HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**The WHO Countrywide Integrated Non-communicable Diseases (CINDI) programme in Slovenia**
Module: 1.9.4	**ECTS: 0.5**
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Key words	public health intervention programmes, CINDI programme, non-communicable diseases, Slovenia
Learning objectives	After completing this module students should: • be familiar with WHO Countrywide Non-communicable Diseases Intervention (CINDI) programme; • increase knowledge about CINDI programme vision for the future; • be able to critically assess the importance of intervention public health programmes in controlling non-communicable diseases.
Abstract	Many different community based intervention projects/programmes were designed and/or implemented since the early 1970s to combat chronic non-communicable diseases, many of them being international. Countrywide Integrated Non-communicable Diseases Intervention programme (CINDI) of the World Health Organization (WHO), Regional Office for Europe, which started to spread its ideas in the 1980s, is one of them. Slovenia as a state officially joined international CINDI programme at the beginning of the 1990s, when its activities were limited to Ljubljana demonstrational area. First few years were used as an introductory period of the programme, while more systematically organized activities begun in the late 1990s. The paper presents the historical development of the CINDI programme in Slovenia, and the role of CINDI Slovenia Preventive Unit in it.

Teaching methods	Teaching methods include introductory lecture, case study, small group discussions, and the whole group discussion (snowball method). After the introductory lecture students need carefully to read the suggested readings on the subject. Afterwards they need to answer the questions and discuss the issue - first in small groups and afterwards in a whole group of students. They are especially addressed to critically discuss on limits and strengths of evaluation of public health programmes.
Specific recommendations for teachers	• work under teacher supervision/individual students' work proportion: 30%/70%; • facilities: a computer room; • equipment: computers (1 computer on 2-3 students), LCD projection equipment, internet connection, access to the bibliographic data-bases; • training materials: recommended readings are available in the internet; • target audience: master degree students according to Bologna scheme.
Assessment of students	Assessment is based on multiple-choice questionnaire.

THE WHO COUNTRYWIDE INTEGRATED NON-COMMUNICABLE DISEASES INTERVENTION (CINDI) PROGRAMME IN SLOVENIA

Jozica Maucec Zakotnik, Zlatko Fras, Lijana Zaletel Kragelj

Theoretical background

The WHO Countrywide Integrated Non-communicable Diseases Intervention Programme

The World Health Organization (WHO) Countrywide Integrated Non-communicable Diseases Intervention (CINDI) programme is an intervention programme with integration as a key concept in prevention of chronic non-communicable diseases (NCD) (1-3). It arose out of experiences of one of the first community-based health intervention projects in Europe - the North Karelia Project in Finland, which started in 1972 and reached remarkable achievements as well as global recognition (4).

The CINDI concept reflects the recognition that a relatively limited number of risk factors are common to some major NCD. Integration roughly refers to (1, 5):

- an intervention that is aimed at several risk factors simultaneously;
- a comprehensive approach that combines various implementation strategies (e.g. policy development, capacity building, partnership etc.) at all levels;
- an intersectorial action that implements health policies, including coordinated action by several sectors to address some major determinants of bad health that are not covered by the health sector as such, and
- a combination of population and high-risk strategies which link the preventive action of various components of the health system (health promotion, public health services, primary care and hospital care).

CINDI interventions are implemented according to the common protocol (6), preferably on a countrywide level.

The CINDI strategy aims at reducing the burden of NCD primarily by reducing unhealthy lifestyle. This should lead to the improvement of individual's risk by affecting biological/physiological risk factors (obesity, high blood pressure, abnormalities in lipid and carbohydrate metabolism, etc.) (5).

The CINDI network in 2007 comprises 29 participating countries (28 Member States of the WHO European Region and Canada) and three candidate countries, The Network is coordinated by the WHO Regional Office for Europe in Copenhagen, Denmark (1).

Case study – the CINDI programme in Slovenia and the role of CINDI Slovenia Preventive Unit

Short history of CINDI programme in Slovenia

The introductory period

A group of general practitioners from the city of Ljubljana introduced this programme for the first time at the end of the 1980s, but Slovenia as a state officially joined CINDI programme at the beginning of the 1990s, when its activities were limited to Ljubljana demonstrational area (7).

