First Meeting of the European Union Physical Activity Focal Points Network
Rome, Italy
21-22 October 2014

Meeting Report

ABSTRACT

The European Commission and the WHO Regional Office for Europe have started a joint initiative that aims at developing and scaling-up monitoring and surveillance of health-enhancing physical activity (HEPA) in the European Union Member States. An important aspect of this initiative is to set up a network of national physical activity focal points to help provide and validate information on physical activity from EU Member States in line with the monitoring framework established by the EU Council Recommendation on HEPA across sectors, and to integrate that information into WHO Europe's information system for nutrition, obesity and physical activity (NOPA).

Keywords

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The first meeting of the network of national physical activity focal points took place in Rome, 21-22 October 2014. The meeting summarised the background and context of the establishment of the network and, through a series of keynote presentations, provided participants with up-to-date information on epidemiology, policy and practice in relation to physical activity. It also gave national focal points a first opportunity to exchange current knowledge and discuss some of the challenges associated with data collection, policy development and practice in physical activity promotion. Finally, the next steps for the network's work plan were discussed and a roadmap for the coming months was agreed.

Background

Despite increasing knowledge about the importance of health-enhancing physical activity for the individual, for health systems and for economies, the proportion of citizens who reach recommended physical activity levels has not increased overall over the past years. In fact, according to the Eurobarometer survey conducted in 2013, 59% of EU citizens never or seldom exercise or play sport.[1] Over half (54%) of respondents did not do any vigorous activity and 44% did not do any moderate physical activity within the past week. These results also show amount of regular activity that people do decreases with age, with 71% of women and 70% of men aged over 55 never or seldom exercising or playing sport.

Globally, a third of adults are insufficiently active and rates of physical inactivity in the EU remain extremely high. The WHO European Region has the highest rates globally of people who spend more than four hours per day in sitting activities.

Given the negative impact of physical inactivity and the rising challenge of obesity, development of policies to promote physical activity is essential.

The EU Physical Activity Guidelines, the EU Council Recommendation on Promoting Health-Enhancing Physical Activity Across Sectors, as well as the WHO Physical Activity Recommendations and the upcoming WHO European Physical Activity for Health Strategy provide policy recommendations that can contribute to reversing this trend.

Some of these principles have been implemented with relative success in several Member States. However, challenges continue to exist, and there is a need to improve the design and implementation of policies that promote physical activity across sectors. In particular, more information and data is needed about policy developments and the epidemiological situation in the field of physical activity in Europe.

Opening and welcome addresses

The aim of the kick-off meeting on 21-22 October 2014 was to establish the focal points network, to agree on a common understanding of its tasks, goals and activities, and to define a road map for the next years as well as a work plan for the specific activities in the upcoming months.

Meeting participants included the newly-nominated European Union national physical activity focal points, representatives of the European Commission (from the Sport Unit in the Directorate General for Education and Culture (DG EAC)) and the World Health Organization (from the WHO Regional Office for Europe), along with invited experts and keynote speakers.

[1] European Commission (2014). Sport and physical activity. Special Eurobarometer 412.

On behalf of the European Commission, Androulla Vassiliou, Commissioner for Education, Culture, Multilingualism and Youth, launched the focal points network. Recognising the health and economic benefits of physical activity, and as the Commissioner whose remit covers sport, Commissioner Vassiliou emphasised the progress that has been made since sport was first introduced as an issue of EU competency in the 2009 Lisbon treaty. The 2013 adoption of the first ever Council Recommendation on promoting health-enhancing physical activity, in particular, has given great impetus to policy action.

Commissioner Vassiliou emphasised, however, the importance of following through on recent positive developments and of turning policy decisions into action. She underlined the critical role of the focal points network in monitoring progress and implementation.

The Commissioner thanked WHO for the collaboration, and the efficiencies and synergies which this joint approach will enable. She wished the meeting participants a productive meeting and encouraged the network to learn from one another and to identify successful approaches to address physical inactivity.

On behalf of WHO, Dr João Breda also welcomed participants and thanked the Italian government for highlighting this issue as an initiative of its EU Presidency and, particularly, for hosting the event. He also thanked the European Commission for the excellent collaboration on this issue.

The *Vienna Declaration on Nutrition and Noncommunicable Disease*[2], adopted by ministers of the European Region in July 2013, provides a clear mandate for the WHO Regional Office to take action to promote physical activity. Responding to this mandate, and having received a very strong signal from Member States, the Regional Office is currently developing a physical activity strategy for the WHO European Region. Such a strategy, alongside this joint initiative with the European Commission, presents a key opportunity to influence the health of citizens across Europe, particularly the most vulnerable among them. Dr Breda welcomed the role that this meeting would have in contributing to these efforts.

On behalf of the Italian government and the Italian Presidency of the Council of the EU, Giovanni Panebianco, General Director of Sport, welcomed participants in Rome. The Italian government was very happy to host the network's first meeting in Rome and is committed to supporting this initiative beyond the period of Italy's EU Presidency. Mr Panebianco thanked the European Commission, and particularly Commissioner Vassiliou, and WHO.

Introduction to the establishment of the European Physical Activity Focal Points Network

EU policy context for HEPA

Yves Le Lostecque, Head of the Sport Unit at the European Commission, outlined the EU policy context in relation to HEPA. This first meeting represents an important date in the calendar for the promotion of HEPA at the European level, following on from other

[2] Vienna Declaration available from: http://www.euro.who.int/en/media-centre/events/events/2013/07/vienna-conference-on-nutrition-and-noncommunicable-diseases/documentation/vienna-declaration-on-nutrition-and-noncommunicable-diseases-in-the-context-of-health-2020

important milestones, such as the presentation of a Council Recommendation on HEPA in 2012 and its adoption in 2013.

As already outlined by the Commissioner, 2014 has been a key year for HEPA in the EU policy context, with the start of the Erasmus+ programme, adoption of the second EU Work Plan for Sport in May, preparations for the first ever European Week of Sport in 2015 and the first year of implementation of the Council Recommendation. All of these initiatives are intended to help reach the objective of promoting the practice of sport and physical activity in the long term.

Mr Le Lostecque introduced his colleagues from the Sport Unit and emphasised that Susanne Hollmann, deputy head of the unit, has responsibility for HEPA and has been the driving force behind the achievements to date.

Physical activity has achieved this status, high on the EU agenda, because the current situation is worrying from a health perspective and long-term action is needed. In addition to the health and wellbeing aspects, however, a physically active population is known to be beneficial for the EU's economy, and the economic dimension of sport is now being underlined more than ever. As a result, there is clear political will to take action now, at both European and Member State levels.

A number of tools – both policy and financial – are available to help turn this political will into action. One such tool is the *EU Work Plan for Sport 2014 – 2017* which is based on defining priorities, putting methods in place and delivering concrete outputs.[3] Within the Work Plan, HEPA has been identified as a key topic. Another key tool is the Erasmus+ programme, which provides funding to support priorities such as HEPA. The Council Recommendation on HEPA is obviously also an important policy tool itself.

