# Cardiovascular disease prevention in Europe - the unfinished agenda

**EuroHeart work package 5:**
**National plans, policies and measures impacting on cardiovascular health promotion and cardiovascular disease prevention**

EUROPEAN HEART NETWORK

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# Acknowledgments

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# Introduction

Cardiovascular disease (CVD) remains the leading cause of death in the European Union, accounting for over 2 million deaths each year. Whilst the risk factors and determinants for cardiovascular diseases are well established, an incomplete picture exists of what individual countries have put in place in terms of strategies and actions to address the heavy human and economic burden that these diseases represent.

Over the last half decade, significant policy developments addressing CVD have taken place in Europe. Amongst them are the Council Conclusions to promote heart health adopted in 2004, the European Heart Health Charter launched in 2007, and the European Parliament Resolution on action to tackle cardiovascular disease adopted with a large majority in July 2007.

To build on these developments and to implement specific provisions in the European Heart Health Charter, the European Heart Network and the European Society of Cardiology agreed to pool their expertise in a joint project called the EuroHeart project. The overarching objectives of EuroHeart are to strengthen cross-sector cooperation; obtain comprehensive comparable information on policies and actions on cardiovascular health promotion and CVD prevention; improve awareness, diagnosis and treatment of women with CVD across Europe; and create a level playing field by introducing national versions of CVD guidelines. These objectives have been detailed in separate work packages.

This report deals with one of EuroHeart's work packages – work package 5 - providing an overview of existing national strategies and actions in the fields of cardiovascular health promotion and/or cardiovascular disease prevention in 16 countries in Europe. The report and its conclusions will be widely disseminated to decision makers in Europe, allowing them to review their national strategies in light of what is happening in other countries. The report is a snapshot of the situation. Addressing CVD is not static, and ongoing review and evaluation of the impact of the strategies that are implemented is essential. The European Heart Network believes that whereas health policy is largely in the domain of the EU Member States, the EU can support them and help level out inequalities within and between countries by, for example, establishing benchmarks through recommendations. Certainly, in terms of considering heart health in other policies, the EU can take a leading role by ensuring effective health impact assessment of measures proposed in a wide range of policies.

# Background

CVD is the main cause of death in women in all European countries and is the main cause of death in men in all countries except France, The Netherlands and Spain. However, there are great differences in mortality rates across Europe.

This is also the case amongst the 16 WP 5 countries as set out in tables 1 and 2 and figures 1 - 4. The death rate from CHD in men in Hungary (105/100 000) is over six times higher than in France (17/100 000). For women, the death rate in Hungary is over nine times higher than in France. The death rate from stroke in men in Estonia (41/100 000) is over 10 times higher than in Iceland (4/100 000). The death rate from stroke in women in Estonia is over three times higher than in Iceland.

There are also noticeable differences in trends in mortality. In Finland the decreases in mortality rates from both coronary heart disease (CHD) and stroke are significant (76% CHD; 74% stroke) from 1972 to 2005. In the same period in Greece, mortality rates for CHD have increased by 11%. But a decrease in death rates from stroke can be noted (48%) in Greece.

In nine of the WP 5 countries, the trends in death rates for CHD in women show that they have declined less compared to death rates for men.

More detailed information on population GDP mortality and selected risk factors can be found in the supplementary report, Country Summary reports on http://www.ehnheart.org/content/itemstory.asp?level0=1456&level1=2096&level2=2176

Source for tables 1 and 2 and figures 1 - 4 is: Allender, S.; Scarborough, P.; Peto, V.; Rayner, M. (2008) European cardiovascular disease statistics 2008. European Heart Network. Brussels.

# Mortality rates for men and women in the 16 WP 5 Countries: Highest to lowest

## Age standardised mortality rates for men and women aged under 65, in the 16 WP 5 Countries: highest to lowest

**Table 1:**
**Coronary Heart Disease**

| MEN | |
|---|---|
| **Country** | Rate per 100 000 |
| Hungary | 105 |
| Estonia | 104 |
| Slovakia | 74 |
| Greece | 50 |
| Finland | 48 |
| UK | 44 |
| Ireland | 39 |
| Belgium | 36 |
| Germany | 33 |
| Slovenia | 33 |
| Iceland | 30 |
| Denmark | 30 |
| Norway | 27 |
| Italy | 25 |
| Netherlands | 22 |
| France | 17 |

| WOMEN | |
|---|---|
| **Country** | Rate per 100 000 |
| Hungary | 28 |
| Estonia | 20 |
| Slovakia | 19 |
| UK | 11 |
| Greece | 10 |
| Belgium | 9 |
| Denmark | 9 |
| Ireland | 9 |
| Germany | 8 |
| Finland | 7 |
| Netherlands | 7 |
| Norway | 6 |
| Italy | 5 |
| Slovenia | 5 |
| France | 3 |
| Iceland | 3 |

**Figure 1:**
**Mortality rates of coronary heart disease in men under 65, per 100,000 population**

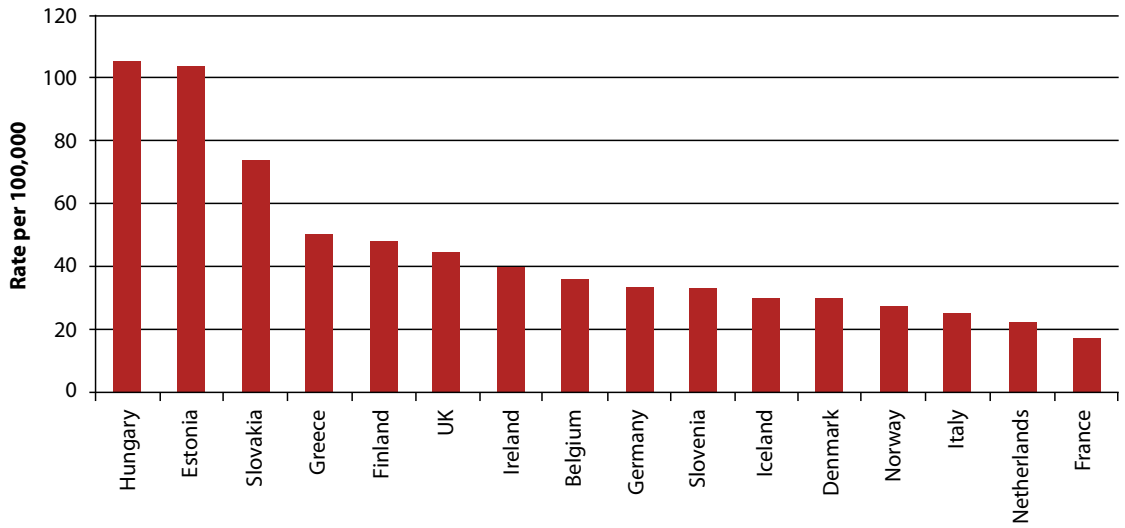
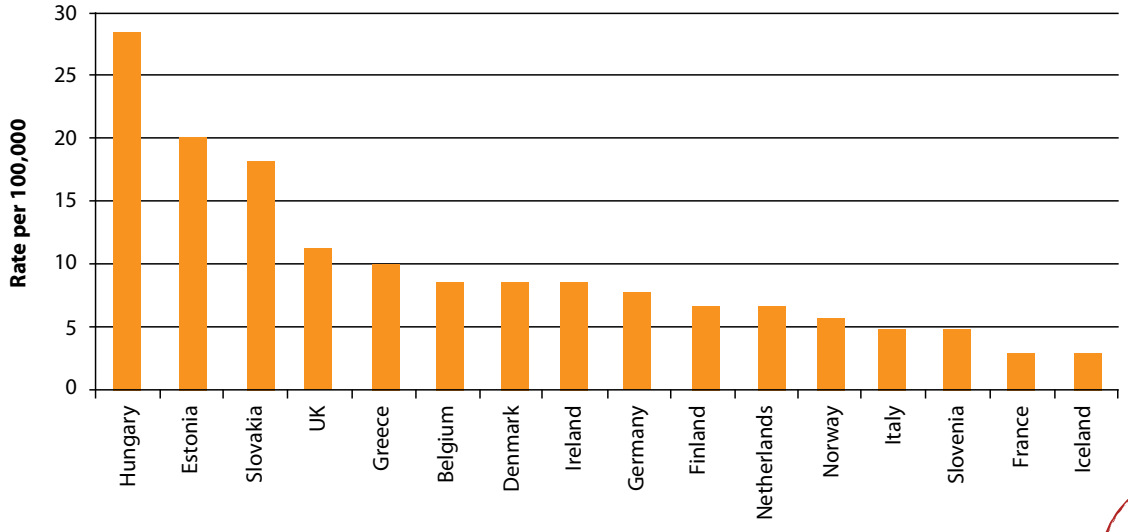



**Figure 2:**
**Mortality rates of coronary heart disease in women under 65, per 100,000 population**




Source: S Allender, P Scarborough, V Peto, M Rayner. European cardiovascular disease statistics. 2008. European Heart Network. Brussels.
Latest available year (ranges from 1997 to 2006)

**Table 2:**
**Stroke**

| MEN | |
|---|---|
| **Country** | Rate per 100 000 |
| Estonia | 41 |
| Hungary | 34 |
| Slovakia | 19 |
| Greece | 14 |
| Slovenia | 13 |
| Denmark | 12 |
| Belgium | 11 |
| Finland | 11 |
| Italy | 9 |
| UK | 9 |
| Germany | 8 |
| Ireland | 8 |
| France | 7 |
| Netherlands | 7 |
| Norway | 7 |
| Iceland | 4 |

| WOMEN | |
|---|---|
| **Country** | Rate per 100 000 |
| Estonia | 16 |
| Hungary | 15 |
| Belgium | 8 |
| Denmark | 7 |
| Greece | 7 |
| Slovakia | 7 |
| Slovenia | 7 |
| UK | 7 |
| Finland | 6 |
| Netherlands | 6 |
| Germany | 5 |
| Iceland | 5 |
| Italy | 5 |
| Norway | 5 |
| France | 4 |
| Ireland | 4 |

**Figure 3:**
**Mortality rates of stroke in men under 65, per 100,000 population**

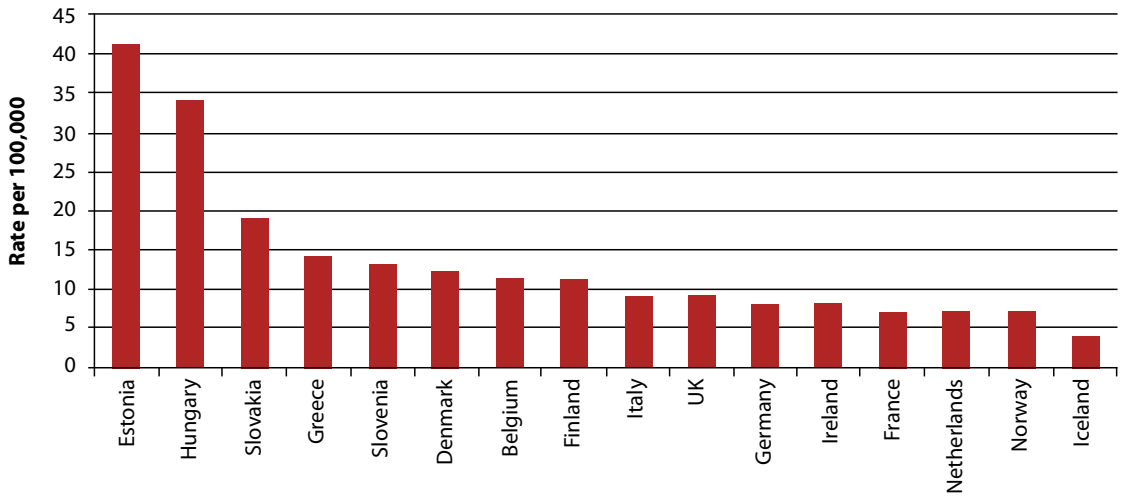
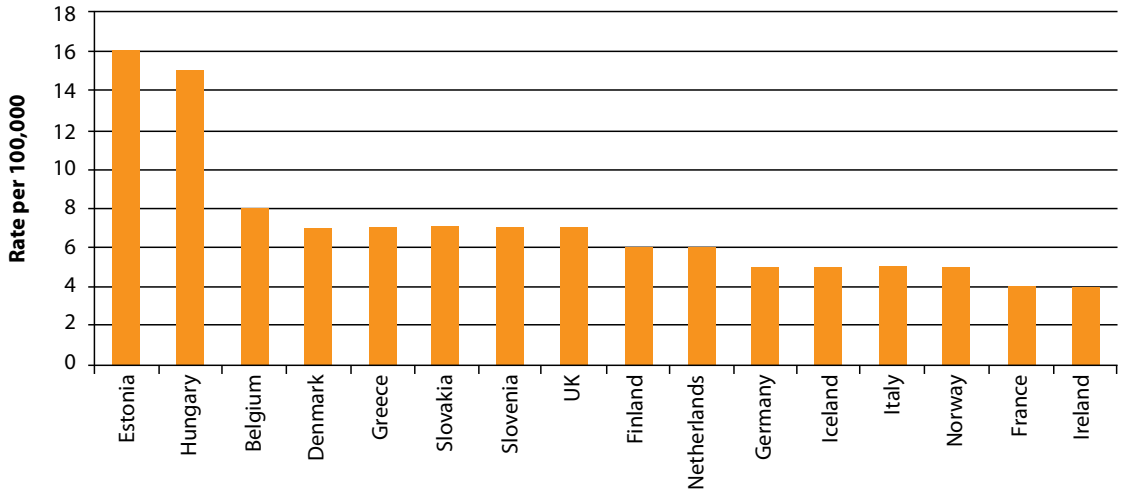



