



European
Commission

2008-2013

EU FUNDED ACTIONS to support the
PUBLIC HEALTH PRIORITIES

Nutrition & Physical
Activity Actions
addressing OBESITY



Consumers,
Health and Food
Executive Agency

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EU funded actions to support
the **EU Public Health**
priorities

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Foreword

The most important daily decision that we make for our health is choosing what to eat. The other significant choice we make is whether we dedicate 30 minutes of our time to do some exercise.

Today, millions of people suffer from non-communicable diseases (NCDs) across Europe. Cardiovascular diseases, cancers, chronic respiratory diseases and diabetes represent a leading threat to human health and development. These four disorders are the world's biggest killers; more people die from NCDs than from all other causes combined⁽¹⁾. In Europe, the four major NCDs together account for 77 % of the burden of disease and almost 86 % of premature mortality⁽²⁾.

Unless addressed, the mortality and disease burden from these health problems will continue to increase.

Poor diet, lack of exercise, overweight and obesity contribute to a large proportion of NCDs. Currently, one in two people in the EU population is overweight or obese⁽³⁾. What is more worrying is that one third of the 11-year-olds have to face the same disorder⁽⁴⁾.


We must reach people. We must teach them that NCDs are largely preventable. They must understand that up to 80 % of heart disease, stroke and type 2 diabetes, and over one third of cancers could be prevented by eliminating shared risk factors; mainly unhealthy diet, physical inactivity, tobacco use and alcohol abuse.

On the other hand, growing evidence highlights that information campaigns alone can not deliver behavioural change. Although more informed consumers make better decisions, this is not enough to modify long-standing eating and activity habits. Therefore, the focus should move towards an '*education/information plus*' approach, with a greater emphasis on influencing the environment within which choices are made.

Obesity is a complex issue that requires integrated actions across sectors. This compendium helps point the way. The brochure demonstrates a number of specific actions that were taken to prevent or reverse the emergence of obesity in Europe.

Many such projects foster the sharing of knowledge amongst experts, policy makers, industry players and other stakeholders, and thus bring European added value to national efforts in tackling obesity.

We have made good progress in strengthening cooperation against obesity and I am confident that these projects will further encourage European organisations to continue their work together towards the common goal of improving the quality of life of European citizens – with particular attention paid to children.



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(1) WHO (2011): Global status report on noncommunicable diseases 2010.

(2) WHO Europe (2012): Action Plan for implementation of the European Strategy for the Prevention and control of Noncommunicable Diseases 2012-2016.

(3) Eurostat (2011): Overweight and obesity — BMI statistics.

(4) WHO Europe (2013): Country profiles on nutrition, physical activity and obesity in the 53 WHO European Region Member States. Methodology and summary.

Introduction

In October 2007, the European Commission published its 2nd Health Programme for the period 2008–13⁽¹⁾ to provide an overarching strategic framework addressing core issues in health. The 2nd Health Programme is structured around four principles (shared values, health and wealth, health in all policies and global health) and has three objectives:

- to improve citizens' health security — protecting citizens from health threats;
- to promote health, including the reduction of health inequalities — fostering good health in an aging Europe;
- to generate and disseminate health information and knowledge — supporting dynamic health systems and new technologies.

The Consumers, Health and Food Executive Agency⁽²⁾ (CHAFEA) was created on 1 January 2005 and it is the main instrument used by the Commission to implement the Health Strategy. This is mostly done via funding schemes for projects, conferences, joint actions and operation grants as well as calls for tender. Work plans are published annually and detail the priorities and criteria for funding. CHAFEA, based in Luxembourg, manages relations with over 3 000 beneficiaries and contractors involved in close to 400 projects/service contracts in the field of health, consumer protection and food safety. It has about 50 staff members with an administrative annual budget of €7.2 million (year 2013).

In 2013, CHAFEA decided to publish a compendium of all nutrition and physical activity actions addressing obesity that were selected for funding under the 2nd Health Programme. The compendium is part of the Executive Agency's contribution to better dissemination of knowledge and best practices generated by funded actions and to improved networking among all actors in the field.

In this brochure, you will find a short description of each action and its major outputs. Projects have been summed up by means of desk research and interviews with project coordinators. Summaries are grouped according to the six action areas of the EU Strategy (better-informed consumers, making the healthy option available, encouraging physical activity, priority groups and settings, developing the evidence base to support policy making, developing monitoring systems). This will allow for obtaining an overview of the themes and subjects covered under the individual actions. Please note that the compendium reflects the state of the projects in February 2014, which means that some details may have changed during the lifetime of the project.

Since 2008, about 20 projects and other activities have been funded by the European Union in the area of nutrition, physical activity and obesity, in the framework of the 2nd Health Programme. These projects and initiatives include capacity building and networking activities, guidelines, exchanges of best practices, surveillance systems as well as conferences. Each of them directly contributed to the implementation of the six priority areas of the EU Strategy and provided good examples of efforts for curbing the obesity epidemic.

(1) <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:301:0003:0013:EN:PDF>
(2) CHAFEA was formerly called the Executive Agency for Health and Consumers (July 2008 to December 2013) and the Public Health Executive Agency (starting in 2005).



Policy context

Obesity Epidemic

Overweight and obesity are defined as having abnormal or excessive fat accumulation that may impair health⁽¹⁾. So, obesity is more than just a cosmetic concern. It increases the risk of serious chronic illnesses such as heart diseases, diabetes, high blood pressure, some cancers and depression. It also shortens life expectancy and adversely affects the quality of life. In Europe, more than one million deaths annually are due to diseases related to excess body weight⁽²⁾. However, even modest weight loss and lifestyle changes can improve or prevent health problems associated with obesity.

Regular consumption of foods high in fat, sugar and salt combined with more sedentary lifestyles have led to a steep rise in obesity in recent decades, resulting in more than half of the EU population now being overweight or obese⁽³⁾. Rates are projected to increase further and in some countries two out of three people will be obese within 10 years⁽⁴⁾. Due to this rapid rise and the associated health consequences, obesity is considered one of the most serious health challenges of the early 21st century.

Obesity also strongly affects economic and social development. Excess body weight in adults is responsible for up to 6% of health care expenditure in the EU and indirect costs are at least two times higher. Furthermore, people in lower socio-economic groups are more likely to be overweight, and this contributes to widening the gap in health and other inequalities.

Obesity in children

In Europe, more and more children have to deal with the problem of obesity. *'Being overweight is so common that it risks becoming a new norm'*, according to the latest report of WHO Europe⁽⁵⁾. Currently, up to 33% of 11-year-olds and 27% of 13-year-olds are overweight or obese. From 2002 to 2010, the number of countries where more than 20% of children were overweight rose from 5 to 11. Similarly to adults, the obesity epidemic threatens children's health with a large proportion of them having diseases such as diabetes, hypertension, orthopedic problems and mental disorders as well as underachieving in school and suffering from low self-esteem. Added to this, such children have a 3-7 times higher chance of being overweight adults.

How can the obesity epidemic be tackled?

Overweight and obesity, as well as the associated diseases, are largely preventable. Supportive environments are essential in making the healthier option of foods and regular physical activity the easiest choice (accessible, available and affordable). Adults need at least 30 minutes of physical activity every day, and children need more. Reformulating food, improved labelling, restricting food marketing and controlled food availability to children enables consumers to choose between good, better and not so good nutrition. National governments can enforce legislation and press for informative labelling and regulated marketing, requiring the private sector to take responsibility. Local governments have a key role in making the healthy choice easy and attractive; especially in the context of urban planning and creating infrastructures that motivate people to engage in leisure time physical activity. At individual level, consumers can be empowered to make informed decisions about their own and their children's diets and physical activity.



(1) WHO Fact sheet N°311 (updated March 2013): Obesity and overweight.

(2) WHO European Ministerial Conference (2006): European Charter on counteracting obesity.

(3) Eurostat (2011): Overweight and obesity — BMI statistics.

(4) OECD (2012): Obesity updates.

(5) WHO Europe (2013): Country profiles on nutrition, physical activity and obesity in the 53 WHO European Region Member States. Methodology and summary.

White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity-related health issues

Today, seven out of the eight major risk factors for premature death (i.e. high blood pressure, high cholesterol level, high blood sugar, excess body weight, inadequate fruit and vegetable intake, physical inactivity and alcohol use)⁽¹⁾ are strongly linked to the way we eat, drink and move.

In response to the growing challenge of poor nutrition, limited physical activity and obesity, the European Commission adopted a six-year Strategy for Europe on Nutrition, Overweight and Obesity-related health issues in 2007⁽²⁾. In several areas the main levels for intervention should be either national or local. This White Paper focuses on the steps that can be taken at EU level and frames action in six areas considering the issue of inequalities within and between Member States. Actions are based on sound scientific evidence showing relations between particular dietary and physical activity habits and certain diseases.

The Strategy underlines the central role of the Commission in encouraging more action-oriented partnerships and taking the lead in establishing a common framework. However, the actions proposed are complementary to and support existing measures in the Member States.

According to the Strategy, measures to tackle obesity must be based on four pillars: 1) a clear reduction in high-risk behaviors (i.e. poor nutrition and lack of exercise); 2) strong intersectoral collaboration linking as many players as possible at all levels, using a wide range of instruments; 3) robust participation of private sector as well as local stakeholders; and 4) systematic evaluation and follow-up to understand what works. So, the Strategy sets out a series of challenges to stakeholders at local, regional, national and European levels emphasising the key role of the food industry, civil society and the media.

The priority areas of the Strategy are as follows:

- 1) **Better-informed consumers** – improving access to clear, consistent and evidence-based information in particular: by reviewing the options for nutritional labelling legislation and regulations around health claims made by the manufacturers of food products; by promoting codes of conduct for advertising and marketing, especially those targeting children; and by developing education and information campaigns for vulnerable groups to increase their knowledge and awareness.
- 2) **Making the healthy option available** – the Common Agricultural Policy (CAP) plays an important role in ensuring the availability of healthy foods across Europe; the food industry is another key player mostly through reformulation to improve the nutritional content of manufactured foods.
- 3) **Encouraging physical activity** – including steps relating to sustainable urban transport and urban planning both of which aim to create a supportive environment to boost participation in leisure time physical activity and sport.
- 4) **Priority groups and settings** – there is growing evidence that obesity more likely affects those in low socio-economic groups.

In addition, excess body weight is increasing significantly among children. Nevertheless, intervening in early ages has proved to be the most effective. These two areas are thus priorities. Also, actions aimed at maintaining a healthy workforce play an important role.

- 5) **Developing the evidence base to support policy making** – using evidence to inform policy by finding out more about: the health impact of physical activity and nutrition; the drivers behind and barriers to preventing obesity in the priority groups; and consumer behavior and the determinants of food choices.
- 6) **Developing monitoring systems** – to obtain sound and comparable data on the prevalence of overweight and its risk factors and to study the current activities in Member States and assess their impact.

To implement the Strategy, a broad range of policies and actions have been, and are currently being developed at all levels. At European level, areas so far considered include: new EU legislation on food labelling⁽³⁾; an EU register of nutrition and health claims⁽⁴⁾; a European Network on reducing marketing pressure on children⁽⁵⁾; industry efforts to reduce salt, sugar, fat and trans fat content of manufactured foods⁽⁶⁾; reform of the Common Agricultural Policy⁽⁷⁾; EU Guidelines⁽⁸⁾ and Council Recommendation⁽⁹⁾ addressing health-enhancing physical activity as well as an EU Action Plan on childhood obesity⁽¹⁰⁾; and continuous collection and dissemination of good practices across Europe. Moreover, two valuable tools are supporting the execution. One of them is the EU Platform for Action on Diet, Physical Activity and Health, a platform of stakeholders across the board interested in the subject. The second one is the High Level Group on Nutrition and Physical activity representing 30 countries across Europe.

In 2010, half way through its lifespan, implementation of the Strategy was assessed jointly by the WHO Europe and the Commission to see how much progress had been achieved and how it could be improved afterwards⁽¹¹⁾. Furthermore, in 2012/13, the Strategy underwent an independent external evaluation to review its success in promoting healthier lifestyles⁽¹²⁾. Results of these evaluations were positive and supported the continuation of the Strategy. The latest evaluation did however identify that, to ensure a more balanced response, greater focus is now needed on physical activity promotion. Continued coordination by the European Commission and maintained or even increased commitments of all stakeholders to fight against overweight and obesity also remain necessary.

(3) Until December 2014, Directive 2000/13/EC is the main EU legislation on the subject. The new Regulation (EU) No 1169/2011 will become effective from December 2014 with the exception of the new mandatory nutrition labelling requirement (which shall apply from December 2016).

(4) Contains information about permitted, rejected and pending claims. <http://ec.europa.eu/nuhclaims/>

(5) It was established in 2008 and consists of 17 European countries and representatives from the WHO, EC, FAO and IOTF <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/policy/member-states-action-networks/reducing-marketing-pressure-on-children>

(6) A survey of over 1 500 European food and drink companies (2009) by the CIAA http://www.foodanddrinkeurope.eu/documents/brochures/CIAA_Glossy_Brochure_Final.pdf and the latest analysis of the commitments made by the EU Platform members to food reformulation http://ec.europa.eu/health/nutrition_physical_activity/docs/eu_platform_2013frep_en.pdf

(7) http://ec.europa.eu/agriculture/policy-perspectives/policy-briefs/05_en.pdf

(8) [www.ua.gov.tr/docs/default-source/gençlik-programi/eu-physical-activity-guidelines-2008-\(ab-beden-eğitimi-rehberi\).pdf?sfvrsn=0](http://www.ua.gov.tr/docs/default-source/gençlik-programi/eu-physical-activity-guidelines-2008-(ab-beden-eğitimi-rehberi).pdf?sfvrsn=0)

(9) <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2013:354:0001:0005:EN:PDF>

(10) http://ec.europa.eu/health/nutrition_physical_activity/docs/childhoodobesity_actionplan_2014_2020_en.pdf

(11) http://ec.europa.eu/health/nutrition_physical_activity/docs/implementation_report_en.pdf

(12) http://ec.europa.eu/health/nutrition_physical_activity/docs/pheiac_nutrition_strategy_evaluation_en.pdf

(1) WHO (2009): Global health risks: mortality and burden of disease attributable to selected major risks.

(2) Available at http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/nutrition_wp_en.pdf

High Level Group on Nutrition and Physical activity

The launch of the Strategy in 2007 has led to the formation of a High Level Group on Nutrition and Physical activity (HLG) with the aim of facilitating the implementation of the six action areas by discussing policy ideas and national practices as well as by executing common European initiatives. The HLG consists of government representatives from all 28 EU member countries plus Norway and Switzerland, and is led by the Commission. Since its establishment, the Group has met three times per year to ensure regular exchange of information on key issues and the follow-up on common activities. Between meetings, group members are working with their national governments and stakeholders to realise the foreseen goals (e.g. redesigning the urban environment to promote cycling and walking, encouraging responsible advertising and reformulating food products). Furthermore, the HLG regularly has meetings with the EU Platform for Action on Diet, Physical Activity and Health.

At their first meeting in November 2007, the Group decided to start working on three areas: salt reduction, effective public-private partnerships and monitoring the implementation of the Strategy.

In July 2008, the HLG approved an EU Framework for National Salt Initiatives⁽¹⁾ with a benchmark of a minimum of 16 % salt reduction over four years for all food products, including salt consumed in restaurants and catering. In parallel with this, a Salt Action Network was established to help countries with their salt reduction work. Besides providing guidance on how to engage industry and how to increase consumer awareness, the network has developed protocols for monitoring. Member States signed up to participate in the campaign work in 2008, and an evaluation to capture national activities was carried out in early 2010⁽²⁾; in 2012⁽³⁾ the WHO Europe conducted a similar exercise. Later, the Group started discussions on extending their activities on reformulation, particularly on fats and sugar; an EU Framework for National Initiatives on Selected Nutrients is now in progress.

During its operation, a subgroup of experts within the HLG also mapped public-private partnership activities at national level to share experiences and lessons learned. As a result, a Working Paper on Public-Private Partnerships for Health was published in 2008⁽⁴⁾. Furthermore, the HLG assisted in monitoring the Strategy⁽⁵⁾ by reviewing the chosen method and list of indicators and by supporting WHO National Focal Points in gathering and submitting requested data. Most recently, the Irish Presidency mandated the Group to develop an Action Plan to address childhood obesity. The overarching goal of the six-year Action Plan⁽⁶⁾, launched in February 2014, is to stop the worrying rise in childhood obesity by 2020.

In summary, as the work on the two major risk factors — unhealthy diet and physical inactivity — is a high priority on the public health agenda and is linked to the prevention of chronic diseases, the work of the HLG is of great significance and the HLG should continue its efforts to help people to carry out the nutrition and physical activity recommendations.



(1) http://ec.europa.eu/health/archive/ph_determinants/life_style/nutrition/documents/salt_initiative.pdf
(2) http://ec.europa.eu/health/nutrition_physical_activity/docs/salt_report_en.pdf
(3) http://www.euro.who.int/__data/assets/pdf_file/0009/186462/Mapping-salt-reduction-initiatives-in-the-WHO-European-Region.pdf

(4) http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/ev20081028_wp_en.pdf
(5) http://ec.europa.eu/health/nutrition_physical_activity/docs/pheiac_nutrition_strategy_evaluation_en.pdf
(6) http://ec.europa.eu/health/nutrition_physical_activity/docs/childhoodobesity_actionplan_2014_2020_en.pdf

EU Platform for Action on Diet, Physical Activity and Health

The EU Platform for Action on Diet, Physical Activity and Health (Platform) is a forum for European-level organisations willing to commit themselves to reverse the worrying trends in obesity, unhealthy diet and physical inactivity. The idea behind the Platform was to create a 'soft' policy instrument which relies on dialogue and voluntary commitments by players of different sectors and could be defined as a 'model of cooperative voluntarism' ⁽¹⁾. The Platform was established in 2005 under the leadership of the Commission, and the number of members has more than doubled since its foundation. Now, it is composed of 35 associations ⁽²⁾ from the areas of nutrition (i.e. dietician associations, food industry, agriculture, caterers and consumer groups), physical activity, sport, health, communication, advertising and media.

Platform members meet regularly (4–5 times per year) to share the outcomes and experiences of their activities, to ensure transparent monitoring and to initiate new actions. Since 2005, more than 300 voluntary commitments have been launched in six areas of action: 1) advocacy and information exchange; 2) marketing and advertising; 3) composition of foods, availability of healthy options and portion size; 4) consumer information including labelling; 5) education and lifestyle modification; and 6) physical activity promotion. All initiatives are publicly available in the Platform commitments database ⁽³⁾. Furthermore, annual reports about the Platform's activities have been published since 2006 ⁽⁴⁾.

Based on the latest available data ⁽⁵⁾, education and lifestyle modification commitments are the most frequent, comprising one third of the total actions. Continual progress and development, however, are being seen in each activity area. One such example is the EU Pledge ⁽⁶⁾, whereby 20 leading food and beverage companies committed themselves not to advertise products to children under 12 years of age; this commitment was extended to company-owned websites in 2012. 21 new commitments were registered in 2012.

Besides continuous dialogue and voluntary actions, members of the Platform monitor their own performance on the basis of a common 'Platform Monitoring Framework' ⁽⁷⁾ to ensure that commitments are followed through on and activities become visible. Evaluation reports are examined by external evaluators to follow the progress. At the 2013 Joint meeting of the Platform and the HLG, Commissioner Borg advised the Platform to reinforce actions — especially in the areas of reformulation and advertising to children — but monitoring and reporting of commitments also need to be strengthened ⁽⁸⁾.

To sum up, during its operation, the Platform has successfully brought together stakeholders across Europe to generate concrete actions and promote exchanges of good practices. The instrument has good potential to deliver important results in support of a healthier lifestyle and environment if commitments are correctly and widely implemented and properly monitored.



(1) Directorate-General for Health and Consumers (2010): Strategy for Europe on nutrition, overweight and obesity related health issues — Implementation progress report.
(2) http://ec.europa.eu/health/nutrition_physical_activity/docs/platform_members.pdf
(3) http://ec.europa.eu/health/nutrition_physical_activity/platform/platform_db_en.htm
(4) http://ec.europa.eu/health/nutrition_physical_activity/key_documents/index_en.htm#anchor0

(5) Annual Report 2013.
(6) <http://www.eu-pledge.eu/>
(7) http://ec.europa.eu/health/archive/ph_determinants/life_style/nutrition/platform/docs/eu_platform_mon-framework_en.pdf
(8) http://ec.europa.eu/commission_2010-2014/borg/docs/speech_31052013_nutrition_en.pdf

Collaboration with World Health Organisation

The World Health Organisation Regional Office for Europe (WHO/Europe) is actively engaged in the fight against obesity by encouraging putting this issue high on the political agenda at both national and international level. Working towards a common goal, the Commission collaborates closely with the WHO to promote healthy diet and physical activity and bring the obesity epidemic under control. Meanwhile the Commission plays its principal role mostly through EU legislation, public health policy, funding schemes and tools like the Platform and HLG. WHO/Europe also works closely with Member States by providing high level scientific and technical support. This structure ensures coherence and consistency in international actions, maximizes efficient use of resources and creates synergies.

WHO/Europe continually advise policy makers, facilitate and coordinate actions, monitor progress and share good practices across a wide range of instruments such as Member States Action Networks⁽¹⁾, surveillance systems and direct consultations. Recently, the Regional Office's support to countries has been guided by the Health 2020 Framework⁽²⁾, the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020⁽³⁾, and the European Charter on Counteracting Obesity⁽⁴⁾, while working on a new Food and Nutrition Action Plan to be adopted in 2014 and a new physical activity strategy for the Region.

In November 2006, WHO/Europe organised a ministerial conference on counteracting obesity which resulted in a Charter⁽⁵⁾ stating that *'the obesity epidemic is reversible'* and *'visible progress should be achievable in most countries in the next 4–5 years and it should be possible to reverse the trend by 2015 at the latest'*. To achieve this, the Charter calls for high-level political will and leadership and whole-government commitment as well as actions beyond health education.

One example of effective collaboration is the actions taken on salt reduction. WHO has set up the recommended level of salt intake as less than 5 g per day (approximately 1 teaspoon) to prevent cardiovascular diseases. As the current intake is far above the suggested amount, both the European Strategy and the WHO European Action Plan address the reformulation of mainstream food products. In 2008, a common European framework was developed, and in parallel with this a European Salt Action Network was established under the auspices of WHO, where both WHO/Europe and the Commission participate as observers. Member States signed up to participate in the Salt reduction campaign work in the course of 2008 and a monitoring report was issued in 2013 by WHO to present an up-to-date view of current initiatives across Europe⁽⁶⁾.

Furthermore, WHO/Europe participated in projects funded under the 2nd Health Programme either in the form of direct agreement (e.g. NOPA, PHAN and COSI) or as collaborating or associated partner (e.g. EURO-PREVOB, ENERGY, EURRECA and INPROFOOD).



(1) <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/policy/member-states-action-networks>

(2) <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020>

(3) http://www.euro.who.int/__data/assets/pdf_file/0003/234381/Wienna-Declaration-on-Nutrition-and-Noncommunicable-Diseases-in-the-Context-of-Health-2020-Eng.pdf

(4) http://www.euro.who.int/__data/assets/pdf_file/0009/87462/E89567.pdf

(5) <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/publications/pre-2009/european-charter-on-counteracting-obesity>

(6) http://www.euro.who.int/__data/assets/pdf_file/0009/186462/Mapping-salt-reduction-initiatives-in-the-WHO-European-Region-final.pdf

The 2nd Health Programme and its Work Plan priorities

Improving health is important in its own right. But it also plays a key role in addressing challenges such as population ageing, security threats or labour shortages. Health has a role to play in achieving Europe's full potential for prosperity, solidarity and security. The new Health Programme will be instrumental in reaching these goals.⁽¹⁾

Although most competence for action to organise and deliver health services and medical care is held by Member States, the EU has the responsibility, as set out in the Treaty⁽²⁾, to undertake certain actions which cannot be taken by individual Member States. The EU Health Strategy, therefore, complements national health policies, but at the same time brings European added-value, for example in relation to cross-border health threats — like influenza — or free movement of patients and medical staff.

The first period: 2003–07

The first coherent and coordinated approach to health policy was set out in the European Community Health Strategy put forward in May 2000⁽³⁾. The Public Health Programme (PHP) 2003–07 was the 1st Health Programme⁽⁴⁾, with a total budget of €312 million for five years. This Programme replaced eight previous actions in the field of health⁽⁵⁾.

The second period: 2008–13

The 2nd Health Programme⁽⁶⁾ came into force on 1 January 2008. The Programme had a total budget of €321.5 million and aimed to finance actions contributing to increased solidarity and prosperity in the EU. The Strategy focused on four principles: strengthening the *EU's voice in global health* along with closer collaboration with WHO; *shared health values* which recognised that values relating to improving health must address inequalities; *health is the greatest wealth*, highlighting the link between health and economic prosperity; and integrating *health in all policies*, which stressed that population health is not an issue for the health sector alone.

The Programme strongly supported cross-border collaboration between Member States and the establishment and maintenance of networks as well as sharing of experiences across Europe. It had three main objectives:

- 1) **Improving health security** — actions were taken to protect citizens against health threats. This included capacity building to respond to cross-border threats and preparing for coordinated responses to health emergencies. This objective also addressed patient safety and EU legislation on blood, tissues and cells.
- 2) **Promoting Health** — under the second objective, the Commission fostered healthy active ageing and helped to bridge inequalities in health. It also continued actions on health determinants⁽⁷⁾ and on the social and physical environments.
- 3) **Health information and knowledge** — under the third objective, the Commission facilitated the exchange of knowledge and best practices in areas where added-value can be provided by bringing together expertise from different countries, for example rare diseases and children's health. It also promoted EU health monitoring and developed ways of disseminating information to citizens, such as the health-EU portal.

While the Programme set up the framework for funding, annual work programmes comprising priorities and specific objectives are adopted by the Commission every year. The Annual Work Plan with the indicative amounts, funding criteria and expected results are published along with the Call for Proposals. A wide range of organisations can apply for funding within the Call: research institutes and universities, public administrations, NGOs and commercial firms. To ensure full participation, a wide variety of financing mechanisms⁽⁸⁾ are offered. Since 2005, the Consumers, Health and Food Executive Agency has assisted with implementation of the Programme.

