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EU Physical Activity Guidelines

Recommended Policy Actions in Support of Health-Enhancing Physical Activity

**Approved by the EU Working Group "Sport & Health"
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1. INTRODUCTION

1.1. Benefits of physical activity

Physical activity is usually defined as “any bodily movement associated with muscular contraction that increases energy expenditure above resting levels”. This broad definition includes all contexts of physical activity, i.e. leisure-time physical activity (including most sport activities and dancing), occupational physical activity, physical activity at or near the home and physical activity connected with transport. Alongside personal factors, environmental influences on physical activity levels can be physical (e.g. built environment, land use), social and economic.

Physical activity, health and quality of life are closely interconnected. The human body was designed to move and therefore needs regular physical activity in order to function optimally and avoid illness. It has been proved that a sedentary lifestyle is a risk factor for the development of many chronic illnesses, including cardiovascular diseases, a main cause of death in the Western world. Furthermore, living an active life brings many other social and psychological benefits and there is a direct link between physical activity and life expectancy, so that physically active populations tend to live longer than inactive ones. Sedentary people who become more physically active report feeling better from both a physical and a mental point of view, and enjoy a better quality of life.

The human body, as a consequence of regular physical activity, undergoes morphological and functional changes, which can prevent or delay the appearance of certain illnesses and improve our capacity for physical effort. At present there is sufficient evidence to show that those who live a physically active life can gain a number of health benefits, including the following:

- A reduced risk of cardiovascular disease.
- Prevention and/or delay of the development of arterial hypertension, and improved control of arterial blood pressure in individuals who suffer from high blood pressure.
- Good cardio-pulmonary function.
- Maintained metabolic functions and low incidence of type 2 diabetes.
- Increased fat utilisation which can help to control weight, lowering the risk of obesity.
- A lowered risk of certain cancers, such as breast, prostate and colon cancer.
- Improved mineralization of bones in young ages, contributing to the prevention of osteoporosis and fractures in older ages.
- Improved digestion and regulation of the intestinal rhythm.
- Maintenance and improvement in muscular strength and endurance, resulting in an increase in functional capacity to carry out activities of daily living.
- Maintained motor functions including strength and balance.
- Maintained cognitive functions and lowered risk of depression and dementia.
- Lower stress levels and associated improved sleep quality.
- Improved self-image and self-esteem and increased enthusiasm and optimism.
- Decreased absenteeism (sick leave) from work.
- In very old adults, a lower risk of falling and prevention or delaying of chronic illnesses associated with ageing.

Children and young people take part in various kinds of physical activity, for example by playing games and participating in different sports. However, their daily habits have changed due to new leisure patterns (TV, internet, video games) and this change has coincided with increasing rates of childhood overweight and obesity. As a result, there is much concern whether physical activity among children and young people has been replaced by more sedentary activities in recent years.

Opportunities to be physically active tend to decrease as we become adults and recent lifestyle changes have reinforced this phenomenon. Due to the great inventions of recent times, there has been a marked decrease in the amount of physical effort necessary to do daily household chores, to go from place to place (car, bus), and even to reach leisure activities (including those with a physical activity content). According to available data, between 40 and 60% of the EU population lead a sedentary lifestyle.

It is therefore important for EU Member States to draw up national plans in support of physical activity in order to help modify unhealthy life habits and promote awareness of the benefits of physical activity in relation to health. These plans would take account of the environment, customs and cultural characteristics of each country.

There is evidence that anyone who increases their level of physical activity, even after long periods of inactivity, can obtain health benefits irrespective of their age. It is never too late to start.

Change can be brought about through widespread innovation in policy and practice, and notably through increased cross-sectoral cooperation and the adoption of new roles by diverse actors who are already well-established and respected in their fields of competence. Big solutions and comprehensive, global strategies cannot and should not be provided. It is rather on the basis of a large number of small changes in policy and practice across the board that our societies may become more movement-friendly.

1.2. Added value of these guidelines

A number of EU Member States have national Physical Activity Guidelines which help government agencies and private bodies to work together in order to promote physical activity.¹ Often these Physical Activity Guidelines also help to channel public money into projects that encourage people to move more. Physical Activity Guidelines exist in

¹ For example: France: Ministère de la Santé et de la Solidarité (2005): Programme Nutrition Santé: Activité physique et santé. Arguments scientifiques, pistes pratiques. – Germany: Bundesministerium für Ernährung, Landwirtschaft und Verbraucherschutz, Bundesministerium für Gesundheit: Gesunde Ernährung und Bewegung – Schlüssel für mehr Lebensqualität. 04.05.2007. – Luxembourg: Ministère de la Santé (2006): Vers un plan national: Alimentation Saine et Activité Physique. – Slovenia: Ministrstvo za Zdravje (2007): Nacionalni program spodbujanja telesne dejavnosti za krepitev zdravja od 2007 do 2012. Povzeto po Strategiji Vlade Republike Slovenije na področju telesne (gibalne) dejavnosti za krepitev zdravja od 2007 do 2012. – United Kingdom: H.M. Government (2008): Healthy Weight, Healthy Lives: A Cross-Government Strategy for England. – United Kingdom: Office of the Deputy Prime Minister; Local Government Association; Department of Culture, Media and Sport; Sport England (2004): Sport and Physical Activity in 2nd Generation Public Service Agreements: Guidance Notes. DCMS, Sport England (2008): Shaping Places through Sport and Health. – Finland: Government Resolution on the Development of Guidelines for Health-Enhancing Physical Activity and Nutrition (2008).

various forms in the USA as well as in the context of the World Health Organisation (WHO).

The EU Working Group "Sport & Health", which is open to participation by all Member States, received a mandate from Member State Sport Ministers meeting under Finnish Presidency in November 2006 to prepare EU-level Physical Activity Guidelines. The most central concern was to have guidelines suggesting priorities for policies that would promote increased physical activity. For this purpose, the Working Group appointed an Expert Group of 22 well-known experts with the specific purpose of preparing such guidelines. While meeting informally, due to the absence of formal Treaty-based arrangements, Sport Ministers acted in line with concerns expressed by the EU Council of Ministers (in particular the Council formation responsible for health). During the years 2002-2006, five Council Resolutions called for EU action to combat obesity, not only as regards nutrition, but also as regards physical activity.²

To ensure the integration of policies which translate into increased physical activity in everyday life, there should be close and consistent cooperation among the relevant public and private actors when policies for sports, health, education, transport, urban planning, working environment, leisure etc. are developed. If policies that promote physical activity are successfully integrated, the easiest available option for citizens should be to choose a healthy lifestyle.

These Guidelines are addressed primarily to policy makers in the Member States, as inspiration for the formulation and adoption of action-oriented national Physical Activity Guidelines. The purpose of the document is not a comprehensive academic review of the subject, nor a redefinition of WHO recommendations and targets. EU added value is provided by focusing on the implementation of existing WHO recommendations for physical activity, by being action-oriented and by being solely focused on physical activity (and not nutrition or other related topics). This document is intended for a wide range of users who deal with physical activity. The use of footnotes, references and specialist terminology has therefore been kept to a minimum.

1.3. Existing physical activity guidelines and recommendations

The World Health Organization (WHO) is a key actor in defining the terms for policies to counteract obesity.³ As part of its activities, the WHO has adopted a number of documents which define individual as well as collective goals related to physical activity and diet.⁴ Some WHO recommendations are addressed to the entire population, while

² COM(2007) 279. 30.05.2007: White Paper on A Strategy for Europe on Nutrition, Overweight and Obesity related health issues. http://eur-lex.europa.eu/LexUriServ/site/en/com/2007/com2007_0279en01.pdf, p. 2

³ <http://www.euro.who.int/obesity>

⁴ World Health Organization (Geneva, 2004): Global Strategy on Diet, Physical Activity and Health. – World Health Organization (WHO Regional Office for Europe, Copenhagen (2006): Steps to health. A European framework to promote physical activity. – WHO Europe Ministerial Conference on Counteracting Obesity (Istanbul, 2006): European Charter on Counteracting Obesity. – World Health Organization (Geneva, 2007): A guide for population-based approaches to increasing levels of physical activity. Implementation of the WHO Global Strategy on Diet, Physical Activity and Health.

others cover specific age groups. The WHO's guidance documents focus on physical activity as a tool for population-based primary prevention and are based on the most recent scientific evidence.

In 2002 the WHO adopted a recommendation to the effect that everybody should practise a minimum of 30 minutes of daily physical activity.⁵ In its White Paper on Sport (Staff Working Document), the Commission noted that "some studies tend to show that even more physical activity can be recommended. This suggests that guidelines to promote physical activity in the EU would be useful. Such guidelines could propose different recommendations for different age groups, such as children and young people, adults and elderly people."⁶

These EU Guidelines follow up on the White Paper on Sport by proposing more concrete and policy-related "Guidelines for Action" which can be found at the end of relevant sections of the text. Guidelines are intended to address decision-makers at all levels (European, national, regional, local), in the public as well as in the private sector. While confirming the approach set out by the WHO, they seek to define useful steps to help translate objectives into action.

The Guidelines also follow up on another strategic document adopted by the Commission. In its White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues, adopted on 30 May 2007, the Commission "believes that the Member States and the EU must take pro-active steps to reverse the decline in physical activity levels in recent decades brought about by numerous factors." The White Paper does not limit the discussion on obesity to its nutritional aspects but makes a strong case for taking such action as may be appropriate to increase physical activity levels and thus remedy the current physical activity deficits. The Commission also underlines that organisational and structural factors which influence people's possibilities to be physically active must be tackled through appropriate policy coordination.

In the Conclusions on the White Paper on Nutrition, Overweight and Obesity related health issues, adopted by the Employment, Social Policy, Health and Consumer Affairs Council⁷, and also in the European Parliament's report on the same White Paper⁸, the importance of physical activity in the fight against obesity and related illnesses has been underlined by both Institutions.