**Figure 4:**
**Mortality rates of stroke in women under 65, per 100,000 population**




Source: S Allender, P Scarborough, V Peto, M Rayner. European cardiovascular disease statistics. 2008. European Heart Network. Brussels. Latest available year (ranges from 1997 to 2006)

# Risk factor prevalence for men and women in the 16 WP 5 Countries: Highest to lowest

**Table 3:**
**Smoking: Latest available year**

| MEN | |
|---|---|
| Country | % |
| Greece | 47 |
| Estonia | 42 |
| Slovakia | 41 |
| Germany | 37 |
| Hungary | 37 |
| Netherlands | 35 |
| Italy | 31 |
| France | 30 |
| Denmark | 29 |
| Finland | 26 |
| Norway * | 26 |
| UK | 26 |
| Ireland | 24 |
| Slovenia | 24 |
| Belgium | 23 |
| Iceland | 22 |

| WOMEN | |
|---|---|
| Country | % |
| Germany | 31 |
| Greece | 29 |
| Netherlands | 26 |
| Hungary | 25 |
| Ireland | 24 |
| Norway * | 24 |
| Denmark | 23 |
| UK | 23 |
| Slovenia | 22 |
| Estionia | 21 |
| France | 21 |
| Iceland | 19 |
| Finland | 18 |
| Italy | 17 |
| Belgium | 16 |
| Slovakia | 15 |

**Figure 5:**
**Percentage of smoking in men aged 15 and over in the WP 5 countries**

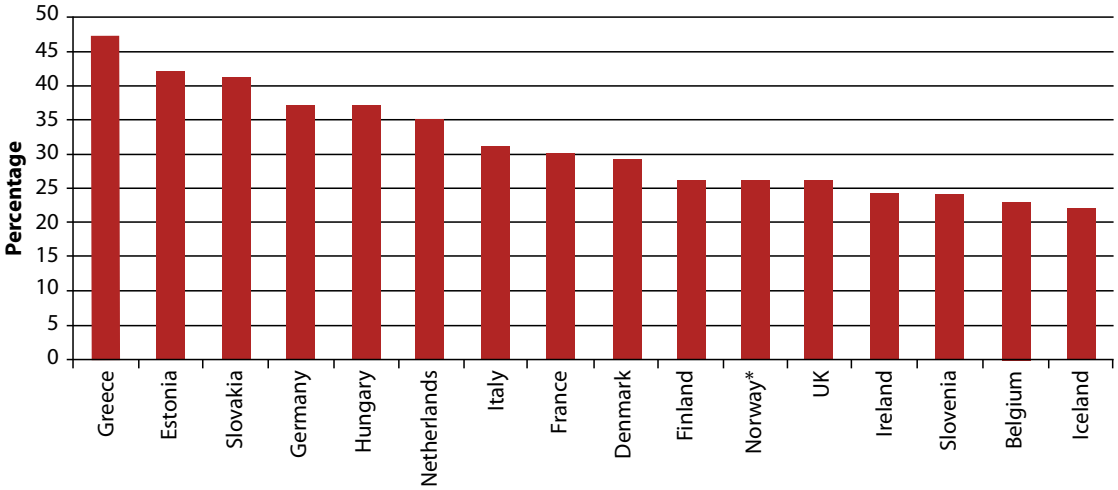
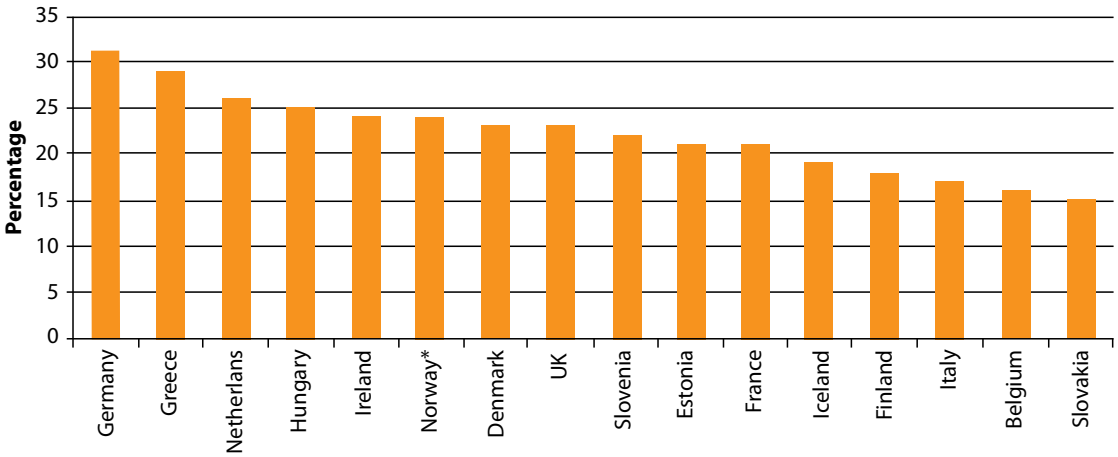



**Figure 6:**
**Percentage of smoking in women aged 15 and over in the WP 5 countries**



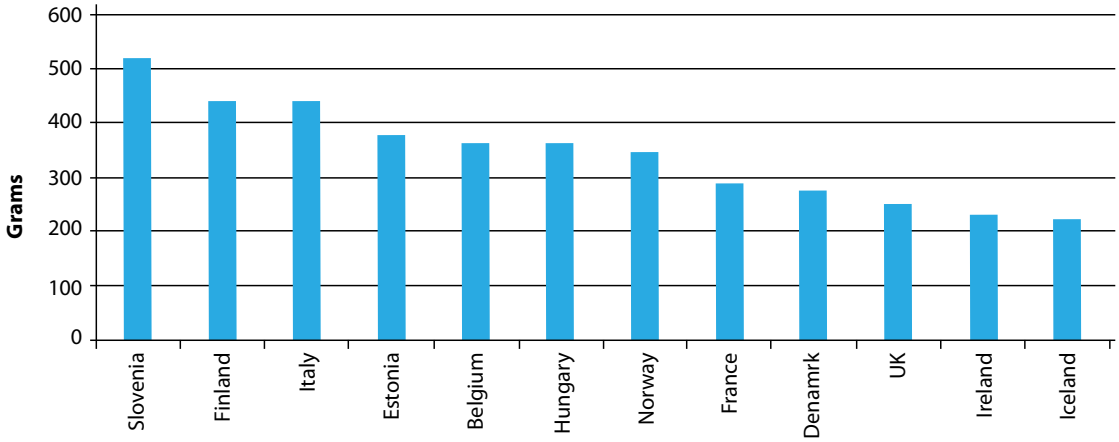

Sources: S Allender, P Scarborough, V Peto, M Rayner. European cardiovascular disease statistics. 2008. European Heart Network. Brussels. Latest available year (ranges from 1998 to 2008).

*Norwegian Directorate of Health, 2009

**Table 4:**
**Fruit and vegetable availability**

| ALL | |
|---|---|
| **Country** | Per person/day |
| Slovenia | 516 |
| Finland | 433 |
| Italy | 433 |
| Estonia | 378 |
| Belgium | 360 |
| Hungary | 360 |
| Norway | 341 |
| France | 288 |
| Denmark | 273 |
| UK | 248 |
| Ireland | 229 |
| Iceland | 224 |

**Figure 7:**
**Fruit and vegetables available in the WP 5 countries**

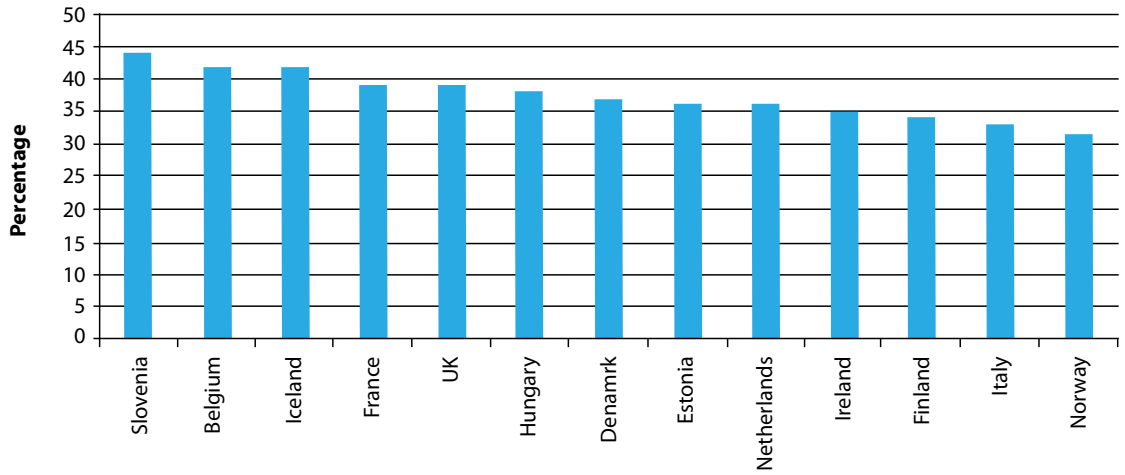



Data was unavailable for Greece, Germany, the Netherlands and Slovakia.
Source: S Allender, P Scarborough, V Peto, M Rayner. European cardiovascular disease statistics. 2008. European Heart Network. Brussels; Latest available year (ranges from 1980/84 to 1997)

**Table 5:**
**Percentage of total energy from fat**

| ALL | |
|---|---|
| **Country** | % |
| Slovenia | 44 |
| Belgium | 42 |
| Iceland | 42 |
| France | 39 |
| UK | 39 |
| Hungary | 38 |
| Denmark | 37 |
| Estonia | 36 |
| Netherlands | 36 |
| Ireland | 35 |
| Finland | 34 |
| Italy | 33 |
| Norway | 31 |

**Figure 8:**
**Percentage of total energy from fat in the WP 5 countries**




Data was unavailable for Greece, Germany and Slovakia.