(1) EC (2006): EU Health Programme: Commissioner Kyprianou welcomes Council political agreement. EC IP/06/1658 published on 30/11/2006.

(2) Article 6 of the Treaty on the Functioning of the European Union.

(3) <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2000:0285:FIN:EN:PDF>

(4) Its full name is Community action in the field of health, 2003–08, Decision No 1786/2002/EC of 23 September 2002. The action was initially planned for six years, but finally was reduced to five.

(5) For example, health promotion, cancer, AIDS and certain communicable diseases, drug addiction, health surveillance and pollution-related diseases, injury prevention and rare diseases.

(6) Full name is Second programme of Community action in the field of health 2008–13. Decision No 1350/2007/EC. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:301:0003:0013:EN:PDF>

(7) For example, nutrition, physical activity, alcohol, tobacco and drug abuse.

(8) Co-financing of projects; Tendering actions to achieve a Programme objective; Co-financing of the operating costs of an NGO or a specialised network; Joint financing of a public body or NGO by the Community and one or more Member States; Joint actions with other Community programmes.

Overview of the relevant Work Plan priorities 2008–13:

2008:

- 1) Healthy living in young people; including life skills training, parental involvement and whole school/whole community actions;
- 2) Reformulation of manufactured foods;
- 3) Promoting physical activity through infrastructure, planning and better use of the physical environment.

2009:

- 1) Reformulation of manufactured foods;
- 2) Promoting physical activity through infrastructure, urban/regional planning and better use of the physical environment, with a particular focus on children and young people;
- 3) Promote European networking in the field of physical activity;
- 4) EU-wide overview of the different types of local community approaches to reducing child obesity, including school-based initiatives.

2010:

- 1) Follow-up of the reformulation of manufactured foods;
- 2) Promote physical activity in socio-economically disadvantaged areas through future planning of infrastructure and through recreational policies and whole community actions;
- 3) Sharing of know-how on community-based initiatives to reduce overweight and obesity.

2011:

Monitoring the implementation of the European Strategy jointly with the WHO.

2012:

- 1) Support for the European Innovation Partnership on active and healthy ageing;
- 2) Local community, including school-based initiatives, to prevent overweight and obesity among children and adolescents;
- 3) Evaluation of the European Strategy;
- 4) Preventing chronic diseases.

2013:

- 1) Addressing chronic diseases and promoting healthy ageing across the lifecycle;
- 2) Childhood Obesity Surveillance Initiative;
- 3) Communicating on nutrition and physical activity;
- 4) Integrated surveillance of NCDs.

The way forward 2014–20

On 26 February 2014, the European Parliament adopted the Commission proposal for the 3rd Health Programme 2014–20⁽⁹⁾, '*Health for Growth*', with an indicative budget of €449.4 million. Building on current work, this new Programme strengthens and emphasizes the links between economic growth and a healthy population to a greater extent than the previous programmes. The general goals of the Programme are to work with Member States to promote innovation in health care, to increase the sustainability of health systems and to improve the health of EU citizens and protect them from cross-border health threats. It will come into force in 2014; the publication of the Annual Work Plan is expected in April/early May. The subsequent Call will follow immediately afterwards.



(9) http://ec.europa.eu/health/programme/docs/prop_prog2014_en.pdf

Conclusions

This Brochure is dedicated to presenting a selection of actions funded under the 2nd Health Programme 2008–13, in the areas of nutrition and physical activity addressing obesity. It aims to promote and disseminate results and knowledge generated by these meaningful actions.

In response to the dramatic rise in overweight and obesity, and the worsening trend of poor nutrition and physical inactivity, the EU began to significantly strengthen its action in this area approximately 10 years ago. Between 2007 and 2013, actions in this field were mostly guided by *The Strategy for Europe on Nutrition, Overweight and Obesity related health issues*⁽¹⁾. In January 2008, the 2nd Public Health Programme⁽²⁾ (2nd PHP) came into force, and clearly called for actions to ‘Address health determinants to promote and improve physical and mental health, creating supportive environments for healthy lifestyles and preventing disease; take action on key factors such as nutrition and physical activity (...), focusing on key settings such as education and the workplace, and across the life cycle’.

As a basis for the identification of capacities, gaps and future funding priorities, the present publication aims to demonstrate the objectives, working methods and outcomes of 20 nutrition and physical activity actions. While the selected actions are thematically grouped according to the six priority areas of the EU Strategy, their scope often covers more than one action area at the same time.

The collection and analysis of initiatives have highlighted that all actions demonstrated good progress towards the EU Strategy’s and the Programme’s strategic goals and specific objectives. However, their real impact will only be visible in a couple of years after all ongoing actions have been finalised.

Clear, consistent and evidence-based information given to consumers was considered as one of the measures to tackle obesity. Both projects addressing Priority 1 **Better informed consumers** focused on empowering young children, paying attention to the long-term aspects. Environmental and awareness raising components were also presented and projects led to increased knowledge which hopefully will shape future behaviour.

The existing set of projects has good potential to contribute to the objectives of Priority 2 **Making the healthy option available** through the identification and exchange of best practices in food reformulation, follow-up of food reformulation activities among SMEs, improving the nutritional quality of food offered to employees, as well as by promoting healthy lifestyles among socially disadvantaged children and their families via ‘local health ambassadors’.

Effective implementation of EU guidelines on physical activity can be supported by shaping environmental conditions. All Priority 3 **Encouraging physical activity** projects have the vision of cre-

ating a health-promoting living environment for EU citizens. Part of the projects focused on the elderly, while another part focused on socially disadvantaged groups. In comparison with other priorities, the projects under Priority 3 put more effort into policy capacity building and networking. However, these projects are also very significant for local communities who are playing a front line role in health promotion.

When it comes to confronting childhood obesity, community-based approaches that incorporate schools and focus on both diet and physical activity are important⁽³⁾. Three out of the five projects under Priority 4 **Priority groups and settings** contribute to preventing obesity among children, focusing on vulnerable groups by promoting healthy eating and physical activity in local communities. The other two initiatives aim to reach people in a certain period of life that is pivotal in determining longer-term obesity risks. All these projects are therefore very relevant not only in tackling obesity, but also in narrowing the gap in health inequalities.

Evidence-based policy making is a means of gathering and sharing better evidence and better understanding of certain conditions so that this can be shared with relevant policy fields. Each action under Priority 5 **Developing the evidence base to support policy makers** aimed to provide solid evidence, experience and knowledge in order to inform stakeholders at a high level. Compared to other priorities, actions under Priority 5 represent a diverse portfolio in terms of themes. Nevertheless, these actions are very significant for national and local authorities in successfully implementing their strategies and policies against obesity.

Monitoring is a central component of the Strategy to ensure proper follow-up of actions. Both projects addressing Priority 6 **Developing monitoring systems** aimed to provide reliable, comparable and regularly updated data both on the causes and on the effectiveness of measures dealing with obesity among adults and children. Both credible systems were built through solid cooperation with WHO/Europe.

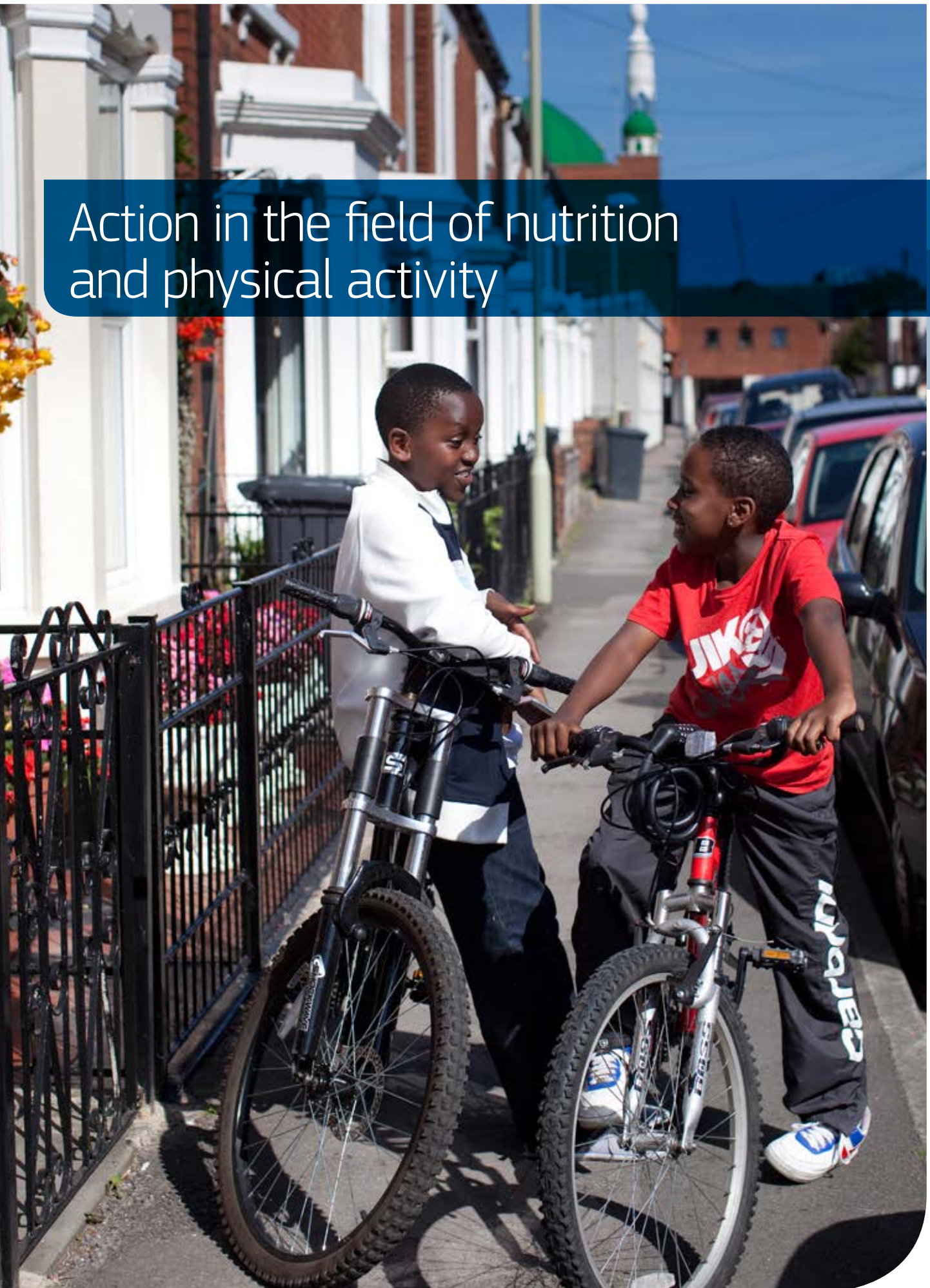
Of the six Calls for Proposals between 2008 and 2013, the 2nd Health Programme served as one of the main funding instruments for implementation of the EU Strategy. Its total financial contribution to the 20 demonstrated actions was approximately €10 million. In terms of the actions, they contributed significantly to at least one of the priority areas of the EU Strategy and they paved the way in the overall landscape of European action against overweight and obesity.

In summary, actions included in this Brochure document the Commission’s commitment to support actions needed to confront the threat of NCDs. On the other side, this overview should allow stakeholders to identify gaps to fill and opportunities for future funding priorities, which can be systematically addressed over the course of the 3rd Health Programme.

(1) http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/nutrition_wp_en.pdf
(2) <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ.L:2007:301:0003:0013:EN:PDF>

(3) Bleich, S. N. et al. (2013): Systematic review of community-based childhood obesity prevention studies.

Action in the field of nutrition and physical activity





Better informed consumers

ACTIVE project

Europe is now facing a childhood obesity epidemic⁽¹⁾. A third of European schoolchildren are overweight or obese. Among children today, obesity is causing a broad range of health problems that previously weren't seen until adulthood. So, an obese child has an increased chance of facing the challenge of diabetes type 2, hypertension and high blood cholesterol levels. Obesity can also be linked to underachievement in school, low self-esteem and depression. It is important to remember that these children have a high possibility of becoming overweight adults and if levels of obesity are not reduced this will lead to an enormous social and economic burden both in Europe and beyond⁽²⁾.

Fortunately, childhood obesity can be largely prevented and controlled by addressing its main risk factors, notably unhealthy diet and physical inactivity⁽³⁾. Although it is clear that this issue requires a broad-based public health approach, the problem cannot be tackled without increasing children's as well as parents' and teachers' awareness as early as possible.

To address one of Europe's most pressing public health challenges on an individual level, ACTIVE proposed a new and fresh approach. Started in 2008, the 24-month-long project aimed to produce a cutting-edge cartoon animation based on scientifically sound and age-appropriate messages for children aged 5–8. The work was coordinated by

'Targeting children early in life with well-packed messages about healthy lifestyles is strategically important.'

Business Solutions Europa, a communication agency with a team of project managers and communication and broadcast specialists. The consortium also included cartoon animators, nutrition experts and a network of museums specially dedicated to children. In addition, a focus group of 600 children from six EU countries (Italy, Ireland, Poland, Bulgaria, Belgium and Spain) were involved in the entire process.

As a first step, a group of experts collected and analysed relevant nutrition, obesity and physical activity initiatives and policies across Europe in order to define the animation's key messages. They highlighted those issues that are important but, at the same time, less exploited in other education campaigns. Furthermore, the group gathered information through a questionnaire on the habits, knowledge and opinion of the focus group (average age 7.5 years). The main conclusions were that although breakfast skipping is very rare at this age, the food chosen often has poor nutrient content. They also found that unhealthy snacks like chips and chocolate are very popular among children. Finally, 10–20% of kids stated that they don't like to spend their spare time actively.

(1) WHO Regional Office for Europe (2007): The challenge of obesity in the WHO European Region and the strategies for response.

(2) AHA Scientific Statement (2008): Population-Based Prevention of Obesity.

(3) Davies, M. M. et al., (2007): Recommendations for Prevention of Childhood Obesity.

These data served as a basis for content preparation. A two-day-long workshop was organised to brief the animators about the key messages of the cartoon. Three themes were selected for translation into three separate animated stories, one about the importance of regular and healthy breakfast, a second one addressing the issue of physical inactivity and a third one talking about proper snacks.

My Friend Boo

In order to develop a product appealing to broadcasters, the partnership decided to make ACTIVE a part of a series (My Friend Boo) produced with the support of two other European projects, ECO-Animation (funded by the LIFE+ programme) and Young Energy Savers (funded by the Intelligent Energy Europe programme). As a result, the 'My Friend Boo' series is addressing a wide range of global issues like energy, climate change, the environment, conservation and health. The series is split into three strands (Energy, Water and Healthy Living) each of which is made up of three episodes.

ACTIVE in numbers in 2010

- Potential to reach 25 million homes through broadcasters (estimation based on TV audiences and ratings)
- Licence agreements with 10 broadcasters in 19 countries
- 160 persons from 25 countries downloaded the teaching material
- 53 organisations from 14 countries requested the teaching material
- 38 articles (in newspapers or online)

Within the framework of the ACTIVE project, the partnership co-produced the three parts that tell positive, inspiring and fun stories about healthier living, focusing on healthy eating and physical activity. A tailor-made teaching pack was also compiled for each episode to support the integration of the cartoon animation into formal and informal (i.e. clubs, associations and family) education. The whole process was coordinated and advised on by a Pedagogic Evaluation Committee and the focus group of children who completed two additional questionnaires to provide feedback about the characters, concepts and clarity of messages. In addition, a group of 500 children and parents, who saw the series for the first time, were also involved in the final evaluation in 2010.

In summary, the project delivered three short animations with age-appropriate messages about the importance of breakfast and regular exercise as well as one about balanced diet and healthy snacks. Cartoons are available online for free in 17 languages, after registration. Three teaching packs are also presented in 15 languages on the website. So, ACTIVE provided an easy-to-use tool for teachers and parents to raise awareness among their children about the importance of healthy living in an age-appropriate way. As a result, on one hand ACTIVE has great potential for directly reaching young Europeans and helping them to adopt healthier behaviour. On the other hand, the project indirectly raised awareness among educators and parents.

In addition, the My Friend Boo series was integrated into the Générations en Santé (2008–12) programme. Générations en Santé is a Franco-Belgian initiative aimed at promoting health, wellness and quality of life by making services and tools available

to schools and practitioners. The programme involves a network of nine public health bodies and is co-financed by the European Union.

Main deliverable

- Episodes and teaching pack in different languages:
http://www.myfriendboo.com/episodes_download/downloads.html
- This link is also available after registration and sent via email.



with the support of



Useful links

Project website: <http://www.animate-eu.com/active/>

<http://www.myfriendboo.com/healthyLiving.html>

<http://www.generationsensante.eu> (in French)

Partners

Main Beneficiary:

Business Solutions Europa Limited
United Kingdom

Associated Partners:

- Clinica Pediatrica, Università di Genova, Istituto G. Gaslini, Italy
- Griffilms LTD, United Kingdom
- MUSEO DEI BAMBINI (EXPLORA), Italy
- Università di Napoli Federico II, Italy



Better informed consumers

Healthy Eco Life project

Overweight and obesity are serious problems in Europe, particularly among children. The prevalence has been rising steadily since 1990 in most EU Member States. Currently, the estimated prevalence for overweight is 30%, and over 60% of those children who are overweight before puberty will remain overweight in early adulthood⁽¹⁾. Furthermore, evidence suggests that even if excess childhood weight is lost, adults who were overweight children retain an increased risk of cardiovascular problems. Although the causes of obesity are complex, prevention offers a less expensive measure as opposed to treatment. Therefore, recommendations for preventing obesity emphasize the importance of early interventions to ensure lifelong healthy lifestyle habits⁽²⁾.

Childhood obesity is emerging in Croatia and Slovenia

Croatia is experiencing similar problems as other countries in Europe. In 2007, data showed that 11% of children were overweight and 67% did not engage in recommended levels of physical activity⁽³⁾. Feeding habits are shaped by aggressive marketing of energy-rich food that is low in nutrients, while education about healthy lifestyle is not properly addressed within the regular curriculum.

Childhood is an important period for forming healthy behaviour.

Although the rate of childhood obesity is slightly lower in Slovenia compared to either Croatia or the EU average, excess weight and obesity have become clearly more prevalent in Slovenian children in recent decades, and Slovenia is one of the European countries where the largest increase can be observed between 2001-02 and 2009-10 (more than 5%)⁽⁴⁾.

The school environment provides an ideal opportunity for ensuring that children understand the importance of good nutrition and physical activity⁽⁵⁾. Most school age children of diverse ethnic and socio-economic groups can potentially be reached through this setting and children spend a significant amount of time there. Finally, school gardening has been found to be very effective not only in increasing children's knowledge but also in raising levels of consumption of fruits and vegetables.

(1) WHO Regional Office for Europe: Obesity data and statistics. Available at: www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/data-and-statistics

(2) Cochrane Summaries (2011): Interventions for preventing obesity in children.

(3) Healthy Eco Life project final report.

(4) OECD: Health at a Glance: Europe 2012.

(5) Mozaffarian, D. et al., (2012): Population Approaches to Improve Diet, Physical Activity, and Smoking Habits.

Innovative promotion of healthy lifestyle to primary school children

To promote healthy lifestyles and raise ecological awareness among school children living in urban areas of Croatia and Slovenia, the 'Healthy Eco Life' project was launched in March 2010. The idea was to test innovative approaches in health promotion in one candidate country (Croatia) and in one EU Member State (Slovenia) to compare the effects of the proposed programme in countries with different social and cultural backgrounds as well as economic development levels. The target group was primary school children in fourth grade (618 youths from Zagreb and 89 youths from Maribor). The 16-month-long project resulted in a creative, learning-by-doing approach including a one-day visit to an eco farm where children could gain experience in growing organic vegetables and taking care of domestic animals.

'It is crucial to develop health promotion programmes based on EU best practices and new methods of work which put pupils at the centre of the learning process.'

Overview of EU and Croatian policies and programmes

An overview of European policy papers, legislation and programmes in the field of health promotion among school children was conducted as a first step to identify those best practices that are potentially suitable for implementation in Croatia. Furthermore, the project team collaborated closely with local stakeholders (school staff, public officials working in the health sector and NGOs) to collect and discuss national programmes and experiences. Within these consultations, similarities and differences in policies and measures implemented in Croatia versus the EU were also assessed. These sources served as a basis for identifying the most appropriate methodologies for the project as well as for creating a Best Practice Compendium. The compendium summarises relevant European policies and demonstrates 22 initiatives across Europe. It is available in both English and Croatian.

Focusing on practical knowledge

After analysing the existing policies and initiatives, the second phase focused on bringing this knowledge together into a training programme on healthy lifestyle complemented by a strong ecological awareness aspect. To prepare age-appropriate training material that is adapted to the needs and knowledge of the target group, a baseline survey was conducted. The survey also assessed similarities and differences in knowledge and attitudes between Croatian and Slovenian children.

Results showed that unhealthy behaviour was common in both groups (see Table). Furthermore, although children had some experiences with gardens and plants, one in five Croatian chil-

dren has never seen and/or touched any domestic animals. This rate was slightly higher among Slovenian children.

	Croatian children	Slovenian children
Daily breakfast	97%	55%
Daily sweets	90%	87%
Daily soft drinks	30%	40%
Daily fast food	10%	19%
Daily fruits	70%	70%
Screening time*	2.7 hours/day	3 hours/day
Play outside	less than 1 h	less than 1 h

*including TV, computer and video games

On the basis of the survey results, a Best Practice Compendium of findings and partners' experiences of the Healthy Eco Life education programme was developed. The programme was designed as a supplement to the current formal curriculum in primary schools. The main activities were learning about health through interactive workshops in classes, and all-day visits to eco agricultural farms. Children participated in baking bread, taking care of animals and organic gardening in practical workshops; they were encouraged to use these principles and values in everyday life. The training material consisted of four modules: Education about healthy food habits; Promotion of physical activity; Fostering mental health; and Raising ecological awareness.

After the programme was developed, 20 trainers were selected and educated through a four-day-long training course on delivering the programme. To evaluate the effectiveness and feasibility of the initiative, 142 workshops were organised in Zagreb and Maribor between September 2010 and June 2011. Classroom workshops lasted for two hours, while eco farm visits were a whole day. At the end, changes in knowledge, attitude and satisfaction with the programme were assessed among the target group using questionnaires and interactive posters. Surveys showed significant improvements in children's knowledge and awareness and also proved that healthy habits were adopted by the participants. Finally, school gardens were created in some schools.

Roadmap for further implementation

The Healthy Eco Life project was not only for children, as it also involved several stakeholders in the field of health promotion from the region. It provided an excellent opportunity for presenting and discussing local, national and European experiences in health promotion and fostered the creation of new networks and initiatives. Stakeholders from Croatia and Slovenia now have a clearer picture on the state-of-the-art in their field and on which steps need to be taken to align with Community policies. By using the training material developed, formal education programmes in primary schools can be complemented and improved.

To ensure the results are sustainable and disseminated, a web-based platform was established. Moreover, two follow-up project proposals (Healthy Eco Life II and Green Pack Junior — Croatia) were prepared within the project period with collaboration involv-

Healthy Eco Life in numbers in 2010

Croatia (Zagreb)

- 10 primary schools (28 classes)
- 618 students
- 112 workshops in schools
- 12 one-day visits to the eco farm

Slovenia (Maribor):

- 2 primary schools
- 89 students
- 16 workshops in schools
- 2 one-day visits to the eco farm

ing six Healthy Eco Life Friends Club members. The 'Healthy Eco Life II — health promotion to children' project aims to adapt and implement the Healthy Eco Life method in urban areas of four countries in the region (Bulgaria, Serbia, Montenegro, and Bosnia and Herzegovina). The 'Green Pack Junior — Croatia' initiative will develop innovative education material using IT and new technologies to improve the knowledge and awareness of school children. It will cover 10 topics about healthy nutrition, the environment, society and economic development. The consortium will use the experience and knowledge gained from the Healthy Eco Life project, as the target age group will be school children aged from 7 to 10 years.

Overall, the project triggered a lot of interest at both regional and EU level which is reflected in the more than 19700 visits to the project website.

HEALTHY ECO LIFE FRIENDS CLUB was established to connect stakeholder groups across Europe. The main idea was to create a platform for sharing experiences and discussing ideas about promoting health and ecology among school children. The Club now has 15 members from six European countries.



Useful links

Project website:

<http://www.petplus.hr/ekolife/pages/indexE.html>

Healthy Eco Life Friends Club:

<http://www.petplus.hr/ekolife/pages/membersE.html>

Partners

Main Beneficiary:

Nature, energy, transformation, plus free choice of each individual
Croatia

Associated Partners:

- Dr. Andrija Stampar, Institute of Public Health, CroatiaEco
- Centar pz, Croatia
- Ecological-Cultural Association for a Better World, Slovenia
- Coram Life Education UK, United Kingdom



Making the healthy option available

Food project

Fighting Obesity through Offer and Demand

Currently, the favourable effects of regular physical activity and a healthy diet are no longer under debate. Physical activity and a healthy diet have been identified as particularly important in counteracting the development of chronic diseases, including obesity, cardiovascular disease, type 2 diabetes and some cancers⁽¹⁾. Despite strong evidence, the majority of the adult population in most countries do not meet the recommendations for physical activity and diet⁽²⁾.

The causes of this are numerous, and included among the list are increases in automation and labour-saving devices that have resulted in a change in the way we live and work. Many workplaces are now sedentary settings and often provide easy access to energy-dense food and beverages. As a result, workplaces are contributing to the epidemic of many severe chronic diseases.

On the other hand, promoting healthy and balanced nutrition in the workplace can bring benefits to companies and their workers⁽³⁾.

The workplace setting offers several advantages: 1) a substantial number of the working population can be reached easily; 2) many people spend more than half of their waking hours at work; and 3) multiple levels of influence on behaviour can be targeted, such as health education and increasing access to healthy food and physical activity.

(1) WHO (2004): Global Strategy on Diet, Physical Activity and Health.

(2) DG SANCO and WHO/Europe (2010): Implementation progress report of Strategy for Europe on nutrition, overweight and obesity related health issues.