The same White Paper goes on to advocate for such measures as the collation and dissemination of new models of intervention and coordination developed at local and regional level, including via the EU High Level Group on Nutrition, Health and Physical Activity. An example of such exchange and peer learning can already be found in the

⁵ See: "Why Move for Health", <http://www.who.int/moveforhealth/en/>

⁶ SEC(2007) 935, 11.07.2007: Commission Staff Working Document: The EU and Sport: Background and Context. Accompanying document to the White Paper on Sport (COM (2007) 391). http://ec.europa.eu/sport/whitepaper/dts935_en.pdf

⁷ http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/97445.pdf 15612/07

⁸ http://www.europarl.europa.eu/news/expert/infopress_page/066-38015-266-09-39-911-20080924IPR38014-22-09-2008-2008-false/default_en.htm

work of the EU Platform for Action on Diet, Physical Activity and Health which includes representatives of European research, industry and civil society. Measures of the kind proposed in these Guidelines could, due to their cross-cutting nature, be developed and evaluated within similar networks at various levels.

For healthy adults aged 18 to 65 years, the goal recommended by the WHO is to achieve a minimum of 30 minutes of moderate-intensity physical activity 5 days a week or at least 20 minutes of vigorous-intensity physical activity 3 days a week. The necessary dose of physical activity can be accumulated in bouts of at least 10 minutes and can also consist of a combination of moderate- and vigorous-intensity periods.⁹ Activities to increase muscular strength and endurance should be added 2 to 3 days per week.

For adults aged over 65, in principle the same goals as for healthy younger adults should be achieved. In addition, strength training and balance exercises to prevent falls are of particular importance in this age group.

These recommendations are in addition to routine activities of daily living that tend to be of light intensity or last less than 10 minutes. However, the currently available dose-response relationships show that for the most sedentary parts of the population, increasing even light or moderate intensity is likely to be beneficial for their health, particularly if the minimum threshold of 30 minutes of moderate-intensity physical activity 5 days a week is not (yet) met. For all target groups, additional benefits can be obtained by increasing intensity.¹⁰

School-aged youth should participate in 60 minutes or more of moderate to vigorous physical activity daily, in forms that are developmentally appropriate, enjoyable, and involve a variety of activities. The full dose can be accumulated in bouts of at least 10 minutes. Development of motor skills should be emphasised in early age groups. Specific types of activity according to the needs of the age group should be addressed: aerobic, strength, weight bearing, balance, flexibility, motor development.

⁹ In adults (young to middle age), mild/light walking (strolling) might represent a physical effort of 3,500 steps per 30 minutes, while the same effect would be achieved by older people through an effort of 2,500 steps per 30 minutes. Moderate walk would thus demand 4,000 steps in adult age and 3,500 steps in old age, while for a vigorous level of walking activity (walking uphill, upstairs or running), 4,500 steps would be needed in adult age and 4,000 in old age.

¹⁰ As specified by the [United States of America Department of Health and Human Services] Centers for Disease Control and Prevention (CDC) and the American College of Sports Medicine (ACSM), intensity levels may be graded as "moderate activity" (burning 3.5 to 7 kcal/min) or "vigorous activity" (burning more than 7 kcal/min). "Moderate activity" includes "Walking at a moderate or brisk pace of 3 to 4.5 mph on a level surface inside or outside, such as Walking to class, work, or the store; Walking for pleasure; Walking the dog; or Walking as a break from work; Walking downstairs or down a hill; Racewalking—less than 5 mph; Using crutches; Hiking; Roller skating or in-line skating at a leisurely pace". "Vigorous activity" includes "Racewalking and aerobic walking—5 mph or faster; Jogging or running; Wheeling your wheelchair; Walking and climbing briskly up a hill; Backpacking; Mountain climbing, rock climbing, rapelling; Roller skating or in-line skating at a brisk pace". See CDC [Centers for Disease Control and Prevention]: General Physical Activities Defined by Level of Intensity. (Undated.)
http://www.cdc.gov/nccdphp/dnpa/physical/pdf/PA_Intensity_table_2_1.pdf

The development of national physical activity recommendations should go hand in hand with the planning and evaluation of policies and interventions to achieve the recommended goals outlined in the WHO's guidance for physical activity promotion. In its White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues, the Commission also proposes that "Sports organisations could work with public health groups to develop advertising and marketing campaigns across Europe that promote physical activity particularly among target populations, such as young people, or those in low socio-economic groups."

The WHO Regional Office for Europe recently collected existing physical activity recommendations being utilised by Member States across the WHO European Region. Sources used were the "International inventory of documents on physical activity promotion"¹¹ combined with information requests to 25 countries (of which 19 were Member States of the European Union) and additional internet searches. Information was found for 21 countries, of which 14 are Member States of the European Union. All the documents describe the general recommendation of "at least 30 minutes of moderate-intensity physical activity 5 days per week" for all adults¹².

Not all documents contained specific recommendations for different age groups (younger people, adults and older adults). The majority of documents included a recommendation of 60 minutes of moderate-intensity physical activity per day for children and young people, but only a few countries had recommendations for the elderly.

Generally, the recommendations of most countries were based on the amount and type of physical activity required for general health benefits. Additionally, some countries had explicit recommendations for certain health outcomes, e.g. healthy bones or heart diseases. Furthermore, certain countries included guidance for specific sub-groups of the population in their recommendations, particularly with regard to obesity and weight management. Some countries also included minimizing screen time/sedentary behaviour to no more than two hours per day in their recommendations.

Although countries generally use the same recommendations, based on those of the WHO, there is much diversity in how they disseminate the physical activity message. Some national documents contain practical advice (e.g. use the stairs, engage in outdoor activities with your family, dance) for the population and for health workers on how to reach the recommended levels of physical activity. Other documents focus more on how policy makers should implement and disseminate the physical activity message. A few countries have designed specific communication tools, for example a pyramid or a pie to illustrate their physical activity recommendations for adults.

¹¹ HEPA Europe – International inventory of documents on physical activity promotion – Copenhagen, WHO Regional Office for Europe, 2006 (<http://data.euro.who.int/PhysicalActivity>)

¹² WHO: Benefits of Physical Activity (last update 2008).
http://www.who.int/dietphysicalactivity/factsheet_benefits/en/index.html

Guidelines for Action

- Guideline 1 – In accordance with the guidance documents of the World Health Organisation, the European Union and its Member States recommend a minimum of 60 minutes of daily moderate-intensity physical activity for children and young people and a minimum of 30 minutes of daily moderate-intensity physical activity for adults including seniors.
- Guideline 2 – All relevant actors should refer to the guidance documents of the World Health Organisation regarding obesity and physical activity and seek ways to implement them.

2. A CROSS-SECTORAL APPROACH

Many public authorities with significant budgets are involved in promoting physical activity. It is only possible to reach the set targets through inter-ministerial, inter-agency and inter-professional collaboration, including at all levels of government (national, regional, local), and in collaboration with the private and voluntary sectors.

Increasing the level of physical activity in the population falls within the remit of several important sectors, most with a major public sector component:

- Sport
- Health
- Education
- Transport, environment, urban planning and public safety
- Working environment
- Services for senior citizens.

Targets and objectives are not enough to ensure effective implementation of national Physical Activity Guidelines.

Guidelines for the development and implementation of policies inducing people to move more should be based on the following quality criteria that have shown to increase the potential for effective policy implementation:

- (1) Developing and communicating concrete goals: What are the precise targets that should be achieved by the policy action? What are the target groups of these policies and in which settings are they approached?
- (2) Planning concrete steps of the implementation process: What is the precise time frame for the policy implementation process? What are concrete milestones and deliverables?
- (3) Defining clear responsibilities and obligations for implementation: Who is providing strategic leadership? Is there any legislative support for the policy actions?
- (4) Allocating appropriate resources: Who has organisational capacities and qualified personnel needed to implement the policy action – or who can develop such

capacities? How can necessary financial resources for implementation of policy actions be secured? How do different sources of funding (national budget, regional and local budgets, private enterprise) relate to each other?

- (5) Creating a supportive policy environment: What policy areas and main policy actors can support the policy action? What policy alliances can be built to advocate the action and to tackle potential political barriers?
- (6) Increasing public support: How can the interest of the population or particular target groups in the policy actions be increased? How can the media be involved?
- (7) Monitoring and evaluating the implementation process and its outcomes: What are key indicators of effective implementation? What are the expected outcomes and how can these outcomes be measured?

All action needs to be customised to its particular context, reflecting the needs of the appropriate target groups and the settings in which they are targeted.

Examples of good practice

In the UK, public sector agreements have been used to provide incentives to achieve specific health targets. Local agencies provide details of how targets will be delivered and evaluated. In the UK these are currently called Local Area Agreements and have been used to promote increased sport and physical activity. One example is in Hertfordshire, where as part of their Local Area Agreement, they identified the need to improve the independence and hence health of their older population. The local strategic partnership identified the following outcome: 'Increase older people's independence and well-being through active participation in sport and physical activity that enables them to lead a healthy lifestyle that will contribute to them keeping fit and well for as long as possible'. They identified the following performance indicators and targets with which to measure this outcome. 'Percentage of adults aged 45+ participating in at least 30 minutes moderate intensity sport and active recreation (including recreational walking and recreational cycling) on 3 or more days a week'. The achievement of the target (+4% on baseline) was linked to a financial reward in the region of £1.2m.

In Germany, the Federal Ministry of Health and the Federal Ministry of Food, Agriculture and Consumer Protection have developed Guidelines on "Healthy Diet and Physical Activity – Key to a Higher Quality of Life"¹³, which will serve as the basis for a National Action Plan aiming to prevent malnutrition, overweight, sedentariness, and the conditions and chronic diseases resulting from them. The Guidelines have five central fields of action:

- *Politics (various sectors and fields)*
- *Education and raising awareness about diet, physical activity and health*
- *Physical activity in daily life*
- *Enhancing the quality of meals served outside of homes (kindergartens, schools, work places, etc.)*

¹³

http://www.bmelv.de/cln_045/nn_749118/SharedDocs/downloads/03-Ernaehrung/Aufklaerung/Eckpunkt PapierGesundeErnaehrung,templateId=raw,property=publicationFile.pdf/Eckpunkt PapierGesundeErnaehrung.pdf

- *Impulses for research.*

In Luxembourg, four ministries (Education, Health, Sports, Youth) launched a multi-sectoral action plan called “Gesond iessen, méi bewegen” (“Eat healthily, move more”) in July 2006. Local stakeholders are encouraged to start actions related, if possible, to both nutrition and physical activity. More than 60 stakeholders, representing different areas (schools, local communities, clubs, workplaces, healthcare associations) have been awarded the label of the national action plan. A cross-sectoral working-group with members from the four ministries is monitoring the action plan, including local initiatives and campaigns.

