Fifth meeting of the European Union Physical Activity Focal Points Network

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Meeting Report
ABSTRACT

The WHO Regional Office for Europe and the European Commission have been cooperating to develop and scale-up monitoring and surveillance of health-enhancing physical activity in the European Union Member States. An important element of this collaboration is the network of national physical activity focal points. These focal points help to provide and validate information on physical activity from EU Member States in line with the monitoring framework established by the Council Recommendation of 2013 and to integrate these data into WHO Europe’s information system for nutrition, obesity and physical activity, NOPA.

The work of the focal point network meetings in 2014 and 2015 has led to the publication of *Factsheets on health-enhancing physical activity in the 28 European Union Member States of the WHO European Region*. The fourth meeting of the focal point network, hosted by the United Kingdom and Queen’s University on 27 September 2016, discussed the preparations for the update of the factsheets on health-enhancing physical activity in the 28 European Union Member States of the WHO European Region and the next steps to be taken to promote and update collected information around the HEPA indicators.

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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, EU Member States have been 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 fifth meeting of this Focal Points Network on 27 September 2016 in Belfast, Northern Ireland.

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

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

Following the 2013 Council Recommendation on HEPA, the European Commission and the WHO Regional Office for Europe have been cooperating to develop and scale-up monitoring and surveillance of health-enhancing physical activity in the European Union Member States. An important element in this context is the work of the Network of National Physical Activity Focal Points to help provide and validate information on physical activity from EU Member States in line with the monitoring framework established by the Recommendation and to integrate them into WHO Europe’s information system for nutrition, obesity and physical activity, NOPA.

The four previous meetings have led to the publication of the Factsheets on health-enhancing physical activity in the 28 European Union Member States of the WHO European Region. ¹

The fifth meeting, held at Queen’s University Belfast on 27 September 2016, discussed the preparations for the update of the factsheets on HEPA in the 28 European Union Member States of the WHO European Region and the next steps to be taken to promote and update collected information around the HEPA indicators. Some of the key indicators in the context of the monitoring framework, a Pan-European physical activity surveillance initiative and an initiative on physical activity in pre-school and schoolchildren were also discussed. In addition, a workshop on valuing physical activity, organised for the Network by the EPHEPA project, took place.

Participants included the Focal Points, representing 25 Member States, the European Commission, represented by staff from DG EAC/Sport Unit, and the World Health

Organization, represented by staff from the WHO Regional Office for Europe. Several external speakers, observers and a rapporteur were also present.2

Welcome addresses
On behalf of WHO and the Regional Director, João Breda welcomed all participants and thanked the Focal Points for their sustained commitment to the process. The Network has now been working together for few years and it is proving very successful and has achieved some significant milestones. The challenge now is to nurture the Network and to scale up its work, so it is important to discuss the next steps.

Olivier Fontaine, European Commission, added his welcome and thanked the UK for hosting the meeting. The high level of attendance is indicative of the ongoing commitment to the Network. The Network is even more important now that the Expert Group on HEPA has come to the end of its mandate.

HEPA developments in the EU context
Olivier Fontaine gave an update on HEPA developments at the EU level. Following the Council Recommendation on HEPA in November 2013, the Commission is required to report on progress with implementation by the end of 2016.

The Commission has facilitated the exchange of good practices through both the Expert Group on HEPA and this Focal Point Network. A document setting out national good practices, compiled by the Expert Group on HEPA, will be published in October 2016.3

Under the monitoring framework for HEPA established by the Council Recommendation, cooperation with WHO and the Focal Point Network has led to publication of the first set of physical activity country fact sheets in September 2015. In line with the agreed three-year cycle, the next edition is planned for September 2018.

The Commission carries out studies to strengthen the evidence base for policymaking. Two recent relevant studies were mentioned4:

- Study on the EU Physical Activity Guidelines
- Study on the contribution of sport to regional development through the Structural Funds (contains guidance on best use and application of Structural Funds).

The third area of activity has been co-financing projects and events. This has included Erasmus+, the programme for Education, Training, Youth and Sport (2014–2020), which has provided 266M€ for sport. In 2016, 11 projects were awarded a total of 4.3M€. Examination of the projects in the database 5 can be useful for the identification, for example, of future partners. For 2017, the deadline for proposals will be 6 April 2017 and a total of 5.6M€ will be allocated for physical activity; there

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2 See Annex 1 for a full list of participants.
3 It will be available on the website http://ec.europa.eu/sport/policy/cooperation/expert-groups-2014-2017_en.htm
4 http://ec.europa.eu/sport/library/index_en.htm
will be a simplified process for applications and funding. Erasmus+ Sport Information Day will take place on 31 January 2017.

Under a European Parliament Pilot Project on HEPA, a call for proposals for promoting HEPA policy measures and actions for refugees was issued. Project grants of up to 60K€ will be awarded to projects covering at least six Member States particularly concerned by the arrival of refugees. 53 project proposals were received for a total available budget of 600K€.

Under Horizon 2020, the biggest EU Research and Innovation programme, a call for proposals on promoting mental health and wellbeing in the young was issued (closed on 4 October). The Commission is currently working on the Work Programme 2018–2020 for adoption in autumn 2017. There will be several rounds of consultation with Member States and this presents the opportunity for research ministries to input ideas on HEPA.

A Massive Open Online Course (MOOC) has been launched on the EU budget and funding for regions and cities. The course is available from 31 October to 9 December 2016 (with the course material available until July 2017) and around 10,000 participants are expected. Further information is available from welcome@cor.europa.eu and registration is on https://www.fun-mooc.fr/courses/CoR/114001/session01/about.

In 2015, the first European Week of Sport was marked in 31 countries by over 7,000 events involving 30 European partners and 5 million participants. In 2016, the week was even bigger (more than 15,000 events, reaching out to more than 10 million participants). Focus was put on the themes of education, workplace, outdoors, sport clubs and fitness centres. The opening event took place on 10 September in Košice, Slovakia, and there was a flagship event on 15 September in Brussels, focusing on good governance. In future, the European Week of Sport will take place between 23 and 30 September throughout Europe.

