Deliverable 5: Health promotion best practices report – health promotion interventions analysis and workshop

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Task 5.1 - Identification of best practices in health promotion interventions in EU countries and assessment of their transferability to the Spanish context

1.1 Introduction

The aim of this task was to collect and report on best practices focusing on health promotion at local level, with, where possible, incorporating an intersectoral approach, and assess their transferability to the Spanish context. This task should help the MoH identify which interventions have the most promising results for a full-scale implementation; in the longer run it will also help better target the Local Implementation of the Health Promotion and Prevention Strategy of the NHS (EPSP) towards financing interventions proven to be highly effective, with measurable outcomes and impacts.

As a result of the research conducted for Task 5.1.1 and 5.1.2, a shortlist of European best practices on health promotion (19 examples) implemented at local level were identified in the following areas:

- Physical (urban planning, environments, biodiversity, etc.) and functional (mobility, pedestrianisation, etc.) environment improvement in order to promote health and wellbeing;
- Promotion of healthy lifestyles through sustainable, comprehensive and intersectoral interventions addressing risk factors such as physical inactivity, unhealthy eating, tobacco and alcohol;
- Local interventions reinforcing participation and community engagement in health promotion interventions to address health inequalities[1].

This report starts with the presentation of the 19 potential best practices on health promotion examples that were initially identified (section 1.2) and follows with a pre-selection of 14 potential best practices (section 1.3). The identified best practices have been informed by the results of a thorough desk research at European level, and consultations and written inputs from our senior study experts. After these examples were identified, information on each of the potential best practices identified was collected, compiled, and analysed by the core study team following a common template (in excel) to ensure comparability and comprehensiveness of available information. The European Commission's criteria to select best practices in health promotion and chronic disease prevention and management in Europe, [2]and the quality criteria for the identification of best practices defined through the prevention and health promotion strategy of the Spanish NHS[3],have been used as the relevant criteria for the preselection of potential best practices.

Once expert opinion was gathered, the study team discussed the findings with the Operational Working Group (OWG), highlighting the elements that could foster (or hinder) successful implementation of the interventions in Spanish municipalities. Following on from this, a final selection of six best practices was made, with the aim of presenting them at the Annual Meeting of the Local Implementation of the EPSP.

[1] This thematic area sometimes overlaps with the other two.

[2] https://ec.europa.eu/health/sites/health/files/major_chronic_diseases/docs/sgpp_bestpracticescriteria_en.pdf

[3]https://www.mscbs.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/docs/MemoriaBuenasPracticasEstrategia_2017.pdf

Finally, this report also includes a number of overarching issues that were considered when deciding which best practices would be the most suitable for the Spanish context. These issues stem out of learning captured in the best practices and insights from the study team and can be useful points to consider in any future work conducted by the Spanish Ministry of Health. Initial long list of good practices.

1.2 Initial long list of best practices

The following examples were found during the desk-research phase, with more details on each practice included in the accompanying excel document:

Potential Best practice	Country	Geographical scope and target population	Thematic areas
		Promotion of Healthy Lifestyles	
Up-to-date health - Running and Walking Center in Tondela (CMMCTND)	Portugal	Tondela: municipality in the central Portuguese subregion of Dão-Lafões Population: 28,946	Promotion of Healthy Lifestyles
Overcoming Obesity	Finland	Seinajoki (the intervention has also been implemented in Rovaniemi, Lapinlahti, Turku, Siilinjärvi, Sastamala and Municipal Federation of Raahe Region). All locations have a population of less than 100,000	Promotion of Healthy Lifestyles / Local Interventions reinforcing the participation
JOGG - Jongeren op Gezond Gewicht	Netherlands	75 municipalities across the Netherlands, the majority of which have a population of under 100,000.	Promotion of Healthy Lifestyles /Local interventions re-enforcing participation and community engagement in health promotion interventions to address health inequalities.
Healthy Kinzigtal	Germany	Population of Kinzigtal is 60,000 but this intervention was only available for 32,000 inhabitants who are insured by the AOK	Promotion of Healthy Lifestyles /Local interventions reinforcing participation and community engagement in health promotion interventions to address health inequalities.
Community Food Initiative Ireland	Ireland	In 2020 the initiatives is being implemented in 14 areas. All of the following locations have a population of under 100,000: Bogside & Brandywell, Co. Carlow, Co. Antrim, Ballyhoura, Inishowen, Offaly.	Promotion of Healthy Lifestyles / Local Interventions reinforcing the participation
Well Communities		Programme that takes place in natural neighbourhoods (often housing estates)	Promotion of Healthy Lifestyles/Local interventions reinforcing

Potential Best practice	Country	Geographical scope and target population	Thematic areas
	United Kingdom	with around 4,000 to 7,000 residents.	participation and community engagement in health promotion interventions to address health inequalities
EPODE - Ensemble Prevenons L'Obesite Des Enfants	France	EPODE has been implemented in over 500 communities in 6 countries	Promotion of Healthy Lifestyles
Samenoud (Embrace)	Netherlands	Province of oos-Groningen Population:135,153	Promotion of Healthy Lifestyles
Hartslag Limburg (Heartbeat Limburg)	Netherlands	Maastricht. Population: 122,000	Promotion of Healthy Lifestyles
Copenhagen's urban development	Denmark	Population: larger than 100,000	Promotion of Healthy Lifestyles /Local interventions reinforcing participation and community engagement in health promotion interventions to address health inequalities.
Stop to think	Portugal	Coimbra Population; 105,842	Promotion of Healthy Lifestyles
Let's Live Healthily. Part of Project Mura	Slovenia	Pomjure Region, Slovenia Population: 114,000 inhabitants	Promotion of Healthy Lifestyles
Physical and Functional Environments			
Heart Healthy Hoods	Spain	Two districts in Madrid, Spain (Villaverde and Chamberí) Villaverde: 126,802 inhabitants. Chamberi: 145,934 inhabitants	Physical and Functional Environments
Free to Move "Liberi di Muoversi"	Italy	School teachers and primary school students (6-10 years), parents. 102.00 inhabitants of Piacenza municipality	Physical and Functional Environments
Walk to School Week, by Living Streets	United Kingdom	Early years, primary and secondary schools across UK	Physical and Functional Environments
The Bristol Approach	United Kingdom	Bristol Population:535,907	Physical and Functional Environments
Sønder Boulevard	Denmark	Neighbourhood in Copenhagen	Physical and Functional Environments
Replace Vehicles with Public Spaces Pontevedra	Spain	Pontevedra city Population: 82,802	Physical and Functional Environments
Dose of Nature Prescription Service	United Kingdom	UK, Borough of Richmond Population: 198,000	Physical and Functional Environments

1.3 Identification of best practices in health promotion and prevention

1.3.1 Pre-selection criteria

After assessing the literature consulted and outcomes of each of the 19 practices, the study team reflected upon the aspects that may differentiate the practices and support the MoH to determine the most useful and transferable interventions, to the Spanish context. These aspects, outlined below, were seen to be the most relevant principles considered to inform the current pre-**selection:**

In the accompanying excel document, in-depth research has been compiled on the following components of each health promotion practice:

- **Level of implementation:** Regional and Local (municipalities of around 100.000 inhabitants).
- **Thematic areas:** interventions ideally with an intersectoral approach covering the following areas:
  - Physical (urban planning, environments, biodiversity, etc.) and functional (mobility, pedestrianisation, etc.) environment improvement in order to promote health and wellbeing.
  - Promotion of healthy lifestyles through sustainable, comprehensive and intersectoral interventions addressing risk factors such as physical inactivity, unhealthy eating, tobacco, and alcohol.
  - Local interventions reinforcing participation and community engagement in health promotion interventions to address health inequities.
- **Relevance and thematic focus/ Strategic adequacy**: Interventions' objectives and outcomes. Examples should be designed specifically to either promote health or reduce health inequities.
- **Time period of implementation**: Whether interventions have been implemented during a minimum period of time. A minimum period of time allows for the intervention to produce results (outputs, outcomes), as well as lessons learnt.
- **Ethical aspects:** Procedures to identify and consider ethical issues (e.g. respect of people's privacy and choice, data protection, identification of conflict of interest).
- **Effectiveness and efficiency:** Whether interventions have met their aims and objectives. Examples should achieve good results compared to the scale of resources deployed and in a reasonable timeframe. This criterion also looks at the availability of tools, training modules or recommendations facilitating their implementation.
- **Equity**: Whether and how an equity approach was included in interventions: how the interventions are aimed at reducing health inequities by taking into account different groups needs according to inequity axes such as gender, age, socioeconomic status, ethnicity, rural/urban, vulnerable groups, etc.
- **Sustainability**: Mechanisms warranting the intervention's sustainability. Examples should be able to be maintained over a longer time period without a disproportionate injection of additional resources (e.g. lifespan of the project, level of actual investment).
- **Evidenced results:** Outcomes, longer term impacts.
- **Participation:** This looks at whether procedures are set up to promote the participation of citizens and stakeholders.

- **Intersectoral collaboration**: Whether interventions have been carried out jointly by several sectors, and whether a multidisciplinary approach was supported by the appropriate stakeholders. Examples should create ownership among the target population and several stakeholders considering multidisciplinary, multi-/inter-sectoral, partnerships and alliances.
- **Evidence and Theory based:** Examples should be built on a well-founded programme theory and be evidence-based. The effective elements (or techniques or principles) in the approach should be stated and justified.
- **Innovation:** Whether interventions have been implemented in the context for the first time.
- **Potential transferability to the Spanish context:** The extent to which interventions can be scaled up to the Spanish setting and to a broader target population/geographic context.

Table 1.1 below provides a summary of how each of the 19 practices meets these criteria. An additional analysis is provided in the subsequent sections below and in the accompanying excel document. It is important to note that to inform our pre-selection, the most decisive criteria have been: 1) whether the best practice has shown evidence results 2) the potential transferability to the Spanish context, and where relevant 3) the innovative aspect of the intervention.

Table 1.1 How each best practice meets the criteria

Best practice	Level of implementation	Relevance and thematic focus strategic adequacy	Time period of implementation	Ethical aspects	Effectiveness and Efficiency	Equity	Sustainability	Evidenced results	Participation	Intersectoral collaboration	Evidence and theory based	Innovation	Transferability to the Spanish context
Up-to-date health - Running and Walking Center in Tondela (CMMCTND)	x	x	x		x	x	x	x	x	x	x		x
Overcoming Obesity	x	x	x		x			x	x	x	x		
JOGG - Jongeren op Gezond Gewicht	x	x	x	x		x	x	x	x	x	x	x	x
Community Food Initiative Ireland	x	x	x			x	x	x	x	x	x		
Healthy Kinzigtal	x	x	x	x	x	x		x	x	x	x		x
Well Communities	x	x	x	x	x	x	x	x	x	x	x	x	x
EPODE - Ensemble Prevenons L'Obesite Des Enfants	x	x	x		x	x	x	x	x	x	x	x	x

Samenoud (Embrace)	x	x	x	x	x	x	x	x	x	x	x	x	x
Hartslag Limburg (Heartbeat Limburg)	x[4]	x	x		x	x	x	x	x	x	x		x
Copenhagen's urban development		x			x			x	x	x			
Free to Move "Liberi di Muoversi"	x[5]	x	x		x		x	Not clear	x	x	x		x
Let's live healthily	x[6]	x	x		x	x	x	x	x	x	x		x
Stop to think	x	x	x		x	x		x			x		x[7]
Heart Healthy Hoods	x	x	x	x	x	x			x	x		x	
Walk to School Week, by Living Streets	x	x	x		x	x	x	x	x	x			x
The Bristol Approach		x	x			x	Not clear	x	x	x		x	x
Sønder Boulevard-		x	x		x	x	x	x	x	x	x	x	x
Replace Vehicles with Public Spaces Pontevedra	x	x	x		x	x	x	x	x	x	x	x	x
Dose of Nature Prescription Service		x	Not clear	x	x				x	x			x

Pre- selected interventions

[4] 122.00 inhabitants

[5] 102.00 inhabitants

[6] 114 inhabitant

[7] Similar projects have been implemented in the Spanish local context.

1.3.2 Pre-selected best practices and analysis

1.3.3 Selection process

Fourteen best practices have been pre-selected by the study team. The selection process was as follows:

- The study team assessed how every intervention matched the key features of a best practice (pre-selection criteria detailed in Section 1.3. above) and completed the data collection tool (accompanying excel document).
- The completed data collection tool was shared with our senior study experts for the assessment of the adequacy and quality of each tool together with the potential transferability to the Spanish context.
- After inputs were received by the senior study experts, the study team compiled the list that is presented below. It is important to note, however, that there was not a clear consensus across the senior study experts on the 14 pre-selected best practices. This was mainly due to the different nature and scope of the best practices.
- This preselection was discussed and agreed with the OWG, and a final list of 6 best practices was selected to present in the Annual Meeting of the Local Implementation of the EPSP.

1.3.4 Pre- selected best practices and potential transferability to the Spanish Context: Best practices in Health promotion

1.3.4.1 Up-to-date health: Running and Walking Center in Tondela (CMMCTND)-Portugal

Name of the intervention	Up-to-date health: Running and Walking Center in Tondela (CMMCTND)
Country	**Tondela, a municipality in central Portugal**
Thematic area	**Health promotion: promoting healthy and active ageing**
Link to best practice	https://webgate.ec.europa.eu/dyna/bp-portal/practice.cfm?id=67 http://chrodis.eu/wp-content/uploads/2017/03/up-to-date-health-running-and-walking-centre-in-tondela.pdf
Description and main features	
- **Aims and objectives:** The main aim of CMMCTND was to reduce the sedentary lifestyle and isolation of adults, (especially the senior population) in Tondela through promoting healthy and active ageing. As part of the project, exercise sessions (2-3 times a week) are organised for the target group in public spaces, dedicated to fitness, walking, jogging, swimming, among others. Some	

Name of the intervention	Up-to-date health: Running and Walking Center in Tondela (CMMCTND)

activities are also oriented to the promotion of cognition and include cultural events, allowing the establishment of partnerships with local institutions. Workshops on health and physical exercise complement theoretical knowledge on the importance and influence of these vital factors in the quality of life of citizens. The intervention also includes the presence of a sports technician at the Health Unit Centres that orients the beneficiaries from the diabetic medical appointments towards an exercise programme in CMMCTND. In addition, the presence of three nurses at the CMMCTND allows for the diagnosis and monitoring of the beneficiaries, registering potential useful information for the general practitioner or the Sports technician in the "Exercise and Physical Health Bulletin".

- **Target population**: adults, especially the senior population in Tondela
- **Strategic adequacy:** CMMCTND aligns with the following strategies:
  - 2012-2020 European strategy and action plan for health ageing in Europe.
  - Portugal's National Health Plan (2016-2020) which includes directives to facilitate health promotion and access to health and social services to reduce the burden of chronic diseases[8].
  - European Parliament resolution on the European Innovation Partnership for the Active and Healthy Ageing (6 February 2013) which noted that there is an urgent need to increase the levels of physical exercise of the elderly population.
  - Portuguese Plan of Walking and Running[9].
- **Time period of implementation:** 2013 to 2014, but unclear if the intervention continued beyond this point.
- **Effectiveness and efficiency:** Physical performance and health indicators are evaluated by a team of nurses and registered in "Exercise and Physical Health Bulletin". These records are then sent by participants to their General Practitioner.
- **Equity:** The programme was designed to include senior citizens living in rural, isolated areas, some of whom have physical disabilities. However, the programme is open to all citizens.
- **Sustainability**: The project is funded through a combination of regional government (80%) and local organisations (20%). Commitment from regional government contributes to likelihood of sustainability of the project.
- **Evidenced results:** A questionnaire conducted in 2014 showed that the beneficiaries feel healthier, with more mobility, more strength and energy, since their participation in the project".[10] Other benefits include increased social

[8] https://www.ejournals.eu/pliki/art/8694/

[9] http://chrodis.eu/wp-content/uploads/2017/03/up-to-date-health-running-and-walking-centre-in-tondela.pdf

[10] http://chrodis.eu/wp-content/uploads/2017/03/up-to-date-health-running-and-walking-centre-in-tondela.pdf

Name of the intervention	Up-to-date health: Running and Walking Center in Tondela (CMMCTND)

contact, reduced isolation and loneliness of senior people, promoting their integration in activities of society.

