APPENDICES

Appendix A: Detailed results on risk factor and NCD policies 1

1. National tobacco policy documents 1
2. National alcohol policy documents 8
3. National diet and nutrition policy documents 15
4. National physical activity policy documents 22
5. National policy documents on several NCDs 29
6. National policy documents on cardiovascular diseases 37
7. National diabetes policy documents 45
8. National cancer policy documents 54

Appendix B: Questionnaires on risk factor policy documents 64

9. Questionnaire on tobacco policy documents 64
10. Questionnaire on national alcohol policy documents 75
11. Questionnaire on national diet and nutrition policy documents 86
12. Questionnaire on national physical activity policy documents 96

Appendix C: Questionnaires on NCD policy documents 107

13. Questionnaire on policy documents on several NCDs 107
14. Questionnaire on (CVD) policy documents on cardiovascular diseases 115
15. Questionnaire on diabetes policy documents 123
16. Questionnaire on cancer policy documents 131
17. Questionnaire on COPD policy documents 139

Appendix D: Equity integration indicators 148

Appendix A: Detailed results on risk factor and NCD policies

This appendix presents the detailed results of the equity integration indicators (EIIs) for policy documents regarding each risk factor and each non-communicable disease (NCD) policy area.

1. National tobacco policy documents

EII1: Inequities mentioned

As shown in Table 1, 14 of the 15 countries explicitly mention health inequities in their tobacco policy documents.

Table 1. Countries mentioning inequities in their tobacco policy documents.

Country response	**Number of countries N (%)**	**Countries**
Yes	14 (93.3%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Greece, Hungary, Malta, Norway, Slovenia, Spain
No	1 (6.7%)	Italy
Total	15 (100%)	

EII2: Equity objectives

As shown in Table 2, 13 of the 15 countries include equity-oriented objectives in their tobacco policy documents. Among these countries, proportionate universalism is the most frequently applied equity approach (n = 10).

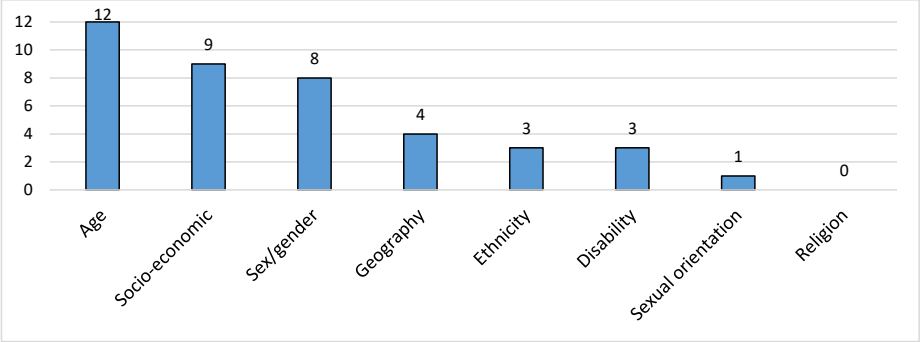
Table 2. Countries including objectives aimed at reducing inequities in their tobacco policy documents by equity approach.

Country response	**Number of countries N (%)**	**Countries**
Objectives with a proportionate universalism approach	10 (66.7%)	Belgium, Croatia, Czech Republic, Finland, France, Germany, Malta, Norway, Slovenia, Spain

Objectives with a universal approach	0 (0%)	
Objectives with a targeted approach	3 (20%)	Estonia, Greece, Hungary
No equity objectives	2 (13.3%)	Bulgaria, Italy
Total	15 (100%)	

Among the countries adopting a proportionate universalism or targeted equity approach, Figure 1 shows that the social determinants of health (SDH) most frequently addressed in policy objectives are age (n = 12), socioeconomic status (n = 9) and sex/gender (n = 8). In contrast, religion is not addressed in the objectives of any country, and sexual orientation is considered in only one country.

Figure 1. Social determinants of health addressed in the objectives of tobacco policy documents (targeted and proportionate universalism approaches only).



EII3: Equity actions

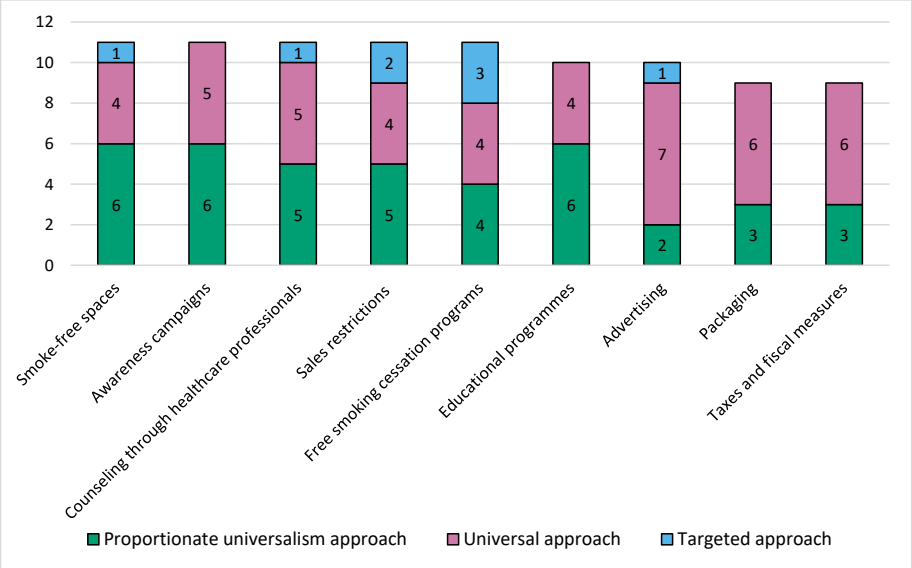
Most countries (n = 12) include actions explicitly aimed at reducing health inequities in their tobacco policy documents. As shown in Table 3, proportionate universalism (n = 8) is the most common equity approach applied to these actions.

Table 3. Countries including actions aimed at tackling inequities in their tobacco policy documents by equity approach.

Country response	**Number of countries N (%)**	**Countries**
Actions with a proportionate universalism approach	8 (53.3%)	Belgium, Croatia, Czech Republic, Estonia, Finland, France, Germany, Spain
Actions with a universal approach	3 (20%)	Malta, Norway, Slovenia
Actions with a targeted approach	1 (6.7%)	Greece
No equity actions	3 (20%)	Bulgaria, Hungary, Italy
Total	15 (100%)	

Figure 2 shows that the most frequently reported actions are smoke-free spaces, awareness campaigns, counselling through healthcare professionals, sales restrictions, and free smoking cessation programmes, each included in 11 countries. The equity approach applied to these actions varies by action type. For some actions, proportionate universalism is the most common approach, while a universal approach predominates for others. The targeted approach is the least frequently used across all action types.

Figure 2. Types of actions in tobacco policy documents by policy approach.



The SDH most frequently addressed in actions adopting a targeted or proportionate universalism approach are age (n = 9) and socioeconomic status (n = 6) (Figure 3). By contrast, religion is not considered in any country, and sexual orientation in only one country.

Figure 3. Social determinants of health addressed in the actions of tobacco policy documents (targeted and proportionate universalism approaches only).

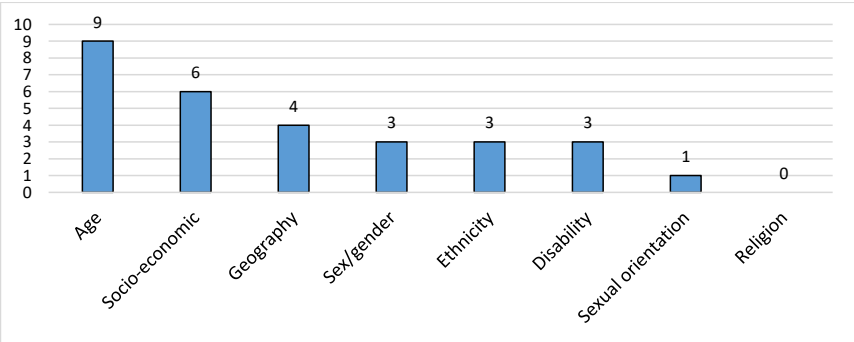


Table 4 presents three illustrative examples of actions reported by national policy experts in relation to their tobacco policy documents.

Table 4. Examples of actions to reduce inequities in tobacco policy documents.

Country	**Type of action**	**Examples**
Finland	Cessation services	People in particular who are in a weaker socio-economic position or who smoke heavily can be encouraged to participate in individual or group counselling by offering free withdrawal services and/or withdrawal medication. The treatment costs can be an obstacle to stopping the use of tobacco and nicotine products. It is also important to inform clients in social welfare services about the reimbursement options (health insurance, income support) for cessation medicines.
Hungary	Screening buses	A comprehensive screening programme, the '"Taking Screening Local"' initiative, was launched in 2019 under the auspices of the National Centre for Public Health and Pharmacy, the predecessor of the National Centre for Public Health, with screening buses taking screening programmes and preventive tests to communities where they have been less accessible to the general population. In this way, the programme not only helps to improve the health of the population, but also to reduce health inequalities,, as the widespread screening can identify smoking and provide minimal intervention through further referral of patients.
Spain	Awareness campaigns	Awareness-raising campaigns [smoking prevention] aimed at young people with a focus on gender and equity (socioeconomic status, ethnicity, etc.), as well as campaigns aimed at abandonment with a gender perspective.

EII4: Monitoring of inequities

The routine monitoring of inequities is the least frequently addressed EII across participating countries, appearing in the tobacco policy documents of only 6 of the 15 countries.

Table 5. Countries establishing routine monitoring of inequities in their tobacco policy documents.

Country response	**Number of countries N (%)**	**Countries**
Yes	6 (40%)	Belgium, Croatia, Finland, France, Slovenia, Spain
No	9 (60%)	Bulgaria, Czech Republic, Estonia, Germany, Greece, Hungary, Italy, Malta, Norway
Total	15 (100%)	

EII5: Health in All Policies (HiAP) approach

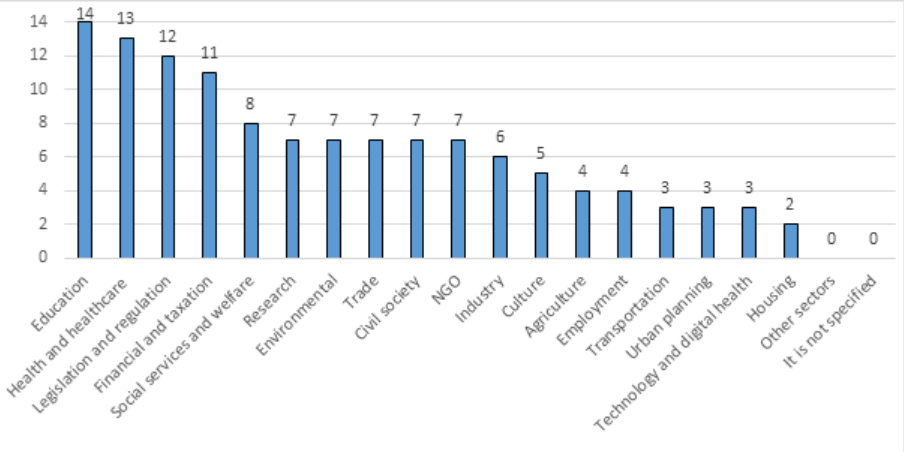
With the exception of Greece, all participating countries report including a HiAP approach in their tobacco policy documents (Table 6).

Table 6. Countries with a HiAP approach in their tobacco policy documents.

Country response	**Number of countries N (%)**	**Countries**
Yes	14 (93.3%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Hungary, Italy, Malta, Norway, Slovenia, Spain
No	1 (6.7%)	Greece
Total	15 (100%)	

Analysis of sectoral involvement in tobacco policy documents shows that education is universally included (n = 14), followed closely by health and healthcare (n = 13), legislation and regulation (n = 12) and finance and taxation (n = 11).

Figure 4. Sectors involved in countries adopting a HiAP approach in their tobacco policy documents.



Country scores: level of equity integration in tobacco policy documents

Overall, most countries incorporate multiple equity integration indicators in their tobacco policy documents (Table 7). Six countries include all four indicators (i.e., all EIIs except equity objectives) and five countries include three indicators.

Table 7. Countries grouped by tobacco policy document equity integration score (EIS).

Score	Number of countries	Countries
4	6 (40%)	Belgium, Croatia, Finland, France, Slovenia, Spain
3	5 (33.3%)	Czech Republic, Estonia, Germany, Malta, Norway
2	3 (20%)	Bulgaria, Greece, Hungary
1	1 (6.7%)	Italy
0	0 (0%)	
Total	15 (100%)	

2. National alcohol policy documents

EII1: Inequities mentioned

All countries with alcohol policies mention inequities in their policy documents (Table 8).

Table 8. Countries mentioning inequities in their alcohol policy documents.

Country response	Number of countries N (%)	Countries
Yes	16 (100%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Greece, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
No	0 (0%)	
Total	16 (100%)	

EII2: Equity objectives

All alcohol policy documents include objectives to reduce inequities (Table 9). The majority use a proportionate universalism approach (n = 14), while two countries apply a targeted approach.

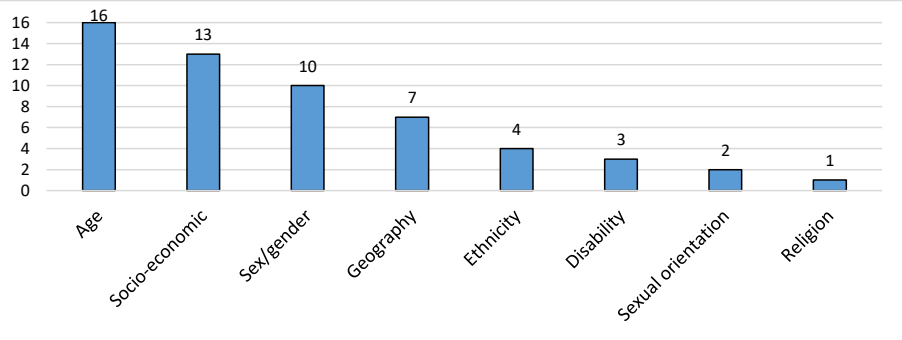
Table 9. Countries including objectives aimed at reducing inequities in their alcohol policy documents by equity approach.

Country response	Number of countries N (%)	Countries
Objectives with a proportionate universalism approach	14 (87.5%)	Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
Objectives with a universal approach	0 (0%)	
Objectives with a targeted approach	2 (12.5%)	Belgium, Greece

No equity objectives	0 (0%)	
Total	16 (100%)	

Among countries that focus on specific social groups—those adopting a proportionate universalism approach (n = 14) or targeted approach (n = 2)—Figure 5 shows that the objectives most commonly aim to reduce inequities related to age (n = 16), socioeconomic status (n = 13), sex/gender (n = 10), and geography (n = 7). In contrast, sexual orientation is addressed in only two countries and religion in just one.

Figure 5. Social determinants of health addressed in the objectives of alcohol policy documents (targeted and proportionate universalism approaches only).



EII3: Equity actions

With respect to actions to reduce inequities included in national alcohol policy documents, all but one of the countries reported such actions (Table 10). The equity approaches reflected in these actions largely mirror those identified for equity objectives: 12 countries adopted a proportionate universalism approach, while three employed a targeted approach.

Table 10. Countries including actions aimed at tackling inequities in their alcohol policy documents by equity approach.

Country response	**Number of countries N (%)**	**Countries**
Actions with a proportionate universalism approach	12 (75%)	Bulgaria, Croatia, Czech Republic, Finland, France, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
Actions with a universal approach	0 (0%)	
Actions with a targeted approach	3 (18.8%)	Belgium, Germany, Greece
No equity actions	1 (6.3%)	Estonia
Total	16 (100%)	

Figure 6 illustrates the wide range of action types used by countries that implemented measures to reduce alcohol-related inequities. The most common actions are awareness campaigns and sales restrictions, both of which were implemented in 12 countries. These are followed by educational programmes and advertising-related measures, both present in 11 countries, and counselling through healthcare professionals, reported in 10 countries. The policy approach varies across action types. Proportionate universalism is particularly prevalent in awareness campaigns, sales restrictions, educational programmes, and counselling interventions. In contrast, the universal approach is most common in advertising regulations and the establishment of alcohol-free spaces.

Figure 6. Types of actions in alcohol policy documents by policy approach.

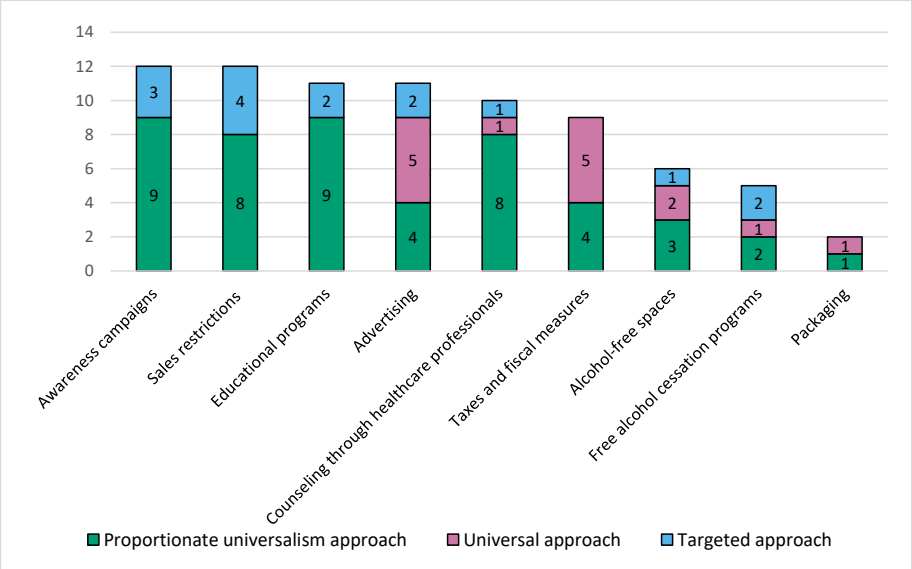


Figure 7 illustrates the SDH most frequently addressed by countries adopting either a targeted or proportionate universalism approach in their equity-related actions. Age is considered in all countries' alcohol-related policy documents (n = 15), followed by socioeconomic status in 11 countries and sex/gender in just over half (n = 8). In contrast, no country addresses disability, and only one includes sexual orientation.

Figure 7. Social determinants of health addressed in the actions of alcohol policy documents (targeted and proportionate universalism approaches only).

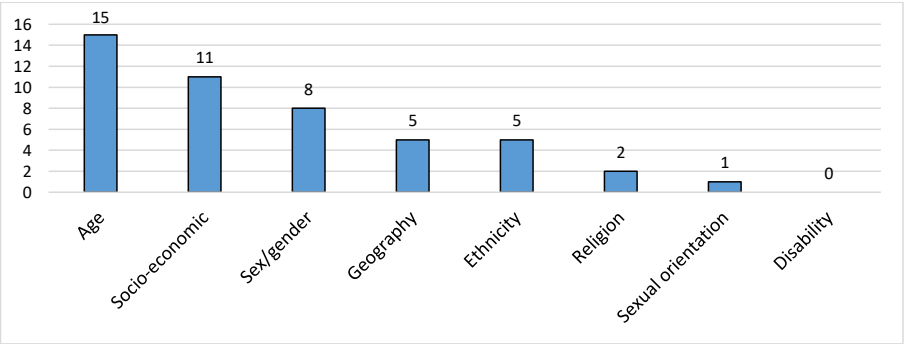


Table 11 presents three illustrative examples of actions drawn from national alcohol policy documents.

Table 11. Examples of actions to reduce inequities in alcohol policy documents.

Country	**Type of action**	**Example**
Belgium	Free water availability	To promote healthier environments, the plan supports the availability of free drinking water where alcohol is sold and encourages a label for restaurants offering a quality range of non-alcoholic alternatives. Initiatives like the "Quality Nights" label are also promoted to support safer nightlife environments.
Italy	Health Equity Audit (HEA)	The policy mandates the use of the Health Equity Audit (HEA) as a key tool for systematically incorporating an equity perspective ("lenses of equity") into all stages of prevention planning and evaluation. Its primary purpose is to identify and address the mechanisms that generate the most relevant health inequalities. The HEA is used both for evaluating ongoing interventions and for designing new actions, ensuring that resources and strategies are differentiated and targeted in proportion to the levels of exposure and vulnerability detected in different population groups.
France	Advertising and sales restrictions	Prevent young people from engaging in excessive alcohol consumption, particularly through better regulation of advertising and supply, compliance with protective prohibitions, and the strengthening of psychosocial skills (action I.4.2).

EII4: Monitoring of inequities

Routine monitoring of alcohol-related inequities was only described in 7 of the 16 countries (Table 12).

Table 12. Countries establishing routine monitoring of inequities in their alcohol policy documents.

Country response	Number of countries N (%)	Countries
Yes	7 (43.8%)	Belgium, Croatia, Czech Republic, Finland, Malta, Portugal, Spain
No	9 (56.3%)	Bulgaria, Estonia, France, Germany, Greece, Iceland, Italy, Norway, Slovenia
Total	16 (100%)	

EII5: HiAP approach

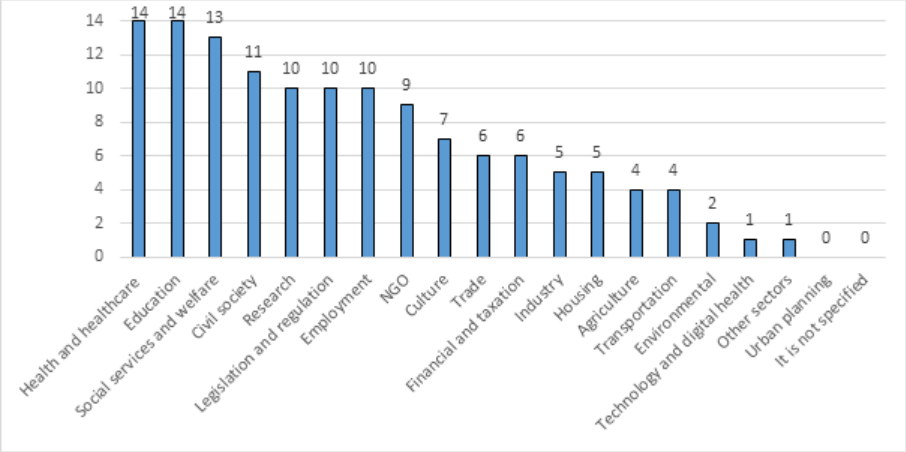
With the exception of Greece, all countries reported having adopted a HiAP approach to reduce alcohol-related inequities (Table 13).

Table 13. Countries with a HiAP approach in their alcohol policy documents.

Country response	Number of countries N (%)	Countries
Yes	15 (93.8%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
No	1 (6.3%)	Greece
Total	16 (100%)	

The health and healthcare and education sectors were represented in 14 of the 15 countries applying a HiAP approach (Figure 8). Social services and welfare were also present in most countries (n = 13), followed by civil society, which was represented in 11 countries.

Figure 8. Sectors involved in countries adopting a HiAP approach in their alcohol policy documents.



