



Second meeting of the European Union Physical Activity Focal Points Network

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Meeting Report

Context

Despite increasing knowledge about the importance of health-enhancing physical activity (HEPA) 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 forthcoming *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, 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 HEPA in the European Union Member States. An important aspect of this initiative has been the establishment of a network of national physical activity focal points¹ 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).

Background

The EU Physical Activity Focal Point Network met for the first time in Rome in October 2014, and focal points had since provided information to WHO on a first set of eight indicators. A second meeting took place at the University of Zurich, Switzerland, on 26 January 2015.

¹ Focal points have been appointed for 28 Member States.

The aims of the meeting were to discuss lessons learned, challenges and concerns encountered when providing data for the first eight identified indicators; and to identify training and support needs to help focal points in providing data for the remaining indicators in the coming months.

Participants included the focal points, representing 24 Member States, the European Commission, represented by staff from DG EAC/Sport Unit and the World Health Organization, represented by staff from the WHO Regional Office for Europe. An external keynote speaker, some external experts (invited as observers) and a rapporteur were also present.²

Opening addresses

On behalf of the European Commission, Susanne Hollmann, Deputy Head of the Unit for Sport Policy and Programme in the Directorate General for Education and Culture (DG EAC), welcomed participants to the meeting and outlined some developments since the first meeting in October. In the intervening time, there have been a number of institutional changes at EU level, notably with the appointment of the new Commission in late 2014. The new Commissioner with responsibility for sport, Tibor Navracsics, has confirmed that HEPA will remain high on the Commission's agenda. The last few months have seen further progress on implementation of the second *EU Work Plan for Sport (2014-2017)* in which HEPA remains a priority. In addition, the Expert Group on HEPA is making good progress, preparations are ongoing for the first European Week of Sport from 7–13 September 2015 and project funding, including for HEPA, has been made available through the Erasmus+ programme.

João Breda welcomed participants on behalf of WHO and thanked all the focal points for their excellent cooperation over the last three months. He also expressed thanks to the European Commission, specifically DG EAC, for this collaboration, which is efficient, in terms of resources and time, and is working towards delivery of better results. Thanks are also due to the University of Zurich for hosting the meeting – and, in particular, to Sonja Kahlmeier for organising the meeting – and to the Swiss government for its support.

WHO is particularly happy that this network – which not only involves such close collaboration between WHO and the European Commission, but also involves many participants from outside the health sector – is putting into practice the multisectoral collaboration at the heart of WHO's *Health 2020* approach. It is important to note that the meeting is taking place immediately prior to a two-day technical consultation with WHO European Region Member States on the draft European Physical Activity for Health Strategy. The aim is for this strategy – WHO's first ever regional strategy on physical activity – to be adopted by the Regional Committee in September.

Dr Breda set out the objectives and format for this second meeting of the focal points. The meeting is intended to review the progress made since the network's first meeting in October 2014, and to discuss the questions and challenges arising from the first stage of the data collection process. This would be followed by a briefing on some key findings from the questionnaire responses, distribution of a preliminary initial draft country profile(s) to each focal point and a discussion on these country profiles. Finally, a new mechanism to support national focal points in this data collection work would be introduced, and the next steps for the network would be agreed.

Following the opening addresses, all the participants introduced themselves. See Annex 1 for a full list of participants.

² See Annex 1 for a full list of participants.

The data collection tool

João Breda introduced the data collection tool and provided an overview of the responses and a summary of the most common questions posed by Member States Focal Points so far.

At the first meeting in Rome, it was agreed to initiate the process of monitoring the implementation of the Council Recommendation by updating existing information on eight of the 23 indicators set out in the monitoring framework set out in the Commission Staff Working Document.³

WHO combined these indicators into a questionnaire setting out all the data required and focal points were asked to complete and return the questionnaire by 20 January 2015. This has now happened and most Member States have sent back their responses. The response to the questionnaire has been highly satisfactory, and WHO has been impressed with the high quality of information and impressive level of detail provided.

The eight indicators included are shown below. The indicator number refers to the numbering in monitoring framework, while the question number shown in brackets afterwards refers to the current WHO questionnaire (See Annex 2):

- Indicator 1: National recommendation on physical activity for health (Question 1)
- Indicator 2: Adults reaching the minimum WHO recommendation on physical activity for health (Question 2)
- Indicator 3: Children and adolescents reaching the minimum WHO recommendation on physical activity for health (Question 3)
- Indicator 4: National coordination mechanisms on HEPA promotion (Questions 4 and 4a)
- Indicator 6: National Sport for All policy or action plan (Questions 5 and 5a)
- Indicator 9: Target groups addressed by the national HEPA policy (Questions 6 and 6a)
- Indicator 22: National HEPA policies that include a plan for evaluation (Question 7)
- Indicator 23: National awareness raising campaign on physical activity (Question 8)

These eight indicators were selected because they were considered to be the more straightforward indicators for Member States to provide data on.