Guidelines for Action

- Guideline 3 – Public authorities responsible for different sectors should support each other through cross-sectoral cooperation to implement policies that can make it easier and more attractive for individuals to increase their level of physical activity.
- Guideline 4 – Authorities responsible for the implementation of sport and physical activity guidelines should consider the use of agreements between central, regional and local levels of Government to promote sport and physical activity. Where appropriate, such agreements can involve specific reward mechanisms. Links between sport and physical activity strategies should be encouraged.
- Guideline 5 – Governments should launch initiatives to coordinate and promote public and private funding devoted to physical activity and to facilitate access for the whole population.

3. POLICY AREAS

3.1. Sport

Public authorities (national, regional, local) spend considerable amounts of money on sport. Taxes as well as sport lotteries are important sources of financing. However it is important that these budgets are used to support physical activity for the population at large.

From a physical activity perspective, the overall aim of a sport policy should be to increase participation in quality sport among all segments of society. As a basis for informed decisions, the physical activity behaviour of the population should be closely monitored in health surveys.

A physically active lifestyle sustained over time requires a nation-wide system of cost-effective sport facilities with low entry barriers and supervision for beginners. Sport infrastructure needs to be made easily available to all layers of the population. This includes public funding of the construction, renovation, modernisation and maintenance of sport facilities and of sport equipment, as well as the use of low cost or free public sport facilities. In the promotion of sport for children and youth, per capita funding can provide the basic financing. Public funding could, for example, prefer promotion of

infrastructures for sport-for-all (e.g. reconstruction of school yards), rather than elite sport complexes.

An important objective of a sport policy aimed at strengthening physical activity among the population is the development of the “sport for all” movement at the local and national levels. Where separate sport and physical activity policies exist, they should be complementary and show the continuum from light intensity physical activity through to competitive organised sport. "Sport for all" programs should aim at encouraging participation in physical activity and sport of all citizens, promoting the perception that the entire population is the target and that sport is a human right, regardless of age, race, ethnicity, social class or gender.

Sport policies should therefore aim at increasing the number of citizens participating in sport and physical activity. For this purpose, necessary resources and key stakeholders should be identified while social and environmental barriers for sport participation need to be addressed, in particular with regard to underprivileged social groups.

In this context, four main groups of actors can be distinguished: the central Government, municipalities, the organised sport sector, and the non-organised sport sector.

3.1.1. Central Government

The Government, as the main funding body, has a central role when distributing funding to sport organisations, federations and municipalities. Central sport authorities may take the following steps:

- Develop national sport and physical activity policies with the overall aim to increase sport participation and physical activity in all segments of the population; strengthening the organizational and financial sustainability of sport organisations; considering equal access to sport and physical activity for everyone, regardless of social class, age, gender, race, ethnicity and physical capacities.
- Develop a guiding document on how to financially support the implementation of specific programmes in agreement with the overall aims of the sport policy.
- Fund sport organisations and municipalities which specifically implement programmes aimed at increasing participation in sports and physical activity across age groups. Programmes aimed at increasing participation in sports among specific and minority groups (immigrants, elderly, disabled and incapacitated) could be prioritised.
- Financially support municipalities and sport organisations for building sport facilities and infrastructure and providing access to these facilities for the general population. The number of square meters of sport facilities in relation to population size can be used as a benchmark in new housing growth areas.
- Encourage inter-ministerial partnerships, especially between the Ministries responsible for Health, Sport, Transport and Education, aimed at promoting lifelong participation in sport and physical activity.
- Establish partnerships with public and private investors and media to promote the sport for all policy.
- Develop and financially support monitoring and evaluation systems aimed at evaluating the effects of the sport policy at different levels and at different times.

Example of good practice

Germany has national guidelines that govern the development of local sport facilities. These guidelines are utilised to develop urban infrastructure for the promotion of active lifestyles. Defined by the methodology of "Integrated Sport Development Planning", a series of steps for the assessment, development and implementation of local infrastructure for physical activity are conducted. In the assessment phase, an inventory of existing sport facilities and recreational areas is created, and a needs assessment of sport facilities and recreational areas based on a population survey is performed. The inventory is then balanced against the needs. In the developmental phase, results of the assessment phase are discussed with local stakeholders and policymakers, and an inter-sectoral co-operative planning group is established. Subsequent meetings serve to collect and structure ideas for improving sport facilities and recreational areas, to discuss and prioritise these ideas as well as to discuss means for their implementation, and to agree on a "catalogue of actions for the improvement of local infrastructures for physical activity" that will be implemented. This includes deciding on and specifying responsibilities and timelines for the implementation of actions. The group is responsible for the implementation of the catalogue of action. In the ideal case, the implementation of the catalogue is monitored by the group, and its effects are evaluated.

3.1.2. Regional and local government

Regions and/or municipalities are responsible for the vast majority of public sport infrastructure and they have a vital capacity to create favourable conditions for the availability of sport to the entire community. Regions and/or municipalities may take the following steps:

- Develop an inventory of all sport and leisure facilities and expand them where necessary, possibly in conjunction with sport organisations.
- Ensure that residents of urban as well as rural areas have access to places of sport in an area easily reachable from home (infrastructure and public transport).
- Ensure open access to sport facilities for all citizens, taking into account gender equality and equal opportunities for everyone.
- Encourage sport participation and social interaction in the local community through local campaigns such as specific sport events and various alternatives besides competitive sports, aimed at increasing the population's levels of physical activity.
- Develop attractive events and activities for the whole community with the intent to create habits of regular physical activity.
- Support local sport organisations to develop and implement projects aimed at promoting physical activity and sport participation in sedentary groups of the population.
- Develop partnerships with universities and experts from the health sector to create offices for support, advice and prescription of physical activity, aimed at promoting physical activity and sport participation in sedentary groups of the population.

Examples of good practice

In the UK (England) information on over 50,000 sport and leisure facilities has been collected and is available for the public to search via the internet. The Active Places database includes information on a wide range of sport facilities – from sport halls to ski

slopes, swimming pools to health and fitness. It includes local authority leisure facilities as well as commercial and club sites.

Local authorities within the UK (England) are also currently assessed according to the percentage of the population living within 20 minutes' walking distance (in urban areas) or 20 minutes' driving distance (in rural areas) from high quality sport facilities.

3.1.3. Organised sport sector

In many EU Member States, sport organisations (confederations, federations, associations, clubs) have a tendency to focus somewhat narrowly on the organisation of competitions. They should be stimulated to define strategies for sports that consider the promotion of sport for all and the impact of sport on public health, social values, gender equality and cultural development.

Sport organisations contribute to the social well-being of communities and can ease pressures on the public budget. Through their versatility and cost-effectiveness, clubs can help meet the needs of the population for physical activity. A major future challenge for the organised sport sector should be to offer high-quality health-related exercise programs nationwide.

Trainers and managers of sport organisations can play an important role in the promotion of physical activity. Their educational background should provide them with all the necessary expertise to help people find the right formula for training and physical activity. It is, however, important that they understand that physical activity must be present in everyday life and cannot be restricted to the time spent in the sport or leisure centre. Thus, they must have access to adequate information on how to increase the amount of activity in everyday life, at home as well as in the workplace and when moving from home to other locations. In particular, cycling or walking from home to the sport centre increases the benefit for the person concerned as well as for his/her environment.

Examples of good practice

The German Olympic Sports Confederation together with the German Medical Association and various health insurance companies have developed a health enhancing programme called “Quality Seal Sports For Health”. Sport clubs have to fulfil the following standardised criteria in order to be awarded the quality seal: target group-oriented offerings; qualified trainers; uniform organisational structure; preventive health check-up; supported by quality management; sport clubs as active health care partners. There are approx. 14,000 certified courses of preventive cardiovascular training, low back training and relaxation available in about 8,000 sport clubs. Accompanying measures such as systematic documentation, quality circles and obligatory follow-up training for the instructors guarantee comprehensive quality management. An add-on communications concept with an online database and the development of the programme “Prescription for Exercise” in cooperation with Health Insurance Companies and the Medical Association ensure high effectiveness.

In Austria, the “Fit for Austria” programme is a public-private partnership. It is publicly funded but administered by the Austrian Sports Federation (the NGO umbrella organisation of organised sports in Austria), Co-operations exist with the Ministry of Health, the public health insurance agency and state governments. A network of 30 “Fit

for Austria”-co-ordinators was installed to provide nationwide expert-support to clubs to increase quality and quantity of health-oriented physical activity-programs in clubs. An annual “Fit for Austria” Convention acts as a practical oriented market-place for the exchange of ideas among trainers. The “Quality badge” for health-oriented physical activity is awarded to programs that fulfil special requirements in administration, content and qualification of leadership.

In Hungary, a special “Senior Sport” programme has been launched as a pilot project aimed at improving physical activity of this age group. A call for applications was opened and 215 projects are being supported by Government. Government also supports 110 organizations participating in the pedometer programme called “Ten thousand Steps”.

3.1.4. Non-organised sport and physical activity

Although physical activity during daily life (walking or cycling to school or work, walking to go shopping, climbing stairs, being active at home etc.) is related to health, sport activities during leisure time may represent an important complement of physical activity. Non-organised sport activities are becoming increasingly prevalent in many countries: frequent attendance at fitness and wellness centres, leisure activities such as swimming, rowing and sailing at seas, lakes and swimming pools, or activities such as walking, hiking, horse riding, cycling in mountains, hills and other outdoor environments. Such non-organised physical activities are particularly interesting because they help people to discover or re-discover that physical activity can be rewarding for the mind as well as the body.

