the transport sector, has a strong focus on reducing the environmental impact of transport. In Portugal transport and environment legislation were combined.

- Three countries (the Netherlands, Norway, Slovenia) reported having legislation documents around workplace conditions which were relevant as they included a reference to HEPA.

Key findings: Policy, Strategies and Action Plans

- Five countries (Finland, the Netherlands, Norway, Slovenia, Switzerland) reported having a specific policy addressing HEPA. In some countries this policy addressed only physical activity, for example the Action Plan on Physical Activity in Norway and the National HEPA program in Slovenia. In other countries, HEPA was combined with additional issues for example the National Action Plan on Sport, Physical Activity and Education (the Netherlands) and in both Finland and Switzerland the main HEPA policy also included diet.
- In Italy, physical activity was not addressed by a stand-alone policy, instead it was embedded within the broader public health agenda, through documents such as the National Prevention Plan (PNP) 2010 – 2012, The National Health Plan 2011-2013, and the Gaining Health Program.
- In Portugal, physical activity was also embedded within the broader health agenda. However, Portugal also reported having a National Program of Walking and Running as a standalone national initiative.
- All seven countries reported relevant policy documents from the health sector. Many countries also reported policies or action plans in the areas of sport (n=5; the Netherlands, Norway, Portugal, Slovenia, Switzerland), transport (n=5; Finland, the Netherlands, Norway, Slovenia, Switzerland) and the environment (n=6; Italy, the Netherlands, Norway, Portugal, Slovenia, Switzerland).
- The health policies tended to focus on the broader agenda of disease prevention and health promotion, although some countries reported policies that targeted specific health issues such as obesity (the Netherlands) and health education (Finland)
- Sports policies covered a range of issues such as inclusion, facilities, and elite performance.
- Some transport policies focussed on the transport sector as a whole, for example the National Travel Plan in Norway, but more usually targeted either walking or cycling or both. Examples include the Dutch Bicycle Master Plan and the National strategy on walking and cycling in Finland.
- Switzerland reported a slightly different approach, with a policy on 'leisure transport' and on 'human powered mobility' (i.e. walking, cycling and other forms of active transport).
- Six countries (with the exception of Finland) reported having policies relating to HEPA in the environment sector. Interesting examples include 'Green and the City' in the Netherlands which emphasises the importance of green environment for health and the importance of playgrounds for children. In Portugal, the National Plan 'Ecotrail' focuses on the development of 'green routes', which includes the redevelopment of roads, canals and abandoned rail lines for non-motorised travel.

- Slovenia reported having several relevant documents in the tourism sector, for example the - Development Plan and Policies of Slovene Tourism calling for investment into the public sports infrastructure.

ii.) What level of integration of physical activity in other policy areas is evident within each of the seven countries? (Q4)

Question 4 of the PAT assessed the degree to which there was evidence of integration of the HEPA agenda within the many and varied health policies (e.g. obesity, diabetes, cardiovascular disease and cancer) and the degree to which there was integration of HEPA within policy areas outside of the health sector, for example, the inclusion of physical activity in policy documents and action plans in the sectors of sport, education, transport and planning.

Key findings:

- All seven countries reported examples of integration of HEPA into policy documents across different government portfolios, both within health and policy documents with other government portfolios.
- Six countries (not Norway) reported the integration of HEPA into other existing policies within the health sectors addressing areas such as disease prevention and/or health promotion.
- Three countries (Italy, the Netherlands, Slovenia) specifically mentioned HEPA was integrated into policies alongside other risk factors associated with NCD prevention such as healthy eating and tobacco control.
- Only three countries (the Netherlands, Norway, Switzerland) reported specific integration of HEPA within sports policy documents. In addition, Norway identified the specific policy links between HEPA and planning for adequate recreational space.
- Integration of HEPA in planning policy was identified in only two countries (the Netherlands and Switzerland).
- Six countries (not Portugal) reported some level of integration of HEPA in transport policy documents and these most frequently were policies on cycling and/or walking. Three countries identified policy links between HEPA and road safety (Switzerland and Slovenia) and street safety (Italy).
- Surprisingly, only three countries reported links between HEPA policy documents within the education sector, which may reflect the presence of legislation guiding the provision of physical education. However, Italy identified the links between HEPA and policy on health education and between HEPA and sport education. The Netherlands identified links between HEPA and policy related to schools. Finland noted that education policy included the need to promote HEPA as a habit within children.

iii.) What evidence is there that the policy development process used a consultative approach? (PAT Q3)

Question 3 aimed to capture the extent to which wider input had been sought from across multiple sectors, both within and outside of government, in the *development* process of the key policies/action plans identified by each country in Question 2. Question 3 asked how *consultative the development process had been in* involving relevant stakeholders. Results on the extent to which national policy development had used a consultative process are summarised in Appendix 5.

Key findings:

- All countries indicated that a formal period of consultation is a requirement for the development of government policy; this was noted as being mandated by law in Portugal and a well-established process in Switzerland.
- All seven countries reported that wide spread consultation had actually taken place for HEPA related policies, involving multiple sectors, both within government as well as with non-government stakeholders. In some countries (for example Italy and Norway) this also included consultation with the private sector.
- The extent of consultation of the HEPA policy varied. Some countries reported wide consultation with around 50 (Finland) and up to 300 (Portugal) stakeholders involved in the process, whereas the Netherlands and Slovenia reported that consultation was limited to a small number of stakeholders.
- In two countries (Finland and Norway) there was an indication of a very clear and formal mechanism of consultation due to the formation of a cross government steering committee or similar.
- In Finland, the main HEPA policy has a formal and ongoing Advisory Committee that serves for a term of years aligned to the program of work. The Committee directs and reviews the planned actions. Membership is diverse from across government and non-government including academic and research sector (specifically the UKK Institute).
- Norway reported a Steering Committee which was set up during the development of the National Action Plan (2005-2009) and involved representatives from eight ministries, and a referent group comprising a wide range of different stakeholders.
- Policy development at the local level was reported to be more controlled and led by the local government or municipality. In most countries the degree of consultation between and within this level of government was led and determined by the local government.

iv. To what extent have international documents been used to guide country level policy development (PAT Q2b)

The PAT also sought information on the use of international guidance documents and/or other supporting materials in the development of national policy related to physical activity (Question 2a). For this item, countries were asked to list any use of international documents. Results on the use of International

Guidance and other documents are summarised in Table 2. Interested readers should see the full country case studies in Part 2 of this document for further details.

Key findings:

- All countries reported using international or global policy and guidance documents although the number of reported documents varied greatly between countries.
- *The Global Strategy on Diet, Physical Activity and Health (WHO 2004)* was the most frequently cited and arguably the most influential document in informing the development and content of national HEPA related policy across the case study countries.
- Other international documents cited by more than three countries included:
 - Ottawa Charter for Health Promotion (1986)
 - U.S. Surgeon General’s report on Physical Activity and Health (1996)
 - Promotion of Health-Enhancing Physical Activity, UKK Institute (1996)
 - The World Health Report (2002)
 - Physical Activity and Health in Europe: Evidence for Action (2006)
 - European Charter on Counteracting Obesity (2006)

Table 2 Use of international documents to inform the development of national policy and strategic documents

	FI	IT	NL	NO	PT	SI	CH
Health for All in the 21st Century strategy (WHO, 1985)					✓		
Ottawa Charter for Health Promotion (WHO, 1986)		✓		✓	✓		
The Rio Conference on Sustainable Development (1992)							✓
Physical Activity and Health: A report of the Surgeon General (US Department of Health and Human Services, 1996)	✓		✓	✓			
Promotion of Health-Enhancing Physical Activity. Development of a European Strategy, Network and Action Program (UKK Institute for Health Promotion Research, 1996)	✓		✓	✓			
Local Agenda 21 (WHO, 1997)					✓		
World Health Organization - Health 21: Health for All in the 21st century (WHO, 1999)					✓	✓	
World Health Report 2002 Reducing Risks, Promoting Healthy Life (WHO, 2002)			✓	✓	✓		
Move for Health, Active Youth, Move your Body, Stretch your Mind (WHO, 2002)						✓	
Global Strategy on Diet, Physical Activity and Health (WHO 2004)	✓	✓	✓	✓		✓	✓
Promoting healthy diets and physical activity (European Commission, 2005)		✓	✓				
Physical Activity and Health in Europe; Evidence for Action (WHO, 2006)	✓		✓	✓			
Promoting physical activity and active living in urban environments: the role of local governments. The solid facts (WHO, 2006)			✓	✓			
European Charter on counteracting Obesity (WHO, 2006)		✓	✓			✓	
Steps to Health; A European Framework to Promote Physical Activity for Health (WHO, 2007)	✓		✓	✓			
Treaty of Lisbon (European Union, 2007)					✓		
White Paper on Sport (European Commission, 2007)			✓		✓		
A Strategy for Europe on Nutrition, Overweight and Obesity related health issues (European Commission, 2007)		✓	✓				
Physical Activity Guidelines for Americans (U.S. Department of Health and Human Services, 2008).	✓						
Closing the gap in a generation health equity through action on the social determinants of health (WHO, 2008)			✓	✓			
2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases (WHO, 2008)		✓	✓				
EU Physical Activity Guidelines: Recommended Policy Actions in Support of Health-Enhancing Physical Activity (Euro Union, 2008)			✓		✓		
Nordic Plan of Action on better health and quality of life through diet and physical activity (Nordic Council of Ministers, 2008)				✓			

v.) What are the similarities and differences in the breadth of settings and populations covered by the key policy documents across the seven countries? (Q9 and Q10)

In addition to identifying the key policy documents (Q2 and Q8), it was deemed desirable to collect some information on policy content, that is the actions (programs, activities, regulations) that were identified within each country. However, the test phase of the PAT instrument showed that collecting information on the content and coverage of entire policy documents, without requiring a complete listing of actions from each document, proved to be very difficult. It was therefore decided to capture only an overview of policy content in two key areas: 1) the coverage of policies in terms of which settings were addressed by key policy documents (Q9); and 2) the coverage in terms of which population groups were targeted (Q10). The results are summarised in Table 3.

Key findings: Policy coverage of different settings

- The sport and leisure setting and the education setting (including both primary and secondary schools) were addressed in national policies in all seven countries.
- All countries also reported that environment and urban planning was mentioned explicitly in policy documents and linked with physical activity.
- Kindergarten (a setting for very young children) was stated in all seven countries.
- Primary healthcare was noted in six of the seven countries (not Switzerland), but clinical health care settings was only reported in three of the seven countries (Finland, Norway, Slovenia).
- Slovenia reported policy actions across all settings whereas others reported having HEPA policy in relatively few settings (Switzerland).
- Slovenia and Portugal specifically identified tourism as an area which was mentioned in the policy documents linked with the promotion of physical activity (for example through the promotion of countryside and outdoor recreation). This was the least frequently cited setting.

Key findings: Policy coverage of specific population groups

- All countries reported policy actions aimed at the general population, young people and older adults.
- Five countries reported policy actions targeted at people with disabilities (Finland, Italy, the Netherlands, Norway and Slovenia).
- Working population was identified in four countries (Finland, the Netherlands, Norway, Slovenia), while women were a specifically targeted group in three countries (the Netherlands, Norway, Slovenia), and people with chronic disease (secondary prevention agenda) were identified in the Netherlands and Slovenia.
- Sedentary and low SES groups, as well as families, were the least frequently targeted population groups.
- Notably, no country reported policy actions aimed at indigenous people. However, this might be due to this specific set of countries, where only Finland has a relevant indigenous population.

Table 3 Policy coverage of different settings and population, by country

	Settings													Population groups											
	Kindergarten	Primary schools	High schools	Colleges/ Universities	Primary health care	Clinical health care	Workplace	Senior/ older adult services	Sport + Leisure	Transport	Tourism	Environment	Urban Planning	Early years	Young people	Older adults	Workforce/Employees	Women	People with disabilities	People with chronic disease	Sedentary/ the most inactive	Low socio-economic groups	Families	Indigenous people	General population
Finland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓			✓	✓		✓
Italy	✓	✓	✓		✓		✓	✓	✓			✓			✓	✓			✓						✓
The Netherlands	✓	✓	✓		✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Norway	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓				✓
Portugal	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓		✓	✓									✓
Slovenia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓
Switzerland	✓	✓	✓	✓					✓	✓		✓	✓		✓	✓									✓

vi.) Examples of specific physical activity actions and interventions included in key policy or strategic / action plans (Question 11)

To provide further detail on the content of the identified key policy documents from each country, and to extend the information over and above the check list of the settings and populations covered within the policies, one item (Question 11) sought examples of key interventions (or ‘measures’ as they are sometimes referred to in Europe). Up to three examples were requested and respondents were invited to provide examples that showed the diversity of their countries’ policy and action plans. No other guidance was given on the selection of the examples. Some respondents also provided details on any evaluation that had been conducted and commented on the success of the program(s).

The examples of actions provided by the seven countries highlight programs across schools setting, primary health care, worksites and whole of community initiatives. Other examples included legislation, grant schemes and actions aimed at improving the education of teachers, doctors and other professionals. The specific examples provided by each country are included in Appendix 6.

Key findings: Examples of policy actions and interventions

- Five countries reported an example of a program or action in the school setting (Finland, Italy, Portugal, Slovenia, Switzerland) and most of these included a strong focus on promoting sports participation.
- Italy reported a program aimed at pre-school aged children.
- The primary care setting was the focus of program examples from three countries (Netherlands, Slovenia and Switzerland). These programs were often collaborations between health and other sectors (usually sports). In Slovenia, the collaboration also involved a health Insurance company and in Switzerland the collaboration included a private sector partner.
- Norway reported a grant scheme which provided funding via NGO’s to community based organisations to run physical activity programs. This scheme covered all settings, types of activity and population groups and funding allocation was coordinated and allocated centrally at the national level.
- Norway also provided an example of a new law (the Working Environment Act) that requires employers to consider promoting physical activity to their employees as part of a systematic approach to health, environment, and security at work. Employers are not required to provide programs on physical activity but rather to consider and offer ways of being active.
- Six countries provided examples of community based and whole of population initiatives. ‘Fit for Life’ in Finland, ‘Move for Health’ in Slovenia, and ‘Allez Hop’ in Switzerland, represent examples of community-wide programs aimed at promoting participation in physical activity. Portugal provided the example of the National Walking and Running Program.
- Norway provided an example of a policy action aimed at increasing the knowledge and education on physical activity and its health benefits in medical and health students and also in teacher education and training.
- Italy highlighted the policy action aimed at developing a surveillance system to monitor risk factors including physical activity in the elderly.

Discussion

A key aim of this project was to collect standardized information on the policy context across a set of seven case study countries. Items on the PAT were structured to elicit information on what policies (or strategies or action plans) existed within each sector, what was their content, and details on their development process (i.e. the use of consultation and of international policy or guidance documents). The PAT specifically sought details on the involvement of multiple sectors and stakeholders and the integration between policy in a complimentary and consistent manner, which are both deemed desirable attributes of national HEPA policies.

The results showed that all countries had both some legislation and a large range of policy documents relevant to HEPA. In several countries physical activity promotion was primarily addressed within policy as part of the broader public health agenda (for example Italy (19) and Portugal (20)). However, five countries reported having specific physical activity policies, three of them solely on physical activity (Finland, Norway, Slovenia)(21-23) and in two countries it was in combination with sport and education (in the Netherlands (24)) or with healthy diet (in Switzerland(25)). The existence of standalone HEPA-specific policies provides some evidence of high level recognition of the importance of HEPA and the need for policy level action to increase population levels of physical activity. However, the results from this study do not provide sufficient information to conclude whether this might reflect *an increase* in political level recognition within each country nor whether there is adequate positioning of HEPA within all possible policy documents. This level of within country appraisal, and viewed over time, is more in-depth and would be worthwhile within countries planning or updating their policy frameworks, but was beyond the scope of this multi-country comparison study.

Most countries reported legislation relevant to HEPA in the areas of health, sport, and education. The most commonly reported sector with legislation was the education sector, with all countries reporting obligatory physical education in schools. Italy was the only country to report legislation on school buildings and the provision of sports facilities. This is an important example of the potential specificity of policy and regulations in support of HEPA and is timely given the increasing focus on improving the built environment to support and facilitate HEPA. Legislation and policy in the transport and environment sectors was also reported by some but not all countries. Increasing population levels of physical activity will require coordinated effort from all sectors and thus the breadth of legislation and policy across a broad range of key sectors is encouraging.

Capturing the content of policy documents was more difficult. Early drafts of the PAT items attempted to collect and summarise the actions (e.g. programs, activities, regulations) but early piloting of the tool revealed that this was too ambitious and time consuming and incurred a high response burden. Moreover, requesting full details on each policy represented an unnecessary duplication of material from multiple documents into the PAT. Therefore, as a compromise, two 'check box' items were developed to capture a summary of the content of the relevant policy documents. However, the results show that this question format provided only an overview on the two selected areas, namely the settings (e.g. workplace, schools, healthcare) and the population sub-groups explicitly targeted by the key national policies related to physical activity. No details were captured on what specific actions were proposed nor on the extent of implementation. There

is scope to improve these PAT questions to capture more information and this is proposed in the recommendations section below.

All seven countries reported policy content addressing kindergarten, primary and secondary schools, environment, and the sport and leisure settings. Most countries reported policy actions within primary health care settings, senior/ older adult services, transport and urban planning. Less frequently reported settings included clinical health care (Finland, Norway, Slovenia) and tourism (Portugal and Slovenia). As already mentioned, no specific details were collected on the type of actions in each of these settings. To overcome this limitation other PAT items captured three examples and these are discussed later.

In terms of population sub-groups, all countries reported that national policy documents on HEPA covered young people and adult populations. The early years (for example children under five years of age) was mentioned by only four countries (Finland, The Netherlands, Norway and Slovenia). Specific population sub groups such as those with disabilities, with chronic disease, low socio-economic groups, and women, were far less frequently reported as being identified within national policy documents related to HEPA. Only two countries (the Netherlands and Norway) reported the specific inclusion of sedentary populations within relevant HEPA policies.

All seven countries reported some level of integration of HEPA across policy documents; this was ascertained by the presence of HEPA content and HEPA-related actions visible within policy documents and across different portfolios. For example, within the health sector there were reported cross-references or inclusion of HEPA in NCD prevention policies and within policies aimed at prevention of obesity, diabetes and cardiovascular disease. The cross referencing within health policies is expected given the scientific evidence on the role of HEPA in the treatment and prevention of disease. However, it is desirable that the proposed HEPA actions and resource allocations are supportive and consistent between policies. Details on these specific aspects of policy integration were not explicitly requested by the PAT item.

National promotion of HEPA has the potential for direct links with national policies on sports and recreation but as the results showed, these links did not always exist. Only three of the seven countries reported cross referencing within sports and HEPA promotion documents. In addition, only two countries reported links within education policy. Conversely, explicit cross-referencing between the promotion of HEPA and policies in the transport sector were reported in six countries. This is a relatively recent development in many countries and the examples of policy reinforcement and promotion of walking and cycling within transport policy are important. Three countries also reported specific mention of HEPA within road safety policy. Surprisingly, only three countries highlighted specific cross-links between HEPA and urban planning. In Norway this was specifically related to the planning of recreational space and both the Netherlands and Switzerland reported cross referencing between physical activity and spatial planning policy documents. The opportunity to influence the planning policy and regulations is recognised as an important area for HEPA promotion as this will help create the environments in which being active is available, convenient, safe, and enjoyable. Much research is underway to inform urban planning policy and translating this into practice is a priority for the future.

Engaging with multiple sectors and specifically those outside of health is critical in national efforts to increase physical activity. Consultation and working in partnership to develop and deliver interventions is therefore a central process. The use of at least some form of consultation process was reported as a requirement for government policy across all seven countries. However, the period of time provided for consultation and submission of feedback on draft policy, as well as the extent to which effort is made to seek and then use the feedback received, was not investigated. These details might be difficult to collect and report, as this is usually a within-agency process and might not always be well documented. How well the consultation process is conducted and how much feedback is used will likely vary between countries and may be indicative of the value placed on the consultation process. The PAT items did not request this level of detail and it may be more easily sought using an interview method rather than written survey.

The existence of formal structures to support ongoing multi sector involvement in HEPA related policy implementation was indicated in only two countries. Finland reported a long standing Advisory Committee including government ministries, NGOs, and the academic and research sector (including the prominent UKK Institute – a research institute. It oversees the main HEPA policy and reviews national actions and progress. This Committee met regularly, reported on an annual basis and assisted with forward planning related to HEPA policy and activities. Similarly in Norway, a Steering Committee was established during the development of the National HEPA Action Plan 2005-2009. This comprised eight ministries and existed with a similar set of functions through 2004-2010. In addition, some countries reported on the role of non-health sectors involvement in the delivery of interventions and actions outlined in the policy and action plans. Engaging partners in a formal and sustained process is recommended by leading international authorities. Experience globally shows that these committees (or taskforces) require high level endorsement from senior levels of government if they are to provide effective decision making and leadership. Only two of the participating seven countries had such a forum providing national leadership, and more efforts are needed to share experiences and success on how to establish and maintain a cross sector group to assist other countries.

In summary, seven PAT items sought to capture the policy context on HEPA within a country, however this proved to be an ambitious and difficult task. HEPA policy may or may not exist as a standalone policy document and, it may or may not be present in policy documents in areas outside of health, which are deemed highly relevant. Examples of a wide range of legislation and policy across the portfolios of health, sport, education and transport were identified across this set of seven countries. Although it proved much harder to capture details on policy content, these seven countries revealed that actions were planned and/or underway to promote and support physical activity across many of the well-recognised key settings and the key population sub groups, although gaps were identified.

The data collected provides a framework for comparing HEPA policy between countries and, as such, can be of particular use in highlighting policy opportunities, either because of gaps (in coverage of a setting or population sub-group) or because of the different approaches taken across these seven countries. Policy examples from one country can be used as illustration and leverage within another country in the quest for creating a stronger policy framework for national action on HEPA.

It proved to be much more difficult to capture specific details about the policy content and actions and, as this is likely to be a major interest of many readers, we suggest reading the individual country case study reports (Part 2). However, even then it is possible that no policy audit or summary can replace the reading of the full policy documents themselves. Nonetheless, as a high level summary, these data collected through PAT illustrate the current status of HEPA policy across seven countries and can stimulate discussion and debate. Improvements and modification to the PAT items could extend this overview and these are discussed below.

PAT Items: Critique and Recommendations

Questions 2 and 8 aimed to capture a summary of the key policy documents within each country. Question 2 specifically requested details of the “*key policy documents*” while question 8 asked for details of “*related action plan(s) which outline an implementation strategy.*” As mentioned above, the titles of key documents in each country varied greatly and included: policy; program; strategy; mission statement; resolution; plan; decree; and action plan. In addition, the title of a document did not always reflect any standard pattern in the content in terms of the level or type of details provided. This variation in the types of documents included within question 2 and question 8 created some confusion for both responders and in the analysis phase.

Recommendation: **Question 2 and 8 should be combined into a single item.**

Recommendation: **The new question should also clearly invite the inclusion of relevant legislation that supports or hinders HEPA.**

Questions 9, 10 and 11 attempted to elicit information on the content of the identified key policy documents. Two ‘check box’ items were used to capture a summary of the settings (question 9) and population groups (question 10) covered in the key national policy documents. Although the check-box approach was well received due to its ease of completion, this approach provided only a very superficial overview of HEPA related actions proposed within policies within each country. In addition, question 11 collected three examples of interventions or policy actions. However, because these were selected to just illustrate the policy content, it is difficult to draw any substantive conclusions about the breadth, depth or gaps in an individual countries’ current national policy on HEPA.

Recommendation: **Consider combining questions 9, 10 and 11.**

Recommendation: **If further detail on policy content is deemed desirable and required, then consider use of an alternative response format. For example the use of a structured table may be one approach to obtaining examples of policy action across key sectors and also capturing via tick box the reach across different population groups**

Questions 3 and 4 aimed to capture details of consultation and integration. It was intended that Question 3 would evoke information on the involvement of different sectors and ministries in the process of policy *development* and Question 4 would elicit information on the presence or absence of cross policy links explicitly written into policy documents. However, this distinction was perhaps not clear enough to users, as there was duplication in the responses provided for these two items.

Recommendation: **Introductory text to Questions 3 and 4 should be modified to provide more clarity on the meaning of and differences between ‘consultation’ and ‘integration’.**

Question 3 on consultation did not request any details such as: the period of time provided for consultation; the effort made to consult with all the appropriate stakeholders; the volume of feedback that is typically provided; or the extent to which the feedback received is used to modify or refine policy. This level of detail on the consultation process was not sought due to concerns of respondent burden. In addition, this type of information may not be available, unless the country lead has ‘inside’ access to these processes and decisions.

Recommendation: **If further details on the process of consultation is deemed useful, consideration should be given to adding additional items to capture details on specific aspects of the consultation process and/or alternative ways to collect this information should be considered (such as supplementary stakeholder and key informant interviews).**

Question 4 sought details on the level of integration of HEPA within relevant health policies and within other key policy documents in other sectors. The responses revealed that this question may not have been understood and responses were largely omitted.

Recommendation: **Question 4 should be revised to state more clearly the intent of the question on policy integration and to ask explicitly for the responder to comment on how well this is being done.**

Question 2b asked respondents to provide a list of any international documents that have been used to inform policy development. However, the term ‘used’ is open to interpretation. It is possible that simply being aware of a document may have been sufficient to constitute ‘used’ by some responders, whereas more direct policy links, and perhaps even cross-referencing, may have been considered necessary in other countries. However, it is of interest to know more about how important and useful different international documents are in supporting and guiding national actions.