(3) Mozaffarian, D. et al. (2012): Population Approaches to Improve Diet, Physical Activity, and Smoking Habits.

‘It is often difficult to have a proper healthy meal at lunch time during the working day. The food offered around workplaces can lack variety or be of poor nutritional content.’

Though employer rationales vary, health promotion programmes may yield economic benefits in terms of, for example, reduced absenteeism, employee health care costs, and employee turnover⁽⁴⁾.

In the **White Paper** on Nutrition, Overweight, and Obesity-related health issues adopted by the European Commission in 2007, workplaces are highlighted as important settings for health promotion: *‘Businesses can also support the development of healthy lifestyles in the workplace. Together with employee organisations, they should also develop proposals/guidelines for ways in which companies of different sizes can introduce simple, cost-effective measures to promote healthy lifestyles.’*

(4) NICE public health guidance (2008): Promoting physical activity in the workplace.

‘The EU employment rate for persons of working age (15–64) was 64.2% in 2012. This means that in 2012, 216.1 million persons were employed in the EU.’

Eurostat

To deal with the growing need for effective workplace interventions, the 28-month FOOD project was launched in 2009. FOOD aimed to introduce simple, cost-effective measures promoting a healthier lifestyle for employees by addressing both demand and supply. Therefore, on one hand, FOOD looked to increase the awareness and capacity of employees to make healthier choices, but it also focused on the nutritional quality of food offered outside the working place. The consortium was based on a public-private partnership coordinated by Edenred (formerly called Accor Services) and represented experts from academia, public authorities and nutritionists from six European countries (Belgium, Czech Republic, France, Italy, Spain and Sweden).

To meet its objectives, FOOD has completed five complementary sets of actions set by the expert panel.

The inventory

The project started by reviewing the existing interventions promoting balanced nutrition in the workplace and restaurants. Seventy programmes were identified and inserted into a consolidated inventory. In analysing these previous programmes, serious concerns were raised; lessons can be summarised as follows: 1) experts found that in most interventions evaluation as well as dissemination were weak; 2) due to the lack of a proper assessment of the knowledge of participants and the low level of presence of professionals in the consortium, unsuitable tools were created; 3) finally, sustainability was also an important but unresolved issue in most cases.

The inventory was further enriched with the findings of the Move Europe programme which has led to a second consolidated inventory.

Understanding needs and benefits

Desk research was followed by two surveys. The first was a quantitative survey mailed to 52 000 employees and 5 000 restaurants to better understand their needs and expectations. The second was a qualitative study, which involved conducting 60 interviews in restaurants.

A total of 4 529 employees and 399 restaurants responded to the questionnaires. Given the cultural differences between the participating countries, detailed results were presented in separate country reports. However, common findings can be summarised as follows. Half of the employees declared that a list of restaurants close to their company which offer balanced food, and nutritional information sent by email, would be the best way to raise their awareness about a nutritional programme. Employees also stated that they need practical and easily understandable information. On the other side, restaurant owners were eager to meet their customers' demand, with 44% of them being aware of this new demand

for healthier food. However, only limited resources are available in terms of time and budget. Chefs also welcome suggestions and believe that they have a role to play; but no 'revolution in their kitchen'.

Recommendations

Following the analysis of the results from the inventory and questionnaires, recommendations were made by the partners. Discussions led to the compromise of having common recommendations in all countries when possible, and specific national ones where appropriate. This resulted in the formation of six common European recommendations for the employees and only one common piece of advice for the restaurants. At national level, the purpose was not to invent new recommendations but to use national guidelines when available and to adapt them to the objectives of the project: giving employees the means to access a balanced lunch break meal and for restaurants to propose it on their menu.

Common Recommendations for Employees

- *Taste the food before adding salt and/or other condiments.*
- *Lower the use of fat and preferably use vegetal oils.*
- *Eat at least five portions of fruit/vegetables per day.*
- *As a dessert, choose a fresh fruit-based option and sometimes as an alternative, a dairy product.*
- *Choose types of cooking that do not add too much fat (steaming, roast, grill, etc.).*
- *Choose water to accompany your lunch.*

Common Recommendation for Restaurants

- *Favour cooking methods such as steam, oven or grill.*

Developing the tools

Nutritional recommendations were translated into a wide range of tools for informing employees and food providers about a balanced and healthy diet. Tools ranged from regular items like posters and leaflets to in-depth information. Guides, videos, on-site training sessions, a blog and websites, an online cooking game, an e-learning DVD for chefs, certificates and window stickers for restaurants, meal vouchers, inserts, and a smartphone application were all developed for this purpose. A geo-localisation tool further enables people to look for a FOOD restaurant near their office or home. Tools are available via the project website in nine languages.

Overall, approximately 4 million employees representing more than 160 000 companies and almost 200 000 restaurants were reached in the six countries with one or more communication tools within the project period. Moreover, face-to-face visits, email communication and pilot studies in three countries (Belgium, Czech Republic and France) resulted in a strong network of nearly 1 800 restaurants following the FOOD recommendations.

Ongoing work

FOOD has successfully managed the often difficult transition from a co-funded project to a self-sustained programme. On 14 December 2011, 23 partners signed a new Consortium Agreement about the continuation of the FOOD programme and took on board two additional countries: the Slovak Republic and Portugal.

Findings and outputs of the FOOD project were disseminated very intensely during the project period as well as after the project was finished. The project was launched to the public in October 2009 with a very successful road show. The campaign 'kicked off' with a double-decker bus travelling to all countries involved, passing through Paris, Brussels, Stockholm, Prague, Milan and ending in Madrid. During the road show, seminars were organised on healthy food, nutritional advice, cooking demonstrations, measurement of body mass index, uses of an overweight stimulator and quizzes and tests about healthy food. This has generated significant media interest. Moreover, FOOD has been presented at more than 50 scientific conferences since 2009. Dissemination is still going on, for example in 2013 FOOD was presented at the 10th World Summit ECOCITY from 25 to 27 September and at the 20th International Congress of Nutrition which took place in Granada from 15 to 20 September.

In December 2012, all results and outputs of the FOOD project were compiled into a final publication. Given the cultural diversity of the participating countries, separate chapters are dedicated to each country in the 204-page-long report. The publication also presents the transition from a co-funded project to a self-sustained programme. The entire document can be downloaded from the project website.

FOOD in numbers in 2013

- approximately 6 million employees;
- more than 200 000 companies;
- 430 000 restaurants;
- network of more than 2 876 FOOD restaurants.

Deliverables

FOR THE GENERAL PUBLIC

- project leaflet in English and French (http://www.food-programme.eu/slider_outils/Annex_10_a_leaflet_of_presentation_en.pdf);
- online cooking game available in seven languages and in different levels according to the cooking skills (<http://game.food-programme.eu/>);
- online FOOD restaurant finder (<http://www.food-programme.eu/en/restaurant-finder-153/restaurant-finder>);
- blog, Facebook page and national websites.

FOR EMPLOYEES

- calendar about fresh fruits and vegetables for the four seasons available in seven languages (http://www.food-programme.eu/slider_outils/Calendar_of_Fruit_and_Vegetables_Sweden.pdf);
- guide / leaflets / cards / posters for employees based on the main FOOD recommendations and practical advice available in different languages (http://www.food-programme.eu/slider_outils/Poster_for_companies_Belgium_nL.pdf);
- shopping list including the main FOOD recommendations and practical advice for Belgium (http://www.food-programme.eu/slider_outils/Annex_52_Belgium_shopping_list.pdf).

FOR PROFESSIONALS (i.e. CHEFS AND RESTAURANT OWNERS)

- certificate and window stickers indicating the commitment to FOOD principles (http://www.food-programme.eu/slider_outils/Certificat_FOOD_EN_A4.pdf);
- guide / leaflet;
- placemat in Sweden (http://www.food-programme.eu/slider_outils/Annex_47_Sweden_Tray_model_sheets.pdf);
- six 5-to-8 minute long videos produced in six languages with English subtitles and containing the following information:
 - national nutrition recommendations shown in a practical way;
 - cooking show and a few pieces of cooking advice presented by a chef

from each nationality, taking into account cultural differences;

- target audience: primarily professional chefs, but can be useful for housewives/husbands;
- available on the website (<http://www.food-programme.eu/en/tools/e-learning-dvd-128>) and also on YouTube.



Useful links

Website: <http://www.food-programme.eu/>

Blog: <http://blog.food-programme.eu/>

Partners

Main Beneficiary:

E DENRED SA
France

Associated Partners:

- Institut National de Prévention et d'Éducation pour la Santé - INPES (until 01/03/2009), France
- Università degli Studi di Perugia, Dipartimento di specialità Medico-Chirurgoche e Sanità Pubblica (UP), Italy
- STOB PLUS OS (STOP PLUS), Czech Republic
- Karolinska Institutet (KI), Sweden
- E DENRED BELGIUM, Belgium
- E DENRED FRANCE, France
- ACCOR SERVICES CZ SRO (AS CZECH REP.) (until 29/06/2010), Czech Republic
- E DENRED ESPAÑA, Spain
- ACCOR SERVICES ITALY SRL (AS ITALY) (until 29/06/2010), Italy
- RIKSKUPONGER AB (AS SWEDEN), Sweden
- Service Public Fédéral Santé Publique, Sécurité de la chaîne alimentaire et environnement - (FESOPH), Belgium
- Agencia española de seguridad alimentaria y nutrición, Spain
- Fundación Dieta Mediterránea, Spain
- Haute École Lucia De Brouckere CIRIHA, Belgium
- Institut Paul Bocuse, France
- E DENRED CZ (from 01/02/2010), Czech Republic
- E DENRED ITALIA (from 01/02/2010), Italy



Making the healthy option available

Healthy Children in Healthy Families

In general these days, people in Europe are living healthier lives and living longer than ever before. Currently, the European population is experiencing a significant increase in life expectancy, now at over 76 years for both men and women⁽¹⁾. This is mainly a result of decreases in certain causes of death and the prevalence of risk factors and increases in socio-economic and living conditions. However, these improvements have not been shared equally within and between countries: substantial differences exist and in many cases are widening.

There are certain areas of Europe, particularly during these times of economic crisis, that have to face big societal challenges such as high levels of immigrants or high ratios of people with low socio-economic backgrounds. As differences in social and economic conditions are the major drivers, health inequalities and their determinants occur prominently in these parts of Europe⁽²⁾. The increasing problems of poverty, social exclusion and health inequalities require new approaches to tackle these problems. Local authorities and organisations have a front line role in addressing health inequalities and are key actors in health promotion.

'Health promotion strategies designed for majority populations are generally not effective for diverse populations'⁽³⁾

'Traditional health promotion activities very often do not reach those people who are most in need'

Health promotion in diverse areas is most effective when congruent with the people's values, beliefs and practices and when provided in the first language of and at an appropriate literacy level for the targeted population. Furthermore, initiatives should be community-driven or developed in collaboration with stakeholders of the targeted community. Effectiveness can be further improved by incorporating community members as role models and by delivering within the community and with the help of community members. Community participation facilitates a sense of ownership and helps ensure that programmes are delivered in a culturally competent manner, both of which ultimately strengthen programme sustainability.

The 'Healthy Children in Healthy Families' project aimed to deliver sustainable services that can contribute to health equity, and adopted local approaches that are in line with the above-mentioned principles. The three-year-long work started in August 2010 under the coordination of University College Lillebælt from Denmark. Both academic institutions and local municipalities were strongly

(1) WHO/Europe (2013): The European health report 2012: charting the way to well-being.

(2) EC Flash report: Health inequalities conference, 23 January 2014.

(3) Alberta health services — Calgary (2009): Health promotion in immigrant and refugee populations: Culturally appropriate strategies for health promotion.

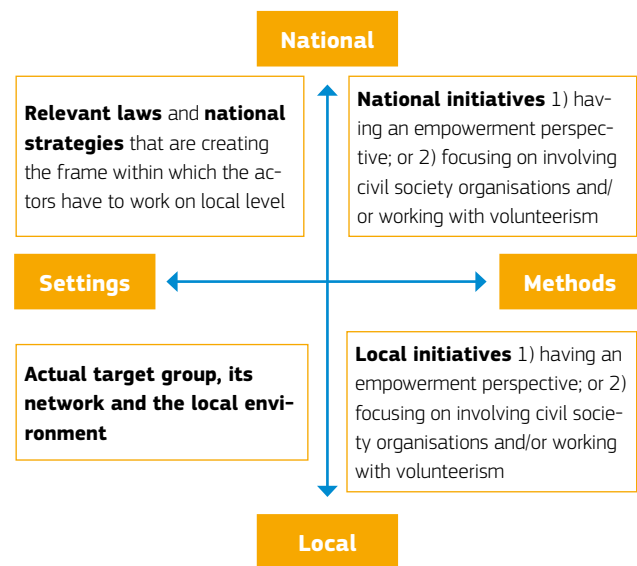
represented in the consortium to create coherence between theory and practice. The project was implemented in 12 local municipalities from six European countries. Each community was characterised by a high degree of immigrants and/or high ratio of people from lower social classes. The general concept of the project was based on a 'local health ambassador' model and an associated training programme enabling persons from informal community networks and organisations like youth clubs, local schools, sport clubs and ethnic associations to promote health among children, young people and their families. The training programme for the 'local health ambassadors' focused on the development of (inter) cultural understanding, coaching and communication- and empowerment skills and strategies for action in areas such as obesity, sedentary lifestyle, unhealthy diet, smoking, alcohol and drugs. By the end, health ambassadors had gained knowledge and skills that helped them to increase awareness and improve health literacy among children, young people and their families.

“The idea of educating “health counsellors” is quite well-known in Denmark.

In a report from the National Board of Health (2005), the authors state that “the use of and education of health counsellors is a frequent and recommendable approach to prevention and health promotion among ethnic minorities”. The health counsellors are often citizens volunteering and not actors from civil organisations’

‘The Healthy Children project developed knowledge on how and where the municipalities can recruit health ambassadors, how they should be trained, how to ensure their continuous commitment and how civil society organisations can be involved.’⁽⁴⁾

Against this background, comprehensive desk research was carried out as a first step to develop ‘an evidence base containing descriptions and analysis of crucial parameters for the project in the participating countries’. The work was organised around four dimensions (see figure). Experts collected relevant initiatives both at national and at local level. Programmes were analysed and used as a source of inspiration for further work. In addition, a broad range of data was gathered to further understand the needs of and possibilities for target groups as well as to study those areas where the project will be implemented. As a result, desk research provided ideas, experiences and recommendations for the upcoming project phases, namely on: 1) training programme and training needs analysis; 2) recruitment of voluntary civil actors; and 3) motivation of the health counsellors.



Competence and needs analysis

Lessons from the desk research have revealed that the real need in the local communities is to get ‘unskilled and peer-like assistance’. Hence, the Healthy Children concept did not aim to train volunteers to become health professionals, but focused more on those social skills and competences that are essential for valuable interaction with children, young people and families and are also relevant for gaining the target groups’ trust and motivating them to adopt healthy habits. Thus, instead of applying a traditional needs analysis method, the project team decided to develop a competence profile for an ‘ideal’ health ambassador as a next step. As a result, the expert group summarised key competences for health ambassadors as follows: basic health knowledge, knowledge of local health system, strong communication skills, good organisational skills, empowerment (ability to increase self-confidence and strengthen relevant skills and knowledge), strong motivation, understanding of ethics and good evaluation skills. Experts also identified some country-specific needs such as being able to work on addiction and drug prevention (including hashish, tobacco and alcohol) with young people and their families.

(4) HEALTHY CHILDREN project.

European frame for the local health ambassador training programme

Using outputs from the desk research and competence analysis, a conceptual framework for the training programme was set up and contained common parts, but stayed flexible thus responding to local needs. The European frame described the fundamental aspects of the training provided, such as the learning objectives, health themes and pedagogical principles. The overall objective of the training programme was to gain the key competences identified and to enable local health ambassadors to: 1) discover risk behaviour and challenges of health in children, young people and their families; 2) initiate health promoting activities for children and young people, and for their families if relevant, in close cooperation with other local civil and public actors; and 3) translate knowledge into specific actions, where the main emphasis was on empowerment.

Besides the European frame, an online sharing point for different education materials that partners identified or developed was set up. This approach ensured that the training programme developed was well adapted to the local structures, culture and health challenges.

Recruitment, training and coaching of health ambassadors

The last project phase was dedicated to testing, evaluating, adjusting and fine-tuning the training materials developed. To foster the recruitment procedure, a wide range of dissemination and communication activities (e.g. advertising in local media, flyers, posters, postcards, conference presentations, direct contact with relevant local organisations) was carried out at local level. In total, 165 volunteers have been recruited and trained to work as local health ambassadors. In most cases, training and health promotion activities were implemented in collaboration with existing local initiatives and through strong cooperation with relevant local organisations. During the project period, health ambassadors worked under the supervision of the national team. By the end, more than 3 300 persons had been reached by the volunteers. The health promotion activities varied broadly in the six participating countries, ranging from organised family dinners through community outdoor sport sessions to a children's choir.

Sustain and upscale results for local communities

Based on feedback from the participating communities, each area managed to mainstream some parts of the project into local health promotion activities. In Vejle, many activities initiated by Healthy Children will continue after the project as both the training programme and the health promotion activities will be integrated into an ongoing local initiative. In Italy, the local health unit has established strong collaboration with the regional voluntary centre. This has created a sustainable structure for ongoing work with volunteers in health promotion. In Spain, there is a high possibility that the Healthy Children approach will be transferred to all local municipalities in the region as it facilitates the implementation of the new health care law. In the UK, there is a chance that the Healthy Children training programme will become a compulsory part of the 'citizenship classes' in secondary schools. In Croatia, the training programme was adopted and is currently used for school-based health promotion activities. Finally, in Norway, the project established and facilitated collaboration between local authorities and local NGOs. This structure ensures the sustainability of the health promoting activities invented by the local Healthy Children team.

Moreover, the results and findings of the Healthy Children project will be utilised in the HEPCOM project aiming to promote and upscale the use of existing health promotion tools and mechanisms. HEPCOM is planning to reach 45 communities across Europe among which one third will be selected from low income areas.

Lastly, the Healthy Children website serves as a toolbox for local communities and civil society organisations that want to find inspiration on how to work more strategically with volunteers as a resource for reaching children and young people in deprived areas with health promoting activities. The team also decided to upload nine digital stories onto the website to explain the philosophy and summarise the main local experiences in a more personalised way.

Strategic areas of the healthy children concept:

- *Political and strategic engagement*
- *Establish a local partnership*
- *Competence and needs analysis*
- *Recruitment of volunteers*
- *Training and education*
- *Health promoting activities*
- *Dissemination*

Deliverables

- Evidence base template: http://www.healthy-children.eu/Portals/24/Gathering%20Evidence%20Template_1.pdf
- Evidence base report: [www.healthy-children.eu/Portals/24/Evidence%20Report%20\(WP4\).pdf](http://www.healthy-children.eu/Portals/24/Evidence%20Report%20(WP4).pdf)
- A snapshot of the 'ideal' health ambassador: www.healthy-children.eu/Portals/24/Training%20Needs%20Analysis%20Template_1.pdf
- European Frame for The Health Ambassador Training Programme: <http://www.healthy-children.eu/Portals/24/Overall%20Frame%20and%20Philosophie%20for%20the%20Training%20Programme.pdf>
- Digital Empowerment. A methodology for digital storytelling: www.healthy-children.eu/portals/24/toolbox/box_Training%20and%20education/01_Methodology_en.pdf
- The project has also developed nine digital stories which are accessible from the website.



Healthy Children

Useful links

Project website: www.healthy-children.eu

Partners

Main Beneficiary:

University College Lillebælt
Denmark

Associated Partners:

- Association for Social Sciences in Extramadura (until 01/01/2011), Spain
- Coventry New Deal for Communities (Coventry City Council), United Kingdom
- Coventry University, United Kingdom
- Instituto Municipal de Asuntos Sociales (Ayuntamiento de Cáceres) (until 01/04/2012), Spain
- Medical School Karlovac, Croatia
- Odense Municipality, Denmark
- Oslo Municipality, Norway
- Regione del Veneto (until 27/08/2010), Italy
- South Denmark European Office, Denmark
- The County of Karlovac, Croatia
- Vejle Municipality, Denmark
- Verona University, Italy
- Ayuntamiento de Arroyo de la Luz (since 01/04/2012), Spain
- Azienda ULSS 20 di Verona - ULSS20 (since 27/08/2010), Italy



Making the healthy option available

SALUX project

'A European network to follow up the reformulation of food. Identification and exchange of good practices for SMEs and consumers.'

In the second half of the 20th century, political and socio-economic developments in Europe resulted in a more secure and abundant food supply than ever before and life expectancy increased steadily⁽¹⁾. However, at the same time a huge increase in several chronic diseases was observed, and it was recognised that these illnesses could be linked to certain dietary and lifestyle factors. In 2003, a Joint WHO/FAO Expert Consultation provided an overview of dietary factors related to undesirable health outcomes⁽²⁾. There was strong evidence that the levels of trans fatty acids (TFA), saturated fatty acids (SFA), salt and sugars were too high in the European diet. Moreover, the expert panel presented convincing evidence that a high intake of these components is linked to an increased risk of chronic diseases such as hypertension, type 2 diabetes, cardiovas-

Dietary factor	Goal
Total fat	15-30 % of energy
Saturated fatty acids	<10 % of energy
Trans fatty acids	<1 % of energy
Total carbohydrates	55-75 % of energy
Free sugars	<10 % of energy
Salt	<5 g/d

cular diseases, stroke and certain cancers. The group made a series of recommendations for action, recognising the role of producers and suppliers in a healthy diet. Furthermore, the Expert Consultation worked out population nutrient intake goals (see table) that should be used in developing healthier food choices.

Reformulation for improving public health

'Reformulating foods and drinks that are actually consumed is crucial for improving public health, as many people are just not interested in healthy eating. (...) An educated population is the most secure foundation for a healthy diet. Education and reformulation are complementary.'⁽³⁾

In the context of healthier food choices, food reformulation can be defined as reformulating existing foods to remove (e.g. trans fatty acids) or reduce (e.g. sugars, saturated fat, salt) certain food components while maintaining characteristics such as flavour, texture and shelf-life. Reformulation of foods is considered one of the key options for achieving population nutrient goals. To date, the compositions of many foods have been modified to assist consumers in bringing their daily diet more in line with dietary recommendations⁽⁴⁾.

The European Commission also acknowledged the potential of reformulation to increase the breadth of healthier choices available

(1) van Raaij, J. et al., (2009): Potential for improvement of population diet through reformulation of commonly eaten foods.

(2) WHO (2003): Diet, Nutrition and the Prevention of Chronic Diseases. Joint WHO/FAO Expert Consultation. WHO Technical Report No. 916.

(3) Winkler, Prof. J., (2013), available at: www.foodnavigator.com

(4) CIAA (2007): Promoting balanced diets and healthy lifestyles: Europe's Food and Drink Industry in Action.

In general, consumers' acceptance, safety aspects, technological challenges and food legislation are the main determining factors for food reformulation.

to the public and the need to assist European citizens in modifying risk behaviour, such as poor dietary habits, that contribute to preventable chronic diseases. Thus, recommendations for the food industry were reinforced in the Commission's Strategy for Europe on Nutrition, Overweight and Obesity related health issues⁽⁵⁾ which was published in 2007 and said: *'Healthy choice is about ensuring the existence of healthy options for the consumer. (...) There is growing interest in the composition of manufactured foods and the role that reformulation can play to make diets healthier. Industry has already taken important steps but these have not always been uniform across products and Member States.'* It stated: *'Private actors have a major role to play in developing the healthy choice for consumers, and in empowering them to make healthy lifestyle decisions: their actions in this area can complement government policy and legislative initiatives at European and national level.'* It made a clear declaration that: *'The food industry (from producers to retailers) could make demonstrable improvements in areas such as the reformulation of foods in terms of salt, fats, particularly saturated and trans fats, and sugars for consumers across the EU and to consider ways to promote consumer acceptance of reformulated products.'*

Challenges of food reformulation

On the other hand, for manufacturers, reformulation is far from simply removing or replacing one ingredient in a recipe; it concerns a whole range of factors⁽⁶⁾. It is crucial to ensure that replacing one ingredient with another actually improves the nutritional properties of the food product significantly, bearing in mind that consumers do not accept any compromise in taste. This demands knowledge about potential substitution ingredients, as well as reconsideration of the overall composition of a food product. New ingredients used in reformulation must be allowed for use in all countries where the product is sold. Besides, different ingredients play their role in the sensory characteristics of a food, and reformulation efforts meeting consumer expectations for taste, texture, colour etc. must be made⁽⁷⁾. In addition to the sensory aspects, salt and to a certain extent sugar traditionally are added to foods for preservation purposes. Also, adapting individual ingredients (e.g. saturated fat) may impact the processing steps required in production. New recipes may necessitate adaptation of technologies involved. Alternative ingredients may require specific handling, or changes in the product technologies, adding to the complexity of reformulation initiatives.

Given the challenging mission of reformulation, particularly for small and medium-sized enterprises (SMEs), the SALUX project was set up to help the food industry — ranging from producers to retailers — to reformulate food, and thereby promote healthy and affordable food choices for consumers across Europe. SALUX worked in particular on the analysis of national and European rules, laws and regulations on food reformulation as well as on the technological and economic influences, and of cultural values that may affect patterns improving nutrition. SALUX also carried out the identification and exchange of best practices in reducing levels of fat, saturated and trans fats, salt and sugar in food manufacturing. In this sense, the network of SALUX collected initiatives from among small and medium-sized food businesses to assess both the impact of programmes and the technical and economic aspects related to food reformulation. The project, launched in August 2011 for a duration of 36 months, was coordinated by Technogrande. The work was based on a network of 15 research centres from 13 countries, namely Italy, Finland, Latvia, Lithuania, Bulgaria, Germany, Romania, the United Kingdom, France, Slovenia, Austria, Hungary and Spain.

'SALUX assumes that the private sector plays a key role in the development of healthy options for consumers and that its cooperation is necessary to complement government policies and legislative initiatives at the European and national levels.'



(5) van Raaij, J. et al., (2009): Potential for improvement of population diet through reformulation of commonly eaten foods.