The period 1990-1994 represented the introductory period of CINDI programme implementation in Slovenia. From late autumn to early spring 1990/91 the initial cross-

sectional CINDI survey (CINDI Risk Factor/Process Evaluation Survey) (8) according to the international CINDI programme protocol (6) was carried out.

The period of institutionalization

In 1994, the CINDI Slovenia Preventive Unit was established as an autonomous unit within the Ljubljana Community Health Centre (9). Besides that it carried out the survey on cardiovascular risk factors, and consequently started to spread the significance of the worrying prevalence rates, with the main aim to increase the level of consciousness among physicians and general population, as well as in politicians, no specific major interventions were performed during this period. The need for immediate action in the field of reducing the overall cardiovascular risk, especially through lowering the imminent burden of arterial hypertension and increased blood lipids levels, became more obvious, when the second CINDI survey, which was carried out in the period of late autumn/early spring 1996/97, registered an increase in the prevalence of major cardiovascular risk factors from the earlier figures (10).

This period was characterized by development of the concept of prevention of NCD and their risk factors at primary health care level.

Today, the CINDI Slovenia Preventive Unit is still the part of Ljubljana Community Health Centre but since many years ago it outgrew the local dimension, the new administrative/institutional organisation is considered.

The period of implementation and spreading of the programme

In 1997, the decision for development some more systematic interventional health promotional and prevention activities through health promotion and health education in group workshops as well as by individual counselling were adopted and put into action. With the initiative of CINDI Slovenia Preventive Unit, many activities had started aiming at influencing political level and decision makers.

The 1996/97-2002/03 period was characterized by some great achievements in the field of healthy lifestyle promotion led by the CINDI programme activities in Slovenia:

- after the second CINDI survey, health promotion and cardiovascular disease prevention philosophy started to spread countrywide;
- in the period 2001-2004 the Ministry of Health of the Republic of Slovenia (MoH) put considerable efforts to overcome the rising burden of chronic NCD among the Slovene population with the following strategic aims:
  - to establish comprehensive intersectorial political cooperation,
  - to develop effective national strategies and action plans, and
  - to carry out projects, tackling NCD.

This process resulted in establishment of the Nationwide Programme on Primary Prevention of Cardiovascular Diseases, launched under the auspices of the MoH in autumn 2001, while it was legally introduced and started with the activities at the beginning of 2002 (11, 12).

The CINDI Slovenia Preventive Unit and its role in the programme

Within the process described above, the CINDI Slovenia Preventive Unit played a proactive role and served as an indispensable partner to the MoH and other expert groups like scientific professional societies, as well as institutions, involved in these complex activities.

Through this cooperation, the concepts of integration, partnership and capacity building have been continuously applied at the national level in political and strategic terms. This approach has enabled development of relatively favourable systemic environment for the CINDI Slovenia Preventive Unit activities. Actions to create supportive environments, to build capacities within the national health care system, and other public systems and environments (educational system, work place, local community) have created conditions where CINDI Slovenia Preventive Unit as a public health institution made a meaningful progress.

Results of the CINDI Surveys have been taken in consideration when allocating national resources to those Slovene regions, in which health indicators (e.g. mortality, NCD prevalence, NCD risk factors prevalence) were the most unfavourable (epidemiologically defined needs of the populations). Interdisciplinary health promotion programme in rural areas (i.e. »Healthy Living« project), financed by the MoH is being implemented in many Slovene regions. Pilot project MURA, dealing with health determinants, has been started in Pomurje (north-eastern part of Slovenia), the most endangered region in terms of social, economic, environmental and health deprivation of the population. Financing of additional health promotion staff at the National and Regional Public Health Institutes has been assured. Funding of the National programme on primary prevention of cardiovascular and other chronic diseases, including assessment of defined adult population for cardiovascular risk (health risk assessment procedure), as well as health education intervention for individuals at higher risk for the development of NCD has been arranged through the National Health Insurance Institute. Again, in this process CINDI Slovenia Preventive Unit played a proactive role.

Implementation of the comprehensive National programme on primary prevention of cardiovascular diseases in Slovenia

As the core and the most comprehensive approach to the reduction of the NCD the systematic programme for the prevention of cardiovascular diseases (CVD) in Slovenia was introduced at the national level in 2001. Programme, as designed, offers probably the most appropriate method for detecting individuals at high risk for the occurrence of a CVD and other chronic diseases.

