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REPORT OF THE 10th MEETING OF THE EUROPEAN UNION PHYSICAL ACTIVITY FOCAL POINT NETWORK

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Background

In the context of the *European Union Council Recommendation on Promoting Health-Enhancing Physical Activity (HEPA) Across Sectors* adopted in 2013 (hereafter referred to as 'the Council Recommendation'), EU Member States were requested to appoint national physical activity focal points, notably to support the monitoring framework for HEPA policies and physical activity.

As part of the collaboration to implement the above-mentioned Recommendation in the EU and to promote physical activity across Europe, the European Commission, Directorate-General for Education and Culture (DG EAC), Sport Unit, and the WHO Regional Office for Europe, Division of Noncommunicable Diseases and Promoting Health through the Life-course, held the tenth meeting of this Focal Points Network on 18-19 June 2019 in Brussels.

The EU Physical Activity Guidelines, the Council Recommendation, as well as the WHO Physical Activity Recommendations and the Physical Activity Strategy for the WHO European Region 2016–2025 provide principles that require policy coherence across Europe.

The European Commission and the WHO Regional Office for Europe have been cooperating to develop and scale-up monitoring and surveillance of HEPA in the European Union Member States. The second edition of the *Factsheets on health-enhancing physical activity in the 28 European Union Member States of the WHO European Region*, for which the Focal Points had collected data, was launched in September 2018.[1]

The tenth Focal Point meeting included discussion on physical activity recommendations, explored partnerships for physical activity promotion and focused on issues relating to cycling, physical activity in older people, physical literacy and the protection of children from unhealthy advertising. To promote multisectoral collaboration, a joint meeting with Member State representatives from agriculture and health took place on the second day, exploring issues relating to cross-sectoral cooperation and the Horizon Europe programme. In addition, participants took part in the seminar on the *Tartu Call for Healthy Lifestyles — two years after, taking stock.*

Participants in the Focal Point meeting included the Focal Points, representing 27 Member States and Norway. Representatives of the European Commission, the World Health Organization, represented by staff from the Regional Office for Europe, external speakers, representatives of civil society organizations and a rapporteur also participated.[2]

[1] Available in English at: http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/country-work/factsheets-on-health-enhancing-physical-activity-in-the-28-eu-member-states-of-the-who-european-region

[2] See Annex 1 for a full list of participants.

Day 1: 10th Meeting of the European Union Physical Activity Focal Points Network

Welcome addresses

On behalf of WHO, Dr João Breda, Division of Noncommunicable Diseases and Promoting Health throughout the Life-course, welcomed participants to the tenth meeting of the Focal Point network. He thanked the Focal Points for their excellent work at the national level and congratulated them on the highly effective collaboration between each other and with the European Commission and WHO.

The meeting involved representatives from other sectors — outside sport, physical activity and health — and sought to facilitate mutually-beneficial cross-sectoral work to promote the wellbeing of Europe's citizens.

WHO is extremely grateful to the Commission for its support for this work to pursue the common mandates within the EU, the benefits of which will extend to the wider European Region.

The Focal Point network is entering a new phase of collaboration and will continue to work towards, ultimately, increasing levels of physical activity and decreasing sedentariness in Europe.

Yves Le Lostecque, Head of Sport Unit, Directorate-General for Education, Culture, Youth and Sport (DG EAC), European Commission, welcomed participants and thanked them, on behalf of the Commission, for their successful work. The inclusion in the programme of a joint meeting with Member State representatives from health and agriculture and participation in the seminar to reflect on progress in the two years since launch of the *Tartu Call for a Healthier Lifestyle* clearly reflect that no one sector can solve the challenges of promoting and facilitating healthy lifestyles and that all actors across sectors need to contribute. The participation of the physical activity Focal Points in these discussions is very welcome and a clear signal that sectors are starting to work together.

The fact that two European Commissioners have already attended Focal Point network meetings is a signal of the growing importance attached to the issue of health-enhancing physical activity and the key role of the network in implementing the first ever Council Recommendation on this issue.

Olivier Fontaine, Sport Policy and Programme Unit, DG EAC added his welcome to participants and thanked them for their continued efforts. The Commission is grateful to WHO for the excellent cooperation on the Focal Points network's work and for organization of the meeting. Negotiation of a new agreement for a further three years of cooperation between WHO and the Commission in this area is in process. He encouraged Focal Points to suggest topics of interest for discussion at future meetings.

Physical activity recommendations

The first session focused on new WHO recommendations on physical activity for young children and the process of updating the existing 2010 physical activity recommendations.

WHO guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age and update of 2010 WHO Recommendations on physical activity for health

João Breda provided an update on WHO guidelines relating to physical activity.

WHO has issued new global *Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age.*[3] These have been prepared according to WHO's guideline methodology on the basis of thorough analysis of best available evidence by experts without conflicts of interest. In addition to the scientific evidence, the process also considers other dimensions, including ensuring that application of the guidelines will not increase socioeconomic inequalities in health and that the guidelines are appropriate for implementation in low and middle-income countries.

In addition, WHO is now launching a process to review the 2010 *Global Recommendations on Physical Activity for Health*.[4] The first phase will be a review of the science, followed by a consultation and discussions. It is important that expertise from the European Region feeds into the process, and all Focal Points are encouraged to engage in the process and facilitate the participation of national experts.

Scientific publications on physical activity recommendations

Karim Abu-Omar and Peter Gelius, WHO Collaborating Centre for Physical Activity and Public Health, Friedrich-Alexander-Universität Erlangen-Nürnberg, Germany, presented an overview of two scientific publications that are in preparation on the basis of the 2018 country factsheets produced by the Focal Point network.

The EU physical activity monitoring framework and the work of the Focal Point network is globally unique, but it is not widely recognized by the international scientific community. This is one of the reasons behind the decision to develop some scientific papers, drawing on information collected for the last monitoring round and publication of the country factsheets in 2018. The intention is that these papers will foster scientific dissemination of data, put Member States efforts on the global map and help assert the network's leadership and give Member States the opportunity to showcase their efforts and produce additional output.

Karim Abu-Omar provided an overview of the first paper, *Physical activity recommendations in European Union countries: An update*, which is currently in pre-final draft and almost ready for publication.

The purpose of the paper is to provide an overview of current physical activity recommendations in all 28 EU countries, to update earlier reviews and to provide more detail than on the 2018 country factsheet publication.

Information was extracted from the responses to question 1 of the country factsheet questionnaire. Additional desk research was also conducted to obtain all the documents listed by Member States. Where necessary, additional online research or consultation of experts was carried out in some countries.

The results have been compiled into a table with national physical activity recommendations for adults (and compared to WHO recommendations) and a figure comparing the age ranges of national physical activity recommendations for children and adolescents. The study shows that the large majority of Member States have recommendations and that this increased between 2011 (16) and 2018 (22). One observation is that smaller countries are more likely to adopt WHO recommendations, while larger countries tend to amend the recommendations in some way. The variation was greatest for the children/adolescent target groups, suggesting that the new WHO recommendations for children under five may be helpful. More recently, there is a

[3] https://apps.who.int/iris/handle/10665/311664
[4] https://apps.who.int/iris/handle/10665/44399

trend to issue recommendations for special populations (e.g., pregnant or lactating women, people with chronic diseases) or specific behaviours (e.g., sedentary behaviour for children).

Peter Gelius provided an overview of the second paper, National physical activity recommendations in EU countries: a review of development methodologies which is in preparation.

The paper seeks to provide an overview of existing methodologies for national recommendation development and, in doing so, provide inspiration and/or a potential blueprint for third countries. It may also help EU Member States identify efficient ways for future updates of recommendations. The paper is being prepared on national recommendations documents retrieved from the 2018 country factsheet answers (Indicator 1) and, where available, on the basis of information extracted concerning the authors, methods and evidence base for the recommendations.

Preliminary results found 15 national documents with more detailed information on the methodology and/or processes for recommendation development. Seven countries had special working groups, seven countries adopted WHO recommendations, nine countries analysed other countries' or international recommendations and seven countries performed literature reviews. The recommendations for five countries featured dedicated methods sections. The results have been compiled into a summary table for national physical activity recommendations development methodology and the paper will include a number of case studies providing more detail on method sections.

In conclusion, the country fact sheet data are valuable and rich. There is a need to clarify some aspects of turning data into papers (e.g., cut-off dates, obtaining additional information from Focal Points).

This experience points to the potential for additional publications to showcase current efforts. Suggestions include a paper showcasing the work of the Focal Point network, a scientific overview of the entire 2018 round of data collection and a comparative analysis of national physical activity policy documents.

Discussion

There was clarification that these papers were still at the draft stage and Focal Points were welcome to engage in the process and provide more data or get involved in writing. All Focal Points whose answers to the question contribute to the paper will be acknowledged, any that contribute to the writing will be included as authors.

There was discussion about whether more recent developments could be added to the first paper. While new developments are welcome, a cut-off date for inclusion of new developments will be set.

Working group discussions on physical activity recommendations

Participants were allocated to small groups to discuss a series of questions:

- *Virtually all EU countries will have physical activity recommendations in the near future, i.e., this development is coming to an end. What are the implications for the Monitoring Framework?*

  There appeared to be consensus that it remains important to monitor the current state of play relating to national recommendations, but that the questions should be refined to cover specific recommendations relating to age groups, specific population groups,

particular settings, types of activity/inactivity (e.g., sitting time, screen time) and the time period covered by the recommendations (e.g., 24-hour period).

It was noted that the Monitoring Framework provides good tools to monitor policy, but that monitoring data on physical activity levels is currently more challenging.

- *WHO is about to update its recommendations, potentially inspiring a new round of national updates. How should EU Member States tackle this task?*

The process to update the WHO recommendations was welcome, and there appeared to be clear agreement that EU Member States should engage with this process. It was suggested that the new WHO recommendation could be highlighted in any new version of the EU Council Recommendation. It was suggested that this could present a good opportunity to integrate the work of the Focal Point network into national and international guideline development processes. One proposal was for Focal Points to work together to submit a common position to the global guideline review process.