Country scores: level of equity integration in alcohol policy documents

Countries generally demonstrate a high level of equity integration in their national alcohol policies. Table 14 presents countries' scores, with 3 and 4 being the most prevalent, each achieved by seven countries.

Table 14. Countries grouped by alcohol policy document equity integration score (EIS).

Score	Number of countries	Countries
4	7 (43.8%)	Belgium, Croatia, Czech Republic, Finland, Malta, Portugal, Spain
3	7 (43.8%)	Bulgaria, France, Germany, Iceland, Italy, Norway, Slovenia
2	2 (12.5%)	Estonia, Greece
1	0 (0%)	
0	0 (0%)	
Total	16 (100%)	

3. National diet and nutrition policy documents

EII1: Inequities mentioned

With the exception of Germany, all countries mention inequities in their national diet and nutrition policies.

Table 15. Countries mentioning inequities in their diet and nutrition policy documents.

Country response	Number of countries N (%)	Countries
Yes	12 (92.3%)	Bulgaria, Croatia, Czech Republic, France, Greece, Hungary, Iceland, Italy, Malta, Portugal, Slovenia, Spain
No	1 (7.7%)	Germany
Total	13 (100%)	

EII2: Equity objectives

Eleven of the 13 countries with diet and nutrition policy documents in place include objectives aimed at reducing inequities (Table 16). Proportionate universalism is the most frequently adopted approach (n = 9), whereas a targeted approach is applied in two countries.

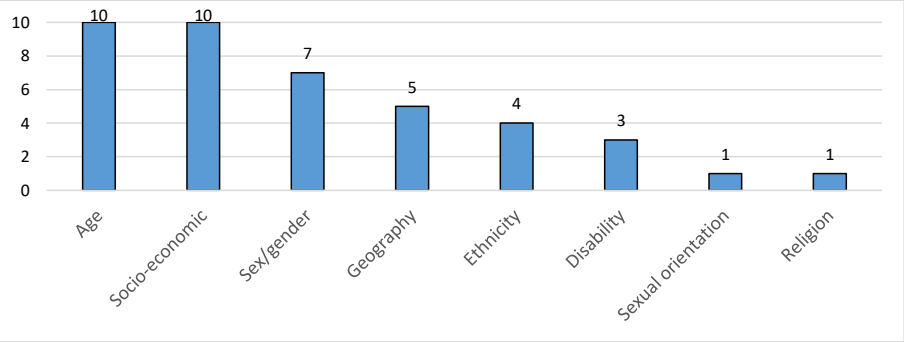
Table 16. Countries including objectives aimed at reducing inequities in their diet and nutrition policy documents by equity approach.

Country response	Number of countries N (%)	Countries
Objectives with a proportionate universalism approach	9 (69.2%)	Bulgaria, Croatia, Czech Republic, France, Italy, Malta, Portugal, Slovenia, Spain
Objectives with a universal approach	0 (0%)	
Objectives with a targeted approach	2 (15.4%)	Greece, Hungary

No equity objectives	2 (15.4%)	Germany, Iceland
Total	13 (100%)	

Among countries that focus on specific social groups—those adopting a proportionate universalism (n = 9) or targeted (n = 2) approach—Figure 9 shows that the objectives most commonly aim to reduce inequities related to age (n = 10), socioeconomic status (n = 10) and sex/gender (n = 7). In contrast, sexual orientation and religion are addressed in only one country.

Figure 9. Social determinants of health addressed in the objectives of diet and nutrition policy documents (targeted and proportionate universalism approaches only).



EII3: Equity actions

As with equity objectives, all but one of the 13 countries include actions to reduce inequities in their diet and nutrition policy documents (Table 17). Proportionate universalism is the most commonly adopted approach (n = 9), while two countries apply a targeted approach and one employs a universal approach.

Table 17. Countries including actions aimed at tackling inequities in their diet and nutrition policy documents by equity approach.

Country response	**Number of countries N (%)**	**Countries**
Actions with a proportionate universalism approach	9 (69.2%)	Bulgaria, Croatia, Czech Republic, France, Iceland, Italy, Malta, Portugal, Spain

Actions with a universal approach	1 (7.7%)	Slovenia
Actions with a targeted approach	2 (15.4%)	Greece, Hungary
No equity actions	1 (7.7%)	Germany
Total	13 (100%)	

Educational programmes are the most common type of action identified in diet and nutrition policy documents (Figure 10), being included in 11 countries. Other frequently reported actions—each included by 10 countries—include reducing salt and/or sugar content in food products, counselling through healthcare professionals, and awareness campaigns. Across most actions, proportionate universalism is the predominant approach, although in some cases a universal approach is adopted almost as frequently. For educational programmes and taxes and fiscal measures, the universal and proportionate universalism approaches are equally represented across countries. In contrast, advertising-related actions most commonly follow a universal approach.

Figure 10. Types of actions in diet and nutrition policy documents by policy approach.

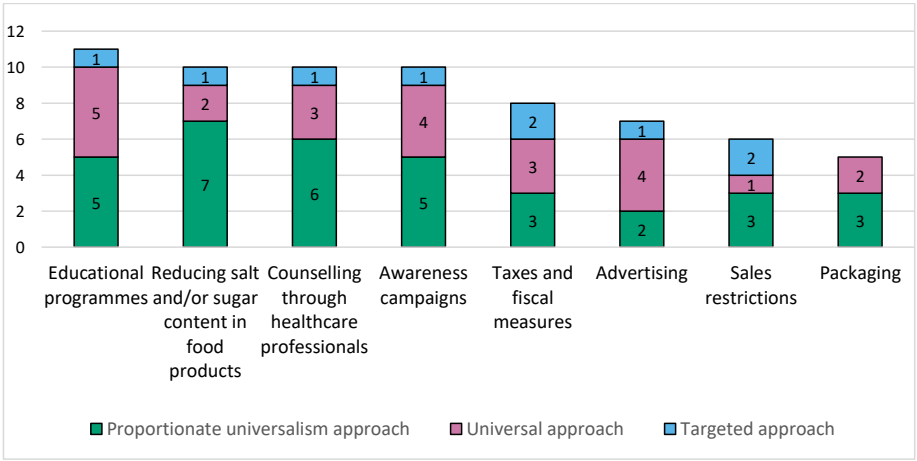


Figure 11 shows that the most frequently addressed SDH in actions adopting a targeted or proportionate universalism approach are age (n = 10) and socioeconomic

status (n = 7). In contrast, religion (n = 1) and sexual orientation (n = 0) are the least commonly addressed determinants.

Figure 11. Social determinants of health addressed in the actions of diet and nutrition policy documents (targeted and proportionate universalism approaches only).

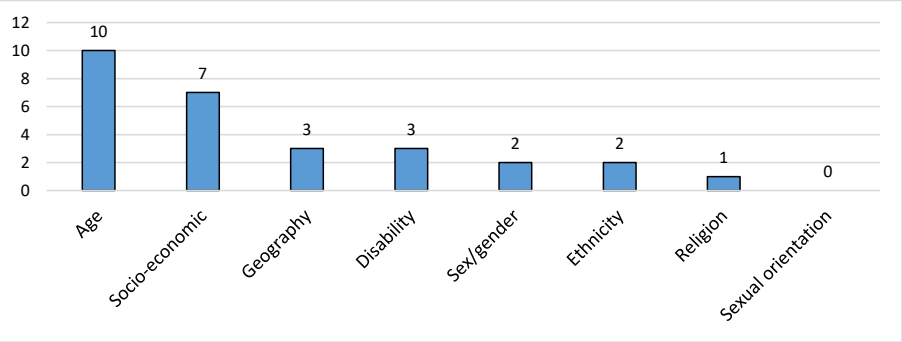


Table 18 presents three illustrative examples of actions drawn from national diet and nutrition policy documents.

Table 18. Examples of actions to reduce inequities in diet and nutrition policy documents.

Country	**Type of action**	**Examples**
Bulgaria	Health mediators	The use of health mediators (as noted in the Health Strategy's plan) is a key intervention addressing socio-economic and ethnic disparities. Health mediators are deployed in communities with a high share of socially disadvantaged and often ethnic minority (e.g., Roma) populations; they facilitate communication, provide culturally appropriate health education on topics like nutrition, and guide people to health services. This intervention specifically considers the needs of groups who, due to poverty, low educational attainment, or language barriers, might otherwise not benefit fully from general health initiatives.
Czech Republic	School canteen meals	The school canteen meals, which nutritional composition is tightly regulated by the relevant decree, are subsidized by the state and therefore highly affordable (average price for parents is 1.27EUR per lunch). Over 80% of children

		and adolescents are eating in school canteens and for the low SES this is very often the only hot food eaten during the day. The school canteens are therefore among the core focus of the Food safety strategy and implementation plan. Provide free or subsidised fruit and vegetable (and milk) schemes, prioritising schools in low-SES areas.
Portugal	Training	To empower individuals, a variety of awareness-raising and training campaigns are being implemented for promoting healthy eating habits, with specific educational measures for families that are beneficiaries of the food aid programs. Actions that increase the knowledge, skills, motivation and self-efficacy for healthy food choices among both socioeconomically vulnerable and priority target groups (e.g., first 1000 days of life, children, adolescents and young adults).

EII4: Monitoring of inequities

Only slightly over half of the participating countries include routine monitoring of inequities in their diet and nutrition policies (Table 19).

Table 19. Countries establishing routine monitoring of inequities in their diet and nutrition policies.

Country response	**Number of countries N (%)**	**Countries**
Yes	7 (53.8%)	Czech Republic, Iceland, Italy, Malta, Portugal, Slovenia, Spain
No	6 (46.2%)	Bulgaria, Croatia, France, Germany, Greece, Hungary
Total	13 (100%)	

EII5: HiAP approach

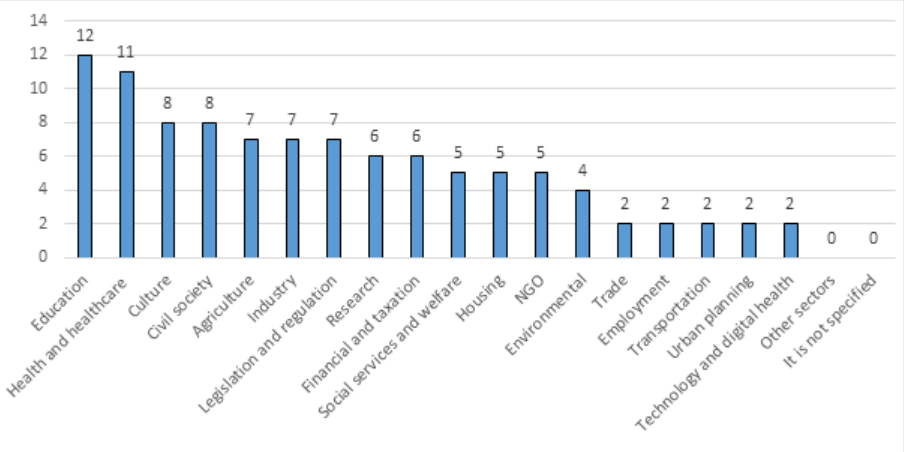
As with equity objectives and actions, most countries (n = 12) incorporate a HiAP approach in their diet and nutrition policy documents. Hungary is the only exception, with no described intersectoral collaboration (Table 20).

Table 20. Countries with a HiAP approach in their diet and nutrition policy documents.

Country response	**Number of countries N (%)**	**Countries**
Yes	12 (92.3%)	Bulgaria, Croatia, Czech Republic, France, Germany, Greece, Iceland, Italy, Malta, Portugal, Slovenia, Spain
No	1 (7.7%)	Hungary
Total	13 (100%)	

All countries adopting a HiAP approach include the education sector in their diet and nutrition policies (Figure 12). Health and healthcare is the next most frequently engaged sector (n = 11), followed by culture and civil society (n = 8 each).

Figure 12. Sectors involved in countries adopting a HiAP approach in their diet and nutrition policies.



Country scores: level of equity integration in diet and nutrition policies

All countries demonstrate a high presence of EIIs in their diet and nutrition policy documents. As a result, most countries are assigned a score of 3 or 4 (Table 21).

Table 21. Countries grouped by diet and nutrition policy document equity integration score (EIS).

Score	Number of countries	Countries
4	7 (53.8%)	Czech Republic, Iceland, Italy, Malta, Portugal, Slovenia, Spain
3	4 (30.8%)	Bulgaria, Croatia, France, Greece
2	1 (7.7%)	Hungary
1	1 (7.7%)	Germany
0	0 (0%)	
Total	13 (100%)	

4. National physical activity policy documents

EII1: Inequities mentioned

All countries with physical activity policies in place mention inequities (n = 16).

Table 22. Countries mentioning inequities in their physical activity policy documents.

Country response	Number of countries N (%)	Countries
Yes	16 (100%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Hungary, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
No	0 (0%)	
Total	16 (100%)	

EII2: Equity objectives

Almost all countries (n = 15) include objectives to reduce inequities in their physical activity policy documents (Table 23). However, approaches differ across countries, with most adopting a proportionate universalism approach (n = 12) and three applying a purely universal approach.

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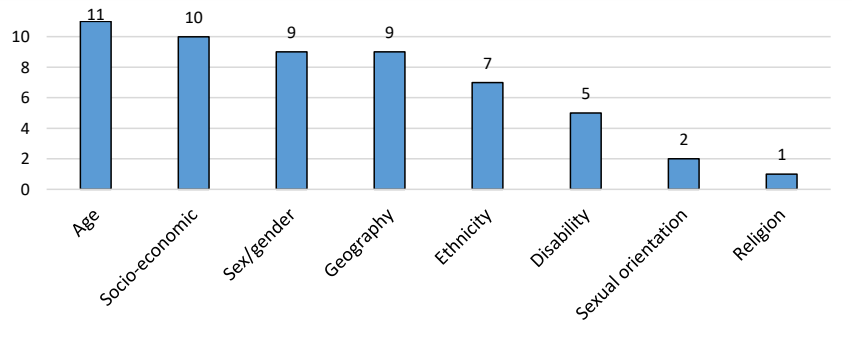
Table 23. Countries including objectives aimed at reducing inequities in their physical activity policy documents by equity approach.

Country response	Number of countries N (%)	Countries
Objectives with a proportionate universalism approach	12 (75%)	Bulgaria, Czech Republic, Estonia, Finland, France, Hungary, Iceland, Italy, Malta, Portugal, Slovenia, Spain
Objectives with a universal approach	3 (18.8%)	Belgium, Croatia, Norway
Objectives with a targeted approach	0 (0%)	

No equity objectives	1 (6.3%)	Germany
Total	16 (100%)	

Among countries that focus on specific social groups—those adopting a proportionate universalism approach (n = 12)—Figure 13 shows that the objectives most commonly aim to reduce inequities related to age (n = 11), socioeconomic status (n = 10), sex/gender (n = 9), and geography (n = 9). In contrast, sexual orientation is addressed in only two countries and religion in just one.

Figure 13. Social determinants of health addressed in the objectives of physical activity policy documents (targeted and proportionate universalism approaches only).



EII3: Equity actions

Table 24 shows that all countries with physical activity policy documents include actions to reduce inequities (n = 16). Most countries apply a proportionate universalism approach (n = 14), while one country adopts a universal approach and one a targeted approach.

Table 24. Countries including actions aimed at tackling inequities in their physical activity policy documents by equity approach.

Country response	**Number of countries N (%)**	**Countries**
Actions with a proportionate	14 (87.5%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Hungary, Iceland, Italy, Norway, Slovenia, Spain

universalism approach		
Actions with a universal approach	1 (6.3%)	Malta
Actions with a targeted approach	1 (6.3%)	Portugal
No equity actions	0 (0%)	
Total	16 (100%)	

Figure 14 shows that a wide range of action types are employed. Infrastructure improvement and educational programmes are the most common (n = 15 each), closely followed by awareness campaigns (n = 14) and counselling through healthcare professionals (n = 12). Proportionate universalism is the predominant equity approach across almost all action types. One exception is counselling through healthcare professionals, for which a universal approach is applied on a slightly more frequent basis.

Figure 14. Types of actions in physical activity policy documents by policy approach.

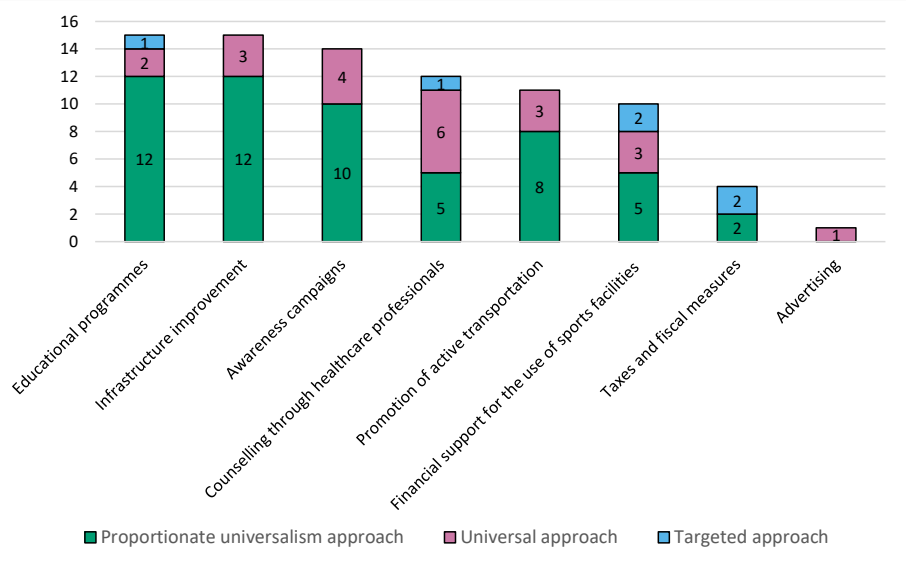


Figure 15 illustrates the most frequently addressed SDH by countries applying a targeted (n = 1) or proportionate universalism (n = 14) approach in their equity-focused

actions. Age is considered in 12 countries, while sex/gender, socioeconomic status and disability are each addressed in 10 countries. In contrast, none of the countries include sexual orientation, and only one considers religion.

Figure 15. Social determinants of health addressed in the actions of physical activity policy documents (targeted and proportionate universalism approaches only).

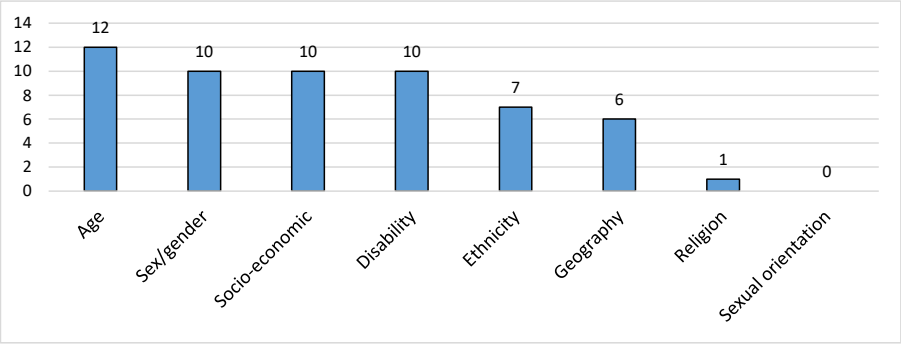


Table 25 presents four illustrative examples of actions reported by national policy experts in relation to their physical activity policy documents.

Table 25. Examples of actions to reduce inequities in physical activity policy documents.

Country	Type of action	Examples
Belgium	Infrastructure improvements	1. Infrastructure improvements are essential to reducing inequalities. The documents emphasise that in neighbourhoods with little green space or unsafe traffic conditions disproportionately affects disadvantaged residents. Investments in safe cycling paths, active school environments and accessible sports infrastructure are therefore a priority. 2. Promotion of active transportation is explicitly linked to equity: children from low-income families have fewer opportunities for safe active commuting. As a response, safe school routes and cycling projects in vulnerable neighbourhoods are highlighted as policy goals.
Czech Republic	Sports facility's accessibility	These facilities should also be accessible to the general public. Emphasis must be placed on

		inclusivity – ensuring access for the broad public regardless of socio-economic circumstances. Sports facilities should be not only multifunctional for the physical development of children and youth but also suitable for specific sports disciplines. Attention must also be paid to ensuring use by children and youth with special educational needs (e.g., visual or physical impairments).
Germany	Evaluation of urban development	Infrastructure projects should strive for a movement-friendly design and the creation of attractive incentives for physical activity. Urban development measures and public construction projects should be examined with regard to their impact on physical activity in everyday life.
Spain	City as our gym	The concept of ""the city as our gym," that is, viewing the city as a public facility for physical activity, to be used by all citizens, while maintaining the principles of equity, gender perspective, coherence, community participation, reducing social inequalities, and promoting physical activity as a cross-cutting theme.

EII4: Monitoring of inequities

Most countries (n = 10) include routine monitoring of inequities in their physical activity policy documents (Table 26), slightly less than other EIIs.

Table 26. Countries including routine monitoring of inequities in their physical activity policy documents.

Country response	**Number of countries N (%)**	**Countries**
Yes	10 (62.5%)	Belgium, Bulgaria, Czech Republic, France, Hungary, Iceland, Malta, Norway, Slovenia, Spain
No	6 (37.5%)	Croatia, Estonia, Finland, Germany, Italy, Portugal
Total	16 (100%)	

EII5: HiAP approach

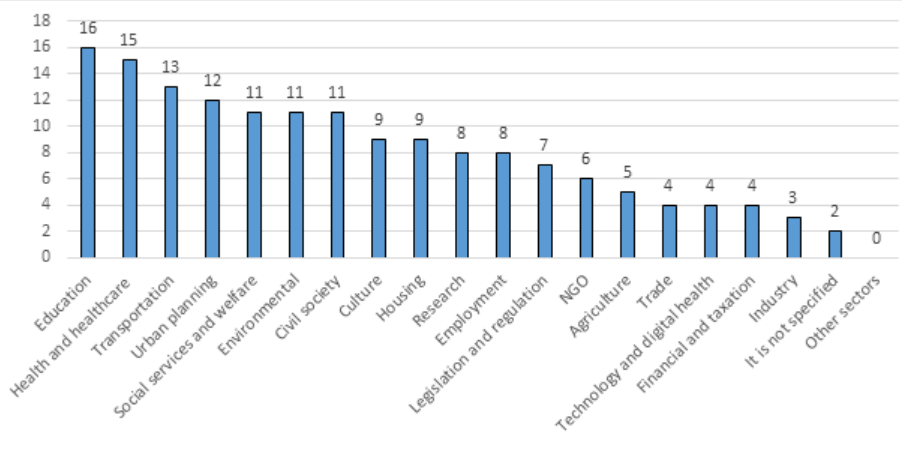
All countries include a HiAP approach in their physical activity policy documents (Table 27).

Table 27. Countries with a Health in All Policies Approach in their physical activity policy documents.