The centre-piece of the Recommendation is made up of the provisions for monitoring, based on the EU Physical Activity Guidelines. A set of 23 indicators has been developed and included in the Recommendation. This is where the work of the focal points network meeting will be so important. The focal points will facilitate this monitoring process at the national level, thus leading to better information and data, which, in turn, will lead to better policies. The work of the focal points network will really be key, therefore, to the implementation of the Recommendation.

The European Commission will support this endeavour, including by funding training and capacity building. The collaboration with WHO is of fundamental importance, and will avoid any duplication of effort as well creating a synergy between the institutions.

Towards the first WHO strategy on physical activity for health

João Breda, Programme Manager for Nutrition, Physical Activity and Obesity at the WHO Regional Office for Europe, outlined progress towards adoption of a strategy on physical activity for the European region. The Regional Office is developing the strategy in response to a clear call from Member States, and is the first of WHO's regional offices to develop a specific strategy on physical activity.

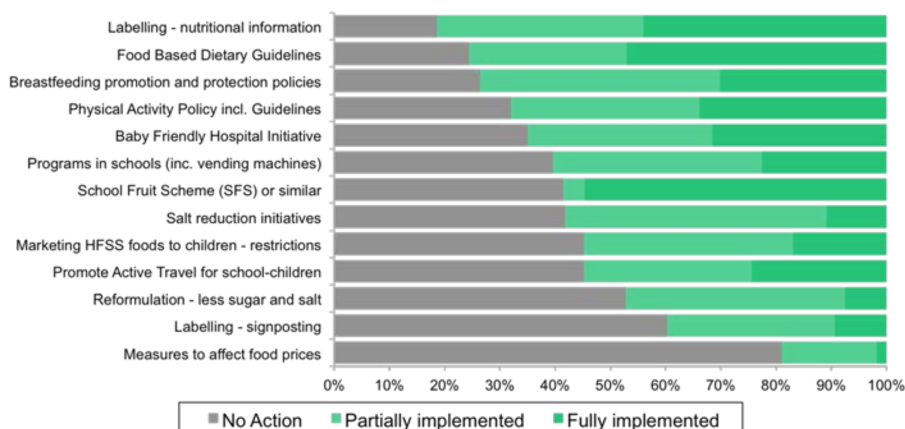
The imperative for taking action to increase physical activity is clear. No EU country has a prevalence of overweight and obesity below 50%, and childhood obesity is a major concern throughout the region. A strong mandate to take action on NCDs, and, specifically, on physical activity and nutrition, exists at both global and regional levels, through the *Global Action Plan for the Prevention and Control on Noncommunicable Diseases* and, for

[3] http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:42014Y0614%2803%29

Europe, through the *Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020*. This combination of strong mandates from both WHO and the EU creates a really powerful push for action.

To recap, WHO recommends that adults aged between 18 and 64 should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week.[4] In order to achieve the targets, a variety of policy responses are needed. Figure 1 shows the level of implementation across the region of two specific policies (Physical activity policy, including guidelines; Promotion of active travel for school-children). The figure shows clearly that very few countries have fully implemented these policies, and that there is scope for a great deal more to be done.

Figure 1 Overview of policy actions implementation across the WHO European Region (2012/13)



WHO, through the Regional Office for Europe, and the European Commission, through DG EAC, are joining forces to support physical activity promotion in the EU by scaling up and further developing monitoring and surveillance of physical activity in Member States. From the perspective of WHO, the progress made with EU Member States through this collaboration will also be used to try and inspire other countries in the region to take similar action.

The NOPA database will be reviewed, redesigned and upgraded to render it more comprehensive, easier to maintain, more user-friendly and accessible for media, policy-makers and the general public. New indicators on physical activity will be added to NOPA, based on, but not limited to, the indicators included in the monitoring framework set up by the EU Council Recommendation on HEPA. As part of this process, country profiles on physical activity for health (modelled on the 2013 country profiles on nutrition, physical activity and obesity) will be prepared by May 2015 (See also sections *EU-WHO cooperation* and *The role of national HEPA focal points*).

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[4] World Health Organization. Global recommendations on physical activity for health. Geneva: WHO, 2010.

The next step in WHO's implementation of the Vienna Declaration is the development of a specific strategy on physical activity for the region. Such a strategy is important because it establishes physical activity as a policy field in its own right, it translates previous global WHO initiatives to the regional level and it provides an impetus to policy-making in Member States. The current draft of the strategy is innovative in its approach, focuses on intersectoral action and promotes broad participation, while providing a shortlist of recommendations for countries.

The strategy is structured around a vision and a specific mission, guided by six principles. The five priority areas, and the 14 key objectives for action in these areas, are shown in Table 1. This structure for the strategy is intended to facilitate effective governance and implementation.

Table 1 Five priority areas and 14 key objectives of the draft regional physical activity strategy

Priority areas	Key objectives
Leadership	Provide high-level leadership by health sector Establish coordination mechanisms, promote alliances
Children/adolescents	Promote physical activity during pregnancy and early childhood Promote physical activity in preschools and schools Promote physical activity beyond school-based settings
Adults	Reduce car traffic, increase walkability and bikeability Provide opportunities and counselling at the workplace Integrate physical activity into prevention, treatment and rehab Improve access to physical activity facilities and offers
Older people	Improve the quality of advice by health professionals Provide infrastructures and appropriate environments Involve healthy but inactive older people in social physical activity
Monitoring, evaluation, research	Strengthen surveillance systems and evaluate policies Strengthen the evidence base for physical activity promotion

The consultation process on this early draft of the strategy will take place throughout 2015, with a view to eventual adoption by the Regional Committee in September.

Addressing equity issues in physical activity for health policy

Belinda Loring, from the WHO Regional Office for Europe, outlined the equity issues that need to be considered in relation to physical activity policies.

Health has been improving across Europe, but these improvements have been uneven and health inequities exist between and within countries. These health inequities have social, economic and environmental causes, and are largely avoidable. Addressing health inequities is about more than social justice – ignoring inequities reduces the impact of health promotion efforts and has large economic and social costs. The importance of tackling inequities is increasingly recognised in global and regional policy documents – acknowledging that it will not be possible to improve overall health unless efforts to address inequities are strengthened.

The pattern of inequities varies from country to country. Health inequities not only exist in relation to income, but also gender, ethnicity, education, place of residence, disability, etc. These variables interact and can sometimes compound one another.

In 2013 a major WHO report on inequities, the *Review of Social Determinants and the Health Divide in the European Region* led by Professor Michael Marmot, identified a

number of policy approaches.[5] These include taking a life-course approach to health equity, addressing the intergenerational processes that sustain inequities, addressing the structural and mediating factors of exclusion and building the resilience, capabilities and strength of individuals and communities. It is noteworthy that, although the report deals with health inequities, none of these recommendations focus on health services, emphasising, yet again, that policy responses need to come from outside the narrow control of the health sector. Addressing inequities requires actions on upstream social determinants, and actions to mitigate consequences.

Another key message is that business as usual will lead to greater inequities, and that equity will not be achieved without a specific focus. To achieve this, universal policies are important but these need to be accompanied by targeted action. Much better data on the distribution of physical activity/inactivity within societies is also needed, especially to enable monitoring of whether policies work well for everybody.