A High Level Group on Grassroots Sport, with 15 members, has been set up by Commissioner Navracsics to assess the role of grassroots sport in its societal and economic dimensions and to identify future actions. The group’s recommendations were published in June 2016 and are available at http://ec.europa.eu/sport/news/2016/0629-hlg-reports-grassroots-sport-diplomacy_en.htm.

In relation to urban mobility, European Mobility Week took place between 16 and 22 September. Other initiatives include Civitas (a database of innovative measures by cities)\(^7\), ELTIS (the urban mobility observatory)\(^8\), the Member States Expert Group on Urban Mobility\(^9\) and the Commission webpage on cycling\(^10\).

Upcoming events relevant to HEPA include the European Summit on Digital Innovation for Active and Healthy Aging\(^11\), the Erasmus+ Sport information day on

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\(^8\) [http://www.eltis.org/](http://www.eltis.org/)


\(^10\) [http://ec.europa.eu/transport/themes/urban/cycling_en.htm](http://ec.europa.eu/transport/themes/urban/cycling_en.htm)

31 January 2017, the EU Sport Forum on 8–9 March 2017\textsuperscript{12} and the EHIS-Eurostat Task Force on 13–14 October 2016. Further information is available from http://ec.europa.eu/sport/ or by contacting EAC-UNITE-C2@ec.europa.eu.

Discussion

There was clarification that adoption of the Horizon 2020 Work Programme 2018–2020 is foreseen in autumn 2017.

It was clarified that it will be possible to make some small changes to update the online version of country factsheets before the next round, where such changes are important and relevant.

Progress towards achievement of HEPA-related targets – the importance of EC/WHO collaboration

João Breda presented an update on progress towards achievement of HEPA-related targets, in order to initiate a discussion on the indicators.

In general, the European Region is making good progress towards the global goal of reducing premature mortality from noncommunicable diseases (NCDs) by 25% by 2025, and may well be the only global region where the whole Region reaches the target. Closer examination of individual countries and of specific indicators, however, reveals a more complex picture. It will be difficult to achieve some of the specific targets unless action is scaled up very quickly. Member States have to report to the UN in 2018 and currently no Member States in the Region are on track in terms of achieving the global targets for adult obesity and very few are on track to meet the physical inactivity target. It is important to ensure that the physical activity target is a motivational factor and to invest in the achievement of the 2025 global target and the Sustainable Development Goal targets.

In 2018, therefore, there is a requirement to report to the EU Council on HEPA and to the UN on NCD targets. This collaboration between WHO and the Commission, therefore, is really making an important contribution to achievement of these targets.

The regional mandate and architecture for action on nutrition, physical activity and obesity is strong, with regional action plans on food and nutrition and on physical activity. Global and regional mandates have recently been reinforced. The new Regional action plan for the prevention and control of noncommunicable diseases in the WHO European Region was adopted in September 2016.\textsuperscript{13} This includes ‘active living and mobility’ as one of the population-level priority interventions, and is one of the areas where there is more prospect of success. The Report of the Commission on ending childhood obesity included physical activity as one of the six key areas for action.

As part of the progress towards meeting the global goals, a number of time-bound commitments were agreed. By 2016, one of the commitments for Member States is to have implemented at least one recent national public awareness programme on diet and/or physical activity. This is the progress indicator related to diet or physical activity where Member States claim to have made most progress – more than 60% of

\textsuperscript{12} http://ec.europa.eu/sport/
\textsuperscript{13} http://www.euro.who.int/__data/assets/pdf_file/0011/315398/66wd11e_NCDActionPlan_160522.pdf?ua=1
Member States in the Region and 24 EU Member States claim full implementation. If most countries have already reached this target, however, it will not be possible to report or show any further progress between now and 2025. For this reason it is important to be very honest and transparent about what is being done in country. There is, therefore, a great opportunity to use the indicators of the EU monitoring framework to ensure that reporting on progress is more meaningful and complete.

The proposal is, therefore, to work together towards greater alignment between the EU Monitoring Framework for physical activity and WHO’s European Region Physical Activity Strategy for the European Region, which feeds into the global WHO process.

Discussion

There was clarification that progress towards the global target to reduce physical inactivity will be assessed primarily using the GHO estimates, because these are the only estimates available for all global regions. The Regional Office is also recommending that other surveillance data from the Region—well-documented national evidence of progress—is taken into account.

Further discussion is needed on potential further collaboration on regional surveillance to track progress in implementing the Physical Activity Strategy. Collaboration on evaluation and monitoring would be extremely valuable and the Regional Office is bringing together scientific advisors to help with this and would be very supportive of any initiative in this area.

Physical activity in the school context—questionnaire and indicators

João Breda reported on one example of an in-depth exploration of one of the indicators, through a recent survey to examine in more detail the issue of physical education in schools, an issue which is of particular interest to policymakers.

The aims of the questionnaire were to inform the fine-tuning of the monitoring process and to gather up-to-date information on PA initiatives in the school context.

Data on this indicator suggest that only five EU Member States have less than two mandatory hours of PE in secondary schools and only four in primary schools. This is encouraging but more detail is needed on the quality of the education and on other aspects of physical activity in schools.

The WHO regional physical activity strategy suggests that:

- Member States should employ an intersectoral approach that involves the education, sports and health sectors in the design of physical education curricula.
- Lessons should integrate a variety of activities and skills that promote positive attitudes that support and enable children and adolescents to lead physically active lifestyles.
- The availability of playgrounds and of appropriate teaching resources and materials should also be ensured.
- The initiatives could include the infrastructure to support physical activity, such as playgrounds, active breaks, free play, active extracurricular activities and provisions for safe active commuting.
Scientific literature recommends creating gender-specific interventions, as boys and girls respond differently to physical activity initiatives (structural interventions have greater impact on boys and behavioural interventions result in deeper changes in girls). It also recommends including a theoretical model as the basis for physical activity initiatives. This helps in the intervention design, variable selection, form of analysis, and evaluation of interventions.