(6) Available at: http://ec.europa.eu/health/archive/ph_determinants/life_style/nutrition/documents/nutrition_wp_en.pdf

(7) EUFIC (2010): Food innovation and reformulation for a healthier Europe — a challenging mission.

‘The food industry in the participant countries is aware of the importance of food reformulation for the consumer’s health and recognises this issue.’

Current situation and reformulation practices

To have a better understanding of the current situation and practice regarding food reformulation and its different national legislation, a number of activities were done in the first project phase: relevant documents published in the last five years were compiled and analysed and focus group discussions on food reformulation with representatives of policy makers, researchers, the food industry and consumer organisations were organized. Furthermore, self-assessment workshops using SWOT (**S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats) and STEEPV (**S**ocial, **T**echnological, **E**conomic, **E**nvironmental/Ecological, **P**olitical and **V**alue-based issues) analysis for food reformulation were arranged to help identify and classify factors that have, or may have, an impact on food reformulation in local contexts. Also, the legal and regulatory environment in which food producers operate and interact, and other specific issues such as technical requirements and cultural values, and technological/economic barriers related to food reformulation, were considered. As a result, the project team was able to provide a comprehensive overview of the current situation and of food reformulation practices in the participating countries. The experts drew several conclusions, but the most important findings can be summarised as follows:

- Diet-related illnesses are a major concern in each participating country, and health and nutrition action plans were developed to reduce the prevalence of such diseases.
- Due to the EU framework for national action on salt reduction, ongoing reformulation initiatives across Europe mainly focus on salt in most countries, though trans fats and sugar are tackled in some European states.
- Most actions rely on voluntary agreements between authorities and food business operators.
- The most relevant food reformulation actions are those taken by the bakery industry for salt reduction in many partner countries.
- The main barriers to food reformulation are in particular: loss of sensorial characteristics of reformulated foods; quality and safety constraints; requirement of a higher use of additives as substitutes; higher costs of production of reformulated products; the presence of numerous protected productions in some countries and lack of updated legislation.

Compendium of good practices

For the aim of providing updated and sound knowledge of manufacturing reformulated food and of efficient campaigns related to consumer awareness or encouragement of food reformulation, good practices were gathered in the participating countries. Also, the definition of ‘*good practice in food reformulation*’ was an objective of this work. After several discussions with key stakeholders across Europe, the final agreed definition was formulated as ‘*activities that significantly contribute to a healthy diet for the target population and do not compromise the safety, the acceptability or the nutritional profile of the product*’. In total, 27 examples of good practices in manufacturing of reformulated food were collected and 21 campaigns were identified. Good practices were analysed in-depth and findings were summarised in a comprehensive report. The collection of good practices served as guiding principles for SALUX recommendations on reformulation addressing food business operators (SMEs), competent national authorities and scientific and research bodies.

Follow-up of food reformulation activities among SMEs

One of the core project activities was a survey on food reformulation among European SMEs with the aim being to support follow-up of the implementation of the EC’s ‘*White paper on a strategy for Europe on nutrition, overweight and obesity related health issues*’. The survey focused on technical and economic aspects, barriers and timelines related to food reformulation. For this reason, approximately 1 000 SMEs were contacted to provide their feedback about key information gaps identified in earlier project phases. The online data collection started in December 2012 and ended in November 2013 with 594 responses. Almost half of the SMEs reported successful reformulation activities. Bakery products and meat or meat products represented more than two thirds of the reformulated food categories and salt reduction was a focus. In most cases, reformulation was achieved by the reduction of the targeted nutrient. The most relevant problems were related to the sensory, economic and technological aspects. More information, education, guidance and support were mentioned among the most important facilitators for further reformulation activities.

Supporting financial decisions on food reformulation

The main aim of this project phase was informing SMEs and providing them with tools to better understand, manage and fulfil any reformulation process either on their own or with the support of a proper consulting firm; all this, from a cost-effectiveness perspective. As food reformulation is expensive due to the high costs of new ingredients, changes in food processing technology, staff time and training as well as the cost of changing labels, financial decisions should be based on proper estimations. At the end of this work, there will be two outputs: 1) a short 'Reformulation Process Guide for SMEs' including all cost items involved in a reformulation process; and 2) a software tool, in the form of an interactive questionnaire, which will give SMEs more precise indications on the critical issues of a specific reformulation process, thus helping them to avoid and reduce unexpected costs or delays. The analysis has to take into account the complexity of parameters involved in the food reformulation (e.g. costs of raw materials and ingredients, equipment, staff, etc.). In detail, the whole reformulation process, from idea generation to launching the reformulated products onto the market, has to be mapped in order to identify all relevant components.

European Clearing House for Agri-Food SMEs and Consumers

The European Clearing House is an online sharing point and platform for stakeholders with a focus on topics related to food reformulation and consumer awareness. It provides users with relevant information and fosters networking among experts. The Clearing House serves as a hub for initiatives, policies and programmes targeting reformulation, the link between increased consumption of energy-dense, nutrient-poor foods and health, the effectiveness and cost benefit analysis of interventions on fat, sugar and salt, and how to evaluate and monitor industry attitudes (follow-up). Forum participants represent academia, ministries of health, food manufacturers, the catering industry, consumer associations and NGOs.

Deliverables

- Analysis of local context: <http://www.salux-project.eu/en/web/analysis-of-the-local-context-188>
- Report about Good Practices: www.salux-project.eu/upload/deliverables/D6_Report_about_the_Good_Practices_identified_and_analysed.pdf
- Digital platform to manage European Clearing House: <http://www.salux-project.eu/sez/clearinghouse>



salux

Useful links

Project website: <http://www.salux-project.eu/>

Partners

Main Beneficiary:

Tecnogranda SpA - TECNOGRANDA
Italy

Associated Partners:

- Critt Agro-Alimentaire de Haute-Normandie - AGRO-HALL, France
- Campden BRI Magyarország Nonprofit Kft., Hungary
- Campden Technology Ltd, United Kingdom
- Canning Research Institute, Plovdiv, Agricultural Academy of Bulgaria, Bulgaria
- Coordinamento delle Associazioni per la difesa dell'ambiente e dei diritti degli utenti e dei consumatori, Italy
- Emona Nutrition Research and Development Department, Slovenia
- INSTITUTE OF FOOD BIORESOURCES, Romania
- ISTITUTO EUROPEO PER LO SVILUPPO SOCIO ECONOMICO, Italy
- Maa- ja elintarviketalouden tutkimuskeskus, Finland
- State food and veterinary service of the Republic of Lithuania, Lithuania
- Technische Universität Berlin, Germany
- UNIVERSITAT DE LES ILLES BALEARS, Spain
- University of Hohenheim, Germany
- University of Natural Resources and Applied Life Sciences, Austria



Encouraging physical activity

IMPALA project

Improving Infrastructures for Leisure-Time Physical Activity in the Local Arena — Good Practice in Europe

Physical activity (PA) is defined as any bodily movement produced by the skeletal muscles, resulting in increased energy expenditure. Regular PA is associated with a lower risk of cardiovascular and overall morbidity and mortality⁽¹⁾. Indeed, physical inactivity was recently ranked as the fourth major risk factor of mortality worldwide by the World Health Organisation⁽²⁾. But regular PA has many other favourable effects beyond physical and mental health. Sport and PA is a powerful tool for preventing social exclusion and also has a significant effect on the economy. Direct savings can be achieved and the increase of health care expenses can be reined in by promoting health and healthy aging, and preventing illnesses.

‘Starting to exercise more is, in the end, always a personal decision. However, incentives may clearly lower the threshold to start exercising.’⁽³⁾

Findings of the Eurobarometer survey on sport and physical activity (No 334)⁽⁴⁾ — based on the responses of 26 788 European citizens — showed that two thirds of the adult population do not reach the recommended levels of PA. Across the EU, far more people get ‘informal’ physical exercise (in such forms as cycling, walking, dancing or gardening) than play organised sport. While the majority of European citizens (65%) do some form of weekly physical activity, a worrying 25% of respondents are close to being completely phys-

‘Adult diabetes is a good example of the financial impacts of the lack of exercise. It has been estimated that at least 25% of all new cases of type 2 diabetes are brought on by lack of exercise. If people were to exercise more, the number of new diabetics could clearly be decreased and the available savings in treatment costs could be at least €10 million per year.’

T. Loikkanen & S. Vähänen, 2011

ically inactive. The survey reveals large disparities among Member States. Citizens of the Nordic countries are the most active, while citizens of Mediterranean countries and the 12 new Member States tend to exercise less than the EU average. While PA takes place in a wide range of formal settings, two thirds of respondents are not members of any sports clubs or centres. Three quarters of survey participants either ‘strongly agree’ (37%) or ‘tend to agree’

(1) EU Working Group ‘Sport and Health’ (2008): EU Physical Activity Guidelines.

(2) WHO (2009): Global health risks: mortality and burden of disease attributable to selected major risks.

(3) Loikkanen, T. and Vähänen, S., (2011): Health enhancing physical activity is a problem solver.

(4) Available at: http://ec.europa.eu/public_opinion/archives/ebs/ebs_334_en.pdf

‘European data indicate that leisure-time physical activity might yield greater health benefits than PA in other domains.’

Abu-Omar & Rütten, 2008

(38%) that their local area provides them with opportunities to be physically active. But 20% of people ‘tend to disagree’ (13%) or ‘strongly disagree’ (7%) that this is the case. This shows almost no variation from the 2005 survey. Half of European citizens claim (54%) that local governments do enough to provide opportunities for physical exercise. However, 35% of respondents feel that their local authority is not doing all it could.

Infrastructures guiding the way toward a healthy and active life

Physical activity and sport require adequate environments. Indoor and outdoor sports facilities, as well as infrastructures for self-organised PA such as parks, lanes or open landscapes, are major resources for PA and sport all over Europe. Therefore, the way cities are designed and built, and access to the natural environment, can be a great encouragement for or a great barrier to PA and active living⁽⁵⁾. The causal relationships between active living and the physical and social environments are complex. However, creating opportunities for active living should be a priority in urban planning.

How can we improve infrastructure for PA and sport? What are good practice examples of policies and instruments for infrastructure development for PA and sport in Europe? How can we reduce social inequalities in access to and usage of facilities/infrastructure for leisure-time physical activity (LTPA) within and across nations? The IMPALA project was set up to deal with these questions and related challenges.

From January 2009 to December 2010, the IMPALA project group, which consisted of 27 institutions from 12 European countries, worked on identifying, implementing and disseminating good practices in the planning, financing, building and managing of local infrastructures for LTPA. The work was coordinated by the Institute of Sport Science and Sport, University of Erlangen-Nuremberg. To gather the information needed, experts analysed national policies, mechanisms and instruments used in the development of infrastructures for LTPA. The project’s focus was on the following three types of infrastructures:

- sports facilities (such as gyms, swimming pools and sports grounds);
- facilities/infrastructure designed for sports and PA (such as playgrounds, walking and cycling paths);
- facilities/infrastructure not designed for sports and PA, but usable for PA and non-organised sports nonetheless (such as parks, lakes, forests and beaches).

New EU guidelines on improving infrastructures for LTPA

As a major outcome of the IMPALA project, European guidelines for improving infrastructures for leisure-time physical activity in the local arena (*IMPALA guidelines*) have been proposed. These guidelines especially focus on social equity, inter-sectoral collaboration and participation. Based on the information from the project assessment phases, a set of quality criteria for policies and mechanisms was developed. The criteria aim to improve opportunities for achieving the principles of equity, inter-sectoral collaboration and participation.

The guidelines set out ways in which infrastructures for LTPA can be assessed and improved across five key areas: policy-making, planning, building, financing and management. They identify 10 best practices, two per key area.

With regard to planning, the guidelines highlight the importance of strategic and long-term planning. They define a set of planning prerequisites, e.g. inventories of infrastructures and databases on sport and PA behaviour, and describe how those prerequisites can be used to promote social equity and inter-sectoral collaboration. The guidelines also provide a ‘good practice’ checklist for use in compiling and advising about planning parameters and in planning concrete action with relevant stakeholders and diverse population subgroups.

The document is available online in five European languages: English, Czech, German, French and Portuguese. The guidelines will enable other relevant organisations and countries to assess related policies and mechanisms. This can be used for further improvement of policies and mechanisms regarding the development of infrastructures for LTPA.

Finally, IMPALA also set out to contribute to harmonising efforts for the development of local infrastructure for LTPA in EU Member States, helping to reduce inequalities in access to infrastructure for LTPA within and across nations. This latter aspect has been started

‘A central theme is the strong emphasis placed on policy and environmental interventions which appear to show most promise for increasing the population’s PA levels. Key features of such interventions are strong government intervention and leadership, community-based action and the potential of a societal role for the organised sports sector.’

IMPALA guidelines

(5) WHO/Europe (2006): Promoting physical activity and active living in urban environments.

on in the 27 associated countries but the harmonisation process needs further support through implementation procedures.

Assessment of existing national policies, mechanisms and instruments in Europe

The IMPALA project used qualitative interviews with experts and policy makers to collect information about existing policies like national laws, guidelines and action plans. Furthermore, there was a focus group interview with end users of LTPA infrastructure in each participating country. A report summarising the findings from individual and focus group interviews as well as document analyses identified a series of gaps and needs across Europe. One main finding was that in participating countries there are only a few national policy documents available that (indirectly) deal with the development of infrastructure for LTPA. In addition, these documents tend to be generic and do not specify rules or guidelines on how to plan, finance, build and manage infrastructures for LTPA. Available policies mostly deal with one type of infrastructure or specific forms of PA only. IMPALA also found a lack of policies on the broader use of and improved access to existing infrastructures.

Also, the accessibility of infrastructure for target groups and the quality of collaboration between national and local government officials and the end users were discussed. Similarly, serious concerns were raised. There is no integrated/inter-sectoral approach in the development process. Different departments (such as sports, health, agriculture, transportation, recreation and infrastructure) on national or on local level work independently from each other. Also, there is the problem of unequal distribution of sport facilities throughout a country, which is the result of poor inter-municipal communication and the desire for competition at the local level.

Finally, the majority of the countries have some kind of inventory of infrastructures, but these are usually not updated, thus not complete. About half of the countries apply per-capita approaches to developing infrastructures. Only a few countries use systematic and comprehensive approaches to needs assessment or participatory approaches that include diverse stakeholders and sectors.

Guidelines integrated into EU physical activity monitoring framework

Very recently, initial success has been achieved. The IMPALA guidelines were integrated into the EU monitoring framework for the implementation of policies to promote health-enhancing physical activity (SWD(2013) 310 final), based on the EU Physical Activity Guidelines (2008). The monitoring framework accompanies the Proposal for a Council Recommendation on promoting health-enhancing physical activity across sectors (COM(2013) 603 final). Within the monitoring framework, the systematic application of the IMPALA EU guidelines builds on one of two indicators to measure the implementation of the EU physical activity guidelines in the areas of 'environment, urban planning and safety'.

The IMPALA project and the new European guidelines reveal the potential that the process of developing LTPA infrastructures provides for the application of policies and systematic mechanisms that promote social equality, inter-sectoral collaboration and participation.

Deliverables

- IMPALA European guidelines: http://www.impala-eu.org/fileadmin/user_upload/2011_IMPALA_guideline_web.pdf
- Report of WP1 — European comparison of national policies: http://www.impala-eu.org/fileadmin/user_upload/impala_report_wp1_policies.pdf
- Report of WP2 — European comparison of national mechanisms: http://www.impala-eu.org/fileadmin/user_upload/wp2_report.pdf

'In all participating countries, different policy documents exist for active lifestyles among the population, yet infrastructure development is often not considered in those documents.'



Useful links

Project website: <http://www.impala-eu.org/>

Partners

Main Beneficiary:

Friedrich-Alexander-Universität Erlangen-Nürnberg
Germany

Associated Partners:

- Faculdade de Desporto - University of Porto, Portugal
- Faculty of Physical Culture Palacky University in Olomouc, Czech Republic
- Høgskolen i Oslo, Norway
- Istituto Universitario di Scienze Motorie, Italy
- Nederlandse Organisatie voor Toegepast-Natuurwetenschappelijk Onderzoek TNO, Netherlands
- Universidad de Extremadura, Spain
- Université Henri Poincaré - Nancy I, France
- University of Jyväskylä, Finland
- University of Southern Denmark, Denmark
- University of Vienna, Austria
- Lietuvos Kuno Kultūros Akademija / Lithuanian Academy of Physical Education-LKKA-, Lithuania



Encouraging physical activity

PASEO project

Building Policy Capacities for Health Promotion through Physical Activity among Sedentary Older People

Ageing is a shift in the distribution of a population towards older ages. The ageing of Europe is caused by a low birth rate and a higher life expectancy among European populations⁽¹⁾. The rate at which the population ages will increase significantly in the coming decades⁽²⁾, therefore, those programmes ensuring that the older population will be living these extra years of life in good health have become a priority in the public health arena⁽³⁾.

There are several areas of concern that, if effectively addressed, will significantly improve the quality of life for older adults. A physically active life is essential for a healthier older population⁽⁴⁾. Regular physical activity (PA) is associated with greater longevity as well as a reduced possibility of physical disability and dependence as it decreases the risk or slows the progression of several age-related conditions such as arthritis, falls and fractures, ischaemic heart disease, lung disease, cancer, diabetes, obesity and depression. Despite these beneficial health outcomes, two thirds of European older people (age 70+) do not engage in any sport or exercise⁽⁵⁾. This emphasizes the great potential of PA to enhance overall health and well-being with ageing and has resulted in an increase in the number of programmes developed to promote PA for older people. Despite the large number of interventions, many projects are not sufficiently implemented or results are not utilised. Strong political engagement, clearly defined leadership for actions

'In 2011, 17.5% of all EU citizens were over the age of 65. The number of aged citizens is expected to nearly double by 2060.'

EUROSTAT

and multi-sectoral involvement are identified as keys to success on both European and national level⁽⁶⁾.

A robust and powerful collaboration between researchers and policy makers

The PASEO project aimed to improve the implementation of programmes by building the necessary policy capacities in 15 European countries. The work was coordinated by the Institute of Sport Science and Sport, University of Erlangen-Nuremberg. Mechanisms to strengthen capacities were intended to be sustained after the project ended. To ensure that the proposed work achieved its foreseen goals and also to multiple its effectiveness, nations were represented by a scientific and a politically influential governmental or non-governmental institution in each participating country. The

(1) Eurostat (2012): Population structure and ageing.

(2) Eurostat (2011): EUROPOP2010 — Population projections.

(3) WHO (2002): Active Ageing: A policy framework.

(4) WHO (1998): The role of physical activity in healthy ageing.

(5) EC Eurobarometer (2010): Sport and physical activity (No 334).

(6) WHO Regional Office for Europe (2007): Steps to health: a European framework to promote physical activity for health.

‘The European Network for Action on Ageing and Physical Activity (EUNAAPA) was a thematic, collaborative network aiming to improve the health, well-being and independence of older people throughout Europe by the promotion of evidence-based physical activity. (...) In January 2009 partners continued collaboration in the PASEO project.’

EUNAAPA project

academic institution (usually a university) was responsible for the scientific input, monitoring and moderation of the national implementation, while the collaborating partner (usually a ministry or a large NGO) supported the execution through its political influences and networking capacities. The project, with a timeframe of 30 months (January 2009 – July 2011), was built on the network and experiences of the previously funded EUNAAPA project (2006–08).

Assessing existing capacities — interesting but very diverse results

First, the PASEO team collected information on existing capacities from policy makers via qualitative interviews (10 to 19 per country) and feedback workshops. The focus was on organisational goals, resources, obligations, opportunities and cooperation with other sectors concerning promotion of PA among sedentary older people. Interviewees represented organisations from the sport, social care, health and other sectors. Findings were summarised in the *‘European report on existing capacities for the promotion of physical activity among sedentary older people’* and presented to policy makers at feedback workshops, resulting in the selection of suitable organisations for national alliances. To better identify the needs and points of view of targeted end users, focus group meetings with older people were also organised in each country.

‘It is notable that several countries do have a large offer, but there is no coordination or inventory. Older people don’t have a clear overview of the existing possibilities, facilities and programmes. Mapping out the offers is also a challenge for the national alliances.’

WHO Health promotion glossary

Results guided the planning process for capacity building. For example, the initial determinant analysis conducted for the German state of Bavaria showed, among other things, that many organisations had a high level of obligations to become active in PA promotion for older people but needed to specify their goal definitions in the field. In Portugal, the conclusions demanded that more investment/importance be placed on elderly PA, as well as more interactions between the health, sports, social and communication sectors. These findings served as a starting point for further actions. In addition, several partners indicated that an alliance of different organisations could contribute to a significant increase of shared knowledge between sectors and organisations. This structure would also facilitate reaching the target group (i.e. sedentary older people) and obtaining financial grants, both of which were claimed to be among the main barriers to success.

Forming national alliances to strengthen policy capacities

The following step was to set up or, alternatively, extend the scope of existing national or regional alliances. The rationale behind this structure was strengthening policy capacities in two key areas: (1) intersectoral structures and (2) intra-organisational capacities.

Strengthening intersectoral structures included building the national alliances with representatives from different sectors committed to working on the project topic and developing means to overcome sectoral barriers in this area. Meanwhile, increasing intra-organisational capacities (i.e. personnel, resources and cooperation within organisations) included working with organisations to qualify personnel, allocate resources and engage in cooperation to develop means for the promotion of PA among sedentary older people.

‘It can at times be very difficult for scientific institutions to engage policy makers in a continued dialogue on health promotion policy.’⁽⁷⁾

Forming national alliances was not an easy task, and PASEO partners made a tremendous effort to overcome these obstacles. To summarise barriers, time was the major difficulty mentioned by several countries, mostly due to tight schedules, political changes, long decision-making processes, organisations’ lack of time, and non-matching timelines between research and policy. Resistance to action was another barrier, in the form of both lack of interest and attraction and lack of cooperation between sectors, organisations and political power. One more obstacle described was the lack of resources, especially financial resources for the actions, but also human resources.

Despite these problems, alliances were successfully established in each participating country and planning processes were initiated by the end of the first project year.

Knowledge exchange between researchers and policy makers

In all nations, important and powerful governmental and non-governmental organisations committed themselves to take action for the promotion of PA among older people, including public health promotion agencies, sport federations, senior citizens’ associations, as well as national or regional ministries in Austria, Belgium, France, Germany and Spain. In several countries, the PASEO alliances were linked to national action plans for physical activity

(7) PASEO project: Collection of minutes of constituent meetings of national alliances (D2).

'Alliance is defined as a partnership between two or more parties that pursue a set of agreed upon goals in health promotion'

WHO Health promotion glossary

promotion. Once the alliances had been established, PASEO project partners led the groups through a cooperative planning process (four to six pre-structured meetings) to strengthen capacities. The main areas of discussion depended on the capacities and deficits identified previously as well as on the composition of the alliance, and included:

- developing intersectoral structures;
- developing intra-organisational capacities;
- raising awareness about the importance of building capacities;
- financing the implementation of the action plan;
- sustaining national alliances beyond PASEO.

PASEO IN NUMBERS IN 2011

- 234 interviews with policy makers
- 130 organisations in the national alliances
- 15 Catalogues of Actions
- 110 individual actions planned
- 70% of actions partially or fully implemented

The primary output of this work was '*Catalogues of Action of the national alliances*' containing specific actions and measures to be implemented to strengthen capacities for PA promotion among sedentary older people in the respective country. There was wide diversity in the content and comprehensiveness of national action plans, but some types of activity are included in many of the documents, e.g. training courses for professionals working with older people, specific events for awareness-raising among older people, booklets/flyers/website to increase knowledge and motivation/participation of the elderly in PA, an inventory of PA facilities, and the search for external funding.

Supporting and monitoring the capacities' strengthening process

70% of the specified actions were fully (40%) or partially (30%) implemented within the project period. In those cases where measures were not carried out within the project duration, respective partners were continuing to seek opportunities for execution.

Two online surveys of all alliance partners were conducted in December 2010 and June/July 2011. The surveys, the Catalogues of Action and the meeting minutes were analysed with respect to the development of capacities. Almost all PASEO partners succeeded in organising regular follow-up meetings of their alliance. Satisfaction levels of alliance members in different aspects of the meetings were high. There were some concerns over the level of commitment and willingness to work together, however, despite this, more than 50% of the alliance members thought this was satisfactory. Most importantly, both intersectoral and intra-organisational capacities increased according to most

members. In almost all cases, project participation led to new contacts and collaborations. Additionally, there was an increase in planned activities, newly formulated goals regarding the topic of PA promotion and especially cooperation with new sectors.

Significant interest from policy makers

Project results were directly disseminated to policy makers at a workshop in Brussels in May 2011, which was attended by around 80 persons in total. The workshop was especially notable due to the high-ranking profile of the organisations and individuals represented, including European NGO networks from the sport, health-care and social sector as well as national and regional ministries. Speakers included representatives of EU institutions (DG SANCO, DG RTD), national policy makers (Secretary of State, Ministry of Health, Norway) and European-level NGOs (sport sector: International Sport and Culture Organisation — ISCA; ageing: AGE Platform). A policy brief summarising the project's background, concept and achievements has been prepared to support dissemination to policy makers. In addition, the project has been presented at various European, national and regional-level events, and findings published in prestigious scientific journals. Moreover, more than 2 000 files have been downloaded from the project website, mostly project flyers in one of the 13 languages available.

PASEO continues beyond the project

Many of the alliances have continued to exist in some form since the end of the project funding, and a few of them promise to play a significant role in their country's PA promotion landscape:

- The Austrian alliance has been carried on by the Viennese public health authority, which has published the Austrian PASEO action plan and continues to offer physical activity classes for senior citizens in general as well as for select target groups (e.g. migrants and seniors of an advanced age). Additional activities include regular training academies for instructors, promotion weeks and a separate sub-project for quality assurance.
- The Belgian alliance continues to exist as an advisory board to the Flemish Minister of Sports. It has set up a workgroup that is currently preparing a plan for renewing the Flemish policy on physical activity in older adults.
- The Czech alliance 'Senior 21' continues to exist as an information platform for partner organisations to share experiences, theoretical background information and news concerning upcoming policies, conferences and seminars.
- The French alliance has been continued in the Region of Lorraine and currently focuses on providing a collaborative platform for professionals and older people to exchange information on physical activity recommendations and existing offers.
- The three local-level alliances that were forged in Italy in the course of PASEO continue to be active. In the period ahead, the alliances will focus on providing new physical activity options to older people, on scientific monitoring and on dissemination of information on the benefits of physical activity to general practitioners.
- The Lithuanian alliance continues to influence national policy making in the field of health promoting physical activity for all age groups. It has implemented a project to develop a Lithuanian online version of the IPAQ physical activity questionnaire funded by the national Ministry of Health. More recently, it organised a large national conference on physical activity and

public health in cooperation with the Lithuanian Parliament and other national sport and public health organisations.