- **Participation:**
  - 2013: 1,387 people attended activities.
  - 2014: 1,420 attendees across 65 local projects.
- **Intersectoral collaboration:** Organisations involved include: municipality of Tondela; partner institutions such as Health Units of Tondela, local associations and parish councils, and Fresenius Kabi-Labesfal; health professionals including doctors and three nurses; 21 Physical Education professionals; nutrition specialists and 1 psychologist[11].
- **Evidence and theory base**: A 2007 study evaluated the sports habits of the population of the Municipality of Tondela. This study found that almost 41% of people aged over 40 were not taking part in sufficient physical exercise, and that this was due to a lack of opportunities to do so in the Municipality[12].
- **Innovation:** Combines exercise with cognitive and cultural activities to tackle healthy ageing.
- **Transferability to the Spanish context:** It is likely that many aspects of this programme could be transferred to the Spanish context because of the cultural-geographic proximity which makes this intervention easily transferable to the Spanish reality. In addition, the intervention has been evaluated with positive results. On the other hand, it is very dependent on interventions from staff from the health sector or sport technicians, so it is unlikely that many areas, especially rural ones, would have the staff and resources to implement this intervention. The topic of healthy ageing is essential as is targeting the rural populations. Perhaps a focus that is more community driven could be adopted. Potentially the intervention was not sustainable as information on the programme is only available for one or two years.

[11] http://chrodis.eu/wp-content/uploads/2017/03/up-to-date-health-running-and-walking-centre-in-tondela.pdf

[12] http://chrodis.eu/wp-content/uploads/2017/03/up-to-date-health-running-and-walking-centre-in-tondela.pdf

1.3.4.2 Well Communities - United Kingdom

Name of the intervention	Well Communities
Country	United Kingdom
Thematic area	Promotion of Healthy Lifestyles
Link to best practice	https://www.uel.ac.uk/research/ihhd/our-projects/well-communities-programme

Description and main features

- **Aims and objectives:** 1) To develop a locally focussed, integrated, community-led approach that improves community health and well-being and is effective and sustainable in even the most deprived neighbourhoods. 2) To engage and empower people to build and strengthen the foundations of good health and well-being in their communities.
- **Target population:** Well Communities is a geographically based programme that takes place in natural neighbourhoods (often housing estates) with around 4,000 to 7,000 residents. The programme is open to everyone across all ages, backgrounds and ethnicities living or working in the target neighbourhoods".
- **Strategic adequacy:** Intervention is aligned with the main strategies at national level.
- **Time period of implementation:** 2007–2020
- **Ethical aspects:** The approaches used in the interventions incorporate national best-practice guidelines and may therefore be expected to have a beneficial impact. Risk management processes are put in place, and health and safety and data protection guidelines are adhered to.
  - In phase 1 a Data and Safety Monitoring Committee was set up before commencement of the cluster randomised controlled study to review procedures and protocols in order to minimise any harm or burdens.
  - In phase 3 the scaled up, mainstreamed programmes will include establishment of a number of Well Communities hubs across a borough or Housing Association area. The hubs will be focused, 'proportionately', in the most disadvantaged neighbourhoods, with wider 'universal' coverage being achieved through a natural ripple out effect across the wider population.
- **Effectiveness and efficiency:** In both Phases 1 and 2 levels of participation and the targets agreed with Big Lottery Fund for healthy eating, physical activity, mental wellbeing, social connectedness and volunteering were exceeded. In phase 2 the degree of change in these participants translated into a net significantly positive change in the whole group on some measures of physical activity (total MET minutes of doing physical activities per week), healthy eating (total quantity of fruit and vegetable in yesterday's diet) and mental wellbeing (hope scale score). Physical activity: 82% of participants did more physical

Name of the intervention	Well Communities
activity at follow-up compared to baseline. Volunteering: 60% participants reported doing more volunteering at follow-up compared to baseline. Other positive outcomes illustrated through case studies and included in the qualitative evidence: – Numbers accessing training and qualifications. – People progressing to paid employment. – Increased community networks and connections. – Increased capacity of local community & voluntary organisations. – Improved relationships and integrated working between local statutory and community & voluntary organisations. – Transformed community spaces. – Additional resources levered into deprived neighbourhoods. Phase 1 (2007 to 2011) was supported by £9.46m from the Big Lottery Fund and delivered in 20 of the most deprived neighbourhoods across London by a multi-sectoral alliance. This partnership was hosted and coordinated by the Greater London Authority. Phase 2 (2012-2015) took place in 11 areas and focussed on testing replicability on a 'natural neighbourhood' basis. ■ **Equity:** Demographic profiles, routinely available data, and mappings of local community assets are produced for each intervention area to build a picture of the demographics and health and well-being of local residents and the characteristics of their neighbourhoods. The number one concern people raise during the community engagement process is the desire to live in a community they feel part of and safe in. Well Communities is open to everyone across all ages, backgrounds and ethnicities living in the target areas. . People ask for activities that bring people together across age, background and ethnicity. However, there are many barriers that make it difficult for some local residents to take part so a variety of methods are used to reach out to and engage people. These include peer approaches, creative approaches, responding to the issues around communications raised by the residents, dealing with language issues, using new media and targeting projects to diverse groups of people. ■ **Sustainability:** Programmes are commissioned by mainly public bodies such as local authorities and housing associations who are interested in this way of working and provide funding and other resources. In phase 3 there will be a strong focus on supporting embedding organisations in the positioning and scaling up of Well Communities appropriately as part of relevant local strategies, structures, and commissioning arrangements. The voluntary and community sectors play a key role in implementing local programmes and Well Communities builds the capacity of local organisations so they can better meet the needs of local people in the future. The programme takes place at the grass-roots of the community and uses community development and coproduction to ensure that new activities build on existing assets, and that local communities are involved in decision making at each stage of development and delivery. A key principle of the approach is that	

Name of the intervention	Well Communities

people should come together and have fun, and a variety of opportunities are provided for people to develop their ideas into projects or help their local community. Disused open spaces and community centres are often brought back into use and contribute to the increased vibrancy of the area.

- **Participation:** Over 35,000 people have participated since 2007.The number of participants in the Well London programme constituted 36% of the entire population of 51,995 in the 11 participating neighbourhoods (although some of the participants are likely to have come from adjoining neighbourhoods). The high level of participation highlights the effectiveness of the Well London approach in engaging disadvantaged populations.

  The acceptability of the programme to local residents is evidenced by the findings from the qualitative strand of the evaluation. At an individual level, participants pointed to factors such as greater confidence and more opportunities for social networking.

  Community benefits commonly included a greater sense of community cohesion and improved links to local officials and service providers.

- **Intersectional collaboration:** A number of organisations work collaboratively to implement this intervention. including London Borough Councils, NHS, community organisations
- **Evidence based theory:** There are two main aims:
  - To provide an effective framework for communities and local organisations to work together to improve health and wellbeing, build resilience and reduce inequalities.
  - To develop the evidence base for a community development approach to health and wellbeing that will influence policy and practice to secure real enhancements to wellbeing and reductions in health inequalities in the most disadvantaged communities."
- **Innovation:** The intervention has won a number of awards. In 2011, the Well London programme won a Health Promotion and Community Wellbeing award from the Royal Society for Public Health. The award recognised the programme's achievements and innovative approach to promoting community health and wellbeing. Its approach was also endorsed by Professor Sir Michael Marmot, Director of UCL's Institute of Health Equity.
- **Transferability to the Spanish context:** Well Communities provides an ambitious model of how to create health at the community level. If Spain takes into account the differences in context, this programme could be replicated. Also, it is important to note that Phase 3 of the intervention will gather further evidence of effectiveness and cost benefits and explore how use of the framework can be scaled up across bigger geographical localities.

1.3.4.3 EPODE - Ensemble Prevenons L'Obesite Des Enfants (Together Let's Prevent Obesity in Children) - France

Name of the intervention	EPODE - Ensemble Prevenons L'Obesite Des Enfants
Country	**France, however, this programme has been implemented in over 6 countries.**
Thematic area	**Health promotion**
Link to best practice	https://epha.org/epode-together-lets-prevent-childhood-obesity/
Description and main features	

- **Aims and objectives:** To establish a large-scale, coordinated, capacity-building approach for communities to implement effective and sustainable strategies to prevent childhood obesity. EPODE takes a holistic, whole-system approach that aims to identify and address all the causes of childhood obesity and get everyone working together to tackle the causes. Stakeholders involved include parents, schools, health professionals, communities, businesses, central and local government.[13] A central coordination team uses social marketing and organisational techniques to train and coach a local project manager in each EPODE community. The project managers are nominated by the municipalities and is provided with tools to mobilise local stakeholders at all levels across the public and private sectors, through a local steering committee and local networks. The EPODE methodology has four key pillars (i) political commitment; (ii) sustainable resources; (iii) support services; and (iv) evidence. This is alongside the evaluation of the programme.
- **Strategic adequacy:** Ties into national strategies including reducing health inequalities e.g. the National Nutrition and Health Programme of 2011-2010 and the current National Programme on Food and Nutrition (PNAN).
- **Time period of implementation:** EPODE began in Northern France in 1992, in the towns of Fleurbaix and Laventie and is still ongoing.
- **Effectiveness and efficiency**: Several evaluations have noted a reduction in obesity within intervention areas compared to comparative areas in the same region. The intervention is part funded by stakeholders from industry providing a sustainable financial model.
- **Equity**: A study conducted by Borys et al. (2016)[14] noted that in seven European communities included in the study, after EPODE interventions, the low socioeconomic groups improved their health behaviours to a greater extent compared to the other socio-economic groups. This was in the area of fruit and vegetable consumption, sugary sweetened beverage consumption, screen exposure. Furthermore in the implementation of EPODE in eight French towns

[13] https://www.cypnow.co.uk/best-practice/article/epode-tackles-childhood-obesity-in-france

[14] https://www.karger.com/Article/Fulltext/446223

Name of the intervention	EPODE - Ensemble Prevenons L'Obesite Des Enfants

(see evidenced results section below), children who attended schools in deprived areas showed a decrease of 2 % (non-significant, p=0.38) in the prevalence of childhood overweight (including obesity), compared with an increase in the prevalence of overweight and obesity in children from disadvantaged households at national level.

- **Sustainability**: As noted above, the intervention is part funded by stakeholders from industry providing a sustainable financial model.
- **Evidenced results**: An evaluation of the application of the EPODE methodology in 7 countries concluded that after the EPODE interventions were implemented, the lower socioeconomic groups improved their behaviours related to energy balance (for example, the consumption of fruits and vegetables, the screen exposure and consumption of sugary drinks) to a greater extent compared to the other socioeconomic groups.
- **Participation:** the involvement of policy makers, especially local ones, is crucial to mobilise the target audience and change local environments. Also, the relevant role of the food industry in this global commitment, through the creation of innovative solutions for a wide range of healthier products was crucial.
- **Intersectoral collaboration**: A key part of the EPODE methodology is the involvement of stakeholders from a range of sectors including industry, local project coordinators who are active members of their community, parents, schools, health professionals, communities, businesses, central and local government[15].
- **Evidence and theory base:** the EPODE methodology has been refined based on the initial pilot study and is based on the four pillars of (i) political commitment; (ii) sustainable resources; (iii) support services; and (iv) evidence. This is alongside the evaluation of the programme.
- **Innovation**: The EPODE method is an innovative model for reducing childhood obesity which has resulted in numerous derivations including the JOGG method.
- **Transferability:** The EPODE method has been utilised in 20 cities in Spain (called THAO in Spain). According to our experts, this intervention seems very transferable to the Spanish context. However, it is important to mention that there is a validated and evaluated intervention for the prevention of childhood obesity (POIBA)[16] that has become a programme and could also be useful.

Summary of THAO – Spain (derived from EPODE)

THAO is a community-based intervention for health lifestyle promotion for children and families. It is derived from the EPODE methodology. It has been implemented in Spain since 2007.[17]

[15] https://www.cypnow.co.uk/best-practice/article/epode-tackles-childhood-obesity-in-france

[16] https://www.aspb.cat/poiba/

[17] https://pubmed.ncbi.nlm.nih.gov/26667707/

A longitudinal cohort study with four years of follow-up and cross-sectional study, found that an increase of 1% in the overweight prevalence after a follow-up of 4 years of Thao-Programme implementation in 10 municipalities with 6 697 children involved. The authors of the study noted that the longitudinal results are encouraging because there is a stabilisation of the overweight and obesity prevalence in the Thao municipalities over the 4 years of child growth.[18]

Drawn from the discussion of this initiative with our senior experts, there was identified another similar initiative in Spain, which is described below:

Name	POIBA: Project to prevent childhood obesity in the city of Barcelona
Country	Spain
Thematic area	Health promotion
Link to best practice	https://www.aspb.cat/poiba/
Description and main features	
■ **Aims and objectives:** Multicomponent programme (classroom, physical activity, family) to prevent overweight and obesity among schoolchildren aged 8-12 years, taking into account social and gender inequality. The programme consists of two different interventions: 1) the global intervention "**We grow up healthy**" and 2) the reinforcement of the intervention "**We grow up healthier". **The specific objectives of POIBA: – To design an obesity preventive intervention that would improve diet-related attitudes and skills, increase physical activity, reduce screen time, and increase hours of sleep. – To design and validate an ad hoc questionnaire to gather information on food, sedentariness, physical activity and screen time, and other data related to overweight and obesity. – To identify the prevalence of overweight and obesity by means of BMI calculation and body fat measurement (triceps skinfold thickness). – To assess the effectiveness of the intervention according to the characteristics of the pupils, their families and schools. – To study the homogeneity of the effect of the intervention in subpopulations of schools in low SES neighborhoods. ■ **Methodology:** The conceptual framework of the project is based on Dahlgren and Whitehead's 1991 model of social determinants.	

[18] http://www.nutricionhospitalaria.com/pdf/9736.pdf

Name	POIBA: Project to prevent childhood obesity in the city of Barcelona

- **Target population:** Schoolchildren aged 8-12 years old. The project begun in January 2009 involving 4139 pupils from 104 schools in Barcelona aged 8-9 years at baseline and a three year follow-up is planned.
- **Strategy adequacy**: NAOS (Spanish acronym for: Nutrición, Actividad Física y Prevención de la Obesidad) strategy established the lines of intervention for different programmes to promote healthy habits and lifestyles in children in Spain. This strategy defines the different environments where initiatives can be implemented: interventions on the school, about physical activity, family interventions or healthcare service interventions.
- **Time period of the implementation**: 2010 – 2014
- **Process and efficacy:** The "We grow up healthy" intervention has been evaluated, both its process and its effectiveness. The main results showed that 12 months after the baseline, there were 31% fewer new cases of obesity in the intervention group than in the comparison group, reaching 48% when the intervention was implemented in a qualified way, according to the established protocol. The effects of the intervention, which is easy to apply and sustainable, were enhanced by close adherence to the protocol.

  A study showed that better programme implementation increased effectiveness in avoiding obesity cases. Consequently, both interventions within the POIBA project have been incorporated into the portfolio of health education programmes that the Barcelona Public Health Agency offers to the city's schools.
- **Equity:** The project includes a perspective in social and gender inequalities. During the evaluation process of "We grow up healthy", disadvantaged environments were oversampled in both groups-Intervention and the comparison group-. 50% of the children belonged to neighbourhoods with a rate of Gross Disposable Household Income lower or equal to the 85.[19] This project focuses specifically on the most disadvantaged groups, which are most at risk and which receive the least support. It also intervenes in the family and school environment.[20]
- **Sustainability:** The Public Health Agency of Barcelona funded the materials and provided teacher training and technical support through community health teams. In addition, throughout the year, the teachers had direct access to the staff of the project team to clarify any doubts and problems that might arise. The teachers had access to the research staff of the project through direct telephone contact, email, and face-to- face interviews when requested by the teachers.

[19] This cut off point has been shown to be a discriminant value of SES in the city of Barcelona: Gabinet Tècnic de Programmeació. Ajuntament de Barcelona. Distribució Territorial de la Renda Familiar a Barcelona (2008). Barcelona, Economia 2009;(87):79–87.

[20] Sánchez-Martínez, F., Juárez, O., Serral, G., Valmayor, S., Puigpinós, R., Pasarín, M. I., Díez, É., & Ariza, C. (2018). A childhood obesity prevention programmeme in Barcelona (POIBA Project): Study protocol of the intervention. *Journal of public health research*, *7*(1), 1129. https://doi.org/10.4081/jphr.2018.1129

Name	POIBA: Project to prevent childhood obesity in the city of Barcelona

A study found that interventions within the POIBA programme are easy to apply and sustainable[21]. After an evaluation phase, the global POIBA intervention “we grow up healthy” was designed to be integrated into the school curriculum and to be sustainable over time, and this is currently being implemented. In addition, a sustainability plan has been developed for the intervention. It was planned thatthe intervention and its reinforcement were part of the set of health educational programmes offered by the Agència de Salut Pública de Barcelona (Spain) to schools, with funding both the cost of the training and the materials borne by the Agencia.[22]. To date, they have already been incorporated into the programme catalogue.