Preliminary results from the 24 questionnaires received highlighted 33 initiatives or interventions. Encouragingly, four countries (Cyprus, Greece, Italy and Portugal) have increased the amount of hours of PE since 2015. Of the initiatives and interventions reported, 29 are based on fostering positive attitudes, 24 are age specific, nine are gender specific and 19 have a theoretical base. Twelve of them involve improvements to play areas and 13 involve continuing physical activity education to teachers. When asked which bodies are involved in designing the school physical education curricula, the education sector is most common by far (23) with the sports sector involved in eight cases and the health sector in seven cases. This points to the ongoing need for much more cross-sectoral working. In the majority of cases (14) only one sector was involved, with only five countries involving two sectors and five countries involving three sectors. This is an important role for the Focal Points Network, which is encouraging cross-sectoral working and should also help facilitate such an approach at the country level.

This more detailed exploration of a particular indicator has been highly successful and is an approach that could be replicated for other indicators in due course.

Discussion

It was suggested that this questionnaire could also be applied to physical activity in secondary schools, since this is also an important area to explore.

Update from WHO Collaborating Centre on physical activity, nutrition and obesity

Professor Adrian Bauman, Australia, presented a short overview of some of the work and challenges of the WHO collaborating centre on physical activity, nutrition and obesity at Sydney University. The work of the collaborating centre is globally focused, but there are several ways in which the centre can help Member States in any region.

One of the capacity building initiatives by the collaborating centre is an online course called *Physical activity and exercise in NCD prevention*. This six-week course starts on 17 October, is run in English and includes lectures, readings and interactive discussion led by experts. It is intended for professionals working in government and NGOs who are relatively new to the issue of physical activity, particularly those working in countries where NCDs are emerging. The course fees are subsidized for participants from low- and middle-income countries. Further details are available from contact.planet@sydney.edu.au or Adrian.bauman@Sydney.edu.au.

In relation to measurement, the centre can help implement STEPS surveillance of physical activity, as it has done with some Pacific countries.

The Centre has also conducted work on intermediate implementation indicators, towards the overall targets for meeting the physical activity recommendations. Countries need first to define their country-specific target and to know the current
prevalence and then needs to be able to assess implementation continuously in order to achieve the 2025 targets. Information is needed on the existence of physical activity policies, and process evaluation including whether the policy has been approved, funded, implemented and sustained. In addition, indicators of success are really needed to know whether policies have been successful – these can include intermediate health metrics of health antecedents that result from the policy implementation.

The Centre is embarking on an international analytic project on the contribution of sport to physical activity. It aims to answer the question of what role and contribution sport makes to total physical activity for adults and children and how this varies by country and the degree to which sport is integrated into society. For this, the Centre needs access to raw population data on sport and also physical activity, and is, therefore, looking for countries to participate. The Centre can provide statistical support, all the analyses and collaboration in any reporting of the results. Any Member State interested in participating should contact Professor Bauman.

Discussion

There was clarification that the collaborators for the sport and physical activity study could be either academic researchers or policymakers, as long as they have access to relevant data in a form which can be harmonized with data from other countries.

Discussion on a proposal for a physical activity surveillance study

Olivier Fontaine introduced a discussion on a proposal for a physical activity surveillance study. In the first round of data collection, the comparability of physical activity prevalence data had been an issue. Many countries are using data from national survey questionnaires, while others are using international instruments or reporting data from EU surveys. During the discussions of this group, and the Expert Group on HEPA, a clear need to work together on surveillance has emerged. The Commission, therefore, has decided to fund a study on this issue and, after exploring the options, has decided to encourage Member State researchers and stakeholders to put together a project to fund under existing EU programmes.

There are two options:

- A project funded by the ERASMUS+ programme, with a maximum EC contribution of 80% and a maximum grant of 400,000 euros (on a project with a budget of 500,000 euros).
- A Horizon 2020 research project, with a budget up to 4 million euros. Currently, however, there is no Horizon 2020 goal that corresponds to this area of research. It may be a possibility in the 2018–2020 programme, but that obviously implies a delay.

In the short term, therefore, the only option is the ERASMUS+ route. This would mean interested Member States and institutions preparing a proposal over the next six months in order to be able to submit a proposal by the deadline in April 2017 for a project to start on 1 January 2018. The maximum duration is up to three years, but given the relatively limited budget a shorter timescale is probably preferable. This could potentially be a first step, to be followed by a larger, more ambitious study under the Horizon 2020 programme at a later stage.
João Breda underlined the importance of this initiative for WHO. There is a very real need to validate the instruments and to harmonize methods. This will require sustained collaboration for an approach based on science and research rigour. It will also require allocation of resources, although innovative approaches should help to minimise costs.

Participants were asked for their thoughts and suggestions on this proposal, and the options outlined.

Discussion

Some disappointment was expressed that the Commission had been unable to take more of a lead on this and directly fund organizations, and that, rather, it remains down to Member States to take the initiative. Both the Commission and WHO, however, are ready to provide as much support as possible.

There was some discussion of the timeframe and the expectation that some meaningful results can be achieved in the time available. There had been some discussion of this idea at the last Expert Group on HEPA meeting and this had already pre-identified some groups that would be highly interested in participation in any such study. Member States interested in participating should identify particular institutions that have expertise in this area and that would be interested in getting involved.

In order to take the work forward, it was suggested that a sub-group further develop the concept and prepare a draft proposal. Portugal indicated that it would be happy to help coordinate this process. This sub-group will then need to convene and identify its support needs, then ask for support from WHO. A number of countries (Belgium, Croatia, Cyprus, Finland, Germany, Netherlands, Slovenia and Sweden) expressed interest in participation. The small working group was asked to take the work forward and prepare a draft proposal for discussion with the Focal Point Network, and other Member States can then decide if they want to participate. Obviously, the more Member States that get involved, the better. Finland offered to lend accelerometers for the study.