The Regional Office followed up on with Member States to provide support in completing the questionnaire and encourage prompt response. Currently, 19 Member States have responded and nine have yet to respond. Although the aim is always for 100% response, WHO is satisfied with this level of response given the short timeframe, some changes that have taken place within Member States, and the level of detail provided in the responses received to date. The richness of the responses is particularly encouraging, and it is already clear that supplementing existing WHO information with data provided by the Member State focal points will greatly improve the country profiles.

Dr Breda reminded participants that all information published by WHO will be validated by Member States. Focal points should be aware that around June they would be asked to seek validation for the draft country profiles.

³ 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.

Feedback on the indicators

Despite the fact that the eight indicators selected for this first round were considered to be the most straightforward, a number of issues have been identified during the data collection process. Table 1 summarises some of the issues identified through the questionnaire process.⁴

Table 1 Findings and observations on completion of the questionnaire

Indicator (Question)	Findings and observations
Indicator 1: National recommendation on physical activity for health (Question 1)	This indicator was generally answered well, but reference information to the actual recommendation was sometimes missing. The questionnaire should have asked for a reference to the recommendations.
Indicator 2: Adults reaching the minimum WHO recommendation on physical activity for health (Question 2)	<p>Many countries gave data from international studies (e.g., Eurobarometer, Health Behaviour of School-age Children (HBSC)). A key issue for WHO is that national data is appropriate.</p> <p>Brand new, revised WHO estimates, developed in a way to improve comparability of data between countries, were presented. From now on, this data will be used to make country comparisons. Member States will still be able to include their own national data in country profiles, with notes to explain that these data are not comparable.</p>
Indicator 3: Children and adolescents reaching the minimum WHO recommendation on physical activity for health (Question 3)	New WHO estimates are also available for adolescents. This data is challenging. Because the data are based on the WHO recommendation of at least 60 minutes daily, the data show a very high prevalence on physical inactivity in adolescents. It is important to bear in mind that these data using different criteria to the adult prevalence indicator.
Indicator 4: National coordination mechanisms on HEPA promotion (Questions 4 and 4a)	<p>The questionnaire process provided very valuable information on Question 4. Answers were often different from those received for nutrition profiles and many countries had gone from having a coordinator to not having one.</p> <p>In relation to funding (Question 4a), many countries said that they do not have funding allocated and States that did answer rarely gave the value by 'Funding by gross domestic product at PPP per capita'. A number of methodological questions were raised on this question.</p>
Indicator 6: National Sport for All policy or action plan (Questions 5 and 5a)	This question was answered relatively well, although there was a large variation in replies, particularly in relation to 'policy areas covered'. Translated versions of the documents were not always available.
Indicator 9: Target groups addressed by the national HEPA policy (Questions 6 and 6a)	There was a large variation in responses to this question and not all of the answers were sufficiently specific leaving some room for misinterpretation. Some, but not all, countries specifically mentioned vulnerable groups that are targeted.
Indicator 22: National HEPA policies that include a plan for evaluation (Question 7)	There appear to be many issues with this indicator. Most countries only listed the policies that include a plan for evaluation. There are clearly problems in knowing the denominator (i.e. the number of policies) and thus the percentages.
Indicator 23: National awareness raising campaign on physical activity (Question 8)	<p>This question was answered fairly well. In due course, it will be necessary to verify that all the campaigns mentioned are at the national level. Information on topics covered was quite vague (if completed at all), and could be improved by making the question more specific.</p> <p>In most cases, no answer was provided to the sub-question on funding.</p>

⁴ One reply had been received the weekend before the meeting so had not been incorporated into the results in Dr Breda's presentation.

Discussion

Participants were invited to comment on Dr Breda's presentation and to further discuss any difficulties and challenges associated with completing the questionnaire.

There were a number of comments on specific indicators:

Indicator 2 (Question 2)

Dr Breda presented the new WHO prevalence estimates (Figures 1 and 2).