Preventive health care of the adult population was for the first time tackled and defined by the »Recommendations of the MoH of the Republic of Slovenia for the implementation of preventive health care at the primary level«. They issued in 1998. They were based on the already developed programme in CINDI demonstration region of Ljubljana. Because the recommendations were probably too complex, their feasibility was questioned from the very beginning. That is also the reason why the MoH in 2001 issued revised version of recommendations, which were much more simple, straightforward and defined the preventive programme as the comprehensive approach to adult population in a specific age period.

Within the framework of primary prevention, two fundamental approaches were used (and still are), i.e., the population approach and the approach to an individual or group of persons that are at high risk for CVD. The two strategies complement one another. Social and environmental changes, different population oriented health education activities, appropriate environmental measures in the broadest sense and the legislation for restricting unhealthy behaviour or enhancing the healthier one have an important role in supporting

people to change their risky behaviour and the degree of expression and quantitative levels of risk factors that physicians may face in individuals in a clinical environment.

Systematically prepared national programme on CVD primary prevention is oriented both, towards health promotion and lowering of risky behaviour at the level of the whole population (population approach) as well as to active identification, stratification and selective treatment of those individuals at high risk for development of manifest disease (individual high-risk approach). In general, this programme consists of population screening and identification of individuals at high CV risk, followed by health education intervention and other therapeutic measures, if necessary.

Population approach

The important basic step is to continuously monitor and evaluate the prevalence of NCD and their risk factors among the population and its specific subgroups, as well as their influence on health in general. Public media assistance is appreciated and selected with respect to the target public and the type of message to be conveyed to the people.

The applied model includes the application of various methods for monitoring, education, organizational partnership, the provision of health care services and the appropriate legislation/ policies and programmes in various social circumstances, such as at the working place, schools, health care institutions or local communities.

Individual approach to high risk individuals

In 2001, the MoH issued an amendment to the previously mentioned recommendations, which represents the basis for the preparation of the National programme on primary CVD prevention. As far as this programme is in question, the recommendations seek to cover all adults in the age group of 35-65 for males and the 45-70 age group for the female part of the population (by such a definition, it was calculated that the gender balance would be achieved, these groups cover 50.96% males and 49.04% females). The main aim of the programme is to screen the whole population in these age groups within five years period. The intervention part of the programme is intended to cover also all other adults with extremely expressed any one of the major CVD risk factors, like obesity, smoking, risky drinking of alcohol, diabetes and high blood pressure.

In terms of organisation, the individual approach to identify persons at high-risk for CVD and other NCD is based on the implementation of four relatively simple, clear and practical steps (Figure 1):

- selection of priority visits/examinations on the basis of a screening questionnaire;
- invitation of individuals for interview/examination (with prior obtainment of lab values on blood glucose and total cholesterol levels);
- execution of a preventive visit (interview/examination) and assessment of absolute global cardiovascular risk;
- intervention – additional diagnostics needed and/or measures for changing the risk profile, based on the healthy lifestyle advice/education intervention and, if necessary, also pharmacological treatment.

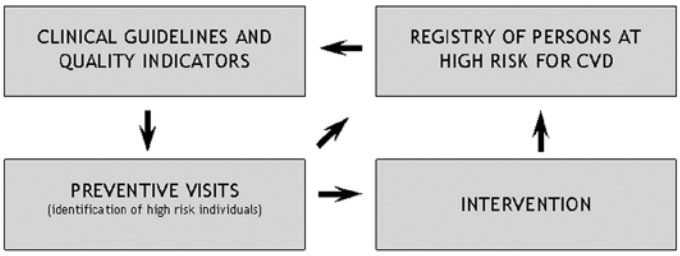

Figure 1. Schematic presentation of the elements and organization of the programmes of primary CVD prevention in Slovenia.

In Slovenia, we have adopted and even »institutionalized« the concept of the so-called global, absolute cardiovascular risk. Every GP in Slovenia performs the preventive interview/examination to an individual person, in order to predict its absolute risk for the occurrence of a cardiovascular event within the next 10 years. Afterwards she/he uses the specially designed risk assessment evaluation form which takes into account the presence and quantitative values of few of the most important, major independent CVD risk factors (age, sex, smoking, systolic blood pressure and total cholesterol). The basis for global individual risk assessment in this case is CVD risk equation derived from the well known Framingham study.

