



Executive summary final report



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Summary

Overall, the EUPAP project have, thanks to highly committed partners made major progress in achieving the overall project objective - to promote good health and to prevent non-communicable disease through an increase of physical activity via physical activity prescription (PAP) programs in health services. To implement a new method in health-care service during a period of an alarming pandemic did put a huge amount of strain on the project. Especially considering the various prerequisites for implementing PAP-S the partners started off with (some partners were already working with PAP, while others were new to the method) as well as during the pandemic needing to adjust to different strategies and restrictions to battle Covid-19.

In settings where a PAP system was already in place or under development, the Swedish PAP (PAP-S) was used to leverage the quality of the local model (Belgium, Italy, Germany and Spain). In settings where PAP was introduced for the first time, or in line with a recent approach, it was implemented according to the possibilities offered by the local system (Lithuania, Malta, Portugal and Romania).

The implementation of PAP-S depended on the local context, the provided national and/or local trainings, healthcare settings, establishment of networks, healthcare professionals involved, and the clinical background of the PAP prescribers.

In conclusions a European model of PAP cannot represent a “one size fits all” model. Five-core components of the PAP-S should all be applied but may be adapted to the particularities of each country and setting.

Background



The European Physical Activity on Prescription (EUPAP) project was launched in March 2019 and finalized in February 2023 (including a one year extension due to Covid-19). In EUPAP organisations from ten EU member states have been partners to facilitate the transfer of the Swedish best practice model for Physical Activity on Prescription (PAP-S). The overall objective have been to promote good health and prevention of non-communicable disease by implementing a country-based physical activity on prescription programme in health services. The project acknowledged the need for collaboration between countries, as well as the added value of interdisciplinary and policy-practice-research collaboration.

The health service is an excellent arena for health promotion due to its coverage and access for the whole population and the prescription of physical activity is a method that can reach and enable different population groups to enhance their physical activity for prevention and treatment of non-communicable diseases. Moreover, given access to health services this includes also socially disadvantaged groups leading to a reduction in health inequalities. In view of that most European countries offer universal coverage, have physical activity on prescription the potential to reach and empower all population groups and as such contribute to improved health equality.

The aim of EUPAP were to:

- To assess the preparedness and feasibility in local health services in selected regions/countries for introducing physical activity on prescription
- To increase the awareness of the importance of physical activity as a measure for prevention and treatment of disease among policy-makers and health professionals
- To develop, translate and provide high quality implementation tools for an European PAP initiative
- To train professions in the core component of the Swedish PAP methodology
- To implement regional or local level activities for contextualized practice transfer
- To monitor the implementation process and to assess the outcome of the implementation of PAP in Europe
- To develop supportive networks and opportunities for sharing experience across Europe including developing sustainability measures.

Figure 1. The five components of PAP.



Adapted from Kallings LV, Leijon M, Hellenius ML, Stahle A. Physical activity on prescription in primary health care: a follow-up of physical activity level and quality of life. *Scand J Med Sci Sports*. 2008;18(2):154-61.

Physical activity on prescription



The Swedish model of Physical Activity on Prescription (PAP-S) is composed of 5 core components – a patient tailored written prescription, evidence-based recommendations, individualized patient-centred counselling, follow-up and a supporting environment.

1. **Individualised patient-centred counselling** is central in the PAP-S model. The overall goal is to integrate physical activity into everyday life, and to support behaviour change. It is built on patient's health, symptoms, diagnoses, potential risk factors, motivation, prior experiences, preferences and need of support. It concludes with a written prescription form which is also an agreement.
2. **The tailored written prescription** should be documented in the patient's clinical record and, if feasible, printed out. It must state of components of physical activity (type, dose, specific activities) possible contraindications and a plan for follow-up. It often includes part of an anamnesis, such as, current physical activity levels, reason for prescription, patient's ambition. Also, a physical activity diary or a pedometer can be attached to it.
3. **The evidence based recommendations** are the scientific knowledge on how to prevent and treat various diseases and conditions using physical activity. These can be used within the healthcare services, for physical activity organisers and for educational institutions. It ensures an evidence-based prescription.

4. **The follow-up** is to adjust the prescription and foster motivation if necessary. The prescriber is responsible for ensuring that the follow-up is done for both, the health outcome(s) and the levels of physical activity. The contact can be through return visits, by phone, letter, e-mail, text message and be done by the same prescriber or other healthcare agents.
5. **Collaboration with activity organisers** (PAP-coaches) is important since the prescription may include structured exercise. Activity organisers can be NGOs like sports, pensioners' or patient associations, public-driven facilities or private businesses like gyms and fitness centres.

The tailored prescription should always state type of physical activity, dose, contraindication and a plan for follow-up and the prescribed physical activity should be integrated into everyday life. Support for behavioural change should also be given. Since that the physical activity is used as treatment, the prescription should be documented in the patient's clinical record.

The basic idea with PAP-S is that the physical activity is performed outside the healthcare services and can include both every day activities and more structured exercise. Collaboration with activity organisers is therefore an important part of PAP-S. Collaborators can be NGOs like sports associations, pensioners' associations and patient associations, or municipal facilities and private businesses, such as gyms and fitness centres.

The PAP-S model has been shown to be an effective method in primary health care to increase physical activity for at least 12 months. The adherence to PAP-S have shown to be as good and it also improves quality of life and cardio metabolic risk factors.