This may particularly be the case for young children, where self-driven unstructured ‘play’ is a crucial component of physical activity that promotes positive physical and mental well being. With increasing land pressures and car use it is important that children’s play spaces are not marginalised in planning and design considerations.

Non-organised or self-organised activities are, however, exposed to some limitations which need to be underlined and may require specific interventions:

- Geographical limitations: it is evident that the motivation to develop a specific activity is strongly determined by geographical conditions, for example only a cold winter season will allow people to practise ice skating or skiing on a large scale, while only a marine or lake environment will induce aquatic entertainments or sports. This reflection, although very obvious, underlines the need that specific sites, suitable and appealing for open-air physical activity, are present in any town or residential environment to stimulate and provide occasions for physical activity during free time. In some cases, different physical activity users of the same natural sites may have conflicting interests. For example, mountain biking may be in conflict with walking. Careful conflict management is required to resolve the needs of different users and preserve the natural environment.
- Socio-economical limitations: economic conditions can represent a strong limiting factor to many self-organised activities as these are often related to relatively high costs. This may mean that some activities are only open to people with middle to high income and closed to others. Specific interventions may contribute to opening access

to self-organised activities to people, particularly young people, regardless of their economic conditions.

- Cultural limitations: access to self-organized activities also depends partly on awareness of the value of physical activity for body and mind. This issue requires focussed interventions to motivate all people to find in their leisure time the most suitable types of physical activity.

It is important to reflect on which activities are more suitable for the self-organised or non-organised sector. Activities associated with locomotion are likely to be the most suitable, i.e. walking or running in a nice and safe environment, if possible in green spaces, and cycling, also in this case with special attention to the safety conditions of the road. Competitive team sports can also in some cases be an interesting possibility of self-organised activity, such as basketball or soccer.

Activity such as walking, jogging or rowing can take place not only in an urban environment but also in a natural environment outside of town. This implies that policies concerning environmental preservation and management can have a high impact on many self-organised physical activities (see also section 3.4 below).

Although the nature of non-organised or self-organised activities make support for such activities optional, the above reflections underline the importance of support given by national or, more often, local government to sustain the development and diffusion of such activities, particularly in view of the above mentioned geographical, socio-economical and cultural limitations..

Example of good practice

In Hungary, the Government finances a programme called “Open Doors” in the framework of which some sport facilities keep their doors open after their official working hours (on week-ends and in the evening) in order to allow families, people living in the neighbourhood etc. to practise sports. In addition, a programme called “Moonlight” is aimed at offering free evening or night sport activities (e.g. table tennis) to groups of young people living in areas of high deprivation. Clubs organising these activities are supported by the Government.

Guidelines for Action

- Guideline 6 – When public authorities (national, regional, local) support sport through public budgets, particular attention should be given to projects and organisations which allow a maximum of people to engage in physical activity, regardless of their level of performance ("sport for all", recreational sport).
- Guideline 7 – When public authorities (national, regional, local) support sport through public budgets, appropriate management and evaluation mechanisms should be in place to ensure a follow-up that is in line with the objective of promoting "sport for all".
- Guideline 8 – When public grants are made available for activities with physical activity content, the eligibility and allocation criteria should be based on the activities foreseen, and on the general activities of the organisations applying for funding. A

specific legal status, organisational history or membership in larger federative structures should not be considered as pre-qualifying. Funding should be directed toward "sport for all" activities, bearing in mind that organisations with an elite sport component may also make a meaningful contribution to the "sport for all" agenda. Public and private actors should be able to compete for funding on an equal footing.

- Guideline 9 – Sport policy should be evidence-based and public funding for sport science should encourage research that seeks to uncover new knowledge about activities that allow the population at large to be physically active.
- Guideline 10 – Sport organisations should provide activities and events attractive to everyone, and encourage contacts between people from different social groups and with different capabilities, regardless of race, ethnicity, religion, age, gender, nationality, and physical and mental health.
- Guideline 11 – Sport organisations should cooperate with universities and higher vocational schools to develop training programmes for coaches, instructors and other sport professionals aimed to advise and prescribe physical activity for sedentary individuals and those with motor or mental disabilities who wish to take up a particular sport.
- Guideline 12 – Low-barrier health-related exercise programs targeting as many social and age groups and including as many sport disciplines as possible (athletics, jogging, swimming, ball sports, strength and cardiovascular training, courses for seniors and youth) should become an integral part of the offerings of sport organisations.
- Guideline 13 – Sport organisations embody a unique potential in prevention and health promotion, which should be drawn upon and further developed. Sport organisations gain a special significance for health policies if they can offer quality-tested and cost-effective programmes in prevention and health promotion.

3.2. Health

There is a strong mutual relationship between physical activity and health. For the purpose of a structured discussion of this relationship, a distinction needs to be made between public health, health care and the health insurance sector.

3.2.1. Public health sector

For physical activity promotion to become a priority in health policies there is a need to focus on physical activity in a broad sense, with a large-scale, population-based, comprehensive and sustainable approach. Health systems can facilitate multilevel coordinated action by making physical activity an effective part of primary prevention, by documenting effective interventions and disseminating research, by demonstrating the economic benefit of investing in physical activity, by advocating and exchanging information and by connecting relevant policies to facilitate links between the health and others sectors to ensure that public policies will improve opportunities for physical activity.

The public health sector should implement interventions or programmes designed to increase physical activity for health only if there is evidence of their effectiveness. Implementation of valid and reliable physical activity interventions and programmes will thus rely on the best available evidence, employ a range of behaviour change approaches and take into account the environmental context of physical activity. Evaluation and risk assessment are also essential to assess the overall balance between benefits and possible increased risks of higher levels of physical activity (e.g. injuries).

An important task for the public health sector is to improve measurements of physical activity for population health surveillance and for better assessment of the effects of physical activity programmes. Better instruments to measure physical activity will allow the identification of population groups which are most in need of physical activity. Questionnaires represent the most frequently used method to measure physical activity at population level. Instruments to assess the physical activity environment are currently being designed and will need to be tested. Objective assessment of physical activity levels (e.g. accelerometers) may also contribute to better population health surveillance.

At a societal level, the public health sector has to work to change norms about physical activity and to develop social support for health-enhancing physical activity at community and population level. These norms can be defined as descriptive norms (promoting the visibility of physical activity), subjective norms (enhancing social approval for physical activity) and personal norms (promoting personal commitment to being more physically active).

In the field of professional education, the public health sector has a leadership role in the training of practitioners involved in health-enhancing physical activity, both public health practitioners and practitioners working with individuals. Training needs of those providing physical activity interventions and programmes imply a combination of knowledge, skills and competencies from several fields (health, physical activity, sports and sports medicine). Alongside programmes to raise awareness of the health benefits of physical activity for all healthcare professionals, this will enhance opportunities for health professionals to engage with a range of organisations and to develop multidisciplinary teams.

Example of good practice

In Slovenia, a national public health plan on health-enhancing physical activity (HEPA Slovenia 2007-2012) was adopted by the Government in 2007. The three main pillars of this plan are recreational free-time physical activity, physical activity at schools and workplaces, and transport-related physical activity. The basic goal of the HEPA national programme is to encourage all forms of regular physical activity to be maintained throughout the entire lifespan. The programme has a broad scope with areas and target groups including: children and adolescents, families, working place, elderly, people with special needs, health/social sector, transport sector and sport organisations.

3.2.2. Health care sector

Health care professionals (medics, nurses, physiotherapists, nutritionists) working with individuals and communities (e.g. schools) can provide counselling in relation to health-enhancing physical activity or can refer them to physical activity specialists. Such personalised guidance will take age, occupation, health status, past physical activity

experiences and other relevant factors into account. Tailor-made advice implies an assessment of actual physical activity levels, motivation levels, preferences, as well as health risks in relation to physical activity, and monitoring progress. Health professionals can empower parents to promote physical activity among their children and help teachers to improve physical education programmes in schools. The efficacy of health professionals to induce positive behavioural changes is documented in the field of promoting physical activity as a habit. However, this role for health professionals would need better recognition both from a professional and a financial perspective.

Through cooperation with professionals from fields such as sport, education, transport and urban planning, health professionals can provide information, knowledge and experience for an integrated local approach to the promotion of healthy, active lifestyles.

Examples of good practice

In the UK, 'Let's get moving' is the name of the Physical Activity Care pathway which is being piloted across fifteen GP surgeries in London from winter 2007 till summer 2008. General practitioners measure a patient's sport and physical activity levels through the use of a GP Physical Activity Questionnaire (published by the Department of Health in 2006). They will then support them to change their behaviour by giving advice and encouraging them to set activity goals. Health professionals will work with patients to overcome barriers to exercise, help set individual goals, signpost patients to local physical activity opportunities and keep track of their progress. Patients ready to change will be encouraged to come up with their own solutions to their barriers to activity; they will be advised to work towards undertaking 5 x 30 minutes of moderate activity a week. The pathway broadens the opportunities for physical activity from indoor aerobics and gyms to health walks in local green spaces and other outdoor exercise in the local natural environment. If patients want to get more physically active after their assessment, they will be given a 'Let's get moving' pack which includes a personal exercise plan, information on local activities they can join, a map of their nearest park and open spaces and diet and exercise advice. GPs will follow up the patient's progress at three and six months.

In Denmark, GPs are encouraged to prescribe physical activity for many lifestyle related diseases, either when they have been diagnosed or to prevent them from developing. GPs in Denmark are also expected to have a discussion with their patients once a year about lifestyle and health.

In Sweden, primary care providers in the county of Östergötland have been prescribing physical activity to patients. An evaluation found that, after 12 months, 49% of those who received the prescription reported adhering to it, and an additional 21% were regularly active.

3.2.3. Health insurance providers

Depending on national or regional arrangements, residents of the European Union are often entitled to reimbursement of their medical expenses from health insurance providers. While some hospitals, community health centres and/or health professionals in some Member States may provide care free of charge, health insurance providers are a cornerstone of many national health systems. Even in Member States with large tax-financed public health sectors, private providers may also be in place.