During the first year of full implementation of the programme, a total of 84,434 visits were performed (50.7% were men), representing around 56.51% of exams as were envisaged following the starting conditions of the programme (i.e., to check 18% of the specific age groups of the adult population annually). In 2003, 114.599 preventive visits/exams were performed, while in 2004 further 111,673 visits were registered. All these give a figure of total 310,706 visits performed in first 3 years of the programme (around 45% of the whole population defined for health risk assessment).

After the global risk is calculated, pharmacological treatment is prescribed, where absolutely indicated, and health education for all individuals at high risk is carried out. Healthy lifestyle advice/education is performed using group or individual treatments, according to the most relevant risk factors identified. Group treatment consists of five workshops (Table 1) which are attended by at least 10-15 people.

Table 1. Healthy lifestyle advice/education - group treatment approach in the programme of primary prevention in Slovenia.

Workshop	Module	Duration
1.Health Promotion and Risk Factors	a. Promotion of Health b. Physical fitness c. Risk Factors	(short: 3 times 2 hours)
2. Healthy Weight Loss		(12 weeks)
3. Healthy Nutrition		(5 weeks)
4. Physical Fitness		(5 weeks)
5. Yes, I quit smoking		(7weeks)

Within the framework of individual approach, all the active primary care physicians, who are mainly specialists in general/family medicine, carry out individual counselling to people who confirmatively expressed their wish to quit smoking and for those who wish to give up risky consumption of alcoholic beverages. Individual counselling encompasses five sessions, each lasting about 15 minutes.

Health education centres establishment, networking and capacity building

Healthy lifestyle advice/education activities are carried out by the Health Education Centres which have been set up in most community health centres around the country, and currently the network of 60 of them operating all over Slovenia. The MoH appointed these centres in 2002.

The personnel performing healthy lifestyle advice/education programmes include physicians, registered/graduated medical nurses and other health care professionals, health education or sport teachers, physiotherapists and psychologists. They have all attended special training to qualify for this work at »School for health promotion and the prevention of chronic non-communicable diseases« and they are constantly improving their knowledge in advanced training seminars, all organized by the CINDI Slovenia Preventive Unit. The »education of educators« principle has been applied. General practitioners are continuously educated by their professional colleagues and nurses are educated by other nurses.

Administratively, the leadership, coordination of implementation of the National programme on prevention of CVD in whole, as well as coordination of implementation and quality assurance of health education programme, in health education centres, is under the responsibility of the CINDI Slovenia Preventive Unit. Under its organisational umbrella the experts from different medical fields are involved within the programme (cardiology, diabetology, dietetics, healthy physical activity, etc.). So far, the »CINDI schools« have trained over 800 health professionals and teachers in the health promotion field who are spreading their knowledge among their colleagues and lay public. With their participation, also local health promotion groups in different community settings in all Slovenian regions were set up.

Over 85,000 participants received advice/education for healthier lifestyle within these workshops and by the individual counselling in the period of 2002-2005.

Legislation, policies and actions

CINDI Slovenia Preventive Unit, together with its partners, takes active role in preparation of public health legislation and different kinds of strategies and policies in the country.

Legislation

From 1996, Slovenia adopted and enacted two very important laws in the field of public health, which intention was to tackle, and to reduce selected unhealthy behaviour in Slovene population:

- The Act on Restriction of the Use of Tobacco Products (1996), which has been recently amended (summer 2007) and is now much stricter than its predecessor, since it prohibits smoking in all covered public places, and
- The Act on Restriction of Alcohol Consumption (2003).

Strategies and policies

In the field of public health strategies and policies, some very important documents have already been adopted in Slovenia. Here again, the CINDI Slovenia Preventive Unit experts and its partners have played the leading role in the preparation and creation of the strategies to achieve the planned strategic goals in the area of chronic NCD. These documents are:

- The Resolution on National Programme of Food and Nutrition Policy from 2005–2010, which was adopted in the Parliament in 2005 (13);
- The Strategy of the Government of the Republic of Slovenia on the field of Health Enhancing Physical Activity 2007-2012, which was adopted by the Slovene government in March 2007 (14);
- The national strategy for tackling inequalities in health on the basis of experiences of project MURA (collaboration of MoH, Flemish government and WHO Centre for Health and development, and local experts) - Health promotion strategy and action plan for tackling health inequalities in the Pomurje region (15);
- the National healthy nutrition guidelines for educational institutions (starting from age 1 year), which was adopted in the Parliament in 2005 (collaboration of MoH and Ministry of education and sport) (16).