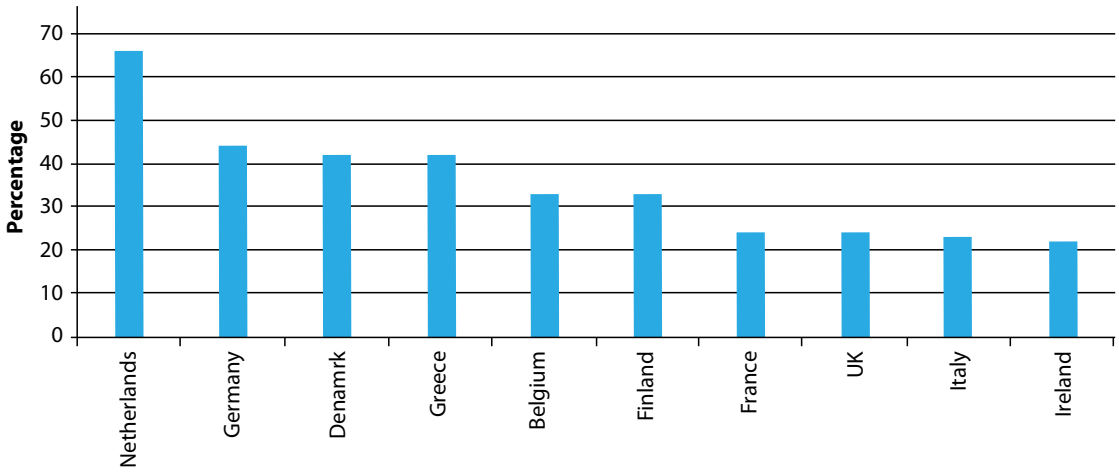
Source: S Allender, P Scarborough, V Peto, M Rayner. European cardiovascular disease statistics. 2008. European Heart Network. Brussels

Latest available year (ranges from 1980/84 to 1997)

**Table 6:**
**People achieving 4 or more days moderate physical activity per week, 2005**

| ALL | |
|---|---|
| Country | % |
| Netherlands | 66 |
| Germany | 44 |
| Denmark | 42 |
| Greece | 42 |
| Belgium | 33 |
| Finland | 33 |
| France | 24 |
| UK | 24 |
| Italy | 23 |
| Ireland | 22 |

**Figure 9:**
**Percentage of people achieving 4 or more days of moderate physical activity per week in the WP 5 countries, 2005**




Data was unavailable for Estonia, Hungary, Iceland, Norway, Slovenia and Slovakia.
Source: S Allender, P Scarborough, V Peto, M Rayner. European cardiovascular disease statistics. 2008. European Heart Network. Brussels.

# The EuroHeart mapping project

This report presents the findings of the EuroHeart mapping project (work package 5) which aims to provide a picture of heart health strategies across 16 countries in Europe. This mapping commenced in September 2007 and was completed in November 2008.

The primary objectives of work package 5 were, through mapping and analysis, to obtain comprehensive comparable information regarding policies, plans and measures impacting on cardiovascular health promotion and cardiovascular disease prevention. It aimed to identify differences and gaps in policies and actions across Europe and determine the essential elements in a comprehensive national strategy on cardiovascular diseases. The work package also aims to improve awareness of the importance of considering heart health in a wide range of policies. The EuroHeart project receives funding from the European Union in the framework of the Public Health programme.

## Methods

The mapping project ran as a collaborative process between the European Heart Network, associated national partners and the British Heart Foundation Health Promotion Research Group (BHFHPRG) at the University of Oxford (the academic partner for this work package). Each partner organisation had a defined role within the project. The European Heart Network provided overall management and administration of the work package and collected data at EU level. The associated national partners were tasked with collecting data within their countries and the BHFHPRG was responsible for the development of data collection tools, the analyses of data and the production of the project report.

An Advisory Board was established and met on three occasions (see Appendix A for details of membership of the board). An initial meeting was convened in October 2007 to discuss the work package 5 plans and to discuss the design and development of data collection tools. A second meeting took place in October 2008 to discuss the findings of the project. A third and final meeting of the Advisory Board took place in March 2009 to discuss dissemination of the findings.

## Questionnaire development

To allow collection of comparable information, it was agreed that structured questionnaires, administered via e-mail, would be the most efficient method of data collection across the participating countries. The BHFHPRG drafted and piloted a structured questionnaire and a set of explanatory notes, based, in part, on similar work undertaken by the World Health Organization (WHO)[1,2] (see Appendix B & C).

## Data collection

The collection of information was done at national level by the associated partners involved in this work package. Three meetings were held for national coordinators, the individuals nominated within each participating country to collect data on behalf of the University of Oxford. An initial meeting in November 2007 briefed the national coordinators about the data collection process they were to undertake, with a view to establishing quality criteria for retrieval and recording of data. Further advice and support was provided via e-mail as national coordinators completed their data collection.

After the initial deadline for return of data had passed, non-respondent national coordinators (n=4) were contacted by e-mail and encouraged to submit their data. This process resulted in all countries submitting data for analysis. Following data checking, several national coordinators were asked to provide missing information. In addition, each national coordinator was asked to collect further information about their country's national policies/strategies or plans (see Appendix D). In June 2008, a second meeting was held to present the initial findings of the project to the national coordinators. Following this meeting, national coordinators were asked to review a summary of the information they had collated and to correct any misinterpretations of the data.

In September 2008, data collected as part of the WHO project[1, 2] was examined in order to assess the comparability of the two data sets, taking into consideration that the data was collected at different time points. The national coordinators were asked to comment on any data discrepancies which were found.

As a result of discussions which took place at the Advisory Board meeting in October 2008, each national coordinator was also asked to compile summary information about their national cardiovascular health promotion and/or disease prevention policy.

A final meeting of the national coordinators took place in March 2009 to agree the final changes to the report and discuss dissemination and follow-up.

## Data analysis

All data analyses were undertaken by the BHFHPRG at the University of Oxford. Data from each country was collated using Excel. Originally the analyses were planned around the development of a matrix taking into account similar types of comparative analysis[1-4] and with reference to the Ottawa Charter.[5] After three rounds of data collection, the associated national partners have produced a sizeable amount of information. However, variability in the data has meant that we have not been able to perform a detailed analysis of all the information. Instead a descriptive analysis was undertaken.

# Results

A summary of key findings is presented here. Further information relating to individual countries can be found in the supplementary report, Country Summary reports, available on http://www.ehnheart.org/content/itemstory.asp?level0=1456&level1=2096&level2=2176

A glossary of terms is given on p. 55

## National organisations

All countries could identify a government department with the main responsibility for public health action relevant to the prevention and control of chronic diseases. Most countries could also identify other government departments and/or other national organisations that were similarly involved.

All countries could also identify the government department with the main responsibility for cardiovascular health promotion and/or cardiovascular disease prevention. A range of other organisations (governmental, non-governmental organisations, charities, professional societies) were involved in cardiovascular health promotion and/or cardiovascular disease prevention in all 16 countries.

Some countries could identify an organisation with responsibility for coordinating the implementation of a policy/strategy or plan on cardiovascular health promotion and/or cardiovascular disease prevention. Ireland reported the organisations responsible for the implementation of identified objectives. Finland reported that a range of actors have taken on responsibility for the implementation of actions to achieve specific objectives.

## National acts, laws and legislation

Table 7 shows the mapping of existing and planned legislation within all 16 countries. Each country reported some type of legislation covering public health, tobacco control and food. Public health legislation was usually general in nature, commonly steering the provision of health and related medical services. Tobacco legislation included provision for bans/restrictions on smoking in public places, restrictions on advertising and sales of tobacco products, and warning labels. Food related legislation varied from labelling requirements to provision of food in school settings. All countries except Greece reported legislation around control of alcohol, commonly relating, for example, to restriction of advertising and/or sales to young people. Eleven of the 16 countries had legislation relating to the promotion of physical activity. This included the organisation and promotion of sport and provision of opportunities for physical activity within schools.

Legislative action around diabetes, cardiovascular health promotion and/or cardiovascular disease prevention, tackling health inequalities and obesity was less common, reported in half or fewer of the countries. Only two countries reported legislation around stress (Belgium, Slovakia), relating to workplace and/or mental health provision.

## National policies/strategies or plans

Table 8 shows the mapping of existing and proposed national policies/strategies or plans within all 16 countries. The most commonly reported national policies were broadly consistent with the areas most frequently covered by legislation.

Fifteen countries reported a national public health policy (excluding Germany, where this type of action is the responsibility of the federal states). Similarly, all countries (apart from Denmark) reported a national tobacco policy. Fourteen countries (excluding Germany and Greece) had national policies relating to coronary heart disease. All countries (apart from Denmark and Greece) had national policies in relation to both food and physical activity.

Figure 10 shows the countries reporting a national policy in relation to cardiovascular health promotion and/or cardiovascular disease prevention, coronary heart disease, hypertension, stroke and hyperlipidaemia. Action in these areas has been tackled in different ways across countries. Most countries had national policy addressing either all or four of these areas. Some countries had adopted national policies in cardiovascular health promotion and/or cardiovascular disease prevention and in coronary heart disease only (Denmark, Hungary) whereas others (like England and Northern Ireland (UK)) reported a national policy on coronary heart disease and a separate strategy on stroke. Germany reported no national policy, but there is regional level policy activity around stroke. Greece reported a cardiovascular health promotion and/or cardiovascular disease prevention strategy in preparation.

Several countries reported programmes or recommendations for programmes/policies that enable early diagnosis (identification of high risk population or screening). These countries are: Belgium, Estonia, France, Greece, Hungary, Ireland and The Netherlands. For example, in the French-speaking Community of Belgium the overall approach to promotion of cardiovascular health includes an objective to improve screening so as to assess overall risk of cardiovascular diseases in the population aged 30 to 75. Generally, countries place the responsibility for the identification and management of screening on general practitioners. Three countries, France, Germany and Ireland, report recommendations for acute first aid, e.g. cardio-pulmonary resuscitation (CPR) and access to and training in the use of external defibrillators.

A range of different approaches was found when countries reported their policy-related action around diseases and lifestyle risk factors associated with cardiovascular disease (alcohol, food, physical activity and tobacco). Eleven countries (and two parts of the United Kingdom) reported national policies addressing obesity, diabetes and all four lifestyle risk factors. Greece reported no national policies in any of these areas. Scotland reported an obesity policy alongside policies relating to all lifestyle risk factors, and Northern Ireland has a diabetes policy and policies relating to all lifestyle risk factors. Slovenia reported a diabetes policy in preparation alongside policies relating to all lifestyle risk factors. Estonia and Hungary have policies about food, physical activity and tobacco. Denmark reported national obesity and diabetes policies.

Eleven countries (excluding Denmark, Estonia, France, Germany and Greece) reported national policies addressing health inequalities. In contrast, few countries have any national policy in relation to stress.

Countries reported a common structure within their policy documentation, even though variation in length was reported across the subject area. Most policy documents reportedly contain information regarding the severity of the health issue in question within the country, goals and timescales to be followed, options for action, recommendations and identification of important agents to support change. Some countries reported the publication of more detailed action plans to support the general statements outlined in policy documents, while others noted the publication of progress reports. Other elements which might contribute to the development of a comprehensive national strategy on cardiovascular disease will be discussed later. Examples of national policies on cardiovascular health promotion and/or disease prevention can be found in the supplementary report, Country Summary reports, available on http://www.ehnheart.org/content/itemstory.asp?level0=1456&level1=2096&level2=2176

**Table 7:**
**Mapping of existing and planned legislation within all WP5 countries**

| Country | Public Health | Cardiovascular Disease | Obesity | Diabetes | Alcohol | Food | Physical Activity | Tobacco | Signatory FCTC | Stress | Inequalities |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium French | ● | ● | ✖ | ✖ | ● | ● | ● | ● | ● | ● | ● |
| Belgium Flemish | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Belgium German | ● | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ● | ✖ |
| Denmark | ● | ● | ● | ● | ● | ● | ✖ | ● | ● | ✖ | ● |
| Estonia | ● | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ✖ | ✖ |
| Finland | ● | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ✖ | ✖ |
| France | ● | ● | ✖ | ✖ | ● | ● | ● | ● | ● | ✖ | ✖ |
| Germany | ● | ● | ● | ● | ● | ● | ✖ | ● | ● | ✖ | ● |
| Greece | ● | ✖ | ✖ | ✖ | ✖ | ● | ✖ | ● | ● | ✖ | ✖ |
| Hungary | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ✖ | ✖ |
| Iceland | ● | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ✖ | ● |
| Ireland | ● | ✖ | ✖ | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● |
| Italy | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ● |
| Netherlands | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ✖ | ✖ |
| Norway | ● | ✖ | ● | ✖ | ● | ● | ● | ● | ● | ✖ | ● |
| Slovakia | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Slovenia | ● | ● | ■ | o | ● | ● | ● | ● | ● | ✖ | ✖ |
| UK England | ● | ✖ | ✖ | ✖ | ● | ● | ✖ | ● | ● | ✖ | ✖ |
| UK Northern Ireland | ● | ✖ | ✖ | ✖ | ● | ● | ✖ | ● | ● | ✖ | ✖ |
| UK Scotland | ● | ✖ | ✖ | ✖ | ● | ● | ✖ | ● | ● | ✖ | ✖ |
| UK Wales | ● | ✖ | ✖ | ✖ | ● | ● | ✖ | ● | ● | ✖ | ✖ |