- The Dutch alliance also continues to exist, currently focusing on the field of physical activity for older people in institutionalised care.
- The Portuguese national alliance continues to run the Portuguese National Walking and Running Programme, which currently involves more than 160 training centres with more than 100 different activities each year. Currently, the group is working on the utilisation of tools to monitor physical activity in the programme.



Useful links

Project website: <http://www.eunaapa.org/Home/>

Selected national alliance websites (in national languages):

- Austria: <http://www.wig.or.at/Bewegtes%20Altern%20in%20Wien.40.0.html>
- Czech Republic: <http://www.senior21.cz/o-alianci/>

Partners

Main Beneficiary:

Friedrich-Alexander-Universität Erlangen-Nürnberg Germany

Associated Partners:

- DEMOCRITUS UNIVERSITY OF THRACE, Greece
- Faculdade de Desporto - University of Porto, Portugal
- Faculty of Physical Culture Palacky University in Olomouc, Czech Republic
- Høgskolen i Oslo, Norway
- Karolinska Institutet, Sweden
- Lietuvos kuno kultūros akademija, Lithuania
- National Institute of Public Health - National Institute of Hygiene, Poland
- Nederlandse Organisatie voor Toegepast-Natuurwetenschappelijk Onderzoek TNO, Netherlands
- Universidad de Extremadura, Spain
- Università degli di Verona, Italy
- Université Henri Poincaré - Nancy I, France
- University of Jyväskylä, Finland
- University of Vienna, Austria



Encouraging physical activity

PHAN project

Promoting networking and action on healthy and equitable environments for physical activity

The EU Physical Activity Guidelines, which were endorsed by EU Sport Ministers at their informal meeting in December 2008, has made a clear statement on the strong connection between physical activity (PA), health and quality of life. It has been proved that an inadequate level of physical activity is an independent risk factor for many chronic illnesses, including cardiovascular diseases, type 2 diabetes and depression and it increases the risk of certain cancers, such as breast and colon cancer. Furthermore, living a physically active life brings many other social and mental benefits and there is a direct link between PA and life expectancy, such that physically active populations tend to live longer and healthier lives than inactive ones.

Currently, there are many concerns that PA among children and youth has been replaced by more sedentary activities. This change has coincided with increasing rates of childhood obesity as well as some conditions that were very rare in this age group 20 years ago (e.g. type 2 diabetes and hypertension). Physical inactivity is also a problem among adults, and the level of inactivity is even higher in the socially disadvantaged groups (SDG) mostly due to their more restricted access to and opportunities for leisure-time PA.

‘There is evidence that anyone who increases their level of physical activity, even after long periods of inactivity, can obtain health benefits irrespective of their age. It is never too late to start.’⁽¹⁾

While participation in PA plays a significant role in improving health

‘Scientific evidence shows that physical inactivity is a leading risk factor for ill health, and that socially deprived groups tend to have low levels of activity.’

WHO/Europe

status, creating opportunities to be more physically active became a priority at both European and national level. This also requires action and support from non-health sectors, such as education, sports and leisure, transport and urban planning. Ensuring that existing or planned PA opportunities/facilities meet the particular needs of the targeted groups is a key for success. Many characteristics of good practice, such as community involvement, partnership working and sustainability apply to all PA projects but there are some specific elements of initiatives targeting youth or SDG.

In February 2010, the European Commission and the WHO Regional Office for Europe jointly launched the PHAN project to address inequalities in PA participation and to increase the level of PA in the long term. Under the umbrella of PHAN, numerous activities were carried out with a common goal of providing Member States with guidance, tools, good practices and exchange platforms regarding PA promotion, with a particular focus on children and SDG.

(1) EU Working Group ‘Sport and Health’ (2008): EU Physical Activity Guidelines.

The project aimed at contributing to these goals through several cross-sectoral networks, and through improved tools for planning and economic assessment of PA promotion. PHAN also supported activities for achieving the targets set at the Fifth Ministerial Conference on Environment and Health and complemented a parallel WHO/DG EAC project (NET-SPORT-HEALTH) as well as the MOVE project.

PHAN involved partners from different sectors such as transport, urban planning, education, tourism, sport and leisure. The group of experts and stakeholders involved was based on existing broad networks such as the Transport, Health and Environment Pan-European Programme (THE PEP), the European Network for Health Enhancing Physical Activity (HEPA Europe), the CEHAPE Youth Network and the WHO Healthy Cities Network.

Networking was a key

The project was built on existing strong partnerships, however it also established several cross-sectoral networks of experts, stakeholders and practitioners across Europe. By building on existing partnerships, special networks were formed around the specific objectives of the project, addressing socio-economic inequalities, youth, tools for PA planning, action at local level and international exchanges of expertise and experience in promoting PA. HEPA Europe acted as a shared 'network of networks' for the project, providing the hub where different working groups and actors, from academia to cities and youth, met in different configurations and working groups.

Networking on inequalities: guidance on promoting physical activity in socially disadvantaged groups

To address inequalities in PA levels, one focus of the PHAN activities was to identify good practices and develop policy guidance to promote PA in SDG with a focus on healthy environments. First, experts summarised and reviewed available evidence on determinants of PA in this particular group and the potential underlying mechanisms. In addition, 93 case studies were collected from which 29 were selected and analysed in-depth. A key dimension of this work was the derivation of recommendations on 'How to target and include socially disadvantaged groups', 'How to deliver interventions that are effective' and 'How to set and monitor realistic objectives and targets'. Furthermore, the compilation and analysis of national policies in relation to the inclusion of disadvantaged groups were carried out. Findings were summarised in a comprehensive report that gave a detailed overview of methods and conclusions on the reviewed evidence, case studies and policies. Key messages were also derived to compile a policy summary that provided future guidance for policy makers. Due to the wide range of target groups and possible interventions, the guidance avoided giving prescriptive recommendations. However, socially disadvantaged groups may need more intensive support at all stages of a project, delivered through a variety of strategies that go beyond information provision.

Networking on improved tools for integrating physical activity into city planning and economic assessment

'People's participation in PA is influenced by the built, natural and social environments in which they live as well as by personal factors such as sex, age, ability, time and motivation. Local governments have a crucial role to play in creating environments that promote opportunities for PA and active living.'⁽²⁾

A network of experts was established to strengthen exchanges of experiences with tools for integrating PA into planning and economic assessment of transport infrastructure and to train and continually support the usage of tools by the participating cities. PHAN set out to recruit 4–5 cities from different parts of Europe and with different PA promotion policy and urban contexts. For that purpose, the European network of Healthy Cities was used as an ideal recruitment hub. Finally, five European cities applied one or more of the selected PA assessment and planning tools and shared their experience for further improvements. The available tools were the 'Health Economic Assessment Tool (HEAT) for cycling and walking', 'A healthy city is an active city: physical activity planning guide' and 'Guidance for economic valuation of transport-related health effects'. A booklet on lessons learned from cities applying HEAT was published as a final step.

Principles for targeted actions:

- Identify the target group and the expected outcomes specifically.
- Recognise that more effort may be required to reach the target group.
- Consider using peers or local facilitators (local champions) to promote activities.
- Include evaluation in comparison to other population groups, recognising that health improvements can only be achieved in the long term.
- Combine changes to the environment with behavioural, social and/or information-related measures.
- Ensure that the target group has easy access to opportunities for physical activity.

In the upcoming project phase, the project group decided to choose HEAT for walking and HEAT for cycling as the two tools to update. Improvements addressed some of the main issues raised by the project cities and focused on four main areas: methodology, usability, reliability and dissemination. To foster the usage of HEAT, monthly interactive training sessions have been conducted for free online since October 2012. Over 520 participants have been trained to date and the training efforts continue beyond the PHAN project. As a result, HEAT has been used not only in the five participating cities, but also further beyond, including evaluations of national cycling plans, transport appraisals and scientific studies.

(2) WHO/Europe (2006): The Solid Facts — Promoting Physical Activity and Active Living in Urban Environments — the Role of Local Governments.

Networking on youth involvement: making physical activity more appealing

What can we do to make PA more friendly and attractive to young people? Although significant progress has been made across Europe in terms of funding, implementing and evaluating PA projects, a deeper understanding of young people and their needs is still required to increase the participation level.

So the PHAN team decided to actively involve a group of youth in a certain project phase to gather their views, experiences and perspectives on this issue. For that reason, 27 delegates from 19 countries were invited to attend a workshop at the 5th Ministerial Conference on Environment and Health in Parma in March 2010. During the workshop the delegates identified 18 Key Aspects from the area of physical and social environment that influence the experience of PA. Particularly important in the physical environment was easy access in terms of both costs and location. In the social environment, a supportive culture and a healthy and adaptive attitude fostered by high-quality mentors and role models were highlighted as main aspects.

This extensive work resulted in one of the main PHAN deliverables, namely *'Young and physically active: a blueprint for making physical activity appealing to youth'*. In this report each of the 18 Key Aspects was discussed in-depth and illustrated by one or more case studies. Case studies were collected through contacts, networks and internet searching with a representative geographical spread. The studies identified ranged widely from full national projects to individuals working in PA with children (e.g. PE teachers). The entire document is available for the general public in English, German, Russian and French.

Most importantly, the group of youth that contributed to the development of the Blueprint is continuing to work together under the newly established European Environment and Health Youth Coalition (EEHYC), which has made PA promotion one of the thematic areas in which the EEHYC intends to promote action and support national governments in the implementation of relevant international commitments.

Strengthen networking and exchange on physical activity promotion

This work provided a platform to evaluate and exchange on the activities of PHAN and to launch project results and publications. This forum was facilitated through three annual HEPA Europe meetings (6th in Olomouc, Czech Republic, 7th in Amsterdam, the Netherlands, 8th in Cardiff, United Kingdom) that brought together the European and international expert community on PA promotion. PHAN supported the organisation of these events.

The physical environment

- *Location — ensure ease of access*
- *Costs — keep these low or preferably free*
- *Outdoor activities — include if possible*
- *Air pollution — avoid polluted locations*
- *Walking and cycling — include if possible*
- *Equipment and facilities — ensure high quality*
- *Sports clubs — use if possible*

The social environment

- *Activity culture — promote positive attitudes*
- *Healthy competition — focus on personal achievement*
- *Mentors — include if possible*
- *Socialising — provide opportunities to develop friendships*
- *Health awareness — emphasize the benefits*
- *Choice — include opportunities*
- *National activities and famous people — include if possible*

The experience of participation

- *Independence and self-confidence — aim to develop*
- *Relaxation — include as an outcome of your activity*
- *Avoid too much activity and the possibility of injuries*
- *Fun — make sure your activity is enjoyable*

Networking towards sustainable results

In all aspects of the project the best available use of networking infrastructures was made, notably the HEPA Europe platform, and emphasis was placed on further developing and strengthening these infrastructures, rather than on starting short-lived ad-hoc initiatives that would have most likely dissolved at the end of the project. The project also capitalised on existing resources and political platforms, such as the WHO European Environment and Health Process, both to ensure the greatest efficiency in the use of resources and to maximize the links with and relevance to structures and platforms that are instrumental to ensuring the sustainability of the project outcomes.

Main deliverables

- Physical activity promotion in socially disadvantaged groups: principles for action.
- Full report: http://www.euro.who.int/__data/assets/pdf_file/0005/185954/E96817eng.pdf
- Policy summary (available in German, French and English): http://www.euro.who.int/__data/assets/pdf_file/0006/193092/PHAN-brochure_ENG.pdf
- Young and physically active: a blueprint for making physical activity appealing to youth (available in German, French, Russian and English): http://www.euro.who.int/__data/assets/pdf_file/0005/175325/e96697.pdf
- Health economic assessment tools (HEAT) for walking and for cycling.
- Web-based tool: <http://www.heatwalkingcycling.org/> and <http://www.euro.who.int/HEAT>
- Methodology and user guide (available in German, French, Polish and English): http://www.euro.who.int/__data/assets/pdf_file/0003/155631/E96097rev.pdf



World Health Organization

Useful links

Project website: <http://www.euro.who.int/PHAN>

Final PHAN project leaflet: http://www.euro.who.int/__data/assets/pdf_file/0016/240334/Networking-for-Physical-Activity-brochure.pdf

PHAN project leaflet (available in German, French and English): http://www.euro.who.int/__data/assets/pdf_file/0005/135149/e94835.pdf

Related networks:

HEPA Europe: <http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/activities/hepa-europe>

Transport, Health and Environment Pan-European Programme: <http://www.thepep.org/en/welcome.htm>

CEHAPE Youth Network: <http://www.euro.who.int/en/media-centre/events/events/2010/03/fifth-ministerial-conference-on-environment-and-health/preparation/youth-participation>

European Environment and Health Youth Coalition: <https://www.facebook.com/EEHYouthCoalition>

WHO Healthy Cities Network: <http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network>

Partners

Main Beneficiary:

WHO Regional Office for Europe,
European Centre for Environment and Health
Denmark



Encouraging physical activity

MOVE project

European Physical Activity Promotion Forum

Health inequalities are preventable as are unjust differences in health status experienced by certain population groups⁽¹⁾. People with a lower socio-economic status (SES) are more likely to experience chronic ill-health and die earlier than those who are more advantaged⁽²⁾. Health inequalities are not only apparent between people of different socio-economic groups — they exist between different genders and different ethnic groups.

Inequalities in health have been an important part of the work of the European Union (EU) since 1992 when specific competencies for public health were included in the Maastricht Treaty. However, large differences in health still exist between and within all countries in the EU, and some of these inequalities are widening⁽³⁾. In 2009, the European Commission adopted a communication on *'Solidarity in health: reducing health inequalities in the EU'* and made clear statements on the importance of addressing and tackling health inequalities, both between and within Member States.

'Inequalities in health arise because of inequalities in society — in the conditions in which people are born, grow, live, work and age.'⁽⁴⁾

The causes of health inequality are complex but they do not arise by chance. The social, economic and environmental conditions in which we live strongly influence health. The communication *'Solidarity in health'*

'Despite improvements in health overall in Europe, health inequalities are worsening.'

A. Gulland 2013

pointed out that health inequalities are due to differences between population groups in a wide range of factors including: living conditions; health-related behaviour; education, occupation and income; health care, disease prevention and health promotion services.

So, the fact that European adults with low socio-economic backgrounds are generally less physically active than those of high SES sees the gap widen further.

'Socially disadvantaged groups face many barriers to an active lifestyle. They have less free time and money; they often have poorer access to leisure facilities and sometimes they simply live in environments that do not really support physical activity.'⁽⁵⁾

(1) Institute of Public Health in Ireland.

(2) Commission Communication (2009): *Solidarity in Health: Reducing Health Inequalities in the EU*. Available at: http://ec.europa.eu/health/ph_determinants/socio_economics/documents/com2009_en.pdf

(3) EC (2013): *Report on health inequalities in the European Union*.

(4) Michael Marmot, Fair Society, Healthy Lives (2010): *Marmot Review*.

(5) MOVE pamphlet.

Given that socially disadvantaged groups (SDG) have lower levels of physical activity (PA) and higher levels of ill-health than the general population, the rationale for focusing PA promotion on these groups cannot be disputed. Thus, the three-year MOVE project was initiated to build capacities for serving socially disadvantaged groups mainly among MOVE partners and their networks. The project focused on three action areas: 1. Identification, assessment and promotion of good practices; 2. Mobilisation of cross-cutting partnerships and networks in PA; and 3. Implementation of pilot actions. In this effort, MOVE targeted four groups of people: youth (12–22 years old), ethnic minorities and immigrants, girls and women and seniors experiencing social disadvantage.

Building on high-impact cross-cutting partnership

Taking up the challenge of the foreseen task required a cross-sectoral approach, which was reflected in the broad partnership behind the project. In order to combine the interdisciplinary know-how, experience and strength, the sport sector, the academic sector, the commercial fitness sector and the architect/urban planning sector were represented in the consortium by eight associated partners and 15 collaborating partners. An initial assessment of partners' capacities for serving socially disadvantaged groups was carried out. The assessment was done via qualitative interviews and focused on the goals, resources, opportunities and obligations of each partner. These assessments served as baseline perceptions of the capacities of each partner. In February 2014, each partner also participated in a post-project interview to determine if and how capacities had changed as a result of the MOVE project.

'Physical activity paves the way for a good life on so many levels. But vulnerable groups are by far less physically active and therefore excluded from the many benefits of an active lifestyle. With MOVE we want to change this.'

Cliff Collins, EHFA

MOVE-ing towards a comprehensive good practice collection across Europe

MOVE activities got underway in March 2011. The first phase focused on the identification and assessment of good practices in community initiatives to promote PA for the specific MOVE target groups. Based on an extensive literature review, a working definition of good practice was adopted and a data collection template was developed for gathering experiences from previous projects. The final form collected data on contact information, approaches and key activities, the target group, the funding and partnership, monitoring and evaluation, project sustainability and transferability and lessons learned.

The MOVE Call for good practices was launched during the MOVE2011 congress. Organisations across Europe were invited to submit their own project experiences via an online survey on the 'WeMoveYou' platform. The Call was closed after eight months with a total of 164 project descriptions. The practices collected were analysed according to a standardised protocol and 109 initiatives were qualified as good practices at the end. The results of these extensive efforts have been the MOVE Handbook and the WeMoveYou web platform with a searchable database of Good Practices. The handbook summarises a number of learning points for PA promotion in socially disadvantaged groups and provides important lessons for those organisations who are already working or planning to work in this challenging field.

From best practice inspiration to pilot project implementation

Drawing inspiration from the collection of good practices, 15 pilot projects were implemented at the local or national level, giving partner organisations fresh opportunities to learn and generate knowledge about promoting PA in socially disadvantaged groups.

For the pilots, partners adapted existing organisational activities to include elements of good practice in one of three areas: management quality, networking or sustainability. Experiences were shared via an online forum which fostered discussions between partners about specific problems and solutions related to the implementation of certain good practices. To further assist the research team, the University of Erlangen-Nuremberg provided consultations via site visits to each pilot project. All partners presented their pilot projects at the MOVE2013 congress in Barcelona and engaged in in-depth discussions with congress participants.

Pilots played an important role in building partnerships and capacities to develop future health-enhancing PA initiatives for socially disadvantaged groups. Additionally, all MOVE partners engaged in further capacity building activities, such as workshops and online discussions to foster networking.

'MOVE is an excellent platform for cross-sector networking and engaging important players that can help us to win the fight for empowerment and social inclusion of disadvantaged young people in Europe.'⁽⁶⁾

(6) ISCA annual report 2012.

'Researchers will need to be proactive in helping to overcome the considerable barriers to working with hard-to-reach populations, including difficulties in recruitment, retention, programme tailoring and flexible delivery, as well as partnerships working to make a difference in getting people more active.'

PHAN project

Everybody's business, also yours! — promotion of MOVE

Promotion of the MOVE project has been carried out through several channels such as the project pamphlet, websites and newsletters for the project partners and for their networks. However, the most important promotion venues were the biannual MOVE congresses, the 'WeMoveYou' web platform and presentations at local, national and European level.

The open-access web platform played an important role in the process of collecting and promoting good practices and served as a hub for sharing information and news about project progress. At the end of the project, the platform will feature a database containing the good practices collected.

The MOVE congresses served as important settings for sharing the learning points contained in the good practices and the pilot projects. The congresses highlighted the challenges and the linkages regarding PA and outreach to socially disadvantaged groups and were feature national and local initiatives that engaged the specific MOVE target groups in innovative and successful ways.

In 2011, the MOVE congress attracted more than 250 participants from all over the world and from very diverse backgrounds: sport organisations and city administrators, private businesses and international institutions, political decision makers and local activists, club coaches and medical doctors. As reflected by the congress programme, several sessions were dedicated entirely to issues related to socially disadvantaged groups and their engagement in PA, and a considerable number of specific sessions dealt with target groups that are central to the MOVE project: youth, girls and women, ethnic minorities and seniors who are socially disadvantaged. Social inclusion and the MOVE project were prominent themes at the MOVE Congress 2013 which was attended by 290 participants from 54 countries. The overall theme looked at innovation, opportunities and changing approaches to tackling the physical inactivity epidemic. Feedback from both congresses was on the whole very positive especially in terms of overall quality of the congress sessions, meeting their expectations of the congress, the number of new contacts and obtaining new ideas from the congress for the participants' own organisations.

Mobilisation of partnership to ensure sustainability

Mobilisation of partnerships is especially important as they will contribute to sustaining the commitments after the end of the project. Thanks to the efforts of the MOVE team, outcomes markedly exceeded the original goal at European/international level (*17 partnerships mobilised versus five planned*); in addition, at national and local level, the numbers planned were achieved (*11 and 50, respectively*). These achievements are very relevant as they created a powerful and sustainable network for promoting PA in socially disadvantaged groups.

MOVE in numbers

- 164 project descriptions were collected
- 109 of these were qualified as good practices
- 15 pilot projects were implemented
- 17 European/international level partnerships were mobilised
- 11 national level partnerships were mobilised
- 42 local & 8 regional partnerships were mobilised

'Lack of role models, disposable income, accessible facilities and awareness of where, how and why to engage in physical activity all constitute barriers to taking up physical activity.'



Useful links

Project website: <http://www.wemoveyou.eu/>

Website of the congress in 2011:

<http://www.move2011.info/>

Website of the congress in 2013:

<http://move2013.info/>

ISCA (International Sport and Culture Association) website:

<http://www.isca-web.org/english/home>

Partners

Main Beneficiary:

International Sport and Culture Association
Denmark

Associated Partners:

- Associació Esportiva CESS, Spain
- Centre for Sports and Architecture at the School of Architecture, Royal Danish Academy of Fine Arts, Denmark
- European Health and Fitness Association, Belgium
- Federation of the European Play Industry, Belgium
- Friedrich-Alexander-Universität Erlangen-Nürnberg, Germany
- Johann Wolfgang Goethe-Universität, Germany
- streetfootballworld gGmbH, Germany
- Università Degli Studi Di Cassino, Italy



Priority groups and settings

Health 25 project

Health promotion for disadvantaged youth

The future of Europe depends on young people, who represent just under one fifth of the EU population⁽¹⁾. In 2012, there were around 92 million youth aged 15–29 in Europe. Leaving formal education (school or university) is a crossroad in life requiring young people to decide either to enter the labour market or to be inactive. In 2011, the employment rate was only 33.5% for those aged 15–24 years, the lowest figure ever recorded by Eurostat.

NEET is an acronym for a young person who is 'Not in Education, Employment or Training.'⁽²⁾

The definition of NEET is in principle straightforward, referring to those who currently do not have a job, are not enrolled in training or are not classified as a student. It is a measure of disengagement from the labour market and perhaps from society in general.

Youth is a special period of life. Although most young people are healthy, more than 2.6 million young people aged between 10 and 24 years die each year worldwide⁽³⁾. A much greater number of young people suffer from illnesses and a greater number still engage in behaviour that endangers not only their current situation, but often their health for years to come. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviour that began in their youth, including among others tobacco use and a lack of physi-

In 2011, 7.5 million young people aged 15–24 and an additional 6.5 million young people aged 25–29 were excluded from the labour market and education in Europe.

EUROSTAT

cal activity. NEETs have an increased risk both of suffering from illnesses and of being engaged in unhealthy behaviour. Therefore, promoting a healthy lifestyle and taking steps to better protect these young people from health risks are critical.

To tackle these health issues, and to ensure better educational and job opportunities, as well as promoting active citizenship, social inclusion and solidarity of young people, the European Commission launched the EU Youth Strategy (2010–18)⁽⁴⁾ in 2009. The Strategy proposes initiatives in eight fields of action: Education and training; Employment & entrepreneurship; Health & well-being; Participation; Voluntary activities; Social inclusion; Youth & the world; and Creativity & culture. Furthermore, the Commission has introduced new indicators, such as the NEET rate, to monitor the

(1) Eurostat.

(2) UK Social Exclusion Unit (1999): Bridging the Gap report.

(3) WHO Fact sheet No 345 (2011): Young people: health risks and solutions.

(4) Available at: eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0200:FIN:EN:PDF

The **EU's Youth Strategy (2010–18)** for encouraging young people to live healthy lifestyles comprises measures to promote mental and physical health (including sexual health), as well as the prevention and treatment of injury, eating disorders, addictions and substance abuse. In particular, the focus is on:

- physical education, education on nutrition, and promoting physical activity to encourage fitness and healthy lifestyles;
- promoting collaboration between schools, youth workers, health professionals and sport organisations;
- making existing health facilities more accessible and attractive to young people;
- raising awareness of how sport can promote teamwork, intercultural learning and responsibility.

labour market and social situation of young people and facilitate comparison between Member States in the context of the Europe 2020 strategy. All of this gives youth issues greater visibility and strengthens the position of young people on the political agenda.

Using sport to help NEETs to move forward

The Health 25 project aimed to improve and preserve the health of NEETs by developing a new health promotion approach addressing this hard-to-reach population and their health determinants. The target group was NEETs between 16 and 20 years of age from five EU countries (i.e. Denmark, Austria, the UK, Italy and France). The Health 25 method had three pillars, a pedagogical/psychological concept, sports sessions and education about healthy lifestyles. Participants' feedback and results from pilot tests were very positive, indicating that the Health 25 approach has good potential to motivate and engage NEETs in health-promoting activities. This can help them to find a way out of the NEET status.