All these documents are directed in ensuring health supporting environment in different types of settings (e.g. healthy schools and healthy kindergartens), and for vulnerable groups of Slovene population, e.g. pregnant women, children, socially and economically deprived citizens, citizens at risk for NCD, and elderly people.

For ensuring health supporting environment for people at workplace, another type of activities with active CINDI Slovenia Preventive Unit cooperation takes place at the National Institute for Occupational Medicine, Traffic and Sports. The project »Fit for work« was established to help in creation of healthier environments and healthier life style of workers in some specific occupational settings (17).

Actions to influence health determinants and tackle inequalities in health

In Slovenia there exist some great interregional differences in many different respects. There exists a very clear trend from southwest to northeast of Slovenia, with the lowest social economic and the worst health indicators in the most north-eastern part of Slovenia, Pomurje Region, where the life expectancy is for about 3 years for men, and for about 2 years for women shorter then in the western part of Slovenia. Additionally, the highest specific mortality for CVD has been registered in this region. MoH has launched an intersectorial and interdisciplinary pilot project MURA, financially supported by the Government of the Republic of Slovenia, to influence health determinants in the broadest sense, in this region.

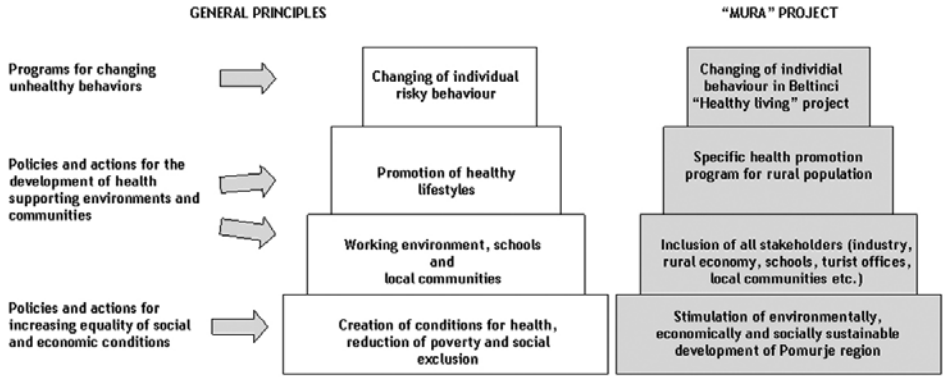

Figure 2. Basic elements for the continuous health promotion among the population - MURA project in Slovenia.

The core philosophy of this project is to stimulate environmentally, economically and socially sustainable development, combined with health promotion programmes in different settings, leading to better health of the population and individuals (Figure 2). Experts from the Regional Public Health Institute Murska Sobota, together with the MoH personel, played the leading role in the project development, coordination and implementation. Specific health promotion programmes for rural population, who is at the greatest risk for unhealthy lifestyle and for manifest NCD, was developed and broadly implemented in this region. CINDI Slovenia Preventive Unit is actively involved in this project (development of different intersectorial strategies, development and implementation of specific health promotion interventions, the evaluation process).

Project is characterized by strong networking of the regional health promotion coordinators, NGOs and interdisciplinary experts, working together in the health promotion in thirty smaller local communities (health promotion project »Healthy Living«). It is probably of special interest to mention also that a network of small and medium size tourist providers has been created to work together with the Regional Public Health Institute to develop a new, healthy tourist offer. Intersectorial collaboration has resulted also in reorientation of agricultural practices towards higher proportion of ecological growing as well as higher proportion of fruit and vegetables growing. Two new high-level educational programmes in the field of tourism and agriculture had been developed in Pomurje Region during the course of the project. Results concerning short-term changes in life style are very promising. This issue is discussed later on. At the same time, the »Healthy living« project has been disseminated from Pomurje Region to all regions in Slovenia.