Country response	**Number of countries N (%)**	**Countries**
Yes	16 (100%)	Belgium, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Hungary, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
No	0 (0%)	
Total	16 (100%)	

Figure 16 illustrates sectoral involvement across the 16 countries adopting a HiAP approach. The education sector is represented in all countries, followed closely by the health and healthcare sector, which is involved in 15. The transportation (n = 13) and urban planning sectors (n = 12) are also prominently engaged.

Figure 16. Sectors involved in countries adopting a Health in All Policies approach in their physical activity policy documents.



Country scores: level of equity integration in physical activity policy documents

As shown in Table 28, all 16 countries demonstrate strong equity integration in their physical activity policy documents. All are assigned a score of 3 (n = 6) or 4 (n = 10).

Table 28. Countries grouped by physical activity policy document equity integration score (EIS).

Score	Number of countries	Countries
4	10 (62.5%)	Belgium, Bulgaria, Czech Republic, France, Hungary, Iceland, Malta, Norway, Slovenia, Spain
3	6 (37.5%)	Croatia, Estonia, Finland, Germany, Italy, Portugal
2	0 (0%)	
1	0 (0%)	
0	0 (0%)	
Total	16 (100%)	

5. National policy documents on several NCDs

EII1: Inequities mentioned

All countries explicitly mention health inequities in their policy documents covering several NCDs, as shown in Table 29. Figures 17 and 18 show the types of inequities and the population groups mentioned in these policy documents.

Table 29. Countries mentioning inequities in their policy documents on several NCDs.

Country response	Number of countries	Countries
Yes	5 (100%)	Bulgaria, Italy, Malta, Portugal, Spain
No	0	
TOTAL	5	

Figure 17. Types of inequities mentioned in policy documents on several NCDs.

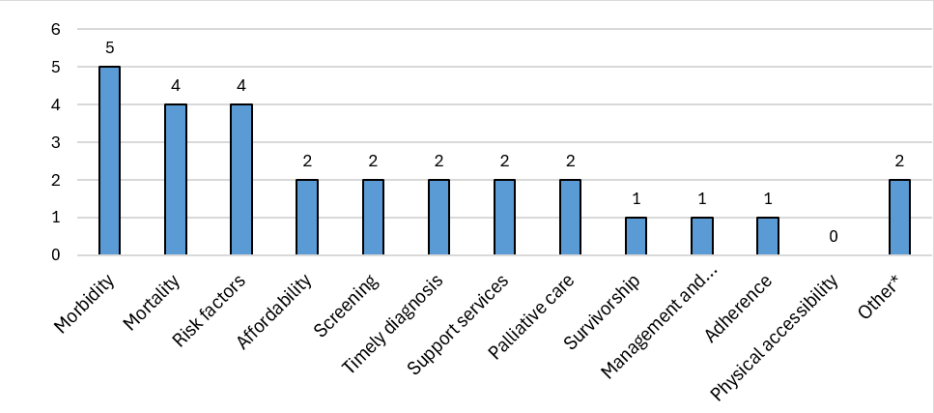
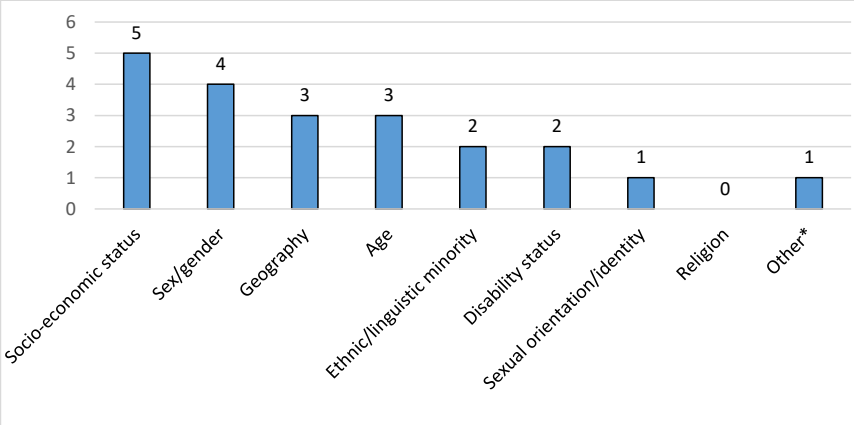


Figure 18. Inequities mentioned in policy documents on several NCDs by population group.



Specific population groups identified as at risk or vulnerable to NCDs

Most countries with policy documents covering several NCDs identify specific population groups as vulnerable or at increased risk with regard to NCDs, the management and treatment of NCDs, and/or exposure to risk factors (Table 30). However, there is considerable variation between the approaches used and the vulnerable groups emphasised in different countries, as shown in Table 31.

Table 30. Countries that emphasise specific population groups as vulnerable with regard to NCDs and NCD treatment.

Country response	Number of countries	Countries
Yes	4 (80%)	Italy, Malta, Portugal, Spain
No	1 (20%)	Bulgaria
Total	5	

Table 31. Examples of specific population groups identified as at risk or vulnerable with regard to NCDs and NCD treatment.

Country	Examples
Italy	The National Prevention Plan pursues a gender approach.
Malta	The document acknowledges that additional considerations need to be taken for specific population groups such as **vulnerable children, adolescents, youth, elderly, people of lower socioeconomic status, people with mental health disorders, people with disabilities, migrants, and LGBTIQ+.**
Portugal	Certain groups are considered as at greater risk: **with low levels of education with low levels of education, low income, homeless, migrants, refugees, due to racial or ethnic origin, ancestry, territory of origin, religion or sexual orientation, gender identity or expression or sex characteristics, with disabilities or suffering from rare diseases, sheltered in institutions, among others**
Spain	Yes, the document explicitly identifies and emphasizes several specific groups as vulnerable in relation to non-communicable diseases (NCDs), their management, treatment, and associated risk factors. Vulnerable groups specifically mentioned include: **people with disability, individuals with sexual and gender diversity, members of different ethnic groups, individuals affected by gender-based violence, people living in rural areas, socially vulnerable groups more broadly, people with mental health conditions, those with complex chronic conditions, frailty, or in situations of vulnerability across the life course (childhood to older age).**

EII2 and EII3: Interventions or actions to reduce inequities in the treatment and management of NCDs and the associated risk factors

As shown in Table 32 and Figure 19, all countries with policy documents on several NCDs include interventions and actions aimed at reducing health inequities related to NCDs. These actions and interventions address inequities in the treatment and management of NCDs, risk factors, or both. Three countries include interventions or actions targeting inequities both in the treatment and management of NCDs and in risk factors. One country reports actions and interventions focused exclusively on inequities in risk factors, while another includes actions only addressing inequities in the treatment and management of NCDs.

Table 32. Interventions and actions to reduce inequities in risk factors and/or in the treatment and management of NCDs.

Country response	**Number of countries**	**Countries**
Interventions/actions to reduce inequities both in the treatment and management of NCDs and in risk factors	3 (60%)	Italy, Portugal, Spain
Interventions/actions to reduce inequities in the treatment and management of NCDs	1 (20%)	Malta
Interventions/actions to reduce inequities in risk factors	1 (20%)	Bulgaria
No actions	0 (0%)	
TOTAL	5	

Figure 19. Focus of interventions and actions to reduce inequities in NCD policy documents.

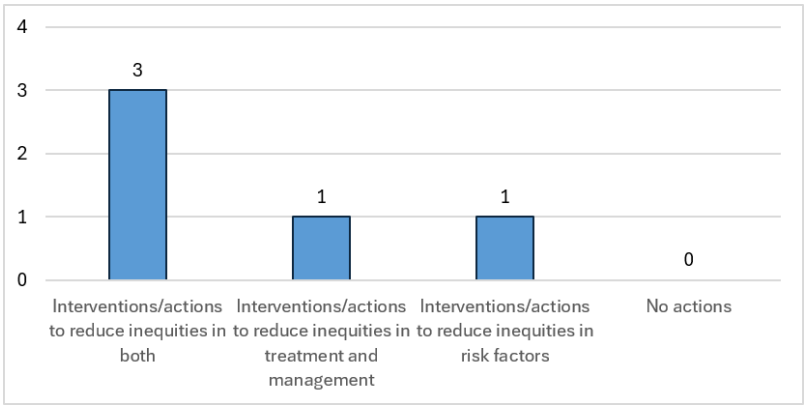


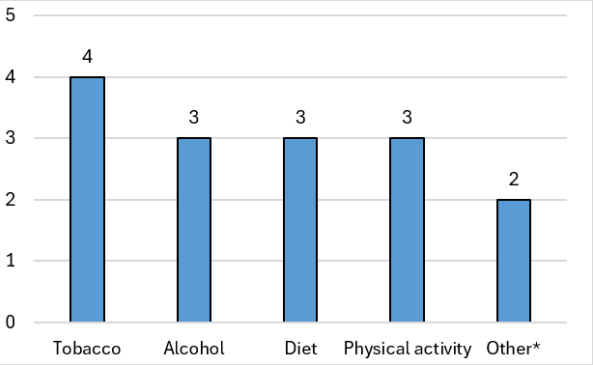
Table 33. Examples of interventions and actions to reduce inequities in the treatment and management of NCDs.

Country	Description of interventions and actions
Italy	The National Plan for Chronic Disease includes social inequalities, frailty and vulnerability among the cross-sectional aspects of chronic care (together with: dissemination of skills, training, support for research; appropriateness in the use of therapies and technologies and adherence to pharmacological therapy; digital health; humanization of care; the role of Associations; the role of pharmacies). Each one of these aspects is addressed through specific objectives, lines of intervention and expected results.
Spain	The documents describe the ongoing implementation and consolidation of the Adjusted Morbidity Groups of the NHS (AMG-NHS), a tool used since 2015 to stratify the population based on morbidity burden. This tool enables regular identification and monitoring of population groups according to their health conditions. It facilitates the planning of tailored healthcare interventions, resource allocation, and research,

	ensuring a structured and continuous monitoring system across the National Health System. This routine stratification process inherently supports the monitoring of inequities in the distribution and burden of NCDs.

When countries reported having actions or interventions aimed at reducing inequities in risk factors in their policy documents on several NCDs, they were asked to specify which risk factors were addressed. These results are depicted in Figure 20.

Figure 20. Risk factors addressed by interventions and actions to reduce inequities in policy documents on several NCDs.



* Other: social determinants of health, environmental pollution

EII4: Monitoring of inequities

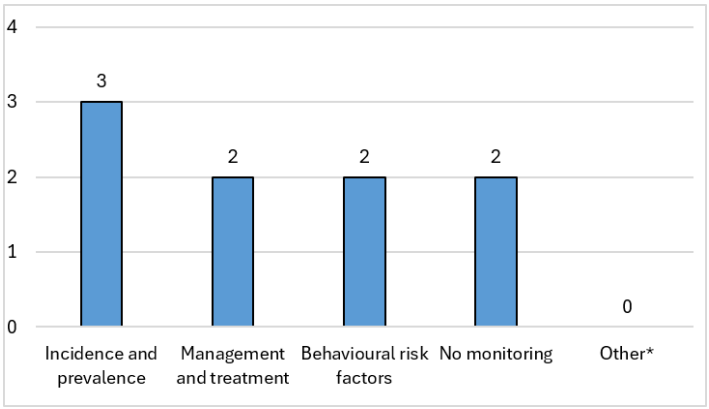
As shown in Table 34 and Figure 21, three of the five countries with policy documents on several NCDs report routine monitoring of inequities related to the incidence and prevalence of NCDs, the treatment and management of NCDs, and/or risk factors.

Table 34. Countries including routine monitoring of inequities in policy documents on several NCDs.

Country response	Number of countries	Countries
Yes, monitoring of inequities in the incidence and prevalence of NCDs	3 (60%)	Italy, Malta, Spain

Yes, monitoring of inequities in the treatment and management of NCDs	2 (40%)	Italy, Spain
Yes, monitoring of inequities in NCD risk factors	2 (40%)	Italy, Malta
No	2 (40%)	Bulgaria, Portugal
TOTAL	5	

Figure 21. Routine monitoring in policy documents on several NCDs encompasses inequities related to:



EII5: HiAP approach

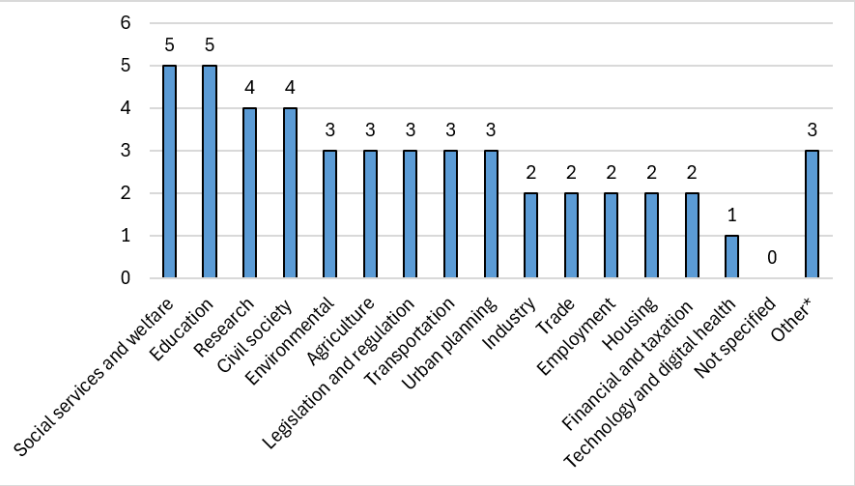
All participating countries with policy documents on several NCDs report including a HiAP approach to address inequities in NCDs and/or in the treatment and management of NCDs (Table 35).

Table 35. Countries with a Health in All Policies approach in their policy documents on several NCDs

Country response	**Number of countries**	**Countries**
Yes	5 (100%)	Bulgaria, Portugal, Italy, Malta, Spain
No	0 (0%)	
TOTAL	5	

All countries adopting a HiAP approach to reduce inequities in NCDs include the social services and welfare sector and the education sector (n = 5 each). The next most frequently involved sectors are research and civil society (n = 4 each), followed by a range of other sectors with more limited representation (Figure 22).

Figure 22. Sectors involved in countries adopting a Health in All Policies approach in their policy documents on several NCDs.



*Other: 1) Media; 2) Arts, faith communities; 3) Sports associations, third sector, law enforcement, scientific societies.

Country scores: Level of equity integration in policy documents on several NCDs

All five countries with policy documents on several NCDs demonstrate a strong level of equity integration. As shown in Table 36, three countries include all four EIIs, while two countries include three indicators.

Table 36. Countries grouped by the equity integration score (EIS) of their policy documents on several NCDs.

Score	Number of countries	Countries
4	3	Italy, Malta, Spain
3	2	Bulgaria, Portugal
2	0	
1	0	
0	0	

6. National policy documents on cardiovascular diseases

EII1: Inequities mentioned

Two countries reported having policy documents on CVDs. As shown in Table 37, both of these documents explicitly mention health inequities. Figures 23 and 24 show the types of inequities and the population groups mentioned in these policy documents.

Table 37. Countries mentioning inequities in their CVD policy documents.

Country response	Number of countries	Countries
Yes	2 (100%)	Czech Republic, Spain
No	0	
TOTAL	2	

Figure 23. Types of inequities mentioned in CVD policy documents.

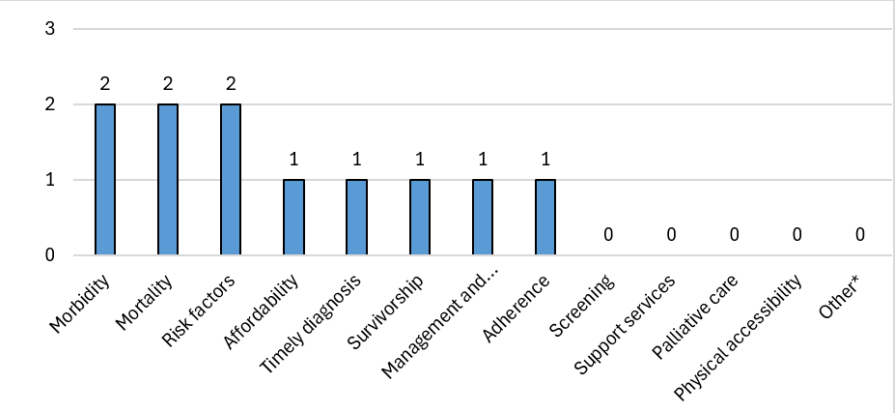
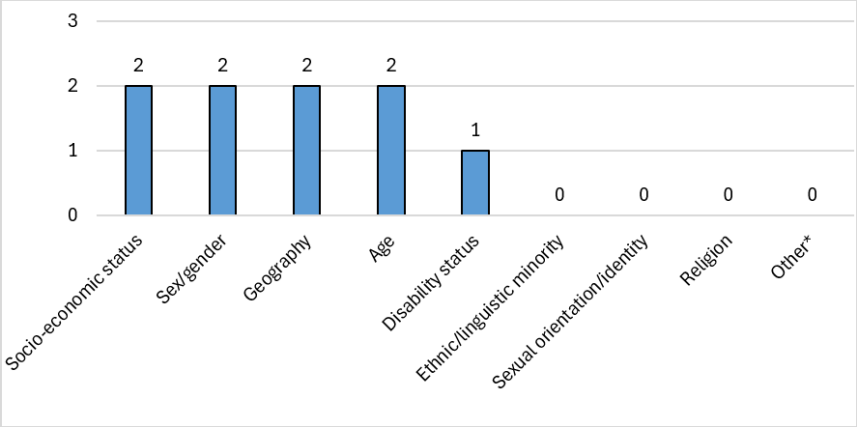


Figure 24. *Inequities mentioned in CVD policy documents by population group.*



Specific population groups identified as at risk or vulnerable to CVDs

One of the two countries with policy documents on cardiovascular diseases, namely Spain, identifies specific population groups as vulnerable or at increased risk with regard to CVDs, the management and treatment of CVDs, and/or exposure to risk factors (Table 38). An example is given in Table 39.

Table 38. Countries that emphasise certain groups as vulnerable with regard to CVDs and CVD treatment.

Country response	Number of countries	Countries
Yes	1 (50%)	Spain
No	1 (50%)	Czech Republic
Total	2	

Table 39. Examples of specific population groups identified as at risk or vulnerable with regard to CVDs and CVD treatment.

Country	Examples
Spain	"The actions must **consider the specific needs of population groups at greater risk due to socioeconomic, gender, or territorial vulnerability.**"

	"**Promoting cardiovascular health from early ages, and in older adults, is a strategic priority to reduce long-term inequities.**"

EII2 and EII3: Interventions or actions to reduce inequities in the treatment and management of CVDs and the associated risk factors

As shown in Table 40 and Figure 25, both countries with CVD policy documents include interventions and actions aimed at reducing health inequities related to CVDs. The documents of both countries include actions/interventions to address inequities in both the treatment and management of CVDs and in CVD risk factors. Examples of such actions/interventions are provided in Table 41.

Table 40. Interventions to reduce inequities in risk factors and/or in the treatment and management of CVDs.

Country response	**Number of countries**	**Countries**
Interventions/actions to reduce inequities both in the treatment and management of CVDs and in risk factors	2 (100%)	Czech Republic, Spain
Interventions/actions to reduce inequities in the treatment and management of CVDs	0	
Interventions/actions to reduce inequities in risk factors	0	
No actions	0	
TOTAL	2	

Figure 25. Distribution of CVD policy documents by the focus of interventions and actions to reduce inequities.

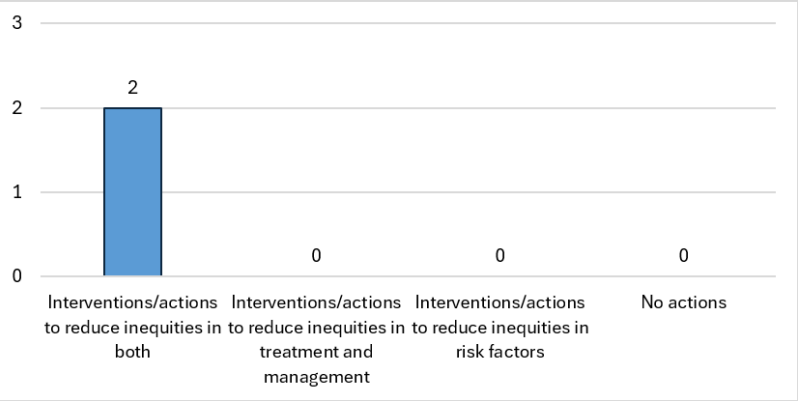


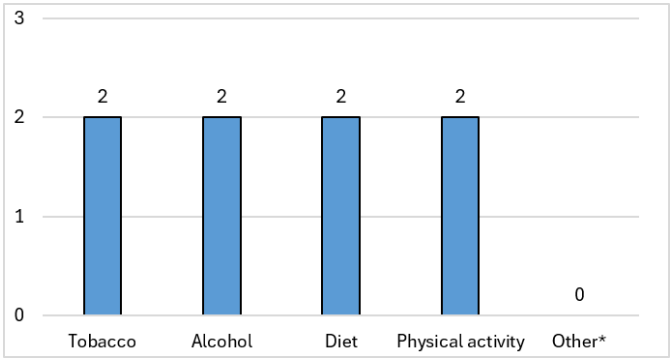
Table 41. Examples of interventions and actions to reduce inequities in the treatment and management of CVDs.

Country	Description of interventions and actions
Czech Republic	The National Cardiovascular Plan of the Czech Republic states that there is an effort to ensure equal regional access to healthcare, including among the various regions of the country, covering both specialized outpatient and highly specialized care. This approach responds to significant regional disparities in health indicators, particularly in the area of cardiovascular diseases. STRATEGIC GOAL 2: Access to and organization of patient-centered care ensures the highest possible quality of life during illness, after recovery, or in the terminal stage. SPECIFIC GOAL 2.1: Ensure access to all forms of follow-up, long-term, and palliative care. SPECIFIC GOAL 2.3: Ensure regional availability of specialized and outpatient care across all regions of the Czech Republic.

	Although the average number of cardiology outpatient clinics in the Czech Republic is adequate in relation to the population, the regional distribution is highly uneven.
Spain	"It is essential to ensure territorial equity in access to high-quality cardiovascular care. The strategy promotes standardized indicators to allow cross-regional comparisons." "Primary care must be reinforced as the foundation for equitable cardiovascular health services." -Address social inequalities in health through the Strategy's actions in an interdisciplinary manner

When countries reported having actions or interventions aimed at reducing health inequities in risk factors in their CVD policy documents, they were asked to specify which risk factors were addressed. These results are depicted in Figure 26.

Figure 26. Risk factors addressed by interventions and actions to reduce inequities in CVD policy documents.



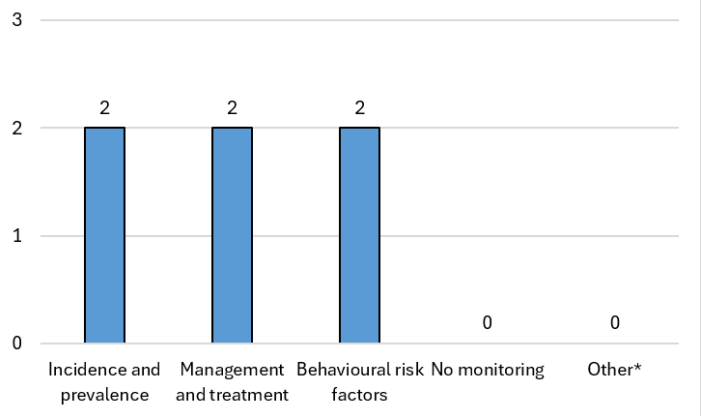
EII4: Monitoring of inequities

As shown in Table 42 and Figure 27, both countries with CVD policy documents report routine monitoring of inequities related to CVD incidence and prevalence, treatment and management, and risk factors.