Recommendation: **Question 2b should be revised to provide a list of key international documents for convenience, and provide space for the responder to add comments on the level of use and the value (or influence) that a document provided in the development of national policy and actions.**

2. Leadership, intersectoral partnerships and policy implementation at national and sub national level

Introduction

It is well recognised that the policy development process involves an extremely complex ‘web’ of individuals, organisations, events, and decisions. Policy is rarely developed based on scientific evidence alone, and is often guided by the interests of key actors within the policy arena. A critical factor for success in both policy development and policy implementation is leadership for the agenda, in this case physical activity, and the coordination of, and engagement with, other sectors and stakeholders. This is of particular importance for HEPA as so many of the interventions and policy levers for change are within the control and functions of sectors outside of health. Not only is lateral coordination and partnership across sectors required but also vertical coordination from national level through regional and provincial level systems to the local level. There is, therefore, great interest in how countries manage these processes and what lessons can be shared. Managing the necessary communication and instilling leadership at all levels is required and much remains to be learned about effectiveness and best practice.

This section presents results on the following four issues:

- i.) Who provides national leadership for HEPA policy and implementation?
- ii.) What structure is there for leadership and implementation at the sub national level (regional and local)?
- iii.) What recommendations, structures or processes support working in partnership and across multiple sectors?
- iv.) What support exists for professional networks and capacity building?

Results

i.) Who provides national leadership for HEPA policy and implementation? (Q18a and Q18b)

The PAT included several items to assess the sources of leadership for physical activity in each country and to identify whether this was from within government, and if so, from which ministry (Question 18a). In some countries, leadership may come from outside of government and, where this exists, it is of interest to know what role is provided by national government, if any (Question 18b). The results are summarised in Appendix 7.

Key findings:

- Leadership for physical activity policy at a national level was most frequently identified to be provided by the national Government and most often by the Ministry of Health.

- Although the Ministry of Health was the most frequently identified provider of national leadership, they did not work in isolation. In the majority of these seven countries there was a clear mechanism for shared leadership across multiple ministries or at least a clear partnership between two or three ministries was stated.
- In Slovenia, the Ministry of Health and the Ministry of Education and Sport were both responsible for physical activity and worked together through a working group to provide leadership.
- In Switzerland, the Federal Office of Sport and the Federal Office of Public Health shared responsibility for leadership on physical activity.
- In Italy, the Ministry of Health was reported to provide the overall leadership and central coordination although implementation of HEPA related actions was reportedly led by sub-national and local levels due to a highly de-centralized system.
- In two countries (Finland and Norway), there was not a single institution providing the overall national stewardship of physical activity, instead there was a formal high level ministerial coordinating structure. For example, in Norway, during the implementation of the national physical activity policy (2005-2009) the Ministry of Health chaired an Inter-ministerial Coordination Committee and the Directorate of Health provided the secretariat functions. The Ministry of Health was responsible for actions in the health sector and other ministries were responsible for the relevant actions in their field. This allocation of responsibility was also reported in other countries.
- Similarly in Finland, a specific multi sector “Advisory Committee” provides advice on the direction and implementation of the Resolution on Physical Activity. This committee is tasked to provide the overall national leadership on physical activity. It comprises representatives from multiple Ministries as well as non-government sector and the academic sector.
- In the Netherlands, there was no specific government ministry taking sole leadership, rather there were a number of institutions that provided supporting efforts and helped to direct action aimed at increasing physical activity. Agencies providing significant support included the National Olympic Committee, National Sports Federation, and Netherlands Institute for Sport and Physical Activity – the latter being very involved in the implementation and delivery of programs.

ii.) What structure is there for leadership and implementation at the sub-national level (regional and local)? (Q19 and Q20)

Two questions in the PAT sought information on who led and supported implementation of policy measures at the national and sub-national/local level (Q20) and the use and influence of national documents (Q19). These items aimed to capture how national level policy documents and leadership at a national level is communicated and used to guide implementation at other levels of influence (e.g. regional, provincial and local government or municipality level). The results are summarised in Appendix 7.

Key findings:

- Responsibility for policy implementation, and specifically the physical activity measures and actions, varied between countries and was more frequently identified to be provided at the regional or local levels rather than on the national level.
- In most of these seven countries there was substantial responsibility and independence at the local level and, thus, the implementation of actions was most often led by or significantly reliant on the role of local government or other delegated organisations. For example, in Finland, the town and rural districts have a key responsibility and, in recent times, they have been developing their own health enhancement strategies (plans) which include physical activity actions. The majority of these plans reflect the national policy agenda although there is some variability in the implementation because of their independence.
- In Italy, every region participating in the national programs has established a Regional PA Network to support the Local (county) Health Services to implement actions. The National Ministry of Health supports (and requires) all participating regions to develop Regional Prevention Plans which are then implemented under regional leadership.
- In Portugal, regional directorates of the National Sports Institute lead and support local level implementation of physical activity actions; local authorities are only responsible for certain specific aspects such as to identify population needs. However, the National Program of Walking and Running is one example where both the national and local level leadership are involved in the implementation.
- In Norway, the County Governor has responsibility for the implementation of all government decisions at the sub-national level. The County Authority is responsible for public health and thus the implementation of physical activity programs.
- In Switzerland, implementation of most policy agendas is led by each of the 26 Cantons and their respective City Administration. This applies to areas such as health promotion, sports, urban design, transport planning and education, and also for physical activity actions. There are “Coordination Conferences” as coordinating mechanisms for different sectors of the governments of the Cantons.
- In the Netherlands, implementation was led more by non-government organisations. Sport organisations and other stakeholders provide the primary leadership for the implementation of many of the programs outlined in the national policy. As mentioned above, the NISB was responsible for establishing and supporting the implementation by regional and local level organisations.

iii.) What recommendations, structures or processes support working in partnership and across multiple sectors? (PAT Q13)

In addition to leadership, successful implementation of policy and actions on HEPA will require necessary ongoing partnerships with key stakeholders. Question 13 sought details on the extent to which there was ongoing collaboration to deliver HEPA related actions. The results are summarised in Appendix 8.

Key findings:

- In all countries, the national policies and action plans emphasised the importance of cross-government actions and working in partnership between different organisations. The sectors commonly identified as having a role or responsibility for HEPA actions were health, sport, education, transport, environment, and urban planning.
- Several countries had specific recommendations on how to work in partnership. For example in Italy, all multi-ministerial agreements have recommendations on how to work together in order to deliver policies and action plans.
- In Norway, the national action plan has a final chapter dedicated to how agencies should work together to deliver actions on physical activity. In addition, the Norwegian policy document itself has the strap-line “*working together for physical activity*”, which emphasises the priority being placed on inter-sectoral collaboration in the development and implementation of the policy.
- The Netherlands reported that several lead agencies had been identified and had received financial support to lead and support working in partnerships at all levels. For example NISB was reported to have been instrumental in linking national organisations together and also linking national policy with implementation at regional and local levels. Financial subsidies are in place to support collaborative working, for example across sport and physical activity and across community schools, sport and culture. The Netherlands reported strong partnership working across all levels.
- Although the principle of inter-sectoral collaboration was well recognised “in theory”, countries reported that it was not always effective across all levels of policy development and implementation. For example, working collaboratively was reported to be much stronger at the national level than at the regional and local levels in Finland. Conversely, Norway reported having strong partnership working at a regional and local level, but found it more challenging to establish strong links between the government and other national bodies such as the Health Directorate, the private sector and non-government organisations.
- Norway was the only country which explicitly reported undertaking a formal assessment of the extent and effectiveness of partnership working. The findings of the evaluation identified several areas for improvement including the need for greater consistency between regions in the types of organisations involved in the collaborations and how these types of partnerships functioned. In addition, this evaluation recommended that collaborative working could be improved through the allocation of clear roles and responsibilities to different actors.
- Two countries reported specific actions aimed at supporting inter sectoral collaboration and partnerships (Finland, Italy). These included the provision of specific training and the development of resources. For example, in Finland, the HEPA Advisory Committee launched a manual to provide advice on how to establish stronger cross-sectoral partnerships. In Italy, specific tools and training activities were available to support health professionals involved in key national projects related to HEPA.

- Only two countries (Finland and Norway) reported on the importance of engaging with the voluntary sector and with private sector organisations; in Switzerland a national program exists for voluntary collaboration with industry.

iv.) What support exists for professional networks and capacity building? (Q25)

Establishing a HEPA or physical activity network is one approach to improving communication and collaboration between interested stakeholders. This has been seen to be highly effective at the regional level with both Europe and the American regions having well established HEPA Networks; the HEPA Europe Network and the RAFA/PANA Network, respectively. In some countries, national professional networks of interested stakeholders on HEPA have been developed and may receive support from government, NGO's or third parties (such as the university sector).

A key role of these networks is to ensure adequate capacity (i.e. knowledge and skills) within the workforce to implement and deliver policy actions. One item on the PAT aimed to capture the existence of any professional network (or similar) supporting and sharing knowledge and experience between the relevant stakeholders working in physical activity promotion (Question 25).

Key findings:

- Five of the participating countries reported the existence of formal networks to link and support professionals within their own country (Finland, Italy, Norway, Portugal, Switzerland).
- Both Italy and Switzerland reported that there was one national network which engaged national and local physical activity experts. These networks aimed to provide a platform for sharing experiences and developing opportunities for future collaboration between relevant stakeholders.
- Portugal reported that there was the National Society for Physical Education, which represented at a national level the scientific community within physical education and sports. In addition, several project specific alliances had been formed, for example, in relation to the program for Walking and Running, the Healthy Cities Network, and a partnerships network around school sport programs.
- In Finland several networks were reported to have been established with a focus on different sub-components of HEPA policy. These included the "Strength for elderly network" and the "Fit for Life network". In addition, networks at the local level had been established by people working within physical activity.
- The Netherlands and Slovenia reported having no official physical activity promotion network. However, the Slovenian National Action Plan outlined a goal to establish a formal national HEPA network. Despite not having such a network, Slovenia reported having a variety of informal networks which have usually formed to deliver specific projects such as Move for Health and the National Program for Primary Prevention of Cardiovascular Disease.

Discussion

The responses from these seven countries indicate that the Ministry of Health provided a significant role in leadership and coordination of national HEPA-related policy development and implementation. In six countries (not Italy) there was either a clear partnership with at least one other ministry or the existence of a larger coordinating committee (in Finland and Norway). In the Netherlands, the non-government sector played a major role. In Italy the Ministry of Health at a National level appeared to work more on its own, although the policy documents themselves do outline that partnerships are needed to deliver the policy and actions plans. No specific national partnerships or multi sector coordinating committee was reported to currently exist in Italy.

Although policy direction and national leadership may be provided by the national government, the majority of the countries reported that there was a very strong role for the regional and local level administrations in the interpretation and implementation of actions. Several countries reported that regional and local area plans were required and these usually followed closely the directions set at a national level. Very limited information was collected on the coordination processes and any support provided to the local level administrations. Switzerland described a process whereby the 26 Cantons (the local level administration) do meet and share work (through 'Conferences') and this would be where the exchange of information and any plans for coordination or collaboration between Cantons could occur. Other countries may have formal processes for leadership and coordination at the local level but these details were not provided in the responses to the PAT questions.

In all countries, the national policies and action plans emphasised the importance of cross-government actions and working in partnership between different organisations. The sectors commonly identified as having a role or responsibility for HEPA actions were health, sport, education, transport, environment, and urban planning. Although the principle of inter-sectoral collaboration was well recognised "in theory", it was reported that it was not always effective across all levels of policy development and implementation. For example, working collaboratively was reported to be much stronger at the national level than at the regional and local levels in Finland. Conversely, Norway reported having strong partnership working at a regional and local level, but found it more challenging to establish strong links between the government and other national bodies such as the Directorate, the private sector, and non-government organisations.

In one country (the Netherlands) implementation was clearly designated to other agencies outside of government and, in this case, outside of health. The Netherlands Institute for Sport and Physical Activity (NISB) is a non-government organisation which aims to promote sport and physical activity in order to improve health, participation, and other social values. NISB was reported to have a significant role in developing programs, delivering training, and building partnerships which were directly related to the implementation of national policy. This organisation brings a considerable history of working in the sport and recreation field and this may both be a benefit and a disadvantage. Benefits include the synergy between sport and HEPA but one disadvantage could be less experience in working in other sectors such as planning and transport as well as an increase in the wider perception that HEPA promotion is a sport sector issue.

Several countries had specific recommendations on how to work in partnership. For example, in Italy all multi-ministerial agreements have recommendations on how to work together in order to deliver policies and action plans. In addition, specific resources and training courses have been developed to support health professionals in understanding how to develop effective partnerships to deliver HEPA policy. In Finland a manual has been produced to provide advice on how to establish stronger cross-sectoral partnerships, while in Norway the national action plan has a whole chapter dedicated to providing guidance on how agencies should work together in partnership to deliver policy actions on HEPA.

Norway was the only country which explicitly reported undertaking a formal assessment of the extent and effectiveness of partnership work in practice(26). Undertaking this type of assessment has been useful in Norway for identifying regional variation in the range of actors involved in HEPA related partnerships as well as the effectiveness of partnership working in different regions. The results of the evaluation have been used to identify areas for improvement. Undertaking a similar type of evaluation in other countries would allow for a similar appraisal of the effectiveness of partnerships and could lead to improvements in HEPA policy implementation. Aside from the example of Norway, limited information was provided on how well these partnerships worked in practice at any of the levels (national, regional, local) nor were any further details provided on how well national policy actions were translated to local actions and the scale of implementation on the ground. Both of these aspects are important additional issues.

One approach to improving communication and collaboration is to establish a professional network(27). The two countries with a long history of working on HEPA (Finland and Switzerland) reported the existence of national networks. For the other countries the links between those interested and working in physical activity promotion were provided through other existing professional associations or were established around specific HEPA projects. It is possible that the latter approach may be the preliminary basis for later forming a national network. Project based networks can identify and develop synergies and then later, the needs and opportunities to expand and establish cross links to other HEPA related activities on a larger scale can develop. It is also quite practical to start a HEPA network from a specific and common focus (i.e. the shared project). Other countries (such as Australia) have seen their relevant professional HEPA network emerge from 'interest groups' within related professional associations (such as sport science, public health, and health promotion). In addition, experiences from within Europe and elsewhere has also shown that it is only possible to sustain a HEPA network when there is sufficient critical mass, interest, and adequate resources to support coordination and a secretarial function. It was notable that Slovenia reported that it had earmarked establishing a professional network as part of the national policy. This could represent a strategic way to initiate a national HEPA network and to secure necessary support for leadership and resources.

Although there has been a lot of interest in working in partnership with private industry and the voluntary sector globally and within Europe, the results revealed few examples in these seven countries. This may be because current practice and examples are limited due to the controversial nature and complexities of public-private partnerships in health promotion, or more likely, the absence of any private sector partnerships in the responses is due to a limitation of the current PAT questions which do not explicitly call for details of these specific collaborations. Other sections of

PAT capture some details on the presence of financial and in-kind contributions from partners, including the private sector, and these results are discussed in a later section of this report.

PAT Items: Critique and Recommendations

Question 18 aimed to assess the sources of leadership for HEPA in each country. Question 18a assessed leadership from government sources and Question 18b captured details of national leadership by organisations outside of government.

Recommendation: **Question 18 captured good data: no changes are proposed.**

Question 19 assessed the extent to which national level policy documents and leadership guides the implementation of policy and other physical activity promotion actions at a sub-national or local level. This question aimed to determine whether there was synergy and coherence between levels of implementation and action.

Recommendation: **Question 19 captured good data: no changes are proposed.**

Question 20 sought information on who provides leadership and coordination of physical activity related activities at the sub-national and local level. Although this question worked well in identifying who provides leadership, it may also be of interest to understand more about the mechanisms and processes for sub-national and local coordination of HEPA related activities. If this is deemed desirable then question 20 should be amended.

Recommendation: **Question 20 should be revised to ask not only ‘who’ provides leadership for physical activity at the sub-national and local level but also ‘how’ it is being coordinated.**

Questions 13 sought information on whether there were recommendations on how agencies should work in partnership to deliver HEPA policy. Overall, this question was well completed by all countries. However, this question did not request an appraisal of the extent to which partnership working was taking place in practice. Some details of the actual practice of working in partnership was provided by some countries in response to question 13 even though the intended focus was on whether there were recommendations on partnership, rather than implementation.

Recommendation: **Consider dividing question 13 in to two parts. The first part (13a) might comprise the existing Q13 and assess presence or absence of any recommendations for working in partnerships; part (13b) could focus on capturing, to the extent possible, how the partnerships work in practice.**

Recommendation: **The private and voluntary sectors should be explicitly included in the wording of the proposed new question (13b).**

It is possible that better insights on the processes involved in developing and sustaining partnerships, as well as the quality of partnership working, would have been obtained via interview or focus group data collection methods. Where resources and time allow, adding such approaches should be considered in future work in assessing physical activity policy and practice.

Question 25 collected information on professional networks.

Recommendation: **Question 25 captured good data: no changes are proposed.**

3. Political Commitment and Funding

Introduction

Questions 16 and 17 of the PAT sought information on the level of political commitment and resourcing of the policy and action plans. It is noted that these questions were more challenging to answer and the details provided in the responses are likely to vary dependent on who completed the PAT questions and how available and willing the relevant authorities were to provide information on funding for the purposes of this demonstration project.

Results

Key findings: Political commitment

- Evidence of political commitment was reported in a number of ways including: the inclusion of HEPA in national policy and key documents (Italy, The Netherlands, Norway), the inclusion of HEPA in official speeches (Finland, Netherlands, Norway, Slovenia) and in the media (Portugal); personal engagement of high level politicians in public sports activities (Portugal) and being physical active personally; and politicians being involved in relevant high level associations or committees (Finland).
- Funding was also seen as an indicator of political commitment. Several countries reported increases in funding over the past few years and suggested this reflected increasing commitment (Finland, Netherlands); conversely others reported no increase or even decreasing funds suggesting this reflected decreasing commitment (Italy, Norway).
- The presence of a HEPA policy, particularly when this was a standalone policy (such as in Norway) or the presence of other legally binding documents (e.g. Italy, Slovenia) were considered to reflect the priority of, and political commitment towards, physical activity promotion. Conversely, the failure to update and renew policy also showed diminishing support (as reported in Norway).
- Although personal involvement in public HEPA events by politicians was interpreted as a sign of political commitment by some countries (e.g. Portugal) in other countries this personal participation by leading political figures was not necessarily considered to translate into a positive political position and actions in favour of HEPA (e.g. Switzerland).
- Slovenia, specifically noted that whilst there were a few examples of political commitment over and above the development of the relevant policy documents, there was still not the level of commitment and awareness and public support that was needed for HEPA.
- Switzerland reported greater political commitment to specific populations and settings, for example young people, sport, and the promotion of walking and cycling. Political commitment was reportedly strong at the sub-national level but at the national level support would depend on the outcome of a proposed new national prevention law.

Key findings: Resourcing and finance

- Provision of details on funding towards HEPA varied in the level of detail by country.
- Five countries provided detailed budgetary information as shown in Table 4. One country reported that it was not possible to provide detailed information as funding for HEPA was spread across many different government offices and government strategies reflecting their long history of investment in HEPA promotion (Finland).
- In all countries, the Ministries of Health and Ministries of Sport were the main contributors to HEPA funding.
- Although no really clear picture emerged in terms of main contributors across countries, in many countries, the Ministries of Health provided most of the funding (Netherlands, Portugal), whereas in others the majority of funding came from sport (Norway) or from the sub-national level (Italy, Slovenia).
- Three countries (Norway, Slovenia and Switzerland) reported funding from the Ministry of Transport.
- In Switzerland, in the medium-term, a large budget share (besides sub-national funding for physical education), will come from the Ministry of Transport within the framework of agglomeration programs for cycling and walking.
- Several countries reported funding from other ministries, specifically Ministry of Labour and Social Solidarity (Portugal), Education (Portugal), Environment (Norway and Slovenia) and Tourism (Slovenia).
- Other non-government sources of funding were identified including sporting organisations such as the Olympic Committee (in Italy), a health promotion foundation (Switzerland), the private sector (Finland) and public lottery agencies (Finland).
- In three countries, sub-national funding (from regional and local level government) constituted a substantial part of the HEPA budget (Italy, Slovenia, Switzerland).

Table 4 Results on Political Commitment and Funding⁵ of Policy and Action Plans on Physical Activity

Country [population size]		Ministries					Additional sub- national funding	Other funding sources
		Health	Sport / Education/ Culture	Transport	Environment	Other		
Finland [5.4m° inhabitants]	Response summary on political commitment	Excellent at the national government level and HEPA frequently mentioned in official speeches. Many organisations and associations active in HEPA have a key politician on their board (e.g. the Prime Minister was the Chairperson of Young Finland Association, Ministry of Health is the Chairperson of Finnish Sport for All Association). At the local (communal) level, there is great variation how committed local officials and key politicians are.						
	Comments on funding	Very diverse and complex funding for HEPA, partly for organisations and partly for projects. It is impossible to say how much money is invested to PA interventions nationwide. But by comparing the main national projects funding has clearly increased over last 10 years (from about 1 m€ to nearly 10 m€).						
	Funding details (no amounts provided)	x	x	x			x	yes x Finnish Machinery Association and Finnish Lotto Employers (ca. 350m€ yearly)
Italy [60.4m° inhabitants]	Response summary on political commitment	Inclusion of promotion of a healthy lifestyle (incl. PA) as a public health priority in the National Preventive Plan (PNP) 2010 – 2012 which is legally binding both at national and at regional level represents the most important political commitment in national public health. However, since around 2010 the political commitment towards implementation seems to have decreased and funds have been cut significantly.						
	Comments on funding	Since CCM started in 2004, over 200 agreements signed in six areas of activity (including surveillance, prevention, support to programs, communication and documentation; social welfare; environment). This involved all regions and most public health institutions. Another 66 agreements were signed as part of the CCM 2008.						
	Funding details	CCM funding for PA: 2005: 0.21m€ 2006: 1.4 m€ 2007: 4.32m€ 2008: 2.6m€ 2009: only total for all projects available 2010: ca 1.6m€ for PA	National Olympic sport committee CONI: 0.45m €					1.9 billion€
Netherlands [16.7m° inhabitants]	Response summary on political commitment	Although HEPA is not a top priority in State Policy there is substantial political commitment for HEPA. For example, in all recent relevant documents PA has been mentioned or is a key topic; budgets to promote PA have risen from 2005-2009 and some interventions (e.g. Beweegkuur) received substantial investments; Until 2010 the Minister and State Secretary have promoted Sports and HEPA in speeches and videos and there is increased awareness in other sectors (health, youth, education, environment) for HEPA and healthy life-style.						
	Comments on funding	Not included is the government funding on PE-teachers, sports education and sports facilities (i.e. swimming pools, sporting fields, gyms).						
	Funding details	<i>Ministry of Health, Welfare and Sport</i> 2005:42.2m€ 2006:77.9m€ 2007:77.5m€ 2008:87.7m€ 2009:100.4m€	<i>Ministry of Education, Culture and Science</i> 2008: 9.4m€ 2009: 7.8m€					

Results – Part B – Cross-country comparison

Country [population size]		Ministries					Additional sub- national funding	Other funding sources
		Health	Sport / Education/ Culture	Transport	Environment	Other		
Norway [4.9m° inhabitants]	Response summary on political commitment	During the last 10 years the promotion of physical activity has received growing attention in national, regional and local politics, leading to a National Action Plan as well as to the inclusion of PA in national policy papers, various plans and Directives. In 2010, the Prime Minister and Minister of Health spoke of the importance of taking steps to enable the people to engage in physical activity as a means of meeting the country's future health challenges but the future of the 2005-09 Action Plan is now unclear. The intention was to update the plan, but as of 2012 this has not occurred.						
	Comments on funding	Funding was allocated to different measures of the National Action Plan. Overall there hasn't been any clear increase of funds in the plan period. While total funds from Culture increased in 2008/09, this was mainly due to one-time grants in both years to the Norwegian Sport Association and a one-time grant to sport arenas in 2009. The largest funding shares went to measures on PA promotion through sports and building/maintenance of sport arenas.						
	Funding details	2005:0.64m€ 2006:0.81m€ 2007:0.76m€ 2008:0.76m€ 2009:0.76m€	2005: 38.1m€ 2006: 95.7m€ 2007: 98.7m€ 2008: 101.7m€ 2009: 114.4m€	2010: 20.3 m€ for walking and bicycle paths 2011: 31.1 m€	2007: 3.9m€ 2008: 4.25m€ 2009: 4.1m€		Some of the bicycle and walking paths are built and financed by the county authorities	
Portugal [10.6m° inhabitants]	Response summary on political commitment	There is political commitment at central government level and the Prime Minister appears frequently in the media carrying out his usual physical activity, even during official visits to various countries. He also regularly participates in major sporting events such as the half-marathon in Lisbon.						
	Comments on funding	Based on the Decree-Law No. 56/2006 of March 15 (Operation of social games) these budgets come from the distribution of profits of 2009 of a total of 500.6 million Euros (of the funds allocated to the Presidency of the Council of Ministers).						
	Funding details (for 2009)	37.7m€ for activities and sport facilities 7.2m€ for youth 2.9m€ for football	Education 4.8m€ for school sport			Labour and Social Solidarity 5.8m€ (leisure, culture and popular sport)		
Slovenia [2m° inhabitants]	Response summary on political commitment	All mentioned documents are legally binding at national or regional level, thus they have to be implemented and in some cases also reviewed. PA and sports are mentioned in political speeches from time to time and some important politicians are also actively engaged in PA and sports, but from the public health point of view PA is still not very high enough on political agenda as it should be.						
	Comments on funding	Ministries are obliged to provide financial resources in their own annual plans. Usually each year they make a call for co-financing non-profit programs that promote HEPA and involvement of specific target groups in sport activities including infrastructural support and support regarding training of experts. Also appropriate professional literature and population oriented promotional materials are co-financed as well as relevant research.						
	Funding details (no amounts provided)	x	x (incl. education)	x	x	Labour Tourism	According to NPS 200- 2010 local communities are the most important source of funds, primarily co- financing the sports programs of children and youth, sports recreation, and the construc- tion/maintenance of sports facilities.	Sport sector: Foundation for Financing Sport Organizations (sport lottery funds) health oriented programs/projects: Health Insurance Institute of Slovenia

Results – Part B – Cross-country comparison

Country [population size]		Ministries					Additional sub- national funding	Other funding sources
		Health	Sport / Education/ Culture	Transport	Environment	Other		
Switzerland [7.8m° inhabitants]	Response summary on political commitment	Different historical phases and events: Very high political support for national Youth and Sport program since the 1970ies until today; Some government programs had political support but only limited funding for implementation; National prevention law currently in parliament, submitted to address lack of coordination and cooperation between the different players in the fields, support to be seen; Many figures of public life like to present themselves as physically active or active in sports. However, this does not imply any particular position towards physical activity promotion as a public task; Growing interest and support for physical activity promotion at the level of cities and cantons; Growing interest and political support for the promotion of walking and cycling.						
	Comments on funding	None						
	Funding details	National Program on Diet and Physical Activity 1.9m€/yr.	50 m€ for the Youth and Sport program Federal Sport Policy Concept 2003-2006: 3m€/yr. 2007-2010: 2.6m€ (ca. 3% of ministry budget), 0.75 m€/yr for health-related measures (ca. 1% of ministry budget)	Federal administration subsidises the private organisation Swiss Hiking (Schweizer Wanderwege) to maintain the national hiking network of 60'000km Federal Law on Infrastructure Fund 143m€/yr for agglomeration programs, in which cycling and walking are to take a central role			Communities and cantons invest ca 415€ /yr. into physical education	Foundation "Health Promotion Switzerland": ca. 3 out of 13m€/yr for support of cantonal N&PA programs

⁵ To allow putting the funding figures into perspective, the number of inhabitants of each country is provided in the first column

°Nr of inhabitants, 2010: from http://en.wikipedia.org/wiki/Demographics_of_Europe#Population_by_country

x = funding indicated but no details reported

Discussion

Insufficient funding and inadequate senior level political support are frequently mentioned as two of the major constraints preventing the scaling up of national action on HEPA. (28) Two items on the PAT attempted to gauge the status of these two factors in the participating countries. Earlier results (reported in results sections above) have shown that all seven countries had a range of national policy documents providing the direction for national action on HEPA. As such, the existence of these policy documents provides one indication of some political commitment and the use of government policy processes to advance and support the promotion of HEPA. However, policy documents alone are not enough, and too often are not fully implemented.