Collection and evaluation of data as a support to evidence based policy development

Data collection and evaluation, as well as analysis of such information constitute the basic element of the quality management process of the health promotion and NCD prevention programmes in Slovenia. There exist three key orientations of collecting data, being at the three different levels with regards to the depth of the problem analysis.

1. CINDI Health Monitor Survey (18).
   This surveys offer the most rough but comprehensive overview on the problems tightly associated with NCDs. This kind of survey was performed in Slovenia for the first time in 2001, and for the second time in 2004. With its national and regional levels, CHMS represent very strong support to development of evidence based policy on both levels, what is extremely important in the process of diminishing interregional differences. At the same time, it is very powerful tool for evaluation of the effectiveness of health promotion programmes. Both databases include data on about 9000 participants' health behaviour. According to the results of the comparison of the data for 2001-2004 in Pomurje region (19), we can conclude, that, in short-term, the activities were extremely successful. For example, the prevalence of use of lard as the kind of fat for food preparation dropped from 30.3% in 2001 to 20.8% in 2004, while the prevalence of every-day consumption of soft drinks dropped from 42.9% to 29.1%. Both differences were statistically highly significant.
2. CINDI Risk Factors and Process Evaluation Survey (3).
   This type of surveys provide the basic data on the WHO CINDI programme progress in Slovenia.
   So far, there were three surveys performed at the demonstrational level (Ljubljana demonstrational region) – in 1990/1991, 1996/1997, and 2002/2003.
   The results showed that, since organized activities, what happened after the 1996/97 survey, CINDI Slovenia Preventive Unit register quite good results of joint national efforts to diminish the prevalence of physiological risk factors. For example, prevalence of smoking decreased by about 18%, from 30.4 to 25.1%, the percentage of people with BMI over 25.0 decreased by nearly 10%, from 61.6% to 56.4%, hypertension prevalence decreased from 43.4% to 39.6%, and the prevalence of people with high LDL-cholesterol from 78.7% to 70.8%.
3. Registry of Individuals at High Risk for CVD (20).
   Data gathered during performed prevention visits (interviews/exams) and individual intervention activities are entered into the specially prepared individual computer forms/frames, installed to the computer programmes running in the consulting rooms (offices, surgeries) of physicians working as family physicians/GPs at the primary health care level. The software and a central data collection system have been created within the framework of the national »Registry of Individuals at High Risk for CVD«. According to The Act on Healthcare Data-bases, the responsible data-holder of this database is the University Medical Centre Ljubljana, with its Department for Vascular Medicine, while operative activities of data collection tasks are carried out according to the special contract with the CINDI Slovenia Preventive Unit.
4. Other data sources.
   There exist also several other very important data sources.
   Among ad-hoc data sources, the Beltinci process evaluation data-base should be mentioned in the first place (21). The data from this data-source also show that the intervention process in Pomurje region is very successful. The study was performed on 158 adults with monitoring/observation of health indicators on physiological risk factors before and after the intervention programme was carried out. After only one year of intervention activities, the average values of systolic blood pressure decreased by 4.7%, diastolic blood pressure by 4.1%, and blood cholesterol by 4.9%. All

differences were statistically highly significant. As there were no significant differences in participants being medicated with antihypertensive (p=0.581) or cholesterol lowering drugs (p=0.267), the decrease could be assigned almost exclusively to the changes in health behaviours (prevalence of use of lard for food preparation: prior the intervention 42.4%, after one year 27.2%).

Two other databases, which could also indirectly serve in the evaluation of the progress of the process, and are of national importance, should be mentioned as well. The Database of Deaths and Death Causes (data-holder: Institute of Public Heath of the Republic of Slovenia) (22), and Cancer Registry (data-holder: Cancer Registry at Institute of Oncology of Republic of Slovenia) (23).

Providing scientific information/evidence for evidence based public health activities

The first scientific paper was published in 1993 (8). Unfortunately, this activity was not the priority for several years, since other activities, like spreading the programme countrywide, were felt as of much greater importance.

In the period after 2001, when the partnership with experts mainly from University Medical Centre Ljubljana, and Department of Public Health of Ljubljana University Faculty of Medicine was established, the period of producing strong scientific evidence was started. Since then, several scientific papers were published in international and domestic scientific and other periodicals (19, 21, 24-38).