Exploring causes and needs

The three-year project started in February 2011 with a comprehensive review of literature. The review provided an outline of NEETs, including research on the reasons why young people are NEET (i.e. social determinants). In addition, interventions or policies targeting NEETs and related to those regions which were subsequently included in the Health 25 field surveys were also collected and assessed. The team identified: 1) low socio-economic status; 2) immigration particularly with a low level of social integration; 3) socially deprived areas; and 4) non-supportive family backgrounds as the main environmental causes of the NEET status. Individual risk factors were: female gender; disabilities or other health problems; lack of work experience; low education level; and criminal behaviour. Regarding the initiatives, results showed that only a limited number of interventions targeting NEET youth had been carried out.

Based on the desk research, a standardised questionnaire for face-to-face and focus group interviews was compiled. Interviews compiled a wide range of data from the physical and mental state of the target group through their relationships, job expectations and motivation for health promotion to their subjective needs. Field surveys were long and time-consuming but provided important details for the upcoming project phases: an overview about oppor-

tunities and motivational factors and also about possible barriers and obstacles.

How to reach, motivate and keep NEETs on track?

Beyond the new health promotion approach, the other key output of the project was the *'Guidelines for Coaches on Engagement, Motivation and Continued Participation of NEETs'*. The guide provided practical advice on how to reach, motivate and educate NEETs. It described the difficulties of working with the target group and gave specific instructions on how to get started *and* complete an intervention targeting NEETs. The concept was adapted from talking therapies, particularly 'Cognitive Behavioural Therapy', and was intended to empower both coaches and NEETs with simple tools and techniques to help them understand topics such as goal setting, and improve levels of confidence, self-esteem and motivation. The techniques were designed to be delivered during training sessions, but can also be applied in the context of seeking job or education opportunities.

'Coaches should be aware that NEETs are not a homogenous group, but rather a cohort of young adults who exhibit a wide range of characteristics.'

Health 25 Guidelines

The Coaching Toolkit

As a next step, a toolkit was designed for professionals who are already working or planning to work with NEETs (sports coaches, youth workers, social workers and public health professionals). The toolkit provided a training template as well as examples of group icebreakers, lifestyle advice and sports activities to engage young people in health promotion. The toolkit contained the following sections:

- Baseline data collection;
- Goal setting and development of personal health plans;
- Sessions on healthy lifestyles including tobacco, harmful use of alcohol, physical activity and nutrition;
- Structured sport/physical activity sessions;
- Motivation and Team Building;
- Group-based skills training;
- Links to local health care systems and community health support;
- Evaluation of progress against individual goals.

As the Coaching Toolkit and the Motivational Guideline are closely related and complement each other, they were merged into one holistic approach that was pilot tested in each of the five countries. Given the significant differences between the participating countries, which were revealed through the interviews, pilot interventions had a set of core criteria but they also included flexible country-specific elements. The main requirement was that the content of the 1.5-hour-long session had to be a combination of physical activity and learning sessions about healthy lifestyles. A minimum

of seven sessions had to be conducted over the course of the programme. Besides these requirements, participating countries were free to plan and implement the pilots according to their settings, resources and target group.

Health 25 key recommendations:

- plan your costs and ensure funding;
- cooperate with local stakeholders — especially with organisations working with NEETs;
- create incentives for participants and provide them with a starter kit;
- provide free and easy access to sports centres, including transport;
- local cooperation with sports clubs is essential — find role models if possible;
- start the day with a healthy breakfast for the group;
- offer at least seven well-structured sessions for long-lasting results;
- make sure that the activities are fun, motivating and informal;
- implementation works best when the sports programme is part of another programme.

Success in the pilot phase: fewer smokers, healthier diet and more sports

Results showed that the Health 25 training and education programme could motivate the target group and in some cases there were measurable changes in risk behaviour such as smoking and sedentary lifestyles. The fact that the programme has been tested in five countries, all with positive results, indicates that the transferability of the programme is high, and can be adapted to the needs and opportunities of different European countries. Finally, the project has involved some partners from the Eastern Europe region who have provided continuous feedback and expressed their concerns and suggestions for a future regional adaptation.

Deliverables

- Health promotion for disadvantaged youth — Literature review and survey report: <http://www.health25.eu/wordpress/wp-content/uploads/2013/11/Literature-Review-and-Survey-Report-incl.-Annexes.pdf>
- Motivational guidelines for coaches: <http://www.health25.eu/wordpress/wp-content/uploads/2011/03/Motivational-Guidelines-For-Coaches-Health-25.pdf>
- Holistic Health Training and Intervention Programme: http://www.health25.eu/wordpress/wp-content/uploads/2014/01/Holistic_Health_Training_and_Intervention_Programme_EN.pdf



Useful links

- Project website: <http://www.health25.eu/>
- Project flyer: http://www.health25.eu/wordpress/wp-content/uploads/2011/11/h25flyer_en.pdf

Partners

Main Beneficiary:

Berufliches Bildungs- und Rehabilitationszentrum Oesterreich Austria

Associated Partners:

- Sportstätten Weinzoedl 1 Betriebs GMBH, Austria
- Azienda Ospedaliero Universitaria Ospedali Riuniti Ancona, Italy
- Heart of Mersey, United Kingdom
- Center for Sundhedsfremme, Denmark
- Réseau Associatif pour le Développement et l'Animation de l'Education et de la Culture en Région Bretagne, France



Priority groups and settings

EPHE project

EPODE for the Promotion of Health Equity

'It is well recognised that risk underlying many age-related non-communicable diseases actually accumulates over the life course, which justifies action from an early age. It appears that investment in the early years (including good nutrition during pregnancy, childbirth and early days and years of life) is one of the greatest potentials for reducing health inequalities within a generation. 6–12 is also the age when children are very receptive to the advice they may be given, in terms of both upbringing generally and nutritional knowledge specifically.'

Commission on Social Determinants of Health, Closing the gap in a generation: health equity through action on the social determinants of Health, WHO 2008.

'Evidence indicates that obesity is rising dramatically among European children, and that it disproportionately affects those in low socio-economic groups⁽¹⁾'

Surveys conducted in some EU Member States suggest that over 20% of the obesity found among men in Europe, and over 40% of the obesity found in women, could be attributable to inequalities in socio-economic status (SES). Evidence also shows that childhood overweight and obesity in Europe is also associated with the SES of parents, espe-

cially mothers. Moreover, when making comparisons across countries, it also appears that childhood overweight is linked to a Member State's degree of income inequality or relative poverty⁽²⁾.

In the White Paper on Nutrition, Overweight, and Obesity-related health issues adopted by the European Commission in 2007, childhood and vulnerable populations are important priority groups for health promotion.

EPODE, 'Together Let's Prevent Childhood Obesity', is an international obesity prevention network. The EPODE European Network, which provides recommendations on childhood obesity prevention⁽³⁾, received the support of the Directorate-General for Health and Consumers (DG SANCO) between 2008 and 2011.

The EU co-funded project 'EPODE for the Promotion of Health Equity (EPHE)⁽⁴⁾' is building on the EPODE methodology which is a coordinated, capacity-building approach for communities so that they can implement effective and sustainable strategies to prevent childhood obesity.

To respond to the growing need for community-based childhood obesity prevention initiatives, the three-year EPHE project started on October 1st 2012.

(1) Robertson, A., Lobstein, T. and Knai, C. (2007), Obesity and socioeconomic groups in Europe: Evidence review and implications for action. November 2007. SANCO/2005/C4-Nutrition-03 funded by the European Commission.

(2) EPHE: EPODE for the Promotion of Health Equity website: http://www.epheproject.com/?page_id=186

(3) Preventing Childhood Obesity: EPODE European Network Recommendations: <http://www.epode-european-network.com/en/ressources-center/224-een-recommendations.html>

(4) EPHE project website: www.epheproject.com

Evidence-based interventions for childhood obesity prevention: Community-based programmes & strong evaluation

The main objective of the EPHE project is to analyse the added value of the implementation of the EPODE methodology in reducing socio-economic inequalities in diet and physical activity among families with children aged 6 to 12, living in 7 different European communities (Belgium, Bulgaria, France, Greece, Netherlands, Portugal and Romania). The project focuses on communities located in European regions and Member States where the premature mortality exceeds 20% of the EU average and communities with different socio-economic profiles. The analysis of the opportunities to sustain the implementation of EPHE best practices in other EU regions and Member States via EU structural funds is also a central aspect of the EPHE project.

The European Commission Communication 'Solidarity in health: Reducing health inequalities in the EU' of 20 October 2009, emphasizes the variations in health-related behaviour, such as quality of nutrition and level of physical activity, and in obesity prevalence according to socio-economic factors within and across countries.

The added value of the methodology is to mobilise stakeholders at all levels (parents, school directors and teachers, social workers, leisure centre educators, the media, municipal services, etc.). Its critical components include political commitment, sustainable resources, support services and strong scientific input drawing on the evidence base, together with evaluation of the programme.

The project particularly focuses on closing the health gap in four main areas:

1. Variety of fruit and vegetable consumption
2. Sedentary lifestyle
3. Sleep in terms of quality and duration
4. Water consumption

In each pilot community (size limited to 10 000 to 40 000 inhabitants for feasibility reasons), local initiatives will be carried out (over a 24-month period) to address two or more of these themes, such as: (1) increase moderate-to-vigorous physical activity; (2) decrease specific sedentary behaviours, such as TV viewing; (3) decrease sugar sweetened beverage consumption; (4) encourage healthy meal patterns (i.e. breakfast consumption); and (5) increase water intake and fruit and vegetables.

Project activities are organised in six work packages. An EPHE Scientific Advisory Board is providing guidance and support to the local EPHE programmes.

Work will start with building scientific knowledge through partnerships between national administrations and universities to advise local authorities on effective actions. The next WP aims to mobilise EU structural funds for the reduction of health inequalities. The last WP is responsible for capacity building and intervention at local level by developing actions and tools on professional training to address health inequalities.

Deliverables and outcomes

- A practical scientific framework (EPHE Guidebook) to analyse and address the social gradient in health inequalities in diet and physical activity-related behaviours of families with children aged 6 to 12.
- A literature review providing a systematic overview of interventions to prevent obesity in children and adolescents from minority groups.
- The EPODE organisation framework at community level to tackle the issue of health inequalities.
- The first evaluation conducted by project coordinators in their communities after awareness-raising and motivation campaigns.
- A pilot intervention implemented and evaluated in 7 communities in Europe (Belgium, Bulgaria, France, Greece, Portugal, Romania and the Netherlands) along with European universities.
- Concrete recommendations, strategies and methods proposed to local, regional and national authorities to invest in EPHE and similar best practices via the EU cohesion policy and structural funds with the objective being to reduce socio-economic inequalities in health-related diet and physical activity-related behaviours of families with children aged 6 to 12 in their community.
- Awareness raised among key opinion leaders and decision makers about the interest of a community-based approach in tackling health inequalities and in particular, about the possibility of doing so in synergy with existing programmes (e.g. Economic and Social Development Programmes, Nutrition and Health Programmes, EPODE Programmes) and mobilising, when appropriate, EU structural funds to support such initiatives at Member State and regional levels, in an integrated, concerted and sustainable manner.
- Increased political support expressed by the communities involved in EPHE to pursue action in the reduction of health inequalities after the course of the project, mobilising external resources including through applications for EU structural funding.
- Health-related diet and physical activity inequalities reduced according to socio-economic indicators in a sample of 150 families with children aged 6 to 12, in each of the 7 communities involved in the EPHE project (target value: significant reduction/improvement in the majority of health indicators which have been selected by the consortium of EPHE's Scientific Advisory Team).

Scientific publications

- EPODE approach for childhood obesity prevention: methods, progress and international development: Borys, J.-M., Le Bodo, Y., Jebb, S. A., Seidell, J. C., Summerbell, C., Richard, D., De Henauw, S., Moreno, L. A., Romon, M., Visscher, T. L. S., Raffin, S., Swimburn, B. and the EEN Study Group, Obesity reviews, 2011. <http://www.ncbi.nlm.nih.gov/pmc/articles/pmc3492853/>
- Characterising the EPODE logic model: unravelling the past and informing the future: Van Koperen, T. M., Jebb, S., Summerbell, C., Visscher, T. L. S., Romon, M., Borys, J.-M. and Seidell, J. C., Obesity reviews, 2011. <http://www.ncbi.nlm.nih.gov/pubmed/?term=EPODE+logic+model><http://>

“Over the past decade, several studies have demonstrated that the prevention of childhood obesity is possible through Community-Based Interventions (CBI’s), to improve eating and physical activity habits. Increasing evidence shows that the most successful interventions are multicomponent, adapted to the local context (cultural and environmental), using the existing local structures and networks of a community, building partnerships and finally, involving the participants in the planning, implementation and evaluation stages”

EPHE project based on EPODE European Network recommendations on childhood obesity prevention



Useful links

- EPHE project website: www.epheproject.com
- EPODE European Network: www.epode-european-network.com

Partners

Main Beneficiary:

PROTEINES SAS
France

Associated Partners:

- Vereniging voor Christelijk Hoger Onderwijs Wetenschappelijk Onderzoek en Patientenzorg Foundation, the Netherlands
- Bulgarian Association for the Study of Obesity and related Diseases, Bulgaria
- Universiteit Gent, Belgium
- Leisure Concepts, The United Kingdom
- NOSTUS Communications and Events LTD, Greece
- Directorate General of Health, Portugal
- Fundatia PRAIS, Romania
- PROTEINES Brussels, Belgium
- Christelijke Hogeschool Windesheim, The Netherlands
- Universidad de Zaragoza, Spain
- Universidade do Porto, Portugal
- Communauté de Communes Flandre, Établissement Public de Coopération Intercommunale, France



Priority groups and settings

4th HEPS Conference

4th European Conference on Health Promoting Schools 'Equity, Education and Health'

University College South Denmark in collaboration with the Department of Education of Aarhus University and the Schools for Health in Europe Network (SHE Network) together with WHO/Europe organised a conference to explore the link between equity, education and health in schools. The 4th European Conference on Health Promoting Schools took place in Odense in Denmark in October 2013.

This action responded to the growing need for health promotion initiatives in schools.

Goals of the conference

Building on the previous three successful European Conferences on Health Promoting Schools — in Greece in 1997, the Netherlands in 2002 and Lithuania in 2009 — the conference aimed to consolidate, strengthen, disseminate and share research, policy and practice within the field of health promotion in schools through: key notes from all parts of the world; interesting poster sessions; and workshops with room for discussion and reflection.

The focus was on equity in health through school-based health promotion, linking equity with key issues such as sustainability, social inclusion, innovation and change.

This event was a great opportunity to share knowledge on the relationship between well-being, health and learning with other experts in Europe and worldwide. The 250 conference participants included decision-makers, researchers and practitioners from the health, ed-

'Studies have repeatedly shown that healthy children perform better in school. Researchers have known this for years, yet health and well-being are still not a top priority in most schools.'

WHO Regional Office for Europe, press release, 7 October 2013

ucation and social sectors, from governmental and local organisations, NGOs, youth organisations and academic institutions.

The specific objectives of the conference were:

- To increase awareness among policy makers about the fact that education and everyday school life play a crucial role in promoting health and well-being and in ensuring equity in health. For this to be successful, strong political commitment to support the health promoting schools approach in Europe is needed.
- To contribute to the further development, implementation and evaluation of effective strategies and policies concerning school-based health promotion.
- To contribute to strengthening the evidence base and encourage knowledge building among politicians, health and education practitioners, researchers, non-governmental organisations and youth organisations across Europe, in facilitating

actions for the development of sustainable health investments among children and young people in the school setting.

- To identify and discuss the links between school-based health promotion, development of citizenship competencies, children's rights and health literacy of children and young people. Furthermore, to discuss how these links are related to improving early childhood education and care and to addressing the problem of early school leaving.
- To contribute to supporting European countries in developing effective strategies, policies, high quality research as well as good practices regarding addressing inequity in health through school health promotion.

'The conference topic is coherent with the overall scope of the second EU public health programme, as one of its objectives is to promote health, including the reduction of health inequalities. The conference promotes the priorities of inclusive growth, social inclusion and up-scaling of local community and school based interventions.'

'Children learn better if they are involved in a school's daily life, if the environment is conducive to learning and being healthy, and if teachers feel engaged', said Zsuzsanna Jakab, WHO Regional Director for Europe, during the conference. 'Policies work when they are based on evidence — the education and health sectors need to work together to implement best practices across the WHO European Region.'

The Conference in Odense covered a wide range of topics, including trends in the latest research on health promotion in schools, which showed that health and learning are influenced by:

- student involvement, which is vital to promoting well-being at school as students who feel they can influence the school's daily life are more motivated and achieve better academic results;
- participatory policy development, as the implementation of a school policy (for example, against bullying) is more effective when pupils are involved in developing it;
- teachers' well-being and health, as the latter cannot be separated from those of schoolchildren. School staff must be included in a holistic approach to health promotion in schools.



High youth involvement

During the conference, 19 students from Odense were talking to students from Macedonia, Lithuania and Estonia about health in schools. On the last day of the conference, the Danish students presented their work and statements from the Youth Conference at the closing session.

The current work on school health promotion in Europe is supported by the Schools for Health in Europe (SHE) Network. The SHE Network, which is coordinated by CBO (Dutch Institute for Healthcare Improvement) as a WHO Collaborating Centre, has national coordinators in 43 European countries. Through this conference and its follow-up, the SHE Network is able to reach policy makers on national and local levels, and raise their awareness of the importance to collaborate closely with schools⁽¹⁾.

To guarantee alignment with current EU public health and education policies, the SHE International Advisory Board consisting of representatives from DG SANCO, DG Education and Culture, the WHO Regional Office for Europe and the Council of Europe was consulted about the conference by the SHE secretariat. A Steering Committee and a Scientific Committee, responsible for reviewing the abstracts, were also set up with the involvement of more than 15 European universities.

This initiative is in line with the new European health policy framework, Health 2020, which addresses the social determinants of health and well-being and calls for a cross-sectoral, whole-of-government approach to health policies.

Health 2020: the European policy for health and well-being

Deliverables

- The evaluation shows that the conference achieved its stated objectives and targets. The conference resolution and the conference report including the keynote papers are available online.



Useful links

- HEPS Conference website: <http://schools4health.dk/conference/>
- WHO Regional Office for Europe, Conference press release 'Healthy Children learn best': <http://www.euro.who.int/en/media-centre/sections/press-releases/2013/10/healthy-children-learn-best>
- WHO Regional Office for Europe 'Health Behaviour in School-Aged Children' (HBSC): <http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/adolescent-health/health-behaviour-in-school-aged-children-hbsc2.-who-collaborative-cross-national-study-of-children-aged-1115>
- WHO Regional Office for Europe 'Social determinants of health and well-being among young children' — Health Behaviour in School-Aged Children (HBSC) Study: International report from the 2009/2010 survey: <http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2012/social-determinants-of-health-and-well-being-among-young-people.-health-behaviour-in-school-aged-children-hbsc-study>

Partners

Main Beneficiary:
University College Syddanmark
Denmark

(1) Schools for Health Network: <http://www.schoolsforhealth.eu/>



Priority groups and settings

HEPCOM project

Promoting Healthy Eating and Physical Activity in Local Communities

'Around 22 million children in the European Union are considered overweight or obese, with the numbers growing by 400 000 every year. They face serious health and social risks, including cardiovascular disease, type 2 diabetes, orthopaedics problems, underachievement in school and low self-esteem, and stand a 60% chance of becoming overweight or obese adults. Even many teenagers who are not overweight are also at risk of these disorders, because of unhealthy diets and low levels of physical activity.'

European Commission Cordis new study to provide insights into young Europeans' health related diet and lifestyle choices, 04.09.2013: http://cordis.europa.eu/news/rcn/36030_en.html

Since the number of overweight children and adolescents has increased steadily since the 1990s, the European Union has given this problem a high priority. There is a need for interventions and policies to tackle obesity.

HEPCOM will contribute to preventing obesity among children and young people in the EU. Started in February 2013, HEPCOM is running for three years and is coordinated by CBO BV (Dutch Institute for Healthcare Improvement).

HEPCOM aims to scale up existing activities by broadening their

scope and by reaching beyond small-scale dissemination and implementation efforts, as well as by extending beyond a few sites or communities. HEPCOM involves 21 institutions from 17 countries.

The initiative is targeting policy makers and decision makers at local, regional and national level, who are involved in strategic planning and overall decision making with respect to health promotion focused on children and young people. It will also involve the active participation of social workers within local communities.

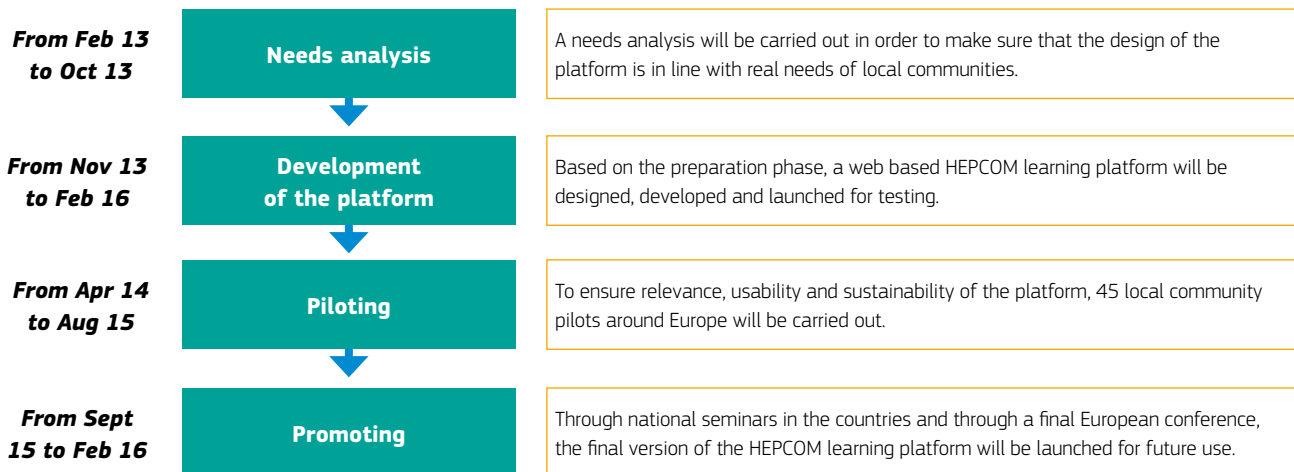
One of the main deliverables of HEPCOM is a European online learning platform that provides stakeholders (communities, schools, school authorities, policy makers and others) with information, tools and resources to support and enhance successful strategies and activities for health-promotion focussing on eating, physical activity and psychosocial health. With this web-based platform, stakeholders will be granted easy access to activities and programmes covering good practice, and get the chance to connect and exchange with each other — within or beyond national borders.

In order to ensure relevance, usability and sustainability of the platform, 45 local community pilots around Europe will be carried out to provide practical guidance and good practice examples on how to use the platform and its tools in order to increase the level of community-based initiatives. Through national workshops in the participating countries and a final European conference, the final version of the HEPCOM learning platform will be launched for future use by the various stakeholders.

The specific objectives of HEPCOM include:

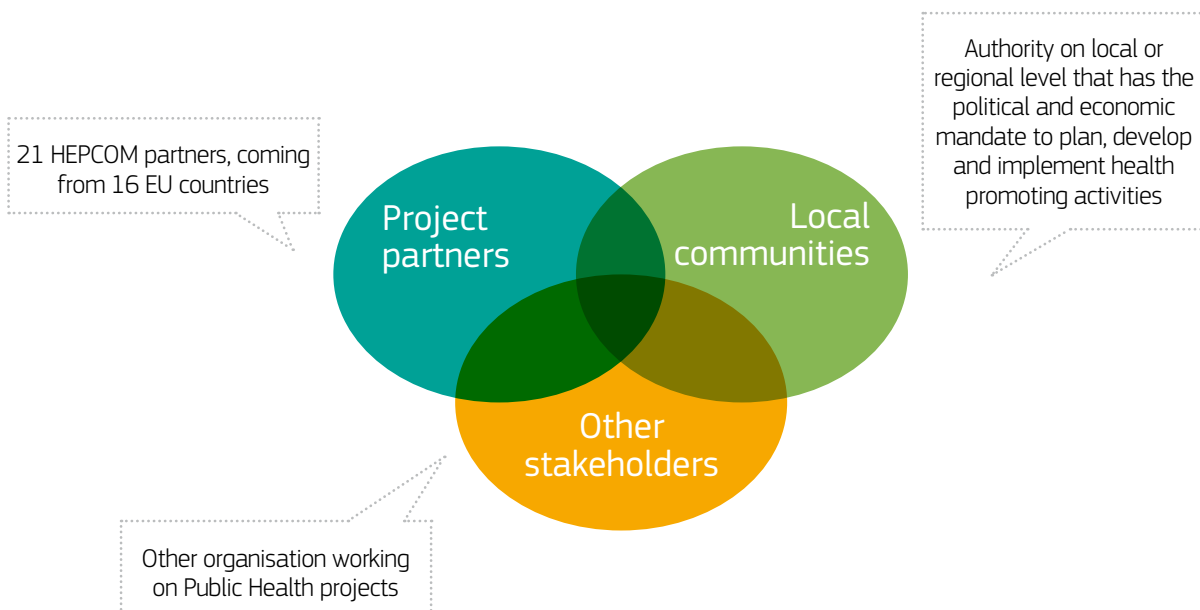
- To create a systematic overview of existing good practice tools;
- To ensure equal visibility for all public health and other European projects that are relevant for local communities and schools;
- To facilitate networking, dissemination and up-scaling of good practice results from public health and other European projects through a web-based learning platform;
- To raise awareness and develop concrete and innovative interventions in 45 local communities around Europe;
- To disseminate project results and good practice throughout Europe;
- To ensure sustainability of the learning platform through the development of a sustainability document.

The project will be developed in four main phases aimed at creating an integrated learning system.



Expected outcomes

- HEPCOM will provide support through the web based learning platform and a substantial up-scaling of good practices tools from former and existing European projects.
- The project will also support important qualification processes at the local level, which will lead to a substantial increase in the level of community and school based health promoting interventions.
- The learning platform will provide a solid basis for sustainable networking between projects and experts and a better uptake, exploitation and up-scaling of initiatives that have already proven successful.





‘The best way to prevent overweight and obesity among children is to have a strategic and whole community approach to the challenge.’