WHO will take the lead in organizing a first online/web meeting of the small drafting group. Portugal offered to host an initial drafting meeting in Lisbon.

Presentations on ongoing projects at the EC/WHO level

There was a series of presentations on ongoing projects in Europe.

Physical activity, education, capacity building and global partnerships – Exercise works!

Ann Gates, of Exercise Works! presented this UK-based initiative which seeks to educate, translate, influence and collaborate on physical activity. The vision of Exercise Works is that the health workforce in every single Member State is put into action to promote physical activity. On the basis that a qualified doctor, nurse, midwife or allied health professional may see half a million patients during their career, there is enormous potential for advocacy and physical activity promotion. Exercise Works, therefore, aims to change the world by training all health professionals to be competent to deliver physical activity – to create a global workforce that is fit for purpose.
In order to get one inactive patient to meet recommended activity levels, doctors need to advise 12 people. This compares to the 50–120 patients that doctors need to advise to get one smoking patient to give up cigarettes.

From ‘cradle to grave’ there are a number of ‘teachable moments’ during which interaction with health professionals can result in behaviour change. Although the ideal is to reach every patient everywhere, priority groups should be targeted first, in line with the WHO regional strategy on physical activity. Innovative approaches, such as adding physical activity advice into immunization programmes in order to reach all children, are worth exploring.

This can be described as a ‘Movement for Movement’ to transform physical activity advocacy and practice by forming a community of practice to achieve results and, in a way, ‘disrupting’ health systems to bring about change.

In the UK, when this project started only four medical schools were doing any teaching on physical activity, now 17 of the 34 medical schools in the country are using the resources – which are freely available and have been endorsed by the UK Council of Deans of Health. More than 8,000 people registered for the online Physiotherapy, Exercise and Physical Activity course in 2016, with more than 45 million social media impressions in the six weeks of the course and more than 58,000 learning activities logged.

This is an exciting project and there is huge potential to transfer it to other countries. Identification of a global host for the resources generated by the project would be very timely.

Discussion

There was some discussion of the role of kinesiologists, and the potential for different professional groups to contribute, potentially easing the burden on doctors and nursing staff. It is recognized that there are different mixes of professions in different countries, and the most important point is to try to transcend professional differences and mobilize all relevant professionals in each Member State. WHO is planning to publish a report with health systems colleagues on the role of health professionals in diet and physical activity.

Eat well, drink well, move

Jean-Claude Coubard, European Healthy Lifestyle Alliance (EHLA) and International Chair on Cardiometabolic Risk (ICCR), provided an overview of the ICCR/EHLA scientific think tank.

ICCR/EHLA aim to:

- Participate in the fight against worldwide epidemic of obesity and its consequences (type 2 diabetes and cardiovascular disease)
- Break the silos between disciplines
- Help transversally and work with other academic organizations, NGOs, etc.

In line with the aim of breaking down silos between different disciplines, the membership is multidisciplinary.
Obesity is a marker that our lifestyle is not adequate all over the world and physical inactivity is estimated to cost the world 67.5 billion dollars every year.\(^{14}\) ICCR’s goal is to manage and prevent abdominal obesity by healthy eating, drinking and physical activity habits. One of its key messages is that improving cardiorespiratory fitness and reducing the waistline are better targets than weight loss.

ICCR develops scientific and educational materials for health professionals and others and develops education programmes, as well as providing information for other agencies and developing partnerships with international academic societies. It regularly organizes international congresses, sub-committee meetings and special meetings on topics of particular interest. Further information is available on [www.myhealthywaist.org](http://www.myhealthywaist.org).

The European Healthy Lifestyle Alliance is a vehicle for the ICCR messages in Europe. The objectives of EHLA are to:

- Raise awareness among stakeholders on the importance of abdominal obesity and its complications
- Translate the ICCR messages into a detailed action plan outlining what is to be done, by whom, and how
- Involve stakeholders into the implementation of actions, and elaborate potential interactions and partnerships with existing platforms and structures
- Provide a discussion forum on lifestyle modification and cardiometabolic health, based on the latest scientific evidences
- Promote consolidated and simple recommendations to the general public.

The key messages of EHLA are that abdominal obesity, as a risk marker, must be assessed by waist measurement and that the focus should be on underlying behaviours leading to abdominal obesity and related health outcomes.

The Alliance has made four key recommendations:

- The link between a sedentary lifestyle, poor nutritional habits, overconsumption of sugar-sweetened beverages and obesity and type 2 diabetes should be emphasized at the clinical and public health levels.
- It is important, so measure it! Waist circumference should be routinely measured as a vital sign during medical visits.
- Overconsumption of sugar-sweetened beverages is a major risk factor for obesity, type 2 diabetes and CVD. Such link between hydration quality and clinical outcomes should be emphasized among health professionals and in public health education campaigns
- Regular physical activity/exercise can substantially reduce the dangerous visceral adiposity/ectopic fat depots even in the absence of weight loss in response to a lifestyle modification program. The importance of tackling inactivity and promoting regular physical activity has to be considered in EU policies to address the obesity epidemic which is a lifestyle epidemic.

The key messages of ICCR/EHLA – *eat well, drink well, move* – have been translated into the ICCR lifestyle pyramid. The ‘Move’ side of the pyramid provides advice on

physical activity in the form of infographics. This tool is available for any Member State to use and to translate into their own languages.

Discussion

There was clarification that, while in younger age groups abdominal obesity tends to be more of a problem for men, it is also a common problem in post-menopausal women.

The IMPALA-net project results and good practices

Alfred Rütten, Institute of Sport Science and Sport, Friedrich-Alexander University Erlangen-Nuremberg, Germany, presented a study on the implementation of the proposed European guidelines on Improving Infrastructure for Leisure-Time Physical Activity in the Local Arena (IMPALA).