The promotion and public endorsement of the HEPA agenda by senior politicians and leaders was reported by several countries to be a positive indication of increasing political support. However it was also noted by several countries that even during the time of this project there were already indications that political support was on the decline, as was funding support. In one country (Norway) the current policy expired (in 2009) and no action to renew and update the policy was started until 2012.

Funding has always been seen as a core indicator of government support (7, 27). General information on funding was provided by all countries and actual figures indicating the scale of investment were provided by five for between 1-5 years. These data are particularly difficult to obtain and were available in those countries that were able to access government sources and/or where there was good transparency of funding contributions. In Finland, a country with a long history of HEPA promotion, funding was reported to be from across a number of government bodies and organizations. Thus, it proved to be too difficult to collate these data.

It is not surprising that the health and sports sectors were consistency identified as major sources of funding. However there were examples across the countries of other government ministries and other non-government sources also contributing financial resources towards HEPA activities. However, it was noted by respondents that it was not possible to report all funding sources and some of the omitted sources could be substantial. For example, health insurance subsidies or private or industry project funding was not captured and Switzerland and the Netherlands noted that these were quite considerable funding sources.

Assessment of both funding and political commitment towards HEPA is difficult and undertaking this via the PAT survey has limitations. Moreover, the answers provided to items on the level of political commitment will clearly depend on who completed the PAT and may reflect concerns about how the data will be used and disseminated.

PAT Critique and Recommendations

Question 16 on the PAT sought an assessment (or judgement) about the amount of political commitment to HEPA. Feedback from countries revealed that this question was challenging to answer, and the response (what is said, amount of detail) might vary by whether a government body or an independent research institution coordinated the completion of the PAT.

Recommendation: **No recommendations are made for changes to this question. However, the instruction should recommend consultation with a range of stakeholders to assist in making a more objective appraisal of the political commitment to HEPA within a country.**

Question 17 requested details of resourcing and finance. Not all countries included details of relevant funding from all sectors. When no funding was specified for a specific ministry, it was unclear whether the amount of funding could not be obtained or whether no funding had been allocated by that ministry. In addition, the PAT did not specifically request details of private sector funding and this was reported to be substantial in several countries.

Recommendation: **A response table could be used to allow respondents to more clearly see which ministries should be included in the response.**

Recommendation: **The question should provide further details on how to indicate that no funding is provided or that funding is provided but the exact value could not be obtained.**

Recommendation: **The PAT item (or the response table) should explicitly call for details of funding from the private sector.**

The PAT asked about financing of HEPA related activities identified in the key policy documents. Capturing details of the budget allocation in other areas or portfolios might provide additional interest and would facilitate comparison of the relative importance of HEPA promotion. For example, it may be useful to understand the proportion of the total health promotion budget which is allocated to physical activity. In addition, it may be of interest to contrast the budget for HEPA against other activities such as sport (i.e. elite and performance level sport). This information might provide a useful comparison of the resource allocation between HEPA and other agendas.

Recommendation: **Consider expanding question 17 to also capture budgetary information on other areas such as the total health promotion budget and the budget allocation for sport.**

4. HEPA Recommendations, Goals and Targets and Surveillance Systems

Introduction

This section presents results on three aspects of national policy and action plans that are regarded as core building blocks for national action on HEPA. Their importance is based on the experiences of many countries over the past 20 years which has shown that establishing national recommendations, setting a national goal (or target), and including measures of HEPA into a systematic behavioural risk factor surveillance system are useful first steps in the development of a national HEPA agenda. The data collected on population levels of participation in HEPA and placed within the context of national recommendations and targets can be a very useful advocacy tool and provide an opportunity to gain political interest and commitment.

PAT items assessed the presence of national physical activity recommendations or guidelines (Question 5), and the presence of clearly stated national goals or targets on population prevalence of physical activity (Question 6). In addition, Question 7 asked about the presence of any other HEPA-related goals or targets, for example targets might be set for provision of afterschool HEPA activities, or modal split between motorized and non-motorized travel. Question 15 asked about the current status of monitoring of risk factors and whether there was a surveillance system which included items on HEPA. This is necessary to formulate evidence based goals and to allow an evaluation of progress towards stated national goals and targets.

This section presents the results on the following PAT questions:

- i. To what extent have physical activity recommendations been developed or endorsed?
- ii. Have national goals been set for physical activity prevalence?
- iii. Is there a surveillance or monitoring system of HEPA?
- iv. What other types of goals relating to HEPA have been adopted?

Results

i.) To what extent have physical activity recommendations been developed or endorsed (PAT Q5)?

Six countries reported the existence of physical activity recommendations. The content of the physical activity recommendations were, in general, quite similar but there were some notable differences. The following results are presented by population group: children/ young people; adults; and older adults. The results for all groups are summarised in Table 5.

Key findings: Young people

- In three countries there were nationally developed guidelines for children and young people (Finland, Norway and Switzerland). Three countries (the Netherlands, Portugal, Slovenia) had adopted and endorsed international or global recommendations, usually from ACSM or

WHO. Italy reported no official recommendations, although their national surveillance systems used internationally accepted HEPA recommendations in their reporting.

- In five countries the recommendations for young people called for at least one hour of moderate-to-vigorous intensity activity daily. However, Finland recommends one to two hours of physical activity for young people per day and Switzerland stated that children at the beginning of school age should do considerably more activity than one hour per day.
- In three countries, the recommendation for young people also included activities for muscle strength and bone health (Finland, Switzerland) or general or cardiovascular fitness (the Netherlands, Switzerland) on 2-3 days per week. Norway did not specify a frequency of fitness related activity, but suggested that activities should be as diverse as possible to develop all aspects of physical fitness (cardio-respiratory, muscle strength, flexibility, speed, mobility, reaction time and coordination).
- In two countries (Norway and Switzerland) the recommendation stated that bouts of at least ten minutes were necessary, a consideration which is otherwise only used for adults.
- Two countries (Finland and Switzerland) also included additional statements on young people limiting time spent in sedentary behaviour.

Key findings: Adults

- Four countries reported national guidelines for adults (Finland, Norway, Slovenia and Switzerland). Two countries (the Netherlands and Portugal) had adopted and endorsed international or global guidelines. As with children and young people, Italy had no official recommendations for adults, although their national surveillance systems used internationally accepted HEPA recommendations in their reporting.
- The HEPA recommendations for adults were more varied than the recommendations for children and young people. The most commonly used recommendation was a minimum of 30 minutes of moderate to vigorous physical activity, either daily (Norway, Portugal, Switzerland) or on 5 days of the week (the Netherlands, Slovenia).
- The Netherlands, which adopted the “5 x 30 minutes” recommendation, also advised that the recommended physical activity level could be achieved by undertaking 20 minutes of vigorous intensity activity on three days of the week or via a combination of moderate and vigorous intensity activity.
- In Finland, the HEPA recommendation states that adults should undertake 2 and a half hour of moderate intensity physical activity or 1 hour and 15 minutes of vigorous intensity activity per week. This activity should be spread across at least 3 days.
- Four countries recommend that activity is undertaken in bouts of 10 minutes (Finland and Norway, Switzerland) or 10 – 15 minutes (Slovenia).
- In only two countries are the benefits of strength and flexibility training explicitly stated (Finland and Switzerland). In Slovenia it is suggested that the exercise should be as diverse as possible, and a recommended distribution of 50% aerobic exercise, 25% flexibility exercise and 25% strength exercise is provided.

- In Norway, no additional activities are included in the HEPA recommendation although it does state that increasing activity beyond the recommended duration and intensity will yield additional benefits.
- Norway also suggests that additional activity above the recommended level may be necessary for preventing weight gain.
- No country reported that their HEPA recommendations addressed time spent sitting in adults.
- Norway reported that they also have specific recommendations on HEPA for people with physical disabilities, not only for adults but for all age groups.

Key findings: Older Adults

- Separate HEPA recommendations for older adults were reported by only one country (the Netherlands).
- Two countries (Portugal and Slovenia) had adopted recommendations for older adults from other international position statements. Portugal referred to the EU Physical Activity Guidelines (quoting WHO recommendations), while in Slovenia, the WHO Physical Activity Guidelines and the ACSM/AHA Physical Activity Reccomentations are used.
- Three countries (Finland, Norway, Switzerland) reported applying their guidelines for adults to the older adult population as well.
- In Italy there were no physical activity recommendations reported for older adults.

Table 5 Existence of National Recommendations on Physical Activity

Country	Key documents/issuing body	Children/Youths	Adults	Older adults
Finland	<p>Youth: Developed by the Young Finland Association in 2008, and adopted by the Ministry of Education and Culture</p> <p>Adults and older adults: UKK Institute, 2008</p>	<p>1-2 h physical exercise daily</p> <p><i>*Exercise for bones, mobility and muscular strength at least 3 times a week</i></p> <p><i>*Avoid sitting for more than 2 hours at a time</i></p> <p><i>*Not more than two hours per day in front of entertainment media</i></p>	<p>Aerobic physical activity for 2 hours and 30 minutes a week at a moderate intensity or 1 hour and 15 minutes a week at a vigorous intensity - an equivalent combination of both is also possible</p> <p>Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week, at least 3 times a week. In addition, muscle-strengthening activities at least twice a week</p>	
Italy	No official national recommendations but the national surveillance systems use internationally accepted physical activity recommendations as cut-off points for what constitutes a “sufficient” level of physical activity			
The Netherlands	The Netherlands policy ‘Time for Sport’ (2005) promotes the international recommendations on (the amount of) physical activity for health	<p>60 minutes moderate intensity activity, each day of the week</p> <p><i>*At least twice a week activity for fitness (strength, agility and coordination)</i></p>	<p>Minimum 30 minutes moderate intensity activity per day, at least 5 days a week or alternatively 3 times a week 20 minutes vigorous intensity physical activity.</p>	<p>30 minutes moderate intensity activity per day, at least 5 days a week, or alternatively 20 minutes vigorous intensity activity per day, at least 3 days a week.</p>

⁺ The information provided by country leads on this item in their PAT was complemented with information from the official recommendation documents available from a separate project.

Results – Part B – Cross-country comparison

Country	Key documents/issuing body	Children/Youths	Adults	Older adults
Norway	Recommendations were first published in 2000 in the report Physical Activity and Health recommendations.	At least 60 minutes of moderate or vigorous physical activity every day <i>*Activities should be as diverse as possible to develop all aspects of physical fitness (cardio-respiratory, muscle strength, flexibility, speed, mobility, reaction time and coordination)</i> This activity could be made up of several sessions during the day, each lasting at least 10 minutes	Adults and older adults are recommended to take at least 30 minutes of moderate or vigorous physical activity every day. This activity could be made up of several sessions during the day, each lasting at least 10 minutes <i>*Increasing activity beyond this duration and intensity will yield additional benefits</i> <i>*More activity may be necessary for prevention of weight gain (in addition recommendations for people with different disabilities)</i>	
Portugal	The country has no official national recommendations for physical activity levels, adopting the recommendations of the European Union.	A minimum of 60 minutes of daily physical activity of moderate intensity	A minimum of 30 minutes daily moderate physical activity for adults, including seniors	
Slovenia	Youth: Slovenia follows WHO Physical Activity Guidelines and ACSM Physical Activity Recommendations. Slovenian non-governmental sport organizations follow EU Physical Activity Guidelines. Adults: Recommendations are included in the National Health Enhancing Physical Activity Program 2007-2012 and the Resolution on the National Program of Food and Nutrition Policy 2005-2010. Older adults: Slovenia follows the WHO Physical Activity Guidelines and ACSM Physical Activity Recommendations	At least 60 minutes of moderate to vigorous-intensity physical activity daily Most of daily physical activity should be aerobic. Vigorous-intensity activities should be incorporated, including those that strengthen muscle and bone, at least 3 times per week Physical activity of amounts greater than 60 minutes daily will provide additional health benefits.	A minimum of half an hour of moderate intensity activity at least 5 times a week Bouts of activity should not be shorter than 10-15 minutes The exercise should be as diverse as possible Recommended distribution is 50% aerobic exercise, 25% flexibility exercise and 25% strength exercise	At least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity. Aerobic activity should be performed in bouts of at least 10 minutes Muscle-strengthening activities should be done on 2 or more days a week

Results – Part B – Cross-country comparison

Country	Key documents/issuing body	Children/Youths	Adults	Older adults
Switzerland	<p>Issued by the Federal Offices of Sport and Public Health, Health Promotion Switzerland and the Network HEPA Switzerland</p> <p>Youth: Physical Activity Disk, 2006</p> <p>Adult: Swiss Physical Activity Pyramid 1999</p>	<p>Adolescents should be active for a total of at least an hour a day, children at the beginning of school age considerably more. All activities of at least 10 min duration can be added up</p> <p>In addition, activities should be carried out several times a week for at least ten minutes that increase bone strength, stimulate the cardiovascular system, increase muscle strength, maintain flexibility, and improve agility</p> <p>Activities and pastimes that involve no physical activity should not last longer than about two hours without interruption</p>	<p>Minimal recommendation of half an hour of moderate intensity activities daily or on most days</p> <p><i>*Each bout of activity should be at least 10 minutes in duration</i></p> <p>Additional benefits can be derived from cardio-respiratory fitness training for 20-60 minutes 3 times a week, strength and flexibility training twice a week, and additional sports activities</p>	

* The information provided by country leads on this item in their PAT was complemented with information from the official recommendation documents available from a separate project.

ii.) Have national goals been set for physical activity prevalence?

National goals are an important component to the development of national policy and agenda setting for resourcing and action. Question 6 on the PAT requested details on the presence of national goals or targets on population prevalence of physical activity. The results are summarised in Table 6.

Key Findings:

- The presence and details of national goals on the prevalence of HEPA varied across the seven countries.
- Six countries reported having a target on the prevalence of HEPA. However, in two countries these were not presented as *quantifiable* or *measurable* targets (Finland, Norway). Instead, these two countries stated a general intent to “*increase*” the number of people who are physically active and/or to “*decrease*” the number of people who take no exercise.
- Italy did not report a specific target for HEPA but having a target to “*contain*” the prevalence of obesity.
- In six countries with national goals on HEPA, specific targets were reported for adults; two countries (Portugal and Slovenia) defined targets for different age groups of adults.
- Only four countries reported specific targets for children and/or young people (the Netherlands, Norway, Portugal, Slovenia) and only two countries (Portugal and Slovenia) reported a specific target for older adults.
- Portugal was the only country to provide separate targets for males and females.
- Three countries presented very specific and detailed targets (the Netherlands, Portugal, Slovenia). Examples include: In 2012 at least 50% of adults and 70% of children will achieve recommended physical activity levels (the Netherlands); and Increase the number of children and adults achieving recommended activity levels by 30% and 20% respectively (Slovenia).
- Two countries (Slovenia and Switzerland) reported specific targets for HEPA over time. For example in Switzerland they had a target for 2003-2006 to “*increase by 1% per year the proportion of physically active people*”. However, this target had not been updated so there was no current measurable goal for HEPA prevalence. In Slovenia they stated a goal of a “*2.5% annual increase of people practicing sports regularly and 1% increase of (currently non) active citizens in sports*”
- In Portugal, the HEPA related target was actually written to focus on reducing the prevalence of “*individuals who spend most of their free time in sedentary activities*”.
- The Netherland and Slovenia also defined targets around reducing sedentary behaviour in addition to HEPA targets.
- Slovenia was the only country to report a specific target for pregnant women as well as for “*currently inactive people*”.
- Finland was the only country to report a specific target to increase the prevalence of HEPA in low socio-economic groups.

Table 6 Presence of National Goals and Targets on Physical Activity

Country	Phrasing
Finland	<p>Resolution concerning the development of health enhancing physical activity and diet, 2008</p> <p>To increase number of people exercising enough for their health and decrease the number of those who does not exercise at all</p>
Italy	None specified
Netherlands	<p>Time for Sport (2005)</p> <ul style="list-style-type: none"> - Youths (12-17 years old) that meet the exercise standard will increase from 35% in 2004 to 40% by 2010 - By 2010 65% (2004 60%) of the adult population in the Netherlands will meet the international exercise standard <p>Power of sport (2008)</p> <ul style="list-style-type: none"> - In 2012, at least 70% of adults (18+) do the recommended amount of exercise (2005 63%) - In 2012, at least 50% of young people (aged 4-17) do the recommended amount of exercise (2005 40%) - In 2012, no more than 5% of adults in the Netherlands are inactive (2005 6%)
Norway	<p>The Action Plan on Physical Activity 2005-2009</p> <p>An increase in the number of children and youth who are physically active for at least 60 minutes per day</p> <p>An increase in the number of adults and elderly people who are moderately physically active for at least 30 minutes per day</p>
Portugal	<p>National Health Plan 2004-2010</p> <p>To reduce the prevalence of individuals who have spent most of their free time with sedentary activities:</p> <ul style="list-style-type: none"> - Persons aged 15-24 years: 45.5% to 15% in males and 64.2% to 16% in females - Individuals of 35-44 years: from 67.5% to 34% in males and 77% to 39% female - Individuals 55-64 years: 70% to 35% in males and 83.2% to 42% female - Individuals of 65-74 years: from 75.5% to 38% in males and from 87% to 44% female
Slovenia	<p>HEPA Strategy 2007 - 2012</p> <ul style="list-style-type: none"> - Increasing the share of young people doing for at least one hour every day by 30%, - Reducing the share of children and adolescents who in their free time spend more than four hours a day sitting in front of the television or computer by 30% - Reducing the share of completely inactive adults by 30% - Reducing the share of adults who in their free time spend more than four hours a day sitting in front of the television or computer by 30% - Increasing the share of adults who are sufficiently active by 20% - Reducing the share of physically completely inactive over-65s by 20% - Reducing the share of over-65s who in their free time spend more than four hours a day sitting in front of the television or computer by 20%

Results – Part B – Cross-country comparison

Country	Phrasing
	<ul style="list-style-type: none"> - Increasing the share of over-65s who are sufficiently active by 20% - Increasing the share of participation of pregnant women in physical activity programs by 40% <p>National Programme of Sport, 2000-2010</p> <ul style="list-style-type: none"> - 2.5% annual increase of people practicing sports regularly and 1% increase of (currently non) active citizens
Switzerland	<p>Sport Policy 2003-2006:</p> <ul style="list-style-type: none"> - First stabilizing and then increasing by 1% per year the proportion of physically active people (adults) <p>Sport Policy 2007-2010:</p> <ul style="list-style-type: none"> - Increase of physically active people

iii.) Is there a surveillance or monitoring system of HEPA?

Question 15 sought information on whether each country had an established surveillance or health (risk factor) monitoring system which included a measure of HEPA. A supplementary question sought comments on how well the surveillance data had been used to progress the national agenda on physical activity (Question 15c). Results by country are shown in Table 7.

Key findings:

- All seven countries reported undertaking national physical activity surveys.
- Finland reported a long-established surveillance system, involving systematic data collection on a regular basis. This surveillance system has been in place since the 1970's.
- For at least two countries monitoring of HEPA is a new process. Portugal and Norway recently conducted their first national surveys and it was intended that this would form the basis for an on-going national surveillance system.
- Some surveys were reported to collect data on sports participation only and not wider physical activity (Slovenia, early Swiss survey in adults).
- Most of the seven countries use self-report instruments only. Objective measurements appear to be only emerging in some countries (Finland, Norway) or in school-based surveys in children (Slovenia).
- It is important to ensure that national surveillance systems are able to assess success against national goals and targets. However, based on the information provided on the national objectives in question 6 and the available information on the surveillance systems, only one country out of the seven (the Netherlands) seemed to be able to assess achievement of their stated goals and targets for HEPA prevalence using their national surveillance system.
- The observed inability of the other countries to assess achievement of their goals and targets using their national surveillance system was due to a range of factors. In Switzerland, the timelines for the national surveillance system (survey conducted every five years) did not coincide with the specified timelines of the HEPA goals. In other cases, surveillance data would be available to track progress but the measure of success remained unclear as no quantified targets had been defined (Finland, Norway, and more recently Switzerland). In the case of Slovenia, no baseline data were available to compare target reach to.
- Six countries (not Portugal) reported use of the surveillance data to support various functions: setting of national targets; use in national policy; planning the HEPA agenda; and advocacy such as raising the awareness of levels and increasing political attention. In Portugal, the first national study of prevalence had only recently been completed and thus the impact of these results on national policy were, as yet, not known.
- A key use of the national surveillance data were to help shape the political agenda around physical activity and particularly to help prioritise specific population groups for physical activity interventions.

Table 7 National surveillance system with monitoring of physical activity, by country

Country	Name of survey	Methods	Populations*			Year est.	Frequency	Use of data
			C	A	OA			
Finland	Nuorten terveystapatutkimus	method not specified	✓					Yes, data used used for planning the PA agenda, to identify target groups in need and to assess the effectiveness of the national PA strategy.
	Kouluterveystutkimus	method not specified	✓					
	HBSC survey	Written questionnaire	✓			1983/84	2-4 years	
	Specialised Health survey	Questionnaire and objective measurement	✓			2008	Foreseen to be repeated in the next few years	
	AVTK	Postal survey (plus objective measurement in year 2000)		✓		1978	Annual	
	Health Examination Survey	Questionnaire and objective PA measurement with sub-sample		✓				
	Adapted AVTK	Postal survey			✓	1972	2 years	
	FINRISK	Postal survey		✓	✓	1972	5 years	
	TNS Gallup	Telephone survey	✓	✓	✓		4 years	
Italy	Okkio alla salute (18 of 21 Regions)	Self-admin. questionnaire	✓			2008	2 years	Results disseminated to support evidence based public health actions, planning and evaluation
	HBSC survey	Written questionnaire	✓			2010	2-4 years	
	PASSI	Telephone interviews (based on BRFSS)		✓		2007	Continuous data collect., annual reports	
	PASSI d'argento	Telephone interviews (based on BRFSS)			✓	2009	Pilot survey in 7 Regions. As of 2011 integrated into PASSI system (above)	
The Netherlands	IPAN / OBIN	Telephone survey Also online option since 2006.	✓	✓	✓	2000	Continuous data coll., reports every 2 years	Used to adapt goals and performance indicators of policies, and also organisations to influence the policy agenda Esp. data on sub-groups (migrants, people
	CBS-POLS	Telephone & oral CAI	✓	✓	✓	2000	Annual	

Results – Part B – Cross-country comparison

Country	Name of survey	Methods	Populations*			Year est.	Frequency	Use of data
			C	A	OA			
	Health survey by RIVM	method not specified	✓	✓	✓		4 years	with disabilities etc.) attracted political attention and subsequent policy measures
Norway		method not specified	✓				1 surveys carried out as basis to develop surveillance system Expected to be every 5-6 years	Surveys helped to initiate objective measurements. The surveys will make it easier to establish quantified targets for the next national plan
		method not specified		✓			1 surveys carried out as basis to develop surveillance system Expected to be every 5-6 years	
Portugal	National study of prevalence	Objective measurement with accelerometers	✓	✓	✓	2008/09	Hoped to serve as basis to develop a regular surveillance system	
Slovenia	SLO Fit- Sports Educational Chart	Motor abilities and physical fitness	✓			1987	Annual	Yes, used for most national PA documents Aimed also to be used for “Health in all policies” approach with other sectors
	HBSC survey	Written questionnaire	✓			2004	2-4 years	
	Interviews on sport participation	Interviews		✓		1973	2 years	
	European Health Interview Survey (EHIS)	Written interviews		✓		2007	Expected to be every 5 years	
	CINDI health monitor	Self-administered questionnaire		✓		2001	3-4 years	
	CINDI health monitor	Self-administered questionnaire			✓	2008	Expected to be every 3-4 years	
Switzerland	HBSC survey	Written questionnaire	✓			1985	2-4 years	Yes, used for Sport Concept and National Program on Diet and Physical Activity Recent decline in cycling in youth detected in Swiss Travel survey helped to raise attention and to create action to address negative trend
	Swiss health survey	Telephone survey		✓	✓	1992	5 years	

*C= Children; A= Adults; OA = Older Adults, est. = established

iii.) What other types of goals relating to HEPA have been adopted?