- *Smaller EU countries may tend to adopt WHO Recommendations while larger ones develop their own. Is this difference desirable or should it be addressed?*

Although there may be some frustration at national differences, these were largely acknowledged to be understandable and inevitable (since this is an issue of national competency within the EU). National authorities are responding to the specificities of their own context.

- *Would EU countries like to see more publications of this kind? If so, which aspects would they like to showcase?*

There is clear enthusiasm among the Focal Points for more publication of scientific or academic papers. There is support for making maximum use of the information collected through the Monitoring Framework and for sharing best practices as widely as possible, in order to convince decision-makers. It was suggested that the focus should be on implementation and the types of publications which could be useful for Focal Points. In addition to publications, it was suggested that a digital platform for Member States to access the data was needed.

Discussion

The small group discussion involving NGOs (no Focal Points) suggested that a two-way exchange with observers could be valuable for the process. It was also noted that the Focal Point Network is a good forum for continued engagement with the Commission on important issues such as active transport, the built environment and fiscal policy.

Partnerships for physical activity promotion

The second session explored the issue of partnerships for physical activity promotion, with presentations from three external networks and a panel discussion.

European Association for the Study of Obesity

Dr Nathalie Farpour-Lambert, President of the European Association for the Study of Obesity (EASO), presented an introduction to the Association.

Established in 1986, EASO is a federation of professional membership associations from 34 countries, which is in official relations with the WHO Regional Office for Europe. EASO is the voice of the European obesity community, representing scientists, health care practitioners,

physicians, public health experts and patients. It also promotes action through collaboration in research, education and policy.

The objectives of EASO are:

- to establish obesity as an urgent and relevant health and wellbeing priority
- to develop evolving evidence-based approaches for preventing and treating obesity across the lifespan
- to promote effective solutions through research, education and policy.

EASO engages with a wide range of stakeholders. The association provides residential training courses for healthcare professionals and has created a new investigator community for collaboration on projects, sharing of experience, expertise and knowledge, and networking. Stakeholder courses are also provided, along with e-learning for health care professionals. A network of collaborating centres for obesity management (COMs) has been established and now has 120 accredited members.

EASO is also a partner in many European projects, including the NoHoW project on evidence-based tools for weight loss maintenance and the PROTEIN project exploring use of the latest communications and machine learning strategies to provide personalized nutrition and physical support to citizens.

EASO also publishes guidelines, position statements and policy documents, and uses social media to disseminate messages and news relating to obesity.

The EASO Patient Council has been established, with patient representatives from 20 European countries to advise and lead on patient-related matters, advocate on behalf of patient perspectives and provide input to EASO national members and to EASO's activities.

EASO contributed to the development of the WHO Global Action Plan on Physical Activity and is involved in the global initiative to develop the first ISO standard for global active cities.

The European network for the promotion of health-enhancing physical activity (HEPA Europe Network)

Wanda Wendel-Vos, National Institute for Public Health and the Environment, Netherlands, and Chair of the HEPA Europe Network, provided an overview of the HEPA Europe Network.

The HEPA Europe vision is for better health and wellbeing in the WHO European Region through more physical activity for all people. Its mission is to provide a forum for the advancement of HEPA research, policy and practice across the Region.

The objectives of HEPA Europe are to:

- foster inter-disciplinary communication and knowledge exchange between researchers, practitioners and policymakers;
- facilitate sharing of experiences and best practices in HEPA promotion;
- contribute to the development of multi-sectoral and inter-sectoral policies and strategies for HEPA;
- strengthen collaboration within and between sectors to advance HEPA research, practice and policy; and
- provide capacity building opportunities to researchers, practitioners and policymakers to strengthen the skillset of the HEPA workforce

The network has 174 members, including 163 organizational members. WHO runs the secretariat of the network and the principal executive body for the network is the Steering Committee.

There are working groups on a variety of issues:

- policy approaches to physical activity promotion
- exchange of experiences in HEPA promotion in children and adolescents
- active ageing: physical activity promotion in elderly
- HEPA promotion in socially disadvantaged groups
- HEPA promotion in health care settings
- sport clubs for health
- workplace HEPA promotion
- environmental approaches to HEPA Promotion
- monitoring and surveillance of physical activity.

Particular successes of HEPA Europe include the annual conference (the 2019 edition to be held in Odense, Denmark, 28-30 August), development of the *Health Economic Assessment Tool for physical activity* (HEAT tool), and the *HEPA Policy Audit Tool* (HEPA PAT tool).

The key challenges facing HEPA Europe are to find the right balance between research, policy and practice in terms of membership and activities, to engage with people from outside the field of HEPA and to obtain funding for specific activities or projects.

Future plans include efforts to strengthen collaboration with WHO and other networks and to increase memberships covering more countries. Membership of HEPA Europe is free and is open to all, and provides a good forum for sharing of good practice.

European Heart Network

Marleen Kestens, European Heart Network (EHN), introduced the work of EHN.

EHN is a Brussels-based alliance of heart foundations and like-minded nongovernmental organisations throughout Europe, with member organisations in 25 countries. EHN works on the prevention and reduction of cardiovascular diseases (CVD), which are still responsible for the largest burden of death and disability in Europe. CVD costs the economies of EU Member States a total of 210 billion euros every year.

EHN's work encompasses prevention, support for patient organisations and a platform for CVD research. EHN recognizes physical inactivity as a major behavioural risk factor for CVD deaths, and notes than more women are dying from physical activity than men.

To progress its work on physical activity, EHN has an expert group on this topic and is currently preparing a paper on physical activity and CVD.

The most common activities of EHN members relating to physical activity tend to be awareness campaigns, work in schools to increase physical activity in school curricula and collaboration with employers to promote workplace activity. In addition, many patient organizations are working on physical activity for secondary prevention and EHN members are actively advocating for provision of physical activity on prescription (with reimbursement of medical professionals when physical activity is prescribed).

EHN calls for the application of health impact assessments across all EU measures, to ensure (at the very least) that no measures will have a negative impact on health. It also advocates for use of structural funds to finance active living projects or, at least, to ensure that no structural funds finance projects which are counterproductive to active living.

Discussion

It was suggested that there could be scope for these three networks to support Focal Points in their work at the national level, and Focal Points were encouraged to consider possible support needs (e.g., tools, technical support, expert advice).

It was noted that physical activity is too often neglected from broader discussion on prevention of noncommunicable diseases (NCDs) and it is important to consider how the importance of physical activity can be promoted in such discussions. One issue that could help would be the recognition of obesity as a disease, for which EASO has been advocating. All EASO's courses have a strong physical inactivity component. WHO is advocating an integrated approach to counselling for NCD risk factors (smoking, diet, alcohol and physical activity). Cross-sectoral working is an essential element of efforts to raise awareness of the importance of physical activity.

In addition, it is important to emphasise that promotion of physical activity should decrease stigmatization and there is a need to provide opportunities for adapted physical activity for people with physical limitations. People living with obesity face numerous challenges including a lack of access to care and to adapted physical activity.

It was pointed out that Switzerland has recognized obesity as a disease and has enabled reimbursement for physical activity on prescription for children.

There was clarification that EHN does not have any guidelines for physical activity for young children specifically relating to cardiovascular disease.

There was clarification that people living with obesity from 20 Member States were invited to join EASO's Patient Council and that the Council has supported the creation of the European Coalition for People Living with Obesity.

In relation to best practice and guidance for physical activity on prescription, it was pointed out that Sweden has a project that is now being transferred, as best practice, to nine countries. The Joint Action on Nutrition and Physical Activity (JANPA) produced a database of good practices on nutrition and physical activity. Furthermore, RIVM in the Netherlands has a database of effective lifestyle interventions and this includes some physical activity interventions.

It was noted that it is important to maintain a focus on HEPA — including active transport and active living — and to avoid a narrow focus on sport-related activity.

Physical activity and cardiovascular disease

Professor Illka Vuori, Finland, representing EHN, presented an overview of the latest science relating to physical activity and CVD.

Physical activity was incorporated into European guidelines for CVD prevention in 2016, with the recommendation that healthy adults of all ages should perform *at least* 150 minutes a week of moderate intensity or 75 minutes a week of vigorous intensity aerobic physical activity or an equivalent combination thereof.[5] More recent guidelines relating specifically to CVD were issued in 2019 by the American Heart Association, adding a caveat that "adults unable to meet the minimum, engaging in some moderate- or vigorous-intensity physical activity, even if less than this recommended amount, can be beneficial" and includes a specific comment on decreasing sedentary behaviour. Important points to note from the 2018 Physical Activity

[5] Piepoli MF, Hoes AW, Agewall S, Albus C, Brotons C, Catapano AL, Cooney MT, Corrà U, Cosyns B, Deaton C, Graham I, Hall MS, Hobbs FDR, Løchen ML, Löllgen H, Marques-Vidal P, Perk J, Prescott E, Redon J, Richter DJ, Sattar N, Smulders Y, Tiberi M, van der Worp HB, van Dis I, Verschuren WMM, Binno S; ESC Scientific Document Group. 2016 European Guidelines on cardiovascular disease prevention in clinical practice: Eur Heart J. 2016 Aug 1;37(29):2315-2381. doi: 10.1093/eurheartj/ehw106.

Guidelines for Americans, relating to CVD, are that the guidelines specify that adults should do *at least* 150 minutes to 300 minutes of moderate intensity or 75 minutes to 150 minutes of vigorous-intensity physical activity, preferably spread *throughout the week*. The Guidelines note that additional health benefits can be gained by doing even more physical activity, and that muscle-strengthening activities are also important. These Guidelines also apply to older adults, with additional recommendations that older adults do multicomponent physical activity that includes balance training as well as aerobic and muscle-strengthening activities and that they determine their level of effort for physical activity relative to their fitness. When older adults cannot do 150 minutes of moderate-intensity aerobic activity they should be as physically active as their abilities and conditions allow.