Partnership in CINDI programme

During the 1999-2004 period, CINDI movement in Slovenia succeeded to join numerous scientific, professional and performance forces in Slovenia and internationally, working within various medical professional societies and health care institution, non-medical institutions and professionals, governmental structures and non-governmental organizations in carrying out their specific activities inside comprehensive programme presented.

Important partnership was developed with the entire primary health care society, with health professionals working in primary health care and public health professionals working in regional public health institutes as well as with some media.

The development of partnership cooperation and strong coalitions for the common welfare of the society is of vital importance for ensuring success of efforts to deal with such a great general societal problem as CVD are. Such a mission has been recognized in our country and a Slovene Forum for the Prevention of Cardiovascular Diseases was established in 2000. This body is operating under the auspices of the Slovenian Society of Cardiology, and within its framework numerous institutions, organizations and societies cooperate, including CINDI Slovenia Preventive Unit.

Additionally, in 2001 within CINDI movement, a strong partnership between University Medical Centre Ljubljana, Department of Vascular Medicine, Preventive Cardiology Unit, Department of Public Health of Ljubljana University Faculty of Medicine, and CINDI Slovenia Preventive Unit was established, what started to create a very strong public health scientific basis in the field of CVD prevention.

CINDI Slovenia Preventive Unit itself has also very close collaboration with CINDI WHO, CINDI Finland, CINDI Canada, UKK Institute Tampere Finland, WHO centre for Health and Development in Venice, National Public Health Institute Sweden, Karolinska

Institute Sweden, and European HEPA Network.

In this place, we need emphasize again, that without a strong and dedicated collaboration of several important partners of the CINDI Slovenia Preventive Unit, the CINDI movement in Slovenia would not be as efficient as it is. In fact, these partners represent at the same time the »outer base« of the CINDI Slovenia Preventive Unit (which is the »inner base«), and stakeholders for the CINDI programme in Slovenia being a sustainable process and not just an attempt.

Funding by the Health insurance Institute of the Republic of Slovenia

The population-oriented programmes for the CVD risk reduction include many of the providers of health care services and their working environment. The implementation of the programme that is carried out in the entire territory of the Republic of Slovenia involves all GP/family physicians practicing in primary health care system who are responsible for their assigned population. As it was already mentioned the family medicine physicians/ GP's (contractors with the Health Insurance Institute of Slovenia) are obliged to perform preventive visits/exams of up to 18% of their total assigned population of a defined age group annually. Health Insurance Institute of Slovenia is funding comprehensive National programme on primary prevention of CVD in Slovenia, including screening, health education interventions, collection and evaluation of data including registry of persons at risk for CVD, coordination of the implementation of the programme as well as whole functioning of the CINDI Slovenia Preventive Unit.

Exercise

Task 1:

Carefully read the following document:

World Health Organization, Regional Office for Europe. Protocol and guidelines: Countrywide Integrated NCD Intervention (CINDI) Programme (Revision of 1994). Copenhagen: WHO Regional Office for Europe, 1996. Available from: URL: http://whqlibdoc.who.int/hq/1994/EUR_ICP_CIND_94.02_PB04.pdf.

Task 2:

Discuss the WHO CINDI programme characteristics with other students.

Task 3:

Visit the WHO CINDI Web Site:

World Health Organization, Regional Office for Europe. Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme. Home page. Available from: URL: http://www.euro.who.int/CINDI.

On the Publication Site find the last issue of CINDI Highlights (Available from: URL: http://www.euro.who.int/CINDI/publications/20020322_3) and read it.

Task 4:

Discuss the WHO CINDI programme development with other students.

Task 5:

Carefully read the following document:

World Health Organization, Regional Office for Europe. A strategy to prevent chronic disease in Europe. A focus on public health action. The CINDI vision. Copenhagen: WHO, Regional Office for Europe; 2004. Available from: URL: http://www.euro.who.int/document/E83057.pdf (Accessed: August 10, 2007).

Task 6:

Discuss the WHO CINDI programme process in the light of the vision for the future with other students.

Task 7:

Critically assess the importance of intervention public health programmes in controlling NCD.

NOTE: For the process being shorter different groups of students could do different tasks and then present their findings to each other.

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