Question 7 asked countries to report whether there were any other relevant or HEPA related targets within the key policy documents. Examples of other related goals could include goals set within transport policy related to walking and cycling trips or mode share, or within education policy regarding PE Curriculum, or within sports policy on participation levels. A summary of the results on other types of goals is presented in Table 8.

Key Findings:

- Five countries (with the exception of Portugal and Italy) reported examples of other HEPA related goals.
- Education related goals were common among most countries; these ranged from broad goals to create opportunities for physical activity in schools (Norway) to legally binding targets - for example for all schools to provide 3 lessons of physical education per week (Switzerland).
- Goals relating to healthcare, transport, and sport were also common among the participating countries.
- Goals within the healthcare setting included a target to increase the knowledge of health professionals with regard to physical activity and healthy diets, and to increase the provision of exercise prescriptions to patients to enable them to access local physical activity services (Finland).
- The Netherlands had also formulated a goal on reducing sports injuries.
- In the transport setting, several countries had goals to increase the number/proportion of cycling trips (Finland, Norway, Slovenia and – although not officially adopted - Switzerland).
- Norway and Slovenia had goals related to increasing the number of children walking or cycling to school; Slovenia also had goals to increase the number of adults walking or cycling to work.
- Other transport related goals included the development of a network of continuous cycle routes and increased road safety (both Norway).
- Environment-related goals were reported by three countries (Finland, Netherlands, Norway). They referred to the provision of sport or playground facilities (all three countries) and the development of supportive environments to support an active lifestyle for children (Finland).
- Other reported goals included increasing opportunities for older adults to be physically active (Finland) and goals targeting HEPA and migrant youths (Netherlands) or people with disabilities (Slovenia).

Table 8 Results on the Presence of Other HEPA related Goals and Targets, by country

	Education / work	Health(care)	Environment	Transport	Sport	Other
Finland	<p>Students and employees have an opportunity to get support and encourage for increasing physical activity</p> <p>Employers have effective ways to enhance physical activity of employees</p>	<p>The knowledge of HEPA and healthy diet is increased in health and exercise professionals</p> <p>Physicians and nurses to give their patients exercise prescriptions</p> <p>In primary health care, there is enough exercise guidance services available</p>	<p>Environment and operational culture of children care and schools support physically active life style.</p> <p>Every age group has “easy reached” sport and exercise places nearby their homes</p>	<p>300 million more trips should be done by walking and cycling by the year 2020</p>		<p>More knowledge, support and opportunities for physically active life style are available for children, youths and families</p> <p>Older people have high-quality, easily reached and cost-effective exercise service available</p> <p>Ever people have good possibilities to every day physical activity</p> <p>“Health in all policies” –principle is taken into account in local decisions</p>
Italy	None reported					
The Netherlands	<p>By 2010, 90 % of all schools will enable every pupil to practise sport every day during and outside school hours</p>	<p>By 2008, sports medicine will occupy a position in its own right within the occupational and educational structure of health care</p> <p>600 professionals will educated to practise the “beweegkuur” program</p> <p>236,000 people will participate in courses</p>	<p>There should be 75m2 green space per household, and 3% of habitation area should be playground for children</p>		<p>By 2010, the likelihood of an injury per 1000 hours of sport will drop by 10% from 1.0 to 0.9 injuries</p> <p>By 2010 the quality mark for modern sports clubs will have been introduced in 25% of clubs</p>	<p>By 2010, the disparity in sports participation among youths from immigrant backgrounds will have disappeared</p> <p>500 sports clubs and sports schools will work together to provide additional supervision, while 50 will focus on care programs for immigrant youths</p> <p>In 2011 a total number of 2500 professionals should be working on a local level to increase youth participation in sport, PA & culture. The main aim is to make links between the sport and PA and educational sector</p>

Results – Part B – Cross-country comparison

	Education / work	Health(care)	Environment	Transport	Sport	Other
Norway	Opportunities for physical activity kindergarten, school and workplace	Focus on physical activity in health and social services	Physical environments that promote an active lifestyle	<p>The proportion of cycling trips out will be increased from 4-5% to 8% by 2019.</p> <p>Increase the proportion of children and young people (<15 years) who are walking or cycling to school from 60 % to 80% before 2019.</p> <p>All cities and towns should shall have a plan for network of continuous bicycle routes by 2013</p> <p>Increase road safety</p>	As many people as possible will be given the opportunity to participate in sport and physical activity.	<p>More in physical activity at leisure time</p> <p>Sectoral and concerted efforts to promote physical activity in the population</p> <p>Enhanced knowledge and improved skills on physical activity and health</p> <p>Communication, physical activity and health and motivation to an active lifestyle</p>
Portugal	None reported					
Slovenia	Establishing and implementing a strategy of physical activity for employees in 10 % of large and medium-sized enterprises and public institutions, and establishing physical activity programs at work for 20 % of employees in the public	Greater healthy life expectancy and further increase in the quality of life for all population groups, health promotion and health education, reduction of health inequalities and early detection of chronic NCDs.		<p>Increasing the share of young people who normally walk or cycle to school and in their everyday routine by 20 %</p> <p>Increasing the share of adults who normally walk or cycle to work and in their everyday routine by 20 %</p>	<p>The main long-term goal is to become a sport nation. That can be reached by:</p> <ul style="list-style-type: none"> -increasing the number of people practicing sports regularly -growth of sports culture awareness of Slovenian nation 	<p>Reducing the share of overweight and obesity in children and adolescents by 10 %,</p> <p>Ensuring equal opportunities for health enhancing physical activity for persons with special needs and for all disabled persons.</p>

Results – Part B – Cross-country comparison

	Education / work	Health(care)	Environment	Transport	Sport	Other
	administration.			Municipality of Ljubljana to increase the share of bicycle trips from 8 % (2003) to 20% in the following years.	-development of sport profession and science; rising the awareness of the individual, -using nature as the largest sport area; building a network of sports facilities and sites for all categories, etc.	
Switzerland	Legally binding obligation of the cantons and communities to provide three lessons of physical education per week in their schools			Increasing physically active transport by 15% within 10 years (not officially adopted*) Increase in the proportion of physically active transport stages within the modal split of overall mobility A reduction of individual motorized transport in favor of public transport and non-motorized transport	By 2006 75% of all communities with more than 10'000 inhabitants should have a sport vision statement and concept.	By the end of 2006 75% of all communities with 5000 to 10'000 inhabitants and 50% of all communities with 2000 to 5000 communities should have a functioning physical activity and sport network with a coordinator

* From: Draft Mission statement on human powered mobility 2002, which was not officially finalized and adopted. An Action Plan on Human Powered Mobility is currently being finalized

Discussion

The adoption of national physical activity recommendations is important for providing consensus on the amount of physical activity needed for the prevention of NCDs. (28, 29) The development and publication of national recommendations can provide a foundation for health promotion interventions, can facilitate clear communication about the amount of physical activity necessary to benefit health, and can provide a starting point for setting objectives and goals. Establishing a national surveillance system to assess physical activity against the recommended levels allows monitoring of population prevalence of physical activity and can assist in evaluating the effectiveness of national policies. (29)

Across these seven countries, six countries reported the adoption of national physical activity recommendations, either developed through a national consultation process or by adopting international recommendations. One country, Italy, had not officially adopted national recommendations but the national surveillance systems used internationally accepted physical activity recommendations as cut-points for what constitutes a “sufficient” level of physical activity and the reporting of national data.

The six countries with national recommendations all reported having separate recommendations for children and adults and most countries reported national recommendations on HEPA for older adults. Mostly, the adult recommendations were extended and applied to the older adult population but in one country (the Netherlands), specific recommendations for older adults had been developed. National recommendations were often tailored to the specific health benefits that can be derived from physical activity for specific population groups. For example, recommendations often stated the benefits of HEPA on healthy growth and development in children, reducing the risk of chronic disease in adults, and maintaining functional independence in older adults. Norway also reported recommendations for people with different disabilities.

The recommendations for each age group were broadly similar across countries, and reflected the international consensus on the amount of physical activity necessary to benefit health. National recommendations and consensus is important for ensuring clear and consistent messages about the health benefits of physical activity, both nationally and internationally. There were however, several differences between countries. None of the countries reported adopting the 2010 WHO Global recommendations although the physical activity ‘pie’ used in Finland is consistent with the new global recommendations. The lack of wide spread adoption of the global recommendations may reflect the temporal relationship between country level recommendations and policies and the release of the global recommendations. It is likely that as policies are revised or as new policies are developed, more countries will officially adopt the WHO Global recommendations.

Six countries had set targets for increasing the prevalence of the population achieving recommended physical activity levels. In four countries these targets were (at least at some point in time) quantifiable while two had simply a statement of intent to ‘increase’ the number of people who are physically active and to ‘decrease’ the number of people who take no exercise. Interestingly, two countries have defined separate targets for reducing sedentary time. There is increasing evidence on the impact of sedentary behaviour on health and the inclusion of actions to limit and reduce

sedentary behaviour in HEPA policy is a positive development. Only Finland had defined a specific target for low socio-economic groups, a population group usually in need of particular attention with regard to health behaviours.

These seven countries were at varying stages of development in terms of establishing a national physical activity surveillance system. Finland established a surveillance system in the 1970s. In 2008 Finland also included objective measurement of physical activity in their national surveillance. Four other countries also reported having an established surveillance system. These have a long history in some countries (Slovenia – 1970s; Switzerland – 1985) but are a relatively recent development in others (Italy and the Netherlands). For two countries (Norway and Portugal), national surveillance was a new process, and plans for ongoing monitoring of physical activity prevalence was still under development.

Most of the seven countries use self-report instruments and no information was available on their validity against objective measurements of physical activity. However, the lack of standardized instruments and presentation of data limits cross-country comparison of physical activity levels. In addition, it is important to ensure that any surveillance systems assess and report physical activity in a way that aligns to the national recommendations and national policy targets. This will facilitate the assessment of progress against specified national goals and targets, thus providing an indicator of the effectiveness of policy interventions. The current PAT items did not specifically ask countries to assess this alignment.

In addition to setting goals around physical activity prevalence, most countries identified a range of other relevant goals relating to HEPA. These were often outside of the health sector and spanned different sectors and settings including education, healthcare, transport, sport, and environment. Increasing population levels of physical activity requires a multi-sector approach. Setting goals and targets across a range of sectors can help to engage multi-sectoral partners in both policy development and implementation, can provide a clear focus for resources and interventions, and can assist in defining clear roles and responsibilities for policy implementation. However, one challenge is then to ensure that the different goals complement and support each other and that sufficient resources are available in the different sectors to avoid competition and conflicts. The development of one common multi-sectoral national HEPA strategy and/or the establishment of a formal coordination committee can be a good way to ensure this. In addition, having clearly defined and quantifiable goals will assist in monitoring progress and determining the success of policy implementation across different sectors.

PAT Critique and Recommendations

Question 5 asked for details of national physical activity recommendation. The information provided by each country varied and ranged from very brief to comprehensive. A comprehensive response to this question should ideally include the document(s) which state the physical activity recommendations, year of publication, the specific wording of the recommendations and the age groups to which the recommendations apply. There is specific interest in the exact wording of the recommendations to allow a comparison of the nuances between countries, for example whether the amount of activity was specified as a 'minimum' or a 'total', whether ten minute bouts are specified as a minimum duration, and whether strength and flexibility exercises are recommended. However, not all of these details were provided in the open ended responses.

Recommendation: **Introductory text to Question 5 should be modified to clearly specify what details should be included in the response.**

Questions 6 and 7 focused on goals and targets. Question 6 asked respondents to state the presence of national goals or targets on population prevalence of physical activity. Question 7 asked about the presence of other HEPA related goals and targets. Both of these questions were well completed by all countries, and the question on 'other goals', in particular, revealed some interesting results.

Recommendation: **No changes are required to questions 6 and 7.**

Question 15 asked about national surveillance on population levels of physical activity. The level of detail provided in response to this question varied greatly. A comprehensive response included the name of the surveillance system, the year it was established, the data collection methods, frequency, the age groups to which the surveillance system is applied, and the use of data. Often, one or more of these details was omitted.

Recommendation: **Question 15 response format should be changed. A table could be used, with separate columns for each variable of interest. This would make it clearer for respondents to understand what details should be included.**

The PAT did not request details on whether the national surveillance system is compatible with the national physical activity recommendations. In addition, the PAT did not assess how well the surveillance system aligned with the national goals and targets on population prevalence of physical activity. In the current project an assessment of this was made by the coordinating group.

Recommendation: **To gain further detail on the compatibility of national surveillance systems with physical activity recommendations and stated goals and targets, an additional sub-question should be added to Questions 15.**

5. Communication and Branding

Introduction

Community-wide communication campaigns are considered to be an important component of a comprehensive approach to physical activity promotion. Large scale campaigns typically use a variety of mass media to convey key messages about the importance of being physically active, with the aim of changing beliefs and attitudes as intermediates to influencing physical activity behaviour. Two items on the PAT sought to identify whether countries had conducted nation-wide communication and/or mass media campaigns, and if so, whether these types of promotional activities were linked by the use of a common branding or slogan (Questions 21 and 22). More information on the specific campaigns conducted in each country can be found in each country report (Part 2 of this document).

Results

Key findings: Presence of national Communication strategy

- All countries, with the exception of Portugal, reported the presence of national physical activity promotional campaigns.
- Campaigns typically aimed to raise awareness of the benefits of physical activity and communicate the amount of activity needed to benefit health.
- Three countries (Finland, the Netherlands, Slovenia) reported using media campaigns to direct or 'signpost' people to programs and other opportunities to be active.
- In Slovenia, the physical activity campaign was reported to be part of a broader health promotion campaign which aimed to raise public awareness of a healthy diet and specifically the importance of consuming more fruit and vegetables per day. The logo used for the campaign is a bike made from fruit and vegetables.
- In the Netherlands, the national campaign is supported by a series of sub-campaigns targeting different population groups including children, the elderly, and people with existing health conditions.
- Communication channels typically included television, websites, and newsletters although some countries reported use of additional channels. For example in the Netherlands, a bus travelled around the country spreading the '30 minutes moving' message.
- Communication campaigns were reported to be mostly coordinated by the health sector (e.g. Italy, Norway, Slovenia, Switzerland) and in some countries without the support of other sectors (e.g. Norway).
- In contrast, the Netherlands reported good collaboration, with engagement from across a range of ministries as well as the national cycling association and other national organisations related to sport and physical activity. A specific example is "**Heel Nederland fietst**" (which translated means 'the whole of the Netherlands is cycling'), a national cycling campaign implemented for a three year period from 2009 to 2012.

Key findings: Use of Common Branding across communications

- Only one country (the Netherlands) reported the use of common slogans across a range of actions aimed at promoting HEPA. In the Netherlands, the '**30 minutes moving**' message is used consistently across all interventions.
- In Norway they used an over-arching slogan "Bedre helse på 1-2-30" ("Better health in 1-2-30") but this was not a mass media campaign aimed at the community but rather it was aimed at stakeholders such as planners and other agencies.
- The other countries reported using a variety of slogans for the different physical activity programs. In Italy, several logos and slogans are in use such as "Guadagnare Salute, rendere facili le scelte sanitarie" (Gaining Health: making healthy choices easier) and "Diamoci una Mossa! in forma con il movimento" (Let's move! Fitness through physical activity).
- One country (Portugal) reported the use of the slogan 'Move Yourself' which was an old program previously delivered by the Portuguese Sports Institute; this was not a national communication campaign but was a slogan still used at the local level by some public administrations.
- Only two countries (Norway and Switzerland) reported engaging in the promotion and use of the 'Move for Health' day, a program led by Agita Mundo, a global initiative and tagline developed in 2004 for WHO World Health Day.

Discussion

Mass media campaigns aimed at raising awareness and education of the benefits of HEPA has a well-established evidence base.⁽³⁰⁾ Although they can be expensive if paid media is used, well developed campaigns can provide a clear and common branding to national efforts to promote HEPA and help to create a common identity.⁽³¹⁾ Moreover they can build links and the identity of relevant stakeholders within the topic of HEPA, particularly if they are involved in the development of a campaign.

Most countries reported some experience with national campaigns and, to date, these have mostly used traditional media channels. Campaigns were most frequently coordinated by the health sector and in some countries were combined with health messages on healthy eating. Some campaign taglines attempted to convey the required amount of activity by including '30 minutes' in the branding or aimed to provide a national message about the benefits of HEPA.

Three countries reported using common branding across national efforts. This has advantages of building campaign awareness, reinforcing the main messages and not confusing the public with multiple, different campaign messages. Portugal reported that an old message was still used at a local level. This is illustrative of good messages having a long shelf-life and, even when program funding finishes, branding is still used and recalled.

Only two countries reported active engagement in global branding of HEPA promotion and specifically the promotion of World Physical Activity Day and 'Agita Mundo'. This suggests there is an opportunity for greater promotion of this global initiative within European countries.

PAT Critique and Recommendations

Questions 21 and 22 on communication and branding were well completed by all countries and no changes to these items are required.

6. Evidence and Evaluation

Introduction

Using effective interventions and conducting appropriate evaluation around national programs aimed at promoting HEPA is deemed best practice. One question on the PAT (question 12) sought details on the extent to which scientific evidence is used to inform policy development, while two items (questions 14 and 22) asked for details of evaluation plans at the national level and the extent to which evaluation of HEPA interventions is conducted at a sub-national, or local level.

This section presents results on the following three issues:

- i.) To what extent have national policies been developed based on scientific evidence?
- ii.) To what extent do countries plan for evaluation of physical activity interventions?
- iii.) To what extent is evaluation of physical activity interventions undertaken at the sub-national and/or local level?

Results

i.) To what extent have national policies been developed based on scientific evidence?

Question 12 sought information on how well the described policies or actions reported in other sections of the PAT reflect the use of current scientific knowledge. Specific country responses can be found in each country report (Part 2).

Key findings:

- Overall, the responses revealed broad consensus that HEPA policies should be based on current scientific evidence. However, the extent to which this occurs in practice varied across the seven countries.
- The Netherlands reported an established process for developing evidence based policy. During the development of policy, the government and the NISB consult with relevant scientific organisations such as universities and research institutes to ensure that the relevant scientific evidence is taken into consideration.
- Portugal and Italy reported using scientific evidence in the development of HEPA strategies but no details were provided on the systems or processes involved.
- Switzerland reported several examples where scientific evidence had been used; this included in the development of the Youth and Sport Program, which reportedly took into account both national and international evidence.

- Finland indicated that the use of evidence to inform interventions varied considerably; some projects were evidence based whereas others were considered to be developed and delivered with very little consideration of scientific evidence.
- In Norway, a stated goal of the Action Plan on Physical Activity 2005-2009 was that all actions should be based on scientific evidence. However, the achievement of this objective has only been partially successful. One particular area reported to be neglected was the consideration of cost-effectiveness evidence.

ii.) To what extent do countries plan for evaluation of physical activity interventions?

One item on the PAT (question 14) requested details on whether countries had specific plans for the evaluation of policy implementation. The countries were asked to report on plans, provide a brief overview, and to state who is responsible for coordinating and/or undertaking the evaluation.

Key findings

- All countries reported that national actions aimed at HEPA were evaluated, however, the extent to which evaluation had been undertaken, who coordinated it, the methods used, and the extent to which the results had been used to inform policy varied considerably.
- Slovenia reported that the national HEPA policy included a specific strategy for evaluation which set out the goals for the strategy and indicated the agencies responsible for evaluation. In other countries, the plans for evaluation were not documented within the key policy documents but were reportedly conducted.
- In Switzerland, evaluation of major HEPA programs was considered to have been weak in the past, although there were reported future plans to evaluate national HEPA activities (including the National Program on Diet and Physical Activity, as well as the overall strategy of Health Promotion Switzerland).
- National evaluation activities was reported to be mostly coordinated by the Ministry (or Directorate) of Health (Norway, Portugal, Slovenia) or by a national institute with relevant expertise (Finland, Italy, Switzerland). In the Netherlands, responsibility for evaluation activities was divided between a national institute and an independent research institute.
- In Finland, evaluation activities were structured into three tiers: 1) national surveillance; 2) evaluation of the national 'health enhancement' program; and 3) project-specific evaluation. Every project is expected to incorporate an element of independent evaluation which is usually conducted by research institutes, universities, or private consultancy firms working in the field of HEPA.
- In Norway, an external evaluation of the National Physical Activity Action Plan had been commissioned which assessed the implementation and outcomes of 15 of the 108 measures stated in the plan.
- In Portugal it was reported that although many of the documents mention evaluation and the need to develop specific plans to monitor health indicators, this was not often translated

into practice. Notably, the National Health Plan does include the need to annually assess the prevalence of obesity but it does not include the evaluation of physical activity behaviour change.

- Evaluation methods mostly included use of postal surveys, web-based questionnaires, and interviews. Only Finland reported the inclusion of fitness testing.
- In most instances, the focus of evaluation efforts was on outcome evaluation. Only Switzerland, Norway and the Netherlands reported undertaking process evaluation. In the Netherlands, for example, the evaluation includes surveys undertaken with stakeholders and professionals working in the field of sports and physical activity as well as an evaluation of the use of communication materials and websites.
- Some countries did not report details of the evaluation methods used and the PAT item did not specifically request this information.

iii.) To what extent is evaluation of physical activity interventions undertaken at the sub-national and/or local level? (Q22)

Key findings

- Four countries (Finland, Norway, Portugal, Slovenia) reported that there was no systematic coordination of local level evaluation of HEPA interventions at the national level; in Switzerland this was foreseen only for one nationally funded program.
- Three countries (Finland, Norway, Switzerland) reported that some evaluation was carried out at a local level but due to the great diversity of both the interventions and evaluation activities it was not possible to provide details on which local schemes were evaluated, nor was it possible to summarise the types of evaluation activities being implemented.
- Two countries (Portugal and Slovenia) reported no evaluation of physical activity interventions at the sub-national and/or local level. However, in Portugal, there were plans to evaluate the implementation of the national program of walking and running which will include a component at the sub-national and local level.
- The Netherlands and Italy reported plans for the evaluation of local physical activity initiatives. In the Netherlands, there were plans to undertake both process and outcome evaluation of the activities undertaken by local governments.
- In Italy, local programs were required to conform to strict project management protocols, including evaluation protocols, in order to receive funding. Although there was variation in the evaluation activities conducted, this approach helped to ensure that evaluation was undertaken on all locally delivered programs. Evaluation results have been used to inform the allocation of funding to the regions.

Discussion

Overall the responses from this set of seven countries revealed that scientific evidence is used to inform policy and practice. This often involved partnership with academic institutes to help provide advice and interpretation. There was however a common view that most policy documents state this as desirable, but in practice, it was not always implemented.

Evaluation of national actions (such as large national programs) was frequently cited as being stated in the policy and program documents; and in most cases was planned or underway. Specific inclusion of the need to evaluate policy can help to demonstrate the importance placed on evaluation. Also it can ensure that clear roles and responsibilities for evaluation are allocated at the outset, and increase accountability for the evaluation to be conducted and reported.

Four countries reported no nationally coordinated, systematic evaluation of HEPA interventions at a local level. Thus, evaluation at the sub-national level was harder to report on due to the diversity of practice and accurate knowledge on what is in place. When evaluation was conducted at a local level, the focus was usually only on outcome evaluation. Few countries reported the inclusion of formative or process evaluation. Process evaluation is particularly important for understanding whether the policy was implemented as intended and can provide useful insight into why a program succeeded or failed. The neglect of process evaluation is an important limitation, particularly given the increasing focus on “how” to implement and “what works”. Increasing efforts through training and examples of best practice should be given priority.

Increasing the quantity and quality of program evaluation at the local level might be facilitated by the production of clear guidelines on appropriate evaluation methods and tools, and/or improved collaboration between program delivers and independent evaluation teams such as academics or research institutes. Funding for evaluation is also a major limiting factor. National policy may need to allocate and/or require co-investment to support implementation of evaluation plans both at national and local levels.

The extent to which evaluation results were used to inform future policy was only rarely mentioned. Two countries noted (under a different question) that national programs were discontinued without consideration of (positive) evaluation results. Using the best available evidence requires good dissemination of findings to those that can use it and influence decisions. Evidence translation is receiving much greater attention in Europe and elsewhere, yet the best ways to undertake translation are not yet well understood. Two factors that are likely to be very important are timeliness and simplicity. How to meet these needs is an area under great scrutiny in the research and practice communities.

PAT Critique and Recommendations

Question 12 sought information on how well the described policies or actions reflect current scientific knowledge of effectiveness. The responses to this question were mixed and in one case did not address the question. Specifically, one country reported on the links between physical activity and health and how epidemiological evidence was used to justify investment in HEPA promotion, however, no reference was made to the use of evidence on the effectiveness of interventions to inform strategies and programs. Some countries provided details of the systems and processes involved in the selection and design of interventions to ensure the latest scientific evidence is used. This information is interesting and may assist other countries in establishing stronger links between policy makers and the research community. However, provision of these details was not explicitly requested in the PAT items and thus not all countries provided this in their response.

Recommendation: Consider revising the wording of Question 12 to more clearly ask about different types of evidence and its use in informing activities and programs.

Recommendation: A new item should be added to capture details of the systems and processes in place for ensuring the latest scientific evidence is taken into account in the development of national policy.