Interventions have different impacts across social groups, but few interventions have been evaluated for their effectiveness in low socio-economic groups. Education campaigns alone, for example, are less effective in low socio-economic groups and have significant potential to make inequities worse. Health interventions typically do not engage as well with people from low-income groups and these groups tend to drop out earlier. It is also known that population-based policies are likely to have a greater impact on inequalities than interventions targeted at individuals.

Given the propensity for well-intentioned policies to make inequities worse, it is important that the principle of ‘first do no harm’ is applied. Inequities in physical activity arise at many levels, such as social context, exposures, vulnerabilities, access to services and consequences. This means that inequities can also be addressed at these various levels and implies that a mix of policies is needed to address inequities. Designing the precise mix of interventions requires careful, sophisticated analysis taking into account the specific national context. While there is growing awareness of inequities, in order to move forward, much greater emphasis on evaluation and monitoring of impacts across social groups is needed.

The epidemiology of physical inactivity

Dr Charlie Foster, from the Nuffield Department of Population Health and the University of Oxford, summarised the relationship between physical activity and health and other benefits, as well as the factors influencing HEPA and the patterns of HEPA within populations.

In relation to physical activity, the health arguments are, of course, important but it is vital to remember that people often participate in physical activity for other reasons, such as enjoyment. Promotion efforts should do more to emphasise these aspects.

Physical activity involves a mix of different activities of varying type and intensity, with differing frequency and for various lengths of time. The complexity of physical activity has implications for the difficulty of measuring it and relevant communication messages. To add to this complexity, there are also many domains of physical activity: work; leisure and play; exercise or sport; household and active travel.

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[5] http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report

A key early study in the epidemiology of physical inactivity was the study by Professor Jerry Morris and colleagues into London bus drivers in 1953.[6] This study identified that bus conductors, who walked up and down stairs to collect tickets, had fewer heart attacks than bus drivers. Over 50 years on since Morris' first study there is now international consensus on the health benefits of physical activity. Physical activity can reduce the risk of cardiovascular disease, hypertension, obesity, breast and bowel cancer, type 2 diabetes, osteoarthritis, osteoporosis and dementia. It can promote psychological well-being and self-esteem, while helping to manage anxiety and depression and to prevent falls. The evidence clearly shows that those who are the least active have the most to gain by increasing their activity levels.

In terms of domain-specific relationships with health outcomes, walking has been shown to reduce the risk of all-cause mortality by 11% and cycling by 10%.[7] Sedentary behaviour, on the other hand, may be a risk factor independent of overall physical activity levels, and further research is needed in this area.

The challenge now is to develop convincing arguments to mobilise other sectors. There are a number of indirect, broader benefits of HEPA-promoting policies (e.g., crime reduction and community safety, economic regeneration, improved workplace productivity, pollution reduction, etc.). It is important to raise awareness of the broader and synergistic benefits (such as for the environment or transport infrastructure). The economic arguments can be powerful and should be made easy for policy-makers to grasp. Policies to promote physical activity save money but can also have an economic impact by inciting spending (e.g., tourism, activities etc.).

The determinants and underlying causes of physical inactivity (or activity) are similar to those for other areas, such as nutrition (Figure 2).

Figure 2 Adapted ecological model of the determinants of physical activity

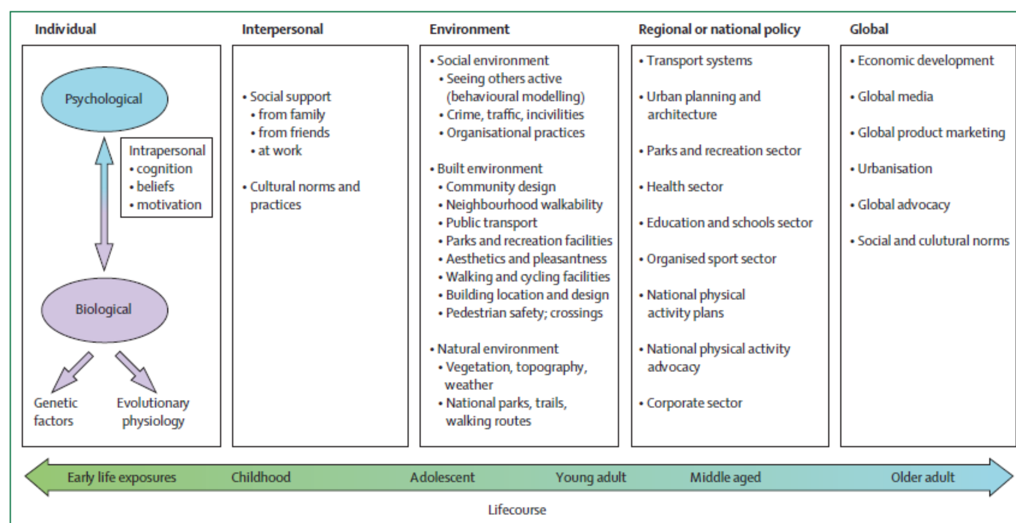

Figure 1: Adapted ecological model of the determinants of physical activity

[6] Morris JN, Heady JA, Raffle PAB, Roberts CG, Parks JW. Coronary heart disease and physical activity at work. Lancet. 1953; 262; 1111-20.

[7] Kelly P, Kahlmeier S, Götschi T, Orsini N, Richards J, Roberts N, Scarborough P, Foster C. Systematic review and meta-analysis of reduction in all-cause mortality from walking and cycling and shape of dose response relationship. International Journal of Behavioral Nutrition and Physical Activity, 2014

Understanding the patterns of behaviour within populations is as important as measuring physical activity. Physical activity declines with age and within both genders. Men start with more physical activity at a younger age and the gap is maintained. There is a steep, graded inequality in the amount of total moderate to vigorous physical activity (MVPA) between people with degrees and people without any qualification. There is a clear negative gradient in the total amount of weekly MVPA with increasing deprivation.

Taking this epidemiological picture into account, a number of key messages emerge for the design of interventions:

- The most inactive people have the most to gain by increasing their physical activity;
- The choice of what physical activity to promote to a particular population or group will have a different level of impact across groups (e.g., gender, age, socio-economic);
- That impact could *increase* inequalities in health and quality of life;
- A mixed approach is important, and interventions should change the determinants of physical activity (e.g., environment, access, legislation).

It summary, it is clear that physical activity has a strong epidemiological evidence base. It is important to be 'policy smart' and to communicate about the various benefits and costs using indicators and messages that will resound with policy-makers. Physical activity behaviour is a complex mix, driven by complex factors and different for different people. For national policy responses it is vital to understand the national physical activity profile. In order to encourage physical activity behaviour change, leadership, structure, adaptation and tailoring are all needed, and a mix of interventions will be required.

In the discussion following Dr Foster's presentation, the importance of increasing physical activity in day-to-day living was emphasised. One of the main reasons that people say they are inactive is lack of time, so the policy goal needs to focus on increasing the activity levels of people who do not have time to specifically dedicate to sport.

The question of whether more objective measurements of physical activity and/or fitness levels could be included, instead of data on participation, was raised. In fact, accelerometers, which give a better measure of intensity of activity, are increasingly being used. It is important to recognise that participation, behaviour and fitness are quite different concepts.