HEPCOM project, 2013

Useful links

- HEPCOM community initiatives to prevent obesity among children and adolescents: www.hepcom.eu
- CBO Netherlands: www.cbo.nl/projecten/hepcom
- EU Prevent: www.euprevent.com
- HEPCOM community initiatives to prevent obesity among children: www.brighton.ac.uk/snm/research/areas/health-promotion/projects/hepcom.php
- HEPCOM — Promoting healthy eating and physical activity: http://www.eufep.at/Downloads2013?file=tl_files/EUFEP_2013/Poster/Felder-Puig_abstract.pdf

Partners

Main Beneficiary:

CBO B.V.
Netherlands

Associated Partners:

- Aarhus University, Denmark
- Bergen University College, Norway
- Business Solutions Europa Belgium Ltd, Belgium
- Croatian National Institute of Public Health, Croatia
- Institutou Ygeias tou Paidiou, Greece
- Istituto Superiore di Sanit, Italy
- Leuphana Universität Lüneburg, Germany
- Ludwig Boltzmann Gesellschaft GmbH, Austria
- Maastricht University, Netherlands
- Mykolas Romeris University, Lithuania
- National University of Ireland, Galway, Ireland
- P.A.U. Education S.L., Spain
- South Denmark European Office, Belgium
- Steno Diabetes Centre Ltd., Denmark
- Stichting euPrevent EMR, Netherlands
- Universidade do Minho, Portugal
- University Blaise Pascal Clermont-Ferrand 2, France
- University College Syddenmark, Denmark
- University of Brighton, United Kingdom
- University of Eastern Finland, Finland



Priority groups and settings

EYTO project

European Youth Tackling Obesity

Currently, approximately 22 million children and young people in the EU are overweight or obese⁽¹⁾.

Obesity in childhood and adolescence can lead to a range of chronic medical problems. Furthermore, it impacts on psychological health and is linked to low self-esteem, poor educational outcomes and reduced overall life chances⁽²⁾.

According to the International Association for the Study of Obesity (IASO), it is a significant public health issue across Europe that now affects one in three children and young people in the UK, almost half of 10–18 year olds in Portugal, over half of 5–17 year olds in Spain, and over a third of 6–17 year olds in the Czech Republic⁽³⁾.

Research highlights a lack of healthy lifestyle campaigns targeted at teenagers, the need to actively involve young people in their design and delivery, and the effectiveness of social marketing in creating campaigns that lead to positive behaviour change.

The European Youth Tackling Obesity (EYTO) project involves groups of young people from disadvantaged communities across Europe creating social marketing campaigns to promote healthy lifestyles amongst their peers, and helps reduce rates of obesi-

'Causal factors include the intake of high fat, salt and sugar foods and drinks, increasing sedentary behaviour and lack of physical activity, as well as financial costs associated with eating healthily, and poor levels of health education and awareness. Obesity is a major health inequality affecting more young people from lower socio-economic groups.'

Social determinants of health and well-being among young people — Health Behaviour in School-Aged Children (HBSC) Study: International report from the 2009/2010 survey. WHO Regional Office for Europe 2012

ty. The National Children's Bureau, UK (NCB) is coordinating this project with partners across Spain, Portugal and the Czech Republic⁽⁴⁾.

The project is targeting 13–16 year olds. These teenage years are pivotal in determining longer-term obesity risks and provide a vital window of opportunity to help disadvantaged young people develop healthier lifestyles; yet interventions to tackle obesity amongst adolescents are comparatively under-developed. Peer-led social marketing campaigns have proved successful in tackling a number of health problems, but the potential for applying these techniques to stem the rise of obesity amongst disadvantaged teenagers has not yet been realised. Interventions have tended to be 'top-

(1) WHO/Europe (2007): The challenge of obesity in the WHO European Region and the strategies for response.

(2) WHO Global Strategy on Diet, Physical Activity and Health — Obesity and overweight fact sheet: http://www.who.int/dietphysicalactivity/media/en/gsf_s_obesity.pdf

(3) International Association for the Study of Obesity (IASO): <http://www.iaso.org/>

(4) The National Children's Bureau, UK (NCB): www.ncb.org.uk/

down' and failed to target vulnerable young people. Unless these groups are effectively engaged in interventions, health inequalities amongst young people are set to widen.

Building a strong EYTO partnership

'There is a need for a more collaborative response that avoids duplication and enables good practice to be replicated across Europe. Partners will work closely to provide a coherent framework for activities that will enable meaningful comparisons to be drawn.'

The main objectives of the EYTO project are to:

- conduct a systematic review of learning from past or current social marketing interventions in each country to promote healthy lifestyles;
- support a network of 20 young volunteers in researching, designing and launching social marketing campaigns across their local communities to promote healthy lifestyles amongst their peers;
- support young people across the partnership in sharing ideas and replicating campaign activities;
- develop a website to launch the campaign (and associated tools and resources) across Europe;
- evaluate the impact of the campaign on outcomes for young people and those working to support them, and disseminate the learning.

'The project builds on the EU Strategy on Nutrition, Overweight and Obesity-related health issues which recommends interventions targeted at lower socio-economic groups that build the evidence base in terms of drivers for preventing obesity in children and adolescents.'

EYTO project 2013

These objectives are translated into work packages. All partners are to collate relevant evidence from their respective countries on the impact of childhood and adolescent obesity interventions which use social marketing approaches. Each participating country is committed to working with existing local youth groups to recruit five young campaign creators. A workshop is to be held in the UK for all the young 'campaign creators', partners and social marketing experts involved in the project to share and compare their campaigns. A website is to be developed to collate all campaign materials and messages, which will be launched via online marketing activities by all partners across Europe. A feedback session with all partners is to be organised to present findings from replication activities; recommendations will be issued for wider dissemination.

Expected outcomes

The EYTO project started in September 2013 and will end in August 2015.

By the end of the project, it is expected that partners and policy makers at local, national and European level will have an increased understanding of successful social marketing approaches to tackling obesity amongst disadvantaged young people. It is expected that at least 80% of young people who engaged in the campaign will have reported increased motivation to eat more healthily and be more physically active. It is also assumed that at least 60% of young people engaging in the campaign will report increased levels of physical activity and fruit and vegetable consumption. There will be evidence of good practices replicated amongst EU Member States participating in the project.



Useful links

- WHO Population-based approaches to childhood obesity prevention: http://www.who.int/dietphysicalactivity/childhood/WHO_new_childhoodobesity_PREVENTION_27nov_HR_PRINT_OK.pdf
- International Association for the Study of Obesity: www.iaso.org
- Briefing on EYTO: <http://www.ctns.cat/news-article/110/new-european-project-eyto>

Partners

Main Beneficiary:
National Children's Bureau
United Kingdom

- Associated Partners:**
- Centre Tecnologic en Tecnologies de la Nutricio i la Salut, Spain
 - Companhia de Ideias Anónimas – Media, Lda., Portugal
 - KOMUNIKUJEME o.s., Czech Republic



Developing the evidence base to support policy making

PoHeFa project

Policy, Health and Family Learning

In traditional health research, increasing overweight and obesity are mostly explained as a change in eating habits and less physical activity, hence proposed traditional solutions are most often focusing on raising the awareness about eating healthy food and having more physical leisure activities.

But according to the rationale of the PoHeFa project, obesity is not only caused by poor nutrition or lack of physical activity, but also related to a social problem, that leads the child to eat too much, and to opt out of physical activities. Hence, to go deeper into the research of obesity related health issues and present more sustainable health promoting activities, it is important to look at the socio-cultural context with the aim of describing more complex solutions, which assist municipalities in ensuring the long-lasting and sustainable effects of their health promoting initiatives⁽¹⁾.

The PoHeFa project took place from July 2009 through June 2012. University College South Denmark (UCS) was the leading partner.

The PoHeFa project was created to help local authorities improve their planning and implementation practices within the field of health promotion towards children, young people and their families.

'The approach in the PoHeFA project was **action oriented research**. This means that the project developed concrete methods and tools, which were gathered and presented. The project tested the conceptual framework in close collaboration with 12 municipalities around Europe, creating useful learning for the partners and the local authorities.'

The consortium was established with partners from 6 European countries; 12 local authorities were chosen for the pilot project:

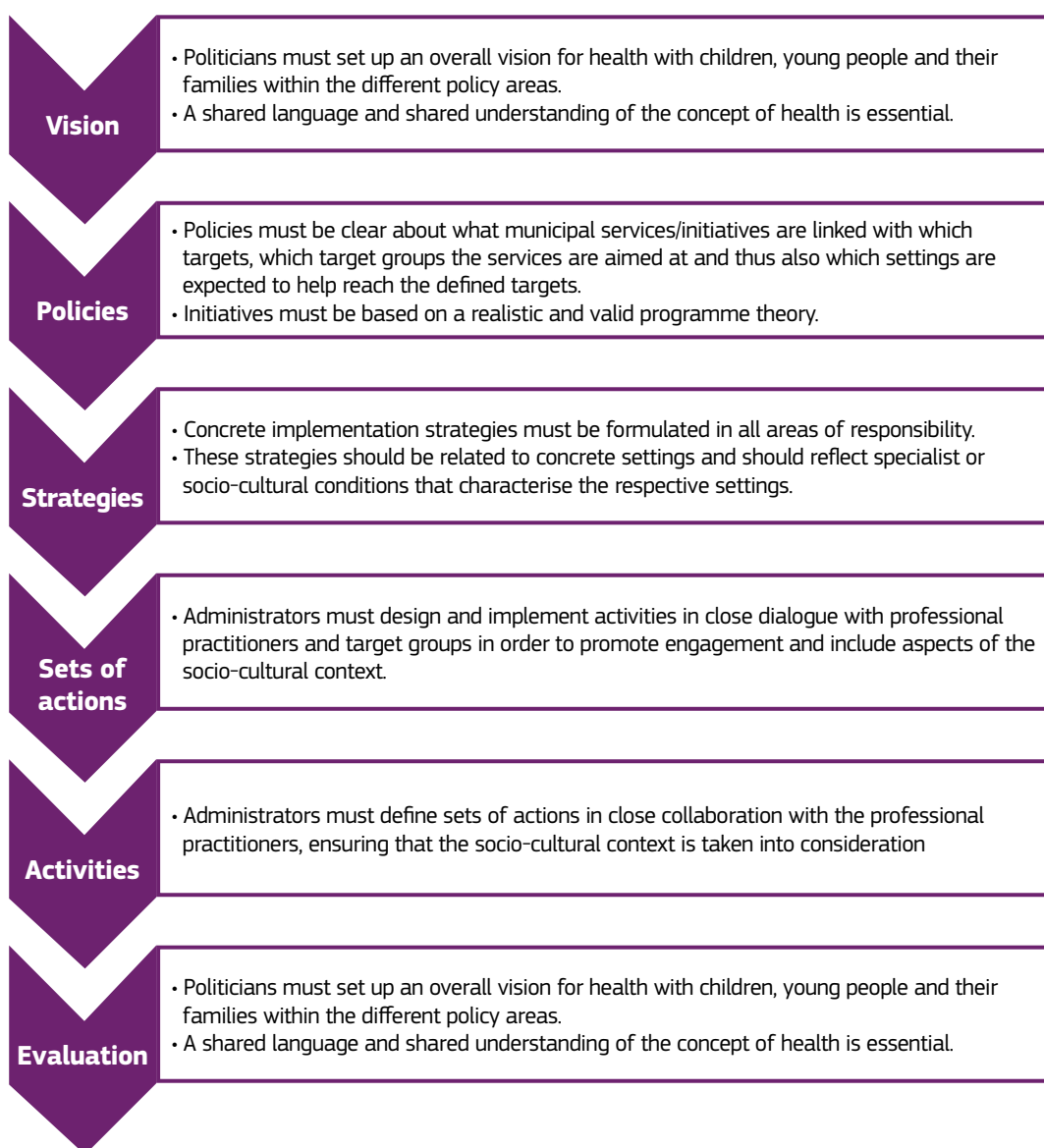
- Denmark: Langeland & Tonder
- Germany: Flensburg & Lütjenburg
- Finland: Jamsa & Hankasalmi
- Cyprus: Egnomi & Lefkara
- Italy: Fossa & Roccadimezzo
- UK: Swindon & Somerset

The project responded to a need to focus on HOW the socio-cultural context of settings influences the effectiveness and sustainability of health promoting activities. Particular attention was paid to activities focusing on children, adolescents and their families. Project activities didn't target health professionals; they mainly addressed local counsellors as the primary focus group.

(1) PoHeFa project description: www.pohefa.eu

Developing a strategic and structured working process in relation to planning, implementation and evaluation of health promoting activities with children, young people and their families

The PoHeFa project aimed to develop methods and tools which can help local authorities to be more active in the field of health promotion:



More specifically, objectives of the project were threefold:

- Gathering experiences, good practice examples and knowledge about local health policies, programmes, practices and initiatives to develop the conceptual framework and recommendations.
- Practical experiences by implementation of the first draft of the conceptual framework which was tested in the 12 pilot municipalities during a trial period. Similarly, training of local policy makers took place, together with the implementation of the first draft of the conceptual framework.
- Dissemination was organised through the PoHeFa website which was set up during the closing months of the project. Six newsletters were also published. The final conference for presenting local practice examples was held in Brussels in June 2012.

A conceptual paper was developed and contained a conceptual framework for gathering knowledge about existing local policies, implementation strategies and practices. Existing knowledge and good practice examples at municipality level, regarding creating a substantial evidence base, were gathered and studied. For instance, the mapping exercise with the six countries involved reflected differences within the health systems; e.g. centralised versus decentralised systems and the complex structure of obesity care. Local authorities received training and coaching from the partners. Policy analysis and recommendations emphasised the need for prioritisation of obesity within wider health policies. The methodology applied and toolkits developed throughout the project are available on the PoHeFa website.

Deliverables and outcomes

Results such as the PoHeFa Method and Toolbox are presented on the PoHeFa website as key features:

10 Key Considerations before starting working with the PoHeFa Method:

<http://www.pohefa.eu/Portals/27/10%20Key%20Considerations.pdf>

The PoHeFa Method:

http://www.pohefa.eu/Portals/27/The%20PoHeFa%20Method_final.pdf

PoHeFa Toolbox:

<http://www.pohefa.eu/TimelineOutputs/Toolbox/tabid/1430/Default.aspx>

Illustration: practical experiences from participating local authorities

- An example of a toolkit presented by one of the six countries involved in this partnership is the Obesity Toolkit for Local Authorities and the Brief Intervention Training Pack — Raising the Issue of Healthy Weight — developed by the National Institute of Adult Continuing Education (NIACE) and the South West Strategic Health Authority in the UK.
<http://www.pohefa.eu/TimelineOutputs/UK/tabid/1445/Default.aspx>
- Another example of the partnership between the PoHeFa project and the Healthy Children project which is also an EU funded project under the EU Health Programme demonstrating that local authorities gain from involvement in European health projects
[http://www.healthy-children.eu/Portals/24/Article%20in%20Parliament%20magazine%20\(1\).pdf](http://www.healthy-children.eu/Portals/24/Article%20in%20Parliament%20magazine%20(1).pdf)

Useful links

Healthy Children project: www.healthy-children.eu

Partners

Main Beneficiary:

Professionshøjskolen Syd, University College Denmark

Associated Partners:

- Heinrich-Böll-Stiftung Schleswig-Holstein Bildungswerk anderes lernen e.V., Germany
- Jyväskylä University of Applied Sciences, Finland
- Landesvereinigung für Gesundheitsförderung e.V. in Schleswig-Holstein, Germany
- Langeland Municipality, Denmark
- REGION ABRUZZO, Italy
- South Denmark European office, Denmark
- South West Strategic Health Authority, United Kingdom
- The National Institute of Adult Continuing Education, United Kingdom
- UNIVERSITY of Cyprus, Cyprus
- Alba Auxilia - ALBA (from 01/07/2010), Italy



Developing the evidence base to support policy making

Obesity Governance project

Obesity is formally listed as a disease of a classic type, regarded both as a psychological debilitation or malfunction and as a life-style disorder⁽¹⁾. According to the OECD report 'Health at a Glance: Europe 2010', the rate of obesity has more than doubled over the past 20 years in most EU countries, and over half of the adult population in the EU is now overweight or obese.

'Partnership, healthy eating and innovative governance as tools to counteract obesity and overweight — Obesity Governance.'

The Obesity Governance project focused on public-private partnerships (PPPs) around manufactured food as a means to counteract obesity and overweight in Europe.

The main objective of the project is to study innovative approaches, such as industry involvement and public-private partnership initiatives, to counteract obesity and overweight in Europe, particularly through reformulation of manufactured food in a relatively broad definition of the concept (the more specific product reformulations being usually a business initiative).

(1) The rates and forms of Public Private Partnerships (PPP) fighting obesity in European countries', Paper prepared by Anita Borch and Gun Roos, SIFO, Norway, for the European Sociology Association's Conference: 'Social Relations in Turbulent Times', Geneva, Switzerland, September 7 – 10, 2011. Working Group: Sociology of Consumption.

'The partnership approach constitutes a central element in the EU White Paper 'A Strategy for Europe on Nutrition, Overweight and Obesity related health issues', May 2007. The White Paper asks for cooperation between industry, research organisations and civil society in the public health and consumer field. What is meant by the Public-Private Partnership is the partnership where at least two of the actors are authorities, non-profit organisations or businesses.'

Obesity Governance Project, SIFO, National Institute for Consumer Research, Oslo, Norway

As an analysis, the project investigated the relationship between the following two major dimensions:

- 1. Regulatory politics** (referring to the different configurations of public-private involvement). The main private actors are the food industry and retailers, but NGOs also play an important part in this dialogue. In some countries, public authorities are still regarded as the driving force in regulation, while corporate involvement and self-regulation is more predominant in others.
- 2. Healthy eating policies.** Policy outcomes include specific initiatives aimed at improving healthy eating, such as product

innovation (healthy product range), public and private labelling schemes, marketing programmes (including in-store marketing) and purchaser-led buying schemes.

'Measures to counteract obesity and other nutrition-related diseases have relied upon proximal "downstream" approaches focusing on the responsibility and obligations of the individual, whereas more "up-stream" approaches focusing on the macro-level policy environment and the role of the supply chain have been neglected.⁽²⁾'

There is a growing need for the development of good practices in the reformulation of manufactured foods. This project aimed to evaluate national experiences with cooperation between industry, retailers, governments and NGOs.

- National and local initiatives in reformulation of manufactured food in the EU-27 Member States and Norway, with the main focus on governance as well as the relationship between the political authorities on the one hand, and the initiatives by the food industries and retailers on the other hand, were identified and analysed via desktop research and interviews. Altogether 235 PPPs were mapped in all European countries, except Luxembourg.
- In-depth studies of selected promising initiatives were conducted with the following aims:
 - 1) describe and evaluate 'best practices in Europe' based on results as far as reformulation of manufactured food from a governance perspective is concerned;
 - 2) develop a framework for benchmarking industrial and governance initiatives;
 - 3) assess the transferability to other countries within the region, and to other regions.

24 'best practices' PPPs were selected based on geographical coverage (the Anglo-American zone, the Mediterranean, the Nordic zone and Eastern Europe). In addition, the promising cases of PPPs represented different types of PPPs: programmes for kindergartens, programmes for schools, programmes aimed at workplaces, campaigns, initiatives aimed at drinking, and labelling.

- At the end of the project, a final stakeholder conference took place in Brussels, with 21 stakeholders from the food industry, retail, restaurants and canteens, governmental institutions, consumer organisations, the scientific community and the

media attending the conference. The conference presented the key findings of the research.

Deliverables

Among the deliverables, different types of best practice partnerships were identified as successful:

- pre-school children: (as target group) Moving Kids Campaigns⁽³⁾ and (as instrument for initiatives) Change4Life⁽⁴⁾;
- labelling (as schemes for food and restaurants as a tool): Keyhole labelling in Denmark, Norway and Sweden⁽⁵⁾;
- workplaces (as setting for initiatives): EU co-funded FOOD programme (reference in the brochure).

Project key findings and recommendations

The project highlighted that it is possible to identify a large number of public-private partnerships in Europe set up to fight overweight and obesity, but there are substantial differences among countries and sectors, especially in Eastern and South-Eastern Europe where PPPs were nearly non-existent. Health-related NGOs were more frequently involved in the identified PPPs than authorities and food businesses. Also, most partnerships were directed towards individuals, in particular children and consumers, but there were many partnerships that targeted institutions, in particular schools which seem to be 'enabled' locations, in that they are considered as obvious and widely accepted settings for health promotion and education interventions. The project indicated that structurally (institutions)-oriented strategies may be more efficient and that holistic public health strategies requiring multi-level actions are urgently needed to fight the increase in obesity and overweight. PPPs are part of the picture of tackling obesity since regulation by government will not solve everything and a partnership across and with society is essential. PPPs are not the solution, but a potential part of the solution.

With regard to evaluation and with complex topics like obesity, the project mentioned the risk that a mapping initiative, as a best practice, can be difficult, considering the lack of specific, measurable outcomes developed by the PPPs and the difficulty in demonstrating results over comparatively short time periods.

Furthermore, the project indicated that among the best practices, more than half of the initiatives were directed toward children. The project revealed that there seems to be an agreement across Europe that obesity among children and youth represents a real challenge, and that PPPs could be a tool used to counteract the epidemic tendencies. However, the project highlighted that there is not such agreement concerning other tools like labels and workplace initiatives.

The project concluded that all identified target groups may benefit from this project, including political authorities, industry, retailers and NGOs. The project also concluded that the best practices may be up-scaled and transferred from one country to another (for instance, in the Nordic countries), but have to be adapted to national or regional food culture, national legislation and political traditions. For instance, the transferability of school and community-based PPPs is high.

Best practices — Aim of evaluation:

- Describe and evaluate 'Best practices in the 27 EU Member States and Norway'
- Develop a framework for benchmarking
- Discuss the transferability to other countries within the region, and to other regions

Public-Private Partnerships as a strategy in counteracting obesity — insights from the European Obesity Governance project research — SIFO

http://www.menu.aau.dk/digitalAssets/46/46943_eivind-sto.pdf

(2) Obesity Governance project, SIFO, National Institute for Consumer Research, Oslo, Norway: <http://www.sifo.no/obesity-governance/>

(3) http://kidshealth.org/kid/feeling/home_family/moving.html

(4) www.nhs.uk/change4life/Pages/change-for-life.aspx

(5) <http://www.norden.org/en/nordic-council-of-ministers/council-of-ministers/council-of-ministers-for-fisheries-and-aquaculture-agriculture-food-and-forestry-mr-fjls/keyhole-nutrition-label>

Publications from the Stakeholder conference in Brussels:

- Report of the Obesity Governance Stakeholder Conference: http://www.sifo.no/obesity-governance/wp-content/uploads/2012/01/Report-from-the-stakeholder-conference_revised_20012012.pdf
- Overview of public/private initiatives — Anita Borch, SIFO: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/Presentasjon-Br%C3%BCssel-2011.pdf>
- Evaluation of public/private initiatives — Michael S. Jørgensen, Technical University of Denmark, DTU: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/Evaluation-Michael-pres-Brx.pdf>
- Public/private initiatives in schools and kindergartens — Maria Loureiro, University of Santiago de Compostela, Spain: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/obesity-governance-Maria-Loureiro-29-09-2011.pdf>
- Public/private initiatives in workplaces — Bent Egberg Mikkelsen, Aalborg University, Denmark: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/Workplaces-Brux29septFinalBent.pdf>
- Public/private initiatives and intervention (cases: drinking/campaigns) — Geof Rayner, PhD, UK: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/campaigns-and-drinking.pdf>
- Public/private initiatives aimed at labelling — Gun Roos, SIFO: http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/OG_Labelling_29092011.pdf
- Introduction on Transferability of best cases — Michael S. Jørgensen, Technical University of Denmark, DTU: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/Transferability-Michael-pres-Brx.pdf>
- Wrap-up of conference and recommendations — Geof Rayner, PhD, UK: <http://www.sifo.no/obesity-governance/wp-content/uploads/2011/10/Conference-Wrap-Up.pdf>



Useful links

- Obesity Governance Project, SIFO, National Institute for Consumer Research, Oslo, Norway: <http://www.sifo.no/obesity-governance/>
- D4 Literature Review — Anita Borch: <http://www.sifo.no/obesity-governance/wp-content/uploads/2012/06/D4-Literature-review.pdf>

Partners

Main Beneficiary:

National Institute for Consumer Research, Statens Institutt for forbruksforskning Norway

Associated Partners:

- National Food and Nutrition Institute, Poland
- Universidade de Santiago de Compostela, Spain
- Aalborg University, Denmark
- Association of Conscious Consumers, Hungary
- Agricultural University of Athens, Greece



Developing the evidence base to support policy making

EUROHEART II project

European Heart Health Strategy II

The European Cardiovascular Disease Statistics 2012 report⁽¹⁾, released in the framework of the European Heart Health Strategy II (EuroHeart II) by the European Society of Cardiology and the European Heart Network, indicates that efforts to reduce heart disease deaths are successful, with mortality now falling in most of the continent. At the same time, the report shows the huge burden that cardiovascular diseases (CVD) presents for Europe's health, and suggests that underlying factors may cause CVD to increase in the near future.

The figures show some progress. Since the 2008 report, there has been a substantial drop in the number of deaths attributed to heart disease. CVD is now responsible for 4 million European deaths annually, down from 4.3 million in 2008 (which represents a drop from 48 % to 47 % of total European deaths).

EuroHeart II was a three-year project, running from March 2011 to February 2014. It followed up on EuroHeart I (April 2007 – March 2010) and was developed by the European Heart Network, along with 30 partners, including the European Society of Cardiology.

Building on the successful achievements of EuroHeart I which aimed at strengthening cross-sector cooperation⁽²⁾ to address

EuroHeart II was a strategic continuity of the EU co-funded project EuroHeart I.

Project deliverables were key to ensure sustainability, and included a **European Heart Health Charter** which was launched (signed by 27 European countries) at European and national levels with the support of the European Commission, the World Health Organization (WHO), the European Heart Network and the European Society of Cardiology.