Figure 1 New WHO estimates on age-standardized prevalence of physical inactivity in adults (18+ years), 2010

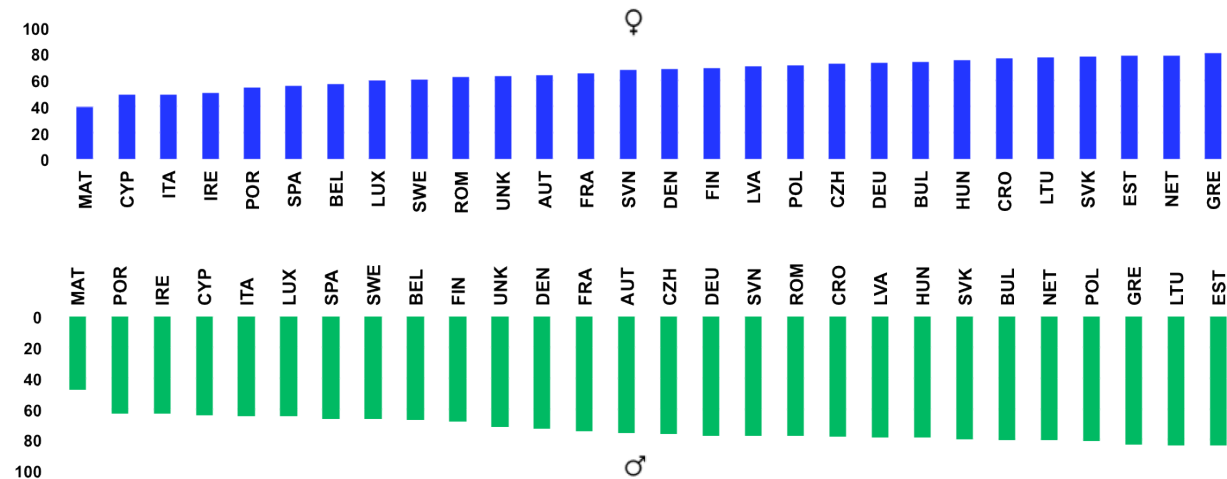
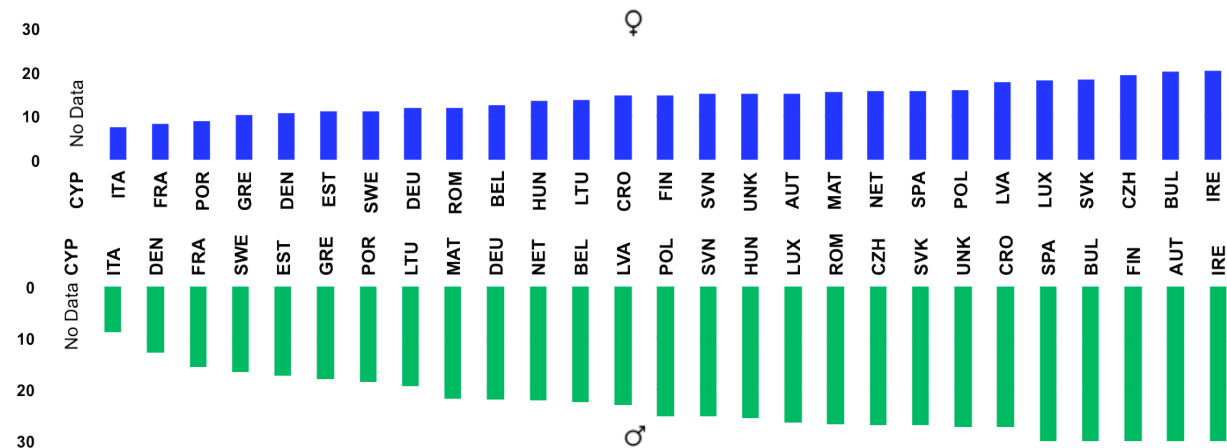


Figure 2 Comparable estimates of prevalence of insufficient physical activity in adolescents (11-17 years), 2010



There was a great deal of discussion about these estimates, and the basis for the figures. These new estimates, published by WHO headquarters⁵, have been calculated based on modelling that takes into account differences in national data collection in order to produce data that is more comparable across countries. Harmonisation of data and comparability is always a tremendous challenge for the European Commission and for WHO, and that is why these estimates are so important. These estimates were published very recently and will be in use for several years to come.

⁵ Global status report on noncommunicable diseases 2014. World Health Organization, 2014. Available from: <http://www.who.int/nmh/publications/ncd-status-report-2014/en/>

Dr Breda agreed to provide further information on the data sources used in the WHO estimates. Focal points who require more detail were asked to email him a request for such information. He emphasised that, because of the comparability of these data, they will be included, but that countries will be able to supplement these figures with their own national data and provide a footnote explaining the differences and stating that these national figures are not suitable for use in international comparisons. There was a request for WHO to include information about the sources and methods of the WHO estimates in each of the country profiles. This might be important for policy purposes – especially if, for example, the WHO estimates are based on older data than the national figures. Dr Breda indicated inclusion of this information might be possible.

Clarification was provided on the age ranges used for ‘adults’ and ‘adolescents’. The new WHO estimates define adults as aged 18 or older and define adolescents as aged between 11 and 17 years. The previous WHO estimates included those aged 15 and older as adults.