All the latest evidence supports the notion that "any activity counts" because there is no lower threshold for reductions in all-cause mortality from physical activity. Most benefits are attained with at least 150-300 minutes of moderate physical activity per week and some health benefits are immediate. Specifically in relation to CVD, a study which took into account all the studies on which the US physical activity guidelines were based *plus* new published after the guidelines, found the same curvilinear curve for physical activity and risk of CVD mortality and of coronary heart disease (CHD) and stroke incidence. There is no lower threshold and no upper limit of physical activity for risk reduction. Achieving the lower limit of the recommended physical activity levels decreases CHD risk by 14% and the risk is reduced by about 25% among those who are highly active.[6] Unusually, this study also considered heart failure — the risk is reduced by 10% in those achieving the minimum recommended levels and by 30% among the most active. More physical activity is needed for the same reduction in relative risk than for other types of CVD.

New studies show that physical activity in *all* domains (leisure, transport, domestic and occupation) lowers the risk of mortality and CVD events.[7] All common types of physical activity reduce the risk of CVD, but evidence on the effectiveness of a large number is lacking mainly because of a lack of adequate research (absence of evidence is not evidence of absence).

In relation to the required intensity of physical activity, new studies suggest that even light physical activity reduces CVD and CHD events in older women, suggesting that all physical activity in daily life may have a role in prevention among this group.[8] Replacing sitting with light-intensity physical activity may provide significant health benefits, especially for older people. Studies suggest that risk reduction is similar for regular physical activity (at least three times a week) and for activity once or twice a week (weekend warriors), so physical activity once or twice a week may be sufficient to reduce CVD mortality regardless of whether or not

[6] Kraus WE, Powell KE, Haskell WL, Janz WL, Campbell WW, Jakicic JM, Troiano RP, Sprow K, Torres A, and Piercy KL, for the 2018 physical activity guidelines advisory committee. Physical Activity, All-Cause and Cardiovascular Mortality, and Cardiovascular Disease. Med. Sci. Sports Exerc., Vol. 51, No. 6, pp. 1270–1281, 2019.

[7] Kyu HH, Bachman VF, Alexander LT, Mumford JE, Afshin A, Estep K, et al. Physical activity and risk of breast cancer, colon cancer, diabetes, ischemic heart disease, and ischemic stroke events: systematic review and dose-response meta-analysis for the Global Burden of Disease Study 2013. BMJ 2016;354:i3857

Wahid A, Manek N, Nichols M, Kelly P, Foster C, Webster P et al. Quantifying the Association Between Physical Activity and Cardiovascular Disease and Diabetes: A Systematic Review and Meta-Analysis. J Am Heart Assoc. 2016 Sep 14;5(9). pii: e002495.

Lear SA, Hu W, Rangarajan S, Gasevic D, Leong D, Iqbal R et al. The effect of physical activity on mortality and cardiovascular disease in 130 000 people from 17 high-income, middle-income, and low-income countries: the PURE study. Lancet. 2017 Dec 16;390(10113):2643-2654.

[8] LaCroix AZ, Bellettiere J, Rillamas-Sun E, Chongzhi Di, Evenson KR, Lewis CE et al. Association of Light Physical Activity Measured by Accelerometry and Incidence of Coronary Heart Disease and Cardiovascular Disease in Older Women. JAMA Netw Open. 2019 Mar; 2(3): e190419.

the prevailing physical activity guidelines are being met.[9] Evidence also suggests that physical activity can be promoted either in long single or multiple shorter bouts— this flexibility may be particularly valuable for the least active and for those with high risk or existing chronic conditions.[10]

Furthermore, the evidence suggests that it is never too late to become active.[11] Doing more physical activity at any adult age is associated with greater reductions in the risk of CVD mortality and decreasing physical activity at any age increases the risk. Increasing physical activity between 40 and 60 years was associated with reductions in risk similar to those associated with maintaining higher levels of physical activity across the adult life course.

There is now strong evidence that high amounts of sedentary behaviour independently increase the risk of CVD mortality and incidence.[12] There is a double hazard because the effects of sedentary behaviour are more pronounced in physically inactive people. There is insufficient evidence to determine if bout length or breaks in sedentary behaviour are associated with health outcomes, but, in older women long bout durations were associated with increased CVD risk.[13]

In conclusion, Professor Vuori proposed three recommendations for physical activity promotion:

- It is important to promote APEASE activities — i.e., affordability, practicability, effectiveness and cost-effectiveness, acceptability, side-effects/safety and equity. With these criteria in mind, the first priorities at individual and community levels should be walking followed by cycling.
- Integrate physical activity into other issues at all levels — Citizens, policy-makers and politicians all know already that physical activity is important, but for very few has it been sufficiently important to prompt action. Physical activity needs to be framed, connected and integrated at all levels to other important issues, with physical activity being part of the solution for various issues (e.g., global warming, traffic congestion, drug use, loneliness).
- Listen to the expectations of the individual — The needs and responses of individuals to physical activity, along with their expectations and possibilities, vary widely. Individual intrinsic motivation is a key for individual participation in activity, and this is driven by individual expectations and experiences of positive emotions. These elements should be taken into consideration more in the design of physical activity messaging and media campaigns.

Discussion

[9] O'Donovan G, Lee IM, Hamer M, Stamatakis E. Association of "Weekend Warrior" and Other Leisure Time Physical Activity Patterns With Risks for All-Cause, Cardiovascular Disease, and Cancer Mortality. JAMA Intern Med. 2017 Mar 1;177(3):335-342.

[10] Jefferis BJ, Parsons TJ, Sartini C, Ash S, Lennon LT, Papacosta O, et al. Objectively measured physical activity, sedentary behaviour and all-cause mortality in older men: does volume of activity matter more than pattern of accumulation? Br J Sports Med. 2019 Aug;53(16):1013-1020.

Shiroma EJ, Lee IM, Schepps MA, Kamada M, Harris TB. Physical Activity Patterns and Mortality: The Weekend Warrior and Activity Bouts. Med Sci Sports Exerc. 2019 Jan;51(1):35-40.

[11] Saint-Maurice PF, Troiano RP, Matthews CE, Kraus WE, Moderate-to-Vigorous Physical Activity and All-Cause Mortality: Do Bouts Matter? J Am Heart Assoc. 2018;7:e007678.

[12] Katzmarzyk PT, Church TS, Craig CL, Bouchard C. Sitting time and mortality from all causes, cardiovascular disease, and cancer. Med Sci Sports Exerc. 2009 May;41(5):998-1005.

[13] Bellettiere J, LaMonte MJ, Evenson KR, Rillamas-Sun E, Kerr J, I-Min Lee et al. Sedentary Behavior and Cardiovascular Disease in Older Women The OPACH Study. Circulation. 2019;139:1036–1046.

Professor Vuori was thanked for the thorough update on the evidence on physical activity and CVD.

There was some discussion of the risks for people, particularly of myocardial infarction, during exercise. For healthy people any amount and intensity of physical activity is without cardiovascular risk. For those with latent heart disease there is a risk but people do not always know about their condition and, in general, the fitter that they are the lower the risk. This means that all physical activity is recommended, but that people need to pay attention to any adverse symptoms.

There was some discussion about the minimum amounts of physical activity for schoolchildren. Professor Vuori considers that there is currently very weak evidence to support proscribing any specific amount (minutes) of physical activity for young children.

It was pointed out that, while counselling does need to be responsive to individual needs, a population-level approach requires guidelines to specify the minimum level required. It was also noted that the extent of the benefit (risk reduction) from a small amount of physical activity depends on the baseline level of physical activity. This also needs to be taken into account for the setting of population guidelines.

Cycling as an active form of transport

The third session focused on issues around the promotion of cycling as a form of transport. Across Europe cycling is increasing as a means of transport, which brings important benefits for physical activity, reduced greenhouse gas emissions and improved air quality. Cycling is covered in the Council Recommendation through inclusion of the indicators on active travel to school or work. Nineteen Member States have programmes to promote active travel to work and 15 have programmes to promote active travel to school. It is clear that there has been, therefore, some progress on commuter cycling, but there remains a great deal of scope to advance this issue further.

EU Sustainable Urban Mobility Policy

Claire Depre, Head of the Sustainable and Intelligent Transport Unit, Directorate General for Mobility and Transport (DG MOVE), European Commission, provided an overview of the policy framework for sustainable transport in the EU.

Transport policies provide vital functions to EU cities, but urban mobility remains largely dependent on conventionally-fuelled passenger cars. This leads to congestion (which is estimated to cost the EU € 270 billion each year through delays) and an impact on climate change as emissions continue to rise, with urban transport accounting for almost a quarter (23%) of transport CO_2 emissions. In addition, there is a clear impact on health due to poor air quality (which causes over 500,000 premature deaths every year in the EU), contribution to physical activity (€ 80.4 billion lost every year) and road accidents, which killed around 25,000 people across the EU in 2016.

The Commission is involved in a number of measures to address these issues, but it is also important to remember that this is an issue of subsidiarity (i.e., Member State competence). There are numerous opportunities to work with cities to identify best practice and enable such practices to be replicated elsewhere.

The relevant policy framework includes the goals for urban mobility to:

- Halve the use of conventionally-fuelled cars in urban areas by 2030, phase them out by 2050

- Achieve CO_2-free city logistics in major urban centres by 2030

In addition, there is a safety-related goal to, by 2050, move close to zero fatalities in road transport and to have casualties by 2020. Furthermore, the *European Strategy for Low Emissions Mobility*, issued in July 2016, sets a target that, by 2050, transport greenhouse gases must be 60% lower than in 1990.

The *Urban Mobility Package* adopted in 2013 identified the need for stronger cooperation between different policy levels to deliver on sustainable urban mobility. The core concept is to implement Sustainable Urban Mobility Plans (SUMPs). There was also a commitment to reinforce EU support for local action on urban mobility between 2014 and 2020 and dedicated legislation on intelligent transport systems, alternative fuels and road safety.

The Graz Declaration, signed in October 2018, signals the start of a new era, with a focus on clean, safe and affordable mobility for Europe. EU ministers committed to a modal shift towards zero-emission means of transport, which is crucial for achievement of the Paris Agreement climate objectives. One of the main elements concerns active mobility to promote health and sustainability.

The Commission has tried to raise awareness and to support cities in a variety of ways, including a one-stop-shop portal for information on SUMPs (along with guidelines and an annual SUMP conference), European Mobility Week, the CIVITAS Initiative, the Partnership on Urban Mobility (as part of the EU Urban Agenda), Smart Cities and Communities, development of sustainable urban mobility indicators and increased funding (€18.5 billion over 2014-2020).