Question 14 on the PAT asked whether countries had clear plans for evaluation of the policy implementation. A comprehensive response to this question would include whether the national policies and action plans include details of the planned evaluation activities, which agencies are identified for overseeing or conducting the evaluation, and what data collection methods are outlined. However for most countries, only some of this information was provided.

Recommendation: Further clarification needed on what to include in the response.

The PAT did not ask about the use of evaluation data for informing future policy development. Nevertheless, some countries reported interesting information on this topic, although this was usually in response to other questions and particularly the question on ‘greatest challenges’.

Recommendation: Information on the use of evaluation results to inform policy should be specifically sought under this question.

Question 22 attempted to capture details of the extent to which evaluation is undertaken at the sub-national and/or local level. This question was reportedly difficult to answer due to the large number of HEPA programs, wide variation in the extent to which evaluation is conducted, and the wide range of evaluation processes and methods which are used. In addition, some countries interpreted this question to be less about the actual evaluation which is undertaken and more about the extent to which local evaluation plans are described in national policy documents. In many cases, evaluation at the local level is decided, coordinated, and undertaken by regional or local agencies, and hence this is often not documented in national policies.

Recommendation: The introductory text to Question 22 should be revised to more clearly state its interest in understanding what evaluation activities are being implemented at a local level.

Recommendation: Consider adding a new question to capture examples of good practice in local level program evaluation This would be particularly helpful for countries which undertake a lot of local level evaluation activities which are too diverse and wide-spread to summarise in Question 22.

7. Successful program, Progress, and challenges

Introduction

Learning, from practical experience, about what has worked and what has not worked in different countries, is critical to advancing knowledge and success in the implementation of HEPA policy and programs. Three questions were included on the PAT to explore successes, progress, and challenges.

Question 21 requested details on up to three examples of interventions which had been successfully implemented following the development of physical activity policies and action plans, and up to three examples of less successful interventions. The results are summarised in Table 9.

Questions 26a and 26b requested up to three examples of areas where greatest progress in the HEPA actions had been made in recent years and up to three examples of issues which remain a challenge to address. Responses to these two questions often drew on examples of successful and less successful interventions (as reported for Question 21) but additional areas of development were identified by some countries. The results of these two items are summarised in Table 10.

Results

Key Findings: Successful interventions

- Development of HEPA policy was cited as a success in Italy, specifically this referred to the health policy 'Gaining Health' which included HEPA actions.
- National HEPA programs were cited among the most successful recent developments, these included: the 'Slovenia on the Move' program in Slovenia; the 'Fit for Life' program in Finland; a national walking and running program (Portugal); as well as running (Slovenia), cycling (Norway, Portugal, Slovenia), and school based programs (Finland, Norway, and Portugal).
- Finland reported a program success aimed at older adults, namely the 'Strength to Ageing' project which offers specialised supervised physical activity for the elderly.
- The Netherlands reported success in increasing membership in sports clubs among migrant youths.
- Other areas of identified success included: inclusion of objective measures of physical activity in a national survey (Norway); the establishment of a regional physical activity network (Italy); and the development of a training course for kindergarten professionals (the Netherlands).

Key findings: Less successful interventions

- Three countries reported challenges in trying to promote physical activity in specific settings including: healthcare (Finland); schools (Norway); and worksites (Slovenia).
- Two countries identified the absence of HEPA interventions aimed at specific target populations as an area of less success. For example in Finland, there had been no specific interventions aimed at immigrants or for the unemployed, despite both these populations being identified as a key priority. Similarly in Slovenia, pregnant women and the elderly were identified as groups who do not have equal access to physical activity opportunities.
- Two countries (Portugal and Switzerland) reported the abolition of successful programs and campaigns as areas of less success.
- Difficulties in establishing inter-sectoral collaborations, particularly with the infrastructure or spatial planning sectors were reported in two countries (the Netherlands, Norway).
- Maintaining interest and commitment from Government during a change in government was reported to be an area of less success in Italy; this issue was reported to be a major contributing factor to the failure of physical activity policy due to the change in priorities and the dis-investment in long-standing and successful interventions

Key Findings: Areas of greatest progress

- Three countries (Finland, the Netherlands, Slovenia) identified an increase in political commitment towards HEPA promotion as an area of progress. In Slovenia this was exemplified by the development of a national HEPA program, and in Finland stronger support was illustrated by an increase in funding.
- Switzerland reported the growing interest in HEPA from both the media and the public as an area of progress. Similarly in Portugal, several large scale events had been implemented to raise awareness of the importance of physical activity (including bike tours and mini-marathons) and these events were reported as major successes, engaging thousands of participants including public figures and politicians.
- The development of national HEPA recommendations was reported as one the greatest areas of progress in Switzerland.
- Three countries reported the development of stronger professional networks and collaboration (Finland, Italy, the Netherlands) and two countries (Slovenia and Switzerland) reported progress in creating stronger 'inter-sectoral working' and emphasised the benefits of working collaboratively across government departments and across different physical activity related sectors.
- Progress was reported in providing HEPA programs for specific population groups. In the Netherlands this progress related to engaging migrant youths in sport and in Norway this was through greater provision for people with disabilities.

Table 9 Successful and less interventions, successes and challenges, by country

Country	Examples of successful interventions	Examples of less successful intervention
Finland	<ol style="list-style-type: none"> 1. Strength to Aging projects 2. Sport Adventure around the World project (primary schools) 3. Fit for Life 	<ol style="list-style-type: none"> 1. Exercise prescription written by doctors and other health care persons 2. PA interventions to unemployed 3. Special PA interventions for immigrants
Italy	<ol style="list-style-type: none"> 1. The national Gaining Health program 2. The Physical Activity promotion Networks 3. New management system within the NHS 	<ol style="list-style-type: none"> 1. Termination of a database of PA programs 2. Discontinuation of the Platform Agreement between Health and Education Ministries
The Netherlands	<ol style="list-style-type: none"> 1. Lokaal actief (Local active): local action plan to promote physical activity and health 2. Program participation of migrant youth in sports 3. Training course for kindergartens professionals 	<ol style="list-style-type: none"> 1. Changes within organisations, professionals and target groups need time to become established 2. Intersectoral collaboration, especially with the spatial planning sector
Norway	<ol style="list-style-type: none"> 1. Bicycle initiatives in towns in the southern region 2. The project on physical activity and school meals in primary schools 3. Objective measurement of physical activity in all age groups 	<ol style="list-style-type: none"> 1. Up-skilling professionals in relevant sectors such as health and education 2. Maintenance of pedestrian paths and bicycle routes 3. More physical education in schools overall and the project on physical activity and school meals in secondary schools.
Portugal	<ol style="list-style-type: none"> 1. Cycling Murtosa/Ciclória. 2. National Program of Walking and Running 3. National School Sports Program 	<ol style="list-style-type: none"> 1. Termination of the “Mexa-se” national campaign
Slovenia	<ol style="list-style-type: none"> 1. Slovenia on the Move / Move for Health program 2. Slovenia Runs 3. Slovenia Cycle 	<ol style="list-style-type: none"> 1. PA interventions in the work environment 2. PA interventions among pregnant women and elderly 3. PA interventions among children and adolescent
Switzerland	<p>No particular national example successfully implemented as the consequence of a policy or action plan. Successful sub-national examples include:</p> <ol style="list-style-type: none"> 1. Development of programs on Nutrition and Physical Activity in cantons 2. Development of sport concepts of cantons funded by their own resources 3. Initiatives of several cantons in Youth and Sport Kids (since 2008). 	<ol style="list-style-type: none"> 1. Discontinuation of the Allez Hop program at the national level. 2. Failure to reach objectives in local sport networks 3. Discontinuation of HPM (physically active transport) activities at Federal Office of Sport.

- Norway reported increased awareness of the importance of physical activity in schools, while in Switzerland one of the greatest areas of progress was the expansion of the youth and sport program.
- Three countries reported advances in national surveillance on HEPA; Italy reported the recently created national surveillance system, while both Portugal and Norway reported the completion of national HEPA surveys which would hopefully serve as the basis for establishing national surveillance systems.
- Norway also reported the development of objective measurement of HEPA using accelerometry as an area of major progress.

Key findings: Remaining challenges

- Interestingly, areas of greatest progress for some countries were reported as remaining challenges for others. For example, Finland reported that an area of progress was gradually increasing funding for HEPA, while other countries reported a range of challenges in regards to funding. Portugal reported a lack of funding for HEPA, Norway reported a lack of consensus on the allocation of funds for HEPA, and Switzerland reported the need for better mechanisms, including funding and structures, for the promotion of HEPA.
- In Slovenia, the same issue was identified as both an area of progress and a remaining challenge; specifically although the improved inter-sectoral partnerships was representative of progress, ongoing management and coordination of these partnerships was reported as a challenge.
- Switzerland also reported progress in developing partnerships with other sectors but the assignment of clear roles and responsibilities was an ongoing challenge.
- Surveillance was identified as an area where further development is needed in two countries. Finland reported a desire to integrate objective measurement into the national surveillance system and Switzerland reported the expansion of the national surveillance system to include all age groups as a challenge.
- Program evaluation was identified as a challenge in two countries (Portugal, Slovenia) as was the need for more professional development in the area of physical activity (Norway).
- Implementing HEPA actions at the local level was identified by two countries (Finland, Italy) and ensuring equity in physical activity provision for low socio-economic groups was identified in the Netherlands.
- The challenge of maintaining consistency in the delivery of HEPA interventions during times of political change was reported in Slovenia.

Table 10 Summary of Identified Areas of Progress and Challenge, by Country

	Finland	Italy	The Netherlands	Norway	Portugal	Slovenia	Switzerland
Political commitment	Progress <i>Strong political commitment</i>		Progress <i>Health and PA has gained more attention in the last 10 years</i>			Challenge <i>Maintaining consistency in PA activities in times of political change</i>	
Funding	Progress <i>Gradually increasing funding</i>			Challenge <i>Difficult to achieve consensus on allocation of funds for PA</i>	Challenge <i>Lack of funding for PA initiatives</i>		Challenge <i>Better mechanisms (funding, structures) needed for supporting action and change</i>
National PA program		Progress <i>Development of a preventive approach</i> Challenge <i>Lack of a national sport strategy</i>			Progress <i>The inclusion of a PA indicator in the national health programs</i>	Progress <i>The development and adoption of a national HEPA program</i>	
Specific groups/ programs			Progress <i>Participation of migrant youths in sport</i> Challenge <i>Low socio-economic groups</i>	Progress <i>Improved provision for people with disabilities</i> <i>Increased awareness of the importance of PA in schools</i>			Progress <i>Extension of the Youth and Sport Program to 5 to 10 year olds in 2008</i>
Establishing / improving surveillance system	Challenge <i>Objective measurement at the population level</i>	Progress <i>The development of a systematic surveillance system</i>		Progress <i>Objective measurement of PA in children, young people, adults and older adults</i>	Progress <i>Completion of the first population prevalence study</i>		Challenge <i>PA monitoring system for all age groups</i>
Program evaluation					Challenge <i>Monitoring and</i>	Challenge <i>Monitoring and</i>	

Results – Part B – Cross-country comparison

	Finland	Italy	The Netherlands	Norway	Portugal	Slovenia	Switzerland
					<i>evaluation of the impact of the national HEPA program</i>	<i>evaluation of the impact of the national HEPA program</i>	
Networks and collaborations	<p>Progress <i>Strengthening of the HEPA network</i></p> <p>Challenge <i>Diversity in how PA is managed at a local level</i></p>	<p>Progress <i>Cultural revolution in network and project management</i></p> <p>Challenges <i>Lack of coordination and collaboration between institutions</i> <i>Differences between north + south in access to services</i></p>	<p>Progress <i>More networks and collaboration between health, sport, schools etc</i></p>				
Inter-sectoral partnerships			<p>Challenge <i>Inter-sectoral collaboration + relations with special planning</i></p>	<p>Challenge <i>Superior urban planning would make PA promotion easier</i></p>	<p>Challenge <i>Lack of inter-sectoral coordination</i></p>	<p>Progress <i>Establishment of an inter-sectoral working group for the implementation of the HEPA plan</i></p> <p>Challenge <i>Managing and coordinating interdisciplinary partners</i></p>	<p>Progress <i>Growing involvement and number of actions by other sectors</i></p> <p>Challenge <i>Clear roles and responsibilities</i></p>
Increased interest in PA among the public and media					<p>Progress <i>Large-scale events (i.e. bike tours and mini marathons) to raise awareness of the importance of PA</i></p>		<p>Progress <i>Growing interest in PA among the public and the media</i></p>
Other				<p>Challenge <i>More professional development in PA is needed</i></p>			<p>Progress <i>Consensus on PA recommendations</i></p>

Discussion

As earlier sections of this report have shown, the policy context for HEPA promotion differed across these seven countries, no doubt reflecting the different stages of HEPA development as a priority issue, different levels of resources, different cultural approaches to health and HEPA promotion, and differences in leadership. Consequently, each country identified different issues when asked about their experiences and specifically examples of: success; failures; progress; and challenges. There was no common issue reported all seven countries, but collectively the themes included: political commitment; funding; partnerships; surveillance; evaluation; implementation of programs in different settings and for different sub population groups; professional networks; and training. In some countries the same issue was both an area of success or progress, as well as a remaining key area of challenge.

Many countries identified specific programs (i.e. interventions) as representative of success in their national approach to HEPA. These included implementation of national initiatives as well as examples of sub-national programs. The development of nationally coordinated programs is a major undertaking and there is considerable interest in learning about the coordination, partnerships, and effectiveness of such programmes. Across this set of countries there are examples of school based programs as well as community based national programs and, in some cases, the program was reported to be a major milestone as the first national action aimed at promoting HEPA. In other countries the selected program demonstrated the continuous investment in a successful HEPA initiative.

Developing and implementing programs in specific settings and those aimed at specific priority sub-populations were reported to be areas of less success by some countries. Notably, addressing low income groups, the health care setting, the workplace and the school setting were mentioned. Each of these areas has been identified as important for HEPA promotion in many leading international documents. Moreover, to some extent there is already a significant number of resources on best practice and how to implement effective HEPA programs within these contexts. Nonetheless, given these areas were identified as challenges, it is likely that further dissemination and sharing of 'how to' is needed in these areas. It is notable that some countries reported progress with HEPA promotion in selected populations and their success and experience should also be shared as widely as possible.

National policy and programs will only be effective if they are disseminated and implemented at the local level. This was an identified challenge by at least one country. Adoption of new actions at the local level requires leadership, support, and funding, as well as adequately trained professionals. As HEPA promotion is still relatively new in several of the countries participating in this project, it is likely that more support is needed to develop implementation at the local level, and in all countries efforts to sustain and reward local level action should be endorsed.

Political commitment is an essential components and necessary to secure resources. Several countries reported an increase in commitment as a success whilst others noted this to be an ongoing challenge. Slovenia noted this particularly but it is likely to be a common concern across all countries and at all levels of government. The short-term nature of government agendas and the disruption that can follow changes in administration can have a major impact on the investment and direction

of HEPA promotion. This can affect both the scale and scope of HEPA action and countries reported the disinvestment in actions following a change in government as well as the non-renewal of policy strategy documents.

It is necessary to establish long-term and cross-government political commitment for HEPA initiatives and ideally beyond the timeframe of a single administrative term. The observations from this project also underline the need to establish HEPA promotion and HEPA related policy more firmly within a government's policy portfolio to prevent its abolition when government priorities change. One way to achieve this can be the development of longer term goals and longer time frames for implementation and review.

The development of national guidelines and targets and the ongoing surveillance and monitoring of HEPA are key components to national action. They are also useful in providing the opportunity to hold governments accountable for their investment and priority towards HEPA. Several countries reported success in the area of population surveillance on HEPA and for one country this included the integration of objective measures in addition to the more standard use of self-report surveys. However, this was also an area where challenges remain. This is perhaps due to the complexity and cost associated with population surveillance as well as the need for practical and feasible instruments. Several countries reported the challenge of extending surveillance to other age groups, notably children, and this is a particular age group where objective measures and more complex sampling methods are required.

Progress with raising awareness among the public and media on HEPA, was reported by two countries, one of them using large scale events as another approach to engaging people in PA.

There is much written about the need for stronger partnerships and cross sector collaboration to develop and implement HEPA related policy and actions. These issues were cited as challenges by several countries, and particularly establishing and maintaining collaborations with non-traditional sectors for the HEPA related agenda by those in the health sector, such as with spatial planning and transport. Links and programs with the sports and education sectors were reported, and often used as examples of success and progress. However, in most countries maintaining effective collaborations was seen to be an area where much more is needed. It is an area where the experiences and examples from others can be useful; this can show how to go about building partners with those sectors who may not have any initial interest in HEPA, and how to sustain effective working relations. There was very little mention of the agenda of 'health-in-all-policies' but this approach is likely to be an important development in the short and mid-term future.

Successful partnerships can also provide opportunities for stronger lobbying and advocacy actions as well as potentially open up a wider number of funding sources for physical activity. In many countries there remains significant opportunity to increase the HEPA related work with other sectors, and with transport and urban planning in particular, to ensure HEPA is considered in every related policy area. The dissemination of successful partnership work on HEPA should be encouraged and supported.

Two other elements were noted as challenges and these were in the areas of evaluation and professional development. There is a need to improve the levels and scope of evaluation activities on HEPA actions in order to demonstrate the impact and learn from the investments. There is likely

to be a need for more guidance on how to approach and undertake evaluation of large-scale national and sub national interventions in ways that are practical and feasible. This is different to undertaking research where there is usually greater capacity for data collection and analysis. There is however, in many countries, a growing field of interested academics and practitioners and collaboration is required to implement good evaluation plans in the field. There also needs to be better communication of the findings from evaluation to multiple audiences including policy makers. Finally, there is also a need to consider incorporating outcome measures, other than health metrics, that might be of interest and required by other sectors. This will allow the impacts and benefits on not only health, but also the co-benefits and can help leverage inter-sectoral support.

The need for more professional development/ capacity building was mentioned in only one country as a challenge. In other countries the development of stronger professional networks was reported as an area of recent success. The role of national and regional HEPA networks is becoming better recognised and the development of national forums to help share information and develop the HEPA professional field should be encouraged. In several other regions, and within specific countries, there has been the development of national courses in HEPA for both researchers and practitioners. These courses are now available and transferable to other countries and regions. In addition to specific courses in HEPA there is a need to look for opportunities to develop and integrate HEPA related content into the professional training of other fields such as teacher training, medical training, allied medical professional training, and in transport and urban planning.

PAT Critique and Recommendations

Questions 21 and 26 were concerned with successes and challenges. Question 21 asked for up to three examples of interventions which had been successfully implemented following the development of physical activity policies and action plans, and up to three examples of less successful interventions. Question 26 asked about the areas of greatest progress and remaining challenges within a country. Although question 21 sought details of specific programs or interventions and question 26 was concerned with broader (non-program specific) issues, there was overlap in the responses provided to these two questions.

Recommendation: Consider revising the terminology used in question 21 to emphasise a stronger focus on programs.

Recommendation: Consider adding some additional text in the introduction to question 26 to emphasise the focus on the broader (non-program specific) issues within a country.

DISCUSSION

This project set out to learn about national policy efforts on physical activity from seven European countries recruited through the HEPA Europe Physical Activity Network. Participating countries were: Finland; Italy; the Netherlands; Norway; Portugal; Slovenia; and Switzerland. Representatives from each country volunteered to engage in a review of their national policy framework and reflect on progress and challenges. Although small in number, these countries represent diverse contexts in which to explore the progress and challenges in national action on physical activity. Specifically, they are diverse in terms of geographical location across Europe as well as the duration and extent of interest and national actions on physical activity. For example, Finland is well known to have a long history in exercise science and national action aimed at promoting physical activity whilst in contrast Slovenia, Italy and Portugal have a much more recent interest. These seven countries are also diverse in terms of their current estimates of the prevalence of physical inactivity.

The following discussion provides a summary of the findings across the key themes and identifies the areas of progress and challenges. In addition, we discuss the implications of these findings for future policy development and implementation.

The findings show that all seven countries had at least some national policy documents outlining an agenda relevant to the broad promotion of physical activity. Some countries had a large number of policies across multiple sectors while other countries had a more defined national framework. Five of the seven countries reported having a specific physical activity policy. In three of these countries it was a stand-alone policy solely focussed on physical activity (Finland, Norway, Slovenia) and in the other two countries the policy document on physical activity was combined with sport and education (in the Netherlands) or with healthy diet (in Switzerland). The development of a stand-alone policy on physical activity was an approach promoted in the early 2000's and called for in the WHO Global Strategy on Diet, Physical Activity and Health in 2004.⁽³²⁾ Countries that had developed a stand-alone policy reported this as an indicator of considerable progress in the development of the public health agenda for physical activity. More specifically, the development of a specific policy was seen as an indication of increasing government support for physical activity promotion. However, stand-alone policies were not evident across all countries and this may be for several reasons. Establishing a stand-alone physical activity policy requires the confluence of several factors including: a supportive minister or high level politician who recognises physical activity as an important issue and who believes that developing a stand-alone policy will be the most effective approach to physical activity promotion; a dedicated physical activity team within the government structure to lead and support the policy process; links with stakeholders and other experts in the field to assist in the policy development process; and adequate financial resourcing and time allocation for the development of the policy. Aligning these factors is a challenge and is likely to explain why establishing policy in some countries has been slow and difficult and in other countries has not started at all.

Developments at a global level, and certainly the recent direction set by the WHO, may be shifting away from single risk factor policies and towards the development of overarching national policy addressing multiple risk factors within a broader NCD treatment and prevention action plan.⁽¹⁰⁾ This direction was initiated as part of the developments post the 2011 United Nations High Level Meeting

on NCD Prevention (4) and is outlined in the WHO Global Action Plan (GAP) 2013-2020 (10). The approach calls for national policy and supporting action plans to articulate the specific actions required to address each of the four common risk factors, as identified in GAP, and this includes physical activity. Although this multi-risk factor approach has some advantages, there is also an element of risk. An intended or unintended outcome might be that more focus is given to some risk factors than others. This might favor those risk factors for which there is existing capacity or stronger advocacy such as tobacco control or unhealthy diets, and result in insufficient focus on physical inactivity. This has been witnessed in some countries in relation to Governments' response to the agenda around obesity prevention. For example, in some cases the policies and action plans have directed considerably more focus on healthy eating and dietary related interventions than on physical activity. To ensure that broader NCD prevention policies contain a robust action plan for physical activity requires vigilance by those directly involved in policy making, as well as advocacy by those who can influence and inform the policy process. The sharing and promotion of good examples of comprehensive NCD action plans between countries would be beneficial. Also, global advocacy efforts and support for countries embarking on this process should be increased to support countries alignment and response to the WHO NCD prevention agenda.

One very encouraging finding from this project is the breadth of relevant actions within policies outside of the health, education and sport sectors. This included policies in the transport and environment sectors and for some countries links were found to physical activity within policy documents addressing national development and tourism. The need for a whole of government approach to address population levels of physical activity requires a strong framework for multi sector actions and a 'joined-up' systems approach. The findings from these countries provide good examples of this happening and they should be used to show other countries examples of what is possible. More examples from other countries would, of course, develop a large repository of exemplars and should be encouraged.

An expansion to the initial scope of this project was the adding of a list of legislation relevant to physical activity. Legislation is the most formal and legally binding instrument of government, and forging direct and indirect links between physical activity and legislation can have several advantages. These links can help raise the level of importance afforded to physical activity within the political agenda and potentially leverage human and financial resources. Requirements outlined in legislation also enhance the need for accountability and action. The inclusion of a summary of legislation by each country developed during the early stages of the project as a result of the interest generated by examples from one or two countries. As a consequence, all countries reviewed, as best they could, their legislative framework to identify linkages to the physical activity agenda.

All seven countries reported having at least some relevant legislation. The most frequently reported sector with relevant legislation was education, with all countries reporting legislation specifying requirements for physical education within the national curriculum. This is perhaps not surprising given that efforts in this area have a long history, and particularly the strong physical education movements of the 1940s and 1950s. Examples of legislation were also frequently reported from within the health sector and linked to the requirements (either stated very generally or sometimes very specifically) to promote health and prevent disease. There were examples of legislation within the transport sector, often these stated requirements for non-motorized transport and/or other

criteria for mobility and carbon emissions and/or road safety. In the environment sector there were examples of laws specifying requirements for access to open space.

Three countries in particular (Finland, the Netherlands and Switzerland) reported a substantial number of legally binding documents with relevance to physical activity. This may reflect a longer history of political interest in HEPA within these countries, for example Finland has at least twenty years of interest and policy action on HEPA related activity. Another similarity of these countries is their historically strong reputation of scientific institutes and leadership in the field of sports science and exercise physiology. They are also examples of countries within Europe at the forefront of linking physical activity with public health. By way of contrast, Slovenia, Portugal, and Italy are three countries that have more recently commenced developing capacity around physical activity. Slovenia established independence in the early 1990s and over the past two decades has been very productive in developing a large range of legislation and policy documents, many with relevance to physical activity. Italy also has a large number of policies although HEPA is a much more recent issue. However, it is too early to assess the impact of many of these policies in these countries due to the relatively short time period. It is also important to note that the *number* of policies is not a good measure of quality and scope, and certainly not a measure of effectiveness.

One particular aspect of interest was the extent to which the existing policies within and between different sectors cross referenced each other and how consistent they were to each other. We found evidence within some of the countries of cross-referencing between different policy documents particularly, and most frequently, between policy documents in the sports and health areas. There was also some evidence of cross referencing between policy documents in transport and the promotion of physical activity. Examples of this were observed through the links between pedestrian mobility and road safety. This alignment of policy between HEPA and the transport sector is encouraging and both illustrates why an inter-sectoral approach is needed to promote different modes of physical activity and is a reminder of the considerable opportunity within this nexus of planning and transport to leverage programs and resources. Aligning these policy agendas can accentuate the co benefits of a physically active community which include reduced congestion and pollution, cleaner more efficient transport systems, and environmental sustainability. These opportunities and examples of complimentary policy still need to be promoted and receive stronger endorsement.