A question was raised about the cut-off points used for questions 2 and 3. Sweden, for example, has a cut-off point higher than 150 minutes of moderate-intensity physical activity (MVPA) weekly. Dr Breda emphasised that the WHO estimates have taken such differences into account, but countries can provide their own data, based on their own cut-offs, with appropriate explanatory notes.

There was a clarification that gender-specific data is needed for indicators 2 and 3.

The implications of countries increasingly using objectively measured data were raised. From WHO’s perspective, there are already difficulties in data collection with existing measurements, so any imminent move towards different types of measurement for international comparison purposes is unlikely.

Indicator 3 (Question 3)

A discrepancy between the WHO recommendation for 60 minutes of MVPA daily for adolescents and the European Commission’s Staff Working Document which refers to ‘every day or on at least five days a week’ was highlighted. In fact, as Ms Hollmann pointed out, the Staff Working Document is in need of some updating, and this is one aspect that will be updated.

As mentioned above, there was clarification that gender-specific data is needed for indicator 3.

In response to a question as to whether, ideally, data on children and adolescents should be disaggregated or combined, Dr Breda stated that disaggregated data is preferable, wherever possible. This also applies to disaggregation of data for disadvantaged groups. This level of detail will not necessarily always be included in the country profiles, but would be enormously useful for WHO and for the NOPA database.

Indicator 4 (Questions 4 and 4a)

A question was raised as to whether the information on national coordinating mechanisms would be more meaningful if it included a qualitative element on the output or effectiveness of such mechanisms. It was suggested that, although this information would indeed be interesting, it could be much more complicated for Member States to answer.

A question was raised about where information on GDP/capita can be found. ‘GDP’, ‘GDP per capita’ and ‘GDP per capita PPP’ are all standard UN indicators, used in country profiles. There was a clarification that the meaning of ‘PPP per capita’ is same as *parité de pouvoir d’achat* in French.

Dr Breda explained that, while standardised data on funding would be ideal, all information on funding is valuable. It is interesting to know, for example, whether a budget line exists and, if so, for how much. From this starting point it will be possible to report the data in the most appropriate way (e.g., per capita). The involvement of different sectors (other than health) and local government poses particular challenges for gathering data on funding. This is a critical indicator because it has clear implications for policymakers and the allocation of more resources.

Indicator 6 (Question 5)

Further guidance was requested on what type of policies should be included in the answer on national sport for all policies. Is this actually meant to refer to HEPA policies? It is useful to recall that these indicators are drawn from the monitoring framework set out in the European Commission's Staff Working Document and, as such, reflects the *EU Physical Activity Guidelines*. There is an argument, therefore, that the wording of this question could be amended (to include HEPA policies) or an additional indicator on HEPA policies could be included.

Indicator 22 (Question 7)

One difficulty in completing the question on inclusion of evaluation in HEPA policies was that, in some countries, it is difficult to know the total number of policies that exist. This makes it impossible to calculate a percentage. The problem is particularly acute in countries with decentralised government (e.g., Spain and the United Kingdom). Dr Breda acknowledged that this question is difficult to answer if information on the denominator (i.e., the number of policies) is unavailable, and that the wording of the question may need to be revisited. He also acknowledged the complications facing focal points in decentralised countries (see also point on national or sub-national data below).

The omission of the education sector from this question was highlighted and WHO undertook to review this.

Indicator 23 (Question 8)

The difficulty in assessing how much money is spent on HEPA awareness campaigns, when such campaigns are part of a bigger, broader health campaign was raised. It was suggested that the combination of Questions 4a and 8 does not give a real picture of HEPA expenditure, since these questions only focus on coordination mechanisms and national awareness campaigns and do not include other elements of HEPA promotion.

It was pointed out that future stages of the questionnaire would include further questions on funding (e.g., indicator 5 on funding for HEPA promotion). It is clear that some of the difficulties raised during this first stage will require further discussion and it may be that several rounds of data collection will be required to collate the necessary information on this important indicator. The *HEPA Policy Audit Tool*, under development for a few years, includes a question on funding dedicated to HEPA and this could prove helpful.⁶ Clearly, this indicator is of fundamental importance for policymakers and for evaluation, so WHO hopes to be able to provide more guidance.

There were also a number of more general points on responding to the questionnaire:

National or sub-national data

There was discussion on whether sub-national (or regional) data should be provided with national data. Questions 6 and 7 specifically refer to possible inclusion of sub-national data. In fact, only national data is required. In some highly decentralised countries, however, only sub-

⁶ Available from: <http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/publications/2011/health-enhancing-physical-activity-hepa-policy-audit-tool>

national data is available, and separate reporting is acceptable in these exceptional circumstances. It may be necessary to review the wording of the questionnaire to make this clear. The particular challenges facing focal points from highly decentralised countries were acknowledged.