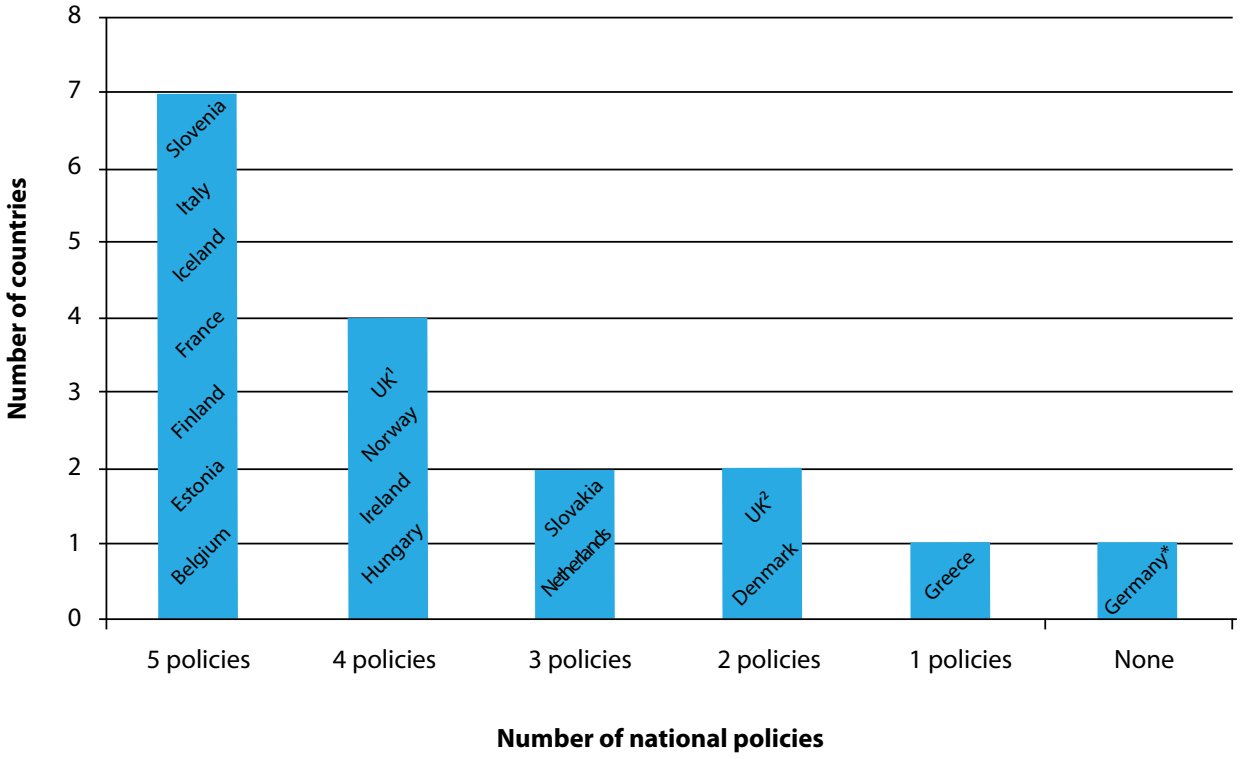
Key: ● = yes; ✖ = no; o = in preparation; ■= don't know, no response

**Table 8:**
**Mapping of existing and planned national policies/strategies and plans in all WP5 countries**

| Country | Public Health | Cardiovascular Disease | Coronary Heart Disease | Hypertension | Stroke | Hyperlipidaemia | Obesity | Diabetes | Alcohol | Food & nutrition | Physical Activity | Tobacco | Stress | Inequalities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium French | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ■ | ● |
| Belgium Flemish | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ■ | ● |
| Belgium German | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ■ | ● |
| Denmark | ● | ● | ● | ✖ | ✖ | ✖ | ● | ● | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ |
| Estonia | ● | ● | ● | ● | ● | ● | ✖ | ✖ | ✖ | ● | ● | ● | ✖ | ✖ |
| Finland | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ● |
| France | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ✖ |
| Germany | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | o | o | ● | ● | ● | ● | ✖ | ✖ |
| Greece | o | o | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ● | ✖ | ✖ |
| Hungary | ● | ● | ● | ● | ● | ✖ | ✖ | ✖ | ✖ | ● | ● | ● | ✖ | ● |
| Iceland | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ■ | ● |
| Ireland | ● | ● | ● | ● | o | ✖ | ● | ● | ● | ● | ● | ● | ● | ● |
| Italy | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ● |
| Netherlands | ● | ● | ● | ✖ | ✖ | ● | o | ● | ● | ● | ● | ● | ✖ | ● |
| Norway | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ● |
| Slovakia | ● | o | ● | ✖ | o | ✖ | ● | ● | ● | ● | ● | ● | ● | ● |
| Slovenia | ● | ● | ● | ● | ● | ● | ✖ | o | ● | ● | ● | ● | o | ● |
| UK England | ● | ✖ | ● | ✖ | ● | ✖ | ● | ● | ● | ● | ● | ● | ✖ | ● |
| UK Northern Ireland | ● | ✖ | ● | ✖ | o | ✖ | ● | ✖ | ● | ● | ● | ● | ● | ● |
| UK Scotland | ● | ✖ | ● | ● | ● | ● | ✖ | ● | ● | ● | ● | ● | ✖ | ● |
| UK Wales | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | o | ● |

Key: ● = yes; ✖ = no; o = in preparation; ■ = don't know, no response

**Figure 10:**
**Countries reporting national policy in relation to cardiovascular health promotion and/or cardiovascular disease prevention, coronary heart disease, hypertension, stroke and hyperlipidaemia**




UK[1] Scotland and Wales
UK[2] England and Northern Ireland

* Germany reports no national policy because competence for health policy strategies lies primarily with the federal states

## National programmes

Table 9 shows the mapping of existing and proposed national programmes within all 16 countries. Programmes to address issues relating to tobacco, public health, physical activity, coronary heart disease and food were most frequently reported across countries, as also shown with, and perhaps linked to, legislative and policy action. Programme activity ranged from multi-media campaigns to action aimed at specific population groups, through different settings – for example, in schools, in workplaces and in primary health care. Programmes adopted various approaches. The majority of programmes reported by most countries were educational programmes designed to influence individual health behaviours. Some countries also reported a population-based approach in some areas, for example, promoting physical activity through structural changes like provision of improved cycling or play facilities. Twelve countries reported a national diabetes programme. Half or more of the countries reported the existence of a national programme on cardiovascular health promotion and/or cardiovascular disease prevention or programmes to address hypertension, alcohol and/or obesity. Less common were national programmes relating to hyperlipidaemia, stroke and stress. Only four countries (Belgium, Finland, Italy, and the United Kingdom) reported specific national programmes to tackle health inequalities.

### The National Child Measurement Programme in England

The National Child Measurement Programme is one element of the Government's work programme on childhood obesity, and is operated jointly by the Department of Health and the Department for Children, Schools and Families. The programme was established in 2005.

Every year, children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) are weighed and measured during the school year to inform local planning and delivery of services for children, and to gather population-level surveillance data to allow analysis of trends in growth patterns and obesity.

The programme also helps to increase public and professional understanding of weight issues in children and is a useful vehicle for engaging with children and families about healthy lifestyles and weight issues. All parents of children who take part in the programme will receive their child's results, regardless of their weight, unless the parent asks not to receive the results.

Further information http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/DH_073787

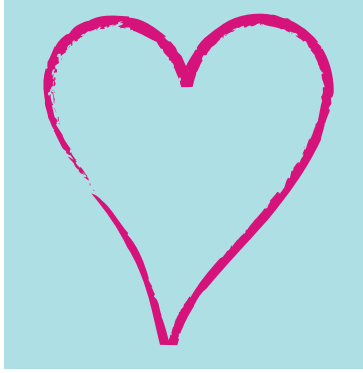


**Table 9:**
**Mapping of existing and proposed national programmes in all WP5 countries**

| Country | Public Health | Cardiovascular Disease | Coronary Heart Disease | Hypertension | Stroke | Hyperlipidaemia | Obesity | Diabetes | Alcohol | Food | Physical Activity | Tobacco | Stress | Inequalities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belgium French | ● | ● | ● | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● |
| Belgium Flemish | ● | ● | ● | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● |
| Belgium German | ● | ● | ● | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● |
| Denmark | ✖ | ● | o | ✖ | ✖ | ✖ | ✖ | o | ✖ | ✖ | ✖ | ✖ | ■ | ✖ |
| Estonia | ● | ● | ● | ● | ● | ● | ✖ | ✖ | ✖ | ● | ● | ● | ✖ | ✖ |
| Finland | ● | ● | ● | ● | ✖ | ● | ✖ | ● | ● | ● | ● | ● | ✖ | ● |
| France | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ✖ |
| Germany | ● | ● | ● | ✖ | ✖ | ✖ | ● | ● | ● | ✖ | ● | ● | ✖ | ✖ |
| Greece | ✖ | ✖ | ● | ● | ■ | ● | ● | ● | ■ | ■ | ● | ● | ● | ■ |
| Hungary | ✖ | ✖ | ● | ● | ■ | ■ | ■ | ■ | ■ | ● | ■ | ● | ■ | ■ |
| Iceland | ● | ✖ | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● | ■ |
| Ireland | ● | ● | ● | ✖ | ✖ | ✖ | ✖ | ✖ | ● | ● | ● | ● | ✖ | ■ |
| Italy | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ● |
| Netherlands | ● | ● | ✖ | ✖ | ✖ | ● | ● | ● | o | ✖ | ✖ | ● | ✖ | ✖ |
| Norway | ● | ✖ | ✖ | ● | ✖ | ✖ | ✖ | ● | ✖ | ● | ● | ● | ✖ | ✖ |
| Slovakia | ● | ● | ✖ | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ● | ● | ✖ |
| Slovenia | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ■ | ■ | ■ |
| UK England | ● | ✖ | ● | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ● | ● |
| UK Northern Ireland | ● | ✖ | ✖ | ✖ | ● | ✖ | ● | ● | ✖ | ● | ● | ● | ● | ● |
| UK Scotland | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| UK Wales | ● | ● | ● | ● | ● | ● | ✖ | ● | ● | ● | ● | ● | ● | ● |

Key: ● = yes; ✖ = no; o = in preparation; ■= don't know, no response

## National guidelines/standards

Table 10 shows the mapping of existing and planned national guidelines/standards within all 16 countries. Two countries reported no national guidelines/standards at all (Denmark and Greece ). All other countries reported national guidelines/standards addressing coronary heart disease and hypertension, with a minority (Belgium, Finland, Ireland) reporting official government endorsement of existing European guidelines. Most countries had national guidelines/standards around the management of hyperlipidaemia (except Denmark, Greece and Italy), diabetes and stroke prevention. Ten countries had obesity guidelines/standards.