- **Evidenced result:** The first POIBA intervention, targeting children aged 9–10 years, reduced the incidence of obesity as measured by adiposity[23]. The intervention could prevent 1 in 3 new cases of childhood obesity in this age range. In the schools where the programme did best (qualified intervention) one in two new cases of obesity were avoided.[24] Physical activity teachers measured pupils’ physical fitness. An adaptation of the Eurofit battery[25] was used, which was designed with the advice of experts in the field and issued as a guide promoted by the project.
- **Participation:** The study involved 30% of schoolchildren born in the city in 2002, who have had a three-year follow-up. The interventions are multilevel (individual, family and school level) therefore include the participation of families and teachers.
- **Evidence and theory based**: The conceptual framework of POIBA is based on the model of social determinants described in 1991 by Dahlgren and Whitehead[26]. Similarly, the POIBA Project includes a school-based intervention, in which most determinants are those relating to lifestyles, addressing mainly those of behavioural kind.

[21] Ariza, C., Sánchez-Martínez, F., Serral, G., Valmayor, S., Juárez, O., Pasarín, M. I., Castell, C., Rajmil, L., López, M. J., & POIBA Project Evaluation Group (2019). The Incidence of Obesity, Assessed as Adiposity, Is Reduced After 1 Year in Primary Schoolchildren by the POIBA Intervention. The Journal of nutrition, 149(2), 258–269. https://doi.org/10.1093/jn/nxy259

[22] Sánchez-Martínez, F., Juárez, O., Serral, G., Valmayor, S., Puigpinós, R., Pasarín, M. I., Díez, É., & Ariza, C. (2018). A childhood obesity prevention programmeme in Barcelona (POIBA Project): Study protocol of the intervention. Journal of public health research, 7(1), 1129. https://doi.org/10.4081/jphr.2018.1129

Sánchez-Martínez F, Brugueras S, Serral G, Valmayor S, Juárez O, López MJ, Ariza C, Group OBOTPPE. (2021). Three-Year Follow-Up of the POIBA Intervention on Childhood Obesity: A Quasi-Experimental Study. Nutrients. 2021 Jan 29;13(2):453

[23] Measured through through triceps skinfold and waist circumference.

[24] Ibid. Ariza, C. et al.(2019) The incidence of Obesity… P. 32

[26] Dahlgren G, Whitehead M. (1991). Policies and strategies to promote equity in health. Stockholm: Institute for Futures Studies.

Name	POIBA: Project to prevent childhood obesity in the city of Barcelona
▪ **Innovation**: A major strength of the study is that it was the first to obtain data on overweight, obesity and its main determinants in children in a large sample of the city of Barcelona.[27] ▪ **Transferability:** The project methodology has been implemented in the city of Barcelona. Therefore, transferability to other similar areas could be feasible. Furthermore, a study[28] also found that this project could have the potential to become a local and national model for preventive interventions.	

We Grow Up Healthy "Creixem Sans": Creixem Sans is a programme to promote healthy eating and nutrition as well as physical activity and a balanced rest. The programme is aimed at students in 4th grade, that is, when they are 9 to 10 years old. The programme is developed in the classroom by the same teachers at the schools. In addition, interested schools can supplement the programme by requesting an activity to work with families. It is recommended that all teachers who complete the programme for the first time attend a 2-3-hour training session that takes place in early September of each course. The teams Community Health of the Barcelona Public Health Agency provide ongoing advice for the implementation of the programme.

1.3.4.4 JOGG - Jongeren op Gezond Gewicht - The Netherlands.

Name of the intervention	Jongeren op Gezond Gewicht
Country	**The Netherlands**
Thematic area	**Health promotion**
Link to best practice	http://chrodis.eu/good-practice/young-people-healthy-weight-jogg-netherlands/
Description and main features	
▪ **Aims and objectives:** Main aim is to reverse the increasing trend of young people (0-19 years) with overweight/obesity**.** The intervention is based on the	

[27] Sánchez-Martínez, F., Juárez, O., Serral, G., Valmayor, S., Puigpinós, R., Pasarín, M. I., Díez, É., & Ariza, C. (2018). A childhood obesity prevention programmeme in Barcelona (POIBA Project): Study protocol of the intervention. Journal of public health research, 7(1), 1129. https://doi.org/10.4081/jphr.2018.1129

Sánchez-Martínez F, Brugueras S, Serral G, Valmayor S, Juárez O, López MJ, Ariza C, Group OBOTPPE. (2021). Three-Year Follow-Up of the POIBA Intervention on Childhood Obesity: A Quasi-Experimental Study. Nutrients. 2021 Jan 29;13(2):453

[28] Ibid.33

Name of the intervention	Jongeren op Gezond Gewicht

EPODE method (see Section 1.3.4.3) and follows 5 pillars: 1) Political and governmental support 2) Cooperation between the private and public sector (public private partnership) 3) Social marketing 4) Scientific coaching and evaluation 5) Linking prevention and health care.

- **Target population**: This intervention is focussed on childhood and adolescence (aged 0 to 19), and their parents and environment. It has been implemented in 75 municipalities in the Netherlands.
- **Strategic adequacy:** JOGG is embedded within Dutch health policy as follows:
  - One of the indicators to evaluate the National Prevention Plan entitled 'everything is health', is the number of municipalities that have implemented the JOGG approach.
  - JOGG was part of the Covenant on Healthy Weight, a joint initiative of 26 organisations in the Netherlands initiated and supported by the Ministry of Health, Welfare, and Sports (MHWS). This ran until 2015 when a special JOGG Foundation was set up and financially supported by MHWS.
  - JOGG is a pillar in the Partnership Overweight Netherlands where stakeholders such as MHWS, Care Insurance Board, Dutch Care Institute and the Netherlands Diabetes Federation, and municipalities in locations where JOGG is implemented.
  - Furthermore, most Dutch municipalities include prevention of overweight and obesity in local health policy documents.
- **Time period of implementation**: Municipalities commit to implementing the JOGG approach for at least three years. The JOGG approach will continue at the national level until at least 2020.
- **Effectiveness and efficiency**: JOGG is funded at the national level by MHWS alongside a financial contribution of 5000 to 10,000 EUR per year from the municipalities, and contributions from private partners. Local contributions vary by municipality but must be committed to for a minimum of three years.
- **Equity:** JOGG focusses on those living in disadvantaged areas. Within these areas, JOGG interventions are focussed on children aged from 9 months to 4 years old. Municipalities are advised to target vulnerable groups and the activities under JOGG are adapted to address the needs of groups for low socioeconomic backgrounds or other disadvantaged groups through social marketing principles.
- **Sustainability**: As noted above, municipalities must pay a commitment fee for at least three years which entitles them to support from the national JOGG foundations. Municipalities also then appoint a local JOGG coordinator to implement the approach. JOGG is embedded within municipalities at a political level, as municipalities are required to adopt the approach and embed in their local policies, and to monitor and evaluate its progress. The national JOGG foundations supports municipalities and partners in relation to sustainability.
- **Evidenced results**: JOGG has been monitored in five municipalities in the Netherlands, as follows:

Name of the intervention	Jongeren op Gezond Gewicht

- In Zwolle, from 2009 to 2012 the percentage of overweight primary school children decreased from 12.1% to 10.6%.
- In Utrecht, from 2010 to 2014 the percentage of overweight primary school children in JOGG neighbourhoods decreased from 25% to 22%.
- In Dordrecht West, from 2012 to 2013 the percentage of overweight primary school children decreased from 35.2% to 34.1%.
- In Amsterdam, from 2011 to 2013 the percentage of overweight primary school children at two JOGG schools in Nieuw West decreased from 41.5% to 37.4%.
- In Rotterdam, in 2013 the percentage of overweight primary school children has stabilised.

- **Participation:** JOGG municipalities are encouraged to carry out a needs assessment to involve all relevant stakeholders and partners and to consult with the target groups. Stakeholder meetings are organised in the early stages of planning JOGG in the municipality, and locals can take part in steering groups, partner groups and working groups.
- **Intersectoral collaboration:** as in EPODE, intersectoral collaboration is integral to JOGG, involving stakeholders across neighbourhoods, schools, homes and health care settings.
- **Evidence and theory base:** The JOGG model is based on EPODE.
- **Innovation:** JOGG is the first time that the EPODE method has been applied within the Dutch context.
- **Transferability:** The intervention shows potential to be applied at the municipal level to the Spanish context using the JOGG method. Both thematic experts agree on the fact that this intervention could be replicated into the Spanish context. What it is interesting about this best practice is the multi sector and comprehensive approach. The results of the evaluation seem modest; however, it is not certain whether this is an indication of overall success. It provides a good model and is built on EPODE. Also is a good example of replication and can be used in a wide variety of settings.

1.3.4.5 Let’s live healthily! - Slovenia

Name of the intervention	Let’s live healthily!
Country	Slovenia
Thematic area	Health promotion

Name of the intervention	Let’s live healthily!
Link to best practice	https://webgate.ec.europa.eu/dyna/bp-portal/practice.cfm?id=92

Description and main features

- **Aim and objectives:** To improve health and to enable inhabitants of a deprived region to take an active role in health promotion and protection, while encouraging local stakeholders to foster the conditions to make this possible. The programme focuses on specific risks factors and a reduction in heart disease, hypertension, cancer, and diabetes.
- **Methodology:** Health promotion intervention in eight local communities with the aim to achieve better health, encouraging participation of the local inhabitants in improving their own health. Activities developed and implemented under the ‘Let’s Live Healthily!’ programme differ per region and community. A key success factor of the pilot project and programme is its bottom-up approach, which reflects the needs, desires, specificities and capacities of the communities and the regions. It was important to culturally adjust and implement the programme to the needs and interests of the local communities. Another key success factor was that it relied and built on local resources and capacities, adopting a partnership approach, as well as setting realistic objectives which can be met within the local context. Examples of the low-threshold community and outreach measures include: Workshops on healthy cooking, joint walking tours with the vulnerable groups and measuring risk factors for Cardiovascular Diseases (CVD) in shopping centres.
- **Target population**: adult people living in rural areas.
- **Strategic adequacy:** Programme has been implemented to the regions in Slovenia as part of Slovenia’s National public Health Programme.
- **Time period of implementation:** 2001–present
- **Effectiveness and efficiency:** Coming today, the ‘Let’s Live Healthily’ programme has been continuously implemented in 50 local communities in the Pomurje region and successfully transferred to all other regions in Slovenia as part of the National Public Health Programme. It has not only impacted the lifestyle of the participants but also enhanced social cohesion and capacities in the communities where it is implemented.
- **Equity:** Programme focuses on promoting healthy lifestyles of adult people living in rural areas in Slovenia. The population identified on this programme were from the rural region in the north east of Slovenia which faces high levels of unemployment, low average levels of education, a high level of rural population and high poverty rates.
- **Sustainability**: To ensure sustainability, it is crucial to build on available infrastructure resources and tailor actions to existing human and financial resources. Investing in the development of human resources is a crucial precondition to implementing and rolling out the programme.
- **Evidenced results:** The initial pilot project was evaluated showing excellent results that indicated that it was very well-received among the target group, and

Name of the intervention	Let's live healthily!

that the selected approach had been successful. It was therefore taken up as a strategic objective of the regional action plan to tackle health inequalities in the Pomjure Region and transferred across Slovenia.

- The 'Let's Live Healthily' programme has been continuously implemented over 12 years in 50 local communities in the Pomurje region and successfully transferred to all other regions in Slovenia as part of the National Public Health Programme. It has not only impacted the lifestyle of the participants but also enhanced social cohesion and capacities in the communities where it is implemented.
- According to the project's Action for Health Report, an internal evaluation conducted found that almost all process and outcome indicators were achieved. Project measured an improvement in lifestyle indicators amongst adults in the Pomurje region.
- Pre- and post-evaluations of participants in the «Let's Live Healthily» show increased knowledge, skills and awareness of healthy lifestyles, as well as increased physical activity levels. They also show sustained nutritional changes among the majority of participants.

- **Participation:** The programme enhanced social cohesion and capacities in the communities where it is implemented.
- **Intersectoral collaboration:** The programme has involved the health, education and social sectors as well as regional and local administrations and planning boards. This programme was recognised as a tool to initiate cooperation between sectors that may see the same health problem from different angles, and agree to take collective ownership of that problem. During the programme it is important to build an expert team with knowledge of health promotion but also from different but complementary fields (medical doctors, nurses, anthropologists, food and nutrition specialists, environmental health specialists, teachers, etc.). Involving interest groups outside the health system in the analysis of health problems in the region is an effective way to build alliances and increase the commitment of regional partners to work on shared objectives.
- **Evidence and theory base:** The programme grew out of a pilot project that was initially targeted at the adult population in rural communities in the Pomurje Region of Slovenia. The pilot project was initially designed based on evidence gathered indicating that mortality rates due to CVD were much higher, and access to health care were lower than the average in Slovenia, due to the lower average number of medical doctors in the rural population of Pomurje. The region has also faced environmental problems and de-population. Region faced social and health inequalities compared to other Slovenian regions. The available data also indicated that the poorer health of the adult population of the Pomurje, particularly of the inhabitants of local rural communities, can be largely attributed to poor lifestyle habits. They were susceptible to insufficient use of preventative health care services, exposure to passive smoking and unhealthy nutrition habits during pregnancy and childhood.
- **Innovation:** The pilot project was the first to recognise and address the issue of health inequalities in Slovenia. Furthermore, the pilot also it included local

Name of the intervention	Let's live healthily!
	coordinators and all structures of local community, and it utilised interactive workshops. ▪ **Transferability:** The intervention has proved highly transferable into other regions in Slovenia. The key lessons learnt reflect what is needed for transfer to be successful and the programme to be sustainable: – The importance of setting realistic, S.M.A.R.T. (specific, measurable, attainable, relevant and time-bound) objectives. Particular attention was dedicated to defining these at the start of the project. Very often it takes years to measure the effect of health promoting activities. To persuade policy and decision makers to support health-promoting activities, it is important to create objectives with outcomes that can be visible in a short time frame, a year for example. Unrealistic objectives set over long time-frames risks de-motivating interest groups and funders (political supporters). Strategic objectives can be modified on the basis of the experiences and results of implementation. – Successful health-promoting measures must be tailored to the target group and be acceptable to them; the uptake of activities must be done by the target group themselves. – To ensure sustainability, it is crucial to build on available infrastructural resources and tailor actions to existing human and financial resources. Investing in the development of human resources is a crucial precondition to implementing and rolling out the programme. It is important to build an expert team with knowledge of health promotion but also involve different but complementary fields (medical doctors, nurses, anthropologists, food and nutrition specialists, environmental health specialists, teachers, etc.). – Involving interest groups outside of the health system in the analysis of health problems in the region is an effective way to build alliances and increase the commitment of regional partners to work on shared objectives.

1.3.4.6 Samenoud (Embrace)- The Netherlands

Name of the intervention	Samenoud (Embrace)
Country	**Netherlands**
Thematic area	**Health promotion**
Link to best practice	https://webgate.ec.europa.eu/dyna/bp-portal/practice.cfm?id=318
Description and main features	

Name of the intervention	Samenoud (Embrace)

- **Aims and objectives:** Embrace is a new primary care model for community-living people aged over 75 years on perceived quality of care. The objective of this programme is to facilitate the ability for older adults to age in their own personal environment by supporting self-management, providing prompt attention to changes in health status, and to preclude amplifying health-related problems.
- **Target population and equity**: older adults with different levels of health and different locations, three municipalities (rural, urbanised rural and industrial).
- **Methodology:** Embrace (Samenoud) is a population-based, person centred and integrated care service for community-living older adults based on the chronic Care Model (CCM)[29] and the Kaiser Permanente Triangle.[30] This population health management model classifies older adults living in the community. The delivery system design includes Elderly Care Teams (ECTs). These multidisciplinary teams are led by the GP, and include an elderly care physician, a district nurse, and a social worker.

  Embrace connects the health system with the community services, and reflects the four key elements of the Chronic Care Model (CCM):

  Self-Management support: helping patients and their families to actively participate in the health care process by using evidenced-based self-management support strategies.

  – Delivery system design: creating primary health care teams that deliver and coordinate proactive, preventive, and coherent care and support, monitor both the process and quality of care, and guarantee follow-up for patients.

  – Decision support: using evidence -based treatment protocols and guidelines by professionals and patients by incorporating them into daily practice.

  – Clinical information systems: electronic patient information system allows on-site access to essential patient information by professionals and patients, treatment, and planning.