Table 42. Countries including routine monitoring of inequities in CVD policy documents.

Country response	Number of countries	Countries
Yes, monitoring of inequities in the incidence and prevalence of CVDs	2 (100%)	Czech Republic, Spain
Yes, monitoring of inequities in the treatment and management of CVDs	2 (100%)	Czech Republic, Spain
Yes, monitoring of inequities in CVD risk factors	2 (100%)	Czech Republic, Spain
No	0	
Total	2	

Figure 27. Routine monitoring in policy documents on cardiovascular diseases encompasses inequities related to:



EII5: HiAP approach

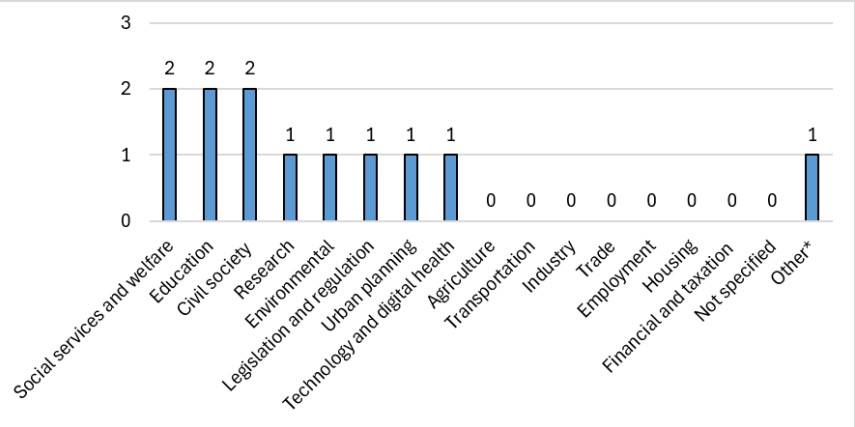
Both countries that have CVD policy documents report including a HiAP approach in these documents to address inequities in CVDs and/or the treatment and management of CVDs (Table 43).

Table 43. Countries with a Health in All Policies approach in their CVD policy documents.

Country response	Number of countries	Countries
Yes	2 (100%)	Czech Republic, Spain
No	0 (0%)	
Total	2	

As shown in Figure 28, social services, education, and civil society are covered in both policy documents, whilst research, legislation and regulation, the environment, urban planning, and technology and digital health are each covered in one policy document. One country also included local governments and intersectoral municipal health initiatives.

Figure 28. Sectors involved in countries adopting a Health in All Policies approach in their CVD policy documents.



*Other: 1) Local governments, intersectoral municipal health initiatives.

Country scores: Level of equity integration in CVD policy documents

Both countries with CVD policy documents include all four EIIs.

Table 44. Countries grouped by CVD policy document equity integration score (EIS).

Score	Number of countries	Countries
4	2	Czech Republic, Spain
3	0	
2	0	
1	0	
0	0	

7. National diabetes policy documents

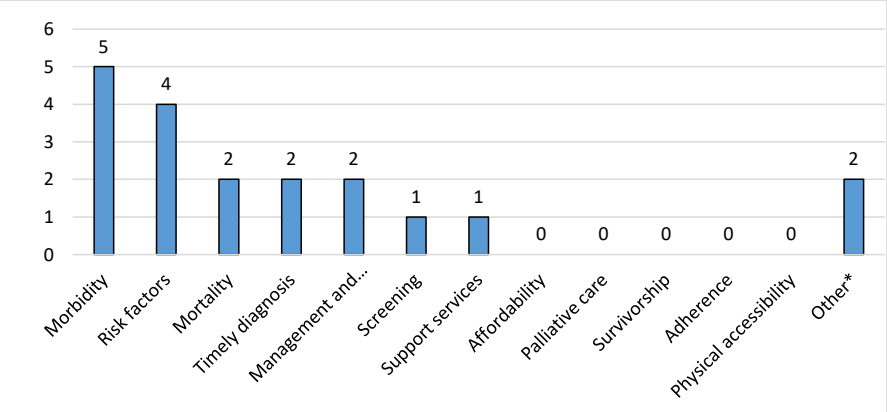
EII1: Inequities mentioned

All six countries explicitly mention health inequities in their diabetes policy documents, as shown in Table 45. Figures 29 and 30 show the types of inequities and population groups mentioned in these policy documents.

Table 45. Countries mentioning inequities in their diabetes policy documents.

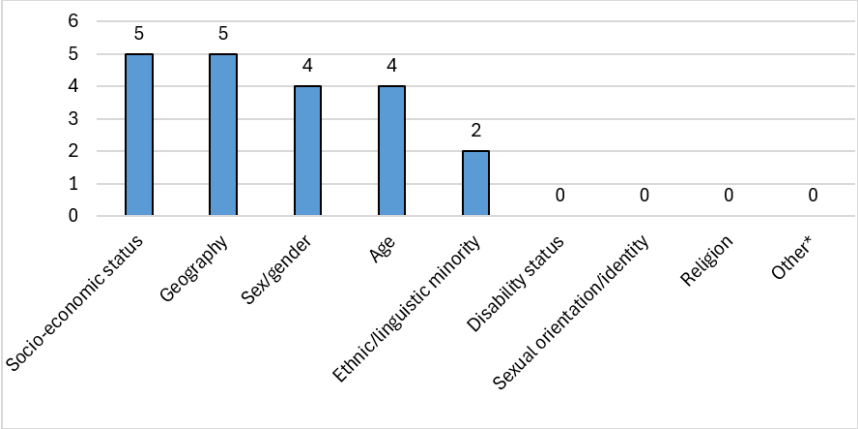
Country response	Number of countries	Countries
Yes	6 (100%)	Germany, Malta, Norway, Portugal, Slovenia, Spain
No	0	
Total	6	

Figure 29. Types of inequities mentioned in diabetes policy documents.



*Other: 1) health literacy; 2) access to the same quality prevention programmes.

Figure 30. Inequities mentioned in diabetes policy documents by population group.



Specific population groups identified as at risk or vulnerable to diabetes

Two-thirds (4/6) of the countries with diabetes policy documents identify specific population groups as vulnerable or at increased risk with regard to diabetes, the management and treatment of diabetes, or related risk factors (Table 46). Examples of population groups identified are presented in Table 47.

Table 46. Countries that emphasise certain groups as vulnerable with regard to diabetes and diabetes treatment.

Country response	Number of countries	Countries
Yes	4 (67%)	Germany, Malta, Norway, Spain
No	2 (33%)	Portugal, Slovenia
Total	6	

Table 47. Examples of specific population groups identified as at risk or vulnerable with regard to diabetes and treatment.

Country	Examples
Germany	People with an increased risk of diabetes are considered as key- sub-target groups: those with

	certain medical aspects: e.g. **individuals with a genetic predisposition, people who are overweight, pregnant women; vulnerable groups**; those with certain social aspects:: e.g. people **with a migrant background, low socioeconomic status, lower levels of education, older age**
Malta	The strategy strives to reach out to vulnerable or hard-to-reach groups. This includes **individuals suffering from social deprivation; individuals who are socially excluded** – these individuals may struggle to cope in managing their diabetes, and would require additional support to manage their condition effectively, **families at risk of poverty / low-income families** – these families were identified in the strategy document as possibly facing additional difficulties in adhering to clinical recommendations due to financial limitations. **Adolescents** – adolescents were also identified as a group who may face challenges with diabetes control, both due to change they would be going through in their personal lives, as well as the challenges faced during the transition from paediatric to adult diabetes care in our local healthcare system, which could lead to missing follow-up appointments and worsening diabetes care. **Women who develop gestational diabetes**.
Norway	“"A distinctive feature of type 2 diabetes is that its incidence among **certain immigrant groups** is significantly higher than in the rest of the population”"
Spain	The strategy identifies specific vulnerable groups at increased risk for developing diabetes or facing barriers in its management. These include: **Ethnic minorities**, particularly people of African, Asian, and

	Latin American origin, who are recommended for annual screening due to higher prevalence; **The Roma population**, noted for less healthy dietary habits (lower intake of fruits and vegetables, higher intake of sugars and animal fats); **Migrants**, with some data showing slightly lower reported prevalence but potential underuse of health services.; **Individuals with lower socioeconomic status or lower educational attainment**, as diabetes prevalence is inversely related to education level; **Populations with limited access to health services**, such as those with sociocultural or geographic barriers.

EII2 and EII3: Interventions or actions to reduce inequities in the treatment and management of diabetes and the associated risk factors

Five of the six countries with diabetes policy documents include interventions and actions aimed at reducing inequities in diabetes—whether in treatment and management, in risk factors, or in both (Table 48 and Figure 31). Two countries outline interventions/actions addressing inequities in both treatment and management and in risk factors, while two focus solely on inequities in the treatment and management of diabetes and one only addresses inequities related to risk factors. Examples of reported interventions and actions targeting inequities in the treatment and management of diabetes are provided in Table 49.

Table 48. Interventions to reduce inequities in risk factors and/or in the treatment and management of diabetes.

Country response	Number of countries	Countries
Interventions/actions to reduce inequities both in the treatment and management of diabetes and in risk factors	2 (33%)	Malta, Spain
Interventions/actions to reduce inequities in the treatment and management of diabetes	2 (33%)	Norway, Portugal

Interventions/actions to reduce inequities in risk factors	1 (17%)	Germany
No actions	1 (17%)	Slovenia
Total	6	

Figure 31. Distribution of diabetes policy documents by the focus of interventions and actions to reduce inequities.

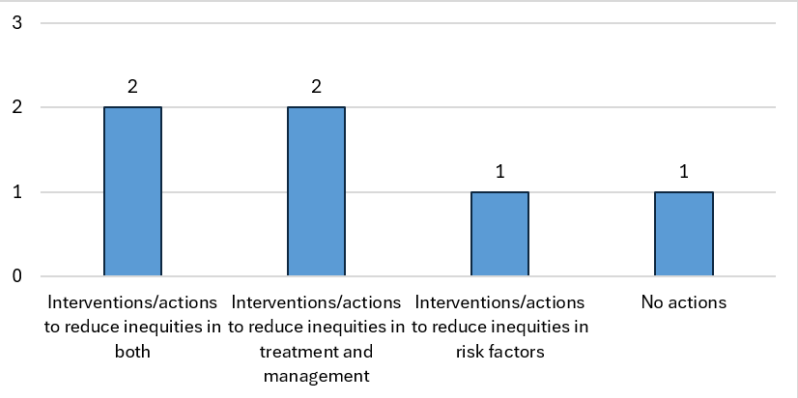


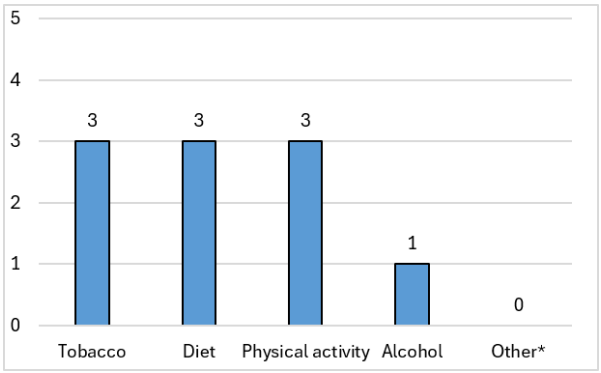
Table 49. Examples of interventions and actions to reduce inequities in the treatment and management of diabetes.

Country	Description of interventions and actions
Malta	"Persons with Type 1 diabetes usually require intensive monitoring of their blood sugar. The current entitlement criteria for the supply of blood glucose monitoring strips for persons with Type 1 diabetes are age-dependent. In order to promote self-management of diabetes, it is recommended that four blood glucose strips daily are given to all patients with Type 1 diabetes." The strategy also proposed measures to improve access to specialist care in Gozo, and the setting up of a transition care clinic to facilitate adolescents' transfer from paediatric to adult services.

Norway	"The Norwegian Childhood Diabetes Registry shows that few children in Norway achieve the treatment goal of HbA1c below 7.5, and there are large differences between pediatric departments in the proportion of children who reach this goal. This indicates a need to improve the quality of diabetes care for children and adolescents in Norway. A project is planned with participation from nine pediatric departments in Norway."
Portugal	"To ensure equitable access to the best care, the PND will continue to promote the use of new technologies, such as insulin delivery systems, and increase the screening for complications. In addition, the programme will intensify awareness campaigns to increase health literacy and promote therapeutic education in people with diabetes or at risk of developing it." "This guideline includes an Individual Health Plan (IHP) for each child or young person with type 1 diabetes (T1D) and a training plan. The IHP is a plan developed by the school health team (SHTE), within the framework of the National School Health Programme (NSHP), in accordance with the therapeutic plan provided during the consultation with the diabetes specialist."

When countries reported having actions or interventions aimed at reducing inequities in risk factors in their diabetes policy documents, they were asked to specify which risk factors were addressed. These results are depicted in Figure 32.

Figure 32. Risk factors addressed by interventions and actions to reduce inequities in diabetes policy documents.



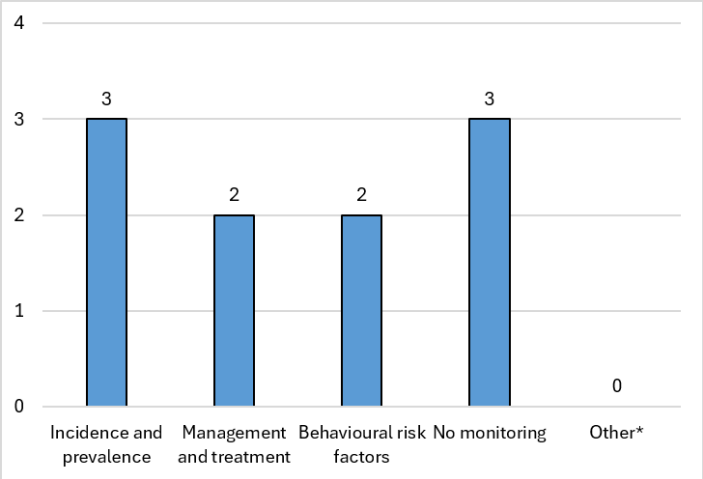
EII4: Monitoring of inequities

Half of the countries with diabetes policy documents (3/6) report routine monitoring of inequities. All three cover monitoring inequities in diabetes incidence and prevalence, while two include inequities related to management and treatment and two cover inequities in diabetes risk factors (Table 50 and Figure 33).

Table 50. Countries including routine monitoring of inequities in their diabetes policy documents.

Country response	**Number of countries**	**Countries**
Yes, monitoring of inequities in the incidence and prevalence of diabetes	3 (50%)	Malta, Portugal, Spain
Yes, monitoring of inequities in the treatment and management of diabetes	2 (33%)	Portugal, Spain
Yes, monitoring of inequities in diabetes risk factors	2 (33%)	Portugal, Spain
No	3 (50%)	Germany, Norway, Slovenia
Total	6	

Figure 33. Routine monitoring in policy documents on diabetes encompasses inequities related to:



EII5: HiAP approach

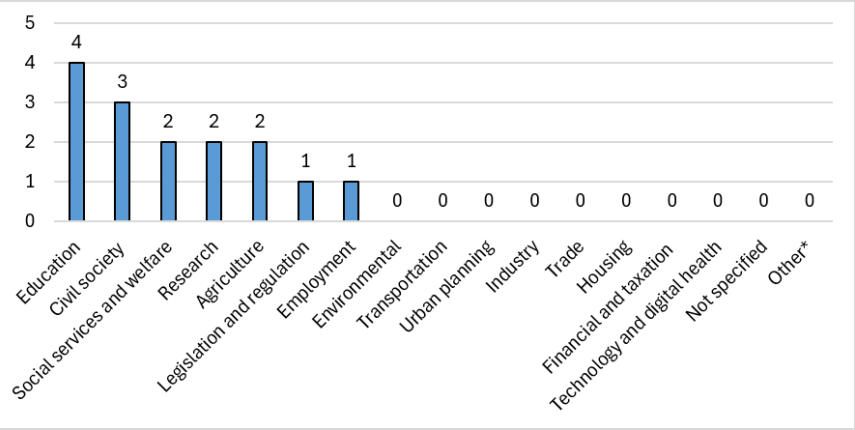
Two-thirds (4/6) of the countries with diabetes policy documents include a HiAP approach to address inequities in diabetes and/or in the treatment and management of diabetes.

Table 51. Countries with a Health in All Policies approach in their diabetes policy documents.

Country response	Number of countries	Countries
Yes	4 (67%)	Malta, Portugal, Slovenia, Spain
No	2 (33%)	Germany, Norway
Total	6	

The education sector is included in all four policy documents adopting a HiAP approach to reduce diabetes-related inequities. Civil society is the next most frequently engaged sector (n = 3), while social services and welfare, research, and agriculture are all mentioned by two countries, and legislation and employment are each covered by one country (Figure 34).

Figure 34. Sectors involved in countries adopting a Health in All Policies approach in their diabetes policy documents.



Country scores: Level of equity integration in diabetes policy documents

Half of the countries (3/6) with diabetes policy documents include all four indicators used for assigning EIS values. The other three countries are assigned a score of 2 (Table 52).

Table 52. Countries grouped by diabetes policy document equity integration score (EIS).

Score	Number of countries	Countries
4	3	Malta, Portugal, Spain
3	0	
2	3	Germany, Norway, Slovenia
1	0	
0	0	

8. National cancer policy documents

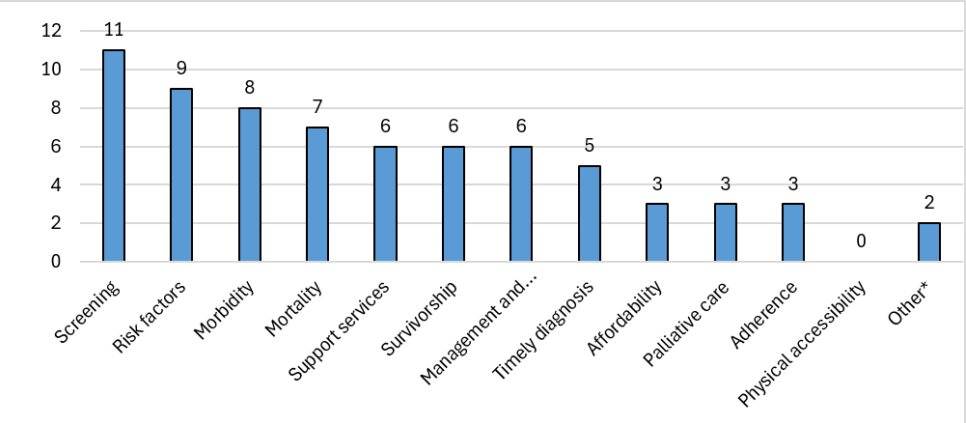
EII1: Inequities mentioned

Almost all countries with cancer policy documents (13/14) explicitly mention inequities, as shown in Table 53. Figures 35 and 36 show the types of inequities and the population groups mentioned in these policy documents.

Table 53. Countries mentioning inequities in their cancer policy documents.

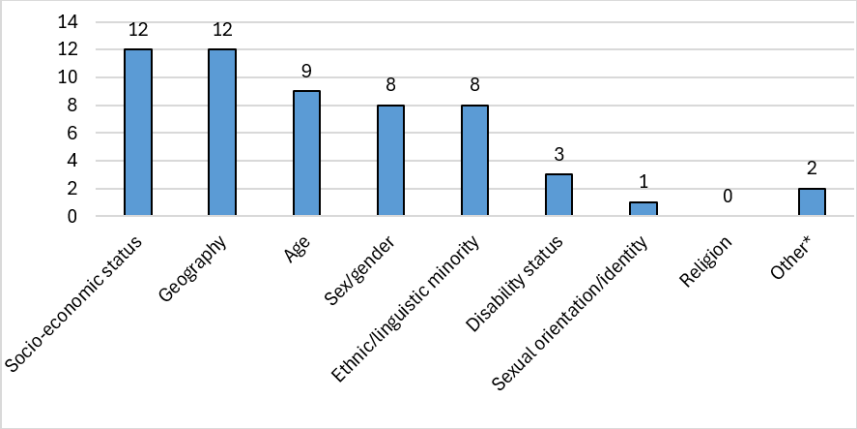
Country response	Number of countries	Countries
Yes	13 (93%)	Bulgaria, Czech Republic, Estonia, France, Germany, Hungary, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain
No	1 (7%)	Croatia
Total	14	

Figure 35. Types of inequities mentioned in cancer policy documents.



*Other: 1) Childhood cancers; 2) General unevenness in care.

Figure 36. Inequities mentioned in cancer policy documents by population group.



*Other: 1) Incarcerated individuals; 2) People with mental health problems.

Specific population groups identified as at risk or vulnerable to cancer

Over half of the countries with policy documents on cancer identify specific population groups as vulnerable or at increased risk with regard to cancer, the management and treatment of cancer, and/or exposure to risk factors, as shown in Table 54. Examples of the population groups considered to be vulnerable to cancer are given in Table 55.

Table 54. Countries that emphasise certain groups as vulnerable with regard to cancer and cancer treatment.

Country response	Number of countries	Countries
Yes	8 (57%)	Croatia, Estonia, Germany, Hungary, Iceland, Italy, Malta, Portugal
No	6 (43%)	Bulgaria, Czech Republic, France, Norway, Slovenia, Spain
Total	14	

Table 55. Examples of the population groups considered to be at risk or vulnerable with regard to cancer and cancer treatment.

Country	Examples
Estonia	**HIV positive** – "Activities on prevention, testing, early diagnosis and treatment of HIV and other sexually transmitted infections will be implemented in the health system nationally"
Hungary	Related to oncopsychology – those suffering from psychological problems and illnesses. These vulnerable/risk groups should be acknowledged in oncology as they need extra attention in care. Those considered at risk are: "those suffering from **psychological problems or psychiatric illnesses in the period before the manifestation of cancer, as well as cancer patients belonging to risk groups** (e.g. adolescents, those who became ill during pregnancy, parents with young children, those living alone, the elderly, **people belonging to minorities, and so on**)"
Iceland	"Little is known about the condition and needs of people who have completed cancer treatment (cancer survivorship) in Iceland. Further research is needed in Iceland to assess this growing group, as this period in an individual's life has received too little attention in Iceland and abroad. In recent years, the Nordic countries have begun to follow up on **people who underwent cancer treatment in their youth**, but this group is particularly vulnerable in this regard, as the disease and difficult treatment are at a sensitive stage in the individual's life. These people need to be offered structured long-term monitoring."