Increasingly, active mobility is now an integral part of urban mobility policy and more support is in the pipeline. Cycling became more prominent since the adoption of *Luxembourg Declaration on Cycling* in 2015 signed by all EU Transport Ministers. Relevant developments include guidance for EU cycling projects (with minimum quality standards for infrastructure), an update of the guidelines for SUMPs (including a topic guide on cycling) and a number of measures to enhance the cyclist safety.

The SUMP concept has been a success. It was based on a systematic stakeholder consultation process, published in December 2013, and is now widely used in Europe and internationally. The concept is supported by guidelines, planning tools, best practice examples, national frameworks, a city database and a European platform/coordination group. An update — SUMP 2.0 — is in preparation. The SUMP Award recognises excellence in authorities' sustainable urban mobility planning.

The City, Vitality and Sustainability Initiative (CIVITAS) has been funded by the Commission since 2002 to create, cleaner, better transport in cities. The Initiative has 80 "living lab" cities and has seen 800 measures implemented, with more than 280 cities participating in its forum. It has included active mobility projects in the past and currently has active mobility projects (e.g., CIVITAS Handshake to make cycling a more attractive option as an everyday mode of transport). The next CIVITAS Forum will take place in Graz, Austria, 2 - 4 October 2019.

European Mobility Week takes place 16-22 September every year as a pan-European campaign that culminates in a car-free day. In 2018, the car-free day resulted in clear reductions in NO_2 and particulate matter. The 2019 theme of European Mobility Week is "Walk with us!", promoting safe walking and cycling. Almost 2,800 cities from 54 countries worldwide registered in 2018, and every year around 7,500 permanent measures are recorded.

The European Innovation Partnership on Smart Cities and Communities includes an action cluster on sustainable urban mobility and, by the end of 2019, €1 billion will have been invested in innovative solutions.

In 2017, the Commission published a detailed study of urban vehicle access regulations, providing a complete overview of Low Emission Zones, urban road tolls, traffic limited zones and traffic restrictions in Europe. Recommendations and best practice on this issue will be published before the end of 2019.

Another important project is the development of Sustainable Urban Mobility Indicators which aims to generate a revised set of indicators (including active mobility) and to develop an online benchmarking tool ("a scoreboard") on sustainable urban mobility.

In conclusion, DG MOVE will continue to do as much as possible to increase cycling and is keen to fully engage with other sectors which can help in this aim.

Discussion

The importance of a cross-sectoral approach to promoting cycling is clear. The Commission has now set up an inter-service group on healthy lifestyles, with 16 different units involved, to foster intersectoral cooperation within the Commission. This group met for the first time in January 2019.

There are also some funding opportunities for cycling initiatives. The Erasmus+ programme, for example, has funded around 14 projects relating to cycling.

There was discussion of the potential for expanding cycle logistics — using bikes for commercial deliveries and cargo — and how the Commission could support this field. One project[14] found that around a quarter of commercial cargo journeys in cities could be carried out by bike. This is one of the reasons behind the development of guidelines for urban mobility planning. For long-term impact, it is important that measures do not only focus only on last mile deliveries, and that, through establishment of distribution centres, bikes can be used further down the delivery chain.

It is important to acknowledge that changes in mobility patterns can lead to new challenges. The recent emergence of electric scooters as a means of mobility, for example, brings with it some new challenges to address. It is clear that investment in infrastructure can help prevent adverse incidents. The example of Copenhagen has shown that it is possible to decrease the number of incidents despite high cycling rates.

Commuter cycling and cardiovascular disease

Professor Lars Bo Anderson, Western Norway University of Applied Sciences, presented an overview of commuter cycling and health.

Using data from Denmark (numbers of people cycling; reduced risk of disease and mortality of cycle commuters; mortality and morbidity data) it is possible to calculate the health benefits for society from cycling. In total, 6,190 deaths per year are prevented every year and, in total, more than 17,465 cases of CVD, type 2 diabetes, cancer or death are prevented annually across the country. This compares with around 800 cycle-related injuries and 26 deaths. The same calculation can be done for commuter cycling only, providing slightly lower results. Commuter cycling prevents 3,679 deaths, 2,610 cases of type 2 diabetes and 3,129 cases of CVD (no data on cancer).

[14] http://two.cyclelogistics.eu/docs/111/CycleLogistics_Baseline_Study_external.pdf

A 2017 systematic review and meta-analysis examined the evidence on cycling and CVD, and, by pooling results from 36 studies, found a 20% reduction in relative risk of CVD incidence or CVD mortality.

Danish cycling statistics, from electronic counters placed around the country to count all the bikes that pass, data show a 10% increase in cycle traffic since 1998 (until which point cycling had been in decline) but a decrease in cycling deaths and injuries. In Copenhagen, the number of cycle trips has increased by more than 30% and the number of cycle-related casualties has declined to a third of its previous level. This may be due to two factors: (a) as more people cycle cycling gets safer, and (b) there have been improvements to the cycling infrastructure. In Aarhus, the changes have not been as dramatic — with a smaller increase in cycling and a smaller drop in cycle-related casualties — and there has been substantially less investment in cycling. In Aalborg, where there has been no real investment in cycling, there has been very little change in cycling and a small drop in casualties.

Examples of best practice in cycling infrastructure investment include:

- provision of plentiful bike parking at train stations;
- separation of bike lanes from traffic and right-hand turn lanes;
- awarding cyclists priority (right of way) over motorists;
- creation of wide super-bike-lanes to connect areas in as short a distance as possible with virtually no stops, and with bridges and tunnels replacing crossings; and
- building of bike bridges over busy roads.

There is a lack of research evaluating natural experiments such as the Førde project or Copenhagen super-bike-lanes, despite the levels of investment and the potential health gains. Neither research foundations or Ministries tend to fund such work. More research into this type of natural experiment is needed to find out what works, validate investments and quantify the health impact.

Discussion

It was noted that it is vital to important to foster links with the urban planning sector.

There was clarification that Professor Anderson conducted the studies described without any additional funding. Publication for this type of study, however, where existing data are used, can be difficult. It was suggested that receipt of infrastructure funding could be conditional on allocation of some of the budget to evaluation, although this would be challenging for some sectors (e.g., road construction) that are not used to evaluating projects in any way.

One proposal was to make it mandatory for all new road construction within the EU to include a bike lane alongside all new roads.

It is acknowledged that active commuters are likely to engage in other health-promoting behaviours, but the study exploring the health impact of bike commuting controlled for those factors with the usual methodological approach.

Cycle-Friendly Employer Certification

Dr Randy Rzewnicki, European Cyclists' Federation, provided an overview of the benefits of cycling to work and of the cycle-friendly employer certification.

The European Cyclists' Federation is an international nongovernmental organization with more than 90 members in 45 countries. It aims to get more people cycling more by making policies more cycling friendly and connecting cycle-minded people.

Cycling in cities is healthy, because the benefits of more physical activity generally outweigh the risks associated with increased exposure to air pollution or with traffic-related incidents. In some of the worst polluted cities in the world, for example, a person would need to cycle for 90 minutes per day for the risks to outweigh the benefits. Use of e-bikes is now opening the possibilities of cycling to new groups of people (e.g., older people, those who are less fit or overweight) and can make cycling to work or school more appealing.

A study applying the WHO *Health Economic Assessment Tool* (HEAT)[15] to the European Union population, found that if all citizens in the EU aged 20-74 cycled or walked an additional 15 minutes per day, 100,000 premature deaths could be prevented each year, saving EU economies €70 - €100 billion annually.

Three-quarters of trips to work in urban areas are very short and are, therefore, ideal for walking or cycling. The Bike2Work project aimed to convince employers of the benefits of cycling to work. Cycle-to-work schemes showed that improving the situation for employees that cycle to work leads to:

- healthier employees;
- increased productivity;
- less space and less complex infrastructure;
- better accessibility to the company;
- relieved congestion especially in peak hours (fewer delays); and
- climate protection, energy and CO2 saving.

The Cycle-Friendly Employer Certification scheme was developed to establish a European standard for cycle-friendly companies in order to help European companies to improve the situation for employees that cycle to work.[16] The scheme involves some checks on employers via a telephone interview, a site visit and discussion with employees. It has been implemented in 14 countries and more than 200 companies have been certified as cycle-friendly employers.

Discussion

There was some discussion about the evidence on the impact of cycling on mental health. There is little literature specific to cycling, but there is a body of evidence on the benefits of regular physical activity for mental health and some studies on the benefits of physical activity for people in the early stages of burn out.

In places where funding is very limited it can be challenging to encourage both forms of active mobility. If, for example, cyclists and pedestrians have to share space it was suggested that this can lead to difficulties. It is really important to promote all forms of active transport, in preference to inactive transport, and not to play one form of active mobility off against the other. One solution, for example, can be to designate one-way streets which combine walking and cycling lanes.

Promotion programme for elderly people in the community using a citizen science approach

Anja Frei, University of Zurich, introduced a novel community-based approach to increasing physical activity in older adults using citizen-science and technology, the CAPACITY project.

[15] https://www.heatwalkingcycling.org
[16] https://cfe-certification.eu/

The aim was to develop and implement a physical activity promotion intervention (*ZameGoLaufe*[17]) for older adults with or without chronic disease living in an urban environment, and which considers individual, interpersonal and environmental factors.

The project focused on enabling and encouraging participation of hard-to-reach people in organized structured walking interventions. It combined a citizen-science approach with modern technology through the development of six mapped walking trails of differing intensity levels, provision of smartphones, creation of a WhatsApp group and a Google calendar, organization of "kick-off meetings" and monthly gatherings, and the setting of individual goals for daily steps and fitness levels.

A pre- and post- evaluation study was conducted before and after the first 6 months of the intervention. After 6 months, results — based on 25 people who participated in the 6-months follow-up — suggested that the main reasons for participation were social, health/being more physically active or enjoyment. The number of daily steps increased by 285 (median) and 86% of participants reported that the programme supported them to walk more. It is important to note that the programme is designed to have sustained impact, so long-term results would be more appropriate.