  Older adults are stratified into three risk profiles, and the intensity, focus and individual or group approach of the care and support depends on the older adult's risk profile.

  – Complex care needs: concerning participants with complex care needs at risk of assignment to a hospital or nursing home.

  – Frail: participants at risk of complex care needs.

  – Robust: participants at risk of the consequences of aging only
- **Participation:** 1.456 older adults participated in Embrace.
- **Intersectoral collaboration**: Each General practice consists of a multidisciplinary Elderly Care Team: a GP, an elderly care physician and two

[29] Coleman K., Austin, B.T., Brach, C.,. Wagner, E.H. (2009) Evidence on the Chronic Care Model in the new millennium. Health aff (Milwood) 2009; 28(1): 75-85

[30] Singh, D., Ham, C., (2006) Improving care for people with long-term conditions: A review of UK and international frameworks. Birmingham: NHS Institute for innovation and implementation.

Name of the intervention	Samenoud (Embrace)

case managers (district nurse and social worker). The Integrated Care Model combines community organisations with the health care system.

- **Strategy adequacy:** The Dutch Ministry of Health, Welfare and Sport launched the 'National Care for the Elderly Programme in 2008, with the goal of transforming the Dutch Healthcare system for older adults. The goal of this programme was to improve care, quality of life and self-reliance of older people by restructuring care and support, with the prerequisite that the integration, quality and costs of the care and support had to improve. Eight Dutch university medical centres started regional collaboration and launched about 75 projects, one of them was Embrace.[31]
- **Time period of implementation**: 2010-ongoing.
- **Effectiveness and efficacy**: .The intervention found modest effects, the most obvious were for elderly people who received case management.[32]
- **Sustainability:** Part of the programme funding comes from grants, health authorities, insurers, municipalities, etc.
- **Evidenced results:** A randomised study[33] showed that Embrace slightly improved the perceived quality of care, particularly for elderly people with complex care needs for whom case management was organised. Caregivers judged implementation of integrated care to be greatly improved, though there was still room for further improvement.
- **Innovation:** Embrace is one of the first care models that aims to offer all independently living elderly people, a person-oriented and integrated care and guidance. It also introduces the use of clinical information system, represented by the Electronic Elderly Record System, a web-based application built for both clinical and research purposes.
- **Transferability:** According to our senior experts this is a very interesting programme for the elderly that show potential of transferability for the Spanish context.

1.3.4.7 Hartslag Limburg (Heartbeat Limburg)- The Netherlands

[31] Spporenberg, S., (2017) Embracing the perspectives of older adults in organising and evaluating person-centred and integrated care. Date Available at: http://www.sophiespoorenberg.nl/publicaties/proefschrift/

[32] Uittenbroek, R. J., Kremer, H., Spoorenberg, S., Reijneveld, S. A., & Wynia, K. (2017). SamenOud, geïntegreerde ouderenzorg in de eerste lijn [Embrace, integrated primary care for older adults]. *Nederlands tijdschrift voor geneeskunde*, *161*, D1141.

[33] Uittenbroek, R.J., Spoorenberg, S.L.W., Brans, R. *et al. (2014)* SamenOud, een model voor geïntegreerde ouderenzorg: studieprotocol van een gerandomiseerde studie naar de effectiviteit betreffende patiëntuitkomsten, kwaliteit van zorg, zorggebruik en kosten. *Tijdschr Gerontol Geriatr* **45,** 92–104. Available at: https://doi.org/10.1007/s12439-014-0062-8

Name of the intervention	Hartslag Limburg (Heartbeat Limburg)
Country	The Netherlands
Thematic area	Health promotion
Link to best practice	http://www.slohealthcounts.org/promisepractice/index/view?pid=3346
Description and main features	

- **Aim and objectives**: Hartslag Limburg is an integrative community-based cardiovascular disease prevention programme promoting a healthy lifestyle.
- **Methodology:** The theoretical framework behind the project was based on up-to-date programme planning and evaluation models, consisting of several stages. The model postulated that a reduction in CVD among the population of Maastricht region could be achieved by means of changes in related risk behaviours. The programme design consisted in a network formed by a large number of participating organisations. The coordinator of the campaigns was the Regional Public Health Institute of Maastricht, other health promotion organisations, the local hospital, general practitioners, welfare services and local authorities. Each of these agencies implemented a number of CVD prevention interventions, and also contributed financially, the network served as the starting point for the implementation of interventions.[34]
- **Target population**: The target population consisted of all inhabitants of the region (n = 180.000). The intervention was implemented in the region of Maastricht (120,000 inhabitants) and four adjacent municipalities (60,000 inhabitants).
- **Equity:** Hartslag Limburg integrates two strategies: (1) a population-wide strategy aimed at all inhabitants with a focus in low socioeconomic status groups, and (2) a subgroup strategy focused on individuals diagnosed with cardiovascular diseases (hereinafter CVD) or multiple physical risk factors for CVD. Between 1999-2003, almost 50% of the interventions (790 interventions) took place in low-income areas. Special attention was paid to reach persons with a low socio-economic status and high-risk community members.
- **Participation:** for the organisation, development, implementation and dissemination of this intervention the participation of the community in the project and intersectoral collaboration were crucial.[35]
- **Intersectoral collaboration:** The main partners in the community project were the city councils of Maastricht and the four adjacent municipalities, the Regional Public Health Institute Maastricht (RPHI), two community social work organizations, and the regional community healthcare organization.

[34] Ronckers, E. T., Groot, W., Steenbakkers, M., Ruland, E., & Ament, A. (2006). Costs of the 'Hartslag Limburg' community heart health intervention. *BMC public health*, *6*, 51. https://doi-org.ezproxy.ub.unimaas.nl/10.1186/1471-2458-6-51

[35] Ronda, G., Van Assema, P., Ruland, E., Steenbakkers, M., & Brug, J. (2004). The Dutch Heart Health Community Intervention 'Hartslag Limburg': design and results of a process study. *Health education research*, *19*(5), 596–607. https://doi-org.ezproxy.ub.unimaas.nl/10.1093/her/cyg076

Name of the intervention	Hartslag Limburg (Heartbeat Limburg)

Collaboration among these partners was achieved through nine intersectoral local health committees, collaboration with experts in the planning and implementation of activities, and expert training for the members of the Health Committees.

- **Time period of implementation:** 1999-2003
- **Effectiveness and efficiency:** Different studies have been produced to evaluate Hartslag Limburg.

  A study[36] was carried out in 2003 to investigate the net effect after five years of intervention, comparing the mean change in risk factors between men and women in the intervention with other men and women in a reference region. Results show that men and women in the intervention region had a favourable change in some CVD risk factors compared to the individuals of the reference area. For example, this study showed change in body mass index (BMI), waist circumference, and blood pressure after five years of intervention.

  Cost-effectiveness of the intervention was measured with Chronic Disease Model of the National Institute of Public Health and Environment (RIVM)[37] in a study analysing the cost and effects of two Dutch. The study found Harstlag Limburg being cost effective.
- **Sustainability:** A total of 790 interventions over the five-year period of the programme and evaluation costed 900.000 euros. The total cost for the coordinating agency was 10%, while 90% of the programme was funded by the programme's network and external subsidy providers. A study [38]showed that the implementation of this community programme improved by sharing the costs between different actors (through subsidies, funding or sponsorships).
- **Evidenced results:** A cohort study comparing the 5-year mean change in risk factors between the intervention community and a control community was carried out. Individuals in the intervention community reduced or prevented age- and time-related increase in body mass index (BMI), waist circumference, blood pressure, and non-fasting serum glucose concentration. Risk factors changed unfavourably in the reference group. The adjusted difference in mean change in these risk factors between intervention and reference group was significant ($p < 0.05$).

[36] Schuit, A. J., Wendel-Vos, G. C., Verschuren, W. M., Ronckers, E. T., Ament, A., Van Assema, P., Van Ree, J., & Ruland, E. C. (2006). Effect of 5-year community intervention Hartslag Limburg on cardiovascular risk factors. *American journal of preventive medicine*, *30*(3), 237–242. Available at: https://doi.org/10.1016/j.amepre.2005.10.020

[37] Bemelmans, W., Van Baal, P., Wendel-Vos, W., Schuilt, J., Feskens, A.A. & Hoogenveen, R. (2008) The costs, effects and cost-effectiveness of counteracting overweight on a population level. A scientific base for policy targets for the Dutch national plan for action. Preventive Medicine 46-2. Available at: https://doi.org/10.1016/j.ypmed.2007.07.029

[38] Ronckers, E. T., Groot, W., Steenbakkers, M., Ruland, E., & Ament, A. (2006). Costs of the 'Hartslag Limburg' community heart health intervention. *BMC public health*, *6*, 51. https://doi-org.ezproxy.ub.unimaas.nl/10.1186/1471-2458-6-51

Name of the intervention	Hartslag Limburg (Heartbeat Limburg)
	The community intervention Hartslag Limburg succeeded in preventing age- and time related unfavourable changes in energy intake, fat consumption, walking, and bicycling[39] particularly among women and those with low SES. ▪ **Innovation:** The programme was based in a unique design as presented above. In January 2001, the World Health Organization selected Hartslag Limburg as one of the twelve demonstration projects based on the potential to adhere to the criteria of "Towards Unity for Health".[40] ▪ **Transferability**: Heartbeat Limburg is another example of a specific programme that could be implemented in Spain. It has a robust evaluation which adds a lot of value to this intervention. The programme was proved to be successful in small municipalities. However, Dutch funding mechanisms may be different to Spanish funding mechanisms. Therefore, if chosen they will need to be adapted to our context.

Examples of major interventions under the Hartslag Limburg **project are**: nutrition parties; debt assistance (people with debts are taught to cook a healthy meal on a small budget); printed guides showing walking and cycling routes; a daily TV guide, aerobics programme, including information about the health advantages of exercising; and antismoking campaigns using billboards, posters, leaflets, computer-tailored nutrition education, nutrition education tours in supermarkets, public–private collaboration with the retail sector, television programmes, food labelling, smoke free areas, stop-smoking campaign, in addition to commercials on local television and radio, newspaper articles, and pamphlet distribution.[41]

1.3.4.8 Community Food Initiative Ireland

Name	Community Food Initiative Ireland
Country	**Ireland**
Thematic area	**Health promotion**

[39]Wanda Wendel-Vos, G. C., Dutman, A. E., Verschuren, W. M., Ronckers, E. T., Ament, A., van Assema, P., van Ree, J., Ruland, E. C., & Schuit, A. J. (2009). Lifestyle factors of a five-year community-intervention programme: the Hartslag Limburg intervention. *American journal of preventive medicine*, *37*(1), 50–56. https://doi-org.ezproxy.ub.unimaas.nl/10.1016/j.amepre.2009.03.015

40 Boelen, 2001 in Ronda, G., Van Assema, P., Ruland, E., Steenbakkers, M., & Brug, J. (2004). The Dutch Heart Health Community Intervention 'Hartslag Limburg': design and results of a process study. Health education research, 19(5), 596–607. https://doi-org.ezproxy.ub.unimaas.nl/10.1093/her/cyg076

41 Wendel-Vos, G. C., Dutman, A. E., Verschuren, W. M., Ronckers, E. T., Ament, A., van Assema, P., van Ree, J., Ruland, E. C., & Schuit, A. J. (2009). Lifestyle factors of a five-year community-intervention programme: the Hartslag Limburg intervention. American journal of preventive medicine, 37(1), 50–56. https://doi-org.ezproxy.ub.unimaas.nl/10.1016/j.amepre.2009.03.015

Name	Community Food Initiative Ireland
Link to best practice	http://chrodis.eu/wp-content/uploads/2017/03/community-food-initiatives.pdf

- **Aim and objectives:** Community Food Initiative Ireland aims to promote greater access and availability of healthy and safe food in low-income areas through a programme of local projects using a community development approach, across the island of Ireland. The programme also aims to positively influence the eating habits of families in low-income communities by addressing the barriers to having a healthy diet and supporting greater access to affordable and healthy food at a local level. The programme supports and encourages the involvement of ten individual community projects, through shared learning, training and collaboration.
- **Methodology:** The initiative funded 10 community food initiatives over three years from 2013 to 2015.
- **Target population:** adults responsible for food shopping and meal preparation for their family and/or their children. This intervention is targeted at low-income groups.
- **Equity:** Many equity dimensions were considered through this initiative and the 10 host organisations only work in disadvantaged areas and the initiatives target audience is specifically families and young people experiencing food poverty in low-income areas in both rural and urban areas. The initiatives also encouraged participation of all low-income community members successfully engaged hard-to-reach marginalised groups including such as men and the migrant population.
- **Participation:** the initiatives encouraged the participation of a range of groups in their local area.
- **Intersectoral collaboration:** The programme involved 10 individual community projects who all collaborated, shared learning and took part in training together. There was collaboration between local population, community-based organisations and local authorities among other stakeholders.
- **Time period of implementation:** 2013 - 2015
- **Sustainability:** Each host organisation encourages local ownership to ensure long-term sustainability of the projects.
- **Evidenced results:** The initiatives were successful in engaging a range of hard-to-reach groups in low-income areas. In year one, the ten initiatives engaged with more than 12,000 persons in activities related to healthy eating, growing food and cooking skills.

Drawn from the review of this initiative with our senior experts, there was identified a similar intervention in Spain, which is described below:

Barcelona Salut als Barris – Barcelona Health in the Neighbourhoods

Name	Barcelona Salut als Barris – Barcelona Health in the Neighbourhoods
Country	Spain
Thematic area	Health promotion
Link to best practice	https://www.aspb.cat/arees/la-salut-en-xifres/la-salut-als-barris/ Catalan version: https://www.youtube.com/watch?v=iK2qtcBlvgc&feature=youtu.be Spanish version: https://www.youtube.com/watch?v=N7mrl6N8Wgw English version: https://www.youtube.com/watch?v=qeVSLK1dPC0&list=PLJpPY7X6uuoDkcg5OT7c7zGC4YSQPfaaA&index=26

Description and main features

- **Aims and objectives:** Community strategy to reduce the impact of social determinants of health of those living in the most underprivileged neighbourhoods in Barcelona. Example of activities undertaken as part of this programme are drug substances' consumption prevention, contraceptive advice, parenting skills programme and also the promotion of social and mental wellbeing.
- **Target population and equity**: The preferred action groups are children, young people, women, the elderly, and immigrants. The strategy focuses on the most disadvantaged neighbourhoods.
- **Methodology:** The strategy uses a systematised methodology structured in five phases of a cyclical process, each of them has the participation of stakeholders and the community's participation.
  - First Phase: search for alliances within the territory and creation of an intersectoral working group.
  - Second Phase: assessment of available resources and the health needs in the neighbourhood. To agree in the lines of action.
  - Third phase: an action plan to design and implement evidence-based interventions.
  - Fourth phase: monitoring and evaluation of the interventions.
  - Fifth phase: sustainability.
- **Participation:** Maximum community participation was found in the second phase which focused on the detection of health assets and needs of the neighbourhood. Furthermore, the third phase: 'action plans' had high participation of the working group. Direct participants of interventions can be found below:
  - 2018: 13.600
  - 2017: 11.734
  - 2016: 9.961

Name	Barcelona Salut als Barris – Barcelona Health in the Neighbourhoods

- 2015: 4.560

- **Intersectoral collaboration:** The strategy counts with the participation of:
  - The Government of Catalonia. Department of Health: General Directorate of Public Health, General Directorate of Planning, CatSalut and suppliers.
  - City councils: health areas, social services, and the Neighbourhood Law office.
  - Primary Health Care
  - Local entities: Third sector and neighbourhood associations.
- **Strategy adequacy**: In 2004, the Catalonia Neighbourhoods Law (Law 2/2004) was designed to improve living conditions in the most disadvantaged neighbourhoods of Catalonia, mainly through town planning interventions. A year later, the Health in the Neighbourhoods programme was developed by the Catalonian Department of Health to improve the health of residents of those neighbourhoods benefitted by the Neighbourhoods Law and to reduce social inequalities in health between neighbourhoods through community health interventions. In Barcelona, this programme was reinforced and called Barcelona Health in the Neighbourhoods (BHiN). BHiN is a community health programme carried out in the most disadvantaged neighbourhoods of Barcelona to reduce health inequalities between them and the rest of the city. The programme was launched in 2007 with the co-leadership of: a) the Public Health Agency of Barcelona; b) the institution responsible for health care in the city (Consorci Sanitari de Barcelona); and c) the city Council. Nowadays, BHiN is one of the oldest community health strategies in Spain.
- **Time period of implementation**: 2007 - ongoing
- **Effectiveness and efficacy:** In 2018, BHiN produced 183 interventions, most of the interventions assessed showed improvements in the health of participants, which could help to reduce health inequalities. The diagnostic procedure used in the BHiN programme allows for a better understanding of the community and its needs, including the availability of resources and health assets to address them. The ties between the different agents involved in the territory are strengthened (neighbours, public service professionals, entities ...), it represents an opportunity for the development of leadership and empowerment of the community, and it facilitates orientation to the action in the subsequent phases of the programme.
- **Sustainability:** Political commitment over the last four years contributed very positively to the sustainability and maturity of BHiN and was translated into higher economic and human resources. Between 2016 and 2018, the budget tripled since social inequalities in health became a priority in the political agenda. The budget of the programme in 2018 was 1.489.138,79 euros.