Italy	"For **migrant patients**, linguistic and cultural differences that aggravate the person's discomfort are of significant importance. The role of the cultural mediator helps to overcome inadequate communication with people who do not speak our language, or have limited knowledge of it, helping to understand different cultures, since even the disease takes on different meanings depending on the country of reference"
Malta	Furthermore, in order to also address health inequalities in our society, preventive measures will seek to target selected vulnerable groups e.g. **children and young people, people working in high risk occupational settings, and people suffering from mental health problems**.
Portugal	Quantify and reduce inequalities in access to screening programs, especially in the following population groups: a) **users without a family doctor; b) migrants; c) transgender users; d) users who are not fluent in Portuguese; e) users residing in rural areas and/or those with greater socioeconomic deprivation.**

EII2 and EII3: Interventions or actions to reduce inequities in the treatment and management of cancer and the associated risk factors

As shown in Table 56 and Figure 37, ten countries with policy documents include interventions and actions aimed at reducing health inequities related to cancer. These actions and interventions address inequities in the treatment and management of cancer, risk factors, or both. Six of these set out interventions or actions to reduce inequities both in cancer treatment and management and in risk factors, while two include interventions or actions to reduce inequities solely in the treatment and

management of cancer and another two only target inequities in risk factors. Examples are provided in Table 57.

Table 56. Interventions and actions to reduce inequities in risk factors and/or in the treatment and management of cancer.

Country response	Number of countries	Countries
Interventions/actions to reduce inequities in both the treatment and management of cancer and in risk factors	6 (43%)	Czech Republic, Estonia, France, Iceland, Italy, Norway
Interventions/actions to reduce inequities in the treatment and management of cancer	2 (14%)	Hungary, Spain
Interventions/actions to reduce inequities in risk factors	2 (14%)	Bulgaria, Malta
No actions	4 (29%)	Croatia, Germany, Portugal, Slovenia
Total	14	

Figure 37. Distribution of cancer policy documents by the focus of interventions and actions to reduce inequities.

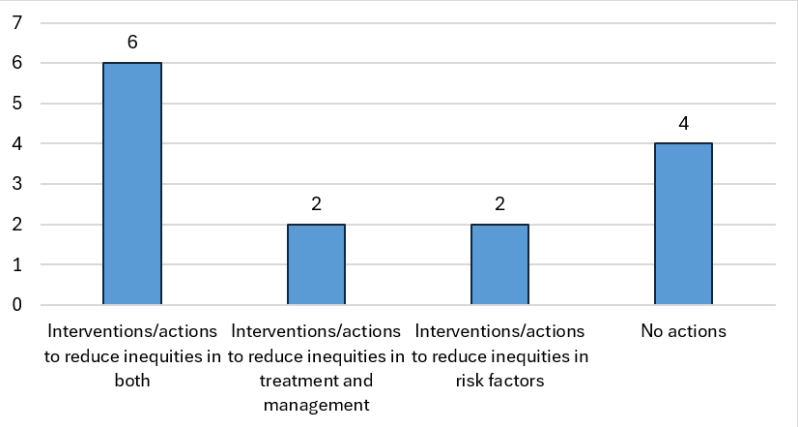


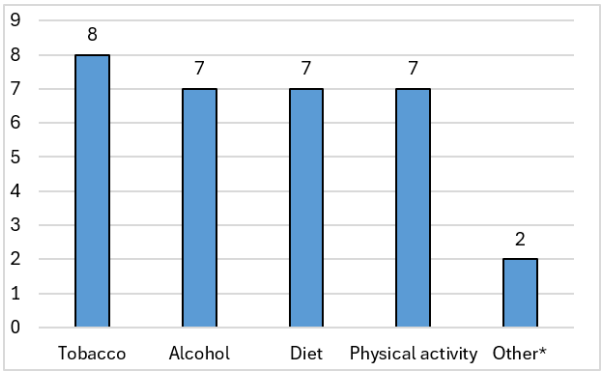
Table 57. Examples of interventions and actions to reduce inequities in the treatment and management of cancer.

Country	Description of interventions and actions
Czech Republic	"The National Cancer Plan for Czech Republic 2030 outlines actions to reduce inequities in cancer care by improving access to treatment in underserved areas, expanding screening programs for early detection, addressing socio-economic barriers, enhancing health literacy, and ensuring affordable care. It also focuses on strengthening healthcare infrastructure to ensure equitable access for all populations, especially vulnerable groups."
Estonia	Targeted activities to improve access to care for patients in remote regions. Targeted activities towards reducing inequalities in screening and early detection. Targeted activities towards reducing age and gender inequalities in survival.
France	The ten-year strategy document sets out several actions to address inequities in treatment and management of cancer in area 4, these are related to patient contact and information, clinical trials, access and inequities overseas populations experience.
Hungary	Increase in telemedicine, and a more centralized system – organizing oncology care facilitites in a hierarchical network order. More accessibility for screening of cervical cancer.
Iceland	" An invitation process, where a predetermined time is included in an invitation letter that is easy to change, increases the likelihood that

	individuals will attend screening. Information about screening and invitation letters need to be available in the most common languages of the community.”

When countries reported having actions or interventions aimed at reducing inequities in risk factors in their cancer policy documents, they were asked to specify which risk factors were addressed. These results are depicted in Figure 38.

Figure 38. Risk factors addressed by interventions and actions to reduce inequities in cancer policy documents.



*Other: 1) Environmental/occupational exposure; 2) Outdoor and indoor pollution, infectious diseases.

EII4: Monitoring of inequities

As shown in Table 58 and Figure 39, only four policy documents out of 14 cover routine monitoring of inequities related to the incidence and prevalence of cancer, the treatment and management of cancer, and/or risk factors. All four include monitoring of inequities in the incidence and prevalence of cancer, while one includes monitoring of inequities in the management and treatment of cancer and three include the monitoring of inequities in cancer risk factors. Three also cover monitoring of inequities in “other” elements related to cancer.

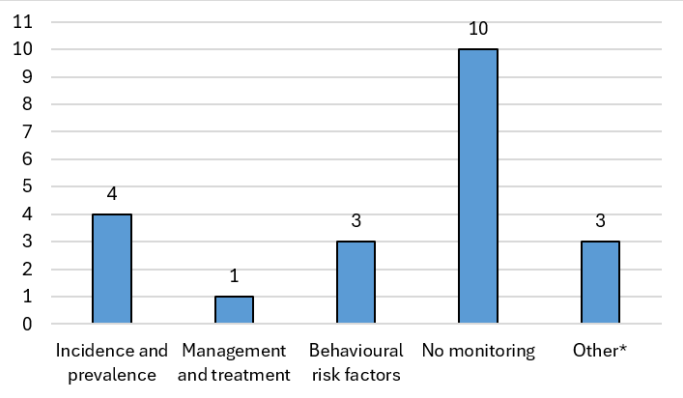
Table 58. Countries including routine monitoring of inequities in their cancer policy documents.

Country response	Number of countries	Countries

Yes, monitoring of inequities in the incidence and prevalence of cancer	4 (29%)	Czech Republic, Estonia, Italy, Spain
Yes, monitoring of inequities in cancer management and treatment	1 (7%)	Czech Republic
Yes, monitoring of inequities in cancer risk factors	3 (21%)	Czech Republic, Estonia, Italy
Other*	3 (21%)	Estonia, Italy, Spain
No monitoring	10 (71%)	Bulgaria, Croatia, France, Germany, Hungary, Iceland, Malta, Norway, Portugal, Slovenia
Total	14	

*Other: 1) Screening, early detection; 2) Screening coverage; 3) Equity perspective analysis of the cancer strategy.

Figure 39. Routine monitoring in cancer policy documents encompasses inequities related to:



EII5: HiAP approach

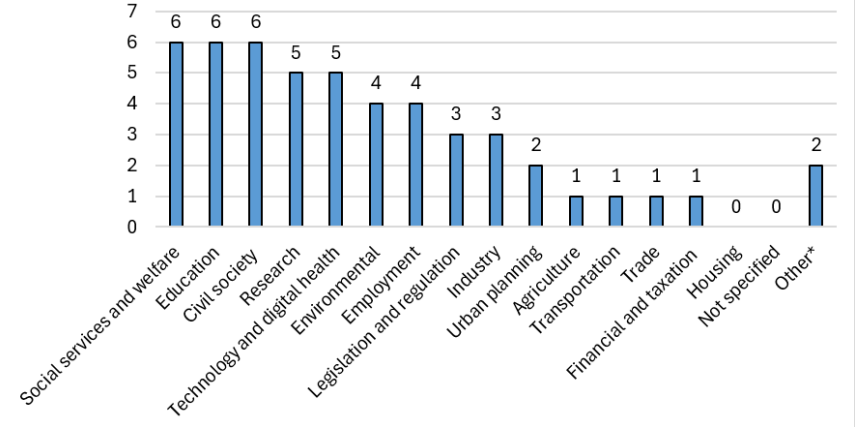
Under half of the countries (6/14) with cancer policy documents report including a HiAP approach to address inequities in cancer and/or the treatment and management of cancer, as shown in Table 59.

Table 59. Countries with a Health in All Policies approach in their cancer policy documents.

Country response	Number of countries	Countries
Yes	6 (43%)	Czech Republic, Estonia, Hungary, Italy, Norway, Spain
No	8 (57%)	Bulgaria, Croatia, France, Germany, Iceland, Malta, Portugal, Slovenia
Total	14	

All countries implementing a HiAP approach to reduce cancer-related inequities include the social services and welfare, education, and civil society sectors (n = 6 each). These are closely followed by the research and technology and digital health sectors (n = 5 each).

Figure 40. Sectors involved in countries adopting a Health in All Policies approach in their cancer policy documents.



Country scores: Level of equity integration in cancer policy documents

The number of EIIs covered varies considerably across the different national cancer policy documents, as shown in Table 60.

Table 60. Countries grouped by cancer policy document equity integration score (EIS).

Score	Number of countries	Countries
4	4	Czech Republic, Estonia, Italy, Spain
3	2	Hungary, Norway
2	4	Bulgaria, France, Iceland, Malta
1	3	Germany, Portugal, Slovenia
0	1	Croatia

Appendix B: Questionnaires on risk factor policy documents

9. Questionnaire on tobacco policy documents

HEALTH INEQUITIES IN NATIONAL NCD BEHAVIOURAL RISK FACTORS POLICIES: A CROSS-COUNTRY QUESTIONNAIRE

Questionnaire instructions

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify how equity is addressed in policies related to behavioural risk factors for non-communicable diseases (NCDs). Thank you for your time.

About the project

This questionnaire is developed as part of **Joint Action PreventNCD project** (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities".
The **Joint Action PreventNCD** aims to reduce the disease-burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The project will also support national strategies and policies of participating countries.

This questionnaire is part of Task 7.2.b+c and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region, FISABIO.

With the questionnaire we are requesting information on whether, and how, **inequities in common NCDs behavioural risk factors are addressed in national policy documents**.

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs behavioural risk factors. The work will result in both general and country-specific recommendations on how existing inequities in NCDs risk factors could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire has been designed along with other behavioural risk factors questionnaires on **tobacco.**

The questionnaire starts with an overview of terms and definitions used in the questionnaire. The questions focus on two main aspects: firstly, whether these national policy documents address inequities; and secondly, whether they describe or propose any concrete actions to reduce these inequities.

How to fill out the questionnaire

- Please provide your name, position, and contact details. This information will help us follow up if needed and ensure the accuracy of our data.
- Carefully read through the definitions of terms in the beginning of the questionnaire.
- Make sure to include the titles and links of the policy documents.
- If your country has a general policy document that addresses multiple behavioural risk factors, please be sure to include all content regarding tobacco as well.
- You will be asked to elaborate your answers in your own words. If you have doubts about what the correct answer is, please mention it in the justification box or reach out to your country coordinator of this questionnaire from JAPrevent-NCDs.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- If you have questions, kindly contact your country coordinator participating in JAPreventNCD WP7.

Definitions used in this questionnaire

Health in all Policies (HiAP) - approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity.

Health inequities (social inequalities in health) –refer to systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health promotion- process of enabling people to increase control over, and to improve their health.

Policy documents – national documents such as strategies, plans and action plans, white papers, relevant national legislation and regulations, national initiatives and the like that are currently in force or approved and will be in force.

Primary prevention - Primary prevention focuses on reducing risk factors to prevent a disease or disorder before it arises. This includes behavioral factors such as low physical activity levels and poor dietary intake; biomedical factors such as overweight and obesity and high blood pressure; and specific protective factors such as immunization.

Social determinants of health - The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Policy - A policy reflects a vision (usually contains a vision statement, explaining the way a government, institution or organization will look in the future...), with inspirational dimensions related to what is it that the government wants to achieve for its population-in this case regarding tobacco prevention and control, both in public health and healthcare system terms. Such statements are often tied, even if only indirectly, to other national goals.

Strategy - A strategy spells out the mission to be accomplished and the generic roadmap to achieve this mission. This is articulated through a mission statement (in essence, outlining the "raison d'etre*tre*" or fundamental purpose of the initiative), succinctly describing why it exists and what it does to achieve its vision. The strategy also includes the layout, design, or concept used to accomplish the vision and mission. A strategy is usually understood with underlying flexibility, being open to adaptation and change when needed in order to fulfil the mission and ultimate goals.

Plan - A plan is a precise arrangement, following a defined pattern, for a definite purpose according to a value chain coherent with the policy and the strategy. It is concrete in nature, although it does not necessarily contain all the details, which in fact are further developed and explained through more specific programmes and projects.

Programme - A programme implies the arranged selection of systematic steps, activities and tasks and deliverables coherently within the plan. The programme addresses the entire set of desired changes to achieve in the field. A programme can be monitored or evaluated in the dimension of the achievement of the goals //deliverables, or the process followed in order to achieve these operational goals, and the resources allocated to facilitate the process. As these activities are often based on arbitrary definitions, it is possible that there are also different combinations of goals and deliverables.

NATIONAL TOBACCO POLICY QUESTIONNAIRE

Main respondent

Name: ____

Position: _____

Institution, department: _____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

Question 1. Does your country currently have any national policy documents for tobacco prevention or a national policy document that includes tobacco prevention? (e.g. a strategy, plan, programme)

☐ Yes, in force

☐ No, but it is under development (please go to question 25)

☐ No (please go to question 25)

Question 2. If yes, kindly specify the title and link to the policy documents, what kind of policy documents these are, and the period the documents are operational.

Question 3. Does/do the policy document/s mention inequities in tobacco use:

☐ Yes

☐ No (please go to question 6)

Question 4. *Kindly elaborate on your answer to question 3 below (max 4000 characters)*

Question 5. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 3. Please, refer the policy document. (max 4000 characters)*

Question 6. Does/do the policy document/s include objectives aimed at tackling inequities in tobacco use?

☐ Yes, addressed to the general population (universal approach) (please go to question 8)

☐ Yes, addressed to specific social groups (targeted approach) (please go to question 7)

☐ Yes, addressed both general population and specific social groups (proportionate universalism approach) (please go to question 7)

☐ No (please go to question 10)

Question 7. Please specify which of the following social factors are addressed in the objectives (choose all that apply):

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)

☐ Age/age groups

☐ Sex/gender

☐ Socio-economic position (e.g. income, education, occupational status or profession)

☐ Ethnic/linguistic minority background (ethnicity, migrant status, national minorities)

☐ Religion

☐ Disability status

☐ Sexual orientation, sexual identity, LGTB+

☐ Other, please name: _____

Question 8. *Kindly elaborate on your answer to question 6 below (max 4000 characters)*

Question 9. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 6. Please, refer the policy document. (max 4000 characters)*

Question 10. Does/do the policy document/s set out specific actions or interventions to reduce inequities in tobacco use?

☐ Yes, for the general population (please go to question 11)

☐ Yes, for specific social groups (please go to question 14)

☐ Yes, for both the general population and specific social groups (please go to question 11)

☐ No (please go to question 18)

Question 11. Please specify which types of actions or interventions are proposed to reduce inequities in tobacco use for the general population (choose all that apply):

☐ Taxes and fiscal measures

☐ Advertising

☐ Packaging

☐ Sales restrictions (by age, type of establishment, placement in stores…)

☐ Smoke-free spaces

☐ Counseling through healthcare professionals

☐ Awareness campaigns

☐ Educational programs

☐ Free smoking cessation programs

☐ Others: ___

Question 12. *Kindly elaborate on your answer to question 11 below (max 4000 characters)*

Question 13. *Please, provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 11. Please, refer the policy document. (max 4000 characters)*

Question 14. Please specify which types of actions or interventions are proposed to reduce inequities in tobacco use for specific social groups (choose all that apply)**:**

☐ Taxes and fiscal measures

☐ Advertising

☐ Packaging

☐ Sales restrictions (by age, type of establishment, placement in stores…)

☐ Smoke-free spaces

☐ Counseling through healthcare professionals

☐ Awareness campaigns

☐ Educational programs

☐ Free smoking cessation programs

☐ Others: ___

Question 15. Please, specify which social factors are considered in actions or interventions mentioned in Question 14:

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (e.g. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant status, national minorities)
☐ Religion
☐ Disability status
☐ Sexual orientation, sexual identity, LGTB+
☐ Other, please name: _____
☐ No actions/interventions for specific social groups

Question 16. *Kindly elaborate on your answer to question 14 and question 15 below (max 4000 characters)*

Question 17. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 14 and question 15. Please, refer the policy document. (max 4000 characters)*

Question 18. Do the documents establish routine monitoring of inequities in tobacco use?

☐ Yes

☐ No (please go to question 21)

Question 19. *Kindly elaborate on your answer to question 18 below (max 4000 characters)*

Question 20. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 18. Please, refer the policy document. (max 4000 characters)*

Question 21. Does/do the policy document describe actions that involve one, or more, sectors beyond the healthcare sector (health in all policies)? (e.g education, environment or civil society)

☐ Yes

☐ No (go to question 25)

Question 22. (If Yes) Please specify which sectors are involved (choose all that apply)

☐ Health and healthcare

☐ Social services and welfare

☐ Education

☐ Culture

☐ Research

☐ Environmental

☐ Agriculture

☐ Industry

☐ Trade

☐ Legislation and regulation

☐ Employment

☐ Transportation

☐ Urban planning

☐ Housing

☐ Technology and digital health

☐ Financial and taxation

☐ Civil society

☐ NGO

☐ Other sectors: _____

☐ Not specified

Question 23. *Kindly elaborate on your answer to question 22 below (max 4000 characters)*

Question 24. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 22. Please, refer the policy document. (max 4000 characters)*

Question 25. Do you have other comments on how your country address inequities in policies to prevent tobacco use?

10. Questionnaire on national alcohol policy documents

HEALTH INEQUITIES IN NATIONAL NCD BEHAVIOURAL RISK FACTORS POLICIES: A CROSS-COUNTRY QUESTIONNAIRE

Questionnaire instructions

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify how equity is addressed in policies related to behavioural risk factors for non-communicable diseases (NCDs). Thank you for your time.

About the project

This questionnaire is developed as part of **Joint Action PreventNCD project** (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities".

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With the questionnaire we are requesting information on whether, and how, **inequities in common NCDs behavioural risk factors are addressed in national policy documents**.

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs behavioural risk factors. The work will result in both general and country-specific recommendations on how existing inequities in NCDs risk factors could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire has been designed along with other behavioural risk factors questionnaires on **alcohol.**

The questionnaire starts with an overview of terms and definitions used in the questionnaire. The questions focus on two main aspects: firstly, whether these national policy documents address inequities; and secondly, whether they describe or propose any concrete actions to reduce these inequities.

How to fill out the questionnaire

- Please provide your name, position, and contact details. This information will help us follow up if needed and ensure the accuracy of our data.
- Carefully read through the definitions of terms in the beginning of the questionnaire.
- Make sure to include the titles and links of the policy documents.
- If your country has a general policy document that addresses multiple behavioural risk factors, please be sure to include all content regarding alcohol as well.
- You will be asked to elaborate your answers in your own words. If you have doubts about what the correct answer is, please mention it in the justification box or reach out to your country coordinator of this questionnaire from JAPrevent-NCDs.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- If you have questions, kindly contact your country coordinator participating in JAPreventNCD WP7.

Definitions used in this questionnaire

Health in all Policies (HiAP) - approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity.

Health inequities (social inequalities in health) –refer to systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health promotion- process of enabling people to increase control over, and to improve their health.

Policy documents – national documents such as strategies, plans and action plans, white papers, relevant national legislation and regulations, national initiatives and the like that are currently in force or approved and will be in force.

Primary prevention - Primary prevention focuses on reducing risk factors to prevent a disease or disorder before it arises. This includes behavioral factors such as low physical activity levels and poor dietary intake; biomedical factors such as overweight and obesity and high blood pressure; and specific protective factors such as immunization.

Social determinants of health - The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Policy - A policy reflects a vision (usually contains a vision statement, explaining the way a government, institution or organization will look in the future...), with inspirational dimensions related to what is it that the government wants to achieve for its population-in this case regarding alcohol prevention and control, both in public health and healthcare system terms. Such statements are often tied, even if only indirectly, to other national goals.

Strategy - A strategy spells out the mission to be accomplished and the generic roadmap to achieve this mission. This is articulated through a mission statement (in essence, outlining the "raison d'etre*tre*" or fundamental purpose of the initiative), succinctly describing why it exists and what it does to achieve its vision. The strategy also includes the layout, design, or concept used to accomplish the vision and mission. A strategy is usually understood with underlying flexibility, being open to adaptation and change when needed in order to fulfil the mission and ultimate goals.

Plan - A plan is a precise arrangement, following a defined pattern, for a definite purpose according to a value chain coherent with the policy and the strategy. It is concrete in nature, although it does not necessarily contain all the details, which in fact are further developed and explained through more specific programmes and projects.

Programme - A programme implies the arranged selection of systematic steps, activities and tasks and deliverables coherently within the plan. The programme addresses the entire set of desired changes to achieve in the field. A programme can be monitored or evaluated in the dimension of the achievement of the goals //deliverables, or the process followed in order to achieve these operational goals, and the resources allocated to facilitate the process. As these activities are often based on arbitrary definitions, it is possible that there are also different combinations of goals and deliverables.

NATIONAL ALCOHOL POLICY QUESTIONNAIRE

Main respondent

Name: ____

Position: _____

Institution, department: _____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

Question 1. Does your country currently have any national policy documents for alcohol prevention or a national policy document that includes alcohol prevention? (e.g. a strategy, plan, programme)

☐ Yes, in force

☐ No, but it is under development (please go to question 25)

☐ No (please go to question 25)

Question 2. If yes, kindly specify the title and link to the policy documents, what kind of policy documents these are, and the period the documents are operational.

Question 3. Does/do the policy document/s mention inequities in alcohol consumption:

☐ Yes

☐ No (please go to question 6)

Question 4. *Kindly elaborate on your answer to question 3 below (max 4000 characters)*

Question 5. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 3. Please, refer the policy document. (max 4000 characters)*

Question 6. Does/do the policy document/s include objectives aimed at tackling inequities in alcohol consumption?