The intervention has now been transferred to participants, with some participants taking over the organization and developing a new strategy to recruit participants (publication of the walking trails in newspapers). Eleven months after the study team had withdrawn, 38 new participants had been recruited and, as of June 2019, there 82 people regularly walked together.

A guidance manual has been developed to describe how to implement this intervention in communities. The first replication of the intervention started in August 2018 and further roll-out is planned. The long-term goal is for the programme to be offered throughout Switzerland, reaching 100 cities by 2024.

In conclusion, the initial phase of programme development was very demanding and recruitment of participants took longer than expected. The intervention has now been successfully transferred to participants, is self-sustained in the pilot city and is being replicated in other Swiss cities, led by volunteer leaders from the community.

Discussion

The team was congratulated on the success of this programme, and, particularly, on the self-sustainability of the model.

There was clarification that the main challenge in the early stages was to recruit participants, but recruitment is now more effective. Later challenges have been to find volunteer leaders and to manage changes in leadership.

Volunteer leaders now receive training and a manual and they sign a contract of commitment. There was interest in having access to the guidance manual for setting up the project, if sharing of the document is possible.

The 6-month evaluation study will be published, but there is currently no ongoing funding for any long-term monitoring of health outcomes. Another assessment of health outcomes as the programme is rolled out across Switzerland is under discussion.

[17] www.zämegolaufe.ch

Health and physical activity literacy

Dr João Breda, WHO Regional Office for Europe, presented an overview of developments in relation to health and physical activity literacy.

Health literacy is seen as a key determinant of health. While this was long considered to mean "delivery of information" the concept of health literacy has evolved and can be defined as:

> *People's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.*[18]

Physical literacy can also be defined in similar terms:

> *The motivation, confidence, physical competence, knowledge and understanding individuals develop in order to maintain physical activity throughout their life.*[19]

The WHO Regional Office for Europe has investigated levels of health literacy in Member States and has identified that levels of health literacy are below the desirable levels in most Member States. There is also a clear relationship between physical activity levels and level of health literacy (as measured by the health literacy index).

WHO is exploring the issues of health literacy for vulnerable groups, including those with lower levels of education and socioeconomic status, older people, ethnic minorities, recent immigrants, people with low proficiency in the national language and people with chronic diseases. Key settings for addressing these issues include healthy cities, educational institutions, workplaces, community settings, healthcare and media platforms and it important to engage with all stakeholders in these different settings.

WHO has developed a European Roadmap for implementation of health literacy initiatives through the life course. This document, which will be submitted to the Regional Committee in September 2019, discusses issues relating to health literacy at four different levels (political; community and city; organizational; individual). It identifies five strategic directions:

- increasing capacity building on health literacy;
- advancing health literacy innovation development and implementation;
- advocating and facilitating cross-sectoral integration of health literacy;
- improving digital health literacy; and
- strengthening health literacy measuring, monitoring and evaluation.

An issue of increasing importance is digital health literacy, with the proliferation of health-related websites, apps and wearable technology devices. Key challenges relating to digital health literacy include data privacy, adequacy and accessibility of devices and platforms, the quality and reliability of information, the question of data ownership and conflicts of interest.

There is a very high degree of interest in improving health literacy. The demand for information on healthy lifestyles, for example, is very high, accounting for three-quarters (74%) of health-related information people seek online.

Eight action areas relating to physical activity literacy have been identified, representing the pillars on which initiatives should build:

- whole-of-government and whole-of-society approach;
- use of technology;

[18] WHO 2013. Health literacy: The solid facts
[19] Whitehead M, 2010. Physical literacy throughout the lifecourse

- build on existing media platforms;
- communication and mass media campaigns;
- monitoring and surveillance of literacy levels;
- initiatives specific to vulnerable groups;
- plain language initiatives;
- training for physical activity and health professionals.

WHO has developed a series of mHealth handbooks as part of the *Be He@lthy, Be Mobile* programme for NCDs. A handbook for mACTIVE is in preparation, with guidance on how to implement national mHealth programmes for physical activity.

The potential benefits of increasing physical literacy are many and various, including increased physical activity levels, empowerment, reduced inequities, increased social capital and resilience, lower health system costs and the enabling and facilitation of public health initiatives. All of these will, in turn, contribute to achievement of SDG 3 on good health and well-being.

Physical activity literacy: Small group discussion

Participants broke into small groups and were asked to discuss three questions relating to physical activity literacy:

1. *What is currently being done in your country to improve physical activity literacy? How could WHO/EC support?*

   In feedback from the groups, a number of examples of country action to improve physical activity literacy were cited. These include the *This Girl Can* and *This Mum Can* adverts from the UK, the "*Manger, bouger*" (Eat, Move) public health messaging used on advertising for foods high in fat, sugar or salt (HFSS foods) in France and the information sessions delivered as part of Sweden's physical activity on prescription scheme.

2. *What are the 'low hanging fruit' or new opportunities for increasing physical activity literacy?*

   The groups proposed various ideas for increasing physical activity literacy:

   - promoting existing physical activity guidelines;
   - prioritizing the empowerment of parents, families and school teachers;
   - making schools more active — embed physical activity in the school day;
   - exploring scope from partnerships with sportswear brands;
   - removing sponsorship of HFSS brands from sporting events;
   - using exercise on prescription schemes as a vehicle for increasing physical activity literacy;
   - focusing on simple ideas, such as increasing daily step counts;
   - developing tools to do intergenerational monitoring (within families) of physical activity levels;
   - prioritising reaching vulnerable groups, e.g., older people.

   It was pointed out that it is important to transmit the right message, delivered by the right people and right methods, at the right time. In order to do this, each Member State may have to do its own situation assessment.

3. *How can technology be used to increase physical activity literacy?*

The groups clearly recognized the considerable potential of technology to increase physical activity literacy, whether through social media messaging or the use of apps as motivational and informational aids.

It was suggested that existing apps could be improved. One such example would be route planning apps (e.g., Google maps), which could usefully show alternative healthy walking routes. It was also suggested that technology could facilitate peer-to-pear learning of children and young people.

The feedback of the groups, clearly highlights the value of developing physical activity literacy and it would be valuable if this issue could be included in the ongoing discussions on health literacy within WHO.

Protection of minors from advertising of unhealthy foods on the basis of the revised Audiovisual Media Services Directive

Maciej Styczen, Directorate-General for Communications, Networks, Content and Technology (DG CNECT).

The Audiovisual Media Services Directive (AVMSD) has been revised in order to update existing rules, as viewers move away from traditional audiovisual media services towards consumption of audiovisual content on-demand and online.

The Directive establishes a level of minimum harmonization. This means that, when transposing the rules, Member States can decide to go further than required by the AVMSD and adopt stricter or more detailed rules for services under their jurisdiction.

Slight revisions to the provisions relating to alcohol advertising mean that the relevant articles (Articles 9 and 22) will now apply to advertising in on-demand services.

In relation to HFSS foods, Member States are required to encourage the use of co-regulation and the fostering of self-regulation through codes of conduct.

Under the revised Directive the scope will be extended to cover video-sharing platforms. Such platforms have a highly specific nature, because they have no editorial responsibility over the content, but play a role in organizing content, in particular by displaying, tagging and sequencing. Under the revised Directive, certain audiovisual commercial communication rules will apply to video-sharing platforms, depending on the level of control that the platforms have over these audiovisual commercial communications:

- for audiovisual commercial communications they control, they will have to apply the same basic qualitative requirements as for TV and on-demand (including basic provision on alcohol advertising);
- for audiovisual commercial communications they do not control, they will have to include these basic qualitative requirements in their terms and conditions; and
- for commercial communications included in user-generated content, they will have to implement a transparency functionality for uploaders to declare such content and inform users about the presence of such commercial communications.

The development of codes of conduct for HFSS foods is envisaged, meaning that Member States will encourage video sharing platforms to use self and co-regulation.

As well as the obligations for Member States to encourage the use of co-regulation and provide favourable conditions for self-regulation at the national level, the revised Directive includes a safeguard enabling Member States to adopt stricter or more detailed rules if they deem that the codes of conduct are not effective enough.

At the EU level, there is also the possibility for Member States and the Commission to foster self-regulation through EU codes of conduct. General criteria for codes of conduct have been developed and these include broad acceptance by stakeholders, clear objectives, monitoring and evaluation, and effective enforcement.

The revised AVMSD has introduced public health as a ground for Member States' to use in order to exceptionally derogate from the free reception and retransmission of TV broadcasts from other Member States. This should apply in situations where, on a case by case basis, there could be a serious and grave risk of prejudice to public health.

The revised Directive entered into force on 18 December 2018. Member States have 21 months to transpose it into national legislation, before September 2020.

Discussion

This is an interesting topic for the Focal Point network because of issues such as screen time and exposure to advertising that negatively influence children. It was suggested that the changes to the Directive are welcome and, from a public health point of view, it is hoped that Member States may go further, particularly in relation to HFSS foods.

There was also some discussion of the importance of educating parents on the issue of screen time and equipping them to resist marketing pressures. This is related to the previous discussion on health literacy. It was also noted that the concept of media literacy is mentioned in the Directive, on the basis that literate populations will be better able to recognize marketing communications. The experience of regulatory schemes has shown, however, that after a certain period of time consumers stop complaining about inappropriate commercial communications, suggesting a lack of media literacy. There is no evidence that promoting health literacy works to reduce the effectiveness of marketing communications. So, while it is ethical to try to improve media literacy this is no substitute for marketing regulation.

Day 2: Joint Meeting of the European Union Physical Activity Focal Points Network with representatives from Agriculture and Health

On the second day of the Focal Point meeting, a joint meeting took place with Member State representatives from health and agriculture.

Health

Wojciech Kalamarz, Directorate-General for Health and Food Safety (DG SANTE), welcomed all participants. This was the first joint meeting between representatives of EU Member States from health, agriculture and sport sectors, reflecting the clear intention to strengthen working across policy sectors to promote healthy lifestyles.

National governments have signed up to achievement of the Sustainable Development Goals by 2030 and to WHO's global targets for NCDs by 2025. These provide a roadmap for Member State action, and the Commission is committed to supporting Member States in these efforts.