Dr Breda added that focal points could use their judgement to decide to report something that is extremely innovative that is happening or is having a major impact at regional level.

What is a HEPA policy?

Further guidance was sought on what is meant by HEPA promotion policies (e.g., in question 6). There was a lack of clarity about when a policy should be considered to be a HEPA policy. Clarification was provided that broader policies that could have an impact on HEPA should be included. For example, any transport policy that promotes active mobility should be included, even if it does not explicitly mention improving health. Transport policies that do not mention promotion of walking, cycling or HEPA, however, should not be included. It was suggested that it would be useful to provide an explanatory note to clarify this question.

Indicator on HEPA policies

There was a suggestion that there should also be an indicator to determine more information about what different HEPA policies exist, before asking specifically about which groups are targeted by those policies.

Defining terms (Sports for All, health-enhancing physical activity, etc.)

Related to the discussions of what should be included as a HEPA promotion policy (questions 6 and 7) or a sports for all policy (questions 5 and 5a), there was some discussion about the definitions and differences between the various terms. This has been a topic of regular discussion within this policy area for many years, and a detailed discussion or review of the concepts is not helpful or appropriate at this stage. In general, health-enhancing physical activity should be seen as the broader term, and sport for all policy would be considered as one HEPA policy.

Eurobarometer data

There was some discussion about the use of Eurobarometer data, and whether it is valid to use this interview-based tool to make comparisons over time. The Commission is aware of the limitations of the Eurobarometer tool as compared to solid statistics, but these are, nonetheless, sometimes the only data available. The work of the focal points to improve data collection is an important step towards addressing these issues.

Health and wellbeing: Other aspects to physical activity than health

There was a comment that it is important to take into account the much broader benefits to physical activity than the health effects. Other factors such as enjoyment, team building, social skills and psychological wellbeing can all play a role. There may be scope for this broader concept of 'health and wellbeing' to potentially be incorporated into the WHO country profiles.

Dr Breda drew the discussion to a close by concluding that, despite the difficulties, the key point is to be transparent about the data provided. Both WHO and the Commission recognise that the data would not be perfect from the outset and that the data quality will improve over time.

Presentation of draft country profiles on physical activity, based on existing NOPA data and latest updates from Member States

The focal points were presented with two draft versions of their country profiles, prepared by the WHO Regional Office. One version was completed on the basis of existing information and

extracted from the most recent obesity and physical activity profiles *prior* to receipt of the questionnaire answers. The second version had been updated to reflect the information after receipt of the questionnaire on the first eight indicators.

The idea behind the country profiles is to provide a brief snapshot of the national situation, and therefore the documents should not generally be longer than four pages. Countries with more complicated reporting, because of their decentralised structure, may, exceptionally, require longer profiles.

The marked differences between the first and second versions of the country profiles clearly demonstrate the enormous value of the questionnaire process. This is also illustrated by the profiles of those countries that have yet to provide their questionnaire responses – the availability of data remains poor.

Discussion

It was agreed that WHO would send the first draft country profiles to the focal points for initial review. Dr Breda stressed, however, that Member States will always be asked to provide final approval, and that WHO will never publish country information without such approval. Focal points should not, therefore, feel obliged to review the profile at this point because there will be a later opportunity.

There was some discussion about how Member States could ensure some kind of quality assurance process for data provided to WHO, and also whether stricter guidelines from WHO are required. When requesting information, WHO requests reference details and evidence for assertions, and such information needs to be checked. This is an important part of the role of focal points, to validate the information that is sent to WHO.

There were some concerns that the considerable differences between the national data and the WHO estimates could create confusion and also undermine the credibility of the country profile documents.

There was discussion about whether the country profiles should be translated into national languages. In general, participants were keen to have the profiles translated into their own language.

Areas of support for Member States

The *Council Recommendation on promoting HEPA across sectors* invited the Commission to provide ‘with the help of scientific experts, targeted support for capacity building and training to national HEPA focal points.’ The following session of the meeting introduced a new mechanism for such support and invited discussion on how this could best meet the needs of national focal points.

Call for tender for a study to support the data collection process

Susanne Hollmann outlined the details of a tender issued by the DG EAC in order to provide support for the focal points. The call for tender for a study to focus on support for the data collection process was launched last year.⁷ The tender was awarded to a consortium led by Friedrich-Alexander University Erlangen-Nuremberg (hereafter referred to as the University of Erlangen) to provide support for data collection and training. The tender process specified that the support must be linked to ongoing data collection processes, in order not to present an

⁷ Call for Tender No. EAC/19/2014

additional burden to Member States. Ms Hollmann encouraged focal points to be clear about their expectations and needs for support in the discussion that followed on the study and the consortium work plan.