**Table 10:**
**Mapping of existing and planned national guidelines/standards in all WP5 countries**

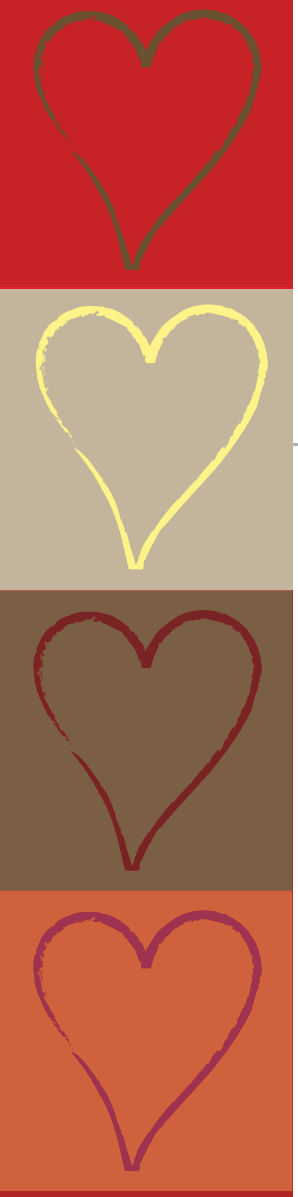
| Country | Cardiovascular Disease | Hypertension | Stroke | Hyperlipidaemia | Obesity | Diabetes |
|---|---|---|---|---|---|---|
| Belgium French | ● | ● | ● | ● | ● | ✖ |
| Belgium Flemish | ● | ● | ● | ● | ● | ● |
| Belgium German | ● | ● | ● | ● | ● | ✖ |
| Denmark | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ |
| Estonia | ● | ● | ✖ | ● | ● | ● |
| Finland | ● | ● | ● | ● | ● | ● |
| France | ● | ● | ● | ● | ● | ● |
| Germany | ● | ● | ● | o | ● | ● |
| Greece | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ |
| Hungary | ● | ● | ● | ● | ● | ● |
| Iceland | ● | ● | ● | ● | ● | ● |
| Ireland | ● | ● | o | ● | ● | o |
| Italy | ● | ● | ● | ● | ● | ● |
| Netherlands | ● | ● | ● | ● | ● | ● |
| Norway | ● | ● | ● | ● | ● | ✖ |
| Slovakia | ● | ● | ■ | ● | ■ | ● |
| Slovenia | ● | ● | ● | ● | ✖ | ● |
| UK England | ● | ● | ● | o | ● | ● |
| UK Northern Ireland | ● | ● | ● | ● | ● | ● |
| UK Scotland | ● | ● | ● | ● | ● | ● |
| UK Wales | ● | ● | ● | o | ● | ● |

Key: ● = yes; ✖ = no; o = in preparation; ■= don't know, no response

## National targets, monitoring and evaluation

Table 11 shows responses relating to national targets on public health, cardiovascular health promotion and/or disease prevention, the presence of any monitoring of existing targets and information regarding systematic public reporting and evaluation of heart health initiatives.

All countries had some type of cardiovascular health and/or cardiovascular disease prevention targets. These were reported as either general targets to reduce the prevalence of cardiac-related ill health within specific population groups and/or targets related to risk factors. Two countries (Finland and Slovenia) and one community in Belgium reported these targets alongside monitoring of achievement, a structure for systematic public reporting of action and the presence of evaluation regarding some type of heart health activity. Similarly, Slovakia reported targets, monitoring of achievement of these targets, evaluation and a structure for systematic public reporting of action in development. Estonia and three parts of the UK (not Northern Ireland) reported targets, monitoring of achievement of these targets, evaluation but no existing structure for systematic public reporting of action. Five countries (France, Iceland, Ireland, Italy and The Netherlands) and one part of the UK (Northern Ireland) reported the existence of targets and some form of monitoring of achievement of those targets. In Italy the prescription of drugs affecting lipid metabolism is linked to the individual risk, measured by a national score (Progetto Cuore).



# General comments

Whilst an overview of reported activities has been presented, only simple descriptive analyses were possible for several reasons. Despite rigorous attempts to standardise data collection methods and the diligence of the data collectors at national level, different countries provided a range of levels of depth of information. This made detailed comparison impractical. Sometimes this was due to a lack of response to requests for key information from government departments within countries. Also, much of the relevant documentation was only available in a country-specific language, so an English-language title or brief summary was relied upon, as translation costs were beyond the scope of the work package.

Despite these practical problems, in common with similar projects, this mapping has found that most of the European countries taking part in this work package have reported existing national strategies and action in the fields of cardiovascular health promotion and/or disease prevention. It is beyond the scope of this project to comment on the effectiveness of such measures within countries or to compare and assess the range of different approaches taken by different countries.

However, the findings suggest that in most countries the links between legislative action, policy measures and programme initiatives were strongest in relation to public health, coronary heart disease, tobacco, food and physical activity. Government and partnership working exists in most countries, although clear coordination of action was not reported in all countries. Guidelines for the management of coronary heart disease and hypertension were common. Most countries reported some type of cardiovascular health promotion and/or cardiovascular disease prevention targets. However, the links between such targets and monitoring, public reporting of measures of progress towards achievement of the targets and national evaluation were much less clear.

It was possible to identify budgets allocated for policy/programme implementation in about half of the 16 countries, and in most instances, data available around funding was incomplete. This could be due to problems with the data collection method, could point to a need for more 'open and transparent' decision making or may reflect a genuine lack of 'ring fencing' of resources to enable cardiovascular health promotion/cardiovascular disease prevention action to be achieved.

**Table 11:**
**Mapping of existing and planned national targets, monitoring and evaluation in all WP5 countries**

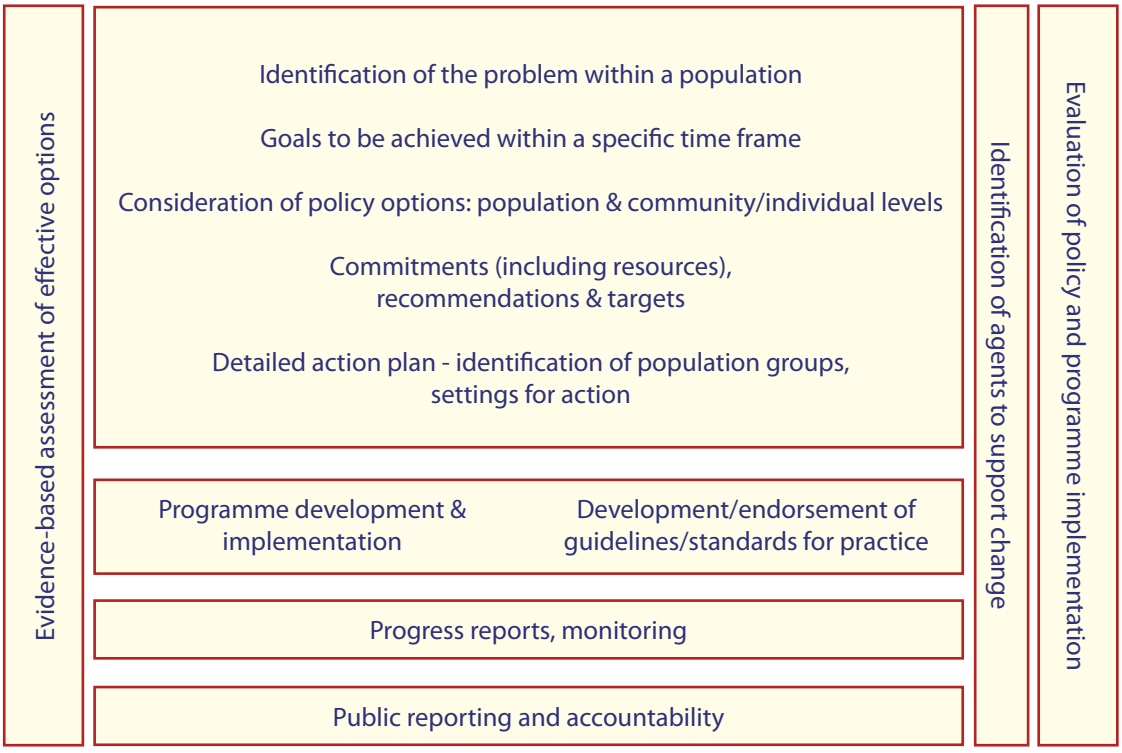
| Country | Public Health | Cardiovascular Disease | Monitoring | Reporting | Evaluation |
|---|---|---|---|---|---|
| Belgium French | ● | ✖ | ✖ | ✖ | ✖ |
| Belgium Flemish | ● | ● | ● | ● | ● |
| Belgium German | ✖ | ✖ | ✖ | ● | ✖ |
| Denmark | o | ✖ | ✖ | ✖ | ✖ |
| Estonia | ● | ● | ● | ✖ | ● |
| Finland | ● | ● | ● | ● | ● |
| France | ● | ■ | ● | ✖ | ● |
| Germany | ● | ✖ | ✖ | ✖ | o |
| Greece | ✖ | ✖ | ✖ | ✖ | ✖ |
| Hungary | ✖ | ● | ✖ | ✖ | ■ |
| Iceland | ● | ● | ● | ✖ | ✖ |
| Ireland | ✖ | ● | ● | ✖ | ● |
| Italy | ● | ● | ● | ● | ● |
| Netherlands | ● | ✖ | ● | ● | ● |
| Norway | ● | ✖ | ✖ | ● | ✖ |
| Slovakia | ● | ● | ● | o | ● |
| Slovenia | ● | ● | ● | ● | ● |
| UK England | ● | ● | ● | ✖ | ● |
| UK Northern Ireland | ● | ● | ● | ✖ | ✖ |
| UK Scotland | ● | ● | ● | ✖ | ● |
| UK Wales | ● | ● | ● | ✖ | ● |

Key: ● = yes; ✖ = no; o = in preparation; ■= don't know, no response

# Essential elements in a comprehensive national strategy on cardiovascular diseases

A series of similar themes emerged from the documentation in different countries, suggesting there may be common elements which are important in the development of national strategies. Figure 11 shows the themes identified in a suggested model. In the following section, examples provided by individual national coordinators illustrate how the themes identified in Figure 11 might apply in the context of real-life policy development and implementation. Further information about these policies can be found in the supplementary report, Country Summary reports on http://www.ehnheart.org/content/itemstory.asp?level0=1456&level1=2096&level2=2176

**Figure 11:**
**Suggested model for essential elements in a comprehensive national strategy**



## Identification of the problem within a population

This element provided background information on the specific problem/s identified in the policy document and the population groups which are affected. In some cases information on how these problems were identified (for example, via national surveys, expert group consensus, etc.) was also provided.

**Example:**
**Action Plan for Promoting Finnish Heart Health for the years 2005-2011**

Cardiovascular diseases are the most common cause of death in both men and women in Finland, but the emphasis has shifted towards older age groups. Although CHD mortality is five times greater among men of working age compared to women, the total number of deaths across the entire population is almost the same in men and women. The health differences regarding morbidity are significant between population groups, and despite the goals of healthcare policies in Finland, these differences have not diminished. Positive development has occurred in all social groups, but it has been slowest to happen in the lower social groups. Adult and childhood obesity have increased. The percentage of overweight young boys aged 12 years increased from 7% to 27% from 1977 to 2005 and girls from 7% to 18%. The percentage of overweight young boys aged 18 years increased from 6% to 25% from 1977 to 2005 and girls from 1% to 13%.

Source: Anna-Liisa Rajala
Action Plan for Promoting Finnish Heart Health for the years 2005-2011 (2005). Finnish Heart Association www.sydanliitto.fi

## Goals to be achieved within a specific time frame

The overall goals of the policy were stated in most policy documentation. This varied from general statements of intent to, more usefully, measurable targets to be achieved within a given time frame.

**Example: Estonian Heart Health Strategy 2005-2020**

The overall goal of the strategy is to achieve a permanent decrease in premature cardiovascular morbidity and mortality among the Estonian population. The goals are to:

- reduce the risk of 30-60 year old Estonians who are already in a high risk group
- reduce the mortality of CVD among 30-65 year olds by 5% by 2010, compared with 2004
- screen at least 90% of high CVD risk people by 2008
- reduce the overall CVD risk by 10%

Source: Marianne Sirel
http://www.sm.ee/eng/pages/index.html

## Consideration of policy options: population & community/individual levels

In some cases, information about a range of possible policy options (for example, using population-based approaches or individually-focused action or a combination of approaches) which had been considered before it was decided on the approach outlined within the policy were provided as background information, along with details about how the decision making process worked.

### Example: Building Healthier Hearts, 1999

The Minister for Health and Children established the Cardiovascular Health Strategy Group to develop a strategic approach to reduce avoidable death and illness caused by CVD. The Group's terms of reference required consideration of initiatives to improve cardiovascular health, the further development of cardiac care and rehabilitation at primary, secondary and tertiary care levels, and the coordination of services for patients. The Minister requested that the Group engage in an extensive consultation process: 53 statutory and voluntary organisations were contacted and 43 submissions were received. Representatives from key organisations were invited to meet the Group and in addition the Group met with hospital, ambulance and community based personnel in the course of site visits. Two separate questionnaires were circulated to hospitals caring for patients with cardiac problems. The Group met on 20 occasions and a number of sub-groups were established relevant to the different needs identified in the terms. The final report emerged from consultations and discussions and from a literature review of treatment and health service developments in Ireland and abroad. The report was developed in the context of other health policy documents. Consistent with national policy the Group was guided by the following basic principles:

- Health and Social Gain
- Equity of Access
- Quality
- Effectiveness and Efficiency and
- Accountability and Audit

Source: Maureen Mulvihill

Department of Health and Children (1999). Building Healthier Hearts - The Report of the Cardiovascular Health Strategy Group. Government Publications Office. Dublin

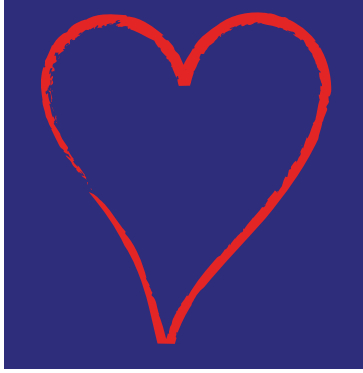
## Commitments (including resources), recommendations & targets

Commonly, recommendations and targets were set in the policy document and, less frequently, information about allocated resources (including financial, personnel etc) was also provided.