Depending on national or regional arrangements, health insurance providers may be not-for-profit agencies with varying degrees of regulation by law, or they may be for-profit private insurance companies, or a combination of both. The degree to which the analysis and recommendations in this section apply to them varies according to the legal and financial nature of health insurance providers.

The promotion of physical activity is potentially one of the most effective and efficient – and hence cost-effective – ways of preventing disease and promoting well-being. Action taken by health insurance providers to encourage their members or clients to be physically active has the potential to yield a high return on investment. Health insurance providers can employ different methods to promote physical activity among their clients:

- For cost-effectiveness and to avoid conflicts with other providers, they can co-operate with existing providers of physical activity programmes, such as non-governmental sport organisations (NGOs), sport clubs, fitness centres etc. Building such alliances allows them to avoid financial investments in personnel and infrastructures for physical activity programmes. However, health insurance providers which purchase services from external providers may need to play an active role in regulating the programme and monitoring its quality.
- They can offer financial incentives such as bonus payments to clients who are (or are becoming) physically active. This strategy is already used by health insurance providers in some EU countries. Such bonus payments can be offered to clients who are regularly participating in physical activity programmes as well as to clients who are achieving a certain level of physical fitness by choosing a physically active lifestyle. Such financial incentives can also be directed to providers of health care services. For example, physicians in primary health care can be financially rewarded for encouraging patients to move more (exercise on prescription). Again, health insurance providers offering such financial incentives need to carefully define and monitor quality criteria related to the processes and outcomes which can be funded.

Public policies inducing health insurance providers to become actors in the promotion of physical activity may differ according to different health systems in Europe. For example, in tax-financed systems governmental agencies at national or regional levels might be more likely to be the purchasing or providing organisation for preventive services (e.g. related to physical activity promotion). This enables the Government more directly to control policy implementation processes but, at the same time, raises issues of external control of quality, effectiveness and efficiency. In some systems independent public bodies such as health insurance funds are often crucial for policy implementation. In addition, private health insurance agencies may play an important role in both systems.

Public or private health insurance providers may develop their own policies for physical activity promotion because of cost-effectiveness or marketing effectiveness. In addition, incentives through public policies (e.g. reduced taxes, subsidies) may attract public as well as private health insurance providers to increase physical activity promotion. Governments can also use legislative tools to define concrete obligations for action in the field of prevention (e.g. mandatory promotion of physical activity by public health insurance funds).

Health insurance companies have an interest in promoting initiatives to spread the message that life-style (physical activity, nutrition, stress management) is one of the main drivers for acquiring or avoiding chronic conditions. They can use the following tools for this purpose:

- Website: health portal with current information on health-related topics and corresponding providers.
- Medical call centres, staffed with physicians for all medical issues, promoting offers from medical check-up providers and health-promoting fitness studios in a pan-European network.
- Development of a so-called “health prevention” fitness profile with standardised medical and physical tests, not only in cooperation with medical institutions and medical doctors but also in the form of mobile test units.
- Development of a national or European network of implementation partners which should offer clients tailored health management programmes in individual settings.
- Development of a network of wellness hotels, wellness providers and personal trainers (health coaches) who provide support on a one-to-one basis for lifestyle change.

There should be a change of paradigm in the sense that public health insurance providers should not only have a duty to provide medical care, but also a duty to promote preventive measures for health. They should be at the centre of a network guaranteeing that all preventive measures are based on cooperation between social insurance companies, ministries responsible for health and social welfare, governmental and non-governmental health bodies, communities and also private insurance companies, in order to avoid a fragmentation of actions and competences. This network could provide know-how and funding in different settings, e.g. kindergartens, schools, companies etc. The overall motto should be that prevention should start as early as possible and should be a lifelong programme.

Finally, private and public health insurance providers should cooperate with corporate clients to promote health-enhancing physical activity in the context of companies. For example, specific “fit for the job programmes” could be implemented together with sport clubs, fitness centres and the mentioned network and tools.

Examples of good practice

The development of prevention policies in Germany during the last two decades provides an example of how health insurance funds may evolve as a main actor for the promotion of physical activity. Since 1989, public health insurance funds in Germany have been obliged by law to be active in the area of prevention and health promotion. In 2000, the head associations of the funds defined their priority areas for action in primary prevention accordingly. Under these definitions, the promotion of physical activity became one of the priority areas. For regulating and monitoring the quality of actions related to the priority areas, funds have agreed upon specified quality goals and developed concrete guidelines for their implementation. As a major outcome of this policy development, most health enhancing physical activity programmes in Germany are either directly offered by health insurance funds or subsidised by them. Since subsidies are restricted by law to evidence-based and quality-assured physical activity programmes, sport clubs and other providers of health-enhancing physical activity programmes which are co-operating with health insurance funds have considerably improved their standards of quality management.

Austria has during the last two decades developed different offers to the clients of social insurance companies. These social insurance companies offer every client a yearly health check. In addition social insurance companies have developed preventive programs for special settings (e.g. prevention of diabetes) together with different non-governmental organisations and sport clubs. In addition, in 1998 a National Health Prevention Agency was founded, with Government funding, which has supported numerous health projects in different settings in all communities.

In Finland, the Fit for Life programme has implemented a campaign, The Adventures of Joe Finn, to encourage sedentary middle-aged men to lead a healthy lifestyle. The campaign includes a handbook on keeping fit, a website, physical training courses, combined courses on cooking and experimentation of different sports, and lorry tours with various events. The programme's partner for the lorry tours was an insurance company which has traditionally insured employees in branches dominated by men, such as the construction industry. In these fields the risk of premature retirement due to disability is high. Participants in the events received an invitation from their employers and were allowed to take part during working hours.

Guidelines for Action

- Guideline 14 – Physical activity data should be included in health monitoring systems at national level.
- Guideline 15 – Public authorities should identify the professions that have the competences necessary to promote physical activity and consider how the relevant professional roles may be facilitated through appropriate recognition systems.
- Guideline 16 – Medical practitioners and other health professionals should act as facilitators between health insurance providers, their members or clients, and providers of physical activity programmes.
- Guideline 17 – Insurance companies should be encouraged to reimburse medical doctors (GPs or specialists) for an annual discussion advising each patient on how to include physical activity into their daily life.
- Guideline 18 – Public authorities should encourage health insurance schemes to become a main actor in the promotion of physical activity.
- Guideline 19 – Health insurance schemes should encourage clients to be physically active and should offer financial incentives. Physical activity upon prescription should become available in all EU Member States.
- Guideline 20 – In Member States where treatment is provided free of charge, the public health system should try through those channels to encourage physical activity in all age groups, including by introducing bonuses for physically active people and encouraging health professionals to promote physical activity as part of a prevention strategy.

3.3. Education

The relation between the education sector and physical activity has three different aspects: physical education at school, physical activity in local communities (e.g. sport clubs) and education and training for physical educators, coaches and health professionals.

3.3.1. *Physical activity promotion at school*

The social settings of schools and sport clubs are important places to enhance health-related physical activities of children and young people. Sedentary children and young people show signs of metabolic problems such as clustering of cardiovascular risk factors. This group of children and young people is continuously growing in many EU countries but may be difficult to reach by sport organisations. On the one hand, these children and young people have often had poor experiences of competitive sports, while on the other hand sport organisations often do not offer appropriate programmes apart from their traditional competitive sport activities. However, physical education is a mandatory subject in schools in most countries and it is possible to offer healthy and appealing physical education in schools to create an interest in physical activity. It is therefore important to evaluate whether increased and/or improved physical education may result in improved health and health behaviour among children and young people.

School-based physical education is effective in increasing levels of physical activity and improving physical fitness. However, to accomplish major health changes one hour of daily physical activity organised as play in the schoolyard or in physical education lessons is necessary. Interventions including physical education only two or three times a week have only shown minor health improvements. The increased amount of physical activity can be attained by increased curricular or extra-curricular time in school and need not be to the detriment of other subjects in the school curriculum. Physical activity can also be integrated into after-school care, which can make the interventions economically neutral.

School-based physical education is the most widely available source to promote physical activities among young people. Therefore, every effort should be made to encourage schools to provide physical activities on a daily basis in all grades, inside or outside the curriculum and in cooperation with partners from the local community, and to promote interest in life-time physical activities in all pupils. Teachers at school are one of the main actors for children and young people's physical activity. However, there are other important actors such as educators in kindergartens, coaches in sport and social clubs and, in particular for children up to the age of 12, their parents.

To maximise learning opportunities in physical education, a range of conditions needs to be met. These include time in the school schedule, a reasonable class size, adequate facilities and equipment, a well-planned curriculum, appropriate assessment procedures, qualified teachers, and positive administrative support for networks linking stakeholders in the areas of physical activity and health care in the local community (e.g. sport clubs). Out-of-school physical activity can be considerably promoted by making sport facilities of schools available after school hours and by building partnerships.

School playgrounds and physical education lessons should be adapted to all pupils, considering in particular appropriate equipment for girls to stimulate their participation in sport and recreation activities. School playgrounds also play a potentially important role in providing play facilities for the community outside school hours.

To make physical education meaningful and successful for all children and youth, innovative learning theories and new perceptions of the physical education subject need to be considered, evaluated, and implemented.

High-quality physical education should be age-appropriate for all children and young people regarding both instructions and content. Instructionally appropriate physical education incorporates the best known practices derived from research into teaching experiences and education programmes that maximise opportunities for learning and success for all.

Teachers should be encouraged to use technology in physical education classes to explore fitness and motor skill concepts in ways that personalise the curriculum to a higher extent than before. Heart rate monitors, video and digital photo equipment, computer software programmes and other equipment to estimate body composition can play a useful role in this context.

There have been some recommendations from European stakeholders in the area of training of physical education teachers (e.g. EUPEA) and in the EU study on "Young people's lifestyles and sedentariness".¹⁴

The role of physical education teachers in promoting physical activity among children and adolescents needs to be expanded in view of the increase in sedentary lifestyles, overweight and obesity. In addition to the time reserved for physical education in school curricula, physical education teachers could play a useful role in helping to address wider physical activity issues such as active commuting between home and school, physical activity during intervals between school hours, the use of sporting facilities after school, and individual exercise planning. Evidence shows that out-of-school physical activity can be considerably promoted by making sport facilities of schools available also after school hours.