Policy development for physical activity promotion

Professor Dr Alfred Rütten, from the University of Erlangen-Nürnberg, outlined the importance of evidence-based policy-making in health promotion for physical activity and how it can be developed.

Unfortunately, there is little understanding of exactly what is meant by evidence-based policymaking, and how to develop it. For health promotion, a broader concept of evidence is required than the very narrow concept of evidence used in other scientific disciplines.

Evidence-based physical activity policy-making should be built on three relevant types of evidence:

- Type 1 evidence – has been proven to be effective physical activity practice for health outcomes (different kinds of activity, intensities of activity and with varying frequency and duration)
- Type 2 evidence – has been proven to be effective practice for promoting physical activity behaviour (types of strategy, different target groups and settings)

- Type 3 evidence – has been proven to be effective practice of physical activity policy-making (various policy agendas, sectors, levels and instruments). There is very little research into this type of evidence.

Priority should be given to the production of evidence to inform the policy-making process. There are different approaches to the synthesis of knowledge. There are lessons to be drawn from evidence-based medicine, which integrates evidence from research, such as randomised controlled trials, and evidence from practical, clinical experience. The ideal method is an interactive approach to pragmatic synthesis of knowledge, whereby a two-way interaction between evidence from research and evidence from policy-making allows for capacity building and adaptation.

A review of the literature (in progress) on physical activity policy-making indicates that there are many publications focused on type 1 evidence, a reasonable amount on type 2 evidence and very, very little literature addressing type 3 evidence. This applies to health promotion more generally, not only physical activity promotion.

Evidence-based physical activity policy-making could build on good practice criteria. These include, for example, a cross-sectoral approach, the setting of clear goals and targets, careful planning, allocated funding and political commitment. Knowledge synthesis – based on the different types of evidence – evaluation and ongoing monitoring are also good practice criteria.

Intersectoral governance structures should be developed to help implement these good practice criteria. These can include ministerial, parliamentary or interdepartmental committees or other linkages, joint budgeting and delegated financing along with methods for public and stakeholder engagement.

The current situation in EU Member States in relation to the good practice criteria and governance structures for evidence-base of physical activity policy-making was examined using, among other sources, the NOPA database. The majority of countries (23/28) reported they do have a national coordination mechanism on HEPA promotion. The sectors most commonly involved were ministries of sport, education/research and health. NGOs, academia and communities were the next most frequently involved. Ministries of sport, followed by ministries of health, most commonly took the lead in the coordination mechanism.

National sport for all policies and/or action plans were reported in 23 countries, but there was no information on specific funding for HEPA promotion. Only eight countries reported having carried out cost-effectiveness calculations of nutrition/physical activity policies and programmes. Half (14) of the countries reported national recommendations on physical activity for health and 17 said that physical activity is included in the national health monitoring system. A variety of different models have been used to implement cross-sector governance.

It is vital to stress that the message is not ‘lets do research first, then develop policy’. In fact, a great deal has already been done to develop good practice criteria and policy-making can build on these good practice criteria and develop intersectoral governance structures that help to implement promising approaches.

In discussion, the question of economic evidence was raised, because this is always a key question for policy-makers and political leaders. In fact, a reasonable amount of evidence exists – such as the EU-wide assessment of economic impact as well as some national studies – and there also tools available to help with this analysis.

Good practice interventions to promote physical activity

Dr Wanda Wendel-Vos, from the Netherlands National Institute for Public Health and the Environment, outlined some criteria for good practice and described a case study of a Dutch initiative to raise the quality of interventions.

One of the key elements of good practice is that interventions should be based on a plan. This plan should cover the objective(s), target population and approach to be taken. It should also set out the boundary conditions, the particular logic model of the intervention (*how* it is to produce results) and how the intervention will be evaluated.

In general, interventions to promote physical activity have tended to be extremely fragmented and the quality of information about interventions is generally poor. There is little learning from others' good practice, making selection of future interventions more difficult.

In response to this situation, a quality assessment system for health promotion interventions was established. The aim of the initiative – a collaboration between seven institutes and the national institute – is to promote good practice and improve intervention quality.

Under this system, those responsible for interventions ('the owners') complete a standardised assessment form. This dossier assessed by practical experts who look at the description and is then assessed by a recognition committee made up of representatives from the scientific, practice and policy fields. After this time-consuming process, requiring time investment by the 'owners' of the intervention and by the committee, interventions are given a label.

The system is based on three levels of recognition: 'well described', 'theoretically sound' and 'effective'. Depending on the type of evidence put forward, effectiveness can be classified as 'first indication', 'good indication' or 'strong indication' (a controlled study design with a six month follow up is required for this).

In total, there are thousands of interventions but relatively few have recognition status. Currently, 68 interventions on physical activity and sports are classified as well-described. Of these, 32 are considered to be theoretically sound but only nine have any indication of effectiveness (two first indication, seven good indication).

The recognition system is now being applied in various ways. The database of interventions is well-used, mainly to view recognised interventions (90% of page views are for recognised interventions). The grant conditions of the Zonmw funds for health research, for example, specify that interventions must be recognised. Increasingly, local municipalities demand that any interventions should have recognition status.

There are similar examples in other countries. In the UK, for example, 957 interventions have recently been assessed using criteria developed by Nesta. This focal points network represents an opportunity for exchange of similar experiences between countries.

There was discussion, following Dr Wendel-Vos' presentation, about whether the lack of interventions classified as having good or strong indications of effectiveness could be due to unrealistically high criteria for effectiveness, particularly for small interventions. In practice, the lack of evidence is usually due to poor definition of goals and/or poor definition or measurement of outcome measures.

The advantages of recognition for 'owners' of interventions are that further funding invitations to collaborate with other partners are more likely. The system has not really been designed, however, to provide any kind of monetary incentive.

Working groups

During the meeting three working group discussion sessions took place. Participants were allocated into three sub-groups and each session addressed a different topic.

Data collection and disaggregation

Given the central importance of surveillance and monitoring mechanisms in relation to physical activity, physical inactivity and sedentary behaviour, the groups were asked to reflect on the availability of data in their countries, the ease of access and data comparability. They were also asked to consider the potential for disaggregation, for example, using the equity lens. Having considered these specifics, they were asked to reflect on the potential for reporting the data, as required by the Council Recommendation, to WHO, and what support might be required to enable this. The three groups were asked to consider specific aspects of the problem.

The first working group specifically considered the role of national health information data. Having considered the national health information data systems on a country-by-country basis, some summary points emerged:

- People from different sectors have different competencies;
- Despite awareness of different sectors actions, working across sectors is a challenge (even if personal communication is good);
- Given the challenges within countries, there are great challenges relating to the comparability of the data.

The second working group considered the variety of data available through different sectors – such as sport, health, transport – and how to optimise the use of this data. Having discussed the situation in the respective countries, the group concluded that a great deal of data is already available. It is also clear, however, that data are not *always* available at the local or national levels. A key issue is that sectors do not communicate enough on data collection.

The third working group focused on the issue of comparability, how it can be improved and the minimum accepted level. Discussion of the data available in the countries concerned revealed a great variety of approaches in use. The 23 indicators of the EU Council Recommendation form an obvious minimum baseline for data to be comparable across countries. The group underlined that to be comparable data needs to be collected using the same protocols and methods. There are some sources of comparable data, such as the Eurobarometer. A mapping exercise of what data is already being collected could be valuable.