An indicator on IMPALA implementation is included in the EU Monitoring Framework. In the first round of data collection by the Focal Points, the vast majority of respondents had replied that the Guidelines were not implemented, but it was unclear whether this was due to a lack of awareness or to implementation issues.

This issue was explored further as part of a study on the implementation of EU physical activity guidelines. The partners were the Institute of Sport Science and Sport (ISS) at FAU Erlangen, University of Zurich, Oxford University, University of Ulster and Cavill Associates.

As the lead partner, ISS is responsible for project coordination, in-depth comparative case studies of six to eight Member States and coordination of case consultancy.

IMPALA.net is a network that has been set up to serve as a bridge between international policy for infrastructure development and promotion of HEPA through sport at the national and local level. It aims to do this by bridging the vertical gap between high-level policy and HEPA infrastructure development and by bridging horizontal gaps between different sectors through national alliances.

It aims to improve access and participation in HEPA through sport by:

1. Improving implementation of policy for HEPA infrastructure development at the national level through creation of national alliances that will develop national action plans in a cooperative planning process for implementation of the IMPALA Guidelines.
2. Positioning sports organizations as leaders in infrastructure development for HEPA and sport promotion through capacity building and implementing a Winter School for stakeholders.

A research partner and one sport organization was selected for each of the participating Member States to set up and maintain national alliances to develop National Action Plans for implementation of the IMPALA guidelines. In total, 18 organizations from 6 EU Member States are taking part.

One example of good practice in building a sustainable coordinating mechanism for physical activity and sport infrastructure development is Lithuania. Partner organizations include Lithuanian Sports University and Lithuanian Physical Activity and Health Association, and they have involved different organizations in building a national alliance. A number of cooperative planning workshops have been held.
The results of the project will not be evident for a couple of years, but the initial steps are very encouraging.

Jacob Schouenborg, International Sport and Cultural Association, Denmark, added some words on the dissemination of the IMPALA guidelines. It is possible to develop alliances and it is important to help that process along. Participants were invited to provide information on what it would take to have better implementation of the HEPA infrastructure in their country and to provide details of the key contact to work through the process of implementing the IMPALA guidelines. It is important that someone in every country takes responsibility for the area of improving physical activity infrastructure and help is available for this process.

The Research into Policy to Enhance Physical Activity (REPOPA) project

Thomas Skovgaard, Department of Sports Science and Clinical Biomechanics, Odense, Denmark, presented an overview of the REPOPA project on bridging the gap between research and policymaking in relation to physical activity.

The five-year REPOPA project, funded by the EU’s Seventh Framework Programme and which finished in September 2016, involved nine partner institutions in six European countries and a partner in Canada involved in evaluating the project. REPOPA aims to integrate scientific research, expert know-how and real world policy marketing to promote HEPA by:

- Building on evidence and experiences on policy-making processes
- Studying ‘win-win’ ways to collaborate between academia and policymakers
- Establishing structures and best practices for future HEPA-promotion.

The overall approach is to integrate best available evidence, expertise and experience-based knowledge available from professionals, along with the needs, values and wishes of the population to make evidence-informed decision making for policymaking.

There were three main phases of the project:

- First phase: Mapping of research and other type of evidence in policy making through a document analysis and stakeholder interviews.
- Second phase: Intervention to test two interventions – policy game interventions on cross-sector decision making; locally tailored interventions on evidence-informed policy making.
- Third phase: Implementation and guideline development.

The first phase (mapping) exercise analysed documents from 21 HEPA-related policy processes in six countries and interviewed 86 stakeholders. Almost none had any systematic or explicit application of evidence to the policy process. Some main factors to facilitate use of evidence in policy were identified: managerial support; evidence-oriented organizational culture; and relevant or easy to use information on best available evidence. The main barriers to an evidence-informed process that were identified were the converse of the ‘facilitator’ factors, and political interests.

In phase 2, some policy games (scenario building) were conducted in Denmark, Netherlands and Romania. Three hypothetical policy games were conducted at the local level, involving 57 participants in one day discussion sessions. The main results of this process were enhanced understanding of local circumstances and the processes shaping HEPA policies, an increased insight into opportunities for collaboration, and
changes in stakeholder attitudes towards the use of evidence. The project then explored whether the policy game tool could be used in a practical way, in a more user-friendly format.

The final phase of the project involved taking the results of the first two phases into a Delphi process. Two rounds of online consultation with more than 80 panellists resulted in a generic list of 25 measurable indicators in four categories. This process was followed by National Consensus Conferences, where national policymakers and other stakeholders were asked to review, prioritize and add indicators. The outcome is a set of Evidence Informed Policy Making (EIPM) indicators in four domains:

- Monitoring and evaluation (four indicators)
- Human resources – competences and networking (five indicators)
- Documentation – retrieval/production (six indicators)
- Communication and participation (10 indicators).

The full set of indicators will be published shortly.

The key message for researchers is that it is vital to work together from the beginning and that simply disseminating knowledge to potential users is likely to be of limited effectiveness. Key elements that are needed include early and meaningful interaction in determining relevant issues and questions, respect and trust among all partners, opportunities for in-person interaction, recognition of the costs of all partners, and effective strategies for arbitrating between diverse and often conflicting perspectives.

Workshop: Valuing Physical Activity

Professor Charlie Foster, University of Oxford, UK, introduced a workshop on Valuing physical activity organised by the EPHEPA project, funded by the Erasmus+ programme. It is clear that figures on economic costs or potential savings are important to generate policy support and to sustain interventions. The workshop aimed to present different approaches for use of economic data to strengthen the work of national Focal Points, reflecting the concerns expressed in previous Focal Point Network meetings about the challenges of making an economic case for physical activity initiatives.

Why does giving physical activity an economic value matter?

Professor Alfred Rütten presented an overview of why economic value matters and the preliminary results of a recently finished systematic review in Germany.