The education and training of the teachers should provide them with the necessary expertise to give clear and precise messages to the pupils as well as to their parents, to raise awareness that physical activity is an essential requirement for health.

Examples of Good Practice

In Hungary, cooperation has started with kindergarten teachers, for whom training courses and conferences are organised to develop their skills and knowledge about healthy and active lifestyles. The Government also supports the publication of information material about early education. A secondary aim of this project is to develop the awareness of parents.

¹⁴ Universität Paderborn (2004): Study on young people's lifestyles and sedentariness and the role of sport in the context of education and as a means of restoring the balance. Final report by Wolf-Dietrich Brettschneider, Roland Naul, et al. <http://ec.europa.eu/sport/documents/lotpaderborn.pdf>

In France, ICAPS (Intervention Centred on Adolescents' Physical Activity and Sedentary Behaviour) is a multi-level, multi-actor programme involving young people, schools, parents, teachers, youth workers, youth clubs, sport clubs, etc. The aim is to encourage young people to be more physically active and to offer opportunities both within and outside of schools. The results from the first four years have been positive and show that actions aimed at reducing obesity levels can be successful.

In the UK, the Government has provided £100 million for an out of school sports programme, 'Sport Unlimited'. The programme aims to increase the opportunities for children and young people to take part in sport out of school hours, thus increasing participation levels to five hours a week. County Sport Partnerships consult with young people to ensure the activities provided are what young people want to do. The programme is a partnership approach and a range of local delivery agents outside of schools also provide facilities and services ranging from youth clubs, sport clubs, the private commercial sector and leisure centres.

3.3.2. Education and training of health professionals

Health professionals need to be prepared to give appropriate counselling on physical activity in relation to the specific conditions of the people they see in their practice. Nurses are often particularly close to patients so may have an opportunity for enhanced interaction. Information about the need for physical activity, the best way to introduce it in everyday life and, therefore, changes in lifestyle should be available to all health professionals during their studies and continuing education in this growing field should be mandatory.

In addition it would be useful to recognise sports medicine as a specialty in the EU, because an important part of sports medicine is preventive medicine to promote health enhancing physical activity.

General practitioners need to be aware of the relevance of physical activity to the prevention of a wide range of diseases and should be prepared to give the appropriate counselling on physical activity. "Exercise referral", where exercise is prescribed to improve the health condition or to reduce the risk of disease, is in some European countries becoming a popular way to propose specific physical activity. Exercise referral often to a leisure centre is generally given by the general practitioner, who then receives a detailed report on its outcome in order to discuss this with the patient.

Apart from specific 'exercise referral' schemes, counselling people to increase their physical activity through activities such as walking and cycling, has become part of the role of general practitioners in many countries. It is important therefore that lifestyle counselling and physical activity behaviour change are included in initial medical training and continuing education.

Example of Good Practice

In most European countries medical education is organised in such a way that practitioners as well as nurses, medics, physiotherapists and nutritionists are obliged to follow every year several courses for updating knowledge and skills. Some such courses

are oriented toward the promotion of physical activity among their patients and the general population.

Guidelines for Action

- Guideline 21 – EU Member States should collect, summarise and evaluate national guidelines for physical activity addressed to physical education teachers and other actors in the development of children and youth.
- Guideline 22 – As a second step, EU Member States could design health-enhancing physical education modules for the training of teachers in, respectively, kindergartens, primary schools and secondary schools.
- Guideline 23 – Information about the need for physical activity, the best way to introduce it in everyday life and changes in lifestyle should be available to physical education teachers, health professionals, trainers, managers of sport and leisure centres and media professionals in the course of their studies and/or professional training.
- Guideline 24 – Topics related to physical activity, health promotion and sports medicine should be integrated into the curricula of health professions in the EU.

3.4. Transport, environment, urban planning and public safety

Transport provides good opportunities to be physically active, but only if the appropriate infrastructures and services are in place to allow for active commuting.

During the last decade evidence of the association between walking, cycling and health benefits measured as hard endpoints such as all-cause mortality, cardiovascular disease (CVD) and diabetes 2 has accumulated. The total amount of walking has been shown to be associated with lower CVD rates and lower risk of Type II diabetes. While commuter walking alone may decrease mortality rates, the benefit seems to be less than can be accomplished with commuter cycling. A 30-35% lower mortality rate has been found in commuter cyclists even after adjustment for other types of physical activity and other CVD risk factors such as obesity, cholesterol and smoking. Studies also support a benefit of walking or cycling to work in relation to lower risk of hypertension, stroke, overweight and obesity.

In children and young people, cycling to school is associated with higher fitness levels. In Denmark, where this mode of transportation is used by almost two thirds of adolescents, an 8% higher fitness level was found in cyclists. This translates into a substantial health benefit because the least fit quartile of children have thirteen times more metabolic problems such as clustering of cardiovascular risk factors than the fittest quartile. Children who biked to school were also five times more likely to be in the upper quartile of fitness. Walking to school is not always associated with higher fitness, probably because the intensity during walking is lower than during cycling. Also in adults, commuter cycling seems to improve health more than commuter walking.

An urban environment that encourages the use of motor vehicles and, therefore, discourages physical activity, is a driving force behind population-wide trends toward overweight and obesity. Environmental factors can have an important role in determining and shaping physical activity patterns. In this context it is important to consider the needs of children and young people independently as their ability to interact with their built environment is restricted. In contrast to adults, children and young people spend large parts of their day at school, have considerable time for recreation, are more likely to accumulate physical activity through play, are not able to drive, and are subject to restrictions placed on them by adults. Negative parental perceptions of the environment, in particular safety, are negatively associated with children and young people's activities in their local neighbourhood. Yet children and young people's engagement in their local environment through physical activity is important for their physical and social well-being as it gives them the opportunity to gain independence and make social contacts.

To promote the attractiveness of cycling and walking as modes of transport, the emphasis on road safety is crucial. If an environment is not perceived as secure for personal or traffic reasons, the majority of the population may adopt motorised modes of transport, particularly at night-time. Similarly, attractive green spaces or safe shared street spaces are important components of an active neighbourhood.

The environmental issue is relevant to the promotion of physical activity not only in the urban context but also in the countryside, in mountains and hills as well as in rivers, lakes and sea. Many types of self-organised physical activity, such as walking, cycling, sailing or rowing, become more rewarding if carried out in a nice natural environment. Based on this view, environmental preservation becomes important not only to protect landscape, wild life, forests or plants but also to provide space and attractive occasions for human physical activity.

In this respect, it is important to set rules for the use of such natural environment to promote physical activity and discourage motorised frequentation. For example, motor boats should leave space for rowing or sailing boats and snow scooters for snow shoe walking or cross-country skiing.

Examples of Good Practice

In most countries walking and cycling have been decreasing. However, a recent systematic review concluded that interventions tailored to people's needs, which targeted the most sedentary or those motivated to change, can increase walking by up to 30-60 minutes per week. Interventions to promote cycling are rare, because improvements in cycling habits depend on the availability of safe biking routes. One non-randomised community intervention in Odense, Denmark, promoted cycling through various initiatives and increased the number of bicycle trips by more than 20% over five years. At the same time, the number of accidents involving cyclists was 20% lower than in the rest of the country. The rate of traffic accidents involving cyclists is lower in countries where cycling is common, probably because these countries (mainly the Netherlands and Denmark) have an infrastructure of safe biking routes and because car drivers are used to taking account of cyclists. However, even in countries without this infrastructure accidents involving cyclists are rare in absolute terms, and the health benefits by far exceed the risks. In studies from Copenhagen the lower number of deaths attributed to cycling to work compared to deaths among passive travellers by far exceeded the total number of injured cyclists in traffic accidents.

Public/private partnerships have been used in some cities to offer publicly available bikes for free, due to the fact that they serve as vehicles for advertisements. An example is the city bike system in the Danish city of Aarhus.

In the Netherlands and Denmark, there is generally physical separation between bicycle paths and lanes for car traffic, which has a major impact on the perception of cycling as a secure and healthy mode of transport.

In Hungary, a special Government Commissioner is in charge of coordinating the building of bicycle paths throughout the country.

In the UK (England), a partnership between Sport England and the Department of Health is targeted at urban designers, master planners and the architects of new communities. Active Designs, a guidance document, promotes sport and physical activity through three key principles:

- Accessibility: Improving accessibility refers to the provision of easy, safe and convenient access to a choice of opportunities for participating in sport, active travel and physical activity for the whole community.*
- Amenity: Enhancing amenity involves the promotion of environmental quality in the design and layout of new sport and recreational facilities, the links to them and their relationship to other development and the wider public realm.*
- Awareness: Increasing awareness highlights the need for increased prominence and legibility of sport and recreation facilities and opportunities for exercise through the layout of the development.*

Since 2003, motorists driving in London have been charged £8 (approx €10) to drive into the central part of the city (London Congestion Charge). While the main objective of this charge was to reduce congestion, it has contributed to a significant increase in cycling across the city, alongside new investments in cycling infrastructure. Transport for London estimates that cycling levels have increased by over 80% since the charge was introduced, with no significant increase in casualties.

The development of the "walking bus" system in a number of countries involves groups of children walking to school or kindergarten under the stewardship of adults. It teaches children relevant knowledge and competences related to road safety, in their role as pedestrians, and provides a safe transport mode in their daily lives during childhood – a phase of life where the dangers posed by motorised traffic can be particularly menacing.

The World Health Organization has recently published the Health Economic Appraisal Tool (HEAT) for Cycling, to help transport planners take better account of the health benefits of cycling when planning new infrastructure. The HEAT for Cycling addresses the issue that while the calculation of cost-benefit ratios is an established practice in transport planning, the health benefits of transport interventions are rarely taken into account. The HEAT provides guidance for the inclusion of health effects of transport-related physical activity in economic analyses of transport infrastructure and policies.