Policy development, implementation and evaluation

For the second working group session, groups reflected on national intersectoral coordination mechanisms in physical activity policy-making. Groups were asked to reflect on these coordinating mechanisms, in the light of good practice criteria.

The first working group was asked to consider the role played by, the assets brought to and the challenges posed by involvement of academia, NGOs, private actors and public/private partnerships. The group considered that these stakeholders definitely have added value and must be involved, but they are often left out.

This group of stakeholders brings many assets to the process. The academic sector brings economic and scientific expertise. The contribution of the voluntary sector and public interest NGOs is often particularly important for raising awareness and advocacy. The

contribution of the private sector – particularly through corporate social responsibility – is also important.

The challenges associated with these groups include sometimes the narrow scope and relatively action-oriented approach of the voluntary sector. The academic sector, conversely, may lack expertise on practical issues. A further challenge is poor communication and lack of trust between sectors and different types of actors.

The second working group considered academia and the different sectors of government. The group itself was made up of different sectors of government – roughly evenly split between the health and sport sectors. The general impression was that, with a few exceptions, very few countries have well established collaboration between sectors. One problem is the lack of funding for collaboration at the national level. The group discussed various possible methods of cross-sectoral communication, but emphasised the clear value of establishing working groups across ministries.

The third group considered the role of academia and other levels of government (e.g., local, regional, national, international). Most countries represented in the group do have some sort of mechanism to facilitate exchange between national and local levels, but this takes very different forms. It was agreed that high level coordinating mechanisms can help push projects forward, raise issues up the agenda, etc.

The involvement of local government clearly brings local knowledge about the current situation, about initiatives that are being implemented and on local needs. This should help ensure that investment really meets local needs. The different levels are also important for identifying good practice and for avoiding duplication.

There are also a number of challenges associated with intersectoral coordination across these levels. Such a process is time consuming and can slow down implementation. A lack of a common language – shared between different actors –can hamper communication. A further issue is the need for clarity on leadership within coordination mechanisms, and recognition that local government needs to maintain autonomy. Further challenges include the need for funding, difficulty in taking into account regional differences within countries and how the use of recommendations can be promoted at local level. In discussion, the importance of generating a sense of 'ownership' of the coordination mechanisms and policy-making process to maximise and sustain the engagement of participants was underlined.

Identifying and reporting on good practice

The final working group session considered examples of good practice interventions to promote physical activity. The groups were asked to consider the different components or characteristics of these interventions, critical success factors and the degree to which the interventions are sustainable.

All three groups discussed the same questions. Synthesising their discussions, a number of key points emerge.

Examples of good practice have a variety of different characteristics, with varying size of intervention, different models of funding etc. Many of the interventions are offered to all, even those that are meant to be targeted.

Successful interventions require the cooperation and 'buy-in' of all partners, as well as ministerial support. Other success factors identified include involvement of famous spokespersons (and not necessarily sports personalities), key committed individuals, strong

local implantation and adequate funding. In addition, well-designed and well-targeted interventions are important, and collaboration with specialist partners or partner institutions may be helpful. Similarly, a strong communication strategy to raise the visibility of the intervention is important.

Problems identified include the lack of collaboration between sectors and the fact that too often interventions reach mainly people who are already active.

In terms of monitoring and follow up, this is very expensive, and that may be why many interventions have been unable to show success. It is clear that different kinds of intervention require different types of evaluation. To improve assessment of how good interventions are, national recognition systems may be needed. If an intervention does not deliver the expected results, there is an obligation to have the courage to stop and transfer the investment elsewhere.

In order to address the sustainability of interventions, the key message is that it is important to think about the exit strategy from the outset.

The Council Recommendation on HEPA

Susanne Hollmann, Sport Unit at the European Commission, outlined the background of and the terms of reference for the national HEPA focal points, and provided some information on the monitoring framework and indicators.

The Council Recommendation on HEPA is a legal act, adopted in Nov 2013, following a Commission proposal including a Staff Working Document[8] and after a process of broad consultations, expert input and impact assessment. The Recommendation is based on the EU Physical Activity Guidelines which were developed by renowned HEPA experts and propose policy actions across sectors.

The Recommendation recommends a number of actions for Member States:

- Develop a cross-sector approach involving a variety of different policy areas. Two specific elements of this approach are identified:
    - Progressive development and implementation of national strategies and cross sector policies
    - Followed by identification of concrete actions in an action plan;
- Monitor physical activity levels and HEPA policies, using the light monitoring framework and the indicators;
- Appoint focal points;
- Cooperate closely among themselves and with the Commission through regular exchange of information and best practices on HEPA promotion.

The Recommendation invited the European Commission to provide assistance to Member States and targeted support to the national HEPA focal points through capacity building and training, to support WHO in developing the NOPA database and country profiles, to examine the possibility of producing European statistics and to submit a progress report to the Council every three years.

[8] European Commission. A monitoring framework for the implementation of policies to promote health-enhancing physical activity (HEPA), based on the EU Physical Activity Guidelines. Commission staff working document, accompanying the Proposal for a Council Recommendation on promoting health-enhancing physical activity across sectors. Brussels, 28.8.2013. SWD(2013) 310 final.

EU-WHO Cooperation

As part of the process of implementation of the Council Recommendation, the Commission has provided WHO with a direct grant and a process for close cooperation has been established. The goal of this collaboration is primarily to support the implementation of the Council Recommendation on HEPA, focusing particularly on the monitoring framework.

More specifically, the aims of the cooperation are to:

- Scale up and fine-tune the online WHO European database on Nutrition, Obesity and Physical Activity (NOPA) to include more information on physical activity;
- Set up a network of EU Member States physical activity focal points;
- Help EU Member States to evaluate their own physical activity policies by developing a mini HEPA policy audit tool and training materials;
- Support EU Member States in the development of physical activity recommendations.

The focal points have been nominated and the network is being launched with this meeting. In addition, an Expert Group on HEPA has been established and funding has started to be provided through the Erasmus+ Sport programme.

The role of the national focal points is to:

- Coordinate at national level the process of making available to WHO information and data related to defined indicators;
- Annually provide reviewed and updated country-specific data related to the defined indicators;
- Participate in regular meetings of national HEPA focal points (as a rule: twice a year).

The monitoring framework

The monitoring provisions are set out in the Monitoring Framework annexed to the Council Recommendation, which lists 23 indicators, for which data is largely available. These indicators are built on and reflect the main themes of the EU Physical Activity Guidelines.

In discussion, participants raised a number of detailed questions about some of the indicators. The most detailed description of the indicators is given in the annexed Staff Working Document. It outlines what each of the indicators includes or does not include (See Annex 3). This document requires some updating, but currently represents the most up to date version.

João Breda presented an overview of the known data sources for the indicators and the latest year of available data (See Annex 4). The table shows that there are some areas where data do exist, although often it requires updating, but there are other areas where national focal points will have to seek out the data sources. Even in some areas where there are data, a lot more detail is required. Taking indicator 22 as an example, yes/no answers have been provided on whether countries have national HEPA policies that include a plan for evaluation. Ideally information is required, however, on how many of the total number of policies include an evaluation plan.