Name	Barcelona Salut als Barris – Barcelona Health in the Neighbourhoods

- **Evidenced results:** Most interventions have been evaluated and showed positive results.[42]
  - A parenting skills programme improved child-rearing skills and social support among parents, and reduced children's negative behaviours and parental stress.
  - A community counselling intervention increased the consistent use of contraception in participants and reduced adolescent fertility rates in the neighbourhoods included in the programme.
  - An intervention providing weekly outings for elderly people isolated at home due to architectural barriers improved self-rated health and mental health, and reduced participants' anxiety.
  - An occupational training programme for young people increased young women's self-esteem.
- **Transferability:** The project methodology has been implemented in 25 neighbourhoods of the city of Barcelona, proving excellent results. BHiN is a good example of a community health programme aiming to tackle health inequalities. The experience of these 12 years may serve future programmes in other territories with similar objectives. Key factors in its scope and results are political will, strong technical capacity and methodology, economic resources, strong partnerships and continued intersectoral and community work.

1.3.5 Pre- selected best practices and potential transferability to the Spanish Context: Best practices in Physical and Functional Environments

1.3.5.1 Free to move (Liberi di muoversi)- Italy

Name	Free to move (Liberi di muoversi)- Italy
Country	Italy, Piacenza municipality
Thematic area	Physical and Functional Environments

[42] Daban F, et al. Barcelona Salut als Barris: Twelve years' experience of tackling social health inequalities through community-based interventions. Gac Sanit. 2020. https://doi.org/10.1016/j.gaceta.2020.02.007

Name	Free to move (Liberi di muoversi)- Italy
Link to best practice	https://www.dors.it/page.php?idarticolo=3235

Description and main features

- **Aims and objectives**: to promote active mobility that expands to embrace broader themes by working, "vertically", on the urban and school context by designing in a participatory way an environment that allows children to move actively, safely and in a joyful way. Through the use of a "toolbox" - built by teachers and based on the principles of teaching by skills - children and their families are accompanied to observe themselves, the context and the environment in which they live with more attentive eyes, to understand how even the small choices of daily life can have an important impact on oneself and on the environment that surrounds us, for a true process of community empowerment.
- **Target population**: School teachers and primary school students (6-10 years), parents.
- **Strategic Adequacy**: Liberi di muoversi project was conducted according to the principles of a broader national programme “Gaining Health". The Protocol was established based on the mandate of the 2010-2012 Regional Prevention Plan and on the methodological references identified during the project "Promotion of physical activity - Actions for a healthy life", which had been shared within the regional network for the promotion of physical activity of the Emilia-Romagna Region.
- **Time period of implementation**: 2013 – 2016
- **Effectiveness, efficiency:** Upon completion of the project, it proved to be an effective tool not only for the promotion of physical activity in childhood, but also for developing effective advocacy action on the issue of active mobility and environmental sustainability. Although “Free to move” is an autonomous project, it shares synergies with other local interventions in favour of active and sustainable mobility. These interventions are carried out in the same school or territory. An example of this is the Pedibus project that constructed home-school walking routes (currently active with 21 lines in 11 primary schools in the city). The “Free to Move” project benefited from the already existing pathways in this project.

  The data from the pilot experience in one school showed that sustainable home-school mobility avoided the production of about 34,500 kg of CO_2, and therefore replaced the "work" of 1,151 trees. The average calories consumed by children who went to school on foot or by bike were also estimated to evaluate the benefits in terms of health and daily physical activity.
- **Equity:** The municipality of Piacenza is characterised by multiculturalism. The activities are developed from the interaction between teachers and children, so they can take into account the starting conditions of the children and also the diversities (cultural origin and socio-economic condition) that can influence the approach to health issues. This equity-oriented approach is aimed at taking into account the characteristics of participants and encourages the participation of

Name	Free to move (Liberi di muoversi)- Italy
	recipients in the development of activities that concern them. This not only gives better results but also increases the chances to reduce health inequalities.

- **Sustainability:** The regional council provided funding to the Piacenza health service authorities for the implementation of the programme. However, the tools for the intervention were entirely developed by the intermediate recipients (primary school teachers) in order to be fully integrated into the curricular activities to guarantee the long-term sustainability. A total budget of 9,000 euros was foreseen for the realisation of the project.
- **Evidenced results**: During the first year of the intervention, teachers were asked to monitor the process through the systematic documentation of the activities carried out and to measure the achieved results through tools for assessing the skills that can be used to measure programme results. The evaluation included:
  - The monitoring of the activities with respect to the time frame foreseen by the memorandum of understanding (hereinafter MoU), and the discussion within the project group of the critical issues and opportunities encountered the comparison of what emerged with respect to the specific objectives formalised by the MoU.
  - The discussion regarding the sustainability and transferability of the project and the evaluation of the effectiveness of the project was instead carried out by the intermediate recipients, by the teachers, who developed a shared set of tools (evaluation rubric, reality tasks, meta-cognitive self-assessment) able to detect the development of skills taking into account the goals shared with the children and each one's starting point.
  - The teachers then returned to the project group a summary of the evaluation carried out on the individual children. Didactic assessment tools include: an observatory methodology through a “reality task”. Children were presented with a situation and it was observed how they reacted. On the basis of their reaction goals were defined with the children and the activities where developed to achieve them.
  - The assessment of learned skills was carried out by observing the behaviour of children in real or simulated situations.
- **Participation:** The project is built through a participative method in two primary schools. The educational relationship in schools provides for the active participation of the subjects involved (children, teachers, adults) in a collaborative dimension of jointly research. For example: the necessary activities, integrated into the teaching subjects, have been developed in a flexible way to be adapted to the context so the teaching methodology can be adopted by the teacher. The development of the different activities was conducted with the participation of the children through the "reality task" method[43], which also allows for an assessment of progress in developing skills. The activities

[43] Reality task method: The assessment of learned skills is carried out by observing the behaviour of children in real or simulated situations. The children are offered a situation and observe how they react. On the basis of what emerges, objectives are defined together with the children and activities are developed to achieve them.

Name	Free to move (Liberi di muoversi)- Italy
	developed from the interaction between teachers and children, enable to take into account the starting conditions of the group, and also the diversities. ▪ **Intersectoral collaboration**: The project represents a collaborative planning experience between the Local Health Authority, the Municipality and the Piacenza Territorial School Office, education authorities and associations. It is an example of how a transversal, intersectoral and interinstitutional collaboration can bring well-being and growth to the community where it is carried out. This collaboration allowed for a participatory planning through every step of the process from the context assessment to the end of the activity. In the first phase, the involvement of the community surrounding the school and attention to environmental determinants prevailed. This allowed to create conditions for collective political and social action, which was indispensable to significantly affect the factors that determine the ways of moving cities. ▪ **Evidence and theory based:** The project follows a participatory community planning according to the precede-proceed model.[44] ▪ **Innovation:** This project was recognised as a best practice by the DORS (in Italian: Centro Regionale di Documentazione per la Promozione della Salute). Prior to this project, there was very little collaboration on health promotion between the local health authority and the municipality through the Territorial School Office, nor an exchange of information between the institution's activities organised around health promotion. ▪ **Transferability:** Similar interventions also exist in Spain such as " Camino Escolar[45]" implemented in Zaragoza or Pontevedra. The methodology of this project is aimed as a toolbox kit that teachers and those involved in health promotion and sustainability can draw on to achieve what they want and can build in their own context, increasing the potential for transferability.

1.3.5.2 Dose of Nature Prescription Service

Name	Dose of Nature Prescription Service
Country	**UK, Borough of Richmond**

[44] The PRECEDE-PROCEED model is a comprehensive structure for assessing health needs for designing, implementing, and evaluating health promotion and other public health programmes to meet those needs. The PRECEDE-PROCEED model invites participation from community members, and has the potential to increase community ownership of the programme.

[45] https://www.zaragoza.es/ciudad/caminoescolar/que.htm

Name	Dose of Nature Prescription Service
Thematic area	**Physical and functional environments**
Link to best practice	https://www.doseofnature.org.uk

Description and main features

- **Aims and objectives:** A Dose of Nature prescription is a ten-week programme that introduces individuals to the mental health benefits of spending time in nature. It aims to inspire lifestyle changes that will have a significant and lasting impact on mental wellbeing. This is achieved through a combination of education, first-hand experience and practical and motivational support, led by a trained Dose of Nature Guide**.**

  Alongside one-to-one contact with the Dose of Nature Guide, clients are also given the opportunity to link with other people in receipt of a nature prescription, and to make independent arrangements to meet for walks or to visit natural environments together. This is an optional, additional element of our Dose of Nature prescription that many people find a highly effective way of ensuring they continue to spend time in nature once the ten-week programme has been completed.
- **Target population:** this programme is designed for:
  - Anyone who feels low, depressed or anxious
  - Anyone who feels stuck in negative patterns of behaviour and wants to make significant changes to their life
  - Anyone experiencing difficulties sleeping
  - Anyone who has suffered trauma in their life
  - Anyone who has suffered from domestic violence
  - Anyone with symptoms associated with a diagnosis of obsessive compulsive disorder (OCD) or attention deficit hyperactivity disorder
  - Anyone willing to improve their engagement with the natural world
- **Strategic Adequacy:** Improving mental health condition of individual and communities. Aligns with health strategies in Bristol.
- **Time period of implementation:** unclear. Now the programme is on hold due to the pandemic.
- **Ethical aspects:** Passed ethics requirements of service prescribed by GP.
- **Effectiveness and efficiency:** No evaluation results are publicly available.
- **Equity:** This intervention is likely to reach vulnerable clinical groups, such as people suffering from depression, anxiety, trauma, obsessive compulsive disorder (OCD) or attention deficit hyperactivity disorder (ADHD), or women who have been victims of domestic abuse. There are also working groups that

Name	Dose of Nature Prescription Service
	address a wider spectrum of non-clinical groups, including primary and secondary age school pupils, students, pregnant women, new parents, older adults, refugees, company employees. However, it remains unclear what is the price to access this programme. In terms of equity, free access to these services would encourage participation from lower-income communities. High prices (or even reduced prices) would be an extra barrier to reach people in such communities. ▪ **Sustainability:** Green spaces that are accessed are free at the point of use. The cost of training the Dose of Nature Guides is unclear, but the guides volunteers so costs of running the service are limited. Improvements in mental wellbeing may reduce costs for NHS. Regular connection and exposure to nature: participants are probably more likely to protect and respect the natural environment. Also, there is a social sustainability component meeting diverse people with different mental health situations may decrease stigmatization and discrimination against people suffering from mental health – therefore, creating a more resilient and connected society[46]. ▪ **Evidenced results:** Evidenced results of this programme could not be found. However, there is other research showing that spending time in nature has positive health benefits, including reduction of stress, anxiety, and depression. Spending time outdoors is also considered to boost the immune system, improve sleep and creativity. Internationally, similar initiatives have shown already positive results: – The Swedish government funds the Alnarp Rehabilitation Garden, is a healing 12-week strategy for people with severe work-related stress, who are often on long-term sick leave. Sixty percent of Alnarp's patients return to work after one year, higher than in any other therapy, and the model is being replicated elsewhere, and now being trialled with traumatised refugees and stroke patients[47] . – New Zealand: in 2018, 85% of participating families noticed positive changes in their child, including more energy, increased confidence and better sleep[48]. – Australia: in Viktoria, the positive effect on people that recreational parks have is estimated to have a value of $80-$200 million per annum in avoided health costs[49]. ▪ **Participation:** Participants discuss their individual needs with psychologist at start of service. After a first analysis, they are matched with trained volunteers who have experience in supporting people improving their wellbeing. The volunteers are neither therapists nor nature experts.

[46] https://www.psychiatry.org/patients-families/stigma-and-discrimination

[47] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5707949/)

[48] (https://www.health.govt.nz/publication/green-prescription-active-families-survey-report-may-2018)

[49] https://www.parks.vic.gov.au/-/media/project/pv/main/parks/documents/about-us/valuing-victorias-parks/valuing-victorias-parks-report-accounting-for-ecosystems-and-valuing-their-benefits.pdf?la=en&hash=6259F14F477AC64BD19E7783E29ECE7FF8C5B506)

Name	Dose of Nature Prescription Service

- **Intersectional collaboration:** This service is delivered by the charity " Dose of Nature[50]", and participants are referred into the service through their General Practitioner.
- **Evidence and Theory based:** International medical research demonstrates that a Green Prescription can deliver physiological and psychological benefits for patients, even if the exact mechanisms by which these accrue are not yet fully understood. Evidence also shows that doctors are ready and willing to give Green Prescriptions, and that an effective partnership with other providers is required.
- **Innovation:** Unclear whether green prescribing has been used in Richmond or Spain before, and therefore this local initiative is seen as one of a kind. Although nature retreats exist in Spain, there is no evidence of existing volunteer-driven programmes similar to Dose of Nature.
- **Transferability** Benefits of engaging with the natural world run across cultures and locations. Individual needs are taken into account within this service. According to our thematic experts, this seems an interesting intervention to foment active mobility. However, it is not clear if the evaluation has given positive results. If positive outcomes are evidenced, some aspects of the intervention may be transferable into the Spanish context.

1.3.5.3 The Bristol Approach

Name	The Bristol approach
Country	Bristol, UK.
Thematic area	Physical and functional environments- Built environment, Community building
Link to best practice	https://www.bristolapproach.org/bristol-approach-projects/air-quality/
Description and main features	

- **Aims and objectives:** To develop playful and accessible digital tools to help residents collect and interpret air quality data, then act on what they found. This project was developed as part of The REPLICATE Project, a five-year European initiative linking Bristol with Florence and San Sebastian. This project has received funding from the European Union's Horizon 2020 research and innovation programme. Prototype sensors used in the air quality project were

[50] https://www.doseofnature.org.uk/

Name	The Bristol approach

developed with support from the Computer Science Research Centre at the University of the West of England (UWE)".

- **Target population:** the target population are the communities in Bristol that have raised their concerns about climate pollution: cyclists, schoolchildren and their parents, taxi drivers and dwellers of social housing. However, this initiative also targets the general population as the results of data monitoring are shared in an open platform and communicated visually with the help of local designers.
- **Strategic adequacy:** Reducing air pollution especially in urban areas. Aligns with local green strategies in Bristol.
- **Time period of implementation:** From 2017 to 2019 Knowle West Media Centre worked with communities in East Bristol to develop playful and accessible digital tools to help them collect and interpret air quality data, then act on what they found.
- **Ethical aspects:** the data is collected by the community members who voice their concerns around air pollution. Therefore, technology is put at the service of the people and the resulting data is open, transparent and accessible to everybody.
- **Effectiveness and efficiency:** Aims and objectives were met. The project engaged over 1,000 people with the process of 'citizen sensing', over 1,232 hours and 693 engagements.
- **Equity:** Groups that were particularly concerned about air quality were: cyclists, schoolchildren and their parents, and taxi drivers. Another group who contacted KWMC directly to get involved were social housing tenants in Bristol suffering from asthma since moving into a new housing development.