### Example: Italian National Prevention Plan 2005 – 2007

The financial resources that the regions have agreed to give for the implementation of the Plan amounted to 240 million euros per year, equivalent to 25% of the share of resources accruing to each region to achieve the objectives of the health plan. In addition to these resources, the regions allocated another 200 million euros to the National Prevention Plan in each of the years 2005, 2006 and 2007. Therefore, each year the total amount of funds the Regions can spend for the National Prevention Plan (all inclusive: vaccinations, extermination of mosquitos/ rats, public hygiene, etc.) is equivalent to 440 million euros.

Source: http://www.epicentro.iss.it/focus/piano_prevenzione/Tabella_CCm.pdf
http://www.ccm-network.it/Pnp_intro



## Detailed action plan: identification of population groups, settings for action

Most policies provided information about what was going to be done, in effect a summary of the key action which will take place as a consequence of the policy. In common with other key elements, this varied between policies from general statements of intent to more detailed accounts of tasks, responsibilities and time scales.

**Example: Coronary heart disease: national service framework for coronary heart disease – modern standards and service models.**

The plan aims to reduce heart disease across the population of England, and also has specific goals directed to high-risk patients. It also aims to reduce health inequalities. The health promotion related action items are directed to health authorities (HAs), local authorities (LAs), primary care groups/trusts (PCGs/PCTs), and NHS Trusts.

By October 2000, HAs, LAs, PCGs/PCTs, and NHS Trusts will:

- have actively participated in the development of Health Improvement Programmes (HImPs)
- have agreed their responsibilities for and contributions to specific projects identified in HImPs
- have agreed a mechanism for being held to account for the actions they have agreed to deliver as part of the HImP
- have agreed a mechanism for ensuring that progress on health promotion policies is reported to and reviewed by the Board
- have identified a link person to be a point of contact for partner agencies

By April 2001, HAs, LAs, PCGs/PCTs, and NHS Trusts will:

- have agreed and be contributing to the delivery of the local programme of effective policies on a) reducing smoking b) promoting healthy eating c) increasing physical activity and d) reducing overweight and obesity
- have a mechanism for ensuring all new policies and all existing policies subject to review can be screened for health impacts
- as an employer, have implemented a policy on smoking
- be able to refer clients/service users to specialist smoking cessation services, including clinics
- have produced an equity profile and set local equity targets

By April 2002 HAs, LAs, PCGs/PCTs, and NHS Trusts will:

- have quantitative data no more than 12 months old about the implementation of the policies on:
    - reducing the prevalence of smoking
    - promoting healthy eating
    - promoting physical activity
    - reducing overweight and obesity
- as an employer, have developed 'green' transport plans and taken steps to implement employee-friendly policies

By April 2003, HAs, LAs, PCGs/PCTs, and NHS Trusts will:

- have implemented plans to evaluate progress against national targets associated with Saving Lives: Our Healthier Nation and local targets

The NSF also lays out what should be included in service models to deliver effective prevention policies and programmes:

- Local players should produce a health improvement programme (HImP) that makes clear the priority attached to improving health and reducing inequalities; refers to recommendations in the Director of Public Health's annual report and to the Local Equity Profile; specifies actions each organisation is responsible for delivering; creates local links to relevant national policies; and specifies structure, process and outcome measures by which local delivery will be judged.
- Local players will work with key stakeholders to establish a local implementation team to develop and oversee implementation of the local delivery plan.

***continued overleaf***

- Local players should carry out health impact assessments on major policy decisions likely to have a direct or indirect effect on cardiac care.
- Local Directors of Public Health should produce an equity profile for their local population, identifying inequalities in heart health and in access to preventive and treatment services. This should directly inform the HImP.
- Health authorities, working with primary care trusts, are expected to establish smoking cessation services for smokers who want to quit. These services should target disadvantaged communities, young people and pregnant women and should be available in a variety of settings, and will feature support, advice and follow-up as well as one week's free nicotine replacement therapy for the smokers least able to afford it.
- A community development approach should be taken, with professionals acting as facilitators to involve local communities in decisions affecting their health.
- The NHS and LAs should develop and implement workplace policies to protect and improve health (including heart health) of staff, and report on progress to their Boards and Councils.

Source: Rebecca Salay

Department of Health (2000) Coronary heart disease: national service framework for coronary heart disease - modern standards and service models. London: Department of Health

## Programme development & implementation

Most policy documentation gave information on how the action plan would be achieved, providing specific information on how the action plan was going to be delivered.

**Example: The Icelandic National Health Plan to the Year 2010**

The Ministry of Health and Social Security will conduct the administrative implementation and revision of the targets of the Plan. The Directorate of Health will make provisions for the collection and processing of information and professional monitoring. District physicians, health care employees, directors of institutions, experts, collaboration boards and health care authority committees will assist in the implementation of various aspects of the Plan, and several work groups have been appointed. They will work towards reaching the targets and ensure monitoring of the implementation of the plan at local level. Close cooperation with hospitals, health centres, health care professionals and other relevant parties is vital for implementation of the Plan. A review or report on the status and progress of the projects covered by the NHP will be published annually.

From the NHP: "Furthermore, it is important that the Health Plan is adhered to at all levels of the health care services and that it has the support of community councils, regional organisations, non-governmental organisations, professional and special-interest organisations, private companies, economic and social partner organisations, families and individuals. It must also be ensured that the policy of the state, communities and social partners in various areas of society promotes improved health in Iceland."

Source: Bylgja Valtýsdottír

The Ministry of Health and Social Security (2001). The National Health Plan to the Year 2010. Long time goals in health care. Reykjavik: The Ministry of Health and Social Security.

## Development/endorsement of guidelines/standards for practice

In some cases, information on how guidelines/standards were to be developed or used to support the delivery of the policy was provided.

**Example: Coronary heart disease: national service framework for coronary heart disease - modern standards and service models**

Formal standards in each area of care were set which the English NHS would be expected to achieve. These standards were based on clear evidence that interventions were clinically and cost-effective. Focus groups reviewed the evidence in each area. Models of care and systems of service delivery which have been shown to be effective and which could help reach the goals of the NSF were also identified.

Source: Rebecca Salay

Department of Health (2000) Coronary heart disease: national service framework for coronary heart disease - modern standards and service models. London: Department of Health

## Progress reports, monitoring

Some policy documents provided information on how progress towards delivery of policy goals would be monitored and reported.

**Example: Healthy throughout life – the targets and strategies for public health policy of the Government of Denmark 2002 – 2010**

The government will present an indicator programme with key figures for overall targets of Healthy throughout Life, risk factors, target groups and settings for health promotion. Trends in these indicators will regularly be updated on the Web site www.folkesundhed.dk. An updated version will be compiled in an annual publication throughout the duration of Healthy throughout Life.

Source: Mads Hyldgaard

Ministry of Interior and Health (2003): Healthy throughout Life – the targets and strategies for public health policy of the Government of Denmark, 2002 – 2010.

## Public reporting and accountability

Some policy documentation also provided information on how progress in achieving the goals of the policy would be made public.

**Example: Building Healthier Hearts, 1999**

The Minister for Health and Children appointed a Heart Health Taskforce to oversee the implementation of the Cardiovascular Health Strategy, reporting to the Joint Oireachtas (Houses of Parliament) Committee on Health and Children, and an Advisory Group to advise on how best to implement the Report's recommendations. Three reports documenting progress were published:

- Heart Health Task Force (2001) Progress Report July 1999-2001. Dublin: Government Publications Office
- Heart Health Task Force (2003) Ireland's Changing Heart (2002). Second report on Implementation of the Cardiovascular Health Strategy. Dublin: Government Publications Office
- Health Services Executive (2006) Ireland Take Heart. Audit of Progress on the Implementation of Building Healthier Hearts 1999-2005. Dublin: HSE, Population Health.

Source: Maureen Mulvihill

Department of Health and Children (1999). Building Healthier Hearts - The Report of the Cardiovascular Health Strategy Group. Government Publications Office. Dublin

## Evidence-based assessment of effective options

A few policies gave information about how research evidence was used to guide the development of the policy, citing the scientific evidence about the effectiveness of different interventions for example.

**Example: The Icelandic National Health Plan to the Year 2010**

Each of the main goals has an overview of the current situation which is based on statistical data or research. The Institute of Economic Studies Report on Cost and Profit analysis was also used in the making of the National Health Plan.

Source: Bylgja Valtýsdottír

The Ministry of Health and Social Security (2001). The National Health Plan to the Year 2010. Long time goals in health care. Reykjavik: The Ministry of Health and Social Security.



## Evaluation of policy and programme implementation

A key element, but one which was reported less commonly in policy documents, provided information about any planned evaluation or scientific studies in place which would assess the 'success' of the policy and inform future planning processes.

**Example: Action Plan for Promoting Finnish Heart Health for the years 2005-2011**

There have been electronic newsletters and the annual report put out by the Finnish Heart Association http://www.sydanliitto.fi

Sosiaalikehitys Ltd is evaluating the Finnish Heart Plan. The mid-term report came out at the end of 2008.

Source: Anna-Liisa Rajala
Action Plan for Promoting Finnish Heart Health for the years 2005-2011 (2005). Finnish Heart Association www.sydanliitto.fi

## Identification of agents to support change

Most policy documentation was able to provide examples of key groups of people who would be required to support implementation of the policy.

**Example: Policy on prevention for the public health – Letter of the Minister of Health, Welfare and Sport (The Netherlands)**

The government calls upon all its partners in prevention with parallel interests – inside and outside health care - to contribute and cooperate in realising the agenda for change and strengthening of the policy on prevention. For example:

- Ministry of Health and other departments (Education, Youth and Families etc.)
- The Health Care Insurance Board (CVZ), National Institute for Public Health and Environment (RIVM), Health Council of The Netherlands (GR), Trimbos Institute etc.
- Local Councils, Municipal Health Services, schools, employers, industry, National Institute of Sport and Physical Activity (NISB)

Source: Marijke Luif
Policy on prevention for the public health – Letter of the Minister of Health, Welfare and Sport on the vision of the government on health and prevention (piece number 22849, no. 134). The Hague, 24 September 2008. www.tweedekamer.nl

# Conclusions

The EuroHeart mapping project set out to obtain comprehensive comparable information on policies, plans and measures impacting cardiovascular health promotion and cardiovascular disease prevention. It aimed to identify differences and gaps in policies and actions across Europe and to determine the essential elements in a comprehensive national strategy on cardiovascular diseases. In many respects, it has been successful. The project has described action around cardiovascular health promotion and cardiovascular disease prevention in 16 European countries and should enable countries to assess their activities against those of others. It has also been possible to identify common elements across policy documentation. This snapshot has revealed that:

- All countries could identify the government department with the main responsibility for cardiovascular health promotion and/or cardiovascular disease prevention. Fewer countries could identify a specific organisation responsible for coordinating action around cardiovascular health promotion and/or cardiovascular disease prevention.

- Every country reported some type of legislation covering public health, tobacco control and food. Most countries reported legislation around control of alcohol and the promotion of physical activity. Legislation for other issues related to diseases and lifestyle risk factors associated with cardiovascular diseases were less common.

- The most commonly reported national policies were broadly consistent with the areas most frequently covered by legislation, namely public health, tobacco, coronary heart disease, food and physical activity. Most countries reported national policies addressing health inequalities. Several countries reported programmes or recommendations for programmes/policies that enable early diagnosis (identification of high risk population or screening).

- Programmes to address issues relating to tobacco, public health, physical activity, coronary heart disease and food were most frequently reported across countries, as also shown with, and perhaps linked to, legislative and policy action.