The need to have strong leadership to initiate and guide any change process is well recognized and this is true for public health policy development and implementation of actions on physical activity. There is however a risk that because physical activity has so many potential links across different ministries and sectors, it can 'fall between the cracks' unless there is capable leadership of the agenda across the government portfolios. We found that in this set of seven countries, the Ministry of Health was usually the sole or dominant lead agency for developing policy on physical activity, whereas the Ministries of Sport were the lead agency for sports related policies and actions.

Good leadership and coordination is necessary to organize and support effective planning, dissemination and implementation of national policy at the regional and the local level. Interestingly, although our study found that all seven countries had recommendations on the need for coordination (and partnerships), few countries had any specific guidance or formal structures in

place to provide support. Two countries had established a formal senior government level mechanism providing oversight, direction and accountability to the implementation of physical activity related policy and actions. Finland has had a national committee comprising representatives from multiple ministries as well as non-government sector and the academic sector, which has been in existence for two or three iterations of their national policy agenda for physical activity. Norway also reported that they established a cross government coordinating committee to guide and support their national policy and action plan. As cross-government leadership and partnership is frequently recommended in this field, there is great interest in the mechanisms and structures that bring together and sustain effective leadership. Many countries wish to learn from other countries' experiences and the examples and experiences of success should be shared more frequently in the literature and through professional networks.

The diffusion of national policy and implementation at sub national levels is of increasing importance as many democratic countries delegate responsibility to the regional and local levels of government. Many countries require sub national jurisdictions (such as regional area and local authorities) to develop their own policy and local implementation plans, an example is the need for local government to develop their own public health plans. A requirement is for these local plans to be coherent with the national policy. Adherence to this and coherence between different local plans is emerging as an important issue. For example in Finland, the local level has independence and responsibility for every action which is not required by Law. The towns and rural districts (approximately 2000+ populations) are required to develop their own Health Enhancement Strategies and this includes plans for physical activity. Although these strategies may follow the main principles exposed in the national documents, it was reported that there was great variability in the implementation between towns and districts because of the degree of autonomy they have from any overarching national implementation.

One barrier to effective implementation of best practice at the sub national level may be insufficient expertise and knowledge on physical activity in the local workforce. This could be addressed through the provision of appropriate resources and tools suitable for the variety of stakeholders across different sectors that can directly and indirectly support the development, tailoring and implementation of local actions on physical activity. Provision of training and support is another major issue. The findings of this study showed a number of different models in place. In the Netherlands, the Netherlands Institute for Sport and Physical Activity (NISB), a government funded agency, provides these functions. As an agency dedicated to developing local implementation, they gain knowledge and experience and can share this between local jurisdictions. Moreover, they can dedicate staff to these tasks to ensure they are completed and there is a follow up and support for stakeholders. Universities can often play an important role in providing training and resource development, and partnerships with interested academics can bring added benefits in terms of access to the latest scientific evidence, good teaching and training skills, as well as interest in ongoing research and evaluation.

Several reviews of the successful components of a national approach to promoting physical activity have identified some core elements and the PAT sought to identify the presence and progress of these components in the participating countries. The presence of nationally endorsed physical activity guidelines (or recommendations as they are sometimes called) is one important component

of national action on physical activity. Guidelines provide a consensus position on the amount of physical activity needed for the prevention of NCDs and they provide the foundation and direction for planning interventions and national communications to the wider community. National guidelines should also inform the setting of national goals and strategic objectives as well as provide the benchmark for the evaluation of progress in increasing population levels of participation.

Six of the seven countries reported that they had national recommendations on physical activity. On inspection, these were broadly similar across countries and in general were consistent with the international agreed evidence. An important development during the course of this project was the launch of the first WHO Global Recommendations on Physical Activity in 2010. However, due to the release being during the project it was not possible to assess the impact within these countries. It is likely that countries without national guidelines will adopt the new WHO global recommendations and this is highly desirable as it avoids duplication of the enormous effort and resources which are required by the rigorous scientific consensus process.

Identifying specific, measurable goals or targets for physical activity is another recognised core component of a national policy and necessary to provide a level of accountability. All seven countries indicated the ambition to increase the proportion of the population meeting recommended physical activity levels. Mostly, the timeframes for achievement were similar and typically stated a 5 or 10 year period. However, the magnitude of change expected (or desired) differed and not all countries stated a quantifiable target. For example, two countries had only statements of broad intent to “increase” physical activity levels. Yet, without specifying a magnitude of change and a time-frame for achievement, these countries are unable to evaluate the success or failure of their national policy and actions against a set target. In contrast, other countries stated very specific targets such as *“to increase the proportion of young people (4-17 years) that meet recommended physical activity levels from 40% in 2005 to 50% by 2012”* as seen in the Netherlands and *“to stabilise and then increase by 1% per year the proportion of physically active people”* as seen in Switzerland. In one country (Portugal), very specific targets were set for different age categories (for example 15-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, 65-74 years) and separate targets were set for males and females. Targets can also be tailored to specific segments of the population based on current levels of physical activity, sometimes seen as the ‘high risk’ approach. For example, several countries had national targets directly targeting the least active segment of the population. It is well recognised that the greatest gains in public health will be achieved by moving the most inactive segments of the population into doing at least some physical activity, therefore setting targets for the most inactive, as well as targets for the whole population, are important considerations for policy goals.

Although the science on the health risks of sedentary behaviour is a relatively new and discrete area of focus, three of the seven countries reported specific goals for reducing sedentary behaviour. Interestingly, Portugal stated all of its HEPA targets in terms of reducing sedentary time rather than increasing time spent being physically active. As the scientific evidence base on sedentary behaviours increases, it is likely that goals on reducing time spent in sedentary activities will become a core component of a comprehensive approach to promoting an active population.

In addition to targets on the prevalence of physical activity, some countries reported goals on other indicators which are related to HEPA. These other goals were in sectors outside of health, such as in sport, education, transport, and environment. Examples included: a requirement for every household to have 75m² of green space (the Netherlands); for 3% of residential areas to be allocated to a playground (the Netherlands); for the proportion of cycling trips to increase from 5% to 8% by 2019 (Norway); and for the knowledge of the benefits of HEPA to be increased among health professionals (Finland). The presence of these targets in other sectors is a very useful mechanism to engage other sectors and ensure their contribution to the national agenda on physical activity and the over-arching target for increasing physical activity levels.

A national surveillance system which includes a measure of physical activity is a necessary requirement for tracking the prevalence of physical activity and progress towards set goals and targets. The specific metrics used in a surveillance system must align with the national physical activity recommendations. Inconsistency between what is measured, what is reported and the stated goals for physical activity have frequently been found in countries around the world. It is also necessary for data to be collected, analysed, and reported in a timely way to support policy and practice. This may be annually or biannually, and as such allow for the evaluation of progress and inform future investments and areas of need. Alignment between the time scales of the surveillance and the timescales of the policy will assist in evaluating the effectiveness of national policies. In these seven countries, five countries reported having an established surveillance system, and in each of these countries this surveillance system was formed after conducting several surveys. Timelines ranged from continual data collection with annual reporting (PASSI, Italy) to a survey which is conducted and reported on a five year cycle (Swiss Health Survey).

Although some countries have a long history of physical activity surveillance, for example Finland, in other countries this is a very recent development. Norway reflects a country that rapidly responded to the physical activity agenda in mid-2000's developing their 2009-2012 national policy on physical activity and indicated the intention to develop a surveillance system. A single point-in-time survey was conducted and it was envisaged that this would form the basis of an ongoing surveillance system. However, as is too often the case, the mechanisms were not put in place and no further national surveys have been completed. A similar situation occurred in Portugal where one national survey was completed but no firm commitment to regular monitoring of physical activity was achieved.

For countries with no surveillance system on physical activity, the first step is often to conduct a national physical activity survey or, in some situations, efforts are directed at adding physical activity to an existing system. Establishing ongoing surveillance requires government support and resources and a long-term commitment to regular data collection and reporting. The value of these data is well recognised as this provides important information on trends in physical activity which can be a powerful advocacy tool. One of the largest sustained monitoring systems is the BRFSS in the USA, which collects data on physical activity prevalence, by state, and can show changing trends in this behaviour over the past 25 years.

Rapid developments are taking place in the use of objective measures of physical activity in national surveillance systems. In this study, Finland reported the inclusion of objective measurements in their

surveillance system and Norway and Portugal reported use of these devices in recent national surveys. Although there is great interest in the more accurate measurement of physical activity, for many countries this type of advanced data collection method is neither feasible nor affordable. For resource-constrained countries the use of self-report survey tools will remain the practical alternative, at least in the short-term.

Another recognised core component of national action is the use of mass communication campaigns. Community wide campaigns can be used to raise awareness of the benefits of active living and educate people on the amount of activity necessary to benefit health. Campaigns can be a motivational tool to prompt behaviour change as well as promote opportunities. Well executed and sustained communication campaigns have been shown to achieve changes in knowledge and awareness as well as behaviour change. The use of a common 'branding' or 'logo' can unify a national communication strategy on physical activity. The use of common 'branding' can enhance public recognition and add consistency and synergy to the suite of communications and related programs, materials or events. Our findings revealed that all countries had a history of some mass media or large scale communication campaigns but, in general, the promotion and marketing tended to be directly linked to specific physical activity programs or initiatives and not an overarching or 'unifying' campaign concept. For example, Finland reported that there were many different providers and stakeholders promoting HEPA related activities and each had their own communication campaigns. Consequently a large range of slogans were in use which may have the unintended consequence of confusing the community and it certainly misses the opportunity to have synergy and cross promotion. Two countries (the Netherlands and Norway) reported the use of an overarching slogan. In the Netherlands, the *"30 minutes moving"* message is used consistently across all interventions, while in Norway they use the slogan *"Better health in 1-2-30"*.

Establishing a common branding and implementing a sustained communication campaign requires the confluence of political support, policy, budget, and capacity. There are only a few examples of large scale communication campaigns within the physical activity field which have been sustained over a long period of time. One example is ParticipACTION in Canada, which is the longest running mass media campaign with a 30 year history. There are other examples such as Active Australia, Change4Life in England, and in developing countries Agita Sao Paulo in Brazil which has also be adopted and modified in other South American countries very successfully.

An important recent development is the recommendation of mass media campaigns as one of the "best buys" by the WHO and the inclusion of this approach in the WHO Global Action Plan.(10) It is therefore important to understand why countries are not adopting and implementing mass communication strategies and what support is required to facilitate their development. It is possible that some countries are unaware of the benefits of communication campaigns and their potential for encouraging and supporting behavior change. However, it is well noted in the literature, that achieving behavior change requires a sustained media campaign and strong integration with other strategies. There is strong evidence to show that unless these features are planned and supported, the impact of media campaigns on behavior change can be limited to short term and modest magnitude. More advocacy efforts and the development of tools, training, and resources to support countries in the implementation of campaigns may also be needed. Another limitation to the implementation of community wide campaigns is the cost and, in the current prevailing economic

context, with limited resources being available for PA, this is a significant barrier. Nonetheless, there is potential to partner with other stakeholders, both non-government, civil society, and the private sector to source funding and sponsorship. There are many examples of this already underway but it is also highly controversial depending on the partner organisations. The debate regarding the merits of collaborating with private industries is ongoing and the prospect of any consensus in the short term is unclear.

Using the best available evidence to inform policy is frequently cited amongst both the academic and policy-making communities. All seven countries reported endorsement of the need to use evidence to inform policy and that this was included in many of the policy documents. However, all countries acknowledged that actually getting evidence-informed actions into policy, and then practice, was a challenge. This was also reported to be the case for securing any evaluation of policy implementation. Although most countries reported strong recognition of the need to evaluate policy, any evidence of evaluation activities was generally weak. There was only one example (Norway) where an external and independent evaluation of national policy had been implemented. In most of the other countries evaluation was more common at the specific program level. Even then it was often patchy and in some countries no evaluation was undertaken at all. The statement of intent to evaluate a national program, for example the 'Mexa-se' in Portugal did not always lead to the evaluation taking place in practice. This gap between stated actions and actual practice can be due to a lack of leadership, resourcing, skills, and any mechanism to hold those responsible for action accountable.

Evaluation at the sub-national level was also well recognized and in most countries was reported to be underway to some degree. However, capturing examples or details of this as part of the project was more difficult due to the diversity of programs and type of evaluation. It was therefore difficult to assess the extent of evaluation at the sub-national levels. The barriers identified reinforce the need for a skilled workforce and for collaboration with those with evaluation expertise. It was noted that most of the evaluation activities focused on outcome evaluation with very little emphasis on process evaluation. Process evaluation has the potential to inform how to implement and deliver successful programs and which components of a program lead to successful outcomes. Process evaluation needs to become a much stronger focus for future evaluation efforts and the development of training packages and sharing of examples of best practice in this area are two approaches to facilitate this. Again the role of agencies outside of national government to support these tasks is clear. In Finland the UKK Institute has provided leadership in training and resources as well as partnered to support undertaking the evaluation. In Italy, programs and other initiatives are required to conform to strict evaluation protocols in order to receive funding. Although these evaluation activities are not standardized because of the diversity of programs, the link to funding ensures that all programs are evaluated. Other countries may encourage funding agencies to adopt similar requirements for evaluation as a strategy to achieving more consistent and well-conducted program and policy evaluation.

The picture from at least these seven countries is that the use of evidence and the evaluation of national policy overall is quite patchy. It is therefore clear that the links between research, policy, and practice still need to be improved. This 'translation gap' is well recognized across much of public health and even science in general. Ensuring that evidence on effective practice in the

promotion of physical activity is used to inform policy and implementation has traditionally relied on the academic community to communicate and share their findings. Academics have often been a strong lobbying voice. However, it is widely recognised that this is not enough and the prevailing methods and processes are not effective. Attention is now focused on how we should collectively work in different ways to improve translation and reduce the time it takes for evidence to be available and put to use. The academic community will still play an important role and those countries that do not have a strong academic field in physical activity and health may be at a disadvantage. However the role of national and regional professional networks can provide an important contribution in this area. Local and regional networks that link those working on physical activity together provide the mechanism for learning and sharing of information, examples, and experience. The task of establishing and maintaining such networks is not insignificant and they themselves require leadership and resourcing. Again partnership with non-government, civil society, and the private sector is possible where shared interests can be aligned.

Bringing together all the key components of a national policy framework directed toward increasing population levels of physical activity is not simple. For some time physical activity has been the 'Cinderella' of risk factors – widely recognized and largely ignored. The UN political declaration and WHO GAP provide a strong endorsement of the importance of physical activity. However, changing population levels of activity will require a whole systems approach. Physical activity can be promoted and supported through many different settings and therefore a large number of stakeholders can be engaged. Although considerable progress has been made since the statement by Morris that *“physical activity is the best buy in public health”* there is still a very long way to go. It is estimated that less than one quarter of all countries have any national policy or action plan addressing physical inactivity. Moreover, many of those countries with policies struggle to secure the necessary resources and level of implementation to achieve the desired success. This project aimed to review progress in a set of European countries to identify both where progress has been made and where support is still needed. Much can be learned by this in-depth analysis of advanced countries and the cross country comparison highlights both similarities and the differences. It is the latter that can stimulate new ideas and opportunities in other countries.

This study aimed to assess the depth and breadth of national policy on physical activity and forge new understanding in an expanding area of public health policy. Undertaking policy research and analysis is critical if we are to improve the policy context of physical activity promotion and understand the key factors which have facilitated or hindered national policy development in this area. Furthermore, the findings can inform future policy strategies and galvanise greater political support for this important public health agenda.

Other studies have shared experiences from individual countries and have used a range of approaches to data collection and analysis. However, until recently there has been no instrument suitable for systematically capturing relevant information on national HEPA policies in a standard format. The Policy Audit Tool was developed to fill this gap and provides a standard methodology for data collection across key areas: an overview of the government structure within the country; the presence of relevant policy and legislation; policy content; and progress with policy implementation at the national and sub national levels. This study reports the first use of PAT in a cross country comparison project with seven participating countries.

A key learning from this study was on the amount of time required to complete the PAT process. Completion took, on average, between 6 and 9 months (once started) and required gathering information from a wide range of sources and ideally in consultation with relevant stakeholders across multiple sectors. The engagement of both government departments and other non-government agencies was desirable to gain access to essential information and insights from different perspectives. Wide consultation increased the accuracy and depth of the policy appraisal information received. Furthermore, the use of an iterative process was found to be most effective. That is, a semi completed PAT was prepared and circulated for contributions and feedback. Several rounds of feedback was found to be necessary to ensure all contributions were shared with the relevant stakeholders and that consensus was reached on the content of the PAT.

Although completing the PAT took more time than originally expected, the process had several advantages for the participating countries. Firstly, it provided a catalyst for greater communication between relevant government departments and also between other stakeholders involved in HEPA. This increase in communication was reported to foster a shared view of the policy framework, progress, and challenges, and develop collaborative working relationships that might lead to joint strategic planning and actions.

The final output of a country-level policy audit is a comprehensive summary of the policy framework supporting the promotion of physical activity within a country. This summary can highlight strengths as well as expose gaps and areas in need of future focus. It can also uncover areas of overlap and duplication, as well as inconsistencies in the policy actions of different sectors aimed at promoting HEPA. Such an overview can help develop a more coherent approach to national efforts.

Undertaking a cross-country comparison of national policy is difficult but the findings can provide countries with an assessment of their current status relative to others. More importantly, the sharing of a policy audit, and the examples contained within, can be very useful in terms of advocacy to leverage greater political support. Furthermore, the sharing of experiences is very helpful to inform future policy development and learn about policy and program implementation. This is particularly helpful for those countries in the early stages of development of a HEPA policy agenda.

Although PAT provided the essential framework for data collection, this project exposed a number of limitations with the tool. Several questions could benefit from revision to improve the clarity and to enhance the level of detail provided. The question order could be improved and the response structure in some questions amended to provide easier completion. Specific recommendations for changes to the PAT have been identified throughout this report. It is therefore recommended that changes are made to the current PAT and an improved Version 2 is published. Further work along these lines is already under consideration in the European Region in 2014.

The current PAT provides a protocol for collating in-depth information on policy within a country. However, some countries, and particularly those countries which are just starting to develop national actions to promote physical activity, might prefer a shorter simpler tool, aimed at capturing just an overview of activities. As such, the idea of developing a short PAT is also under consideration with preliminary work underway in Australia. Conversely, some countries may desire a more detailed understanding of the policy context, particularly around policy implementation and understanding the barriers to action from different stakeholders' perspective. In this context, qualitative interviews with key stakeholders might be considered to complement the data collected through the PAT.

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Appendices

Appendix 1 Summary matrix of criteria for successful national policy

Bull et al. 2004 Policy content analysis(12)	WHO ¹ Guide to implementation 2007	WHO ¹ Steps to health 2007 (17)	Daugbjerg et al. 2009 Policy content analysis (14)	Bellew et al. 2008 Policy content analysis (6)	Shilton 2010 Policy content analysis (15)	Criteria used in the PAT ²
Consultation with key stakeholders		Collaborative approach		Highly consultative in development		Consultative approach in development
		Evidence-based, effective actions		Evidence informed		Evidence based
National guidelines/ recommendations on physical activity	National physical activity guidelines	National guidelines		Defined national guidelines for physical activity	Physical activity guidelines	National recommendations on physical activity levels
	Identification of national goals and objectives	Clear and measurable goals and indicators SMART ³ objectives	Goals or targets specified for certain population groups and time periods			National goals and targets
Time frame of the policy commitment and implementation of the action plan		Framework for action/ National action plan	Implementation plan Clear timeframe specified for the implementation of the plan			Implementation plan with a specified timeframe
Multiple strategies targeting different population groups	Multiple interventions strategies Cultural sensitivity Target the whole population as well as specific population groups	Comprehensive, integrated, inter-sectoral approach Environmental, social and population strategies in order to support individual strategies Sensitivity to cultural differences Tools and resources	Clearly identified population groups targeted		Health system reorientation to support prevention and health promotion Well mobilized, strategic and professional advocacy	Multiple strategies
Working at different levels	A coordinating team	Division of responsibilities	Involvement of national government, sub-national	Roles clarified and	Cross-government ways of	Leadership and

¹ World Health Organization

² Health Enhancing Physical Activity Policy Audit Tool

³ Specific, Measurable, Attainable, Realistic, Timely

Bull et al. 2004 Policy content analysis(12)	WHO ¹ Guide to implementation 2007	WHO ¹ Steps to health 2007 (17)	Daugbjerg et al. 2009 Policy content analysis (14)	Bellew et al. 2008 Policy content analysis (6)	Shilton 2010 Policy content analysis (15)	Criteria used in the PAT ²
	Support from stakeholders Leadership and workforce development Implementation at different levels within "local reality"	Supportive national leadership Complementary and collaborative approaches Actions at individual, institutional, community, environment and policy levels Collaborate and build capacity at regional and local levels	authorities, municipalities	performance delineated	working Buy-in, investment from other sectors Professional mobilization Workforce development	coordination
		Building networks and alliances				Networks
Working through coalitions, alliances, partnerships		Partnership building	Involvement of NGOs, private sector, media, associations, educational institutions, employers etc.	Active through multi- strategic, multi-level partnerships		Partnerships
Stable base of support	High-level political commitment	Political support Sustainable, long-term strategy		Political support	Endorsed and supported at the highest level politically Central agency support Buy-in, reorientation from other systems, long-term commitment	Political commitment
Sustainable resources	Funding	Sufficiently resourced Financial resources	Specified budget allocated	Resourced adequately - long-term investment	Innovative and sustained funding models Well resourced, fiscal mechanisms to ensure adequate and sustained funding	On-going funding
Surveillance or health monitoring systems		Standardized surveillance protocols	Surveillance / monitoring system		Regular monitoring	Surveillance or health monitoring systems

Bull et al. 2004 Policy content analysis(12)	WHO¹ Guide to implementation 2007	WHO¹ Steps to health 2007 (17)	Daugbjerg et al. 2009 Policy content analysis (14)	Bellew et al. 2008 Policy content analysis (6)	Shilton 2010 Policy content analysis (15)	Criteria used in the PAT²
Evaluation of the policy and action plan implementation	Monitoring and evaluation	Evaluation of goals and indicators Output, process and outcome indicators	Evaluation of the implementation and results	Evidence generating Independently evaluated	Commitment to monitoring and evaluation Research and evaluation of effectiveness	Evaluation
	Dissemination of the national action plan and the associated programs	Mobilizing at local level				Links between policy and practice
Identity	Clear program and plan identity				A 'brand'	Identity
		High-profile communication plan		Widely communicated	Integrated, sustained and strategic social marketing	Communication Strategy
Integration of physical activity policy within other related agendas	Integration of physical activity within other related sectors	Integrated, multidisciplinary approach Integrated into national health policy Vertical and horizontal integration	Involvement of different sectors	Developed in stand-alone and synergistic policy modes	Cross-sector collaboration and joined up planning	Integration across other sectors and policies

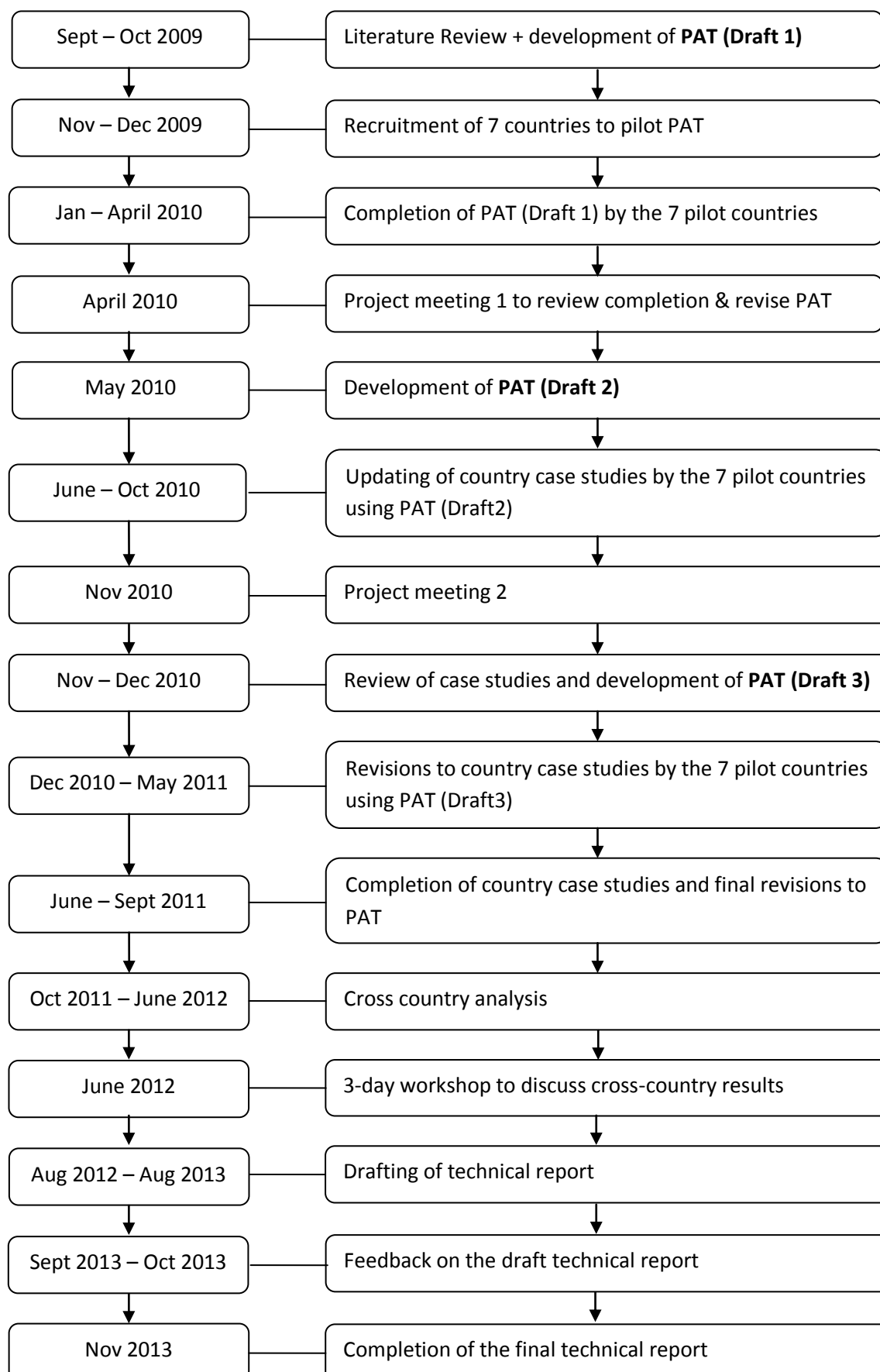
Appendix 2 Summary of methods and protocols for completion of the PAT