Focal points are encouraged to supply as much information as possible. Specific figures and percentages, for example, are required wherever possible and where yes answers are given to ‘yes or no’ questions further details should be provided. In relation to indicators such as numbers 14 and 16, which ask for information on schemes, information is required

on levels at the national level or at sub-national for countries with decentralised government structures. Information on excellent examples of good practice at the local level could, however, also be included. Documents in national languages can be provided – or at least links to the relevant documents – but summaries in WHO EURO languages (English, French, German and Russian) may be required at some stage.

There was some discussion of the differences between the recommendations for the amount of physical activity for health. That is, where the national recommendations are not yet updated to be in line with the WHO recommendation how should indicator number 1 be reported? There was clarification that this indicator requires a response to the question 'Is there a national recommendation?' and, if so, 'what is it?'

Planning and next steps

João Breda outlined the tasks ahead for the focal points, presented a draft roadmap for the activities of the network and explained the connections between the EU policy approach to HEPA and the forthcoming WHO physical activity strategy for Europe.

The main deliverables expected from the focal points are to help with completion of the country profiles and provision of data, and links to the evidence, on the indicators. The country profiles are intended to provide an extensive description of physical activity in the country, and may include data beyond the scope of the 23 indicators.

Concretely, the next steps were set out as follows:

- **Mid-November**: It was agreed that WHO would send out a questionnaire setting out all the required data. Focal points would be invited to send comments.
- **20 January 2015**: deadline for focal points to return the questionnaire with a first (informal) reply for the eight simplest indicators (numbers 1,2,3,4,6,9,22 and 23). At the meeting a deadline of end of December for this phase was discussed, but a new deadline of 20 January has now been established. The information on these indicators will be used to prepare an initial draft country profile.
- **26 January 2015:** Meeting of the national focal points to discuss the draft country profiles and the data collection tool.
- **End April 2015:** Deadline for focal points to return fully completed questionnaire.
- **June 2015:** Deadline for validation and fine-tuning of the completed country profiles and meeting of the expert group.
- **September 2015:** Official launch of the revamped, updated NOPA database (extended to include all the indicators) and country profiles.

To facilitate the task of the national focal points, WHO will fill in the questionnaire as far as possible from existing data. The focal points will then need to check, review, update and complete the information. It was stressed that the information to be provided by the end of December is draft information – provided on an informal basis – and there will be an opportunity to review and validate in the months that follow.

Both WHO and the European Commission are acutely aware of the need to minimise the burden of reporting, and all efforts will be made to avoid overlap and duplication and to facilitate the task as far as possible.

Ideally, in future there will be an annual cycle of reconfirming the data. Obviously, the task will be more difficult and time consuming the first time. Annual updating, however, should be relatively quick and easy to do, and will ensure that the NOPA database stays up to date.

A number of other precise questions were raised about the indicators. It was agreed that focal points would have the opportunity for a short period of review to provide feedback, and ask questions, on the questionnaire. This feedback should be returned to WHO quickly. Focal points were encouraged to share their feedback with the whole network, as part of establishing a dialogue within the network, which could be continued at the next meeting in January 2015.

The draft terms of reference for the focal points will be revised in light of the discussion at this meeting and will be sent to national focal points. A written version of the roadmap for the next months, along with clarification of the interplay between this network and other structures will also be sent. Participants will also have the opportunity to review the report of the meeting in due course.

Conclusion

On behalf of the European Commission, Susanne Hollmann thanked participants and thanked WHO and other partners for the preparation. The national focal points network has now been established and the fruitful exchanges started here will be useful in the future. The Commission remains ready to support this process and, specifically, to support the focal points in their tasks. Further close work with WHO, ensuring synergies with WHO's work across the region, will remain a priority.

João Breda also thanked participants for their participation and enthusiastic contributions to an excellent meeting. WHO is delighted to be working with the broad range of participants represented here – discussing health issues with stakeholders from outside the health sector is always a priority for WHO. The meeting was privileged to have been addressed by Commissioner Vassiliou – and this reflects the extremely high level of political commitment to this issue. He thanked the Commission and emphasised how happy WHO is to be working in such a close partnership. Thanks were also due to the hosts for providing such a wonderful venue for the meeting. He also conveyed particular thanks to the WHO team for the organisation of the meeting and all the work behind it.

List of Annexes

Annex 1: Scope and purpose of the meeting

Annex 2: List of participants

Annex 3: Proposed indicators to evaluate HEPA levels and HEPA policies in the EU, taking into account the EU Physical Activity Guidelines (EU PA GL). Annex to the EU Council Recommendation.

Annex 4: EU Light Monitoring Framework Data Availability table

Annex 1
Scope and purpose

Context

Despite increasing knowledge about the importance of health-enhancing physical activity for the individual, for health systems and for economies, the proportion of citizens who reach recommended physical activity levels has not increased overall. Rather, evidence shows that rates of physical inactivity in the EU remain extremely high.

The EU Physical Activity Guidelines, the EU Council Recommendation on Promoting Health-Enhancing Physical Activity Across Sectors, as well as the WHO Physical Activity Recommendations and the upcoming WHO European Physical Activity for Health Strategy provide policy recommendations that can contribute to reversing this trend.

Some of these principles have been implemented with relative success in several Member States. However, challenges continue to exist, and there is a need to improve the design and implementation of policies that promote physical activity across sectors. In particular, more information and data is needed about policy developments and the epidemiological situation in the field of physical activity in Europe.

Following the 2013 Council Recommendation on HEPA, the European Commission and the WHO Regional Office for Europe have started a joint initiative that aims to develop and scale-up monitoring and surveillance of health-enhancing physical activity in the European Union Member States. An important aspect of this initiative is to set up a network of national physical activity focal points to help provide and validate information on physical activity from EU Member States in line with the monitoring framework established by the Recommendation and to integrate them into WHO Europe's information system for nutrition, obesity and physical activity, NOPA.

Aim of the meeting

The aim of the kick-off meeting on 21-22 October 2014 is to establish the focal points network, to agree on a common understanding of its tasks, goals and activities, and to define a road map for the next years as well as a work plan for the specific activities in the upcoming months.

Participants

Newly-nominated European Union national physical activity focal points; European Commission, represented by staff from DG EAC/Sport Unit; World Health Organization, represented by staff from the WHO Regional Office for Europe.

Annex 2
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Annex 3
Recommendations Council

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I

(Resolutions, recommendations and opinions)

RECOMMENDATIONS

COUNCIL

COUNCIL RECOMMENDATION

of 26 November 2013

on promoting health-enhancing physical activity across sectors

(2013/C 354/01)

THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty on the Functioning of the European Union, and in particular Article 292, in conjunction with Articles 165 and 168 thereof,

Having regard to the proposal from the European Commission,

Whereas:

(1) The benefits of physical activity, including regular sporting activity and exercise, across the life course are paramount and include lowered risk of cardiovascular disease and of some types of cancers and diabetes, improvements in musculoskeletal health and body weight control, as well as positive effects on mental health development and cognitive processes. Physical activity, as recommended by the World Health Organization (WHO), is important for all age groups, and has particular relevance for children, the working population and the elderly.