The evidence base on the health benefits of physical activity is well known and very well documented. There are also good existing reports on the economic costs of physical inactivity. The links between the benefits of physical activity and the costs of physical inactivity, however, were less well documented. High costs of physical inactivity do not necessarily mean, for example, that the situation can be changed and lead directly to economic benefits. The question is, therefore, does physical activity promotion pay?

Some HEPA promotion interventions are not effective enough or they are too expensive. It is important to identify interventions that successfully increase physical activity levels at an affordable cost.
The study was a systematic analysis of existing reviews of the cost effectiveness of physical activity interventions, and 25 studies were included in the review. In addition, 130 single health-economic evaluation studies were examined and categorized, in order to analyse the cost effectiveness of approaches.

It is important to note that there were some issues with regard to study quality and the comparability of studies, with differences in terms of the type and quality of studies included, the various costs considered and how the benefits were calculated.

The conclusions of the study are that the lack of physical activity in the population causes annual costs of billions of Euros and that a sufficient degree of physical activity can lead to health benefits many times higher.

The overwhelming majority of studies are cost-effective and have considerable health economic benefits. However, comparison between studies and clear ranking of cost-effectiveness remain difficult.

Measures that reach large segments of the population at low cost are particularly cost effective. Policy and environmental strategies of physical activity promotion that target the entire population are particularly recommendable for primary promotion.

Physical activity programmes (e.g., health sport classes) are often effective but have limited reach and are usually cost-intensive. From a health economic perspective, they can be recommended, especially for difficult-to-reach target groups or target groups with health-related risk factors or pre-existing conditions. Sports clubs have a particular potential for physical activity promotion, but there is a dearth of high-quality studies and health economic analyses on this topic.

Worksite health promotion is often viewed positively by existing studies, but different perspectives and/or contexts have to be considered. Physical activity promotion in school can also be done in a cost-effective way, but basic factors need to be adequately considered.

**What are the best buys for physical activity interventions?**

Nana Anokye, Brunel University London, UK, presented an overview of the best buys for physical activity interventions, with an overview of the current evidence and a policy relevant approach.

It is important to make the case for the cost effectiveness of physical activity interventions, in order to demonstrate what method is the best use of limited available resources.

To date a number of approaches have been used to addressing this issue:

- Systematic literature reviews of existing economic evaluations – in order to compare different studies the costs of interventions are converted to costs per person and cost-effectiveness rations reported as cost per incremental quality-adjusted life year (QALY) gained, disability-adjusted life years (DALYs) gained, life years gained (LYG), MET-hours gained.
- Model-based approach—identifying a list of interventions and conduct a review on the effect estimate for each intervention and create a common method for assessing all the interventions. The answer obtained depends on the data input, and the quality will reflect the quality of initial data.
Using the model-based approach Roux and colleagues estimated the cost effectiveness of various interventions in 2008 and 2015. They found interventions were more cost-effective in middle-aged adults (50 to 64 years), with cost-effectiveness ratios 38% to 47% lower than in 25- to 64-year-olds. This highlights the potential difficulty in using one cost-effectiveness figure for the entire population and the importance of considering cost effectiveness for different population groups.

There are a lot of areas where current knowledge remains inadequate. There is a lack of data on which types of interventions from which sectors are more likely to be cost effective. Cross-sectoral working is known to be important for HEPA promotion and, therefore, information on which interventions and sectors are effective is needed to facilitate and encourage such cross-sectoral collaboration.

Modelling approaches need to take into account the relationship between various individual characteristics and the uptake and maintenance of physical activity following interventions and the future consequences of activity levels. The EMPHASIS model, funded by the Department of Health in England, is designed to take these elements into consideration when modelling cost effectiveness.

EMPHASIS is a collaboration between Brunel University, the University of Oxford, University College London and St George’s University. EMPHASIS is an individual-level ‘micro-simulation’ model designed to account for characteristics of particular groups (e.g., age and income group) when modelling cost effectiveness. At the same time, the modelling will predict after how many years the intervention will be most cost effective.

The target population used for EMPHASIS is those who are at least five years of age and insufficiently active. A range of interventions delivered in different sectors and targeted at different age groups – and which have been found to be effective – were considered.

The model is based on a sample from the Health Survey of England. For this sample, the predicted baseline risks for cardiovascular disease, diabetes, depression, musculoskeletal injuries and other health outcomes are estimated. The methodology for these risk calculations could be adapted for other countries. Based on the individual characteristics, the predicted changes in physical activity over time are also estimated (taking into account cross-sectional population data and secular trend data). The next step is to predict the impact of additional physical activity on risk. The model is then run twice – once to estimate the cost effectiveness assuming normal care and a second time including the intervention.

The model’s outputs include cost effectiveness, summarized as incremental cost per QALY, and intermediate outcomes such as the number of people increasing physical activity levels, cases of CHD, stroke and depression avoided and life years gained. Importantly, the model can give different policy perspectives – generating estimates for a short-term horizon or life-time estimates.

The EMPHASIS model can be used for both short-term and long-term cost effectiveness decision making by different funding sector and age group. It can also show resource use per intervention at the programme level (i.e., set up costs) and at the patient level, as well as savings from avoided treatment and care. Importantly, it can also provide information on the timing of expenditure, savings and health benefits, including at which point the savings incurred balance the cost of
interventions. It can also be used as a basis for developing return-on-investment models.

Meeting participants can use the EMPHASIS model in a number of different ways. In a similar context, with similar population characteristics and interventions, the reported results can be used. In other cases where the population is similar but the interventions are different, it is possible to replace intervention-specific parameters such as the uptake rates, costs and effect sizes of the interventions. Conversely, if the interventions are similar but the population different, it is possible to replace the population-specific parameters (i.e., risks of events, sample dataset). Where both populations and interventions are different, both sets of parameters can be modified.

**How to value the cost of physical inactivity to health services**

Dr Nick Townsend, University of Oxford, gave an overview of how the costs of physical inactivity to health services can be estimated, using the example of estimates calculated for England.