  This project is likely to have contributed to reducing the digital divide and strengthening community bounds. Citizens and community representatives are taught how to build and work with the portable sensors. At the same time, these individuals are trained on how to make sense of the collected data and connected to digital artists to visualise the results and share the data 'story' back to their communities. The data is accessible via an open-source platform, which allows interested individuals and third parties to view it. This initiative also allows affected communities to take action and voice their situation.
- **Sustainability:** This project was developed as part of The REPLICATE Project, a five-year European initiative linking Bristol with Florence and San Sebastian. The REPLICATE Project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 691735. This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 691735. Prototype sensors used in the air quality project were developed with support from the Computer Science Research Centre at the University of the West of England (UWE).
  - Social sustainability: this project offers the agency to communities to participate in science, learn new technological skills, connect with each other and get involved in pollution tracking. The technology can be used to track

Name	The Bristol approach
other variables such as humidity, so it is expected that participants use similar methods to solve other environment-related concerns. – Environmental sustainability: communities who are more aware of environmental threats are expected to become more mindful of environment protection. ■ **Evidenced results:** The air quality pilot ran from 2017 to 2019. Through the damp homes and air quality pilots (2016-2019) – both part of the REPLICATE project – KWMC engaged over 1,000 people with the process of 'citizen sensing', over 1,232 hours and 693 engagements[51]. ■ **Participation:** people and issue led. This process was participative as concerned groups were able to work with sensors and share the stories back to their communities. The transformation of the air quality data into creative communicative messages also enforced the participation of the creative sector of the communities and allowed to spread the awareness even further. ■ **Intersectional collaboration:** Collaboration between university (UWE), local residents, Knowle West Media Centre (arts centre and charity). Implementing findings will involve different sectors including local authorities, housing, and transport sectors. ■ **Innovation:** Yes, any similar project at local or national level has not yet been found. ■ **Transferability:** Based on the evidence gathered, this initiative can be transferred into the Spanish context, if co-produced with local communities. This initiative is aligned with the Ministry for Ecological Transition and Demographic Challenge (Miteco)'s vision on making data on air pollution transparent and accessible to everyone. At the moment, the air quality in Spain is analysed through static monitor stations and uploaded to an open access platform. However, it seems that alternatives to official stations are entering the market as it is needed. Kunak is a similar system, but commercial, and 50 times cheaper than an official station. In 2018, it received 1,6M€ from Horizon 2020. A Spanish adaptation of The Bristol Approach would be beneficial to contribute to data creation for open access and to empower communities to participate in the process.	

1.3.5.4 Sønder Boulevard- Denmark

[51] Air quality monitoring systems

https://elreferente.es/innovadores/horizonte-2020-dota-de-16me-a-kunak-para-mejorar-la-conectividad-del-medioambiente-y-la-industria/

https://www.miteco.gob.es/es/calidad-y-evaluacion-ambiental/temas/atmosfera-y-calidad-del-aire/calidad-del-aire/visor/default.aspx

https://www.miteco.gob.es/es/prensa/ultimas-noticias/el-miteco-presenta-una-nueva-herramienta-para-conocer-la-calidad-del-aire-en-espa%C3%B1a-en-tiempo-real/tcm:30-512001

Name	Sønder Boulevard
Country	Denmark
Thematic area	Physical and functional environments
Link to best practice	https://globaldesigningcities.org/publication/designing-streets-for-kids/

Description and main features

- **Aims and objectives:** A sustainable approach to create green, recreational urban space and economic value. The project was designed in a working-class neighbourhood with small apartments to provide the residents a more active and playful transformation. The space was activated through playful elements, including playgrounds and spaces for games and sports. Pedestrian paths, planting and landscaping, and seating extend throughout the boulevard.
- **Methodology:** In 2004, the City Council of Copenhagen decided to earmark almost two and a half million euros to revitalise the sixteen thousand square metres of the Sønder Boulevard and to adapt it to present-day needs. This was completed in 2007. Six workshops were organized in which residents and local businesspeople were able to express their wishes which in many cases, and as might be expected, were fragmentary and divergent. In view of this, a strategy was adopted in order to return to the boulevard its lost relevance and former numbers of people. It consisted in assigning to the space a great number of uses and a wide range of activities that, by juxtaposition or superimposition, could respond to all the requirements gleaned in the workshops. Trees, pavement and grass were used to create a so-called "strip park" with a perennial garden, a playground for toddlers, a playing field, a track for BMX bikes and seating areas with different ambiances. The layout of the boulevard was designed to not favour one activity over another. As Sønder Boulevard is no longer a traffic corridor, speed limits have been lowered to 30 km/h and 40 km/h to encourage the area's attractiveness.
- **Strategic adequacy:** Yes, in line with the municipal and national strategies.
- **Time period of implementation:** 2004–2008
- **Target population:** Citizens and visitors of Copenhagen
- **Equity:** The project was designed in a working-class neighbourhood with small apartments.
- **Participation and intersectoral collaboration:** Engaging local residents and business owners was key to the design process. The design team held six workshops to ensure community input while developing design and implementation strategies. Through these activities, the team recognized that community members had different wants for the space. This was addressed by creating discrete zones throughout the linear park. With spaces for sports, children, pets, and more, these areas allow for a wide range of activities.

Name	Sønder Boulevard

- **Evidenced results:** Five years after the project started, the City of Copenhagen studied its impact on the surrounding neighbourhood. The number of successful new businesses, shops, and restaurants surrounding the site rose 375%. A satisfaction survey among residents showed that 78% of people were "happy" or "very happy" with their local public spaces, up from 22% before. Sønder Boulevard is now the eighth-most-used public space in Copenhagen. On a list of the 10 most-used public spaces in the city, it is the only space that is not a regular tourist destination. The survey also found out that 600,000 people visit the boulevard each year and spend 129.5 minutes on average in the park and 14.9 minutes per visit on travelling. It is calculated that the value of all park activities is USD 22.5 million.

  Another relevant aspect is that proximity and access to the green area Sønder Boulevard has increased the value for proximal properties by USD 63 million, leading to increased tax revenues of USD 2.2 million each year. Related to his, Harnik and Welle (2009) reference more than 30 studies that show parks have a positive impact on property values, which can be measured up for to 2,000 feet (600 meters). From the equity perspective, it is noteworthy how this park accessibility effects on housing prices and affordability in Copenhagen. Sønder Boulevard in Copenhagen has had benefits for its users and on the value of properties near the park.
- **Evidence and theory base:** This project is recognised in Designing Streets for Kids[52] as it captures international best practices, strategies, programmes, and policies that cities around the world have used to design spaces that enable children of all ages and abilities to utilize cities' most abundant asset – streets.
- **Transferability**: It is interesting as an urban regeneration programme. In Spain there are experiences such as the "Llei de Barris of the Generalitat of 2004" or " Pla de Barris of the Barcelona City Council".

Llei de Barris

The Law 2/2004, of 4 June, on the improvement of neighborhoods, urban areas and towns that require special attention " LLei de Barris", provides the Catalan administrations with instruments to improve the districts, urban areas and towns that, by their conditions, require special attention by the public authorities.

Projects eligible for funding must include interventions in some of the following areas: the improvement of public spaces and the provision of green spaces, the rehabilitation and equipment of the collective buildings, the provision of equipment for collective use, information technologies in buildings, the promotion of the sustainability of urban development, especially in terms of energy efficiency, savings in water consumption and waste recycling, gender equity in the use of urban space and facilities, the development of programs that lead to a social, urban and economic improvement of the neighborhood, and the accessibility and removal of architectural barriers .

[52] https://globaldesigningcities.org/publication/designing-streets-for-kids/

1.3.5.5 Replace Vehicles with Public Spaces Pontevedra: Fewer cars, more city

Name	Replace Vehicles with Public Spaces Pontevedra: Fewer cars, more city
Country	Spain, city of Pontevendra
Thematic area	Physical and functional environments
Link to best practice	http://www.pontevedra.gal/publicacions/fewer-cars/files/assets/common/downloads/publication.pdf http://activeenvironments.eu/media/space-review-evidence-exemples-practice.pdf

Description and main features

- **Aims and objectives**: The main aim of this project is to eliminate cars and replace the space with public spaces.
  The aims of the policies and investments within this project were the following[53]:
  - To promote fewer cars and more transport by foot. Using the city spaces designed for car parking, to promote physical activities.
  - To improve the quality of public spaces.
  - To transform the city towards a 'child-friendly' city, with the aim to promote a happier and healthier childhood, combined with a "traffic calming" strategy in all urban space, to increase safety and quality of public spaces.
  - To promote pedestrians. Limit the quantity of cars in the city to gain more public space to create walking itineraries with wide areas to walk.
  - To make pedestrians at the centre of an intermodal transport strategy.
  - To make bicycles a safe transport option.
  - To provide clear messages to promote active transportation.
  - To teach school children and other populations groups about active mobility.
  - To increase the percentage of children walking to school.
- **Target population:** Citizens and visitors of the city of Pontevedra.
- **Strategic adequacy:** In Spain, 3% of annual mortality is attributable to air pollution, which causes serious health problems, among which are pneumonia, respiratory infections or lung cancer. The reduction of traffic in cities improves the quality of the air that is breathed, and also has associated another series of 'collateral' effects, such as the decrease in the use of fossil fuels, thus limiting the greenhouse effect emissions that contribute to climate change. In addition, the limitation for the use of private vehicles forces citizens to seek other ways of

53 http://activeenvironments.eu/media/space-review-evidence-exemples-practice.pdf

Name	Replace Vehicles with Public Spaces Pontevedra: Fewer cars, more city

getting around that are usually healthier: walking or cycling to work and running errands avoids sedentary lifestyle, in addition to being cheaper.

- **Time period of implementation:** 1999–present
- **Equity:** This “urban reform” was based on the principle of “giving city back to the people” and that owning a car does not allow to occupy the public space. For example, Pontevedra’s Safe Routes to School programme, “Camino Escolar,” encourages children to walk to school without caregivers and bears the motto “The city takes you to school.” Local businesses, identified by stickers near their entrances, give support to students when needed.
- **Participation and intersectoral collaboration:** In particular, the Pontevedra’s Safe Routes to School programme, “Camino Escolar,” encourages children to walk to school without caregivers and bears the motto “The city takes you to school.” Here also local businesses, identified by stickers near their entrances, give support to students when needed.
- **Sustainability:** The initiative has been maintained for more than 10 years. Positive results help also with sustainability, as for example, in Pontevedra, 80% of children between 6- and 12-years old walk to school without an adult. This was the direct result of long-term efforts that aimed to deprioritize motor vehicles in urban planning and to improve families’ safety and well-being.
- **Evidence results:** Pontevedra has been considered a healthy city by the increase of green areas, places to practice sport, as well as its fluvial beach.
  - In 1999 traffic was closed in the city centre and since then it has managed to reduce vehicle pollution in the urban area by 66% between 1999 and 2014.
  - Fewer cars: In 1997, up to 52,000 motorized vehicles inundated city streets. Today, “better on foot” policies have brought the numbers down to 17,000.
  - Safer traffic: Traffic calming measures, such as reducing the maximum speed to 30km/h. On the same streets where 30 people died in traffic accidents from 1996 to 2006, only three died in the subsequent 10 years, and none since 2009.
  - In 14 years, 40 km of footpaths and cycling paths have been created near the rivers.
  - It has been constituted as an inclusive social city that allows people with some physical disability to move smoothly throughout the city.

  This was achieved by large-scale investments in infrastructure, with public campaigns on road safety, active mobility culture (as for example, Metrominuto) and safe active routes to school.
- **Innovation:** The successes of Pontevedra have been recognised in terms of innovation, urban quality and social inclusion and as such it is seen as an example of a model city. The city has been awarded a number of prizes, including the UN-Habitat Dubai International prize in 2014 and the 2015 Center for Active Design award. The policies, programmes, and physical improvements carried out by the City of Pontevedra were also inspired by the work of

Name	Replace Vehicles with Public Spaces Pontevedra: Fewer cars, more city
	Francesco Tonucci and his initiative, City for Children (“La Città Dei Bambini” in Italian). ▪ **Transferability:** the city has been internationally recognised and the outcomes are certainly worth replication. In addition, this initiative has already been implemented for over 20 years in a Spanish municipality. Such a project shows the power of what can happen when a common and cohesive vision for health is established. Pontevedra has gradually developed traffic calming initiatives combining physical, normative and informative measures which have contributed to boosting residents’ walking habits and dramatically reducing the use of motorized vehicles to move around the city. Larger cities may apply identical principles, bringing together traffic calming and density reduction measures, as well as implementing district by district interventions to withdraw private cars from those public spaces that should be enjoyed by pedestrians, cyclists, users of public transport and citizens in general. In metropolises where the bus and tube networks leave passengers within walking distance of their destination, “better on foot” policies are similarly applicable with initiatives of intermodality.

1.4 Preselection of the best practices

The purpose of this selection was to prioritise those tools that fall under the thematic areas provided by the MoH, namely promotion of healthy lifestyles, reinforcing participation and community engagement and physical and functional environments, with an equity and intersectoral approach, and if possible, that have been implemented with satisfactory results.

1.4.1 Overarching points

This sub-section provides a number of elements that were taken into account for the preselection of best practices. Most of the points in this section were gathered during the data collection exercise, and/or were raised and discussed with the senior study experts:

- Given the broad nature of each thematic area there was a risk that the preselection was not in line with the MoH expectations. The MoH was asked to provide a list on key topics identified as specific health problems that need to be addressed (i.e food or child mobility).
- In some cases, many projects belonged to multiple categories (thematic areas). Therefore, the division of two best practices per area was difficult to follow. It was agreed that it was not necessary to present the practices in a rigid category and therefore each best practice can cover different aspects of these thematic areas.
- Across the interventions provided, there are examples that are broad and those that are more specific. In that sense, it was decided to include examples of the two kinds. The broader more holistic programmes are attractive because they show where we need to get too/ the direction. However, these programmes are large and require investments, and perhaps structural changes and commitments that might not be feasible at all scales.

The reality is that sometimes a city/town might need a more specific targeted intervention for a topic that they have prioritized. It was agreed to include both types.

- Likewise, there are programmes which perhaps the process/methodology is the best practice and others where it is the specific problem addressed itself that is the best practice (i.e. Cambridge Wellness vs reducing adolescent substance abuse). Thus, it would be good to have examples and models of those as well. Both examples have been considered when preselecting the best practices to be presented.
- Sometimes, meeting all/ some of the preselection criteria was not sufficient for preselecting an intervention. In some cases, the intervention could meet mainly all the preselection criteria, but there was very a similar intervention already implemented in the Spanish context. It was agreed that in those cases in which a practice has been developed in the Spanish context, if all the criteria to be considered a best practice is matched, the Spanish intervention was also included.
- In other cases, one intervention might not meet most of the criteria, but it had a strong innovation component, and therefore was prioritised.
- Finally, in some instances, the geographical scope of the intervention was larger than 100.000 inhabitants, however the intervention was seen to be innovate or to provide something worth exploring. In those cases, the practice was pre-selected. Nevertheless, overall the identification has been made with a special focus on geographical areas with less than 100,000 inhabitants.

1.4.2 Selected best practices to be presented at the Annual meeting for the local implementation of the EPSP strategy

Discussions with the OWG led to the selection of six initiatives to be presented in the Annual meeting for the local implementation of the EPSP strategy:

- Ensemble Prevenons L´Obesite Des Enfants (EPODE) (Juntos Prevenimos la Obesidad Infantil) – France / Other initiaves following EPODE methodology
- Sonder Boulevard - Copenhague, Denmark
- Salut als Barris - Barcelona, España
- Community Food Initiative (Iniciativa Comunitaria de Alimentación) - Irlanda
- Let’s Live Healthily (Vivamos de Forma Saludable) - Eslovenia
- Menos Coches, Más Ciudad - Pontevedra, España

2 Task 5.2 - Presentation of best practices in the VII annual meeting for the local implementation of the EPSP strategy

2.1 Background

Each year the Ministry of Health, in coordination with the Spanish Federation of Municipalities and Provinces (FEMP), organises the Annual Meeting on Local

Implementation of the Health Promotion and Prevention Strategy in the SNS. Each year, the meeting is centred on one specific topic, apart from including an update on the local implementation. In 2020, the topic was the presentation of some of the initiatives selected in this project: Good practices in health promotion in the local context. The objective was, thus, to present some best practices in the local context that can be transferred, developed and implemented in different Spanish municipalities. The Meeting is directed to the representatives of municipalities interested in advancing in health promotion, and this include those who are already working on the local implementation of the EPSP in their municipality, and those who are interested in starting this line of work: coordinators of local implementation, professionals involved in local implementation, technicians, political representatives, etc.[54].

This year the annual meeting for the local implementation of the EPSP strategy was held on the 23 of November 2020. This event was planned to be organised as a physical meeting in Madrid, gathering more than 180 participants from municipalities interested in advancing in health promotion. However, due to Covid-19 developments, this event was organised virtually through a webinar that was broadcast via YouTube[55] .

Participants of this meeting included members of the Health Promotion Working Group, the Working Group for the Local implementation of the National Strategy on Health Promotion and Prevention, Institutional committee of the National Strategy on Health Promotion and Prevention, Local coordinators for the Local implementation of the National Strategy on Health Promotion and Prevention and National Healthy Cities Network (Spanish Federation of Municipalities and Provinces), and other who work in health promotion at the local level. In total, and thanks to the virtual organisation, the event gathered a bigger audience with more than 500 participants.