Study on the implementation of the EU Physical Activity Guidelines

Professor Dr Alfred Rütten, University of Erlangen, Germany, provided an overview of the study objectives and process, and of the consortium that has been awarded the tender.

It is important to emphasize from the outset, that this study is intended to be a highly interactive process, rather than a study of an exclusively academic nature.

There are three pillars of the study:

- A. Enabling national focal points to collect data on the implementation of the guidelines based upon the 23 indicators in the Council Recommendation.
- B. Performing a specific situation analysis and an identification of priority action areas in a group of Member States. *This will help improve long-term implementation strategies for the Guidelines by providing more detailed information on where countries stand and by identifying assets and barriers to implementation. This will be postponed to the second half of the tender period.*
- C. Developing training material and training modules for national focal points. *This will provide Member States with materials that they can use to train staff in the monitoring of the implementation of the Guidelines in the future, beyond the current round. The training materials will be developed in collaboration with the focal points.*

The members of the consortium and their roles are as follows:

- University of Erlangen – Responsible for coordination, contact with DG EAC, national focal points and WHO and for the situation analysis;
- University of Zurich – Taking the lead in collecting and analysing data;
- University of Ulster – Leading on desk research, verification and analysis of focal point data;
- Cavill Associates (subcontractor) – Leading on the development of training materials.

In relation to task A – data collection on indicators – there is considerable time pressure to provide support the focal points in the data collection process up to June 2015. During March and April the plan is to provide support to focal points through webinars or a workshop meeting. The aim is then to complete the physical activity country profiles, in collaboration with WHO.

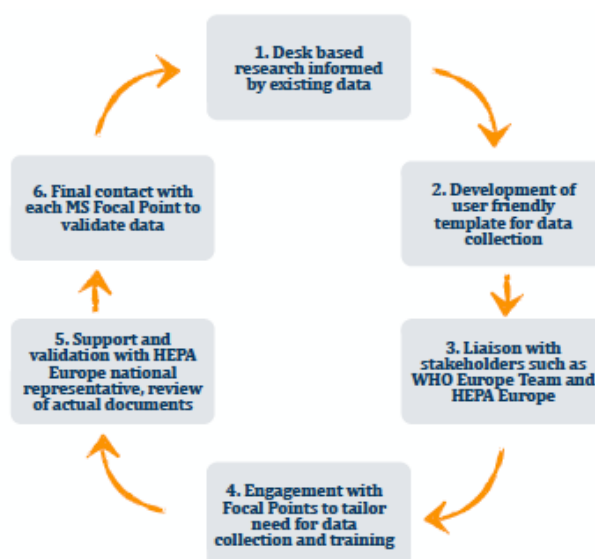
The consortium has identified three groups of indicators:

- Group 1: Indicators for which information is publicly available from international databases for all or most Member States.
- Group 2: Indicators for which information is publicly available but may be incomplete or not up-to-date.
- Group 3: Indicators for which information is not publicly available, and for which alternative ways of data collection will need to be explored.

It is important to get feedback from the focal points on which of the 23 indicators pose the greatest difficulties for data collection, and which category each indicator falls into.

The circular process envisaged for this process is shown in Figure 3.

Figure 3 Interactive process for data collection (Task A)



This needs to be a highly interactive process, whereby focal points provide feedback and the support team can further refine the question or provide a template for responses.

Suggestions will be made in the context of this study as to how to update the Commission's Staff Working Document .

Dr Breda commented that the involvement of this group of academics represents a tremendous asset to facilitate the focal points' work and to improve the quality of data reporting.

Discussion

In response to a question on the timeframe for this work, it was clarified that the support from the Erlangen team is available from now and will run through until June 2015 on the remaining indicators.

There was some discussion about the different ways that support could be provided to focal points, e.g., through webinars or workshop meetings. Participants confirmed that such support would indeed be very welcome. Given the short timeframe, however, a face-to-face meeting was likely to prove challenging and there was, therefore, a preference for remote support through webinar(s), phone calls, etc. It was suggested that one webinar could be organised to explain the methodology used to generate the WHO prevalence estimates (the Global Health Observatory figures).

Professor Rütten asked focal points for their feedback on the indicators. Namely, which ones are easiest, which pose most difficulty and what barriers are anticipated for the data collection.

Several focal points commented that it is difficult to give meaningful feedback on an indicator until after they have tried to collect the data on that particular indicator. The table below summarises the comments received on specific indicators (Table 2).