There are a number of steps in the process.

*Define physical inactivity*

There are many different ways to define physical inactivity. One common way is to apply metabolic equivalents (METs), but the data is often missing, another way is to use the percentage of adults meeting the WHO physical activity guidelines. With the latter, it is important to take into account the changes to recommendations which will have impacted on the trend data.

*Identify physical inactivity related diseases*

WHO identifies five key diseases: ischaemic heart disease, stroke, colon cancer, diabetes and breast cancer. The list of identified conditions where there is strong evidence that physical activity reduced prevalence identified by Lee and colleagues I 2012 also included depression and falling.

*Calculate the proportion of the identified diseases due to physical inactivity*

This means calculating the proportion of disease due to physical inactivity, expressed as the population attributable fraction (PAF). This corresponds to the proportional reduction in population disease that would occur if exposure to a risk factor were reduced to an alternative ideal exposure scenario (i.e., everyone meeting the WHO recommendations). In order to calculate the PAF, data on the prevalence of the risk factor in the population and the relative risk of disease associated with the risk factor are needed.

*Apply proportions to cost data stratified by physical inactivity-related diseases*

Data on the costs associated with the particular diseases are then required. The PAFs can then be applied to these data in order to estimate the costs associated with physical inactivity.

This process generated an estimate of £455 million costs of physical inactivity to health services in England for 2013/14, equivalent to £8.17 per person. It is possible, where the relevant data exist, to examine the overall figure and see which sub-group

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of disease conditions account for the greatest economic costs or for which sector of health services (e.g. general medical, pharmaceutical, outpatients) physical inactivity is generating the greatest costs. The data can be broken down into geographical areas and by level of deprivation.

There are many factors to consider when examining trends in this data over time. There may be changes in the PAF estimates, changes in health service organisation and funding paths or other changes in data or data collection.

To summarise the results of the study in England, the costs of physical inactivity in 2013/14 were estimated to be £455 million in total, equivalent to £8.17 per head. These figures relate to five disease areas, so therefore are likely to underestimate the total value of disease related to physical inactivity (musculoskeletal or mental health conditions are not taken into account). In addition, these figures only take into account direct costs to health services, and do not take into consideration indirect costs, such as lost productivity. The figures are unable to account for different age, gender, ethnic and social class structures between regions. What the figures do represent is a combination of physical inactivity prevalence and cost of treatment.

**The Health Economic Assessment Tool (HEAT) for walking and cycling**

Dr Sonja Kahlmeier, University of Zurich, gave an overview of the Health Economic Assessment Tool for walking and cycling.

It is known that walking and cycling can contribute significantly to physical activity. They also help straddle sectoral boundaries because cycling and walking help different sectors to achieve their own goals – such as reducing emissions, congestion, road traffic injuries, etc – and contribute to several Sustainable Development Goals.

Until fairly recently economic models in transport did not take health into account. This prompted development of the HEAT tool to integrate health benefits into standard transport economic models. This online tool ([www.heatwalkingcycling.org](http://www.heatwalkingcycling.org)) enables economic assessment of health benefits of walking or cycling. The initial focus is on premature mortality prevented (and is therefore a conservative estimate), but other factors such as morbidity or absenteeism could be included.

The tool was initially designed for transport planners, because transport is a policy area where economic assessment really is key. The tool provides a clear answer to the question ‘for a given volume of walking or cycling within a defined population what is the economic value of the health benefits?’ The HEAT approach is based on best available evidence. It is transparent and is adaptable to different concepts. The idea is that people will conduct the assessment once and share the results. Many people and institutions have been involved in this collaborative project over the years. Various different areas of expertise have been included.

The potential uses of HEAT include planning new projects, evaluating existing projects, assessments of current use and modelling projections of future levels. All that is required to perform the analysis is information on the number of people affected and the levels of walking or cycling. Based on the given volume of walking/cycling per person, the tool then estimates the protective benefit (e.g., reduction in mortality) as a result of walking or cycling. When the population that stands to benefit (i.e., number of people affected) is included, the model can calculate the estimated economic savings. This is expressed using the value of statistical life.
commonly used in transport models, which is different to healthcare costs or other estimates.

HEAT has been widely applied and adopted both within and beyond Europe for a variety of applications. The project website has been visited about 700,000 times since 2011. England and Sweden, for example, have incorporated HEAT tools into the official transport toolboxes. Austria has used it to estimate the health effects of the national cycling masterplan. A number of cities are using the tool, including Barcelona, Brighton and Hove, Florence, Glasgow, Kuopio, Modena, Nantes, Parnu and the French Healthy Cities network. At the EU level, it has been used to estimate that if all citizens in the EU aged between 20 and 74 cycled or walked an additional 15 minutes per day, 100,000 premature deaths could be prevented each year.

The tool is available at [www.heatwalkingcycling.org](http://www.heatwalkingcycling.org), along with the method and user guide (updated August 2014). A new version is forthcoming and will include a module that allows the calculation of the impact air pollution to be shown separately, this is important to be able to show policymakers. There are occasional online training sessions webinars, and these are also advertised on the website.

**Discussion**

There was clarification that, according to the information available, the tool has been used mainly in academia for scenario analysis. In other examples it has been used to make a case for a new investment or show the impact of a previous intervention.

In many countries, people like to use their cars and politicians are generally reluctant to implement unpopular measures. The tool has been created in the expectation that showing some hard figures can help to convince politicians and provide them with the information to be able to counteract lobbying from pro-car groups and make a strong case for taking action.

**How to value physical activity in sport settings**

Sarah Ruane from Sport England, UK, presented an introduction to making the economic case for sports role in improving health.

In December 2015, a new sports strategy for England was published and, following on from this, Sport England published its own strategy in May 2016, *Sport England: Towards an active nation 2016-21*. This presents a fundamental shift, with a much greater proportion of funding and focus going to tackling inactivity. This will be underpinned by a new workforce strategy, a new coaching strategy and improvements to measuring physical activity through the new Active Lives survey, which will provide a lot more detail and depth on physical activity and attitudes. The new remit covers everyone from the age of five upwards. The distinction between sport and physical activity has now been completely removed.