☐ Yes, addressed to the general population (universal approach) (please go to question 8)

☐ Yes, addressed to specific social groups (targeted approach) (please go to question 7)

☐ Yes, addressed both general population and specific social groups (proportionate universalism approach) (please go to question 7)

☐ No (please go to question 10)

Question 7. Please specify which of the following social factors are addressed in the objectives (choose all that apply):

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)

☐ Age/age groups

☐ Sex/gender

☐ Socio-economic position (e.g. income, education, occupational status or profession)

☐ Ethnic/linguistic minority background (ethnicity, migrant status, national minorities)

☐ Religion

☐ Disability status

☐ Sexual orientation, sexual identity, LGTB+

☐ Other, please name: _____

Question 8. *Kindly elaborate on your answer to question 6 below (max 4000 characters)*

Question 9. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 6. Please, refer the policy document. (max 4000 characters)*

Question 10. Does/do the policy document/s set out specific actions or interventions to reduce inequities in alcohol consumption?

☐ Yes, for the general population (please go to question 11)

☐ Yes, for specific social groups (please go to question 14)

☐ Yes, for both the general population and specific social groups (please go to question 11)

☐ No (please go to question 18)

Question 11. Please specify which types of actions or interventions are proposed to reduce inequities in alcohol consumption for the general population (choose all that apply):

☐ Taxes and fiscal measures

☐ Advertising

☐ Packaging

☐ Sales restrictions (by age, type of establishment, placement in stores…)

☐ Alcohol-free spaces

☐ Counseling through healthcare professionals

☐ Awareness campaigns

☐ Educational programs

☐ Free alcohol cessation programs

☐ Others: ___

Question 12. *Kindly elaborate on your answer to question 11 below (max 4000 characters)*

Question 13. *Please, provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 11. Please, refer the policy document. (max 4000 characters)*

Question 14. Please specify which types of actions or interventions are proposed to reduce inequities in alcohol consumption for specific social groups (choose all that apply)**:**

☐ Taxes and fiscal measures

☐ Advertising

☐ Packaging

☐ Sales restrictions (by age, type of establishment, placement in stores…)

☐ Alcohol-free spaces

☐ Counseling through healthcare professionals

☐ Awareness campaigns

☐ Educational programs

☐ Free alcohol cessation programs

☐ Others: ___

Question 15. Please specify which social factors are considered in actions or interventions mentioned in question 14:

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (e.g. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Religion
☐ Disability status
☐ Sexual orientation, sexual identity, LGTB+
☐ Other, please name: _____
☐ No actions/interventions for specific social groups

Question 16. *Kindly elaborate on your answer to question 14 and question 15 below (max 4000 characters)*

Question 17. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 14 and question 15. Please, refer the policy document. (max 4000 characters)*

Question 18. Do the documents establish routine monitoring of inequities in alcohol consumption?

☐ Yes

☐ No (please go to question 21)

Question 19. *Kindly elaborate on your answer to question 18 below (max 4000 characters)*

Question 20. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 18. Please, refer the policy document. (max 4000 characters)*

Question 21. Does/do the policy document describe actions that involve one, or more, sectors beyond the healthcare sector (health in all policies)? (e.g education, environment or civil society)

☐ Yes

☐ No (go to question 25)

Question 22. (If Yes) Please specify which sectors are involved (choose all that apply)

☐ Health and healthcare
☐ Social services and welfare
☐ Education
☐ Culture
☐ Research
☐ Environmental
☐ Agriculture
☐ Industry
☐ Trade
☐ Legislation and regulation
☐ Employment
☐ Transportation
☐ Urban planning
☐ Housing
☐ Technology and digital health
☐ Financial and taxation
☐ Civil society
☐ NGO
☐ Other sectors: _____
☐ Not specified

Question 23. *Kindly elaborate on your answer to question 22 below (max 4000 characters)*

Question 24. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 22. Please, refer the policy document. (max 4000 characters)*

Question 25. Do you have other comments on how your country address inequities in policies to prevent alcohol consumption?

11. Questionnaire on national diet and nutrition policy documents

HEALTH INEQUITIES IN NATIONAL NCD BEHAVIOURAL RISK FACTORS POLICIES: A CROSS-COUNTRY QUESTIONNAIRE

Questionnaire instructions

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify how equity is addressed in policies related to behavioural risk factors for non-communicable diseases (NCDs). Thank you for your time.

About the project

This questionnaire is developed as part of **Joint Action PreventNCD project** (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities".
The **Joint Action PreventNCD** aims to reduce the disease-burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The project will also support national strategies and policies of participating countries.

This questionnaire is part of Task 7.2.b+c and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region, FISABIO.

With the questionnaire we are requesting information on whether, and how, **inequities in common NCDs behavioural risk factors are addressed in national policy documents**.

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs behavioural risk factors. The work will result in both general and country-specific recommendations on how existing inequities in NCDs risk factors could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire has been designed along with other behavioural risk factors questionnaires on **diet and nutrition.**

The questionnaire starts with an overview of terms and definitions used in the questionnaire. The questions focus on two main aspects: firstly, whether these national policy documents address inequities; and secondly, whether they describe or propose any concrete actions to reduce these inequities.

How to fill out the questionnaire

- Please provide your name, position, and contact details. This information will help us follow up if needed and ensure the accuracy of our data.
- Carefully read through the definitions of terms in the beginning of the questionnaire.

- Make sure to include the titles and links of the policy documents.
- If your country has a general policy document that addresses multiple behavioural risk factors, please be sure to include all content regarding diet and nutrition as well.
- You will be asked to elaborate your answers in your own words. If you have doubts about what the correct answer is, please mention it in the justification box or reach out to your country coordinator of this questionnaire from JAPrevent-NCDs.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- If you have questions, kindly contact your country coordinator participating in JAPreventNCD WP7.

Definitions used in this questionnaire

Health in all Policies (HiAP) - approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity.

Health inequities (social inequalities in health) –refer to systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health promotion- process of enabling people to increase control over, and to improve their health.

Policy documents – national documents such as strategies, plans and action plans, white papers, relevant national legislation and regulations, national initiatives and the like that are currently in force or approved and will be in force.

Primary prevention - Primary prevention focuses on reducing risk factors to prevent a disease or disorder before it arises. This includes behavioral factors such as low physical activity levels and poor dietary intake; biomedical factors such as overweight and obesity and high blood pressure; and specific protective factors such as immunization.

Social determinants of health - The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live,

work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Policy - A policy reflects a vision (usually contains a vision statement, explaining the way a government, institution or organization will look in the future...), with inspirational dimensions related to what is it that the government wants to achieve for its population-in this case regarding diet and nutrition, both in public health and healthcare system terms. Such statements are often tied, even if only indirectly, to other national goals.

Strategy - A strategy spells out the mission to be accomplished and the generic roadmap to achieve this mission. This is articulated through a mission statement (in essence, outlining the "raison d'etre" or fundamental purpose of the initiative), succinctly describing why it exists and what it does to achieve its vision. The strategy also includes the layout, design, or concept used to accomplish the vision and mission. A strategy is usually understood with underlying flexibility, being open to adaptation and change when needed in order to fulfil the mission and ultimate goals.

Plan - A plan is a precise arrangement, following a defined pattern, for a definite purpose according to a value chain coherent with the policy and the strategy. It is concrete in nature, although it does not necessarily contain all the details, which in fact are further developed and explained through more specific programmes and projects.

Programme - A programme implies the arranged selection of systematic steps, activities and tasks and deliverables coherently within the plan. The programme addresses the entire set of desired changes to achieve in the field. A programme can be monitored or evaluated in the dimension of the achievement of the goals //deliverables, or the process followed in order to achieve these operational goals, and the resources allocated to facilitate the process. As these activities are often based on arbitrary definitions, it is possible that there are also different combinations of goals and deliverables.

NATIONAL DIET AND NUTRITION POLICY QUESTIONNAIRE

Main respondent

Name: ____

Position: _____

Institution, department: _____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

Question 1. Does your country currently have any national policy documents for promoting healthy diet or a national policy document that includes promotion of a healthy diet? (e.g. a strategy, plan, programme)

☐ Yes, in force
☐ No, but it is under development (please go to question 25)
☐ No (please go to question 25)

Question 2. If yes, kindly specify the title and link to the policy documents, what kind of policy documents these are, and the period the documents are operational.

Question 3. Does/do the policy document/s mention inequities in diet and nutrition:

☐ Yes
☐ No (please go to question 6)

Question 4. *Kindly elaborate on your answer to question 3 below (max 4000 characters)*

Question 5. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 3. Please, refer the policy document. (max 4000 characters)*

Question 6. *Does/do the policy document include objectives aimed at tackling inequities in diet and nutrition?*

☐ Yes, addressed to the general population (universal approach) (please go to question 8)

☐ Yes, addressed to specific social groups (targeted approach) (please go to question 7)

☐ Yes, addressed both general population and specific social groups (proportionate universalism approach) (please go to question 7)

☐ No (please go to question 10)

Question 7. Please specify which of the following social factors are addressed in the objectives (choose all that apply):

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (e.g. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant status, national minorities)
☐ Religion
☐ Disability status
☐ Sexual orientation, sexual identity, LGTB+
☐ Other, please name: _____

Question 8. *Kindly elaborate on your answer to question 6 below (max 4000 characters)*

Question 9. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 6. Please, refer the policy document. (max 4000 characters)*

Question 10. Does/do the policy document/s set out specific actions or interventions to reduce inequities in diet and nutrition?

☐ Yes, for the general population (please go to question 11)

☐ Yes, for specific social groups (please go to question 14)

☐ Yes, for both the general population and specific social groups (please go to question 11)

☐ No (please go to question 18)

Question 11. Please specify which types of actions or interventions are proposed to reduce inequities in diet and nutrition for the general population (choose all that apply):

☐ Taxes and fiscal measures

☐ Advertising

☐ Packaging

☐ Sales restrictions (by age, type of establishment, placement in stores...)

☐ Reducing salt and/or sugar content in food products

☐ Counseling through healthcare professionals

☐ Awareness campaigns

☐ Educational programs

☐ Others: ___

Question 12. *Kindly elaborate on your answer to question 11 below (max 4000 characters)*

Question 13. *Please, provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 11. Please, refer the policy document. (max 4000 characters)*

Question 14. Please specify which types of actions or interventions are proposed to reduce inequities in diet and nutrition for specific social groups (choose all that apply)**:**

☐ Taxes and fiscal measures

☐ Advertising

☐ Packaging

☐ Sales restrictions (by age, type of establishment, placement in stores…)

☐ Reducing salt and/or sugar content in food products

☐ Counseling through healthcare professionals

☐ Awareness campaigns

☐ Educational programs

☐ Others: ___

Question 15. Please, specify which social factors are considered in actions or interventions mentioned in question 14:

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (e.g. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Religion

☐ Disability status
☐ Sexual orientation, sexual identity, LGTB+
☐ Other, please name: _____
☐ No actions/interventions for specific social groups

Question 16. *Kindly elaborate on your answer to question 14 and question 15 below (max 4000 characters)*

Question 17. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 14 and question 15. Please, refer the policy document. (max 4000 characters)*

Question 18. Do the documents establish routine monitoring of inequities in diet and nutrition?

☐ Yes
☐ No (please go to question 21)

Question 19. *Kindly elaborate on your answer to question 18 below (max 4000 characters)*

Question 20. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 18. Please, refer the policy document. (max 4000 characters)*

Question 21. Does/do the policy document describe actions that involve one, or more, sectors beyond the healthcare sector (health in all policies)? (e.g education, environment or civil society)

☐ Yes

☐ No (go to question 25)

Question 22. (If Yes) Please specify which sectors are involved (choose all that apply)

☐ Health and healthcare

☐ Social services and welfare

☐ Education

☐ Culture

☐ Research

☐ Environmental

☐ Agriculture

☐ Industry

☐ Trade

☐ Legislation and regulation

☐ Employment

☐ Transportation

☐ Urban planning

☐ Housing

☐ Technology and digital health

☐ Financial and taxation

☐ Civil society

☐ NGO

☐ Other sectors: _____

☐ Not specified

Question 23. *Kindly elaborate on your answer to question 22 below (max 4000 characters)*

Question 24. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 22. Please, refer the policy document. (max 4000 characters)*

Question 25. Do you have other comments on how your country address inequities in policies to promoting healthy diet?

12. Questionnaire on national physical activity policy documents

HEALTH INEQUITIES IN NATIONAL NCD BEHAVIOURAL RISK FACTORS POLICIES: A CROSS-COUNTRY QUESTIONNAIRE

Questionnaire instructions

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify how equity is addressed in policies related to behavioural risk factors for non-communicable diseases (NCDs). Thank you for your time.

About the project

This questionnaire is developed as part of **Joint Action PreventNCD project** (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities".
The **Joint Action PreventNCD** aims to reduce the disease-burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The project will also support national strategies and policies of participating countries.

This questionnaire is part of Task 7.2.b+c and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region, FISABIO.

With the questionnaire we are requesting information on whether, and how, **inequities in common NCDs behavioural risk factors are addressed in national policy documents**.

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs behavioural risk factors. The work will result in both general and country-specific recommendations on how existing inequities in NCDs risk factors could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire has been designed along with other behavioural risk factors questionnaires on **physical activity.**

The questionnaire starts with an overview of terms and definitions used in the questionnaire. The questions focus on two main aspects: firstly, whether these national policy documents address inequities; and secondly, whether they describe or propose any concrete actions to reduce these inequities.

How to fill out the questionnaire

- Please provide your name, position, and contact details. This information will help us follow up if needed and ensure the accuracy of our data.

- Carefully read through the definitions of terms in the beginning of the questionnaire.
- Make sure to include the titles and links of the policy documents.
- If your country has a general policy document that addresses multiple behavioural risk factors, please be sure to include all content regarding physical activity as well.
- You will be asked to elaborate your answers in your own words. If you have doubts about what the correct answer is, please mention it in the justification box or reach out to your country coordinator of this questionnaire from JAPrevent-NCDs.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- If you have questions, kindly contact your country coordinator participating in JAPreventNCD WP7.

Definitions used in this questionnaire

Health in all Policies (HiAP) - approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity.

Health inequities (social inequalities in health) –refer to systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health promotion- process of enabling people to increase control over, and to improve their health.

Policy documents – national documents such as strategies, plans and action plans, white papers, relevant national legislation and regulations, national initiatives and the like that are currently in force or approved and will be in force.

Primary prevention - Primary prevention focuses on reducing risk factors to prevent a disease or disorder before it arises. This includes behavioral factors such as low physical activity levels and poor dietary intake; biomedical factors such as overweight and obesity and high blood pressure; and specific protective factors such as immunization.

Social determinants of health - The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live,

work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Policy - A policy reflects a vision (usually contains a vision statement, explaining the way a government, institution or organization will look in the future...), with inspirational dimensions related to what is it that the government wants to achieve for its population-in this case regarding physical activity, both in public health and healthcare system terms. Such statements are often tied, even if only indirectly, to other national goals.

Strategy - A strategy spells out the mission to be accomplished and the generic roadmap to achieve this mission. This is articulated through a mission statement (in essence, outlining the "raison d'etre" or fundamental purpose of the initiative), succinctly describing why it exists and what it does to achieve its vision. The strategy also includes the layout, design, or concept used to accomplish the vision and mission. A strategy is usually understood with underlying flexibility, being open to adaptation and change when needed in order to fulfil the mission and ultimate goals.

Plan - A plan is a precise arrangement, following a defined pattern, for a definite purpose according to a value chain coherent with the policy and the strategy. It is concrete in nature, although it does not necessarily contain all the details, which in fact are further developed and explained through more specific programmes and projects.

Programme - A programme implies the arranged selection of systematic steps, activities and tasks and deliverables coherently within the plan. The programme addresses the entire set of desired changes to achieve in the field. A programme can be monitored or evaluated in the dimension of the achievement of the goals //deliverables, or the process followed in order to achieve these operational goals, and the resources allocated to facilitate the process. As these activities are often based on arbitrary definitions, it is possible that there are also different combinations of goals and deliverables.

NATIONAL PHYSICAL ACTIVITY POLICY QUESTIONNAIRE

Main respondent

Name: ____

Position: _____

Institution, department: _____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

Question 1. Does your country currently have any national policy documents for promotion physical activity or a national policy document that includes physical activity promotion? (e.g. a strategy, plan, programme)

☐ Yes, in force

☐ Yes, in force

☐ No, but it is under development (please go to question 25)

☐ No (please go to question 25)

Question 2. If yes, kindly specify the title and link to the policy documents, what kind of policy documents these are, and the period the documents are operational.

Question 3. Does/do the policy document/s mention inequities in physical activity:

☐ Yes

☐ No (please go to question 6)

Question 4. *Kindly elaborate on your answer to question 3 below (max 4000 characters)*

Question 5. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 3. Please, refer the policy document. (max 4000 characters)*

Question 6. Does/do the policy document/s include objectives aimed at tackling inequities in physical activity?

☐ Yes, addressed to the general population (universal approach) (please go to question 8)

☐ Yes, addressed to specific social groups (targeted approach) (please go to question 7)

☐ Yes, addressed both general population and specific social groups (proportionate universalism approach) (please go to question 7)

☐ No (please go to question 10)

Question 7. Please specify which of the following social factors are addressed in the objectives (choose all that apply):

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)

☐ Age/age groups

☒ Sex/gender

☐ Socio-economic position (e.g. income, education, occupational status or profession)

☐ Ethnic/linguistic minority background (ethnicity, migrant status, national minorities)

☐ Religion

☐ Disability status

☐ Sexual orientation, sexual identity, LGTB+

☐ Other, please name: _____

Question 8. *Kindly elaborate on your answer to question 6 below (max 4000 characters)*

Question 9. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 6. Please, refer the policy document. (max 4000 characters)*

Question 10. Does/do the policy document/s set out specific actions or interventions to reduce inequities in physical activity?

☐ Yes, for the general population (please go to question 11)

☐ Yes, for specific social groups (please go to question 14)

☐ Yes, for both the general population and specific social groups (please go to question 11)

☐ No (please go to question 18)

Question 11. Please specify which types of actions or interventions are proposed to reduce inequities in physical activity for the general population (choose all that apply)

☐ Taxes and fiscal measures

☐ Advertising

☐ Financial support for the use of sports facilities (e.g., free services for certain groups, tax deductions…)

☐ Counseling through healthcare professionals

☐ Infrastructure improvement (e.g., sports areas and green spaces)

☐ Promotion of active transportation (e.g., bike lanes, safe routes, healthy routes, school routes…)

☐ Awareness campaigns

☐ Educational programs

☐ Others: ___

Question 12. *Kindly elaborate on your answer to question 11 below (max 4000 characters)*

Question 13. *Please, provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 11. Please, refer the policy document. (max 4000 characters)*

Question 14. Please specify which types of actions or interventions are proposed to reduce inequities in physical activity for specific social groups (choose all that apply)**:**

☐ Taxes and fiscal measures

☐ Advertising

☐ Financial support for the use of sports facilities (e.g., free services for certain groups, tax deductions…)

☐ Counseling through healthcare professionals

☐ Infrastructure improvement (e.g., sports areas and green spaces)

☐ Promotion of active transportation (e.g., bike lanes, safe routes, healthy routes, school routes…)

☐ Awareness campaigns

☐ Educational programs

☐ Others: ___

Question 15. Please specify which social factors are considered in actions or interventions mentioned in question 14:

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (e.g. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Religion
☐ Disability status
☐ Sexual orientation, sexual identity, LGTB+
☐ Other, please name: _____
☐ No actions/interventions for specific social groups

Question 16. *Kindly elaborate on your answer to question 14 and question 15 below (max 4000 characters)*

Question 17. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 14 and question 15. Please, refer the policy document. (max 4000 characters)*

Question 18. Do the documents establish routine monitoring of inequities in physical activity?

☐ Yes

☐ No (please go to question 21)

Question 19. *Kindly elaborate on your answer to question 18 below (max 4000 characters)*

Question 20. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 18. Please, refer the policy document. (max 4000 characters)*

Question 21. Does/do the policy document describe actions that involve one, or more, sectors beyond the healthcare sector (health in all policies)? (e.g education, environment or civil society)

☐ Yes

☐ No (go to question 25)

Question 22. (If Yes) Please specify which sectors are involved (choose all that apply)

☐ Social services and welfare

☐ Education

☐ Culture

☐ Research

☐ Environmental

☐ Agriculture

☐ Industry

☐ Trade

☐ Legislation and regulation

☐ Employment

☐ Transportation

☐ Urban planning

☐ Housing

☐ Technology and digital health

☐ Financial and taxation

☐ Civil society

☐ NGO

☐ Other sectors: _____

☐ Not specified

Question 23. *Kindly elaborate on your answer to question 22 below (max 4000 characters)*

Question 24. *Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to question 22. Please, refer the policy document. (max 4000 characters)*

Question 25. Do you have other comments on how your country address inequities in policies to promote physical activity?

Appendix C: Questionnaires on NCD policy documents

13. Questionnaire on policy documents on several NCDs

HEALTH INEQUITIES IN NATIONAL NCD POLICIES: A CROSS-COUNTRY QUESTIONNAIRE ON INTEGRATED NCD-POLICIES

About the project

This questionnaire has been developed as part of the Joint Action PreventNCD project (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities". The Joint Action aims to reduce the disease burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The Joint Action will also support participating countries' national strategies and policies that aim to reduce the burden of cancer and NCDs.

This questionnaire is part of sub-task 7.2.bc of the Joint Action PreventNCD and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region in Spain, FISABIO.
With the questionnaire we are gathering information on whether, and how, **inequities in NCDs and in treatment and management are addressed in national policy documents.**
The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs, in the treatment and management of NCDs, and in behavioural risk factors for these diseases. The work will result in both general and country-specific recommendations on how existing inequities could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire concerns **national policy documents on** and is part of several questionnaires in sub-task 7.2bc that cover national policies on: a) integrated NCDs, b) cancer, c) diabetes, d) cardiovascular diseases, d) chronic obstructive pulmonary disease (COPD).

The questionnaire starts with an overview of terms and definitions used in the questionnaire and questions on who has filled out the questionnaire. The questions concern first whether these national policy documents address inequities; and secondly, if the documents describe or propose any concrete actions to reduce these inequities

Who should fill out the questionnaire:

The questionnaire should be filled out by national-level country experts who are involved in national policy development and/or implementation in the domain of the questionnaire.

How to fill out the questionnaire:

- Please provide your name, position, and contact details
- Carefully read through the list of definitions in the beginning of the questionnaire.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.

- You will be asked to elaborate on your answers in your own words. If you have doubts about what the correct answer is, please explain it in the justification box.
- If you have questions, kindly contact your country coordinator participating in Work Package 7.

Definitions used in this questionnaire

Adherence – also called compliance. It describes the degree to which a patient correctly follows medical advice, for example, following a treatment or care plan, or taking prescribed medicines correctly.

Health inequities (social inequalities in health) – Health inequities are systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health in all Policies (HiAP) – approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity

Morbidity – occurrence of disease within a population. Typical indicators are incidence or prevalence per 1000 individuals, notification rate, hospitalization rates for the disease, and other measures that demonstrate the extent of amount of disease or condition.