Table 2 Comments on the indicators by meeting participants

Indicator Number	Indicator (shorthand description)	Comments
2	Prevalence adults	This indicator has already been identified as challenging.
7	Health-oriented sport clubs (Sports Clubs for Health Programme)	More information is needed on what this means. Does it apply to grassroots clubs only? Is it only for clubs that make big announcements on health? The experts had already identified that more guidance would be needed on this indicator, and it may be one of the indicators that will be revised in the updating of the Staff Working Document.
10	Monitoring and surveillance of physical activity and sedentary behaviour included in national monitoring	Data on sedentary behaviour was mentioned as very difficult to find.
11	Counselling on physical activity performed by health professionals	<p>Clarification was sought on the meaning of this indicator. In fact, as set out in the Council Recommendation, this indicator relates to the health sector and refers to counselling performed by health professionals. It could be helpful to spell this out more clearly in the Staff Working Document.</p> <p>The importance of the primary care sector in promoting physical activity was emphasised and there appears to be emerging consensus about what works in primary care. This is likely to be an important area of further discussion in the future.</p>
12	Training on physical activity in curriculum of health professionals	<p>This indicator was highlighted as challenging for some, particularly where there is no common curriculum for professional education. WHO is aware that this is not easy data to collect and is trying to obtain data from the medical/health professional schools.</p> <p>In other countries there are other health professionals (e.g., physiotherapists) whose role is to provide physical activity advice. It is not clear whether these should be included or not. If they were excluded, however, this would give a false impression that there is no health sector training on physical activity.</p>
22	National HEPA policies that include a plan for evaluation	It is unclear what is meant by evaluation in this context.

In general, it is difficult to know whether there is enough physical activity within a component to classify it as HEPA e.g., for HEPA in teacher training. More guidance is needed on what should be included or excluded for such indicators.

It was noted that there is no specific question on prevalence of physical activity among older people and it is not always clear whether older adults (e.g., over 80) are included in the 'adults' data. This reinforces the point that as much disaggregation of national data as possible is useful.

Table 3 Expert group initial classification of the indicators by degree of difficulty

GROUP 1	GROUP 2	GROUP 3
<i>Information on indicator is available from an international database.</i>	<i>Information on indicator is available but needs to be updated.</i>	<i>No information on indicator available.</i>
Desk-based and verified or updated by National Focal Point	Desk-based and verified or updated by National Focal Point	Methodology for collecting data to be developed

2. Prevalence adults 3. Prevalence children	1. Guidelines 4. National coordination 6. National sport for all policy 9. Target groups addressed in HEPA policy 10. Monitoring and Surveillance included in national monitoring 11. Counselling on PA 13. PE in Primary and Secondary 17. Walking and Cycling 19. Travel to place of work 20. Active Travel schemes 22. Evaluation 23. Awareness Raising campaign	5. Funding allocation to HEPA 7. Sports Clubs for health 8. Recreational opportunities, social disadvantaged groups 12. Training on PA curriculum 14. Schemes for school related health promotion 15. HEPA in training of PE teachers 16. Schemes of promoting active travel to school 18. Guidelines for infrastructure 21. Schemes for elderly
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The expert group had classified the indicators into the three groups (Table 3). Of the indicators classified as group 3, where methodology for data collection needs to be developed, many had already been mentioned by participants. Focal points were encouraged to submit further comments and questions to the expert group.

Discussion of further task and timeline, conclusions

The next steps⁸ are envisaged as follows:

Mid April 2015: the complete questionnaire with all 23 indicators was sent out. There would also be further work on development of a web tool that will be used next time round for the data collection and country profile preparation. A schedule for the webinars would be established.

End of May 2015: Focal points are required to return the questionnaires by 27 May. During this period webinar(s) and other support from the tender group is planned.

June 2015: WHO will prepare the revised country profiles. The third focal point meeting will take place on 24 June in Lisbon for discussion on the country profiles and a final fine-tuning exercise and validation.

September 2015: Launch of the country profiles and the updated NOPA database at high-profile WHO and EU launch events. Ideally, the idea is to launch the profiles during the EU Week of Sport and at the same time as the Regional Committee meeting in Vilnius in September, when the European Strategy on Physical Activity for Health will hopefully be adopted.

Dr Breda thanked participants, on behalf of WHO, for their enthusiastic participation and the valuable discussion. WHO is very encouraged by the progress and is confident that country profiles will be a reality by September. The discussion has highlighted a number of issues which WHO will seek to address. It is hugely encouraging to see various different sectors working together effectively on this issue.

Susanne Hollmann thanked participants on behalf of the Commission for all their contributions and a fruitful discussion. She looked forward to seeing participants again at the next meeting in June.

⁸ The dates have been updated to reflect changes to the schedule since the meeting.