Guidelines for Action

- Guideline 25 – In all parts of their territory which are suitable for commuter cycling, Member State authorities at national, regional and local levels should plan and create appropriate infrastructure to allow citizens to cycle to school and to work.
- Guideline 26 – Other types of active commuting should be systematically considered in national, regional and local planning documents, the aim of which should be to ensure conditions for safety, comfort and viability.
- Guideline 27 – Investments in infrastructure for commuter cycling and walking should be accompanied by targeted information campaigns to explain the health benefits of active commuting.
- Guideline 28 – When planning authorities give permits to build new developments, or when public authorities build new neighbourhoods themselves, they should integrate in their authorisation or in their planning the need to create a safe environment for the practice of physical activity by the local population. In addition, they should also consider distances and ensure opportunities for walking or cycling from home to train stations, bus stops, shops and other services and to recreational places.
- Guideline 29 – Local governments should consider cycling as an integral part of town planning and engineering. Cycle tracks and parking spaces should be designed, developed and maintained in respect of basic safety requirements. Local governments are encouraged to exchange best practice throughout the EU to find the most suitable economic and practical solutions.
- Guideline 30 – Public authorities responsible for traffic police services should ensure that appropriate levels of safety are provided for pedestrians and cyclists.
- Guideline 31 – Public authorities should pursue not only the protection of the natural environment *per se* but also its potential to provide attractive outdoor spaces for physical activity. Effective conflict management should be put in place to balance the needs of different users, particularly motorised versus non-motorised visitors.
- Guideline 32 – Public authorities should seek to ensure that children’s play needs are not marginalised in community planning and design.

3.5. Working environment

Physical demands at the workplace have undergone far-reaching changes in the course of the last century and this process is still in progress. In general, hard labour has been largely eliminated in the industrialised part of the world. The vast majority of today's occupations in the EU have a low overall energy demand and when work is demanding it tends to be a local, often monotonous load in specific muscles that constitutes the strain. Thus, on one hand the energy demand at the work site is well below what is recommended for a healthy lifestyle, but on the other hand certain tasks may create an enhanced risk for the development of muscular-skeletal disorders.

In this light it would be valuable if work site plans or programmes were implemented for the workers to include physical activity in their daily or weekly routine. This could counteract both a daily low energy turnover and local strain on specific muscles including the back muscles, and also help the workers keep an acceptable aerobic fitness level.

Such programmes have been implemented in relation to evaluation criteria such as well-being, sick leave, risk factors for chronic diseases, skeletal-muscle disorders, and cost-benefit. Overall such interventions have positive outcomes especially for well being, but also for total energy expenditure and fitness level. Most studies report on effects on sick leave and some on cost-benefit effects.

Available evidence supports the idea that the workplace should be the primary site in adult daily life where a physically active lifestyle is supported and that this should be a matter of concern for employers and trade unions. The social partners need to make an active contribution in this field, without which governmental objectives cannot be reached.

The work environment has a long tradition of being critically evaluated. In the past the focus has been on the physical and the toxicological environment. Today, healthy food and a policy against smoking and alcohol have become increasingly common. To this should be added the possibility to have a physically active lifestyle. If skeletal muscle disorders and other work-related chronic diseases are a problem, prevention programmes should be offered.

Examples of Good Practice

32 workplaces were involved in a two-year pilot scheme, Well@Work, in the UK. The scheme involved businesses ranging from a large food manufacturer and a hospital to a small rural business. The pilot project evaluated a range of interventions that would encourage sport and physical activity in the workplace. "Activate your Workplace" built on the success of Well@Work. It was a one-year training and support programme to help workplaces design, deliver and monitor healthy activities while developing internal capacity to ensure that programmes are sustainable. Following completion of the programme, participating organisations should have an active and healthy workplace policy and a member of staff trained and knowledgeable in workplace health along with a qualification from the Royal Institute of Public Health. Partnership working is at the heart of "Activate your Workplace" which is being led by The Centre for Workplace Health, St Mary's University College, Twickenham, London, in partnership with Sport England, Transport for London, the London Development Agency, the Fitness Industry Association and NHS London. The partners provide funding or offer incentive packages and access to their expertise and services.

In Luxembourg, the Ministry of Health gives annual rewards to businesses offering health enhancing programmes in the workplace, including programmes and initiatives in relation to physical activity. The award is called "Prix Santé en entreprise" ("Health at workplace reward") and was awarded for the first time in 2008.

Guidelines for Action

- Guideline 33 – In their agreements, employers and trade unions should include requirements for the workplace which facilitate a physically active lifestyle. Examples of such requirements include: (1) Access to adequately equipped indoor and outdoor exercise facilities; (2) Availability, on a regular basis, of a physical activity professional for joint exercise activities as well as for individual advice and instruction; (3) Support for workplace-related sport participation; (4) Support for using cycling and walking as transportation to and from the workplace; (5) If the work is monotonous or heavy to the extent that it implies an increased risk of skeletal muscle disorders, access to exercises specifically designed to counteract these diseases; (6) A physical activity-friendly working environment.
- Guideline 34 – National health certificates could be awarded to workplaces where a healthy physically active lifestyle is given high priority.

3.6. Services for senior citizens

Increasing evidence points to the importance of physical activity for older adults. Although health conditions during aging can be considered in great part the results of lifestyle during adulthood and possibly even during youth, the level of physical activity of older adults is an important determinant for their level of fitness and for their continued ability to lead an independent life. The positive effects of continued physical activity include both psychological (life satisfaction) and physical, physiological and social health conditions. It has been shown that participation in a regular exercise programme is an effective tool to reduce or prevent a number of functional declines associated with aging, including among octogenarians and nonagenarians. There is increasing evidence that physical activity may maintain cognitive functions and have a preventive effect on depression and dementia (the psychiatric disorders most frequent among the elderly).

Physical activity including specific muscle training (strength and balance) plays an important role in improving the quality of life of senior citizens. While studies have shown that regular physical activity and/or exercise in advanced age does not significantly lengthen life expectancy, improved physiological and psychological conditions help maintain personal independence and reduce demands for acute and chronic care services. This may have significant economic benefits, as the resultant cost savings are likely to more than compensate for the costs of well-designed exercise programmes. It will be important to personalise exercise programmes for older persons, corresponding to the level of fitness that can be achieved and taking into account their specific needs. Special attention is needed for the role of physical activity in case of development of age-associated impairment, functional disability, and cognitive decline.

Cultural, psychological and health factors often inhibit physical activity and exercise in older age. Thus, special care is needed to create and support the motivation of elderly people to be physically active, particularly if they are not used to being physically active.

Research is needed to explore possibilities to change attitudes towards physical activity in the present pre-elder generation. Moreover, awareness of the beneficial effects of a

good lifestyle including various physical activities needs to be raised among the elderly and in society.

Relevant to the maintenance of physical activity is socio-economic status and living conditions, either at home or in a residential facility. The planning of residential facilities should take into account physical activity, in particular in relation to the opportunity to walk inside and outside and participate in specific activities within the community.

Health services, local government and voluntary organisations may play an important role in breaking resistance to start or continue physical activity in older people. They can promote initiatives which overcome on the one hand the possible economic restrictions and on the other hand psychological and cultural inhibitions. Primary care physicians can give assistance to older patients to realise the benefits by encouraging them to increase their physical activity levels, by prescribing appropriate exercise regimes and by referring them to physical activity and exercise specialists.

On an every-day basis, walking at moderate speed in an urban context is likely to be the most advisable physical activity for old people. A minimum of 30 minutes has been proposed on the basis of available studies. It needs to be stressed that this should be a walk for the (pleasure of) walking, not carrying things, and keeping an adequate pace. Staircase climbing is a second useful exercise. Taking care of the house and gardening may complement these everyday activities. In some European countries, there is a tradition of performing physical exercises at home at a fixed moment of the day (generally in the morning). While the health benefit of such exercises is undoubtedly positive, research is needed into their precise effects.

It is worth underlining that walking in an urban environment requires a guarantee of safety which is seldom fulfilled in European towns due to high-intensity traffic. Locomotion is slower in the elderly and sensory abilities (sight, hear) are often impaired, which make old people more exposed to traffic-related accidents. Security from aggression and violence may also represent an essential guarantee required by old people to leave their homes without fear. The availability of shops, meeting points (cafes, libraries) are further reasons that may encourage walking in the town or in the neighbourhood.

Additional physical activity specifically oriented at elderly people, such as muscle strength training, swimming or other types of fitness activities to improve cardiovascular function and muscle strength, may represent a valuable complement on a periodic basis (two to three times per week) to everyday activities.

Examples of Good Practice

The "European Network for Action on Ageing and Physical Activity (EUNAAPA)", funded by the European Commission, has identified good practice in the promotion of physical activity among older people. This includes good practice in exercise programmes and courses for older people that are in place in different Member States. For example, the German Olympic Sports Association runs a programme named "Truly fit from 50 on" targeted at attracting older people to join specially designed exercise classes. EUNAAPA has also identified good practice in developing policies for the promotion of physical activity among older people. For example, governmental organisations in the Netherlands were successful in linking the topic of physical activity

to initiatives originally solely geared toward promoting elite sport prior to the Olympic Summer Games.

In Finland, a national health exercise programme for older adults, Strength in Old Age, promotes the autonomy and quality of life of independently living older adults with decreased functional capacity. This is achieved by increasing leg muscle strength and balance exercise of the target group and by developing services. Activities are provided especially for over 75-year-olds. The programme (2005-2009) is a large cooperation project carried out by the Ministry of Social Affairs and Health, the Ministry of Education, the Finnish Slot Machine Association and several other actors. It is coordinated by the Age Institute. The programme develops suitable forms of group exercise, including gym and balance exercises and home gymnastics. Actors in the public, private and third sectors are encouraged to form networks, develop exercise services and improve conditions for exercise and everyday mobility.