Mortality – a term used to describe the occurrence of death in a population due to a disease or condition within a population. Typical indicators for cause-specific mortality are cause-specific deaths per 1000 individuals, death-to-case ratio, and other measures that show number of deaths due to a specific disease or condition.

Palliative care – specialized care for seriously ill (often in the context of terminal illness) patients and their families; the care focuses on providing relief from pain and other symptoms of the illness and/or side effects of medication. The goal is to improve the quality of life for the patient and family, not curing the disease or condition.

Physical accessibility to health care- the availability of good health services within reasonable reach of those who need them and of the opening hours, appointment systems and other aspects of service delivery that allow people to obtain the services when they need them.

Policy documents – national documents such as strategies, plans and action plans, programmes, white papers (if they constitute adopted policy or policy aims), national initiatives and the like that are currently in force or approved and will be in force.

White papers **–** Used in some countries, typically documents from the government that outline content and/or aims of policy and/or existing or proposed legislation. White papers are often in a form of a report to the Parliament

Risk factors – Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (In this questionnaire we are specifically interested in smoking, alcohol consumption, physical activity and diet).

Social determinants of health – The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Survivorship – proportion of individuals who survive a specific disease over a defined time period. Often measured as a survival rate, typically the percentage of people who are alive after a certain time.

Respondents

Main respondent

Name: ____

Position: ____

Institution, departement: ____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

_____

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify if and how equity is addressed in policy documents on non-communicable diseases (NCDs) across European countries.

Thank you for your time.

QUESTIONNAIRE ON NATIONAL POLICY DOCUMENTS ON INTEGRATED NCDs

This questionnaire regards policy documents that integrate several NCDs. These may be a stand-alone NCD policy, strategy, action plan, white paper or other type of national health policy document, where NCDs comprise a significant proportion of the document. The questions address if and how inequities in NCDs, in health and care services for NCDs and in risk factors are addressed in the policy documents.
* *Please note that other questionnaires will regard disease-specific policy documents, such as policy documents specifically on cancer or diabetes.*

Question 1. Does your country currently have any national policy documents (strategy, action plan, programme, white paper, other national initiatives) that cover several NCDs (e.g., an NCD-strategy)?

☐ Yes, in force
☐ No, but it is under development (*go to Question 24*)
☐ No (*go to Question 24)*

Question 2. Kindly provide the titleitle and link to the policy documents, specify what kind of policy documents these are and the period the documents are operational:
(e.g., "NCD-strategy of Norway, www.ncdstrategy.no, National NCD strategy, 2025-2028")

1.
2.
3.

Question 3. Do the documents mention inequities in NCDs in the population?

☐ Yes
☐ No (*go to Question 8*)

Question 4. The documents mention inequities between different population groups in NCDs related to (choose all that apply):

☐ Morbidity (for example incidence or prevalence) of NCDs
☐ Mortality of NCDs
☐ Behavioral risk factors (alcohol, tobacco use, diet/nutrition, physical activity)
☐ Affordability of treatment and care
☐ Physical accessibility of treatment and care
☐ Screening
☐ Timely diagnosis and/or early detection
☐ Survivorship (for example 5 or 10 year survival rate after diagnosis)

☐ Ongoing management and monitoring, incl. complication prevention and management
☐ Support services for patients and their families
☐ Adherence to treatment
☐ Palliative care
☐ Other (please specify): _____

Question 5. The inequities in NCDs referred to in the documents concern differences between population groups defined by (choose all that apply):

☐ Geography (e.g. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (e.g. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Disability status
☐ Sexual orientation, sexual identity, LGBTQ+
☐ Religion
☐ Other (please specify): _____

Question 6. Kindly elaborate on your answers to Question 4 and 5 below:

Question 7. Please provide text excerpts in English (Google or AI-translated is fine) that regard inequities in NCDs in the documents (covering all the inequities you have chosen in Questions 4 and 5).
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 8. Do the documents identify or emphasize specific groups as vulnerable (e.g., (national minorities, LGBTQ+, migrants, etc.) to or at particular risk regarding NCDs, management and treatment of NCDs, or regarding risk factors to NCDs?

☐ Yes
☐ No *(go to Question 11)*

Question 9. Kindly elaborate on your answer to Question 8 below:

Question 10. Please provide text excerpts in English (Google or AI-translated is fine) that include information on your answer to Question 8 and 9.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 11. Do the documents describe and/or establish routine monitoring of inequities in NCDs, in treatment and management of NCDs, or in risk factors of NCDs?

☐ Yes
☐ No (*go to Question 13*)

Question 12. The documents describe routine monitoring of inequities in:

☐ Incidence and/or prevalence of NCDs
☐ Management and treatment of NCDs
☐ Behavioural risk factors of NCDs
☐ Other (please specify):_____

Question 13. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in treatment and management of NCDs?

☐ Yes
☐ No (*go to Question 16*)

Question 14. Kindly elaborate on your answer to Question 13 below:

Question 15. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 13 and 14.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 16. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in risk factors of NCDs inequities in risk factors of NCDs?

☐ Yes
☐ No (*go to Question 20*)

Question 17. The specific actions, interventions or other approaches to reduce inequities in risk factors of NCDs regard inequities in (choose all that apply):

☐ Tobacco consumption
☐ Alcohol consumption
☐ Diet
☐ Physical activity
☐ Other (please specify):_____

Question 18. Kindly elaborate on your answer to Question 17 below:

Question 19. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 17 and 18.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 20. Does/do the policy document describe actions that involve one, or more, sectors beyond the health and healthcare sector (health in all policies) to address inequities in NCDs and/or in treatment and management of NCDs? (e.g education, environment or civil society)

☐ Yes
☐ No (*go to Question 24*)

Question 21. Please specify which sectors are involved (choose all that apply):

☐ Social services and welfare
☐ Education
☐ Research
☐ Environmental
☐ Agriculture
☐ Industry
☐ Trade
☐ Legislation and regulation
☐ Employment
☐ Transportation
☐ Urban planning
☐ Housing
☐ Technology and digital health
☐ Financial and taxation
☐ Civil society
☐ Other sectors: _____
☐ Not specified

Question 22. Kindly elaborate on your answer to Question 21 below:

Question 23. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Questions 21 and 22.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 24. Do you have other comments on integrated NCD policies and how your country addresses inequities in NCDs, in treatment and management of NCDs, and in risk factors?

14. Questionnaire on (CVD) policy documents on cardiovascular diseases

HEALTH INEQUITIES IN NATIONAL NCD POLICIES: A CROSS-COUNTRY QUESTIONNAIRE ON CVD POLICIES

About the project

This questionnaire has been developed as part of the Joint Action PreventNCD project (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities". The Joint Action aims to reduce the disease burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The Joint Action will also support participating countries' national strategies and policies that aim to reduce the burden of cancer and NCDs.

This questionnaire is part of sub-task 7.2.bc of the Joint Action PreventNCD and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region in Spain, FISABIO.

With the questionnaire we are gathering information on whether, and how, **inequities in NCDs and in treatment and management are addressed in national policy documents.**

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs, in the treatment and management of NCDs, and in behavioural risk factors for these diseases. The work will result in both general and country-specific recommendations on how existing inequities could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire concerns **national policy documents on cardiovascular diseases** and is part of several questionnaires in sub-task 7.2bc that cover national policies on: a) integrated NCDs, b) cancer, c) diabetes, d) cardiovascular diseases, d) chronic obstructive pulmonary disease (COPD).

The questionnaire starts with an overview of terms and definitions used in the questionnaire and questions on who has filled out the questionnaire. The questions concern first whether these national policy documents address inequities; and secondly, if the documents describe or propose any concrete actions to reduce these inequities

Who should fill out the questionnaire:

The questionnaire should be filled out by national-level country experts who are involved in national policy development and/or implementation in the domain of the questionnaire.

How to fill out the questionnaire:

- Please provide your name, position, and contact details
- Carefully read through the list of definitions in the beginning of the questionnaire.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- You will be asked to elaborate on your answers in your own words. If you have doubts about what the correct answer is, please explain it in the justification box.

- If you have questions, kindly contact your country coordinator participating in Work Package 7.

Definitions used in this questionnaire

Adherence – also called compliance. It describes the degree to which a patient correctly follows medical advice, for example, following a treatment or care plan, or taking prescribed medicines correctly.

Health inequities (social inequalities in health) – Health inequities are systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health in all Policies (HiAP) – approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity

Morbidity – occurrence of disease within a population. Typical indicators are incidence or prevalence per 1000 individuals, notification rate, hospitalization rates for the disease, and other measures that demonstrate the extent of amount of disease or condition.

Mortality – a term used to describe the occurrence of death in a population due to a disease or condition within a population. Typical indicators for cause-specific mortality are cause-specific deaths per 1000 individuals, death-to-case ratio, and other measures that show number of deaths due to a specific disease or condition.

Palliative care – specialized care for seriously ill (often in the context of terminal illness) patients and their families; the care focuses on providing relief from pain and other symptoms of the illness and/or side effects of medication. The goal is to improve the quality of life for the patient and family, not curing the disease or condition.

Physical accessibility to health care- the availability of good health services within reasonable reach of those who need them and of the opening hours, appointment systems and other aspects of service delivery that allow people to obtain the services when they need them.

Policy documents – national documents such as strategies, plans and action plans, programmes, white papers (if they constitute adopted policy or policy aims), national initiatives and the like that are currently in force or approved and will be in force.

White papers **–** Used in some countries, typically documents from the government that outline content and/or aims of policy and/or existing or proposed legislation. White papers are often in a form of a report to the Parliament

Risk factors – Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (In this questionnaire we are specifically interested in smoking, alcohol consumption, physical activity and diet).

Social determinants of health – The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Survivorship – proportion of individuals who survive a specific disease over a defined time period. Often measured as a survival rate, typically the percentage of people who are alive after a certain time.

Respondents

Main respondent

Name: ____

Position: ____

Institution, departement: ____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

_____

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify if and how equity is addressed in policy documents on non-communicable diseases (NCDs) across European countries.

Thank you for your time.

QUESTIONNAIRE ON CVD POLICY DOCUMENTS

This questionnaire regards policy documents specifically related to CVDs. These may be a stand-alone CVD policy, strategy, action plan, white paper, or other type of national health policy document, where CVDs comprise a significant proportion of the document. The questions address if and how inequities in CVDs, in CVD health and care services, and risk factors are addressed in the policy documents.

Question 1. Does your country currently have any national policy documents (strategy, action plan, programme, white paper, or other national initiatives) for CVDs or specific cardiovascular conditions?

☐ Yes, in force
☐ No, but it is under development (*go to Question 24*)
☐ No (*go to Question 24)*

Question 2. Kindly provide the titleitle and link to the policy documents, specify what kind of policy documents these are and the period the documents are operational:
(For example - ""Heart health strategy of Norway, www.hearthealthstrategy.no, National cardiovascular diseases strategy, 2025-2028")

1.
2.
3.

Question 3. Do the documents mention inequities in cardiovascular diseases within the population?

☐ Yes
☐ No (*go Question 8*)

Question 4. The documents mention inequities between different population groups in cardiovascular diseases related to (choose all that apply):

☐ Morbidity (e.g., incidence or prevalence) of cardiovascular diseases
☐ Mortality of cardiovascular diseases
☐ Behavioral risk factors (alcohol, tobacco use, diet/nutrition, physical activity)
☐ Affordability of treatment and care
☐ Physical accessibility of treatment and care
☐ Screening
☐ Timely diagnosis and/or early detection
☐ Survivorship (for example 5 or 10 year survival rate after diagnosis)

☐ Ongoing management and monitoring, incl. complication prevention and management
☐ Support services for cardiovascular disease patients and their families
☐ Adherence to Treatment
☐ Palliative care
☐ Other (please specify): _____

Question 5. The inequities in cardiovascular diseases referred to in the documents concern differences between population groups defined by (choose all that apply):

☐ Geography (f. ex. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (f. ex. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Disability status
☐ Sexual orientation, sexual identity, LGBTQ+
☐ Religion
☐ Other (please specify): _____

Question 6. Kindly elaborate on your answers to Question 4 and 5 below:

Question 7. Please provide text excerpts in English (Google or AI-translated) that regard inequities in cardiovascular diseases in the documents (covering all the inequities you have chosen in Questions 4 and 5).
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 8. Do the documents identify or emphasize specific groups as vulnerable (e.g., (national minorities, LGBTQ+, migrants, etc.) to or at particular risk regarding cardiovascular diseases, management and treatment of cardiovascular diseases, or regarding risk factors to cardiovascular diseases?

☐ Yes
☐ No (*go to Question 11)*

Question 9. Kindly elaborate on your answer to Question 8 below:

Question 10. Please provide text excerpts in English (Google or AI-translated is fine) that include information on your answer to Question 8 and 9.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 11. Do the documents describe and/or establish routine monitoring of inequities in cardiovascular diseases, in treatment and management of cardiovascular diseases, or in risk factors of cardiovascular diseases?

☐ Yes
☐ No (*go to Question 13*)

Question 12. The documents describe routine monitoring of inequities in:

☐ Incidence and/or prevalence of cardiovascular diseases
☐ Management and treatment of cardiovascular diseases
☐ Behavioural risk factors of cardiovascular diseases
☐ Other (please specify):_____

Question 13. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in treatment and management of cardiovascular diseasesn aim to reduce inequities in treatment and management of cardiovascular diseasesinequities in treatment and management of cardiovascular diseases?

☐ Yes
☐ No (*go to Question 16*)

Question 14. Kindly elaborate on your answer to Question 13 below:

Question 15. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 13 and 14.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 16. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in risk factors of cardiovascular diseases inequities in risk factors of cardiovascular diseases?

☐ Yes
☐ No (*go to Question 20*)

Question 17. The specific actions, interventions or other approaches to reduce inequities in risk factors of cardiovascular diseases regard inequities in (choose all that apply):

☐ Tobacco consumption
☐ Alcohol consumption
☐ Diet
☐ Physical activity
☐ Other (please specify):_____

Question 18. Kindly elaborate on your answer to Question 17 below:

Question 19. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 22 and 23.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 20. Does/do the policy document describe actions that involve one, or more, sectors beyond the health and healthcare sector (health in all policies) to address inequities in cardiovascular diseases and/or in treatment and management of cardiovascular diseases? (e.g education, environment or civil society)

☐ Yes
☐ No (*go to Question 24*)

Question 21. Please specify which sectors are involved (choose all that apply):
☐ Social services and welfare
☐ Education
☐ Research
☐ Environmental
☐ Agriculture
☐ Industry
☐ Trade
☐ Legislation and regulation
☐ Employment
☐ Transportation
☐ Urban planning
☐ Housing
☐ Technology and digital health
☐ Financial and taxation
☐ Civil society
☐ Other sectors: _____
☐ Not specified

Question 22. Kindly elaborate on your answer to Question 21 below:

Question 23. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Questions 21 and 22.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 24. Do you have other comments on cardiovascular disease policies and how your country addresses inequities in cardiovascular diseases, in treatment and management of cardiovascular diseases and in risk factors?

15. Questionnaire on diabetes policy documents

HEALTH INEQUITIES IN NATIONAL NCD POLICIES: A CROSS-COUNTRY QUESTIONNAIRE ON DIABETES POLICIES

About the project

This questionnaire has been developed as part of the Joint Action PreventNCD project (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities". The Joint Action aims to reduce the disease burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs.The Joint Action will also support participating countries' national strategies and policies that aim to reduce the burden of cancer and NCDs.

This questionnaire is part of sub-task 7.2.bc of the Joint Action PreventNCD and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region in Spain, FISABIO.

With the questionnaire we are gathering information on whether, and how, **inequities in NCDs and in treatment and management are addressed in national policy documents.**

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs, in the treatment and management of NCDs, and in behavioural risk factors for these diseases. The work will result in both general and country-specific recommendations on how existing inequities could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire concerns **national policy documents on diabetes** and is part of several questionnaires in sub-task 7.2bc that cover national policies on: a) integrated NCDs, b) cancer, c) diabetes, d) cardiovascular diseases, d) chronic obstructive pulmonary disease (COPD).

The questionnaire starts with an overview of terms and definitions used in the questionnaire and questions on who has filled out the questionnaire. The questions concern first whether these national policy documents address inequities; and secondly, if the documents describe or propose any concrete actions to reduce these inequities

Who should fill out the questionnaire:

The questionnaire should be filled out by national-level country experts who are involved in national policy development and/or implementation in the domain of the questionnaire.

How to fill out the questionnaire:

- Please provide your name, position, and contact details
- Carefully read through the list of definitions in the beginning of the questionnaire.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- You will be asked to elaborate on your answers in your own words. If you have doubts about what the correct answer is, please explain it in the justification box.

- If you have questions, kindly contact your country coordinator participating in Work Package 7.

Definitions used in this questionnaire

Adherence – also called compliance. It describes the degree to which a patient correctly follows medical advice, for example, following a treatment or care plan, or taking prescribed medicines correctly.

Health inequities (social inequalities in health) – Health inequities are systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health in all Policies (HiAP) – approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity

Morbidity – occurrence of disease within a population. Typical indicators are incidence or prevalence per 1000 individuals, notification rate, hospitalization rates for the disease, and other measures that demonstrate the extent of amount of disease or condition.

Mortality – a term used to describe the occurrence of death in a population due to a disease or condition within a population. Typical indicators for cause-specific mortality are cause-specific deaths per 1000 individuals, death-to-case ratio, and other measures that show number of deaths due to a specific disease or condition.

Palliative care – specialized care for seriously ill (often in the context of terminal illness) patients and their families; the care focuses on providing relief from pain and other symptoms of the illness and/or side effects of medication. The goal is to improve the quality of life for the patient and family, not curing the disease or condition.

Physical accessibility to health care- the availability of good health services within reasonable reach of those who need them and of the opening hours, appointment systems and other aspects of service delivery that allow people to obtain the services when they need them.

Policy documents – national documents such as strategies, plans and action plans, programmes, white papers (if they constitute adopted policy or policy aims), national initiatives and the like that are currently in force or approved and will be in force.

White papers **–** Used in some countries, typically documents from the government that outline content and/or aims of policy and/or existing or proposed legislation. White papers are often in a form of a report to the Parliament

Risk factors – Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (In this questionnaire we are specifically interested in smoking, alcohol consumption, physical activity and diet).

Social determinants of health – The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Survivorship – proportion of individuals who survive a specific disease over a defined time period. Often measured as a survival rate, typically the percentage of people who are alive after a certain time.

Respondents

Main respondent

Name: ____

Position: ____

Institution, departement: ____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

_____

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify if and how equity is addressed in policy documents on non-communicable diseases (NCDs) across European countries.

Thank you for your time.

QUESTIONNAIRE ON NATIONAL POLICY DOCUMENTS ON DIABETES

This questionnaire regards policy documents specifically related to diabetes. These may be a stand-alone diabetes policy, strategy, action plan, white paper or other type of national health policy document, where diabetes comprises a significant proportion of the document. The questions address if and how inequities in diabetes, in health and care services for diabetes and in risk factors are addressed in the policy documents.

Question 1. Does your country currently have any national policy documents (strategy, action plan, programme, white paper, other national initiatives) for diabetes in general or specific types of diabetes (for example type 2 diabetes)?

☐ Yes, in force
☐ No, but it is under development (*go to Question 24*)
☐ No (*go to Question 24*)

Question 2. Kindly provide the titleitle and link to the policy documents, specify what kind of policy documents these are and the period the documents are operational:
(For example - "Diabetes strategy of Norway, www.diabetesstrategy.no, National diabetes strategy, 2025-2028")

1.
2.
3.

Question 3. Do the documents mention inequities in diabetes within the population?

☐ Yes
☐ No (*go to Question 8*)

Question 4. The documents mention inequities between different population groups in diabetes related to (choose all that apply):

☐ Morbidity (e.g., incidence or prevalence) of diabetes
☐ Mortality of diabetes
☐ Behavioral risk factors (alcohol, tobacco use, diet/nutrition, physical activity)
☐ Affordability of treatment and care
☐ Physical accessibility of treatment and care
☐ Screening
☐ Timely diagnosis and/or early detection
☐ Survivorship (for example 5 or 10 year survival rate after diagnosis)
☐ Ongoing Management and Monitoring, incl. complication prevention and management

☐ Support services for diabetes patients and their families
☐ Adherence to treatment
☐ Palliative care
☐ Other (please specify): _____

Question 5. The inequities in diabetes referred to in the documents concern differences between population groups defined by (choose all that apply):

☐ Geography (f. ex. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (f. ex. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Disability status
☐ Sexual orientation, sexual identity, LGBTQ+
☐ Religion
☐ Other (please specify): _____

Question 6. Kindly elaborate on your answers to Question 4 and 5 below:

Question 7. Please provide text excerpts in English (Google or AI-translated) that regard inequities in diabetes in the documents (covering all the inequities mentioned you have chosen in Questions 4 and 5).
Please include whole paragraphs of relevant text.
(Up to 4000 characters)

Question 8. Do the documents identify or emphasize specific groups as vulnerable (e.g., (national minorities, LGBTQ+, migrants, etc.) to or at particular risk regarding diabetes, or in the management and treatment of diabetes, or regarding risk factors to diabetes?

☐ Yes*:*
☐ No (*go to Question 11*)

Question 9. Kindly elaborate on your answer to Question 8 below:

Question 10. Please provide text excerpts in English (Google or AI-translated is fine) that include information on your answer to Question 8 and 9.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 11. Do the documents describe and/or establish routine monitoring of inequities in diabetes, in treatment and management of diabetes, or in risk factors of diabetes?

☐ Yes
☐ No (*go to Question 13*)

Question 12. The documents describe routine monitoring of inequities in:

☐ Incidence and/or prevalence of diabetes
☐ Management and treatment of diabetes
☐ Behavioural risk factors of diabetes
☐ Other (please specify):_____

Question 13. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in treatment and management of diabetes?

☐ Yes
☐ No (*go to Question 16*)

Question 14. Kindly elaborate on your answer to Question 13 below:

Question 15. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 13 and 14.

Question 16. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in risk factors of diabetes inequities in risk factors of diabetes?

☐ Yes
☐ No (*go to Question 20*)

Question 17. The specific actions, interventions or other approaches to reduce inequities in risk factors of diabetes regard inequities in (choose all that apply):

☐ Tobacco consumption
☐ Alcohol consumption
☐ Diet
☐ Physical activity
☐ Other (please specify):_____

Question 18. Kindly elaborate on your answer to Question 17 below:

Question 19. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 22 and 23.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 20. Does/do the policy document describe actions that involve one, or more, sectors beyond the health and healthcare sector (health in all policies) to address inequities in diabetes and/or in treatment and management of diabetes? (e.g education, environment or civil society)

☐ Yes
☐ No (*go to Question 24*)

Question 21. Please specify which sectors are involved (choose all that apply):

☐ Social services and welfare
☐ Education
☐ Research
☐ Environmental
☐ Agriculture
☐ Industry
☐ Trade
☐ Legislation and regulation
☐ Employment
☐ Transportation
☐ Urban planning
☐ Housing
☐ Technology and digital health
☐ Financial and taxation
☐ Civil society
☐ Other sectors: _____
☐ Not specified

Question 22. Kindly elaborate on your answer to Question 21 below:

Question 23. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 21 and 22.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 24. Do you have other comments on diabetes policies and how your country addresses inequities in diabetes, in treatment and management of diabetes, and in risk factors?