- It was difficult to identify budgets allocated for policy/programme implementation, and in most instances, data available around funding was incomplete.

- Most countries reported national guidelines/standards addressing coronary heart disease and hypertension, the management of hyperlipidaemia, diabetes and stroke prevention and obesity.

- Most countries reported some type of cardiovascular health and/or cardiovascular disease prevention targets. The links between such targets and monitoring, public reporting of measures of progress towards achievement of the targets and national evaluation were much less clear.

Despite the value of these findings, there is a sense of frustration for all those involved in EuroHeart work package 5 that it remains beyond the scope of this project to comment on the effectiveness of any measures taken within countries or to compare and assess the range of different approaches taken by different countries. In part, this is due to the methods used, which were limited by the funding available for the project. However, even with more generous funding, those seeking the answers to questions about which types of cardiovascular health promotion and cardiovascular disease prevention action works for which population group and in which context are likely to be limited by the lack of available, robust and standardised information across different European countries.

# Recommendations

- There is a need for cooperation and pan-European level data gathering to enable the assessment of the effectiveness of different cardiovascular health promotion and cardiovascular disease prevention actions or interventions.

- More efforts in and reporting of surveillance, monitoring and evaluation of existing and planned activities are required. It is also recommended to have built-in mechanisms to renew established strategies and guidelines.

- An in-depth comparison of well-developed cardiovascular policies, their resources, implementation and results in a selected number of countries is needed.

- A further recommendation is to review the policy literature, surveys for other relevant policies and perform a policy content analysis.

# References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2. L Joossens and M Raw The Tobacco Control Scale: a new scale to measure country activity Tobacco Control 2006; 15: 247-253

3. Swinburn B and Egger G. Preventive strategies against weight gain and obesity. Obesity Review 2002; 3(4):289-301.

4. World Health Organisation Comparative analysis of nutrition policies in the WHO European Region. Copenhagen: World Health Organisation 2006

5. World Health Organisation Ottawa Charter for Health Promotion. World Health Organisation for Health and Welfare, Ontario. 1986

# Appendix A: Advisory Board for Work Package 5

The Advisory Board for this work package was composed of:

| | |
|---|---|
| George Andrikopoulos | Hellenic Heart Foundation |
| Jill Farrington/<br>Albena Arnodova | WHO – Europe |
| Robin Ireland | EuroHealthNet |
| Tor Jungman | Finnish Heart Association |
| Marleen Kestens | European Heart Network |
| Susanne Løgstrup | European Heart Network |
| András Nagy | Hungarian Heart Foundation |
| Ruairi O'Connor | British Heart Foundation |
| Sophie O'Kelly | European Society of Cardiology |
| Michael O'Shea | Irish Heart Foundation |
| Mike Rayner | British Heart Foundation Health Promotion Research Group, University of Oxford |
| Per Tornvall | European Society of Cardiology |

# Appendix B: Questionnaire

Please complete this questionnaire with reference to the accompanying explanatory notes. Underlined terms are explained in the Glossary.

National Coordinator:

Country:

Please address any queries and return the completed questionnaire to Gill Cowburn, British Heart Foundation Health Promotion Research Group by e-mail: gill.cowburn@dphpc.ox.ac.uk

**Deadline for return of questionnaire: Friday 15th February 2008**

## A. National organisations

*A1. Which Government department (such as the Ministry of Health) has the main responsibility for public health action relevant to the prevention and control of chronic diseases?*

.....
.....
.....
.....

*A2. Are any other Government department/s involved in public health action relevant to the prevention and control of chronic diseases?*

.....
.....
.....
.....

*A3. Which Government department has the main responsibility for cardiovascular health promotion and/or cardiovascular disease prevention?*

.....
.....
.....
.....

*A4. Are any other national organisations (such as a National Institute) involved in public health action relevant to the prevention and control of chronic diseases?*

☐ *Yes (Please give details)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*A5. Are these national organisations involved in cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes (Please give details)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*A6. Are any non-governmental organisations, professional societies or charitable organisations involved in cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes (Please give details)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*A7. Is any organisation responsible for coordinating the implementation of a policy/strategy or plan on cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes (Please give details)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*A8. In your country, which key organisation/s would be considered to be the 'driving force' behind cardiovascular health promotion and/or cardiovascular disease prevention?*

.....
.....
.....
.....

*A9. Please add any other comments about information in section A*

.....
.....
.....
.....

## B. National Acts, Laws, legislation, Ministerial Decrees (or equivalent)

*B1. Does your country have any national Acts, Laws, legislation, Ministerial Decrees (or equivalent) in place to address any of the following areas?*

| | **Yes** | No | Don't know | Type (e.g. Act, Law, Legislation, Ministerial Decree) | Year, Title, and websites (or PDF files, if exist) |
|---|---|---|---|---|---|
| Public health | | | | | |
| Cardiovascular disease | | | | | |
| Obesity | | | | | |
| Diabetes | | | | | |
| Alcohol | | | | | |
| Food and nutrition | | | | | |
| Physical activity | | | | | |
| Tobacco | | | | | |
| Stress | | | | | |
| Inequalities | | | | | |
| Any other relevant areas | | | | | |

*B2. Please add any other comments about information in Section B*

.....

.....

.....

.....

## C. National policies/strategies or plans

*C1. Does your country have any national health policies/strategies or plans on public health action relevant to the prevention and control of chronic diseases?*

☐ *Yes Year - Titles (original and English) - Websites/PDF files, if exist - Allocated funding*

.....

☐ *No*
☐ *Don't know (Please explain)*

.....

*C2. Does your country have any national health policies/strategies or plans on cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes Year - Titles (original and English) - Websites/PDF files, if exist - Are the policies/strategies integrated? - Allocated funding*

.....

☐ *No*
☐ *Don't know (Please explain)*

.....

*C3. Does your country have any national policies/strategies or plans in place to address any of the following specific areas?*

| | **Yes** | No | Don't know | Year, Titles, and websites (or PDF files, if exist) Allocated funding |
|---|---|---|---|---|
| Coronary heart disease | | | | |
| Hypertension | | | | |
| Stroke | | | | |
| Hyperlipidaemia | | | | |
| Obesity | | | | |
| Diabetes | | | | |
| Alcohol | | | | |
| Food and nutrition | | | | |
| Physical activity | | | | |
| Tobacco | | | | |
| Stress | | | | |
| Inequalities | | | | |
| Any other relevant areas? | | | | |

*C4. In your country, which national policies/strategies or plans have been considered most important in influencing cardiovascular health promotion and/or cardiovascular disease prevention?*

.....

.....

.....

*C5. Please add any other comments about information in Section C*

.....

.....

.....

## D. Policies/strategies or plans in preparation

*D1. Are there any relevant national policies/strategies or plans currently in preparation?*

☐ *Yes (Please give details)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*D2. Please add any other comments about information in Section D*

.....

.....

.....

## E. National programmes

*E1. Does your country have any country-wide programmes on public health relevant to the prevention and control of chronic diseases?*

☐ *Yes Year - Titles (original and English) - Websites/PDF files, if exist - Allocated funding*

.....

☐ *No*
☐ *Don't know (Please explain)*

.....

*E2. Does your country have any country-wide programmes on cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes Year - Titles (original and English) - Websites/PDF files, if exist - Are the policies/strategies integrated? - Allocated funding*

.....

☐ *No*
☐ *Don't know (Please explain)*

.....

*E3. Does your country have any country-wide programmes in place to address any of the following specific areas?*

| | **Yes** | No | Don't know | Year, Titles, and websites (or PDF files, if exist) Allocated funding |
|---|---|---|---|---|
| Coronary heart disease | | | | |
| Hypertension | | | | |
| Stroke | | | | |
| Hyperlipidaemia | | | | |
| Obesity | | | | |
| Diabetes | | | | |
| Alcohol | | | | |
| Food and nutrition | | | | |
| Physical activity | | | | |
| Tobacco | | | | |
| Stress | | | | |
| Inequalities | | | | |
| Any other relevant areas? | | | | |

*E4. Which country-wide programmes have been successfully implemented?*

.....

.....

.....

*E5. Please add any other comments about information in Section E*

.....

.....

.....

## F. Programmes in preparation

*F1. Are there any relevant country-wide programmes currently in preparation?*

☐ *Yes (Please give details)*

.....

☐ *No*

☐ *Don't know (Please give details)*

.....

*F2. Please add any other comments about information in Section F*

.....

.....

.....

## G. National guidelines/standards

*G1. Has your country adopted any country-wide guidelines/standards relevant to cardiovascular disease prevention/treatment and care which address any of the following areas?*

| | **Yes** | No | Don't know | Year, Titles, and websites (or PDF files, if exist) Allocated funding |
|---|---|---|---|---|
| Coronary heart disease | | | | |
| Hypertension | | | | |
| Stroke | | | | |
| Hyperlipidaemia | | | | |
| Obesity | | | | |
| Diabetes | | | | |
| Alcohol | | | | |
| Food and nutrition | | | | |
| Physical activity | | | | |
| Tobacco | | | | |
| Stress | | | | |
| Inequalities | | | | |
| Any other relevant areas? | | | | |

*G2. Please add any other comments about information in Section G*

.....

.....

.....

## H. National targets, monitoring and evaluation

*H1. Does your country have any national targets on public health relevant to the prevention and control of chronic diseases?*

☐ *Yes (Please give details of target/s and websites or PDF files, if exist)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*H2. Does your country have any national targets on cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes (Please give details of target/s and websites or PDF files, if exist)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*H3. Has your country undertaken any monitoring of progress towards achievement of any targets relevant to cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes (Please give details of target/s and websites or PDF files, if exist)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*H4. Does your country have a structure for systematic public reporting on cardiovascular health promotion and/or cardiovascular disease prevention?*

☐ *Yes (Please give details of target/s and websites or PDF files, if exist)*

.....

☐ *No*
☐ *Don't know (Please give details)*

.....

*H5. What evaluation of programmes relevant to cardiovascular health promotion and/or cardiovascular disease prevention has been undertaken?*

.....

.....

.....

*H6. Please add any other comments about information in Section H*

.....

.....

.....

Thank you for your help and time in completing this questionnaire. Please return the completed questionnaire to Gill Cowburn by e-mail to gill.cowburn@dphpc.ox.ac.uk

by Friday 15th February 2008.

# Appendix C: Explanatory notes for Questionnaire

These explanatory notes are designed to help you to complete questionnaire 1. Words which are underlined in the questionnaire have been defined in the glossary (see page 55).

### General issues

Please complete the questionnaire in English. Where information is only available in the original language, please provide a brief summary translation in English.

We are interested in collecting information about national policies/strategies or plans and programmes which are currently relevant in your country. This could include, for example, a recently published action plan or legislation which has been in force for a considerable time. We also want to find out about country-wide policies/strategies or plans which exist as 'intentions' and those country-wide programmes which have actually been implemented.

Please use the 'don't know' column only when you have been unsuccessful in finding the requested information, and then provide a short explanation of the attempts which you have made to gather the required information. Provide URLs and pdf files wherever possible. There is a section at the end of each part of the questionnaire for you to add any further comments.

Please contact Gill Cowburn (e-mail gill.cowburn@dphpc.ox.ac.uk) if you are not sure about what information we are asking you to collect or where it might be found.

### A. National organisations

In this part of the questionnaire, we are interested in finding out how health promotion and disease prevention structures are organised in your country. We would like to know which government departments, non-governmental and other national organisations are involved in some way in contributing towards the promotion of health and the prevention and management of chronic disease, particularly cardiovascular disease. This information should be available directly from government sources or from the organisations involved. Details required are the name of the organisation (please provide an English language translation) and the URL, where appropriate.

**For example:**

In the UK, the Department of Health has overall responsibility for public health, http://www.dh.gov.uk

Some typical government departments to consider include:
Ministry of Health, Ministry of Agriculture; Ministry for Children and/or Education; Ministry for the Environment, Ministry for Home & Community, Ministry for Cultural Affairs

Some typical non-governmental organisations to consider include:
National Heart Foundations, Consumer groups, Lobbying organisations, Medical Societies, Voluntary groups

We have also asked you (in question A7) to find out which organisations are responsible for coordinating the implementation of a policy/strategy or plan. By this we mean any organisations which are coordinating either government and/or non-governmental action.