(2) Physical activity, being a prerequisite for a healthy lifestyle and a healthy workforce, contributes to the achievement of key objectives defined in the Europe 2020 Strategy notably with regard to growth, productivity and health.

(3) While efforts to promote health-enhancing physical activity (HEPA) have been stepped up by public authorities in some Member States over the past years, rates of physical inactivity in the Union remain unacceptably high. The majority of European citizens do not engage in sufficient physical activity, with 60 % never or seldom playing sport or exercising. The lack of leisure-time physical activity tends to be more common in the lower socio-economic groups. There are currently no indications that those negative trends are being reversed for the Union as a whole.

(4) Physical inactivity has been identified as a leading risk factor for premature mortality and disease in high-income countries world-wide, being responsible for about 1 million deaths per year in the WHO European Region alone. The detriments caused by the lack of physical activity in the Union are well recorded, as are the significant direct and indirect economic costs associated with the lack of physical activity and related health problems, especially in view of the fact that most European societies are ageing rapidly.

(5) Recent research indicates that sedentary behaviour might be a risk factor for health outcomes, independent of the influence of physical activity. In the Union, these findings should be taken into account when considering further actions in this area.

(6) As regards physical activity levels, there are vast discrepancies between Member States. While some have made considerable progress in increasing the proportion of citizens who meet the minimum level of recommended physical activity, many others have made none or even regressed. Current policies have so far not had a decisive impact in reducing the physical inactivity levels for the Union as a whole. There is considerable potential to learn from successful approaches to develop and implement HEPA policies.

(7) Physical education at school has the potential to be an effective tool to increase awareness of the importance of HEPA, and schools can be easily and effectively targeted to implement activities in this regard.

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(8) A number of policy areas, in particular sport and health, can contribute to the promotion of physical activity and can provide new opportunities for Union citizens to become physically active. For this potential to be fully exploited, and therefore for physical activity levels to increase, a strategic cross-sectoral approach in the field of HEPA promotion, including involvement at all levels of all relevant Ministries, bodies and organisations, in particular the sport movement, and taking into account existing and on-going policy work, is indispensable. The availability of more information and better data on physical activity levels and HEPA promotion policies is an essential element to underpin this process and a requirement for policy evaluation aimed at leading to more effective future policy development and implementation.

(9) The EU Physical Activity Guidelines (EU PA GL) [1], as referred to by the Council and by the Representatives of the Governments of the Member States, meeting within the Council, in their conclusions of 27 November 2012 [2] on promoting HEPA, and by the Council in its conclusions entitled 'Healthy Ageing across the Life-cycle' [3], advocate a cross-sectoral approach covering all thematic areas responsible for HEPA promotion.

(10) The 2011 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions entitled 'Developing the European Dimension in Sport' invited the Commission and the Member States to continue progress, based on the EU PA GL, towards the establishment of national guidelines, including a review and coordination process, and to consider a Council Recommendation in that field.

(11) The Resolution of the Council and of the Representatives of the Governments of the Member States, meeting within the Council, on a European Union Work Plan for Sport for 2011-2014 [4] recognised the need to strengthen cooperation between the Commission and the Member States in sport in a few priority areas, including the promotion of HEPA. In July 2012, the Expert Group 'Sport, Health and Participation', established in mid-2011 in the context of that Work Plan, expressed support for a new Union initiative to promote HEPA.

(12) The Council conclusions of 27 November 2012 on promoting HEPA acknowledged the need for further action at Union level and called on the Commission to present a proposal for a Council Recommendation, including a light monitoring framework based on a set of indicators covering the thematic areas of the EU PA GL,

[1] EU Physical Activity Guidelines, welcomed in the Presidency Conclusions of the Informal meeting of the EU Ministers, responsible for sport, in November 2008.
[2] OJ C 393, 19.12.2012, p. 22.
[3] OJ C 396, 21.12.2012, p. 8.
[4] OJ C 162, 1.6.2011, p. 1.

HEREBY RECOMMENDS that Member States:

1. Work towards effective HEPA policies by developing a cross-sectoral approach involving policy areas including sport, health, education, environment and transport, taking into account the EU PA GL, as well as other relevant sectors and in accordance with national specificities. This should include:

   (a) the progressive development and implementation of national strategies and cross-sectoral policies aimed at HEPA promotion in line with national legislation and practice;

   (b) identification of concrete actions for the delivery of those strategies or policies, in an action plan, where considered appropriate.

2. Monitor physical activity levels and HEPA policies by making use of the light monitoring framework [5] and indicators set out in the Annex, according to national circumstances.

3. Within six months from the adoption of this Recommendation, appoint national HEPA focal points [6], in accordance with national legislation and practice, to support the above-mentioned monitoring framework, and inform the Commission of their appointment.

   The national HEPA focal points will, in particular, be tasked to coordinate the process of making data on physical activity available for the monitoring framework; those data should feed into the existing WHO European database on nutrition, obesity and physical activity (NOPA); they should also facilitate interdepartmental cooperation on HEPA policies.

4. Cooperate closely among themselves and with the Commission by engaging in a process of regular exchange of information and best practices on HEPA promotion in the relevant Union level structures for sport and for health as a basis for strengthened policy coordination,

[5] The monitoring framework will set out a minimal set of reporting requirements on general aspects of HEPA promotion that can be addressed by all Member States. It will be implemented in close synergy and cooperation with the WHO, thereby avoiding duplication of data collection.
[6] The focal point will be the main contact person in the Member State for providing information and data corresponding to the indicators table in the Annex, which will form part of the questionnaire to be addressed to the focal points by the WHO.

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HEREBY INVITES the Commission to:

1. Assist Member States in adopting national strategies, developing cross-sectoral HEPA policy approaches and implementing corresponding action plans by facilitating the exchange of information and good practice, effective peer-learning, networking and identification of successful approaches to HEPA promotion.

2. Promote the establishment and functioning of the HEPA monitoring framework, in line with the indicators listed in the Annex, based on existing forms of monitoring and data collection in this field, and using to the largest extent possible existing information and data, by:

   (a) providing, with the help of scientific experts, targeted support for capacity building and training to national HEPA focal points, including with a view to the data collection process, and, as appropriate, to other representatives from relevant public authorities;

   (b) examining the possibility to use data collected in the context of this monitoring framework to potentially produce European statistics on physical activity levels every three years;

   (c) supporting the WHO in further developing the physical activity aspects of the NOPA database by adapting it to the monitoring framework set out in the Annex;

   (d) supporting and closely cooperating with the WHO in the preparation and issuing of country-specific overviews on HEPA and analysis of HEPA trends.

3. Report every three years on progress in implementing this Recommendation, on the basis of information provided within the reporting arrangements set out in the monitoring framework and of other relevant information about HEPA policy development and implementation provided by Member States, and evaluate the added value of this Recommendation.

Done at Brussels, 26 November 2013.