Historically, there has been inadequate attention to demonstrating the value of sport in England. Given the limited resources, it is vital to prove that all investments are worthwhile. This focus on return on investment may not be new for the health sector, but the sport and leisure sector has tended to focus purely on participation numbers rather than any broader estimate of benefits. Health and Local Authority Commissioners need this evidence to be able to decide to invest in physical activity promotion.
Sport England decided, therefore, in 2013 to start developing an evidence-based economic modelling tool to determine the cost effectiveness of sport and physical activity interventions for the health sector. The Health Economics Consultancy at the University of East Anglia was commissioned to undertake an evidence review and develop the tool. Following development, user testing and development of a user guide, the model, MOVEs, was launched at the Public Health England Conference in 2015. It can be used to plan or evaluate interventions and provides a cost utility analysis (expressed as cost per QALY).

Suzanne Gardner, Sports England, presented an overview of the second version of the tool, MOVEs 2, which includes 69 sports or activities. This revised version includes DALYs and hip fractures, to ensure that it is valuable for those involved in social care planning. The model is based on a number of principles and assumptions, and it is very important to be clear and transparent about these when reporting and presenting results. The second version of the model factors in estimates of drop-off in levels of activity. It is important to note that the model does not take into account the health profile of patient groups and the data are for over 16s. In addition, the costs of injuries due to sport or physical activity are not included in MOVES.

The tool is in spreadsheet format and there are 15 mandatory fields to be completed and three advanced fields. The data to be imputed include: demographics of the population and their baseline level of physical activity; the type, intensity, duration and frequency of the intervention activity; the scale of the intervention (number of participants, time frame, annual drop off/maintenance) and the programme costs. The advanced parameters include risk reduction from physical activity and discounting.

The model then calculates the return on investment outcomes, including health outcomes for ‘without the intervention’ compared to ‘with the intervention’ and the health service treatment cost saving, the QALYs gained and DALYs avoided. It will also give estimates of costs per QALY gained or per DALY lost, an assessment of whether the intervention is cost-effective and the return on investment to health services.

The outcomes will vary depending on the time-horizon used in the modelling. A five-year scenario, for example, is unlikely to capture all the long-term health benefits of increased physical activity. The model can also generate treatment and probabilistic scenarios, giving information on numbers needed to treat, i.e. what needs to be done in order to avoid x numbers of events. By modelling many different scenarios, the model can generate a probabilistic cost-effectiveness scatterplot.

To present the data in a very user-friendly format to clinical commissioning groups, the results can be presented in terms of numbers of cases of different conditions or different health outcomes that have been averted in the short and/or long term.

A number of ideas for future development of the model are being explored. These include an online version of the tool, a social care version of the model and even a specific model on treatment.

The tool, user guide and presentations are available for download from [http://www.sportengland.org/movestool](http://www.sportengland.org/movestool) and queries can be addressed to get.healthy@sportengland.org
What is needed next for valuing physical activity – a view from a user

Dr Wanda Wendel-Vos, National Institute for Public Health and the Environment (RIVM), Netherlands, provided some comment on the workshop presentations.

One of the challenges facing those involved in policymaking is identification of which interventions represent the best use of resources. The workshop has given a clear answer about why it is important to assign an economic value to physical activity – because policymakers want to identify the intervention which will bring the greatest benefit.

Identifying such an option, however, is not so easy. Literature gives somewhat contradictory results on the ‘best buys’ for physical activity. It can depend on the intervention, the target population and how impact is defined. The workshop has presented a number of examples and tools to help with this process – namely, the EMPHASIS model, the HEAT tool, the MOVES tool and an example of how to calculate costs of physical inactivity to health services.

It is unclear whether participants would have enough information to be able to successfully convince colleagues in their countries of the need to put a value on physical activity, particularly in countries where not all the data and instruments exist.

It would be useful for the HEPA Focal Point Network to discuss what is really needed, in practical terms, to be able to carry out these analyses to put an economic value on physical activity.

Discussion

There was a suggestion that a high level group on physical activity would be useful, in order to persuade decision-makers that they really need to take action. It is important to foster the political will to take action and this is the first challenge to overcome in many countries.

It was pointed out that economic information is only one aspect of the political discourse, which reflects current values and attitudes. More expertise in political science, and recognizing the value of narrative, could be helpful in relation to establishing political will. Economic data is part of this, but should not be the only element.

Charlie Foster wrapped up the workshop with some concluding remarks. The tools introduced during the workshop present opportunities for valuing possible future scenarios, for highlighting which interventions are likely be cost effective, for assessing investments in active transport and for estimating the costs of physical inactivity to health services and, therefore, communities. Participants were asked to consider which of the tools were likely to prove more useful and whether additional tools are still required. It is hoped that the workshop helped participants to think about how health economics can be useful for their work on this issue.

Concluding remarks and next steps

Olivier Fontaine reminded participants of the timetable for producing the next version of the country factsheets by September 2018. Data collection will take place between October 2017 and May 2018 and Focal Point approval of the draft factsheets will be needed in May 2018. Meetings are planned, therefore, for April 2017, October 2017
(at the start of the data collection process) and in February 2018 (in the middle of data collection).

João Breda closed the meeting by once again thanking the Focal Points for their ongoing collaboration and thanked all participants for their enthusiastic participation in this meeting with a very packed programme. The Focal Point Network is a flagship project and this is important to showcase initiatives taking place in Europe. The innovative tools presented during the workshop have great potential to enrich the future reports and factsheets and thanks are due to the EPHEPA project for organizing the workshop. He also welcomed the collaboration with the HEPA Europe Conference. Finally, he thanked the United Kingdom and Queen’s University for hosting the meeting, and expressed gratitude to WHO colleagues for all the organization and logistics.
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