LIST OF ANNEXES

Annex 1 List of participants

Annex 2 Questionnaire sent to focal points

Annex 1

List of participants

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Annex 2

Questionnaire sent to focal points

1. Does a national recommendation on physical activity and health exist in your country, i.e. an officially adopted statement on the duration, intensity and frequency of physical activity behaviour that the population should reach?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes:</i> <input type="checkbox"/> for adults <input type="checkbox"/> for young people <input type="checkbox"/> for elderly people	<i>If no:</i> <input type="checkbox"/> currently being developed <input type="checkbox"/> not foreseen for development in the next 2 years

2. What is the percentage of adults in your country reaching at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or an equivalent of vigorous-intensity physical activity, or a combination of moderate- and vigorous-intensity activity?	
Percentage:	
Source document:	
Age range used to define "adults" (x to y years):	

3. What is the percentage of children and adolescents in your country reaching at least 60 minutes of moderate- to vigorous-intensity physical activity (MVPA) daily?	
Percentage:	
Source document:	
Age range used to define "children" (x to y years):	
Age range used to define "adolescents" (x to y years):	

4. Has a specific coordinating mechanism (e.g. working group, advisory body, coordinating institution etc.) been developed for HEPA promotion in your country?		
<input type="checkbox"/> Yes		<input type="checkbox"/> No
<i>If yes, please provide the following:</i>		<i>If no, please continue with question 5.</i>
Name of the body:		
Year of establishment:		
Names of participating stakeholders:		
Name of leading institution:		

4a. Has funding been allocated to this coordinating mechanism?		
<input type="checkbox"/> Yes		<input type="checkbox"/> No
<i>If yes, please provide the following (in Euro):</i>		<i>If no, please continue with</i>
Total funding:		

<i>Funding per capita:</i>		<i>question 5.</i>
<i>Funding by gross domestic product at PPP per capita:</i>		

5. Does your country have a national policy and/or a national action plan on Sport for All promotion?		
<input type="checkbox"/> Yes		<input type="checkbox"/> No
<i>If yes, please provide the following:</i>		<i>If no, please continue with question 5a.</i>
Name of policy/action plan:		
Year of publication:		
Issuing body:		
Policy areas covered:		
Web link to the document:		
Status:	<input type="checkbox"/> draft version	
Status:	<input type="checkbox"/> final version	
<i>Please continue with question 6.</i>	<input type="checkbox"/> adopted	

5a. Is Sport for All addressed specifically in other policy documents?		
<input type="checkbox"/> Yes		<input type="checkbox"/> No
<i>If yes, please provide the following:</i>		<i>If no, please continue with question 6.</i>
Name of the policy:		
Year of publication:		
Issuing body:		
Policy areas covered:		
Web link to the document:		
Status:	<input type="checkbox"/> draft version	
	<input type="checkbox"/> final version	
	<input type="checkbox"/> adopted	

6. Which target groups do national (or sub-national*) HEPA promotion policies address?	
<i>*where relevant, i.e. in countries with a decentralized or federal structure</i>	
Target groups:	

6a. Which target groups in particular need of physical activity are specifically addressed by the policy/policies?	
<input type="checkbox"/> low socio-economic groups <input type="checkbox"/> people with low levels of physical activity <input type="checkbox"/> elderly people <input type="checkbox"/> ethnic minorities <input type="checkbox"/> other – please specify:	

7. What is the percentage of national or (or sub-national*) HEPA policies that include a clear intention or plan for evaluation?	
<i>*where relevant, i.e. in countries with a decentralized or federal structure</i>	
<i>Sport sector</i>	
_____ out of _____ policies include a clear intention or plan for evaluation.	
Please indicate the names of these policies:	_____
<i>Health sector</i>	
_____ out of _____ policies include a clear intention or plan for evaluation.	
Please indicate the names of these policies:	_____
<i>Transport sector</i>	
_____ out of _____ policies include a clear intention or plan for evaluation.	
Please indicate the names of these policies:	_____
<i>Environment sector</i>	
_____ out of _____ policies include a clear intention or plan for evaluation.	
Please indicate the names of these policies:	_____

8. Does a clearly formulated, national campaign for physical activity education and public awareness raising exist?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	
<i>If yes, please provide the following:</i>		<i>If no, you have completed the survey.</i>	
<i>Name:</i>	_____		
<i>Topics covered:</i>	_____		
<i>Responsible body:</i>	_____		
<i>Link to website:</i>	_____		
<i>Annual budget (in Euro)</i>	<i>Total funding:</i>		_____
	<i>Funding per capita:</i>		_____
	<i>Funding by gross domestic product at PPP per capita:</i>	_____	

Thank you very much for participating in this survey!

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