Country	Author(s)	Contributors	Summary of methods use to complete the PAT
Finland	Tommi Vasankari , <i>UKK Institute of Health Promotion Research, Finland</i>	Pekka Oja (Institution/ Organsiation) Ilkka Vuori (Institution/ Organsiation) Jyrki Komulainen (Institution/ Organsiation)	<ul style="list-style-type: none"> • A first draft of the tool was completed by Tommi Vasankari. • Feedback was sought from several experts (see ‘contributors’) and from two ministries (Ministry of Health and Social Affairs and Ministry of Education and Culture). • No feedback was received from either of the Ministries.
Italy	Alberto Arlotti , <i>Health Service, Emilia Romagna Region, Italy</i> Silvia Colitti , <i>Consultant for the Emilia Romagna Region, Italy / Chile</i>	Roberto D’Elia + Antonio Federici <i>Italian Ministry of Health</i> Mario Bellucci, Michela Donatucci + Roberto Gueli , <i>Italian Ministry of University and Research (MIUR)</i> NAME? <i>National Olympic Committee (CONI)</i> Vincenzo Manco , <i>Italian Union “Sport for All” (UISP)</i> Alberto Fiorillo , <i>Italian NGO-League for Environment (Legambiente)</i>	<ul style="list-style-type: none"> • Compilation of a first draft of the template • Compilation of a list of potential stakeholders/experts from multiple sectors • Invitation to collaborate by email and telephone conferences • Four weeks were given to receive feedback • No feedback was received from the Ministry of Transport
The Netherlands	Anita Vlasveld, Jan Willem Meerwaldt + Ineke Kalkman , <i>Netherlands Institute for Sport and Physical Activity, The Netherlands</i>	Maarten Koornneef, Helmie Ramakers + Han Haitisma , <i>Ministry of Health, Welfare and Sport</i> Marieke Verhaaf, Jeroen Hoyng, Peter-Jan Mol, Peter Barendse, Geeske van Asperen, Sofie van den Hombergh, Robby Aldenkamp, Ben Weghorst + Remco Boer , <i>Netherlands Institute for Sport and Physical Activity</i> Julie Ng-A-Tham , <i>Ministry of Infrastructure and Environment</i> Jantine Schuit , <i>National Institute for Public Health and the Environment (RIVM)</i> Martine Werensteijn , <i>Wandelplatform-LAW</i> Eddy Engelsman , <i>WHO</i>	<ul style="list-style-type: none"> • Consultation among NISB colleagues to identify relevant stakeholders • Consultation with ministry of VWS for all questions (policy, implementation, processes and evaluation) that relate to the sector sports and p.a. and connections with other sectors • Internal consultation of colleagues who are involved in programs and projects in which sports and physical activity are related to other sectors, like health, welfare, cycling, environment. • Consultation of documents and other ministries and organisations in case additional information was needed
Norway	Olov Belander , <i>Norwegian Directorate of Health, Norway</i>	Elisabeth Sæthre , <i>The Norwegian Directorate for Nature Management</i> Sunniva Sjøttne + Gyda Grendstad , <i>The Norwegian Public Roads Administration</i> Grete Haug , <i>The Norwegian Directorate for Education and Training</i> Stig Magnar Løvås , <i>The Norwegian Labour Inspection Authority</i> Sigrun Andenæs , <i>The Norwegian Labour and Welfare Service</i>	<ul style="list-style-type: none"> • The Norwegian Directorate of Health was responsible for the process. • The whole template and some of the translated questions were sent out to the directorates involved in The Action Plan on Physical Activity 2005-2009. • Some directorates answered directly and had a later opportunity to give feedback to a revised version of the template. • The Ministry of Culture provided further information on Sport. • The majority of PAT was completed by the Norwegian Directorate of Health, Department of Healthy Public Policy.

Country	Author(s)	Contributors	Summary of methods use to complete the PAT
Portugal	<p>Jorge Mota, Ana Marques, Margarida Pereira + Rute Santos, <i>University of Porto, Portugal</i></p>	<p>Information not provided</p>	<ul style="list-style-type: none"> • Translation of the template to Portuguese • Completion of the template, using available policy documents from across multiple sectors, combined with background knowledge • Identification of experts from each sector (governmental and non-governmental) and invitation to collaborate by filling the template with their specific knowledge, i.e. to provide further input and additional comments • Three weeks were given to receive the filled templates • Due to the lack of answers, a new contact by phone was made and two more weeks were given to complete the task • Finally, all the information was collated into one single document.
Slovenia	<p>Andrea Backovič Juričan, <i>National Institute of Public Health, Slovenia</i> Rok Poličnik, <i>Ministry of Health, Slovenia</i> + Nika Berlic, <i>Ministry of Health</i></p>	<p>Vesna Kerstin Petrič, <i>Ministry of Health</i> Ignac Polajner, Mateja Reberšak, Vida Starič Holobar, Ksenija Švalj + Zoran Verovnik, <i>Ministry of Education and Sport</i> Mateja Markl, <i>Ministry of Transport and Slovene Road Safety Council</i> Etbin Tratnik, <i>Ministry of Labor, Family & Social Affairs</i> Jožica Maučec Zakotnik, Mojca Gabrijelčič Blenkuš, Mojca Bevc Stankovič, Mojca Janežič + Andreja Drev <i>National Institute of Public Health</i> Luka Mladenovič, <i>Urban Planning Institute of the Republic of Slovenia</i> Tanja Udrih, <i>Clinical Institute for Occupational, Traffic and Sports Medicine</i> Gorazd Cvelbar, <i>National Olympic Committee</i> Barbara Konda, <i>FIT International Institute</i> Saška Benedičič Tomat + Aleš Kranjc Kušlan, <i>Sports Union of Slovenia</i> Marjeta Kovač + Boris Strel, <i>Faculty of Sport of the University of Ljubljana</i> Janet Klara Djomba, <i>Faculty of Medicine of the University of Ljubljana</i> Ema Mesarič, <i>Regional Institute of Public Health Murska Sobota</i> Igor Krampač, <i>Regional Institute of Public Health Maribor</i> Andrej Klemenc, <i>Regional Environmental Center</i></p>	<ul style="list-style-type: none"> • Making a list of potential partner organizations/ institutions from multiple sectors • Identification of individual experts from each sector (governmental and non-governmental) • Partly filling in the case study template by Andrea Backovič Juričan and Mr. Rok Poličnik from the Ministry of Health • Sending the invitation to identified experts from different sectors to collaborate in case study by completing the partly filled template using their specific knowledge and by providing further input and additional comments • One and a half month were given to receive the filled templates • Finalizing template by Andrea Backovič Juričan • Sending further specific question(s) to additionally identified experts • One and a half month were given to receive the filled templates • Finalizing the template and further consultation with some specific partners from Slovenia • Reducing the content according to suggestions and comments of partners from other collaborating countries and some experts from Slovenia

Country	Author(s)	Contributors	Summary of methods use to complete the PAT
Switzerland	<p>Brian Martin, Eva Martin + Sonja Kahlmeier, University of Zurich, Switzerland.</p>	<p>Nadja Mahler, Swiss Federal Office of Sport Andy Biedermann, Swiss NGO Alliance Nutrition and Physical Activity Roger Keller, Swiss Federal Office for the Environment Heidi Meyer, Swiss Federal Roads Office Peter Schild, Swiss Federal Office for Spatial Development ARE Othmar Brügger, Swiss Council for Accident Prevention bfu Günter Ackermann, Foundation Health Promotion Switzerland Liliane Bruggmann, Swiss Federal Office for Public Health</p>	<ul style="list-style-type: none"> • The Physical Activity and Health Unit of the Institute of Social and Preventive Medicine (University of Zurich) was responsible for the collection of information and the consensus process. • The Swiss project group compiled a first draft based on their experience and knowledge. • This draft was then discussed at a workshop of the Swiss NGO Alliance Nutrition and Physical Activity; furthermore, the Federal Office of Sports provided first comments. • A first version of the document was then sent out for consultation to the following national institutions: Federal Office of Public Health (FOPH); Federal Office of Sports; Federal Roads Office (FEDRO); Federal Office for Spatial Development (ARE); Federal Office for the Environment (FOEN); Swiss Council for Accident Prevention; Foundation Health Promotion Switzerland. • When the key information had been included, the document was sent out for a second round of consultation. • The content and the template were then refined with the international project group in a stepwise process.

Appendix 3 Project timelines and tasks



Appendix 4 Summary of legislation and policy documents by sector and by country

Finland

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution			
Physical activity	<ul style="list-style-type: none"> • Government Resolution on Policies to Develop Health-Enhancing Physical Activity, 2002 • Resolution concerning the development of health enhancing physical activity and diet, 2008 		<ul style="list-style-type: none"> • Report of the Committee on Development of Health-Enhancing Physical Activity, 2001 • National recommendations for the local promotion of HEPA, 2000
Health		<ul style="list-style-type: none"> • National plans to develop health education 1983 • Health for All by the Year 2000 (1986) • Health enhancement political program 2007 – 2011 	<ul style="list-style-type: none"> • Report of the Ministry of Health to the parliament on health policy (1985) • Health in all policies (HiAP), 2006
Sport	<ul style="list-style-type: none"> • Sport / exercise, 1998 • Resolution of enhancing sports and exercise, 2008 		<ul style="list-style-type: none"> • Report of the Sport Committee, Wellbeing through physical activity - physical activity for all, 1990
Education	<ul style="list-style-type: none"> • The Education Act, 1998 (Perusopetuslaki) 		
Transport		<ul style="list-style-type: none"> • Policy and action plan on cycling promotion, 1992 • Policy and action plan on cycling and walking, 2001 • National strategy on walking and cycling to year 2020, 2010 • Action plan on Walking and Cycling to year 2020 	
Environment			
Other			

Italy

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution	<ul style="list-style-type: none"> Italian Constitution, 01/01/1948, Article 32 		
Physical activity			
Health	<ul style="list-style-type: none"> Law 23/12/1978 n. 833: National Health System (Sistema Sanitario Nazionale, SSN) Decree law reform 254 Law 26/05/2004 n. 138 – Creation of the Italian Centre for Disease Control and Prevention (CCM) Decree of the Minister of Health 1st July 2004 Decree of the Minister of Health 18th September 2008 Ministerial Decree 01/04/2007, n. 326 - National Platform on Nutrition, Physical Activity and Tobacco addiction Prime Minister Decree – 04/05/2007- Documento programmatico Guadagnare Salute (Gaining Health Program) 	<ul style="list-style-type: none"> First National Prevention Plan 2005-2009. National Health Plan (Piano Sanitario Nazionale PSN) 2003 – 2005 National Health Plan (Piano Sanitario Nazionale PSN) 2011-2013 State – Regional Government Agreement, 29/04/2010 National Prevention Plan (PNP) 2010 – 2012 Regional Health Prevention Plans 	<ul style="list-style-type: none"> State – Regional Government Agreement, 23/03/2005
Sport	<ul style="list-style-type: none"> Law 16/02/1942 n. 426 - The Italian National Olympic Committee (CONI) Ministerial Decree 28/02/1983 		
Education	<ul style="list-style-type: none"> Decree Law 18/12/1975 Decree Law n. 297, 16/04/1994: body of laws and dispositions concerning educational programs Protocol n. 1148/A1, 19/03/1997 Protocol n. 1381/C17, 05/01/2007 Ministry Note, Protocol n. 4273, 04/08/2009 Ministry Circular Letter, 01/07/1997 		
Transport			
Environment		<ul style="list-style-type: none"> Official Gazette, General Matters, n. 88, 16/04/2010 	
Other			

The Netherlands

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution			
Physical activity		<ul style="list-style-type: none"> National Action Plan on Sport, Physical Activity and Education, 2008 	
Health	<ul style="list-style-type: none"> Public Health Act Law Public Healthcare 2008 Health Insurance Law 	<ul style="list-style-type: none"> Opting for a Healthy Life, Public Health Policy in the Netherlands 2007-2010 Being Healthy and Staying Healthy: A Vision of Health and Prevention, 2007 Memorandum on Obesity; Out of Balance: the Burden of Obesity, 2009. [Upcoming: New public health policy] 	
Sport		<ul style="list-style-type: none"> What Sport sets in Motion, 1996 Sport Exercise and Health 2001 Time for Sport, 2005 The power of Sport, 2008 Together for Sport, 2006 Excellence at Every Level, 2009 	<ul style="list-style-type: none"> Olympic Plan 2028
Education	<i>A law is mentioned but no details are provided</i>	<ul style="list-style-type: none"> Sport, Physical Activity and Education 	
Transport		<ul style="list-style-type: none"> The Dutch Bicycle Master Plan (1999) Cycling in the Netherlands, 2009 Mobility Policy 	
Environment		<ul style="list-style-type: none"> National Plan Environment and Health, 2008-2012 Green and the City Spatial Planning Policy 	<ul style="list-style-type: none"> Agenda for a living countryside: multi-year program for a living countryside' (2007-2013)
Other	<ul style="list-style-type: none"> Law Social Support Working Conditions Act Working Conditions Decree Working Conditions Regulation 		

Norway

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution			
Physical activity		<ul style="list-style-type: none"> The Action Plan on Physical Activity (2005-2009) 	
Health	<ul style="list-style-type: none"> Primary Health Services Act Municipal Health Services Act <i>[Upcoming: Public Health Act]</i> <i>[Upcoming: Health and Care Services Act]</i> 	<ul style="list-style-type: none"> The Parliament White Paper No.16 (2002-2003) Prescription for a healthier Norway White Paper No. 47 (2008-2009) The Coordination Reform Proper treatment – at the right place and right time <i>[Upcoming: New health care plan]</i> 	
Sport		<ul style="list-style-type: none"> White Paper No. 14 to the Storting (1999) Sport in a State of Change Sports policy document 2007-2011 - Open and inclusive sport <i>[Upcoming: A new white paper on sport]</i> 	<ul style="list-style-type: none"> Provisions regarding grants for facilities for sport and physical activity – 2010
Education	<ul style="list-style-type: none"> Kindergarten Act Regulation concerning a Framework Plan for Content and Tasks for Kindergartens Law on Primary and Secondary Education (The Education Act) 		
Transport	<ul style="list-style-type: none"> Road Traffic Act 	<ul style="list-style-type: none"> The National Transport Plan 2006-2015 National cycling strategy - safe and attractive to bicycle (2003) National cycling strategy - Attractive to cycling for all (2007) The National Transport Plan 2010-2019 <i>[Upcoming: National walking strategy]</i> 	
Environment	<ul style="list-style-type: none"> Outdoor Recreation Act The Planning and Building Act 	<ul style="list-style-type: none"> White Paper No.39 (2000-2001) Outdoor recreation (Friluftsliv) - A way to better the quality of life The Government's Environmental Policy and the State of the Environment in Norway <i>[Upcoming: National action plan for outdoor recreation]</i> 	

		<i>areas]</i>	
Other	<ul style="list-style-type: none"> • Working Environment Act (1 Jan 2006) • Labour and Welfare Administration Act • National Insurance Act • Labour Market Act • Social Welfare Act 	<ul style="list-style-type: none"> • The Norwegian Action Plan on Nutrition (2007-2011) 	

Portugal

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution	<ul style="list-style-type: none"> • Constitution of the Portuguese Republic - April 2nd, 1976 • Law No. 3-A/2010 of April 28th 		
Physical activity			<ul style="list-style-type: none"> • National Program of Walking and Running
Health		<ul style="list-style-type: none"> • National Health Plan 2004 – 2010 	
Sport	<ul style="list-style-type: none"> • Law No. 169/99 of September 18 • Decree-Law No. 56/2006 of March 15 • Law No. 5 / 2007 of January 16 - Law on Physical Activity and Sport • Resolution of the Council of Ministers No. 53/2007 (DR, Series I, No. 67, April 4) • Decree-Law No. 169/2007 of 3 May • Decree-Law No. 315/2007, of September 18 • Decree-Law No. 273/2009 of 1 October 	<ul style="list-style-type: none"> • Contract-Program nº461/2010 of 19 of July 	
Education	<ul style="list-style-type: none"> • Law No. 46/86 of 14 October - Law of the Education • Decree-Law No. 6 / 2001 of January 18 • Decree-Law No. 74/2004 of March 26 • Order of the Secretary of State for Education, September 27, 2006 • Order No. 12 591/2006 of June 16 		
Transport			
Environment	<ul style="list-style-type: none"> • Law No. 48/98 of August 11 • Decree-Law No. 310/2003 of 10 December 	<ul style="list-style-type: none"> • Regional Operational Programs (2007-2013) • National Plan Ecotrail 	
Other			

Slovenia

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution			
Physical activity		<ul style="list-style-type: none"> National Health Enhancing Physical Activity Program 2007-2012 	
Health	<ul style="list-style-type: none"> Health Care and Health Insurance Act, 1992 Health Services Act, 1992 Patients Rights Act, 2008 Diabetes Prevention and Care Development Program 2010-2020 	<ul style="list-style-type: none"> Instructions for the Implementation of Preventive Health Protection at the Primary Level, 1998 Rules Amending the Instructions for Implementation of Preventive Health Care at Primary Level, 2001 Resolution on the National Program of Food and Nutrition Policy 2005-2010 Resolution on the National Plan of Health Care 2008-2013 	
Sport	<ul style="list-style-type: none"> Law of Sport of the Republic of Slovenia, 1998 	<ul style="list-style-type: none"> National Program of Sport, 2000-2010 <i>[Upcoming: National Program of Sport 2011-2020]</i> 	
Education	<ul style="list-style-type: none"> Kindergarten Act Elementary School Act Vocational Education Act-1, 2007 		
Transport	<ul style="list-style-type: none"> Road Traffic Safety Act, 2008 Law Amending the Road Traffic Safety Act, 2010 	<ul style="list-style-type: none"> Resolution on the Transport Policy of the Republic of Slovenia, 2006 Resolution on the National Program on Road Safety, 2007-2011 	
Environment	<ul style="list-style-type: none"> Spatial Planning Act, 2002 Spatial Planning Act, 2007 	<ul style="list-style-type: none"> Spatial Development Strategy of the Republic of Slovenia, 2004 	
Other	<ul style="list-style-type: none"> Law on Disabled Persons Organisation, 2002 	<ul style="list-style-type: none"> Resolution on National Program of Safety and Health at Work, 2003 Slovenia's Development Strategy, 2007-2013 Development Plan and Policies of Slovene Tourism, 2007-2011 Tourism Policy (2009 and 2010) 	

Switzerland

Sector	Legislation	Policy/ Action plan	Other relevant documents
Constitution			
Physical activity		<ul style="list-style-type: none"> National Program on Diet and Physical Activity, 2008-2012 	
Health	<ul style="list-style-type: none"> Federal Health Insurance Law, 1996 	<ul style="list-style-type: none"> Health Objectives for Switzerland, 2002 	
Sport	<ul style="list-style-type: none"> Federal Law on the Promotion of Gymnastics and Sport, 1972 	<ul style="list-style-type: none"> Strategy of the Federal Council for a Sports Policy in Switzerland, 2000 	
Education	<ul style="list-style-type: none"> Federal Law on the Promotion of Gymnastics and Sport, 1972 		
Transport	<ul style="list-style-type: none"> Federal Law on Walking and Hiking Paths, 1985 Federal law on the Infrastructure Fund, 2006 	<ul style="list-style-type: none"> Mission Statement on Human Powered Mobility, draft, 2002. Sustainable Development Strategy – Guideline and Action Plan 2008-2011 – Extract on ‘Human Powered Mobility’ Federal Leisure Transport Strategy, 2009 	
Environment	<ul style="list-style-type: none"> Freedom to Roam, 1907 Federal CO₂ Law, 1999 	<ul style="list-style-type: none"> National Environment and Health Action Plan, 2001-2007 	
Other			

Appendix 5 Use of consultation processes during policy development

<p>Finland</p>	<p>Both policies and action plans are usually developed by an Advisory Committee. The committees usually comprise members from governmental organisations (e.g. Ministries of Health, Education and Culture, Environment, Labour and Transport), local authorities and representatives from NGOs (both health and sport; from research institutes and associations familiar with more practical work). Examples include the Finnish Heart Foundation, the UKK Institute, and the LIKES Research Center.</p> <p>In the case of certain policy papers, a more extensive consultation process is used. This “hearing” on policies gives many relevant organisations (like health and sport associations) the opportunity to influence the policy.</p> <p>When national policies and action plans are planned, the ministries responsible for the main topic (in case of HEPA usually Health and Education and culture) usually provide the chairpersons and secretary. All other organisations have a possibility to influence the process and the content of the policy and action plan.</p> <p>At the local level (towns and rural districts), the local government is fully responsible for both planning and implementation of the policies and action plans, but they might call upon local NGOs (like health associations and sport clubs) or private companies from the HEPA sector to support the planning or implementation of the policies/action plans.</p>
<p>Italy</p>	<p>Laws, Decrees, Protocols and Circular Letters are developed through a political process that involves political stakeholders, with the cooperation of technical officers for each specific area or topic. Sometimes, a technical working table or a parliament group is appointed in order to develop or amend a legal text. For Charters, Agreements, Programs and Plans, a more extended consultative process is undertaken, with the involvement of a wider group of stakeholders. For example, the technical panel for the elaboration of the Gaining Health Program was composed of representatives of the central government agencies, the regions and provinces, the associations representing the sectors of the food production chain, consumers groups and the leading national labour unions. These actions and interventions integrate different actors, at central, local and community level, in coherence with a networking approach.</p> <p>In order to support the implementation of National Preventive Plan (PNP), a Project Management Group (PMG) was created and formally approved with a Ministry Decree (January 2007). With a networking logic, the challenge was to improve the setup of the project managers of public health, developing tools and training programs to support the implementation of the PNP. One of the main strengths and achievements of the PNP is in fact the creation of a network of referents at regional and local level for public health planning.</p>

<p>The Netherlands</p>	<p>The Ministry of Health Welfare and Sport, Sports Division policy documents from 1996 onwards (<i>What sport sets in motion</i>, 1996) involved a consultation process but it was limited to a small number of the most relevant stakeholders like NOC*NSF, NISB and the VNG (Union of local authorities). However, the policy document <i>Sport, Exercise and Health</i> (2001), which covered most health aspects of sports (e.g. injuries, doping) including physical activity, was based upon extensive consultations with sports organisations, municipalities, universities, organisations in public health and sports health care. Sports organisation were involved for the positive aspects and for the prevention of side-effects and because sports organisations / umbrella organisations were sometimes ‘claiming’ the monopoly of exercise (while in fact only about 5% of all physical activity in the population is related to sports). For the <i>Time for Sport</i> (2005) document, several discussion sessions were organized (sports organisations, local public health, other government departments) and many partners participated in the policy making process. For the goal setting component, a special report was written by TNO and RIVM. The memorandum <i>Together for Sport</i> (2006) was launched with a specially organised event for multiple stakeholders.</p> <p>The <i>Olympic Plan 2028</i> (2009) was based on a collaboration between sports organisations, government, local authorities, private companies and the media. Many stakeholders have been involved and shall be involved in the future planning and implementation. Also in the formulation and implementation process of the cycling policy various stakeholders took part: NISB, Cycling association, Netherlands Cycling Union, and several others.</p>
<p>Norway</p>	<p>The Action Plan on Physical Activity 2005 – 2009 is the result of collaboration between eight ministries: Labour and Social Inclusion; Children and Equality; Health and Care Services; Culture and Church Affairs; Environment; Transport and Communications; Local Government and Regional Development; and Education and Research. In addition, the Ministry of Agriculture and Food contributed to the formulation of some measures in its area of responsibility and was allocated responsibility for three of these measures. The Ministry of Health and Care Services and the Norwegian Directorate of Health had overall responsibility for the coordination of the Action Plan.</p> <p>There was an extensive process involving collaborating partners through different meetings and written comments during 2003/04. A steering committee made up of the eight ministries was also established and, during the development of the plan, there was a reference group made up of various organisations, including: NGOs (e.g. The Norwegian Olympic and Paralympic Committee and Confederation of Sports, Diabetes Association, Cancer Society, Council for Road Safety, Guide and Scout Association); Working life (e.g. Confederation of Trade Unions (LO), Confederation of Norwegian Enterprise (NHO), The Confederation of Vocational Unions (YS)), public sector organisations (e.g. Public Roads Administration, Directorates for Nature Management, Labour and Welfare Service, Education and Training, Children, Youth and Family Affairs, Integration and Diversity and State Housing Bank) and several others</p>