For the Council

The President

D. A. BARAKAUSKAS

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ANNEX

Proposed indicators to evaluate HEPA levels and HEPA policies in the EU, taking into account the EU Physical Activity Guidelines (EU PA GL) ([1])

Thematic areas of the EU PA GL	Proposed indicators and variables/units	Data availability
International PA recommendations and guidelines (EU PA GL 1-2)	1. National recommendation on physical activity for health Yes/no	(****)
	2. Adults reaching the minimum WHO recommendation on physical activity for health or equivalent national recommendations Percentage of adults reaching a minimum of 150 minutes of moderate-intensity physical activity per week, or 75 minutes of vigorous-intensity activity, or an equivalent combination	(****)
	3. Children and adolescents reaching the minimum WHO recommendation on physical activity for health or equivalent national recommendations Percentage of children and adolescents reaching at least 60 minutes of mode-rate- to vigorous-intensity physical activity daily or on at least five days/week	(****)
Cross-sectoral approach (EU PA GL 3-5)	4. National coordination mechanism on HEPA promotion Yes/no; if yes, further details	(****)
	5. Funding allocated specifically to HEPA promotion By sector (health, sport, transport etc.): — total funding, — per capita, — by gross domestic product at PPP per capita, in Euros.	(*)
'Sport' (EU PA GL 6-13)	6. National sport for all policy and/or action plan Yes/no; if yes, further details	(****)
	7. Health-oriented sport clubs (Sport Clubs for Health Programme) Implementation of the guidelines developed by HEPA Europe/TAFISA project: yes/no; if yes, description	(**)
	8. Framework to support opportunities to increase access to recreational or exercise facilities for low socio-economic groups Existence of a framework: yes/foreseen within the next two years/no; and, if yes, description	(***)
	9. Target groups addressed by the national HEPA policy By target group (groups in particular need of physical activity (e.g. low socio-economic groups, people with low levels of PA, elderly, ethnic minorities etc.))	(****)
'Health' (EU PA GL 14-20)	10. Monitoring and surveillance of physical activity and sedentary behaviour Physical activity and sedentary behaviour included in the national health monitoring system: yes/no; if yes, further details	(***)
	11. Counselling on physical activity performed by health professionals Counselling on physical activity: yes/no; if yes: reimbursed as part of primary health care services: yes/no	(***)

([1]) The information and data that Member States are recommended to provide in the context of the light monitoring framework are expected to improve over time. Support for that framework is proposed to come from the cooperation and capacity building activities foreseen in this Recommendation.

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Thematic areas of the EU PA GL	Proposed indicators and variables/units	Data availability
	12. Training on physical activity in curriculum for health professionals — number of hours for nurses, doctors, — mandatory or optional, — clear assessment and accreditation structures to reflect the learning outcomes of the subject.	(**)
'Education' (EU PA GL 21-24)	13. Physical education in primary and secondary schools — number of hours per school level, — mandatory or optional, — national or sub-national regulation.	(***)
	14. Schemes for school-related physical activity promotion Existence of a national or sub-national scheme: yes/no; if yes, further details	(**)
	15. HEPA in training of physical education teachers HEPA being a module in training of PE teachers at bachelor's and/or master's degree level: yes/no; mandatory/optional	(**)
	16. Schemes promoting active travel to school National or sub-national (where relevant) schemes to promote active travel to school (e.g. walking buses, cycling): yes/no, if yes: description	(***)
'Environment, urban planning, public safety' (EU PA GL 25-32)	17. Level of cycling/walking Main mode of transport used for your daily activities (car, motorbike, public transport, walking, cycling, other)	(****)
	18. European Guidelines for improving Infrastructures for Leisure-Time Physical Activity European Guidelines for improving Infrastructures for Leisure-Time Physical Activity being applied systematically to plan, build and manage infrastructures: Yes/not yet but foreseen within the next two years/no	(**)/(***)
'Working environment' (EU PA GL 33-34)	19. Schemes to promote active travel to work Existence of a national or sub-national (where relevant) incentive scheme for companies or employees to promote active travel to work (e.g. walking, cycling): yes/no, if yes: description	(***)
	20. Schemes to promote physical activity at the work place Existence of a national or sub-national (where relevant) incentive scheme for companies to promote physical activity at the work place (e.g. gyms, showers, walking stairs etc.): yes/no	(***)
'Senior citizens' (EU PA GL 35-37)	21. Schemes for community interventions to promote PA in elderly people Existence of a scheme for community interventions to promote PA in elderly people: yes/no; if yes: description	(***)
'Indicators/evaluation' (EU PA GL 38)	22. National HEPA policies that include a plan for evaluation x out of y national HEPA policies (sport, health, transport, environment, by sector) include a clear intention or plan for evaluation	(****)
'Public awareness' (EU PA GL 39)	23. Existence of a national awareness raising campaign on physical activity Yes/no, if yes: description	(***)

Data availability:

(*) data not yet collected.
(**) data not yet collected but planned within NOPA.
(***) data available (i.e. included in country templates or through other available source) but not yet validated, or needs updating.
(****) data available and validated within NOPA.

Annex 4
EU Light Monitoring Framework
Data Availability

Indicator, EU Council Rec. Light Monitoring Framework	Data source(s)	Year
1. National recommendation on physical activity for health	WHO NOPA	2009/2011
2. Adults reaching the minimum WHO recommendation on physical activity for health or equivalent national recommendations	WHO NOPA/GHO	2014
3. Children and adolescents reaching the minimum WHO recommendation on physical activity for health or equivalent national recommendations	WHO NOPA/GHO	2014
4. National coordination mechanism on HEPA promotion	WHO NOPA	2009/2011
5. Funding allocated specifically to HEPA promotion	WHO NOPA (only similar indicator available)	2009/2011
6. National sport for all policy and/or action plan	WHO NOPA	2009/2011
7. Health-oriented sport clubs (Sport Clubs for Health Programme)	Limited data from “Sports Club for Health Network”	?
8. Framework to support opportunities to increase access to recreational or exercise facilities for low socio-economic groups	No data available	
9. Target groups addressed by the national HEPA policy	WHO NOPA	2009/2011
10. Monitoring and surveillance of physical activity and sedentary behaviour	WHO NOPA	2009/2011

Indicator, EU Council Rec. Light Monitoring Framework	Data source(s)	Year
11. Counselling on physical activity performed by health professionals	WHO NOPA (only similar indicator available)	2009/2011
12. Training on physical activity in curriculum for health professionals	Upcoming HEPA Europe/WHO Survey	???
13. Physical education in primary and secondary schools	Data on some countries in WHO NOPA, EURYDIS project report	2009/2013
14. Schemes for school-related physical activity promotion	EURYDIS project report	2013
15. HEPA in training of physical education teachers	No data available	
16. Schemes promoting active travel to school	WHO NOPA	2009/2011
17. Level of cycling/walking	WHO NOPA	
18. European Guidelines for improving Infrastructures for Leisure-Time Physical Activity	No data available	
19. Schemes to promote active travel to work	WHO NOPA (only similar indicator available)	2009/2011
20. Schemes to promote physical activity at the work place	No data available	

Indicator, EU Council Rec. Light Monitoring Framework	**Data source(s)**	**Year**
21. Schemes for community interventions to promote PA in elderly people	**WHO NOPA (only similar indicator available)**	**2009/2011**
22. National HEPA policies that include a plan for evaluation	**WHO NOPA (only similar indicator available)**	**2009/2011**
23. Existence of a national awareness raising campaign on physical activity	**No data available**	