Guidelines for Action

- Guideline 35 – In view of increasing longevity in European societies, EU Member States should increase research into the link between physical activity of senior citizens and their psychological and physiological health as well as into the identification of means to enhance awareness of the importance of being physically active.
- Guideline 36 – Public authorities should provide facilities which make physical activity more accessible and attractive to elderly people, being aware that spending money on such facilities will save money on medical treatment.
- Guideline 37 – Special attention should be paid by personnel in charge of caring for elderly people at home and in institutions to ensure that suitable amounts of exercise, compatible with the health conditions, are maintained.

4. INDICATORS, MONITORING AND EVALUATION

The implementation of policy actions for physical activity promotion should be monitored on a national and, potentially, EU level. The following indicators are likely to yield important information on policy implementation processes and outcomes:

A. Rate of population reaching adequate physical activity levels

– Indicators:

- (1) Population rate meeting the recommendations for health-enhancing physical activity; population rate participating in leisure-time physical activity (structured exercise and lifestyle) and active transportation (commuting etc.); daily patterns of physical activity behaviour in terms of intensity, frequency and duration of the activity; physical activity levels of population, including subgroups (elderly people, children, etc.);
- (2) Fitness levels (cardiovascular fitness, strength, etc.).

– Means: physical activity monitoring at population level using objective measurement methods, such as motion sensors, and subjective methods, such as questionnaires.

B. Development and implementation of physical activity related policies

- Indicators: policy input through the formulation of national policies, strategies or actions; policy process (implementation) and output through effective legislation, implementation programmes and adequate funding (e.g. number of staff hired); policy outcomes in terms of e.g. the rate of population being obese, kilometres of bicycle paths built.
- Means: policy implementation monitoring system.

Distal outcome indicators of policy implementation such as changes in population rates participating in physical activity (point A above) are already monitored by existing health monitoring systems in most EU countries. Proximate outcome indicators such as policy input, process and output (point B) are neither monitored by the EU nor by most EU countries. The WHO Global Strategy on Physical Activity and Diet recently published “A Framework to Monitor and Evaluate Implementation”, suggesting the establishment of monitoring systems for physical activity policy implementation at national level. In order to appreciate the impact of any public initiative on the physical activity level of the population, it is necessary to conduct some sort of survey before the intervention and then repeat it over time.

Although much attention has been given to monitoring methods targeting individuals, certain questions may be better answered with a shift in focus to other targets of measurement including individual and non-individual methods.

Individual monitoring techniques are usually divided into subjective and objective methods. Subjective methods (self-reporting) include questionnaires made available by mail, e-mail or on the internet, as well as telephone surveys. Objective methods include pedometry, accelerometry, heart rate monitoring, combined monitoring and doubly-labelled water.

Non-individual monitoring methods are those which do not have an individual as the target of measurement but a group of individuals or an area. Much of this information may already be collected but perhaps for other purposes, for example national export-import statistics or crime-protection programmes. Examples are the number of cars in the household, work place, region, country; number of bicycles; number of television sets, PCs, game consoles, dishwashers, washing machines, tumble dryers, annual number of miles travelled by car, number of people using the stairs relative to the elevators in a certain location, number of gym/sport club memberships, number of physical activity classes in curricula and teacher absence reports from physical activity classes.

Examples of Good Practice

In the UK, the English Active People Survey is the largest ever survey of sport and active recreation to be undertaken in Europe. It identifies how participation varies from place to place and between different groups in the population. The survey also measures the proportion of the adult population that volunteer in sport on a weekly basis, club membership, involvement in organised sport/competition, receipt of tuition or coaching, and overall satisfaction with levels of sporting provision in the local community. The questionnaire was designed to enable analysis of the findings by a broad range of demographic information, such as gender, social class, ethnicity, household structure, age and disability. The first year of the survey was conducted between October 2005 and

October 2006, and was a telephone survey of 363,724 adults in England (aged 16 plus). Due to the success of the survey it is being repeated annually until 2010.

Sport England has built on the Active People survey research by analysing the data further, producing 19 market segments with distinct sporting behaviours and attitudes to help understand the nations' attitudes and motivations – why they play sport and why they don't. The segments provide the knowledge to potentially influence people to take part. Each segment can be explored at differing geographic levels. It is possible to find out what people's sporting habits are in a particular street, community, local authority or region. This includes information on specific sports people take part in as well as why people do sport, whether they want to do sport and the barriers to doing more sport. In addition, the segments provide information on media consumption and communication channels, social capital, health indicators including obesity and engagement in the wider cultural sphere.

Guidelines for Action

- Guideline 38 – The implementation of policy actions for physical activity promotion should be monitored regularly, based on pre-defined indicators to allow for evaluation and review.

5. PUBLIC AWARENESS AND DISSEMINATION

5.1. Public awareness campaigns

Successful implementation of physical activity guidelines depends to a large extent on changes in public perceptions and changes in individual behaviour. Public awareness campaigns are therefore an important tool in the implementation of physical activity guidelines.

When a public awareness campaign is being planned, it may be useful to look at what has been done in similar campaigns in other countries and how those campaigns have been evaluated. External conditions (timeframe, budget) should be addressed as soon as possible when planning a campaign. Cooperation partners (scientists, institutes, spokespersons, PR and communication agencies, creative agencies) need to be defined and a reference group (NGOs, trade unions, national and international experts, including experts from the media) are likely to be useful, in particular to test ideas and messages.

Community involvement should be achieved ("grassroots marketing"). In this context, important steps may be to use the internet to raise awareness, to send material to local health personnel and schools, to make local press releases, to ask experts in the local community to write feature articles, and to involve local celebrities.

Media professionals are a key player to achieve changes in public and individual attitudes. In view of the increasing relevance of mass communication media, particularly television, in determining lifestyles, it has become important that professionals active in that field are aware of the issues of physical activity in relation to health and environmental impact and of the possibilities which mass media present to influence people's behaviour.

Guidelines for Action

- Guideline 39 – To have an impact, public awareness campaigns should be combined with other forms of intervention within a coherent strategy.

5.2. EU HEPA Network

As stated in the European Commission's 2007 White Paper on Sport, there is great potential for enhancing public health through physical activity. The second action proposed in the “Pierre de Coubertin” Action Plan accompanying the White Paper is that “[t]he Commission will support an EU Health-Enhancing Physical Activity (HEPA) network”.

An EU HEPA network should strengthen and support efforts and actions to increase physical activity levels and to improve the conditions favourable to a healthy lifestyle across Europe. It should also provide a European platform for sharing the development and implementation of evidence-based policies, strategies and programmes.

From 1996 until 2001, the first European Network for the Promotion of Health-Enhancing Physical Activity existed as a programme funded by the European Union and was instrumental at the time in facilitating exchange and providing support for the development of integrated national approaches. As no such platform was in place after 2001, HEPA Europe, the European network for the promotion of health-enhancing physical activity (HEPA Europe), was founded in May 2005 in Denmark. At its 3rd annual meeting in May 2007, HEPA Europe counted 52 members covering 23 European countries, including 16 EU Member States, and one observer from a country outside Europe. It closely collaborates with the WHO Regional Office for Europe.

The objectives of HEPA Europe include: 1) to contribute to the development and implementation of policies and strategies for HEPA in Europe; 2) to develop, support, and disseminate effective strategies, programmes, approaches, and other examples of good practice; and 3) to support and facilitate the development of multi-sectoral approaches to the promotion of HEPA.

HEPA Europe relies on a multi-sectoral approach of physical activity promotion involving experts from the health, sports, education, environment, transport, urban planning and other sectors from across Europe. It has the ambition to participate in all areas of HEPA promotion across Europe.

HEPA Europe contributes to the development of an evidence base on the effectiveness of approaches to physical activity promotion and to making this evidence easily available. It aims to target population groups which are most in need of increasing their physical activity levels for health (depending on age, region, socioeconomic status etc.), as well as to identify supportive conditions for being physically active (including actions from different sectors including sport, health, urban planning or transport). HEPA Europe also supports the development of improved measurement and monitoring of physical activity at population level. Activities on the assessment of the overall balance between benefits

and possible increased risks resulting from increased population levels of physical activity are also carried out (including cost-benefit analyses).

In view of the useful role already played by the HEPA Europe Network, an EU HEPA Network should not supplant the existing network, but rather find ways to develop common activities. The exchange of information and good practice already practised in the HEPA Europe Network should be taken as a model to emulate and the WHO Regional Office for Europe (European Centre for Environment and Health, ECEH) should be invited to continue playing a key role in this connection. The European Commission should look for a way to provide support to HEPA Europe for its EU activities and projects. Project grants should be given on the basis of specific applications following a restricted call for proposals.

In this way, the Network should have the potential to play an important role in disseminating and promoting the implementation of these EU Physical Activity Guidelines across the EU.

Example of Good Practice

The HEPA Europe Network holds annual meetings open to all organisations or individuals interested in the promotion of health-enhancing physical activity with a European perspective. Members and interested parties are regularly informed of ongoing activities and events through the maintenance of a HEPA Europe website. Advocacy booklets on physical activity and health with key facts and figures for policy makers are disseminated through the network. An inventory of existing approaches, policy documents, and targets related to physical activity promotion in different European countries is regularly updated. The network was involved in the collection of case studies of collaboration between the physical activity promotion community and the transport sector, providing an overview of European experiences. A review of cost-benefit analysis (CBA) methodology with regard to walking and cycling, together with a tool for such analysis, is one of several ongoing projects.

Guidelines for Action

- Guideline 40 – The dissemination and implementation of these EU Physical Activity Guidelines at EU level should be supported through an EU HEPA Network based on the existing European network for the promotion of health-enhancing physical activity (HEPA Europe).
- Guideline 41 – The European Commission is called upon to consider how best to give financial support to an EU HEPA Network for this purpose and how to involve the Network in the implementation and assessment of HEPA-related projects and the dissemination of results.

ANNEX: LIST OF EXPERTS

These Physical Activity Guidelines were drafted by an Expert Group consisting of the following experts:

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The Expert Group was chaired by the Sport Unit of the Directorate-General for Education and Culture of the European Commission, which also played the role of a secretariat. The EU Working Group "Sport and Health" appointed the members of the Expert Group and supervised the drafting process.

The Expert Group's logistical expenses were covered by the European Commission.