16. Questionnaire on cancer policy documents

HEALTH INEQUITIES IN NATIONAL NCD POLICIES: A CROSS-COUNTRY QUESTIONNAIRE ON CANCER POLICIES

About the project

This questionnaire has been developed as part of the Joint Action PreventNCD project (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities". The Joint Action aims to reduce the disease burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The Joint Action will also support participating countries' national strategies and policies that aim to reduce the burden of cancer and NCDs.

This questionnaire is part of sub-task 7.2.bc of the Joint Action PreventNCD and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region in Spain, FISABIO.
With the questionnaire we are gathering information on whether, and how, **inequities in NCDs and in treatment and management are addressed in national policy documents.**
The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs, in the treatment and management of NCDs, and in behavioural risk factors for these diseases. The work will result in both general and country-specific recommendations on how existing inequities could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire concerns **national policy documents on cancer** and is part of several questionnaires in sub-task 7.2bc that cover national policies on: a) integrated NCDs, b) cancer, c) diabetes, d) cardiovascular diseases, d) chronic obstructive pulmonary disease (COPD).

The questionnaire starts with an overview of terms and definitions used in the questionnaire and questions on who has filled out the questionnaire. The questions concern first whether these national policy documents address inequities; and secondly, if the documents describe or propose any concrete actions to reduce these inequities

Who should fill out the questionnaire:

The questionnaire should be filled out by national-level country experts who are involved in national policy development and/or implementation in the domain of the questionnaire.

How to fill out the questionnaire:

- Please provide your name, position, and contact details
- Carefully read through the list of definitions in the beginning of the questionnaire.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- You will be asked to elaborate on your answers in your own words. If you have doubts about what the correct answer is, please explain it in the justification box.

- If you have questions, kindly contact your country coordinator participating in Work Package 7.

Definitions used in this questionnaire

Adherence – also called compliance. It describes the degree to which a patient correctly follows medical advice, for example, following a treatment or care plan, or taking prescribed medicines correctly.

Health inequities (social inequalities in health) – Health inequities are systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health in all Policies (HiAP) – approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity

Morbidity – occurrence of disease within a population. Typical indicators are incidence or prevalence per 1000 individuals, notification rate, hospitalization rates for the disease, and other measures that demonstrate the extent of amount of disease or condition.

Mortality – a term used to describe the occurrence of death in a population due to a disease or condition within a population. Typical indicators for cause-specific mortality are cause-specific deaths per 1000 individuals, death-to-case ratio, and other measures that show number of deaths due to a specific disease or condition.

Palliative care – specialized care for seriously ill (often in the context of terminal illness) patients and their families; the care focuses on providing relief from pain and other symptoms of the illness and/or side effects of medication. The goal is to improve the quality of life for the patient and family, not curing the disease or condition.

Physical accessibility to health care- the availability of good health services within reasonable reach of those who need them and of the opening hours, appointment systems and other aspects of service delivery that allow people to obtain the services when they need them.

Policy documents – national documents such as strategies, plans and action plans, programmes, white papers (if they constitute adopted policy or policy aims), national initiatives and the like that are currently in force or approved and will be in force.

White papers **–** Used in some countries, typically documents from the government that outline content and/or aims of policy and/or existing or proposed legislation. White papers are often in a form of a report to the Parliament

Risk factors – Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (In this questionnaire we are specifically interested in smoking, alcohol consumption, physical activity and diet).

Social determinants of health – The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Survivorship – proportion of individuals who survive a specific disease over a defined time period. Often measured as a survival rate, typically the percentage of people who are alive after a certain time.

Respondents

Main respondent

Name: ____

Position: ____

Institution, departement: ____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

_____

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify if and how equity is addressed in policy documents on non-communicable diseases (NCDs) across European countries.

Thank you for your time.

QUESTIONNAIRE ON NATIONAL POLICY DOCUMENTS ON CANCER

This questionnaire regards policy documents specifically related to cancer. These may be a stand-alone cancer policy, strategy, action plan, programme, white paper or other type of national health policy document, where cancers comprise a significant proportion of the document. The questions address if and how inequities in cancer, in health and care services for cancer and in risk factors are addressed in the policy documents.

Question 1. Does your country currently have any national policy documents (strategy, action plan, programme, white paper, other national initiatives) for cancer or some particular cancer types?

☐ Yes, in force
☐ No, but it is under development (*go to Question 24*)
☐ No (*go to Question 24)*

Question 2. Kindly provide the titleitle and link to the policy documents, specify what kind of policy documents these are and the period the documents are operational:
(For example - "Cancer strategy Norway, www.cancerstrategy.no, National cancer strategy, 2025-2028")

1.
2.
3.

Question 3. Do the documents mention inequities in cancer in the population?

☐ Yes
☐ No (*go to Question 8*)

Question 4. The documents mention inequities between different population groups in cancer related to (choose all that apply):

☐ Morbidity (for example incidence or prevalence) of cancer
☐ Mortality of cancer
☐ Behavioral risk factors (alcohol, tobacco use, diet/nutrition, physical activity)
☐ Affordability of treatment and care
☐ Physical accessibility of treatment and care
☐ Screening
☐ Timely diagnosis and/or early detection
☐ Survivorship (for example 5 or 10 year survival rate after diagnosis)

☐ Ongoing Management and Monitoring, incl. complication prevention and management
☐ Support services for cancer patients and their families
☐ Adherence to treatment
☐ Palliative care
☐ Other (please specify): _____

Question 5. The inequities in cancer referred to in the documents concern differences between population groups defined by (choose all that apply):

☐ Geography (f. ex. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (f. ex. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Disability status
☐ Sexual orientation, sexual identity, LGBTQ+
☐ Religion
☐ Other, please name: _____

Question 6. Kindly elaborate on your answers to Question 4 and 5 below:

Question 7. Please provide text excerpts in English (Google or AI-translated) that regard inequities in cancer in the documents (covering all the inequities you have chosen in Questions 4 and 5).
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 8. Do the documents identify or emphasize specific groups as vulnerable (e.g., national minorities, LGBTQ+, migrants, etc.) to or at particular risk regarding cancer, or in the management and treatment of cancer, or regarding risk factors to cancer?

☐ Yes
☐ No (*go to Question 11*)

Question 9. Kindly elaborate on your answer to Question 8 below:

Question 10. Please provide text excerpts in English (Google or AI-translated is fine) that include information on your answer to Question 8 and 9.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 11. Do the documents describe and/or establish routine monitoring of inequities in cancer, in treatment and management of cancer, or in risk factors of cancer?

☐ Yes
☐ No (*go to Question 13*)

Question 12. The documents describe routine monitoring of inequities in:

☐ Incidence and/or prevalence of cancer
☐ Management and treatment of cancer
☐ Behavioral risk factors of cancer
☐ Other (please specify):_____

Question 13. Do the policy documents set out any specific actions, interventions or other approaches with an aim to reduce inequities in treatment and management of cancer?

☐ Yes
☐ No (*go to Question 16*)

Question 14. Kindly elaborate on your answer to Question 13 below:

Question 15. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 13 and 14.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 16. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in risk factors of cancer?

☐ Yes
☐ No (*go to Question 20*)

Question 17. The specific actions, interventions or other approaches to reduce inequities in risk factors of cancer regard inequities in (choose all that apply):

☐ Tobacco consumption
☐ Alcohol consumption
☐ Diet
☐ Physical activity
☐ Other (please, specify):_____

Question 18. Kindly elaborate on your answer to Question 17 below:

Question 19. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 22 and 23.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 20. Does/do the policy document describe actions that involve one, or more, sectors beyond the health and healthcare sector (health in all policies) to address inequities in cancer and/or in treatment and management of cancer? (e.g education, environment or civil society)

☐ Yes
☐ No (*go to Question 24*)

Question 21. Please specify which sectors are involved (choose all that apply):

☐ Social services and welfare
☐ Education
☐ Research
☐ Environmental
☐ Agriculture
☐ Industry
☐ Trade
☐ Legislation and regulation
☐ Employment
☐ Transportation
☐ Urban planning
☐ Housing
☐ Technology and digital health
☐ Financial and taxation
☐ Civil society
☐ Other sectors: _____
☐ Not specified

Question 22. Kindly elaborate on your answer to Question 21 below:

Question 23. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 21 and 22.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 24. Do you have other comments on cancer policies and how your country addresses inequities in cancer, in treatment and management of cancer, and in risk factors?

17. Questionnaire on COPD policy documents

HEALTH INEQUITIES IN NATIONAL NCD POLICIES: A CROSS-COUNTRY QUESTIONNAIRE ON CHRONIC OBSTRUCTIVE DISEASE POLICIES

About the project

This questionnaire has been developed as part of the Joint Action PreventNCD project (https://preventncd.eu/) Work Package 7 (WP7) on "Social Inequalities". The Joint Action aims to reduce the disease burden of non-communicable diseases (NCDs) in Europe. One of its key objectives is to tackle social inequalities in NCDs. The Joint Action will also support participating countries' national strategies and policies that aim to reduce the burden of cancer and NCDs.

This questionnaire is part of sub-task 7.2.bc of the Joint Action PreventNCD and is led jointly by the Norwegian Directorate of Health and the Foundation for the Promotion of Health and Biomedical Research of Valencia Region in Spain, FISABIO.

With the questionnaire we are gathering information on whether, and how, **inequities in NCDs and in treatment and management are addressed in national policy documents.**

The information will be used to create a comparative overview and evaluation of how participating countries are using policy to reduce inequities in NCDs, in the treatment and management of NCDs, and in behavioural risk factors for these diseases. The work will result in both general and country-specific recommendations on how existing inequities could be better addressed through relevant policies on national level.

About the questionnaire

The present questionnaire concerns **national policy documents on chronic obstructive pulmonary disease (COPD)** and is part of several questionnaires in sub-task 7.2bc that cover national policies on: a) integrated NCDs, b) cancer, c) diabetes, d) cardiovascular diseases, d) chronic obstructive pulmonary disease (COPD).

The questionnaire starts with an overview of terms and definitions used in the questionnaire and questions on who has filled out the questionnaire. The questions concern first whether these national policy documents address inequities; and secondly, if the documents describe or propose any concrete actions to reduce these inequities

Who should fill out the questionnaire:

The questionnaire should be filled out by national-level country experts who are involved in national policy development and/or implementation in the domain of the questionnaire.

How to fill out the questionnaire:

- Please provide your name, position, and contact details
- Carefully read through the list of definitions in the beginning of the questionnaire.
- You will be asked to copy relevant text from the policy documents in English. This can be translated with the help of Google Translate or other AI-tools. Please include whole paragraphs of relevant text.
- If there is more than one policy document, when copying and pasting the excerpts, make sure to reference the document where it belongs.
- You will be asked to elaborate on your answers in your own words. If you have doubts about what the correct answer is, please explain it in the justification box.

- If you have questions, kindly contact your country coordinator participating in Work Package 7.

Definitions used in this questionnaire

Adherence – also called compliance. It describes the degree to which a patient correctly follows medical advice, for example, following a treatment or care plan, or taking prescribed medicines correctly.

Health inequities (social inequalities in health) – Health inequities are systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair, avoidable and systematic differences in health outcomes in the form of differences in health status or in the distribution of health resources between different population groups.

Health in all Policies (HiAP) – approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity

Morbidity – occurrence of disease within a population. Typical indicators are incidence or prevalence per 1000 individuals, notification rate, hospitalization rates for the disease, and other measures that demonstrate the extent of amount of disease or condition.

Mortality – a term used to describe the occurrence of death in a population due to a disease or condition within a population. Typical indicators for cause-specific mortality are cause-specific deaths per 1000 individuals, death-to-case ratio, and other measures that show number of deaths due to a specific disease or condition.

Palliative care – specialized care for seriously ill (often in the context of terminal illness) patients and their families; the care focuses on providing relief from pain and other symptoms of the illness and/or side effects of medication. The goal is to improve the quality of life for the patient and family, not curing the disease or condition.

Physical accessibility to health care- the availability of good health services within reasonable reach of those who need them and of the opening hours, appointment systems and other aspects of service delivery that allow people to obtain the services when they need them.

Policy documents – national documents such as strategies, plans and action plans, programmes, white papers (if they constitute adopted policy or policy aims), national initiatives and the like that are currently in force or approved and will be in force.

White papers **–** Used in some countries, typically documents from the government that outline content and/or aims of policy and/or existing or proposed legislation. White papers are often in a form of a report to the Parliament

Risk factors – Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Behavioural risk factors - behaviours which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (In this questionnaire we are specifically interested in smoking, alcohol consumption, physical activity and diet).

Social determinants of health – The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

Survivorship – proportion of individuals who survive a specific disease over a defined time period. Often measured as a survival rate, typically the percentage of people who are alive after a certain time.

Respondents

Main respondent

Name: ____

Position: ____

Institution, departement: ____

E-mail: _____

Country: _____

Other respondents who have been involved (Names, email, institution, position):

_____

We sincerely appreciate your participation in responding to this questionnaire. Your valuable feedback will contribute to identify if and how equity is addressed in policy documents on non-communicable diseases (NCDs) across European countries.

Thank you for your time.

QUESTIONNAIRE ON NATIONAL POLICY DOCUMENTS ON CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

This questionnaire regards policy documents specifically related to COPD. These may be a stand-alone COPD policy, strategy, action plan, white paper or other type of national health policy document, where COPD comprises a significant proportion of the document. The questions address if and how inequities in COPD, in health and care services for COPD and in risk factors are addressed in the policy documents.

Question 1. Does your country currently have any national policy documents (strategy, action plan, white paper, or other national initiatives) for chronic obstructive pulmonary disease (COPD) or specific COPD conditions?

☐ Yes, in force
☐ No, but it is under development (*go to Question 24*)
☐ No (*go to Question 24)*

Question 2. Kindly provide the titleitle and link to the policy documents, specify what kind of policy documents these are and the period the documents are operational:
(For example - "COPD-strategy of Norway , www.COPDstrategy.no, National COPD strategy, 2025-2028")

1.
2.
3.

Question 3. Do the documents mention inequities in COPD within the population?

☐ Yes
☐ No (*go to Question 8*)

Question 4. The documents mention inequities between different population groups in COPD related to (choose all that apply):

☐ Morbidity (e.g., incidence or prevalence) of COPD
☐ Mortality of COPD
☐ Behavioural risk factors (alcohol, tobacco use, diet/nutrition, physical activity)
☐ Affordability of treatment and care
☐ Physical accessibility of treatment and care
☐ Screening

☐ Timely Diagnosis and/or early detection
☐ Survivorship (for example 5 or 10 year survival rate after diagnosis)
☐ Ongoing management and monitoring, incl. complication prevention and management
☐ Support services for COPD patients and their families
☐ Adherence to Treatment
☐ Palliative care
☐ Other (please specify): _____

Question 5. The inequities in COPD referred to in the documents concern differences between population groups defined by (choose all that apply):

☐ Geography (f. ex. regions, counties, neighborhoods, urban vs. rural)
☐ Age/age groups
☐ Sex/gender
☐ Socio-economic position (f. ex. income, education, occupational status or profession)
☐ Ethnic/linguistic minority background (ethnicity, migrant background, national minorities)
☐ Disability status
☐ Sexual orientation, sexual identity, LGBTQ+
☐ Religion
☐ Other (please specify): _____

Question 6. Kindly elaborate on your answers to Question 4 and 5 below:

Question 7. Please provide text excerpts in English (Google or AI-translated) that regard inequities in COPD in the documents (covering all the inequities mentioned you have chosen in Questions 4 and 5).
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters**).**

Question 8. Do the documents identify or emphasize specific groups as vulnerable (e.g., national minorities, LGBTQ+, migrants, etc.) to or at particular risk regarding COPD, or in the management and treatment of COPD, or regarding risk factors to COPD?

☐ Yes:
☐ No (*go to Question 11*)

Question 9. Kindly elaborate on your answer to Question 8 below:

Question 10. Please provide text excerpts in English (Google or AI-translated is fine) that include information on your answer to Question 8 and 9.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 11. Do the documents describe and/or establish routine monitoring of these inequities in COPD, in treatment and management of COPD, or in risk factors of COPD?

☐ Yes
☐ No (*go to Question 13*)

Question 12. The documents describe routine monitoring of inequities in:

☐ Incidence and/or prevalence of COPD
☐ Management and treatment of COPD
☐ Behavioural risk factors of COPD
☐ Other (please specify):_____

Question 13. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in treatment and management of COPD?

☐ Yes
☐ No (*go to Question 16*)

Question 14. Kindly elaborate on your answer to Question 13 below

Question 15. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 13 and 14.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 16. Do the policy documents set out any specific actions, interventions, or other approaches with an aim to reduce inequities in inequities in risk factors of COPD?

☐ Yes
☐ No (*go to Question 20*)

Question 17. The specific actions, interventions or other approaches to reduce inequities in risk factors of COPD regard inequities in (choose all that apply):

☐ Tobacco consumption
☐ Alcohol consumption
☐ Diet
☐ Physical activity
☐ Other (please specify):_____

Question 18. Kindly elaborate on your answer to Question 17 below:

Question 19. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Question 22 and 23.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters**)**

Question 20. Does/do the policy document describe actions that involve one, or more, sectors beyond the health and healthcare sector (health in all policies) to address inequities in COPD and/or in treatment and management of COPD? (e.g education, environment or civil society)

☐ Yes
☐ No (*go to Question 24*)

Question 21. Please specify which sectors are involved (choose all that apply):
☐ Social services and welfare
☐ Education
☐ Research
☐ Environmental
☐ Agriculture
☐ Industry
☐ Trade
☐ Legislation and regulation
☐ Employment
☐ Transportation
☐ Urban planning
☐ Housing
☐ Technology and digital health
☐ Financial and taxation
☐ Civil society
☐ Other sectors: _____
☐ Not specified

Question 22. Kindly elaborate on your answer to Question 21 below

Question 23. Please provide text excerpts in English (Google or AI-translated) that include the information on your answer to Questions 21 and 22.
Please include whole paragraphs of relevant text and provide the links to the documents.
(Up to 4000 characters)

Question 24. Do you have other comments on COPD policies and how your country addresses inequities in COPD, in treatment and management of COPD and in risk factors?

Appendix D: Equity integration indicators

The questionnaires were thematically structured and aligned with a set of **Equity Integration Indicators** (EII) EIIs were developed based on the main questionnaire items to assess and compare the extent to which the policy documents of different policy areas address inequities and also for assigning an "equity integration score" for each of the countries documents in each policy area under study. The EIIs are slightly different for behavioural risk factor policy documents and NCD policy documents.

A) Equity integration indicators for behavioural risk factor policy documents:

- **EII1: Inequities mentioned.** Based on Question 3, (coded as '"yes"'/'"no"'). This indicator captures whether countries explicitly mention health inequities in their policy documents.
- **EII2: Equity objectives.** Based on Question 6 (coded as '"yes (general population)"', '"yes (specific social groups)"', '"yes (both)"', or '"no"'). This indicator reflects whether countries include objectives aimed at reducing inequities in their policy documents. In the analysis of the results, the answer '"yes (general population)' "has been interpreted as a having objectives with a universal approach, '"yes (specific social groups)"' as having objectives with a targeted approach, and '"yes (both)"'has been classified as including objectives with a proportionate universalism approach. The same reasoning was applied to EII3: Equity actions.

  For objectives with a targeted approach or a proportionate universalism approach, the following sub-dimension was assessed:

  - Social determinants of health addressed (Question 7), by using the modified PROGRESS+ framework.

- **EII3: Equity actions.** Based on Question 10 (coded as '"yes (general population)"', '"yes (specific social groups)"', '"yes (both)"', or '"no"'). This indicator assesses whether countries include actions aimed at reducing health inequities in their policy documents.

For actions with a universal approach or a proportionate universalism approach the following sub-dimension was assessed:

Type of actions for the general population (Question 11).For actions with a targeted approach or a proportionate universalism approach, two additional sub-dimensions were assessed:

- Type of actions for specific social groups (Question 14).
- Social determinants of health addressed (Question 15), by using the modified PROGRESS+ framework.

By distinguishing between actions targeting the general population and those targeting specific populations, each action could be classified according to its equity approach: universal, targeted or proportionate universalism. For example, if a country implements advertising regulations for both the general population and specific populations, this action is classified as reflecting proportionate universalism.

- **EII4: Monitoring of inequities.** Based on Question 18 (coded as '"yes"'/'"no"'). This indicator identifies countries that establish routine monitoring of health inequities within their policy documents.
- **EII5: Health in All Policies (HiAP) / multi-sectoral approach.** Based on Question 21 (coded as '"yes"'/'"no"'). This indicator captures whether sectors beyond healthcare are involved in the actions described in policy documents.
  - Sectors involved (Question 22)

B) Equity integration indicators for NCD policy documents:

The equity integration indicators applied to policy documents addressing NCDs are largely similar to those used for behavioural risk factors. However, they are not identical, reflecting differences between disease-specific treatment and prevention and the prevention of behavioural risk factors. These differences emerged during document review and through feedback received during questionnaire development.

The equity integration indicators for NCD policy documents are described below.

- **EII1: Inequities mentioned.** Based on Question 3 (coded '"yes"/"no"'), this indicator captures if the policy documents explicitly mention inequities. For documents mentioning inequities, the following subdimensions were assessed:
  - Area(s) of inequity addressed (Question 4):
  - Population groups affected (Question 5), by using the modified PROGRESS+ framework.
- **EII2: Interventions or actions to reduce inequities in treatment and management.** Based on Question 13 (coded '"yes"/"no"'). This indicator assesses whether countries include actions or interventions aimed at reducing inequities in treatment and management of NCDs in their policy documents.
- **EII3: Interventions or actions to reduce inequities in risk factors.** Based on question 16 (coded '"yes"/"no"'). This indicator assesses whether countries include actions or interventions aimed at reducing inequities in risk factors in their policy documents. If interventions addressing inequities in risk factors were reported, the following sub-dimension was assessed:
  - Risk factor addressed (Question 17).
- **EII4: Monitoring of inequities.** Based on Question 11 (coded '"yes"/"no"'). This indicator is capturing if countries include routine monitoring of inequities in NCDs, risk factors or in treatment in the policy documents. If the documents were reported to cover monitoring of inequities, the following sub-dimension was assessed**:**
  - Monitoring focus: Incidence and/or prevalence of, management and treatment of NCDs, behavioural risk factors for cardiovascular disease, or other.
- **EII5: Health in All Policies (HiAP) / multisectoral approach.** Based on Question 20 (coded '"yes"/"no"'). This indicator captures whether the countries involve other sectors beyond healthcare to reduce inequities in their policy documents. For policy documents indicating a multi-sectoral approach to reducing inequities, the following sub-dimension was assessed**:**
  - Sectors involved (Question 21).