In question A8, we ask you to identify key organisations which would be considered to be the 'driving force' behind cardiovascular health promotion and/or cardiovascular disease prevention. Here,

we are trying to establish a consensus view from within your country rather than your own opinion. So, if the general consensus from within your country is that organisations X and Y are the key organisations which drive action forward, please tell us about them. If, however, no consensus exists in your country, please state your own personal view but tell us that this is your own opinion (for example, in my opinion, organisations A, B & C do most to drive change).

**B. National Acts, Laws, Legislation, Ministerial Decrees (or equivalent)**

Here, we are interested in locating any legislative mechanisms which exist in your country to promote healthier lifestyles. This information should be available directly from government sources. Please list all of the legislation (or equivalent) which you can locate. For each, provide the year of publication or enactment, title (please provide an English language translation, if necessary) and the URL.

**For example:**

In the UK, the Tobacco Advertising and Promotion Bill was introduced in February 2001, http://www.publications.parliament.uk/pa/ld200001/ldbills/026/2001026.htm

**C. National policies/strategies or plans**

In this section, we want to establish what national health policies/strategies or plans exist in your country to promote health and prevent and manage chronic disease, particularly cardiovascular disease. This information should be available directly from government sources. For each, provide the year of publication, title (please provide an English language translation, if necessary) and the URL.

**Policy example:**

In the UK, the white paper "Choosing Health: making healthy choices easier" (2004) sets out an integrated public health policy which includes addressing cardiovascular disease and cancers, alongside risk factors like tobacco, healthy eating, obesity, physical activity and alcohol

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

We are keen to identify how much funding has been allocated to each policy/strategy or plan. This information should be available directly from government sources and from the organisations involved in developing and/or delivering policies/strategies or plans. Please provide details of the amount of allocated funding for each policy/ strategy or plan (where this information is available) in the original currency and Euros and provide a URL reference, where possible.

**For example:**

In the UK, in 2005, the School Food Trust was allocated 15 million GBP (21,526,676 EUR) from the Department for Education and Skills to promote the education and health of children and young people by improving the quality of food supplied and consumed in schools.

http://www.schoolfoodtrust.org.uk/content.asp?ContentId=232

We would also like you to record whether or not the policies and/or strategies you locate are integrated or not. By this we mean do they aim to act on either several diseases (like cancer and cardiovascular disease) and/or across a range of risk factors (like tobacco, food and nutrition and physical activity)?

**Example of an integrated plan:**

In the UK, an integrated action plan "Delivering Choosing Health; making healthy choices easier" was published in 2005
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105713.pdf

Example of 2 (non-integrated) action plans addressing particular risk factors:
Department of Health (2005) Choosing a better diet: a food and health action plan London: Department of Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105709.pdf

Department of Health (2005) Choosing activity: a physical activity action plan London: Department of Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105710.pdf

Dates covered by the plans: all three publications are ongoing from 2005

In question C4, we are interested in finding out which national policies/strategies or plans have been considered most important in influencing cardiovascular health promotion and/or cardiovascular disease prevention. Here, as in section A, we are trying to establish a consensus view from within your country rather than your own opinion. If no consensus exists in your country, please state your own personal view but tell us that this is your own opinion.

Further information will be collected about the details of these policies/strategies or plans in Questionnaire 2.

**D. Policies/strategies or plans in preparation**

In this part of the questionnaire, we want to know about any relevant policies/strategies or plans which are being developed in your country but which are not currently in action. This is information you are likely to gather as you collect information to complete other sections of the questionnaire, for example when you are contacting government departments or other organisations. For each, provide the year of proposed publication and summary information about the area to be addressed.

**For example:**

In the UK, a new national strategy for stroke is being prepared, consultation ending October 2007

Further information will be collected about the details of these policies/strategies or plans in Questionnaire 2.



## E. National programmes

In this section, we want you to record information about any country-wide programmes which are being implemented in your country to promote health and prevent and manage chronic disease, particularly cardiovascular disease. By this, we mean programmes which are intended to have national coverage and which are implemented across the whole country, not at regional or local level. The exceptions to this are countries (like Belgium, Germany and the UK) where health is the responsibility of regional government, where information from each region would be recorded.

This type of information should be available directly from government sources or from the organisations involved in developing and/or delivering the programmes. For each, provide the year of publication, title (please provide an English language translation, if necessary) and the URL.

We are interested in how much funding has been allocated to each programme. This information should be available directly from government sources and from the organisations involved in developing and/or delivering the programmes. Please provide details of the amount of allocated funding for each country-wide programme (where this information is available) in the original currency and Euros and provide a URL reference, where possible.

We would also like you to record whether or not the country-wide programmes you locate are integrated or not. By this we mean do they aim to act on either several diseases (like cancer and cardiovascular disease) and/or across a range of risk factors (like tobacco, food and nutrition and physical activity)

**For example:**

from 2003, the Food Standards Agency has continued to develop and deliver a salt awareness/reduction programme for the general public
http://www.food.gov.uk/healthiereating/salt/

This is a non-integrated national programme with a total campaign spend for Phase 3 (from 2007) of 4 million GBP (5,755,535 EUR)

http://www.food.gov.uk/news/pressreleases/2007/mar/saltconsumptioncampaign

In question E4, we are interested in finding out which country-wide programmes have been successfully implemented. As in section A and C, we want to establish a consensus view from within your country rather than your own opinion. If no consensus exists in your country, please state your own personal view but tell us that this is your own opinion. We ask specifically about monitoring and evaluation in section H.

Further information will be collected about the details of these programmes in Questionnaire 2.

### F. Programmes in preparation

In this part of the questionnaire, we want to know about any relevant programmes which are being developed in your country but which are not currently in action. This is information you are likely to gather as you collect information to complete other sections of the questionnaire, for example when you are contacting government departments or other organisations. For each, provide the year of proposed publication and summary information about the area to be addressed.

**For example:**

In the UK, a new programme will be implemented to address earlier identification and treatment as part of the National Alcohol Strategy

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218

### G. National guidelines/standards

In this section, we are interested in finding out whether your country has adopted any country-wide guidelines/standards to guide the delivery of cardiovascular disease prevention as well as treatment/care. Include any governmental or non-governmental guidelines/standards, if they are widely used in your country (for example, the joint European guidelines). This information should be available directly from government sources and from the organisations involved in developing and/or delivering the guidelines/standards. For each, provide the year of publication, title (please provide an English language translation, if necessary) and the URL.

**For example:**

In the UK, The National Service Framework for coronary heart disease was launched in 2000 and sets 12 standards for improved prevention, diagnosis and treatment, and goals to secure fair access to high quality services. The standards are to be implemented over a 10-year period.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094275

Further information will be collected about the details of these guidelines/standards in Questionnaire 2.

### H. National targets, monitoring and evaluation

Here, we are interested in finding out about any national targets which have been set to promote health and prevent and manage chronic disease, particularly cardiovascular disease. This information should be available directly from government sources.

Specifically we would like information (where it exists) about:

Targets at a population level
- mortality, morbidity
- biological factors (like blood pressure)
- behavioural factors (like physical activity levels)

Targets for treatment/care
- for example, around cardiopulmonary resuscitation, emergency services, rehabilitation etc.

For each, provide the date of publication and the date by which the target should be achieved, details of the target (please provide an English language translation, if necessary) and any relevant URL.

**For example:**

In the UK, a Public Service Agreement (PSA) target for obesity was set in 2004 "To reduce the year on year rise in the prevalence of obesity in children under 11 by 2010, in the context of a broader strategy to reduce obesity in the population as a whole"

http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Obesity/DH_4133952

We also want to record any country-wide monitoring or evaluation activity which has taken place. Questions H3 and H4 ask for information about monitoring and reporting of progress towards achievement of targets and/or plans.

**For example:**

a report published in November 07 summarises details of the public opinion research, business research and compliance data relating to the first three months since the smokefree law was introduced in the UK.

http://www.smokefreeengland.co.uk/thefacts/latest-research.html

Question H5 asks about the availability of published evaluation reports on relevant programme implementation.

**For example:**

In the UK the National Evaluation of Local Exercise Action Pilots was published in 2007

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073600

We gratefully acknowledge your help and the time you will spend in sourcing the information to complete questionnaire 1. Please return the completed questionnaire to Gill Cowburn, British Heart Foundation Health Promotion Research Group by e-mail to gill.cowburn@dphpc.ox.ac.uk
by Friday 15th February 2008.

Further details will be sought from you in a second phase of data gathering in spring 2008.

# Appendix D: Additional data collection

**By e-mail:**

I would be grateful if you could provide me with further information about the existing national policies/strategies or plans which you have already listed in questionnaire 1. This was section C in the questionnaire.

For each policy you have listed please provide the following information - in English

Title of policy document
Total number of pages in the policy
At which population group is the policy targeted?
Contents page (titles of each section)
Key themes of the policy (no more than 2-3 paragraphs)
Any other interesting features in the policy

This extra information will really bring the project alive so I appreciate the time it will take to complete it. Please return the completed information to me by e-mail no later than Wednesday 4th June 2008

# Glossary

**Allocated funding:**
A defined amount of money which has been provided to pay for a specific purpose, and which cannot be used for any other purpose

**Cardiovascular disease or CVD:**
includes coronary heart disease, stroke (cerebrovascular accidents) and all other diseases of the circulatory system

**Cardiopulmonary resuscitation or CPR:**
an emergency treatment which aims to restart heart and breathing activity when it has stopped during cardiopulmonary arrest

**Country-wide:**
action intended to have national coverage and to be implemented across the whole country

**Emergency services:**
response and provision of medical aid during an acute episode

**Health promotion:**
a process of enabling people to increase control over and to improve their health. Health promotion uses strategies at the primary level of prevention which are designed to facilitate behavioural and environmental changes which are conducive to health enhancement

**Charitable organisation:**
an organisation which exists to use donated funds for public benefit

**Disease prevention:**

**Primary prevention:**
aims to deter disease before it occurs

**Secondary prevention:**
any strategy (such as early detection and prompt treatment of disease) which aims to reduce the presence of an existing disease in a population, thus preventing further deterioration and/or early death

**Goal:**
a statement of a desired outcome

**Guidelines:**
an agreed series of actions and strategies used to guide practice

**Health policy/ strategy:**
a written, formally adopted consensus about health issues which need to be addressed and approaches to be used to achieve change. For example, a policy includes a set of statements and decisions defining goals, priorities and main directions for attaining these goals. It may also include strategies for how the policy is to be implemented

**Integrated:**
bringing together a range of issues across different areas which are worked on and progressed together rather than separately

**National:**
a geographical area defined by fixed borders

**Non-governmental organisation:**
an organisation which undertakes some of the tasks of a national government, but is not a government department or part of one, and which operates to a greater or lesser extent at arm's length from the government

**Plan:**
a scheme, prepared according to policy and strategic directions, and defining activities, to generate products/targets set to achieve desired goals

**Prevention and control of chronic disease:**
the use of specific strategies to reduce and manage the occurrence of a disease in a population

**Professional societies:**
organisations which act as learned societies for people with shared professional qualifications and interests

**Programme:**
a series of related and connected activities which are designed to deliver specific objectives

**Public health:**
the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society. Modern public health is concerned with addressing determinants of health across a population

**Standards:**
a set of pre-defined levels of activity to be achieved

**Target:**
an agreed and declared quantitative output which can be used to assess progress towards achievement of a goal

**Treatment:**
the provision of medical services (including rehabilitation services) to alleviate symptoms following diagnosis of illness



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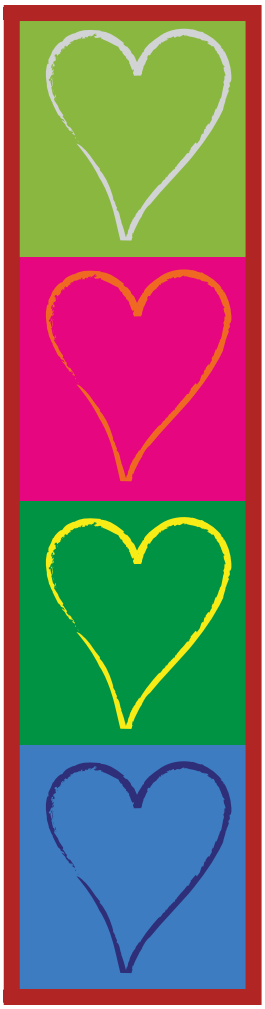

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