Result

When transferring an intervention or a method to a new setting it is important to consider the political environment, sound knowledge of public health interventions, the epidemiological situation, resources, availability, and skills of local people, organisational factors and characteristics of the target population. During the first phase of EUPAP, a feasibility study was conducted to assess the prerequisites for the implementation of PAP-S. The objective for the feasibility study was to increase the knowledge of the context towards physical activity prescription in 10 European regions to understand their accessibility for the transfer of PAP-S, specifically to:

1. Determine relevant indicators and variables related to PAP-S to be used in the planning and monitoring of the implementation process
2. Create common guidelines to proceed with the data collection
3. Provide an overview of the situation in 10 European regions
4. Compare the situation of each region with the PAP-S model.

Data showed that some partners had a solid background and strong network to launch the EUPAP implementation, while other had less experience and underdeveloped network, that is, Catalonia-Spain, Denmark, Flanders-Belgium, Italy and Portugal. Other partners, such as Romania and Lithuania, with less experience and specific material, but with established networks, permits to start from training, using the adapted PAP-S materials and piloting the implementation to end-users. Malta was found as having little experience and specific materials and a weak or undeveloped network. For the situation in Sweden challenges include optimising the method and, for instance, improving follow-ups to maintain physical activity and health outcomes, but also improving documentation and develop national monitoring.

Implementation Tools

To facilitate the implementation in partner countries EUPAP developed, updated, or translate implementation tools for the Swedish PAP methodology into English. Partners were responsible of translating relevant tools into local languages. These tools were available for use in the project implementation phase and are now legacy after that the EUPAP project have been finalized.

Manual on Evidence for Physical Activity in Prevention and Treatment of Disease in English (FYSS-short)

FYSS-short was written by the Swedish Professional Associations for Physical Activity and includes general information on methods used (incl. literature search and quality assessment), the structure of each diagnosis chapter, and how to use

FYSS. FYSS-short includes 32 diagnoses, and two appendices (List of Terminology and Questions forming the basis for diagnosis-specific advice).

PAP/FaR Methodology Guideline

The Methodology Guideline aims at providing guidance for prescribing physical activity within the health care system. The Methodology Guideline is comprised of 26 pages, and describes the theoretical basis, scientific evidence and practical consideration and experiences of the PAP-S method. The document is clearly structured and well written.

Prescription Form

The EUPAP Prescription form was developed with instructions on how to use it.

EUPAP Guideline in English

The final version of the EUPAP Guideline was developed based on information from an interactive workshop, collected data from evaluation of the methodology guideline, outcomes and results as well as shared experiences with the implementation of PAP-S in the partner countries/regions). All partners have acted as critical friends, provided feedback and reviewed the guideline including all implementation tools (EUPAP guideline, FYSS-short, prescription form, and list of terminology) with regard to quality, readability, user-friendliness and values for users. Partners used back translation and conducted quality control of the translated diagnoses.

EUPAP Training and Education

A specific PAP-S course curriculum for a three day course were developed for the EUPAP project. The courses were held by PAP-S experts. Specific educational materials (e.g., film and presentations) were also developed and published on EUPAP.org for the support of local implementation. These trainings were aimed for health care professionals (practitioners) as well as educators (incl. project partners). A train-the-trainer approach was used, meaning that that practitioners/educators who participated in the EUPAP course then trained other professionals in their local context in the PAP-S methodology. This approach were used to ensure the sustainability of the local trainings and to reach more professionals.

EUPAP implementation

The results of the implementation can be summaries through the categories: training, healthcare settings, end-users, networks and stakeholders, and views about PAP. Of all trained professionals, about 25 per cent were general practitioners, 9 per cent physicians, 5 per cent nurses and about 2 per cent physiotherapists.

Different health-allied professionals such as exercise specialists and PAP coaches made up approximately 13 per cent of those involved in training. In all healthcare settings, partners involved staff already working in the healthcare. In most partner countries, only general practitioners and medical doctors are allowed by law to prescribe. Partners therefore created different solutions for collaboration between prescribers and other health professionals within the healthcare setting, as well as with professionals from outside of the healthcare to link PAP with local community and stakeholders. Some examples are exercise specialists working in close collaboration with primary health care (Belgium/Flanders, Spain/Catalonia and Portugal), physiotherapists that assume an autonomous role in the process (Malta), and community nurses that support general practitioners in counselling physical activity (Romania). During the implementation process, the routines of the healthcare settings and the professionals and other staff involved in the PAP implementation changed as a result of the involvement of (1) new professional profiles involvement, and/or (b) new administrative and clinical procedures.

Overweight and obesity were the main reasons for prescribing PAP, followed by diagnoses within psychiatry and mental health. The measures used by partners to evaluate physical activity and sedentary habits, quality of life and disease related factors were done using different tools but consistent in terms of the measures taken. The results show that end-users (patients) change their routines during the therapeutic process, the long-term behavioural change is however unclear. Despite a short period of implementation, some changes were observed after experiencing working with PAP, such as a more positive view of physical activity in prevention and treatment among prescribers and other staff involved in the PAP implementation.

Conclusion



- Systematic work with counselling and prescription of physical activity can greatly prevent diseases, lessen the risk of complication with diseases, and reduce the health gap in the population. This might lead to a healthier population, which might lead to reduced need for health care and pharmaceutical products.
- The organisational level has an important impact on sustainability and effectiveness of a PAP model. The management of the health services needs to be aware of the importance of physical activity in treatment and prevention of diseases.
- It is important to measure and investigate the readiness for implementation of a PAP model, both at the policy level and within the health care setting.
- Implementing PAP in a healthcare setting requires a dynamic and flexible approach, tailored to the specific context. Also, implementation of physical activity in treatment of diseases needs to be interdisciplinary and cannot solely rely on the prescriber.
- Lessons learned from the EUPAP implementation can form the basis for introducing or development of PAP models in other countries or regions.



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