It is important to focus on promoting the health of children, since these are the most vulnerable members of society. It is vital to ensure that they grow up in healthy and safe environments. Not only schools but also sport clubs and cinemas and their direct surroundings, need to be healthy and safe environments, where no forms of marketing of foods high in fat, salt and sugar are allowed.

There is a need to obtain data to be able to convince policymakers in other sectors of the case for investing in prevention. Currently only 3% of EU health spending is allocated to prevention,

despite the huge social and economic burden of NCDs on the European population. There is a need to shift the balance from treatment to prevention. There is also a need to work together and identify synergies between policy areas. Public health authorities alone cannot address the challenges of unhealthy and sedentary lifestyles. A health-in-all-policies approach is needed and it is important to reach out to those sectors that often have the largest influence on health determinants, such as education, sport, marketing, agriculture, urban planning and finance.

The Commission is, therefore, placing a strong emphasis on a multi-disciplinary approach and on multisectoral partnerships to identify and share validated best practice. CHRODIS PLUS is a joint action on chronic diseases, to support Member States by stepping up together and sharing best practices to alleviate the burden of chronic diseases.

Funding from the new Horizon Europe programme — through the clusters relating to food and to health — can be used to address health inequalities. There is an urgent need to avoid widening the health gap, both between and within Member States.

Representatives would have the opportunity to exchange views on how coordination and cooperation can be improved. Participants were encouraged to exchange contact information and to continue with cooperation after the meeting.

Agriculture

Brigitte Misonne, Directorate-General for Agriculture and Rural Development (DG AGRI), welcomed participants and the involvement of the agriculture sector in this meeting.

The EU School fruit, vegetables and milk scheme has provided concrete experience of cross-sectoral working. DG SANTE has been an active partner in the reform of the school scheme. Traditionally, there have not been many links between DG EAC and DG AGRI, but there has been sharing of fresh ideas through this cooperation on healthy lifestyles.

DG AGRI met with stakeholders from multiple sectors across Member States in October 2018 to take stock after one year's implementation of the school scheme.

This meeting of Member State representatives from agriculture, health and sports sectors is most welcome and the outcome keenly anticipated.

Sport

Marisa Fernandez Estéban, DG EAC, further welcomed participants on behalf of the Sport Policy and Programme Unit, and welcomed the organization of another cross-sectoral meeting on healthy lifestyles.

The SDGs provide a very clear mandate for this work, to create healthy and sustainable communities. Sport contributes to personal development, as well as to community cohesion. It is estimated that €1 invested in sport can save €3 in health care. The European Week of Sport has gone from strength to strength since its launch five years and, in 2018, 30 million people participated under the hashtag #BeActive.

The *Tartu Call for A Healthy Lifestyle*, signed by three Commissioners in 2017, identified 15 actions to promote healthy lifestyles. This has helped the Commission to adopt a coherent approach and to enhance cooperation between Commission services.

She thanked all colleagues for their efforts in organising the meeting and to WHO for its support.

WHO

João Breda welcomed all participants on behalf of WHO and thanked all Member States for their continued efforts to work together and break down silos. He also thanked the Commission for the fruitful collaboration with WHO.

Progress urgently needs to be scaled up in order to meet the SDGs and the global targets on NCDs. The European Region is on track to meet the overall target to reduce NCD mortality by 25%, but this is mainly due to changes in the Eastern part of the Region. Although there has been some progress in the European Union, further advances are required. In the Region as a whole, unless action is rapidly scaled up the targets relating to physical inactivity and obesity will not be reached.

WHO is committed to providing support and guidance to Member States for tackling NCDs throughout the life-course. Regional action plans have been adopted on physical activity and on food and nutrition. The food and nutrition action plan will come to an end in 2020. There remains much further room for improvement on food and nutrition policy in the Region, so Member States and WHO will discuss follow-up to the action plan.

It is clear that the life-course approach needs to be stronger in order to tackle these issues. WHO is working on foods for infants and young children and promotion of breastfeeding. There is also scope for improvement within the health sector, in terms of managing conditions such as obesity, hypertension and type 2 diabetes.

Policy should be driven by data, which points to the importance of effective surveillance. A good example is the WHO Childhood Obesity Surveillance Initiative in the European Region, which is the biggest example of such surveillance in the world.

Both the physical activity and the food and nutrition strategies place a strong emphasis on partnerships. It is clear that this will continue to be a key theme — effective partnerships are needed to translate policy into action.

A final theme to emphasize is the importance of research and innovation in this field. Effective interventions and policies need to be identified and funding models adapted to support innovative solutions.

Cross-sectoral cooperation: what works?

João Breda presented an introduction to one of the topics for discussion by the working groups: what works for cross-sectoral cooperation?

It is important to acknowledge that there are many common challenges to cross-sectoral cooperation. These include, for example, working in silos, continuously changing agendas which focus on short term results, a fear of losing control of policy areas, the lack of a mandate for cross-sectoral work, distribution of funding, alignment between regional and national governments, conflicts of interest and transparency and differing priorities. Physical activity, for example, is often accorded a low priority.

For effective cross-sectoral collaboration it is important to have common goals. Overarching goals can be used as an entry point, then shared interests and priorities can be identified. It is important to frame the issue in ways that are relatable for other sectors and then to agree on a joint initiative with common goals, targets and agenda.

Collaboration requires organization, including establishment of coordination mechanisms, definition of clear roles and responsibilities, conducting regular meetings to ensure flow of communication and setting up shared decision-making and ownership. There are also resource

implications — cross-sectoral collaboration builds on the need to use scarce resources more efficiently and dedicated funding is needed.

Member States have already given the Commission and WHO the mandate to pursue cross-sectoral collaboration. There are a number of areas where the Commission and WHO could support and encourage cross-sectoral cooperation. These include organization of cross-sectoral meetings, facilitation of contact with other sectors, dissemination of good practice and provision of support for monitoring.

The next multi-financial framework: Horizon Europe

Jean-Luc Sion, DG SANTE, and Karen Fabbri, the Directorate-General for Research and Innovation (DG RTD), presented an overview of the forthcoming Horizon Europe programme.

Discussions on the next European Union budget, the Multi-Financial Framework 2012-2027, are ongoing, with a view to ensuring simplification, transparency and flexibility.

Horizon Europe[20] is the EU research and innovation framework programme (2021- 2027) which aims:

- to strengthen the EU's scientific and technological bases and the European Research Area (ERA);
- to boost Europe's innovation capacity, competitiveness and jobs;
- to deliver on citizens' priorities and sustain our socio-economic model and values.

The Commission proposes a budget of €100 billion, with an additional €4.1 billion proposed for defence research in a separate proposal for a European Defence Fund. Horizon Europe will support efforts to tackle climate change, achieve the SDGs and to boost the Union's competitiveness and growth.

The European Union has 7% of the world's population, but conducts 20% of global research and development work and is responsible for one-third of high-quality scientific publications. The level of business research and development investment, however, is lower than in the United States, Japan or Korea. Europe can do better, therefore, at transforming knowledge and skills into leadership in innovation and entrepreneurship.

Horizon Europe is structured around three main pillars:

- excellent science
- global challenges and European industrial competitiveness[21]
- innovative Europe.

These are underpinned by a horizontal theme of widening participation and strengthening the European Research Area.

The Commission has proposed a budget of €52.7 billion for Pillar 2, Global challenges and European industrial competitiveness. This includes clusters on health, food and culture.

[20] Horizon Europe documents are publicly accessible:
Common understanding of the co-legislators on the Framework Programme: https://data.consilium.europa.eu/doc/document/ST-7942-2019-INIT/en/pdf
Corrigendum on Annex III :
https://data.consilium.europa.eu/doc/document/ST-7942-2019-COR-1/en/pdf
Partial General Approach adopted by the Council on the Specific Programme:
https://data.consilium.europa.eu/doc/document/ST-8550-2019-INIT/en/pdf

[21] Health; culture, creativity and inclusive society; civil security for society; digital, industry and space; climate, energy and mobility; food, bioeconomy, natural resources, agriculture and environment

Horizon Europe is intended to signal a new way of working, with a process of "co-creation" across DGs. A number of ambitious mission areas have been defined: Adaptation to climate change, including societal transformation; Cancer; Soil health and food; Climate-neutral and smart cities; Healthy oceans, seas, coastal and inland waters. For each of these, mission boards are being established — to be composed of up to 15 members (individuals appointed in a personal capacity) from among industry, academia, policymakers, practitioners, end-users and key stakeholders — and should meet for the first time in early September, with a view to providing the Commission with a scoping document by the end of 2019.

A new, more ambitious and objective-driven approach to European partnerships is also being pursued. This will feature a simple architecture and toolbox, a coherent life-cycle approach and strategic orientation. This includes rationalisation and reform of health cluster partnerships, reducing the current 13 partnerships to seven. In addition, a proposal for a food systems partnership with four research and innovation areas to address systemic issues to accelerate transition pathways to sustainable and healthy food systems is under consideration. The four research and innovation areas are: food safety of the future; dietary shift; food-related waste; microbiome.

Health cluster

It is proposed that the health cluster has six main areas of intervention:

- health throughout the life course
- environmental and social health determinants
- non-communicable and rare diseases
- infectious diseases
- tools, technologies and digital solutions for health and care
- health care systems.

Food, bioeconomy, natural resources, agriculture and environment cluster

There are seven proposed intervention areas:

- biodiversity and natural capital
- food systems
- environmental observation
- agriculture, forestry and rural areas
- bio-based innovation systems
- seas and oceans
- circular systems.

Following the 2015 Milan EXPO, three Commissioners established FOOD 2030, an EU research and innovation policy framework to transform nutrition and food systems. Its priorities are: nutrition for sustainable and healthy diets; climate smart and environmentally sustainable food systems; circularity and resource efficiency of food systems; and, innovation and empowerment of communities. The framework is intended to drive food system transformation through research breakthroughs, innovation and investment, open science and international collaboration.

The food systems theme in the Horizon Europe food cluster can be seen as the implementation vehicle for FOOD 2030 and calls for proposal will target four priorities:

- food systems transformation — environmentally sustainable, circular and resource efficient food systems from land and sea;

- healthy diets and personalised nutrition;
- food safety and authenticity;
- consumer behaviour, lifestyle and motivations for better health and environmental sustainability along the food value chain.