[54]https://www.mscbs.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/Jornadas/VII_Jornada_Implementacion_Estrategia.htm

[55] https://www.youtube.com/watch?v=08fBOX1k4Ps

2.2 The agenda

VII Jornada sobre Implementación Local de la Estrategia de Promoción de la Salud y Prevención en el SNS

Buenas prácticas en promoción de la salud en el entorno local

Lunes 23 de noviembre 2020

10:30 - 13:00

Formato virtual

Hora	Contenido
10,30 - 10,45	Bienvenida • Pilar Aparicio, Directora General de Salud Pública. Ministerio de Sanidad • Daniel de la Rosa, Presidente de la Red Española de Ciudades Saludables (FEMP) y Alcalde de Burgos.
10,45 - 11,00	Actualización de acciones de la Implementación Local de la Estrategia de Promoción de la Salud y Prevención en el SNS • Ana Gil Luciano, Jefa de Área de Promoción de la Salud y Equidad. Ministerio de Sanidad.
11,00 - 12,30	Presentación de Buenas prácticas en promoción de la salud en el entorno local[1] • Carme Borrell, Gerente de la Agència de Salut Pública de Barcelona. • Carolyn Daher, Coordinadora de la Iniciativa de Planificación Urbana, Medioambiente y Salud (ISGlobal). 1. Ensemble Prevenons L´Obesite Des Enfants (EPODE) (Juntos Prevenimos la Obesidad Infantil) – Francia / Otras iniciativas siguiendo la metodología EPODE 2. Salut als Barris - Barcelona, España 3. Sonder Boulevard - Copenhague, Dinamarca 4. Community Health Initiative (Iniciativa de Salud Comunitaria) - Irlanda 5. Let's Live Healthily (Vivamos de Forma Saludable) - Eslovenia 6. Menos Coches, Más Ciudad - Pontevedra, España Presentación realizada en el marco de la petición de servicios "Mejorando las acciones de salud pública mediante la mejora de información en equidad y determinantes sociales de la salud y la mejora de herramientas para evaluar las intervenciones de promoción de la salud" del Servicio de Apoyo a Reformas Estructurales de la Comisión Europea
12,30 - 13,00	Conclusiones y cierre • Pilar Campos, Subdirectora General de Promoción, Prevención y Calidad. Ministerio de Sanidad

[1] Esta presentación se lleva a cabo con la financiación de la Unión Europea vía el Programa de Apoyo a Reformas Estructurales (SRSP) en colaboración con la Dirección General de Apoyo a las Reformas Estructurales de la Comisión Europea (DG REFORM)

2.3 The presentation

As already stated, during this meeting, the presentation of the different best practices identified by ICF study team took place. Carme Borrell (Director Public Health Agency of the Barcelona) and Carolyn Daher (Coordinator of the Urban Planning, Environment and Health Initiative ISGlobal), Senior thematic experts in this project, presented the six selected best practices previously preselected together with the OWG. The intended objective was initially intended not only to present best practices but also to discuss and gather the views of stakeholders on the barriers and facilitators to implement these best practices in Spanish local municipalities. The first objective was accomplished, however given the short timeframe of the presentations due to the online format of the meeting, it was not possible to hold a discussion with stakeholders on the barriers and facilitators for the implementation of these best practices.

The presentation covered, for each best practice: the description of the intervention and main objectives it aims to address, country, geographical, thematic area, results of the intervention, success factors of each intervention and potential transferability to the Spanish context.

The full agenda of the event can be found in Annex 1.

The presentations can be found in Annex 2.

2.4 Q&A

Following on from the presentations, the audience was invited to pose questions to the presenters. The discussion focused on a number of questions regarding the best practices presented, as well as more general issues. A summary is presented below.

2.4.1 Best practice specific questions

- **Is there a possibility that you could provide us with more information about the POIBA programme?**

  More information about POIBA can be found in Section 1.3.4.3 of this report.

- **How do you address the impact on equity driven by the price increase in houses from urban change - Copenhagen's Sonder Boulevard project?**

  Regenerations programmes (both physical and social) that consist of improving the infrastructure may cause the so called " gentrification" which is the process whereby the character of a poor urban area is changed by wealthier people moving in, improving housing, and attracting new businesses, often displacing current inhabitants in the process.

  In this case, gentrification is caused by an increase in prices. A way to assess the impact on equity driven by the price increase in houses is to conduct an in-depth analysis of whether there has been population change since the intervention was implemented. This is, which people had to leave, and which people have come. According to Carme Borrell, Director of the Public Health Agency of Barcelona, there is an increasing body of information available in the literature that supports the notion that gentrification has a negative effect on the health of the population.

- **Have you assessed whether the Salut als Barris programme is having any effect on the generation and strengthening of community networks?**

Carme Borell, Director of the Public Health Agency of Barcelona, confirmed that the impact of the programme on the generation and strengthening of community networks has not been evaluated. However, the agency conducted a cross-sectional study where they assessed what occurred in those neighbourhoods where a stronger community action took place. The results suggested that where community action is stronger, health improves and inequalities decline.

2.4.2 General questions

- **Could the rapporteurs comment on the methodology for assessing the health impact of interventions (urban, educational, social, etc.) Are there common impact assessment questionnaires to combine Criteria?**

  Most evaluations aimed at assessing the health impact of an intervention are conducted taking into account a before-after analysis, although ideally there should be also a control group. It is important to mention that the evaluative design will depend on the resources. You can find some useful resources to assess the Health impact of interventions in the links below:

  - https://www.who.int/heli/impacts/hiabrief/en/
  - https://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_a6_frep_11_en.pdf
  - http://hdl.handle.net/10668/2553

2.5 Additional resources

2.5.1 Core set of skills and principles to be able to design and adapt the different interventions/best practices

Because in reality the transferability of a successful project depends on many temporal, cultural, political and other factors, adjustments almost always should be made. Having best practice examples is useful but having the core set of skills and principles to be able to design and adapt the best practices is also critical. Some examples can be found below:

- **Compendium of best practices of child friendly cities**: https://issuu.com/bernardvanleerfoundation/docs/compendium_of_best_practices_of_chi
- **Place Standard Tool Scotland**. This is an excellent tool for planning health and public space interventions https://www.placestandard.scot/
- The following organisation has many case studies and also some tools, but not from Europe https://www.880cities.org/resource-hub/
- **Cities Alive**, this document has some case study example and lays out the arguments for designing programmes for children https://www.arup.com/perspectives/publications/research/section/cities-alive-designing-for-urban-childhoods
- **Guidelines for safe mobility to and from school** https://aa9276f9-f487-45a2a3e78f4a61a0745d.usrfiles.com/ugd/aa9276_86afa50296c945a59dcb9b0bf3a9b941.pdf

- **The Partnership for Public Space** has a number interesting resources, tools and best practice examples. Here is one that is relevant for streets. https://www.pps.org/article/streets-as-places
- **NACTO** has a lot of information about urban and transport planning. They have a search button to look for case studies by theme: https://nacto.org/publication/urban-street-design-guide/
- **Nature Based Solutions EU projects.** These are larger EU projects that are ongoing but should provide some best practices: https://ec.europa.eu/easme/en/news/nature-based-solutions-are-helping-address-urban-challenges

2.5.2 List of the programme topics that communities could implement related to urban planning, transport and environment to address health in a holistic way.

- **Child/Adolescent friendly design**. Children almost never have a voice or are consulted in programmes that affect their health, especially about urban planning, transport etc. However, they need interventions that are specifically tailored to them and their needs, and if possible should be included as collaborators in any intervention. An example from the USA is Growing up Boulder: http://www.growingupboulder.org/all-projects.html
- **Nature Based Solutions and access to greenspace (eg. Dose of Nature Prescription)**. This is a big and emerging area. How can nature be integrated into communities to improve health. However,if not done carefully can cause gentrification which is a major negative output for equity.
- **Social and Nature Prescribing**, two other related but slightly different emerging intervention areas where patients are ¨prescribed¨ by the health system activities that foster social contact/cohesion and/or contact with nature. This type of programme is increasingly backed up by evidence, though likely to lack best practices at the moment.
- **Elderly populations.** The demographic reality of Spain (and most EU cities) urgently requires more thinking and programmes about how to meet the needs of and foster healthy lifestyles for the elderly. This relates to urban planning and mobility and requires specific thinking for this group.
- **Promoting Active and sustainable mobility** this is key to addressing so many of the health issues faced in urban areas.
- **Citizen Science and collaborative methods for community health**. This relates to programs that use co-creation between communities, government and academia. This is a valuable option for communities to explore and address health issues. An example can be found here: https://www.env-health.org/citizen-science-monitoring-of-air-quality-in-and-around-madrid-schools-confirms-the-need-to-cut-air-pollution-from-transport.Additionally in Barcelona there was a project called xAire: http://www.ub.edu/opensystems/es/projectes/3205. The organization Mapping For Change has also done some really interesting projects using citizen science.
- **Digital Innovation, new approaches to programmes**. This is an example of a programme that will in the future provide case studies about urban issues that are related to health http://www.ub.edu/opensystems/es/projectes/3205.

2.5.3 Some resources from non-EU countries

- Bloomberg Philanthropies has a number of resources, find for instance this podcast specifically for using data to address equity https://govex.jhu.edu/wiki/data-points-podcast-episode-55-creating-racial-equity-in-grand-rapids/
- Sustainable Oakland, this larger document features examples of programmes that have worked for a variety of topics: https://cao-94612.s3.amazonaws.com/documents/Sustainable-Oakland-Report-Template-V20-2018-01-12-5bFINAL5d.pdf
- NACTO website has case examples: https://nacto.org/publication/urban-street-design-guide/
- This programme from mayors https://mayorsinnovation.org/policy-topics/transportation/transportation-climate-change/

2.6 Conclusions

The objective of this report was to present national and international best practices in health promotion implemented in the local context, ideally in municipalities with less than 100.000 inhabitants **and preferably having an intersectoral approach.** Whereas a number of the interventions presented in this report had a wider geographical scope, this report provides diverse examples of interventions that in most of the cases have been implemented successfully across the European Union.

After analysing each of these interventions in detail, a number of key elements found in all of them merit consideration as best practices in the local context, notably they are seemed to:

- be informed by scientific evidence.
- have clear and measurable objectives and targets.
- are participatory / co-created.
- explicitly include equity.
- include monitoring and evaluation of impacts and the process.
- are replicable in other contexts.
- are linked or create synergies with other projects and plans at the local / regional / national level.

Regarding the transferability into the Spanish context, in general most of the interventions presented across within this report, contain elements that show a high potential of transferability to the Spanish context. In addition, some of the projects presented in this report, or very similar programs to those, have already been implemented in Spain which shows that these programs are replicable to various context. The cultural-geographic proximity, and the possibility to replicate the interventions in other contexts are key factors that all these interventions have in common.

Furthermore, a number of features should be taken into account when implementing health promotion interventions in the local context, which arose during the analysis of these best practices. These are:

- The importance of setting realistic, S.M.A.R.T. (specific, measurable, attainable, relevant and time-bound) objectives. Particular attention needs to be dedicated to defining these at the start of the project. Very often it takes years to measure the effect of health

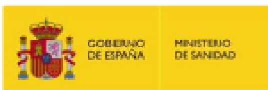
promoting activities. To persuade policy and decision makers to support health-promoting activities, it is important to create objectives with outcomes that can be visible in a short time frame, a year for example. Unrealistic objectives set over long timeframes risk de-motivating interest groups and funders (political supporters). Strategic objectives can be modified on the basis of the experiences and results of implementation.

- Successful health-promoting measures must be tailored to the target group and be acceptable to them; the uptake of activities must be done by the target group themselves.
- To ensure sustainability, it is crucial to build on available infrastructural resources and tailor actions to existing human and financial resources. Investing in the development of human resources is a crucial precondition to implementing and rolling out the programme. It is important to build an expert team with knowledge of health promotion but also involve different but complementary fields (medical doctors, nurses, anthropologists, food and nutrition specialists, environmental health specialists, teachers, etc.).
- Ensuring cross-thematic and sectoral participation/ collaboration.

Finally, having best practice examples is useful but having the core set of skills and principles to be able to design and adapt the best practices is also critical and that is why several tools have been provided across this report to help users replicate these programs into the different context.

Annex 1 Agenda of the event

2020 11 23
Programa VI Jornad



VII Jornada sobre Implementación Local de la Estrategia de Promoción de la Salud y Prevención en el SNS

Buenas prácticas en promoción de la salud en el entorno local

Lunes 23 de noviembre 2020

10:30 - 13:00

Formato virtual

Hora	Contenido
10,30 - 10,45	Bienvenida • Pilar Aparicio, Directora General de Salud Pública. Ministerio de Sanidad • Daniel de la Rosa, Presidente de la Red Española de Ciudades Saludables (FEMP) y Alcalde de Burgos.
10,45 - 11,00	Actualización de acciones de la Implementación Local de la Estrategia de Promoción de la Salud y Prevención en el SNS • Ana Gil Luciano, Jefa de Área de Promoción de la Salud y Equidad. Ministerio de Sanidad.
11,00 - 12,30	Presentación de Buenas prácticas en promoción de la salud en el entorno local[1] • Carme Borrell, Gerente de la Agència de Salut Pública de Barcelona. • Carolyn Daher, Coordinadora de la Iniciativa de Planificación Urbana, Medioambiente y Salud (ISGlobal). 1. Ensemble Prevenons L´Obesite Des Enfants (EPODE) (Juntos Prevenimos la Obesidad Infantil) – Francia / Otras iniciativas siguiendo la metodología EPODE 2. Salut als Barris - Barcelona, España 3. Sonder Boulevard - Copenhague, Dinamarca 4. Community Health Initiative (Iniciativa de Salud Comunitaria) - Irlanda 5. Let's Live Healthily (Vivamos de Forma Saludable) - Eslovenia 6. Menos Coches, Más Ciudad - Pontevedra, España Presentación realizada en el marco de la petición de servicios "Mejorando las acciones de salud pública mediante la mejora de información en equidad y determinantes sociales de la salud y la mejora de herramientas para evaluar las intervenciones de promoción de la salud" del Servicio de Apoyo a Reformas Estructurales de la Comisión Europea
12,30 - 13,00	Conclusiones y cierre • Pilar Campos, Subdirectora General de Promoción, Prevención y Calidad. Ministerio de Sanidad

[1] Esta presentación se lleva a cabo con la financiación de la Unión Europea vía el Programa de Apoyo a Reformas Estructurales (SRSP) en colaboración con la Dirección General de Apoyo a las Reformas Estructurales de la Comisión Europea (DG REFORM)

Annex 2 Presentations

BP Presentation.pdf

Presentación de buenas prácticas de promoción de la salud en el entorno local

Carme Borrell, Gerente de la Agència de Salut Pública de Barcelona

Carolyn Daher, Coordinadora de la Iniciativa de Planificación Urbana, Medioambiente y Salud (ISGlobal)

Trabajo realizado en el marco de la petición de servicios "Mejorando las acciones de salud pública mediante la mejora de información en equidad y determinantes sociales de la salud y la mejora de herramientas para evaluar las intervenciones de promoción de la salud" del Servicio de Apoyo a Reformas Estructurales de la Comisión Europea

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Programa 4:

Community Food Initiative (Iniciativa Comunitaria de Alimentación) - Irlanda

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Community Food Initiative

Irlanda

Descripción : Promoción de alimentos saludables en zonas de bajos ingresos utilizando un enfoque de desarrollo comunitario

País: Irlanda

Alcance geográfico: Inicialmente se ejecutó de 2013 a 2015 en 10 sitios. Entre 2019-2021 las iniciativas se están implementando en 14 áreas, incluyendo lugares con una población de menos de 100.000 habitantes..

Área temática:

- Promoción de estilos de vida saludables: nutrición saludable, actividad física,
- Mejora del bienestar social y la salud mental

3

Community Food Initiative

Irlanda

- **Promover un mayor acceso y disponibilidad de alimentos sanos y seguros en zonas de bajos ingresos** a través de un programa de proyectos locales que utiliza un enfoque de desarrollo comunitario en toda Irlanda.
- **Influir positivamente en los hábitos alimenticios** de las familias de bajos ingresos, abordando las barreras para tener una dieta saludable y apoyando un mayor acceso a alimentos asequibles y saludables a nivel local.