	<p>organisations such as the Norwegian Institute of Public Health, the Research Council of Norway, The Norwegian Knowledge Centre for the Health Services, and the National Council for Senior Citizens (a full listing of members is available in the full country report PAT).</p>
Portugal	<p>During the development of the National Health Plan 2004-2010 and the different national programs, more than 300 contributions were received from many sectors: health, education, physical activity, environment, local public administration, nutrition, municipalities, and civil society among others. The Consultation processes with relevant experts are established in Portuguese laws.</p>
Slovenia	<p>Consultation process among relevant stakeholders should be a normal part of the national documents development, but in practice it is sometimes hard to involve all relevant stakeholders. Before a national document is adopted, a draft of the document is available to the professionals and general public for open debate. Subsequently, it must go through a process of inter-ministerial consultation and coordination. For example, during the development of the National HEPA Program several national stakeholders (governmental and NGO's) were included in the consultation process (see appendix 2).</p>
Switzerland	<p>Strategy of the Federal Council for a Sports Policy in Switzerland, 2000: involved broad consultation of all relevant partners during development of policy document. But no further involvement of partners in definition of measures.</p> <p>National Program on Diet and Physical Activity 2008-2012 (Nationales Programm Ernährung und Bewegung 2008–2012): The 1st development phase involved the main national partners and representatives of the cantons, and three workshops were held with more than 100 participants from different interested circles. The actual program was developed in a second phase, led by the Federal Office of Public Health in cooperation with the Federal Office of Sport, the foundation Health Promotion Switzerland and the Coordinating Conference of the Health Directors of the Cantons. Before being agreed on by the Federal Council, the program had the usual consultation round with the relevant units of the federal administration.</p> <p>Federal laws: there are well established processes for consultation with all relevant public and private partners during the preparation and establishment of federal laws in Switzerland.</p>

Appendix 6 Examples of policy actions from country policies and plans

Examples of up to three actions (programs, regulations, interventions or other) included in the national policy or action plans	
Finland	<p>For children there is a new plan which aims to make the school day more active (during and after the normal school day). One target of the plan is to activate the children who have been marginalized from sport and PA. The Ministries of Education, Health and Social Affairs and Defence are involved.</p> <p>For 16 +years - the Fit for Life Program aims to activate physically inactive people in Finland; it comprises exercise groups (e.g. Fit for Life groups) in nearly all towns and greater rural districts, and worksites are encouraged to activate non-exercising employees.</p> <p>For elderly, there is a Strength in Old Age Program aimed at increasing physical activity services for elderly nationwide by increasing the co-operation with local organisation (communal, private and third sector). The program started in 2005 and due to its success will be extended nationwide from 2010-2014.</p>
Italy	<p>As part of the implementation of “Gaining health” program, CCM leads 8 projects that integrate PA with other sectors, such as nutrition, environment, public transportation and street safety. Examples are: Best practices on nutrition and physical activity in preschool aged children, Gaining health in teenagers, and a surveillance system on lifestyle and risk factors in elderly people</p>
The Netherlands	<p>Communities on the move: aimed to promote an active lifestyle among specific groups with low socio-economic background. It targets elderly, youth with low education level, migrant groups and people with chronic diseases. This is one of the promising and successful interventions that is promoted (with extra financial support) within the framework of the National Action Plan Sports and Physical Activity.</p> <p>Physical activity promotion through primary health care (Beweegkuur = ‘A Course of Exercise’) - a lifestyle program commissioned by the Dutch Ministry of Health, Welfare and Sports (VWS), sports division and developed 2007-2012 by NISB in cooperation with Dutch umbrella and patient organisations. <i>Beweegkuur</i> is a combined lifestyle intervention tailored to the individual needs of patients either with health problems or with a high risk of developing health problems. The GP practice is responsible for the inclusion of the patient, their coaching and supervision and their referral to paramedic and/or local exercise coaches or a sports physician. The aim of the 12-month intervention is to ease transfer to local exercise facilities.</p> <p>Meedoen: sport participation of migrant youth - ‘Meedoen’ (Dutch word for ‘join’) is a program that promotes sport to reach educational and societal goals as is a cooperation between municipalities, sport organizations and sport clubs. Sport organizations are supported to develop a strategy/intervention that motivates youth to become a member of a sport club. Municipalities link the sport clubs to primary and secondary schools. Hereby, municipalities and sport organizations collaborate in making sport widely available and interesting for youth. NISB is the national coordinator of the program and supports municipalities, sport organizations and sport clubs in executing the program. In 2009, 500 sport clubs participated in ‘Meedoen’. They recruited 20.400 new youth members from which approximately half had a migrant background.</p>

Examples of up to three actions (programs, regulations, interventions or other) included in the national policy or action plans	
<p>Norway</p>	<p>Examples of interventions from The Action Plan on Physical Activity 2005-2009 from different sectors and types of measures:</p> <p>Measure no 23 – funding NGOs - Allocate funds to NGOs that would like to contribute to the work of adapting local “low threshold” activities. The funding came from the health sector, and the nineteen counties administered the funding to the NGOs. Funding levels changed from year to year (range approx. 40,000 - 60,500 EUR/year across years of 2005 – 2009). Around 500-700 activities were funded every year and most grants were awarded to local organisations, some grants awarded to regional organisations, e.g. a regional sports organisation and some locally. Wide variety of activities are funded including: “walking buses” to school for children, outdoor recreation activities to promote mental health, outdoor camps for disabled young people, swimming classes for foreigners, dancing and walking groups for the elderly etc. Evaluation shows that this funding is an important type of work but that it is a challenge to reach the right groups: the inactive.</p> <p>Measure no 43 – a new law - A new Working Environment Act obliges employers to consider physical activity for their employees as part of the systematic health, environmental and security work in the enterprise. Section 3-4 has been modified. Section 3-4. <i>Assessment of measures for physical activity</i> “In connection with systematic health, environment and safety work, the employer shall assess measures to promote physical activity among the employees.” Implementation of this article would only be subject to follow-up if the employer can provide documentary evidence that promotion of physical activity among employees is a core element of the organisation’s activities. The article does not require an employer to undertake programs to promote physical activity among the employees, but only to ascertain the possible means of doing so. Therefore, the supervisory authorities cannot require an employer to implement those measures.</p> <p>Measure no 104 – higher competence - Strengthen the tuition of physical activity and health in elementary education courses and in postgraduate and upgrading courses for doctors and other social and health personnel. Norway and Sweden have published a book Aktiviteshåndboken on the use of physical activity in prevention and treatment and approx. 25,000 copies of the Norwegian version were sent to universities, university colleges, doctors, physiotherapists etc. Around 10,000 doctors and physiotherapists received the book free of charge. www.helsedirektoratet.no/fysiskaktivitet/aktivitetshandboken/). The book is available in Norwegian, Swedish and English and may be downloaded from www.fhi.se/Publikationer/Alla-publikationer/Physical-Activity-in-the-Prevention-and-Treatment-of-Disease/</p>
<p>Portugal</p>	<p>SCHOOL SPORT (School Sports Program 2009-2013) - The sport in schools, in addition to a duty under the current legislative framework in the education system (Law No. 46/86 of 14 October - Law of the Education), is an instrument of great importance and usefulness in combating school failure and improving the quality of teaching and learning. In addition, the School Sport promotes healthy lifestyles that contribute to the balanced education of students and enable the development of sport in Portugal. Available data (2009/2010 report) indicates that school sport engaged 158,727 students from 6864 teams, in 33 different sports. Documents (only in Portuguese)</p> <p>NATIONAL PROGRAM FOR WALKING AND RUNNING (created 2009) is Government initiative aimed at promoting healthy lifestyles among the population through the walking and running. Decree-Law No. 169/2007 of 3rd May defines PSI obligations,</p>

Examples of up to three actions (programs, regulations, interventions or other) included in the national policy or action plans	
	<p>which include the adoption of programs that aim to integrate physical activity into everyday lifestyles. This program is a partnership between the PSI, the Portuguese Athletics Federation and the Porto Faculty of Sport. The Program aims to work in partnership with different responsibilities (e.g. Municipalities, decentralized services of PSI, District Athletics Associations and Clubs) and includes the creation of a City Walk and Run Centres in each municipalities, a web platform for the National Program of Walking and Running (www.marchaecorrída.pt) to support and ensure information is available to all interested citizens.</p> <p>'CICLORIA' PROJECT approved by POVT (Thematic Operational Program for Territorial Enhancement) Axis IX Innovative Actions for Urban Development Accessibility and Urban Mobility and aims to enhance the natural heritage landscape and to change the pattern of urban mobility. The region of Aveiro is stated as an example for the promotion of soft modes of mobility for the entire population and sectors. Document: http://issuu.com/jcmota/docs/aula-2_cycling-murtosa_final</p>
Slovenia	<p>Golden Sun (related to NPS) - Golden Sun program, managed by the Ministry of Education and Sports from 1997 onwards is for 5- 8 years and lasts for four years. Each year it includes about 84% of all targeted children (58,800). Children receive additional information on physical activity (skating, skiing, swimming, cycling, hiking, etc.) and on completion of the program each child receives an award medal. Krpan (related to NPS) is managed by the Ministry of Education and Sports since 1999 onwards, is for 9-11 years and lasts for three years (in second triad). Every year it includes 65% of all targeted children (36,100). The program aims to enrich the school physical education with additional motivational approaches aimed at pupils who are normally not involved in additional sports programs. Every year for the successful completion of the program children receive an award (bronze, silver or gold medal).</p> <p>Move for Health (previously called <i>Slovenia on the Move- Move for Health</i>) (related to HEPA Slovene Program, NPS and Transport Policy) This is a national and population-oriented HEPA promotion project/program, financially supported by Health Insurance Institute of Slovenia and occasionally by PA-related EU project. Ministry of Health and the Ministry of Education and Sport support the program morally. It encourage inactive or inadequately active adults, elderly citizens of Slovenia and families to engage in regular moderate physical activity and uses a network of health & sports professionals/organizations along with mass media to promote HEPA recommendations.</p> <p>Prescription for healthy life through sport/physical activity (related to NPS) (link: http://www.receptzaziviljenje.si/) is an annual event of the Olympic Committee of Slovenia and Association of Sport Federations (OCS-ASF) and aims to facilitate cooperation between sport and health sector in encouraging citizens to start and practice different types of sport. Every year 100.000 leaflets/prescriptions with instructions for healthy sport and physical activity are distributed through sport associations and other partner organizations. The concrete sport actions that support this project are Slovenia Runs (for Health) (link: www.slovenijatece.si/) and Slovenia Cycle (link: http://www.slovenijakolesari.si/).</p>

Examples of up to three actions (programs, regulations, interventions or other) included in the national policy or action plans	
Switzerland	<p>Youth and Sports -> - Youth and Sports is the national sports promotion program for 5-20 year olds. It reaches more than half a million children and adolescents every year and now also has offers for 5 to 10 year old children. Youth and Sports is based on the Federal Law on the Promotion of Gymnastics and Sport.⁴</p> <p>Allez Hop -> For about a decade, Allez Hop offered weekly activity sessions (e. g. Nordic walking) for middle age adults. In the best years, more than 20'000 individuals were reached. Allez Hop started as a private initiative, but became part of a measure in the Strategy of the Federal Council for a Sports Policy in Switzerland. See also points 2 and 21. ⁵Document available at http://bjsm.bmj.com/content/early/2010/06/01/bjsm.2009.070201.full</p> <p>Primary care interventions -> A number of approaches for physical activity promotion have been developed in Switzerland. They have been coordinated and were part of a measure in the Strategy of the Federal Council for a Sports Policy in Switzerland. ⁶Document available at www.panh.ch/material/casestudy</p>

⁴ More detailed information: Kelly P, Cavill N, Foster C. An Analysis of National Approaches to Promoting Physical Activity and Sports in Children and Adolescents. Report. Oxford, British Heart Foundation Health Promotion Research Group, University of Oxford 2009. *Report and summary report available at* www.panh.ch/material/casestudy

⁵ More detailed information: Wanner M, Martin-Diener E, Bauer G, Stamm HP, Martin BW. Allez Hop, a nation-wide program for the promotion of physical activity in Switzerland: what is the evidence for a population impact after one decade of implementation? Pretest posttest survey and population-based cross-sectional surveys. *Brit J Sport Med*, in press.

⁶ More detailed information: Bize R, Surbeck R, Padlina O, Peduzzi F, Cornuz J, Martin B. Promotion of physical activity in the primary care setting: The situation in Switzerland. *Schweiz Z Sportmed Sporttraumatol* 2008, 56 (3), 112–116.

Appendix 7 Summary of leadership and coordination at a national and sub-national level

	Leadership and Coordination at the national level (Q18a and b)	Coordination of implementation at a sub-national and local level (Q19 and Q20)
Finland	Government delegated coordination of HEPA to the Advisory Committee, its membership is named by government and delegates are from governmental organisations, local authorities and NGOs. This Committee plans new actions and supports the larger nationally funded projects.	In Finland, the local level has independency in every action which is not requested by Laws. The town and rural districts (~200+) are developing their own Health Enhancement Strategies and this includes PA. These strategies often follow the main principles and action identified at the national level. There is however great variability of the implementation between towns and districts because of their number and the independence from any overarching national implementation.
Italy	At national level, the stewardship for HEPA promotion is with the Ministry of Health, General Directorate of Prevention, Healthy Lifestyle Unit. This is a key role because of the increasing decentralization of decision making to sub-national levels, and this requires a strong coordination and solid links between national, local, public and private institutions. All national level policy documents are implemented at sub-national and local level due to the decentralized health system.	All national level policy documents are implemented at sub-national and local level due to the decentralized health system. Every Region participating in the CCM-Project “Promoting Physical Activity - Actions for a Healthy Life” has created a Regional Network consisting of the PA delegates of the local (county) Health Services. The CCM coordinates and provides support to the Regions in writing their Regional Prevention Plans which then are implemented under the authority of the Regions.
The Netherlands	The role of national government is to develop policy plans, provides subsidies for implementation and provide national/international coordination There is not <i>one</i> organisation in the Netherlands responsible for implementation of activities in the field of PA, instead various larger organisations like NOC, NSF and NISB, and the municipalities provide more leadership, depending on the topic. There are also smaller organisations that play a role. Most of the stakeholders work together and meet each other through networks.	There is good and close cooperation both on political and professional level between national and local level and between government and NGOs (like sports organizations). There are several ‘platforms’/alliances for different themes; there is regular contact and coordination on political level and stakeholders work together on programs like NASB and Olympic Plan 2028 (Planning, building and maintenance of facilities is almost exclusively the domain of the local authorities. Communities receive financial resources from the National Sport and Physical Activity Plan (NASB) to implement at local level promising interventions to encourage inactive people to move. The interventions are accessible and focus on target groups which are generally inactive. Regional advisors support municipalities in implementation. Concerning the organisation of sport and sport activities on a local level, the sport clubs play the most important role.
Norway	<i>The Action Plan on Physical Activity (2005-2009)</i> had an inter-ministerial coordination group, represented by all eight ministries. Current issues, priorities and reporting of the measures were reviewed. The Ministry of Health and Care Services had overall responsibility for physical activity and chaired the group. The Norwegian Directorate of Health had a secretariat function.	The County Governor has the primary responsibility for the implementation of governmental decisions at sub-national level. The new public health act (2009) outlines the tasks of Regional Authorities in public health. The County Governor was given more responsibility, specifically to implement central policy documents in the local context, and to be aware of each municipality’s ability to deliver. Experts from the County Governor’s office supervise local activities. The county

	Leadership and Coordination at the national level (Q18a and b)	Coordination of implementation at a sub-national and local level (Q19 and Q20)
	In day to day work, the Norwegian Directorate of Health has responsibility for the measures in the health sector. Corresponding directorates of other ministries were responsible for the implementation of other measures. Examples are the Ministry of the Environment and Directorate for Nature Management, the Ministry of Transport and Communications and Norwegian Public Roads Administration, the Ministry of Education and Research and the Norwegian Directorate for Education and Training. The directorates are then responsible for implementation of the strategy through their subordinate departments.	authority is divided into different areas (for example, culture, sports and public health, transportation, education, planning and the environment, industry and innovation). The County Authority is responsible for coordinating regional work and tasks that are too large or too complex for the municipalities to manage alone. The national government has an overriding authority and supervises both county and municipal administration. At local level the municipalities are responsible. At regional level, in addition to the county governor and the county authority, there are nearly 20 public authorities that to various degrees are central in public health work. Examples include the Norwegian Board of Health Supervision, the Norwegian Labour and Welfare Service and the Norwegian Public Roads Administration.
Portugal	Different ministries are responsible for interventions relating to different issues, for example the Ministry of Health has responsibility for interventions on health issues. In other sectors the relevant ministry or Secretary of State assumes a leadership role.	At the regional level, the Regional Directorates of the Portuguese Sports Institute PSI ensure and monitor the activities undertaken and supported by the PSI, in accordance with its business plan and in collaboration with the central unit. The local authorities are responsible for: cooperation with other public and private organizations to develop sport actions, especially with associations, schools and local governments; to ensure up-to-date knowledge on the national sport situation; identify the needs of populations in relation to physical activity and sport; update files on players, clubs, associations and sports facilities; and collaborate with the relevant sport organizations. At the local level, leadership is usually attributed to the Alderman of Sports of each municipality. Other municipalities have Municipal Companies that manage all activities relating to physical activity and sport, whose administrator is the responsible for the activities related to this area. The National Program of Walking and Running is an example of a synergy between different levels of action. It is coordinated at national level but is implemented at local level in all municipalities. The central government is responsible for training local level organisations and institutions to develop local initiatives by creating Municipal Walking and Running Centres. These centres intend to enhance the work that several municipalities develop in the context of the Municipal Walking and Running strategy
Slovenia	Responsible bodies for leadership and coordination of the National HEPA Program are the Ministry and Health and the Ministry of Education and Sport. In April 2010, we established the intersectoral working group, which will be responsible for coordinating	The municipalities are responsible for providing leadership and coordination of physical activity related activities at the local levels. At the regional and national level it is a little bit more complicated. It differs from region to region. There has been a constant rivalry between health, education and

	Leadership and Coordination at the national level (Q18a and b)	Coordination of implementation at a sub-national and local level (Q19 and Q20)
	<p>implementation of the National HEPA Program. The working group will also prepare the annual action plan(s) with the concrete tasks and financial resources necessary for the implementation.</p> <p>The Ministry of Education and Sport is also responsible for the preparation, leadership and coordination of the general National Program of Sport as well as Annual National Programs of Sport (NSP). One of the goals set in NPS refers to promotion of sports preventive activities to improve health condition of Slovenians together with the Ministry of Health and other departments.</p>	<p>sport sectors and in addition with NGOs as well.</p>
Switzerland	<p>There is not one single institution providing overall stewardship. However, there are different bodies responsible for partial aspects, including: Federal Office of Sport (Concept of the Federal Council for a Sports Policy in Switzerland, 2000; Sport); Federal Office of Public Health (National Program on Diet and Physical Activity 2008-2012 and physical activity in everyday life) and Foundation Health Promotion Switzerland (promotion of healthy body weight).</p> <p>The federal administration is represented (together with representatives of cantonal governments, of health insurances and with other partners) in the foundation board of Health Promotion Switzerland. There is no clear mechanism for government support to the foundation's activities</p>	<p>Leadership and implementation is led as follows:</p> <ul style="list-style-type: none"> • Health promotion authorities in cantons and cities • Sport promotion authorities in cantons and cities • Urban planning authorities in cantons and cities • Transport planning authorities in cantons and cities • Education authorities in cantons and cities <p>Institutionalised coordinating mechanisms (so-called coordination conferences) exist for the members of governments of the cantons (so-called councillors) in the respective sectors (e.g. public transportation, health etc.).</p> <p>In addition, there is a "Network HEPA Switzerland" which provides a voluntary exchange platform for stakeholders at the canton and community level.</p> <p>In Switzerland there are several good examples of synergies and coherence including the development of programs on nutrition and physical activity in cantons, supported by the non-ministerial structure Health Promotion Switzerland. In the case of the integrated projects of Suisse Balance combining physical activity and nutrition (www.suissebalance.ch), the activities are supported by both Health Promotion Switzerland and the Federal Office of Public Health.</p> <p>Other examples include the development of sport strategies of cantons, following the initiative of the Federal Office of Sport but funded by their own resources, and the initiatives of several cantons in Youth and Sport Kids.</p>

Appendix 8 Summary of recommendations, structures or processes to support working in partnership

Q13. Are there recommendations of how <i>agencies/ institutions/ stakeholders</i> should be <i>working together</i> to deliver the policy / action plan(s)?	
Finland	<p>The Finnish governmental policy papers have strong recommendations that the actions should be done in cross-governmental manner and partnerships between different organisations are strongly encouraged. Cross-sector work is very good at the national level, at the local level it is increasing but not as good as at national level. When requesting funding for different actions, the principles of collaboration have to be considered. Also, communal organisations are more frequently working together with voluntary (third sector) and private sector.</p> <p>The HEPA Advisory Committee launched the manual how to promote HEPA cross-sectionally at communal / town level, autumn 2010</p>
Italy	<p>At national level, there are many examples of protocol agreements signed between institutions, agencies and associations, as a result of “Gaining Health” (available in Italian at www.ccm-network.it/GS) All multi-ministerial agreements have recommendations on how work together, in order to deliver policies or action plans. Technical groups have been created to support the Regions in the planning process, which implicates stakeholder involvement in all phases of the project. Specific tools and training activities are available for operators, in PNP context as well as for CCM projects.</p>
The Netherlands	<p>In the policy documents recommendations are made concerning collaboration.</p> <p>National Action Plan Sports and Physical Activity (NASB) - an extensive coordination and supporting task has been commissioned to NISB. Working together does not only take place at national but also regional and local levels. The sports umbrella NOC*NSF is coordinating the PA-projects within the sports sector.</p> <p>At National Level - NISB Works on national level together with the National Nutritional Centre (Voedingscentrum), National Institute for health promotion (NIGZ), Institute for Consumer Affairs and Safety (Consument & veiligheid) enz.</p> <p>At Regional level - NISB Works together with 12 regional sports organisations in 2 different ways: - on development of interventions, methods and instruments; - on implementation of interventions, methods and instruments. Usually NISB formulates an assignment (on a contract basis) for the regional sports institutes. Regional sports organisations are being stimulated to work together with municipal health authorities (GGD'en) and regional care and welfare organisations. NISB facilitates the meetings between those organisations.</p> <p>At local level different sections of the local government work more and more together to reach common targets (for instance more healthy people, better physical environment, more facilities and possibilities for physical activity, but there is still a lot of work to do at this level.</p> <p>In general most policy documents contain recommendations about partnerships or alliances between sectors. That is certainly the case with the policy documents about sport (VWS) and the framework for sport, p.a. and education.</p> <p>The collaboration between public health campaigns (e.g. PA and food, PA and sports injuries) is being coordinated by ZonMw; the Netherlands organisation for health research and development</p>
Norway	<p>There is no general recommendation of how agencies/institutions/stakeholders should work together. In numerous strategy documents on public health, an inter-sectorial approach is used.</p> <p>For The Action Plan on Physical Activity 2005-2009, for example, Chapter seven of the action plan is called <i>Working together for physical activity</i> and the measures in this chapter are about how to work inter-sectionally. In the action plan there are some measures connected to partnership work at regional and local level.</p> <p>There is not the same development of written partnerships relating to physical activity at a national level (government, directorate, private sector and non-governmental organisations) in Norway. It is unclear why it this has not been carried to the national level. It appears to be easier to implement the partnerships at local and regional level and more difficult to commit to them at a national level. The evaluation shows that the interaction between NGOs,</p>

Q13.	Are there recommendations of how <i>agencies/ institutions/ stakeholders</i> should be <i>working together</i> to deliver the policy / action plan(s)?
	<p>municipalities and the state, and in some cases the private sector, is well established and well-functioning in some places at local level. At the same time, there are big regional and local variations. Several of the informants from the evaluation of the action plan have indicated that cooperation from the parties in working life has been poorly developed, low prioritised or has not functioned as intended.</p>
<p>Portugal</p>	<p>In the translation of "European Union Guidelines for Physical Activity: Recommended Policies for the Promotion of Health and Welfare", published by the PSI, the importance of working together across sectors is mentioned, namely: Sports, Health, Education, Transport, environment, urban planning and public safety, Environment in the workplace and Services for senior citizens.</p> <p>The Program for Walking and Running is also a document in which an alliance is created: PSI, the Portuguese Athletics Federation and the Porto Faculty of Sport.</p> <p>Healthy Cities Network is another example of an alliance between the Directorate-General of Health and Municipalities, working to increase citizens' health and physical activities levels.</p> <p>School sport has partnerships with various sports federations, clubs, municipalities and the media (those with an important purpose on marketing)</p>
<p>Slovenia</p>	<p>The National HEPA Program includes recommendations how the stakeholders on different levels (international, national and local) should be working together to achieve goals and purpose of the strategic document. General HEPA promotion is a joint responsibility of all relevant ministries like ministry responsible for health, the ministry responsible for education and sport, the ministry responsible for transport, the ministry responsible for the environment and spatial planning, and the ministry responsible for labor, family and social affairs (and also ministry responsible for higher education and scientific research). <i>The ministry responsible for health</i>, plays a central role.</p> <p>Aiming to achieve a more efficient involvement of <i>NGOs</i> in political dialogue, the Government of the Republic of Slovenia adopted in October 2003 the Strategy for a Systemic Development of NGOs in Slovenia during the period 2003-2008. This document defines the significance of cooperation of <i>NGOs</i> in achieving a comprehensive and sustainable social development, in addition to improving the well-being of the society, its quality of life and social security.</p> <p><i>Local communities</i> have a key role in facilitating and promoting a healthy lifestyle and health enhancing physical activity through the specific planning and construction of infrastructure – playgrounds, parks, cycle and foot paths, gymnastic and training areas, as well as through the encouragement of financing and co-financing of programs promoting a healthy lifestyle, health enhancing physical activities, training programs, and sport and recreation programs. One of the most important features and activities is the motivation of local communities and involve all structures of local communities in the program (local authority, school, pre-schools, pharmacy, community health centre, societies and associations, shops, restaurants).</p>
<p>Switzerland</p>	<p>General recommendations are included in several of the documents. The "National Program on Diet and Physical Activity" has stated the intention and the general principles. New developments have been the program's strategic steering group including both the health and the sport sector and the initiative actionsanté for voluntary collaboration from the industry</p>