A new strategic plan for implementing Horizon Europe is in preparation. This will provide more detail on the content of the work programmes and calls for proposals in the first four years. Early involvement and exchanges with Member States and consultation with stakeholders and the public at large are scheduled to take place during summer 2019. This will be followed by co-creation at the EU Research and Innovation Days, 24-26 September. Extensive exchange with the new European Parliament is envisaged. Once the Strategic Plan has been finalized and endorsed by the new Commission, the first Horizon Europe Work Programme will be drafted and, in 2021, Horizon Europe will begin.

A web-based consultation was launched in June 2019[22] and the feedback of the consultation will be discussed at the EU Research and Innovation days in Brussels, 24-26 September 2019. This will be followed by further feedback in autumn 2019.

Discussion

There was discussion of how the issue of physical activity is seen within the Horizon Europe framework. It was pointed out that the importance of sport, through its contribution to society and to the health impact of physical activity, is often overlooked. It was clarified that this is an important element of "health throughout the life course". The co-creation process underpinning Horizon Europe provides multiple opportunities for input and for priorities to emerge, as well as to break down silos. Physical activity Focal Points were encouraged to liaise with national research and policy-making counterparts (particularly research representatives) to emphasize the importance of raising this issue in discussions on Horizon Europe and the Strategic Plan.

There was also discussion about the notable absence of specific references to health in the overall multi-financial framework and a perception that the health priorities are focused on health care, rather than prevention and health promotion. A lack of explicit attention to health inequalities as a priority was also noted. There was clarification that health will be part of the European Social Fund +, that the Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases will be driving investment in health. A unit within DG RTD is now specifically looking at prevention issues and prevention will also be included through integration of nutrition into food systems transformation work. There was clarification that there is the option for Member States to voice preferences via the Steering Group, e.g., to shift towards a much greater proportion of health spending on prevention and health promotion.

Working groups

Participants split into working groups to discuss three topics: Cross-sectoral cooperation; Horizon Europe – health cluster; Horizon Europe – food cluster.

Cross-sectoral cooperation

The working group was asked to discuss three questions about cross-sectoral collaboration between health, sport and agriculture. The feedback can be summarized as follows:

[22] https://ec.europa.eu/info/news/have-your-say-future-objectives-eu-funded-research-and-innovation-2019-jun-28_en

1. *What are some of the **common goals** that the three sectors are trying to achieve in the promotion of well-being?*

In discussion of the common goals, the group emphasized the importance of common language. A number of possible common goals were identified:

- using schools and workplaces as key settings
- using healthy eating
- using general practitioners as providers of information and counselling
- responsibility and empowerment at different levels (individuals, communities, Member States)
- inequalities (leave no one behind)
- sustainability throughout the life course.

2. *What are some possible **new approaches** to promote cross-sectoral cooperation?*

New approaches could include replicating examples of best practice (such as the Living Healthy initiative in Croatia), ensuring use of common language and mapping common goals across sectors.

3. *What **funding** and other resources are required to better facilitate working together across sectors?*

One thing that is fundamentally important to facilitation of cross-sectoral working, along with funding and resources, is political will. Suggestions for ways to maximise available resources and their efficient use included:

- a sugar tax to raise funds for increasing physical activity in schools
- financial incentives
- unique common budget line
- combining resources.

Horizon Europe — health cluster

The working group on the Horizon Europe health cluster concentrated on the consultation process for the Strategic Plan.

The take home message is that cross-sectoral coordination is already taking place. There was already a high level of awareness of the DG SANTE coordination group on health promotion and prevention.

Coordination is essential both between the Commission and Member States and within Member States, to ensure that the Strategic Plan reflects Member State needs. It is important to raise awareness of the co-create process and how it will work for Horizon Europe.

The discussion raised some questions on the mandate of the Multi-annual Financial Framework.

There was a strong message that Member States are willing to coordinate their actions and will consider needs for implementation/translation research for the design, monitoring and evaluation of programmes, in addition to basic research.

Another strong message was that, more than ever, there is a clear need to advocate for the importance of health, and, within that, nutrition and physical activity. It is clear that a co-create type process within Horizon Europe is essential to ensure that the European Social Fund + gives sufficient weight to health. It is important that the appropriate expert is invited to

meetings where specific topics are discussed. Member State Ministry of Health representatives should be invited when health topics are to be discussed in European Social Fund + discussions.

Horizon Europe — food cluster

The working group covering the Horizon Europe food cluster used the approach of a co-create session to address two issues: Dietary shift towards sustainable and healthy diets; Personalized nutrition.

Dietary shift towards sustainable and healthy diets

A sub-group of participants considered how consumers and producers could be nudged towards healthier, sustainable diets. They were asked to consider whether there is sufficient evidence for plant-based diets, what the co-benefits would be and to identify the knowledge and technical gaps and the barriers.

Feedback suggested that there is indeed enough evidence to encourage a shift towards plant-based diets, but there remains a need to increase awareness. There would be clear co-benefits for individuals — in terms of health — and for the environment, in terms of sustainability.

There are many areas where there are considerable gaps in awareness, including among health professionals, teachers, chefs and cooks, influencers, families and households and food chain operators. The barriers include misinformation, economic bottlenecks including the costs of healthy diet, lack of time for food preparation, the need for more available and affordable healthy choices and the lack of cross-sectoral cooperation and institutional innovation.

Personalized nutrition

A sub-group considered issues around personalized nutrition and these considered the following questions: For whom should we personalize? What are the co-benefits? What are the knowledge and technology gaps?

There was some confusion about the term "personalized nutrition", which is often used to refer to nutrition based on genetic testing. It was clarified that this concept was more intended to refer to nutrition for specific groups such as older people, children, people with specific health issues. It was suggested that an alternative term, such as "adapted nutrition for specific groups" might be more appropriate.

There was a discussion on the balance between encouraging different citizen choices and empowering public health authorities to drive change. It is clear that there is a need to do more to implement policies. Barriers identified include the influence of food industry sectors. There is a need to modify food environments to become less obesogenic, and this type of process requires bringing different Ministries and stakeholders together.

Concluding remarks

Wojciech Kalamarz thanked the speakers, working group rapporteurs and all participants for their contributions. This meeting has built on the success of the first joint meeting of the EU physical activity Focal Points and the High Level Group on Nutrition and Physical Activity that took place in Luxembourg in October 2018.

From now on, efforts will focus on building more collaboration within the three sectors of nutrition, sport/physical activity and agriculture. All participants are encouraged to stay in touch and to use existing online networks and platforms.

The Horizon Europe process will continue, and representatives are welcome to contact their national research counterparts to provide input to the draft Strategic Plan. Participants are also

encouraged to attend the EU Research and Innovation Days in September. In the meantime, the Commission will continue to work closely across sectors, between DG AGRI, DG SANTE, DG EAC and DG RTD.

Seminar: Tartu Call for a Healthy Lifestyle — 2 years later

Meeting participants attended a seminar to reflect on progress in the two years since the Tartu Call for a healthy lifestyle was launched in Tartu, Estonia, during the European Week of Sport in September 2017 by Commissioners Navracsics (Education, Culture, Youth and Sport), Andriukaitis (Health and Food Safety) and Hogan (Agriculture and Rural Development).

The Tartu Call demonstrated the firm commitment of the Commissions to work across policy areas and to develop further cooperation across the health, sports, education and food sectors. It comprised 15 commitments for joint actions to promote healthy lifestyles.

The seminar was opened and moderated by Sir Graham Watson, Europe Active, who highlighted the unique nature of the Tartu Call — as a collaboration between three Commissioners — reflecting the real need for cross-sectoral collaboration in order to meet the challenges of unhealthy diet and physical inactivity. There is an urgent need for more action to prevent obesity and diet-related diseases and to promote health.

Commissioner Navracsics addressed the conference and pointed out that the challenges remain immense, particularly as technology has, in addition to the benefits it confers, encouraged sedentary lifestyles and with the decline in physical activity in children's daily routines. Some of the key actions to promote physical activity and healthy lifestyles include:

- allocation of ERASMUS+ funding for HEPA projects (15 projects supported to date, €11 million funding for 2019);
- establishment of European Week of Sports as an annual event to promote healthy lifestyles (more than 18 million people took part in 2018);
- increasing the financial support from the European Institute of Innovation and Technology (EIT) to develop and boost innovative approaches to promote and raise awareness of the benefits of healthy lifestyles (€84 million in 2018 to EIT Health and EIT Food);
- cooperation between DG EAC and WHO to implement the monitoring framework on HEPA and develop country factsheets to report on progress.

On behalf of Commissioner Hogan, Jerzy Plewa, presented DG AGRI's reflections on progress since the Tartu Call was launched. The Commission has provided support to Member States to implement the new EU school fruit, vegetables and milk scheme, which was launched in 2017. In 2016/17, more than 20 million children were reached by the scheme, which distributed more than 255 million kg of fruits or vegetables and 200 million litres of milk. Children have also participated in educational events, developed school gardens and taken part in cooking workshops. The EU policy on the promotion of agricultural products has a role in supporting healthy dietary practices, with a specific budget on improving nutritional and health aspects (€79.1 million for 2019 work programme).

Commissioner Andriukaitis reflected on the good example of a multidisciplinary, cross-sectoral approach set by the Tartu Call. This is very much in line with what is needed — health in all policies. All involved can be proud of the achievements to promote healthy lifestyles. The efforts to fulfil the commitments of the Tartu Call have shown clearly that the Commission can act as one, with the singular objective of promoting healthy lifestyles.

The meeting heard testimonials from organisations contributing to achievements under the Tartu Call. These included:

- reflections from Estonia (under whose EU Presidency the Tartu Call was issued);
- description of Sweden's physical activity on prescription scheme, which is currently being co-funded for roll out as best practice;

- an outline of the impact of European Week of Sports in Ireland;
- a summary of the European Company Sports Games, which took place in La Baule, France, in 2018 to promote workplace physical activity;
- feedback on key messages from the Healthy Food Systems conference organized as part of the Austrian Presidency;
- an overview of the EU-funded EUROFIT project to increase physical activity levels of football fans through programmes delivered by coaches at club facilities;
- the launch of the European Frâich'Fantasy to emphasize the value of the consumption of European fresh fruit and vegetables;
- a summary of research by the EU's Joint Research Centre on reducing the exposure of children to food and beverage marketing.