4

Objetivos

- Financiar iniciativas alimentarias en la comunidad en toda Irlanda, (2013-2015)
- Proporcionar apoyo técnico, formación colectiva y facilitar el trabajo en red
- Alentar a los proyectos a que consideren la sostenibilidad a largo plazo desde el inicio del programa
- Promover el aprendizaje compartido
- Identificar mejores prácticas y aumentar la concienciación sobre el programa

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Grupo Objetivo

- Adultos que son responsables de la compra de alimentos y la preparación de comidas para su familia y / o niños (de 0 a 19 años)
- Centrado en las personas de zonas desfavorecidas. Las actividades se adaptan para abordar las necesidades de las personas de bajos nivel socioeconómicos y otros contextos desfavorecidos a través de principios de marketing social.

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Proceso para establecer CFI

Trabajador encargado del desarrollo y de establecer la infraestructura

Involucración de la comunidad local y las partes interesadas, por ejemplo, a través de comités, redes aprendizaje establecidas en ubicaciones de CFI

Proyectos comunitarios locales a través de organizaciones "anfitrionas", que se adaptan a las necesidades locales, por ejemplo, grupos de jardinería de mujeres

Apoyo continuo, incluidas oportunidades de creación de redes y apoyo a la evaluación

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Factores claves del éxito

- **El apoyo a los programas no consiste sólo en la financiación**

Apoyo proporcionado por un trabajador del desarrollo de Healthy Food for All incluye: asesoramiento técnico, capacitación, oportunidades regulares de "networking" y evaluación continua.

- **Criterios de selección**

Se requería que los proyectos se llevaron a cabo en una organización establecida con una trayectoria demostrada en la gestión de subvenciones y proyectos par permitir centrarse en el desarrollo de la propia CFI en lugar de tareas administrativas.

- **Acción dirigida**

Todos los proyectos se encuentran en comunidades con una desventaja socioeconómica

- **Redes**

Tres reuniones de creación de redes que se celebran cada año para permitir la formación y el intercambio de conocimientos

- **Plazo de financiación**

A lo largo de los tres años del proyecto, los proyectos buscan fuentes de financiación adicionales y que la organización anfitriona pueda continuar ejecutando el proyecto una vez finalizada la financiación inicial.

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CFI- Resultados

- En el primer año, **más de 12.000 personas participaron en actividades de CFI relacionadas con la alimentación saludable**, el cultivo de alimentos y habilidades culinarias (por ejemplo, grupos de jardinería).
- Una **amplia gama de participantes involucrados en proyectos**, desde niños hasta personas mayores, de orígenes marginados y de todos los géneros.
- Los participantes **reportaron mejores niveles de salud y bienestar**, mejor estado de ánimo, más motivación para hacer otras cosas (por ejemplo, ir a caminar).
- En el futuro se pueden realizar mejoras en la CFI, incluida la ampliación de la gama de actividades relacionadas con los alimentos, **como presupuestar, comprar, almacenar, preparar y cocinar comidas saludables y seguras**.

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Equidad

- El grupo objetivo para el CFI tiene un bajo nivel de ingresos y experimenta la pobreza alimentaria
- En los proyectos comunitarios han participado con mujeres y niños, pero también hombres y poblaciones migrantes

Transferabilidad

- El modelo podría ser útil para programas específicos. El tema de la alimentación saludable podría no ser el más urgente según el contexto local española, pero el modelo en sí podría aplicarse a otras cuestiones.

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Programa 5:

Let’s Live Healthily (Vivamos de Forma Saludable) - Eslovenia

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Let’s Live Healthily “"¡Vivamos saludablemente!"

Parte del Proyecto Mura Eslovenia

Descripción: Profesionales de la salud pública apoyados por equipos multidisciplinares de expertos realizan actividades de promoción de la salud

País: Eslovenia

Alcance geográfico: Región de Pomjure, Eslovenia con 114.000 habitantes, actualmente está operando en 50 comunidades.

Área temática:

- Promoción de estilos de vida saludables: nutrición saludable, actividad física, una vida libre de drogas,
- Comportamiento seguro en carretera y la promoción de un entorno Seguro
- Mejora del bienestar social y la salud mental
- Apoyar la detección precoz de enfermedades cardiovasculares.

Objetivos

- Promoción de estilos de vida saludables entre los habitantes adultos en áreas rurales locales.
- Mejorar la salud y permitir que los habitantes de una región desfavorecida tengan un papel activo en la promoción y protección de la salud, a la vez que se alienta a las partes interesadas locales a fomentar las condiciones para hacerlo posible.

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Descripción

Profesionales de la salud pública apoyados por equipos multidisciplinares de expertos realizan actividades de promoción de la salud relacionadas con:

- enfermedades cardíacas, hipertensión, cáncer y diabetes
- peso corporal y pérdida de peso saludable
- nutrición, cocina saludable,
- promoción del autoabastecimiento de hortalizas
- diagnóstico precoz de cáncer de mama
- actividad física
- control del estrés
- control de otros factores de riesgo (IMC, porcentaje de grasa corporal, nivel de colesterol).

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Factores clave de éxito

- Enfoque ascendente, que refleja las necesidades, deseos, especificidades y capacidades de las comunidades y las regiones.
- Se basa en los recursos y capacidades locales, adoptando un enfoque de asociación, así como estableciendo objetivos realistas que puedan cumplirse en el contexto local.
- Involucra a partes interesadas de la comunidad local en actividades del programa, eg: escuelas, tiendas, empresas locales, organizaciones voluntarias, farmacias, medios de comunicación, iglesias y proveedores de ofertas turísticas
- Para apoyar la implementación del programa se estableció una red de promoción de la salud con más de 140 profesionales (expertos y coordinadores locales) de diversas instituciones, organizaciones no gubernamentales y comunidades locales

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Resultados 1/3

- El proyecto piloto inicial fue evaluado mostrando buenos resultados, indicando que fue bien recibido entre el grupo objetivo y que el enfoque seleccionado había tenido éxito.
- No sólo ha impactado en el estilo de vida de los participantes, sino también ha mejorado la cohesión social y las capacidades en las comunidades donde se implementa.
- El programa se ha transferido a 50 comunidades locales comunidades de otras regiones de Eslovenia.

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Resultados 2/3

- De acuerdo con el Informe de Acción para la Salud del proyecto, una evaluación interna realizada **encontró que casi todos los indicadores de procesos y resultados se lograron**.
- Las evaluaciones previas y posteriores de los participantes en el «Vivamos saludablemente» **muestran un mayor conocimiento, habilidades y conciencia de estilos de vida saludables, así como mayores niveles de actividad física.** También muestran cambios nutricionales sostenidos entre la mayoría de los participantes.

Table 10: Perceived change of lifestyle among participants in program «Let's Live Healthily»

Perceived change of lifestyle (self-reported)	% Participants
Nutrition (any change)	95 %
Consumption of more vegetables	67 %
Consumption of more fruit	53 %
Consumption of less fat	64 %
Consumption of less salt	36 %
Increased physical activity	36 %
Self-rated increased knowledge about healthy lifestyles	65 %

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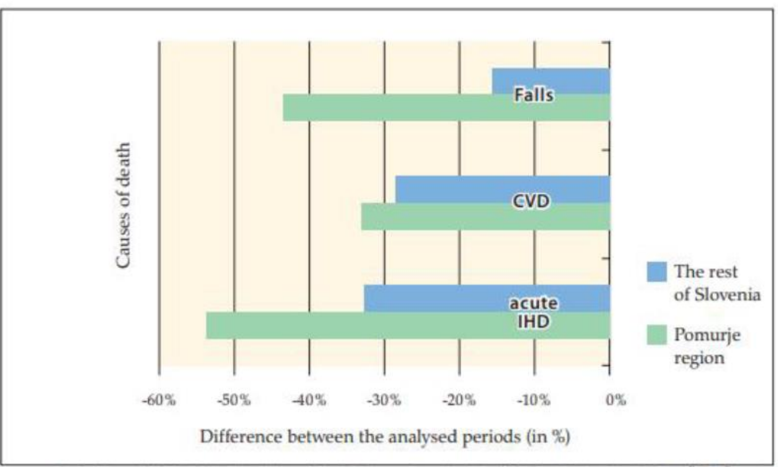
Resultados 3/3

Figure 5: Causes of death where SMR decreased for Pomurje region more than in the rest of Slovenia, for people younger than 65 years of age, comparing periods 1997–1999 and 2003–2005



Source: Institute of Public Health of Republic of Slovenia, calculated by Sonja Tomšič, Jožica Šelb Šemerl

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Equidad

La intervención ha sido en una de las regiones más desfavorecidas de Eslovenia. Tiene los ingresos más bajos y tasas del desempleo más alta y expectativa de vida más baja de todo el país.

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Transferabilidad

La intervención ha demostrado ser muy transferible, al menos lo ha sido cuando se transfiere la intervención a las demás partes de Eslovenia. Las lecciones clave aprendidas reflejan lo que se necesita para que la transferencia tenga éxito y que el programa sea sostenible:

- La importancia de establecer objetivos realistas, S.M.A.R.T. Se dedicó especial atención a definirlos al inicio del proyecto.
- Las medidas exitosas de promoción de la salud deben adaptarse al grupo objetivo y ser aceptables para ellos; la adopción de actividades debe ser realizada por el propio grupo objetivo;
- Para garantizar la sostenibilidad, es crucial aprovechar los recursos de infraestructura disponibles y adaptar las acciones a los recursos humanos y financieros existentes.
- Involucrar a grupos de interés fuera del sistema de salud en el análisis de los problemas de salud en la región es una manera eficaz de construir alianzas y aumentar el compromiso de los socios regionales de trabajar en objetivos compartidos.

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Programa 6:

Menos Coches, Más Ciudad - Pontevedra, España

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Reemplazar vehículos por espacios públicos Pontevedra

España

Descripción : Reemplazar vehículos por espacios públicos Pontevedra: Menos coches, más ciudad (1999–)

País: España

Alcance geográfico: Ciudad de Pontevedra con 82 800 habitantes

Área temática:
Mejora del entorno físico y funcional con el fin de promover la salud y el bienestar;

22

Objetivos

Eliminar coches y sustituir ese espacio por espacios públicos. La creación de una ciudad para niños y familias se hace mejor a través de una planificación urbana integral.

Se pusieron en servicio nuevas políticas:

- Limitando la presencia de coches en la ciudad, haciendo más espacio disponible para caminar.
- Aumentar los peatones en el centro de la ciudad y limitar la presencia de coches
- Más carriles bici Restauración de características históricas y naturales
- Rehabilitación de la construcción
- Un aumento de las zonas verdes
- Zonas peatonales y diseño de caminos más peatonales.

Esto se logró mediante inversiones en infraestructura a gran escala junto con campañas públicas sobre seguridad vial, cultura vial y caminar a la escuela.

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'For me, this is paradise': life in the Spanish city that banned cars

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Metrominuto apoya la intermodalidad basada en peatones

Pontevedra ha lanzado el primer mapa peatonal europeo que muestra información sobre distancias a pie y tiempos de viaje entre los principales lugares dentro de la ciudad para apoyar la caminata como el principal medio de movilidad.

Copiado por muchas ciudades, incluyendo París, Londres y Florencia.

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Resultados

- En 1999 el **tráfico fue cerrado en el centro de la ciudad y desde entonces se ha logrado reducir la contaminación de los vehículos en el área urbana** en un 66% entre 1999 y 2014. (En España, el 3% de la mortalidad anual es atribuible a la contaminación atmosférica, que causa graves problemas de salud)
- **Menos coches**: En 1997, hasta 52.000 vehículos motorizados inundaron las calles de la ciudad. Hoy en día, las políticas "mejores a pie" han bajado esta cifra a 17.000.
- **Tráfico más seguro:** Medidas de reducción del tráfico, como reducir la velocidad máxima a 30 km/h. En las mismas calles donde 30 personas murieron en accidentes de tráfico de 1996 a 2006, sólo tres murieron en los siguientes 10 años, y ninguno desde 2009 (2017).

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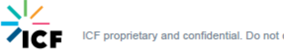
Factores claves del éxito

- Establecieron y partieron de una visión común cohesionada
- Enfoque multi-sectoral
- Establecieron estrategias y indicadores basados en los objetivos principales
- Facilitaron el cambio de comportamiento y estilos de vida en hacerles lo más ¨fáciles¨



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Transferabilidad

- La iniciativa ya se ha implementado desde hace más de dos décadas en un municipio español.
- Muestra el poder de lo que puede suceder cuando se establece una visión común y cohesionado para la salud.
- Pontevedra ha ido desarrollando gradualmente iniciativas de pacificación del tráfico que han contribuido a impulsar los hábitos de los residentes a caminar y a reducir drásticamente el uso de vehículos motorizados para moverse por la ciudad.
- Se necesita una evaluación sobre los efectos en la salud.

→ Las ciudades más grandes pueden aplicar principios idénticos, combinando medidas de pacificación y reducción de la densidad del tráfico, así como la implementación de intervenciones por distrito para retirar los coches privados de los espacios públicos para priorizar a peatones, ciclistas y usuarios del transporte público.

→ En las ciudades donde las redes de autobuses y metros dejan a los pasajeros a poca distancia de su destino, las políticas de "mejor a pie" son igualmente aplicables. Sin embargo, se requiere un sistema de transporte público fiable y asequible para mayoría de la población.

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Conclusiones finales

Elementos de las mejores prácticas

- Están informadas por la evidencia científica
- Tienen objetivos y ¨targets¨ claros y medibles
- Son participativos/co-creadas
- Incluyen de manera explícita la equidad
- Incluyen monitoreo y evaluación de los impactos y el proceso
- Son replicables en otros contextos
- Están vinculadas o crean sinergias con otros proyectos y planes a nivel local/regional/nacional

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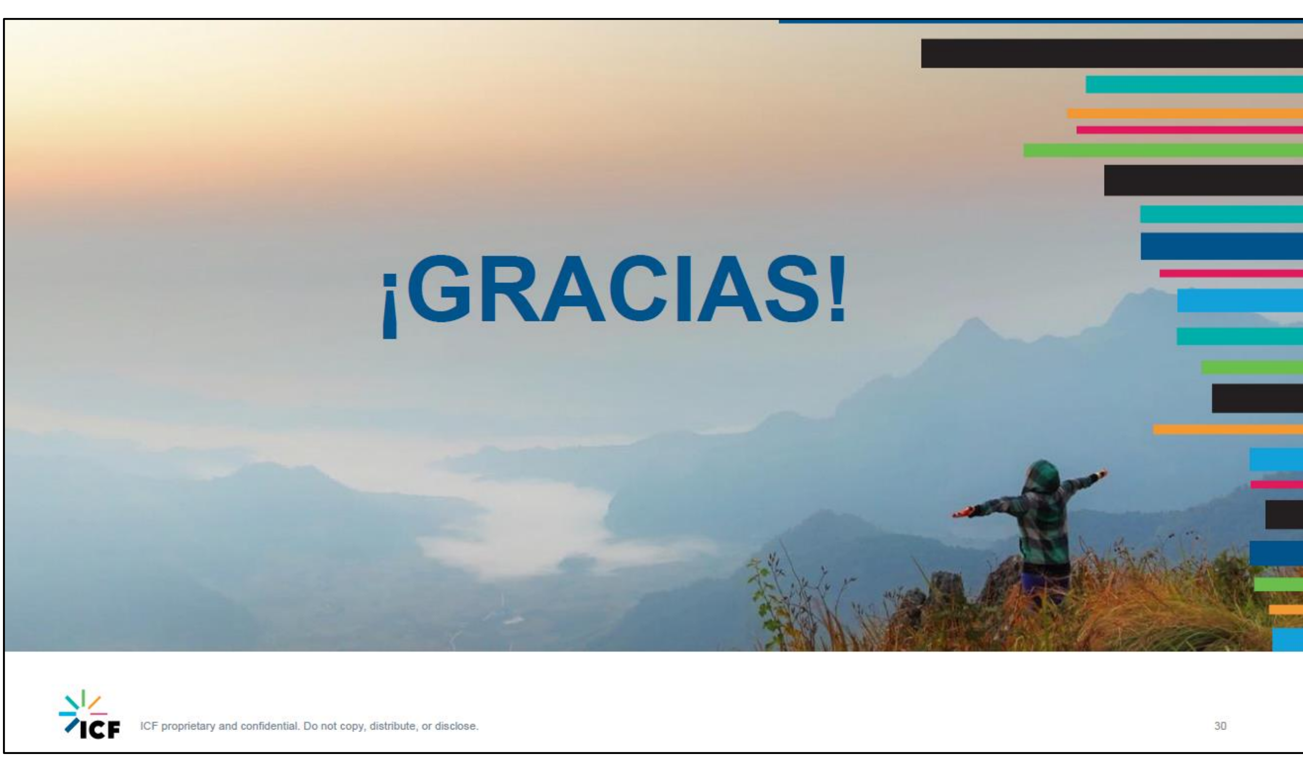

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