Sirpa Sarlio, Ministry of Social Affairs and Health in Finland, described the economy of wellbeing theme that is being developed for the Finnish presidency. This approach explores the intertwined nature of health, wellbeing and the economy. A horizontal tool for policy-making is being developed, which recognizes the value of health in itself but also for growth, productivity, social stability and attraction of investment. A conference on this theme is taking place in September, in order to feed into Council Conclusions on the Economy of Wellbeing.

A panel discussion on healthy lifestyles explored a range of issues including, for example

- the key role that local governments (Amsterdam Healthy Weight Programme) and food business operators (Ahold-Delhaize) play in promoting healthy lifestyles, creating healthy food environments and reducing marketing and advertising of unhealthy food options, and
- synergies that the sport sector has with transport, tourism and employment, as well as health.

Actors at different stages of the food supply described efforts to increase availability and affordability of healthy foods, such as fruits and vegetables, as well as initiatives to promote their consumption and raise awareness of the associated health benefits, including through health professionals. The importance of further efforts to create healthier environments, particularly for vulnerable groups, was a clear theme.

Commissioner Andriukaitis delivered the closing remarks, summarizing some of the concrete steps that have been taken by the Commission and issuing a call for further action. It is clear that "business-as-usual" ways of working will not be sufficient; new "business-as-healthier" approaches are required to invest in healthy nutrition and active lifestyles. He repeated that public health authorities cannot address these challenges alone and that a health-in-all-policies and multi-stakeholder approach is needed. He specifically called upon the food business operators to redouble their efforts to ensure that healthy diets are increasingly in line with governmental dietary guidelines and that marketing to children of foods high in fat, salt and sugar is reduced. Commissioner Andriukaitis further referred to the Commission work on health inequalities and on identifying and sharing validated best practices through the Commission's Steering Group on Promotion and Prevention and the best practice portal.

The seminar ended with a ceremony to award certificates honouring best practices that promote healthy and sustainable food systems and that are conducive to reaching SDG 3 (target 3.4) to reduce NCD mortality.

Annex 1: List of Participants

AUSTRIA
ChristianHalbwachs
Austrian Sports Ministry

Karin Schindler
Federal Ministry of Labour, Social Affairs, Health and Consumer Protection

BELGIUM
Nancy Barette
Sport Vlaanderen, Department of Culture,
Youth, Sport & Media

Olivier Courtin
Attaché
Studies, Research & Development
Sport administration of Federation Wallonia

Marlan De Schryver
Flemish Agency for Health and Care

BULGARIA
Denitsa Pancheva
Head of Unit International Cooperation
European Programmes and Projects
Ministry of Youth and Sports

CROATIA
Goran Lipavic
Ministry of Agriculture

Slaven Krtalić
Head of Unit for Promotion of Physical Activity,
Croatian National Institute of Public Health

Sanja Musić Milanović
Head of Health Promotion
Croatian Institute of Public Health

CYPRUS
Chrystalla Constantinou
Ministry of Agriculture, Rural Development and Environment

Michael Michaelides
Scientific Director
Cyprus Sports Medicine & Research Centre (KAEK)

Fani-Anna Poiriazi
Physical Education Consultant
Secondary Education
Cyprus Ministry of Education and Culture

CZECH REPUBLIC
Hana Dvořáková
Project Manager
Centre for Public Health Promotion
National Institute of Public Health

Jitka Maskova
Ministry of Agriculture

DENMARK
Lene Breum Larsen
Danish Veterinary and Food Administration

Marc Künkel Pedersen
Administrative Officer
Prevention
Danish Health Authority

ESTONIA
Tiina Möll
Adviser
Sports department
Estonian Ministry of Culture

Kairis Ulp
Former chair of the Estonian Presidency of the Council of the EU

FINLAND
Päivi Aalto-Nevalainen
Division for Sport
Ministry of Education and Culture

Sirpa Sarlio
Ministry of Social Affairs and Health

FRANCE
Martine Duclos
Sport medicine
French Ministry of Sports

Jean-François Toussaint
Director
Institut Recherche Médical Epidémiology Sport/IRMES

GERMANY
Ute Winkler
Head of Division,
Department 422
Federal Ministry of Health

GREECE
Eleftheria Axioti
Focal Point Assistant
Department of Sports Scientific Support and Education
Ministry of Culture and Sports

HUNGARY
Eszter Sarkadi-Nagy
National Institute of Pharmacy and Nutrition

Eszter Thury
Ministry of Agriculture

Réka Veress
HEPA focal point
Ministry of Human Capacities

IRELAND
James Lavelle
Assistant Principal Officer
Sports Policy Division
Department of Transport, Tourism and Sport

ITALY
Daniela Galeone
Head of Office on NCD - Prevention
Ministry of Health

Igor Lanzoni
Expert Advisor HEPA National Director PA
Physical Activity Health and Wellness
Italian Mouvement Sport Popular

Patrizia Anna Paola
Ministry of Agriculture

Magdalena Catalina Stancu
Ministry of Agriculture

LATVIA
Kaspars Randohs
Senior Expert
Department of Sport
Ministry of Education and Science of Latvia

LITHUANIA
Inga Gerulskienė
Senior Officer
Public Health Promotion
Ministry of Health

Vidmantas Ašmonas
Ministry of Agriculture
Lithuania

LUXEMBOURG
Francois Kraus
Ministry of Agriculture, Viticulture and Rural Development

Alexandre Husting
Advisor International and EU affairs
Ministry of Sport

MALTA
Robert Portelli
Head of Programmes
Sport Malta

Pauline Vassallo
Ministry for Health

NETHERLANDS
Désirée Hoefnagel
Ministry of Agriculture

Wanda Wendel-Vos
Senior researcher Sport, Physical Activity and Health
National Institute for Public Health and the Environment (RIVM)

POLAND
Monika Niewiarowska
National Support Centre for Agriculture

Małgorzata Szukalska – Wrona
Chief Expert
Ministry of Sport and Tourism

PORTUGAL
Paulo Rocha
Head of Division
Sport for All - Sport Department
Portuguese Institute of Sport and Youth

ROMANIA

Vasile Dreve
Ministry of Agriculture

Ciprian Ursu
Senior Public Health Specialist
Health assessment and priority non-communicable diseases
National Institute of Public Health

SLOVAKIA
Lucia Miličková
Public health worker
Department of Health Promotion
Public Health Authority

SPAIN
Enrique Lizalde
Head of Sport and Health Department
Spanish Agency for Health Protection in Sport

SWEDEN
Eva Jirskog
Swedish Board of Agriculture

Kajsa Mickelsson
Analyst
Department of Living Conditions and Lifestyles
Public Health Agency of Sweden

UNITED KINGDOM
Beelin Baxter
Senior Policy Manager
Department of Health and Social Care

EUROPEAN COMMISSION

Sandra Caldeira
Joint Research Centre
European Commission

Claire Depre
Head of Unit
Directorate General for Mobility and Transport

Karen Fabbri
Head of Sector
Directorate General for Research and Innovation

Marisa Fernandez Estéban

Directorate-General for Education and Culture
Unit Sport Policy and Programme

Olivier Fontaine
Policy Officer
Directorate-General for Education and Culture
Unit Sport Policy and Programme

Wojciech Kalamarz
Head of Unit
Health determinants and international relations
Directorate-General for Health and Food Safety

Yves Le Lostecque
Head of Sport Unit
Directorate-General for Education and Culture
Unit Sport Policy and Programme

Brigitte Misonne
Directorate-General for Agriculture and Rural Development

Jean-Luc Sion
Directorate-General for Health and Food Safety

Maciej Styczen
Legal Assistant
Directorate-General for Communications Networks, Content and Technology

TEMPORARY ADVISERS

Clare Farrand
The George Institute for Global Health

Romeu Mendes
Portuguese Directorate-General of Health

REPRESENTATIVES OF OTHER ORGANIZATIONS

European Association for the Study of Obesity (EASO)
Nathalie Farpour-Lambert
President
Switzerland

European Cyclists' Federation
Randy Rzewnicki
Senior Expert Health & Transport Health Policy
Belgium

EHN - European Heart Network
Marleen Kestens
Manager Prevention
Belgium

Ilkka Vuori
Finland

Lars Bo Andersen
Western Norway University of Applied Sciences
Norway

OBSERVERS
Simon Plasschaert
EU Attaché Sport
Flemish government - Sport Vlaanderen
Belgium

WHO COLLABORATING CENTRES

Karim Abu-Omar
Friedrich Alexander University Erlangen Nürnberg
WHO Collaborating Centre for Physical Activity and Public Health
Germany

Peter Gelius
Friedrich- Alexander-Universität Erlangen-Nürnberg
WHO Collaborating Centre for Physical Activity and Public Health
Germany

Anja Frei
Senior Researcher
University of Zurich
WHO Collaborating Centre for Physical Activity for Health
Switzerland

WORLD HEALTH ORGANIZATION

Regional Office for Europe
João Breda
Programme Manager
Nutrition, Physical Activity and Obesity
Division of Noncommunicable Diseases and Promoting Health Through the Life-course

Kremlin Wickramasinghe
Technical Officer
WHO European Office for Prevention and Control of Noncommunicable Diseases

Stephen Whiting
Technical Officer
Nutrition, Physical Activity and Obesity
Division of Noncommunicable Diseases and Promoting Health Through the Life-course

Lea Nash
WHO Consultant
Nutrition, Physical Activity and Obesity
Division of Noncommunicable Diseases and Promoting Health Through the Life-course

Liza Villas
Programme Assistant
Nutrition, Physical Activity and Obesity
Division of Noncommunicable Diseases and Promoting Health Through the Life-course

Jesús Onn Toi Chew Ambrosio
Programme Assistant
Nutrition, Physical Activity and Obesity
Division of Noncommunicable Diseases and Promoting Health Through the Life-course

Rapporteur
Karen McColl

The WHO Regional Office for Europe

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World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int