<http://www.heartcharter.org/>

the significant burden of CVD in Europe and to determine specific areas of policies and public health interventions which can contribute to preventing avoidable deaths and disability, the objective of EuroHeart II was to pursue the reporting and analysis of the current situation with regard to cardiovascular and circulatory diseases in the EU. The EuroHeart II project allowed a strategic approach that also helped in addressing other non-communicable diseases. The project provided outputs that can be used to

(1) The European Cardiovascular Disease Statistics Report, 2012 Edition, available at: <http://www.escardio.org/about/Documents/EU-cardiovascular-disease-statistics-2012.pdf>

(2) **The achievements of the EuroHeart I project were reflected by:** 1) Mobilisation of broad support for cardiovascular health promotion and cardiovascular disease prevention with a view to achieving stronger cross-sector cooperation, through the launch of a European Heart Health Charter; 2) Mapping and analysis of national plans, policies and measures impacting on cardiovascular health promotion and cardiovascular disease prevention which aimed to obtain

comprehensive comparable information on policies and actions impacting on cardiovascular health (CVH) promotion and CVD prevention in 16 EU countries. It provided a model for national plans; 3) Improving the awareness, diagnosis and treatment of cardiovascular disease in women — it also provided recommendations for awareness campaigns targeting women and for educational programmes for health professionals; 4) Improving prevention practices at primary care level by developing local language versions of the web-based interactive CVD risk assessment tool, HeartScore; and 5) Improving the standards of clinical practice by facilitating the translation, adaptation and implementation of the European guidelines on CVD prevention.

develop Community initiatives to promote cardiovascular health. EuroHeart II's target group was policy makers and stakeholders involved in the promotion of public health and prevention of CVD across Europe.

The specific objectives of EuroHeart II are addressed through major project work:

- to provide the most up to date statistics on CVD in Europe⁽³⁾ (including a cost of disease study in the EU) and analyse these data;
- to identify the most effective and cost effective CVD prevention policies;
- to predict future coronary heart disease (CHD) trends;
- to share knowledge on nutrition, physical activity and the prevention of cardiovascular diseases in Europe⁽⁴⁾;
- to build capacity in the cardiovascular patients' community;
- to evaluate the ESC-European Association for the Study of Diabetes (EASD) guideline on prevention of cardiovascular disease in diabetic patients⁽⁵⁾.

There is a strong political will in the EU to address CVD: this is reflected in the Council Conclusions (2004), the European Heart Health Charter (2007) and the European Parliament Resolution (2007).

EuroHeart II responded to these calls for action by organising before the end of the project a European policy conference and regional workshops on the latest evidence on nutrition, physical activity and prevention of CVD. The seminars for the CVD patient community empower stakeholders, including the WHO and the World Bank and other organisations interested in CVD prevention, allowing them to make a larger impact on health-related nutrition and physical activity as well as health-care related policies across societies in Europe. The data collected allows for predicting future trends and identifying the most effective and cost-effective CVD prevention policies.

The deliverables and outcomes of the EuroHeart II project are:

- to allow decision makers to develop CVD prevention policies based on the most up-to-date statistical and economic data, analyses and scientific impact models;
- to empower wider stakeholder groups to assess and address the situation in their countries;
- to help empower the CVD NGO sector to make a larger impact on health-related nutrition and physical activity policy in their countries through conferences and meetings presenting the latest evidence;
- to assist in strengthening the impact of the CVD patient community in the decision making process through the sharing of knowledge and experience;
- to contribute to improving the outcome for diabetic patients with CVD through providing information on practice characteristics related to the implementation of the diabetic guideline and changes in health outcomes and comparing countries in Europe where the guideline has been extensively disseminated and those countries where the guideline has been poorly disseminated.

Main deliverables to date

Evaluation of ESC-EASD guideline: <http://www.ehnheart.org/euroheart-ii/euroheart-ii-publications/publication/788-evaluation-of-esc-easd-guideline-.html>

CHD mortality projections to 2020, comparing different policy scenarios: <http://www.ehnheart.org/euroheart-ii/euroheart-ii-publications/publication/787-chd-mortality-projections-to-2020-comparing-different-policy-scenarios.html>

Identifying the most effective and cost-effective public health nutrition policy options for CVD prevention: <http://www.ehnheart.org/euroheart-ii/euroheart-ii-publications/publication/786-identifying-the-most-effective-and-cost-effective-public-health-nutrition-policy-options-for-cvd-prevention.html>

Death rates from heart disease in the European Union published online on 26 June 2013 in the European Heart Journal: <http://www.ehnheart.org/euroheart-ii/euroheart-ii-publications/publication/738-death-rates-from-heart-disease-decline.html>

European Cardiovascular Disease Statistics 2012: <http://www.ehnheart.org/euroheart-ii/euroheart-ii-publications/publication/673-european-cardiovascular-disease-statistics-2012.html>

- About World Heart Day
World Heart Day was created in 2000 by the World Heart Federation to inform people around the globe that heart disease and stroke are the world's leading cause of death, claiming 17.1 million lives each year.
- About the European Society of Cardiology
The European Society of Cardiology (ESC) represents more than 75 000 cardiology professionals across Europe and the Mediterranean. Its mission is to reduce the burden of cardiovascular disease in Europe: <http://www.escardio.org/Pages/index.aspx>
- About the European Heart Network
The European Heart Network (EHN) is a Brussels-based alliance of heart foundations and like-minded non-governmental organisations throughout Europe, with member organisations in 26 countries. The EHN plays a leading role in the prevention and reduction of cardiovascular diseases, in particular heart disease and stroke, through advocacy, networking, education and patient support, so that they are no longer a major cause of premature death and disability throughout Europe.
- European Guidelines for CVD prevention: <http://www.escardio.org/communities/councils/ccp/e-journal/volume12/Pages/cardiovascular-disease-prevention-guidelines-cp-reviewed.aspx#.UtPTvmD-mnw4>

(3) <http://www.escardio.org/about/what/advocacy/EuroHeart/Pages/2012-CVD-statistics.aspx>

(4) <http://www.ehnheart.org/euroheart-ii/euroheart-ii-conferences.html>

(5) <http://www.escardio.org/about/what/advocacy/EuroHeart/Pages/WP9-ESC-EASD-guidelines.aspx>



Useful links

Project website: <http://www.ehnheart.org/euroheart-ii.html>

Partners

Main Beneficiary:

European Heart Network
Belgium

Associated Partners:

- Asociacion Espanola para el desarrollo de la epidemiologia clinica, Spain
- Deutsche Herzstiftung e.V. /German Heart Foundation, Germany
- Društvo za zdravje srca in ožilja Slovenije, Slovenia
- European Society of Cardiology, France
- Fondazione italiana per il cuore - Italian Heart Foundation, Italy
- FUNDACION ESPAÑOLA DEL CORAZON, Spain
- Fédération Française de Cardiologie, France
- Gdański Uniwersytet Medyczny (Eng.: Medical University of Gdansk), Poland
- GOETEBORGS UNIVERSITET / University of Gothenburg, Sweden
- Heart of Mersey Partnerships CIC, United Kingdom
- Icelandic Heart Association ses, Iceland
- Institute for Clinical and Experimental Medicine (Institut klinické a experimentální medicíny in Czech), Czech Republic
- Irish Heart Foundation, Ireland
- Istituto Superiore di Sanità, Italy
- Italian Association against Thrombosis and cardiovascular diseases Onlus, Italy
- Ligue Cardiologique Belge - Belgische Cardiologische liga, Belgium
- Magyar Nemzeti Szívalapítvány – Hungarian National Heart Foundation, Hungary
- Medical Research Council, United Kingdom
- National Heart Forum, United Kingdom
- National Institute for Health and Welfare, Finland
- Nederlandse Hartstichting, Netherlands
- Portuguese Heart Foundation, Portugal
- Queens University Belfast, United Kingdom
- Saint Georges Hospital Medical School, United Kingdom
- Slovak League for Prevention and Treatment of Cardiovascular Diseases - Heart to Heart League, Slovakia
- The Chancellor, Masters and Scholars of the University of Oxford, United Kingdom
- The Provost, Fellows and Scholars of the College of the Holy and Undivided Trinity of Queen Elizabeth near Dublin, Ireland
- Thomayer University Hospital (Fakultní Thomayerova nemocnice s poliklinikou in Czech), Czech Republic
- University of Liverpool, United Kingdom



Developing the evidence base to support policy making

Community-Based Childhood Obesity Project

Overweight and obesity are rising dramatically, particularly amongst European children, having a striking impact on their health. The Strategy for Europe on Nutrition, Overweight and Obesity related health issues emphasises that actions at the local level, mainly targeting children, can be effective in improving behaviour in the long run⁽¹⁾.

'The aetiology of obesity is complex and eating and physical activity habits are likely to be developed at a young age'⁽²⁾. An 'obesogenic' environment elicits the consumption of too much energy and discourages physical activity. The need for obesity prevention in the whole population has stimulated the implementation of hundreds of community-based initiatives (CBIs) across Europe⁽³⁾.

CBIs are multi-factorial strategies aimed at changing behaviours through interventions focused both on individual behaviours and the environment. Modifying unhealthy habits requires changing perceptions, the micro-environment (e.g. schools, homes, neighbourhoods) and the macro-environment (e.g. education and health systems, governments, the food industry and society's attitudes and beliefs) so that healthy behaviours prevail. Interventions must be adapted to fit the local context, so almost all CBIs execute a mixture of strategies at a local level.

'Things we learn in our early years shape who we are as adults. To beat obesity, nothing is more important than developing a healthy eating habit and a physical activity routine during the early stage of childhood. That's why the use of community-based initiatives (CBIs) is very essential and specifically encouraged.'

Schools for Health in Europe (SHE) is an initiative of the Dutch Institute for Healthcare Improvement CBO.

<http://www.schools-for-health.eu/she-network/>

As a lot of activities are currently being carried out, there is a need for a comprehensive overview of the different types of local community-based approaches reducing childhood obesity, to facilitate the sharing of methods and approaches across Member States. Therefore, the European Commission launched a call for tenders in 2010 for a service provider to create a roadmap of the European community-based initiatives (CBIs, in the meaning of the WHO definition⁽⁴⁾) focusing on childhood obesity.

The study on CBIs and preventing childhood obesity through community-based initiatives was led by RIVM (Dutch National Institute for Public Health) during 2011 in collaboration with the WHO Regional Office for Europe.

(1) The Strategy for Europe on Nutrition, Overweight and Obesity related health issues: http://ec.europa.eu/health/ph_determinants/life_style/nutrition/keydocs_nutrition_en.htm

(2) The European Food Information Council (EUFIC): Preventing obesity through community-based initiative: <http://www.eufic.org/article/en/health-and-lifestyle/food-for-all-ages/artid/Preventing-childhood-obesity-through-community-based-initiatives/>

(3) Bemelmans, W. J. E., Verschuur, M., van Dale, D. et al. (2011), An EU-wide overview of community-based initiatives to reduce childhood obesity. Bilthoven, The Netherlands: RIVM.

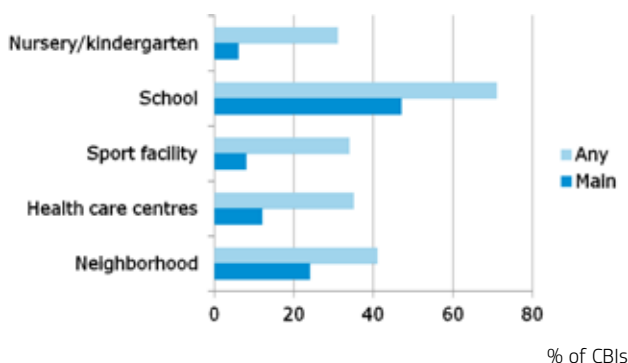
(4) The WHO definition Community-based initiatives (CBI) adopt a holistic approach to health paying equal significance to the physical, mental, social and spiritual well-being of individuals. CBI programmes represent integrated bottom-up socioeconomic development models that rely on full community ownership and intersectoral collaboration.

A comprehensive survey methodology for the data collection was developed to identify CBIs in the 27 EU Member States and in Iceland, Liechtenstein, Norway and Switzerland. In total, 83 CBIs (implemented between 2005 and 2011 in 17 countries) were analysed (see Table 1 of the final report as well as the graph showing the settings targeted).

The report 'An EU-wide overview of community-based initiatives to reduce childhood obesity' submitted by RIVM in December 2011, presents the outcomes of this survey. Its target audience covers policy makers at different levels, as well as public health professionals involved in executing CBIs.

Country	Number of CBIs	Total number of projects
Belgium	3	11
Czech Republic	1	2
Denmark	2	10
France	4	9
Germany	5	8
Greece	2	3
Hungary	3	5
Iceland	2	3
Ireland	4	12
Latvia	1	1
Netherlands	14	27
Poland	2	2
Romania	2	2
Spain	12	29
Sweden	7	22
Switzerland	2	8
UK	17	78

CBIs: Settings involved and age range of children targeted



Age range 0–18 years old.

The final report applies a practical approach and presents the following key elements:

- the results on obesity policy and CBIs in general;
- the degree of implementation and costs;
- the contents of CBIs, quality indicators, reported effectiveness of CBIs and practical experiences as reported by the CBI coordinators;
- a section for public health professionals on 'how to use this report as a practical toolkit';
- the overall conclusion and recommendations for policy makers.

Deliverables and outcomes:

Overall, 64% of CBI respondents indicated a specific goal for nutrition, 57% for physical activity and 38% for changing body weight. The analysis showed that health professionals in general (other than medical doctors) and teachers were most often involved as the providers of activities. The most frequently reported educational activities that directly targeted children were general educational information (89%), group education (88%) and counselling sessions (57%). Seven CBIs reported measurable effects on body weight and on the prevalence of overweight.

Examples of strategies applied in the CBIs studied:

Example of skill development of parents – Parental support (Sweden)

The parents were offered two sessions of motivational interviewing. Each session lasted 45 minutes where the parents discussed issues related to diet, physical activity and sleep with a trained health educator.

Example of professional training – Lebenslust (Germany)

During the project the kindergarten teachers' interest increased, the project's topics became more familiar to them, so they started to care more for their own as well as their children's eating habits... Moreover, kindergarten teachers' confidence in their possibilities of influencing the children's eating habits increased during the project.

Examples of activities – strategies directly targeting children - Delta project (Spain)

Educational workshops for schools, children's theatre, puppetry, storytelling, educational games (some of their own design), health fairs and youth meetings.

In addition to the report and the analysis of data related to CBIs, RIVM provided a set of conclusions summarised as follows:

- The survey revealed that attention paid to obesity at an (inter) national level has stimulated implementation of hundreds of CBIs in European countries in recent years.
- For the purpose of comparison, the report stressed the need for standardisation of the methodology for better scientific evaluation and data collection. The evaluation of CBIs relied on the collection of information on:
 - process indicators (e.g. central partnerships, local steering committee meetings);
 - output indicators (e.g. number of local actions, participation of families and children);
 - outcome indicators (e.g. changes in dietary habits, physical activity, BMI, well-being and knowledge).
- Overall, it was difficult to compare interventions due to variances in outcomes and quality of study designs. The project team therefore recommended that a database facility should become available soon to facilitate the optimal exchange of (detailed) information. Accessibility of high-quality intervention material would stimulate the improvement of CBIs. It is recommended that the database be developed in an interactive way, including an option to continually update information on the effects, costs and reach of CBIs.
- The report and database can inspire the development of new initiatives or improvement of ongoing CBIs. The available evidence suggests 'the more comprehensive, the better'.
- Prioritising childhood obesity and facilitating the implementation of CBIs within a national policy framework are important conditional factors, but the local situation and the community needs should be the primary entry point to start from. The report and a database can subsequently assist in developing an optimal approach.

Useful links

- Presentation with the final results prepared by RIVM: http://ec.europa.eu/health/nutrition_physical_activity/docs/ev20120209_co02_en.pdf
- The report refers to the NOPA database as an international database to consider using as a source of information in the future: <http://data.euro.who.int/nopa>
- Final report: http://ec.europa.eu/health/nutrition_physical_activity/docs/report_cbis_childhood_obesity_en.pdf

Partners

Main Beneficiary:
Rijksinstituut voor Volksgezondheid en Milieu
The Netherlands



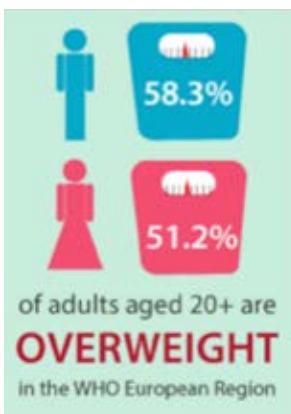
Developing monitoring systems

NOPA II project

Monitoring the implementation of the European Strategy for Nutrition and Physical Activity 2012–14

The burden of diseases associated with poor nutrition continues to grow in Europe. Poor diet, overweight and obesity contribute to a large proportion of non-communicable diseases, including cardiovascular diseases and cancer, the two main killers in the EU region.

National surveys in most countries indicate excessive fat intake, low fruit and vegetable intake and an increasing problem of obesity, all of which not only shorten life expectancy, but also harm the quality of life⁽¹⁾.



The WHO Regional Office for Europe and the Directorate-General for Health and Consumers of the European Commission established a three-year direct agreement called 'Monitoring the implementation of the European Strategy for Nutrition and Physical Activity' (NOPA I)⁽²⁾ which ran from 2008–11. Both parties have continued this collaboration in 2012–14 through the second phase (NOPA II) in

The NOPA Database Project forms the primary contribution of the EU to the provision of reliable, current and comparable data on Nutrition, Obesity and Physical Activity issues, and its effective dissemination to important stakeholders. The data and information compiled on each country and accessible online include national and sub-national surveillance data, policy documents, action to implement policy and examples of good practice in programmes and interventions.'

WHO NOPA Database
<http://data.euro.who.int/nopa/>

order to ensure the full cycle of surveillance, monitoring and evaluation of the policies they are currently implementing.

The NOPA database project is the basis for the monitoring of the progress so far towards the achievement of the commitments in the European Charter on Counteracting Obesity (2006), the WHO European Food and Nutrition Policy Action Plan (2007–12) and the White Paper on a Strategy for Europe on nutrition, overweight, and obesity-related health issues (2007)⁽³⁾.

(1) WHO Nutrition website: <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition>

(2) The achievements of the NOPA I project were reflected by the set up of: 1) an integrated web-based database on diet, nutrition, physical activity, relevant policy documents, projects and legislation in the 27 EU countries; 2) (a) an analytical system to measure progress in the obesity reduction strategy in Europe and (b) a clear reporting methodology; 3) a definition and illustration of good practice in key policy areas; 4) (a) guidelines on data collection and standardisation; (b) nutritional and physical activity surveillance and policy intelligence capacity strengthened in five countries.

(3) WHO NOPA Database: <http://data.euro.who.int/nopa/>

'There is a need to perform regular evaluation and review of policies, and to have internationally comparable core indicators'⁽⁴⁾

Objectives

The information system and its IT platform (NOPA database) initiated by NOPA I are being further developed and fine-tuned under NOPA II.

More specifically, the project aimed to:

- continue expanding and linking existing web resources on diet, nutrition and physical activity, country policy documents, policy implementation tools and legislation;
- develop an integrated web based system able to analytically describe nutrition and physical activity policies and measure the country progress towards the achievement of the key commitments of obesity reduction strategies and report in a clear, easy to understand way;

- identify and illustrate good practices in the areas of diet, nutrition, physical activity and obesity prevention;
- strengthen the quality of data collected by Member States, and continually update and expand the data;
- enable Member States to make comparisons and share information on specific policy areas such as labelling, taxes, affordability and availability.

The NOPA database compiles information from the 53 WHO European Member States. As a monitoring tool, the database can encourage policy makers to identify gaps and needs in data collection and policy development. WHO/Europe manages the NOPA database in close collaboration with the Information Focal Points⁽⁵⁾ and WHO Nutrition Counterparts in countries.

Table 1⁽⁶⁾: WHO European database on nutrition, obesity and physical activity (NOPA)

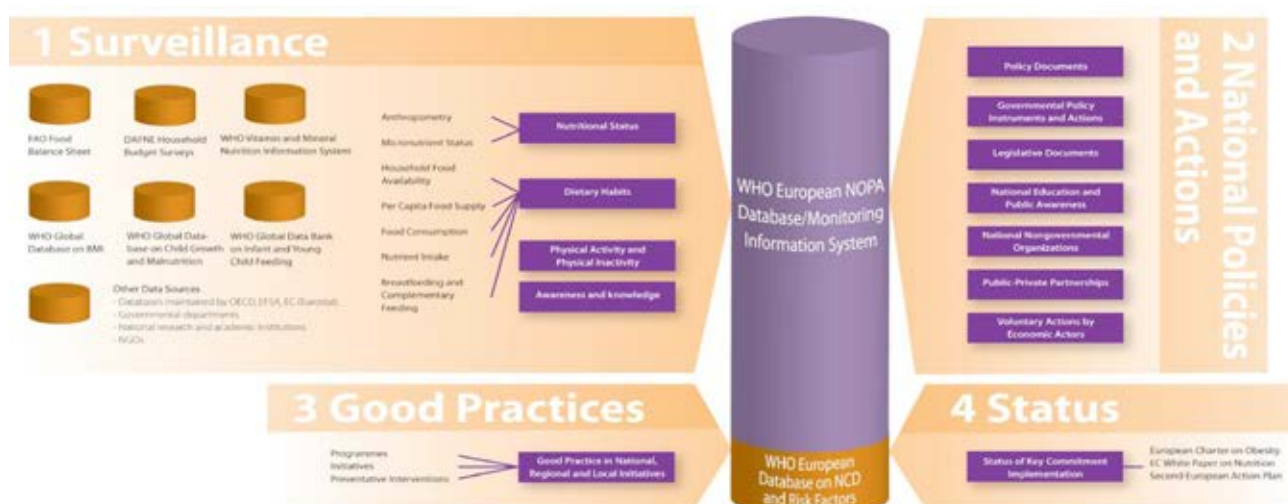
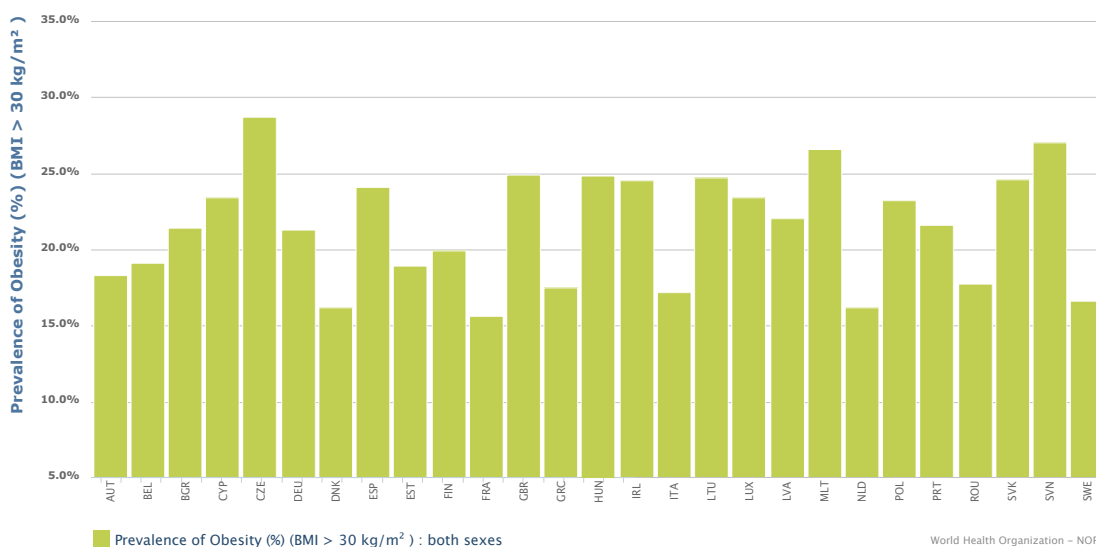


Table 2: NOPA database visuals

Prevalence of Obesity (%) (BMI > 30 kg/m²)
intercountry comparable estimate (WHO criteria for adults) , Source: NOPA



(4) The European Charter on Counteracting Obesity: http://www.euro.who.int/__data/assets/pdf_file/0009/87462/E89567.pdf

(6) Wijnhoven, T., Bollars, C. and Racioppi, R.: WHO European Database on Nutrition, Obesity and Physical Activity (NOPA). Presentation at the 2nd Meeting of the HEPA Europe-EU Contact Group, Amsterdam, 12 October 2011.

(5) Each of the 27 EU Member States has appointed a National Information Focal Point to assist WHO in implementation of the NOPA project. They met for the first time in Brussels in September 2008 and were joined by the project's Advisory Group, Steering Committee and WHO experts.

NOPA II outcomes so far

- **The Network of information focal points** that are supported and reinforced in collaboration with the nutrition and non-communicable disease (NCD) counterparts of the Member States; the focal points met regularly, in addition to the WHO national counterpart meetings, to discuss the methodological issues, and to assess the outcome and the use of the database outputs. Meetings of EC and WHO networks were also used to collect information, validate existing data and verify the progress of data analysis.
- **The Operational tools:** information templates, information sources for data collection and data analysis procedures are being improved, further developed and fine-tuned, and also discussed with the information focal points. Supportive tools to guide data collection and to standardise the project and policy selection and analyses are being prepared, taking into account recommendations already developed by EC projects. A better functioning integrated approach to the information system will be developed where more data (enabling to cross more NCD related variables) will be inserted and directly centralised in the database.
- **Capacity building:** support has been provided to the countries that are involved in the childhood obesity surveillance initiatives (COSI), including training of the staff on data collection and analysis. Countries that do not have solid information systems were offered assistance with the aim of establishing new surveillance systems.
- **Networking and integration with other systems and projects such as the European Childhood Obesity Surveillance Initiative⁽⁷⁾.** Synergies are being established with projects aimed at developing policy appraisal tools, evaluating obesity prevention programmes and assessing levels of physical activity, and with the database of commitments of the European Platform for Action on Diet, Physical Activity and Health.



World Health Organization

Useful links

- WHO NOPA Database
<http://data.euro.who.int/nopa/>
- WHO NOPA Database visuals
<http://www.whonopa.eu/visual/Show/1>
- WHO Publication 'Mapping salt reduction initiatives in the WHO European Region' (2014)
<http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2013/mapping-salt-reduction-initiatives-in-the-who-european-region>
- WHO country profiles covering developments in nutrition, physical activity and obesity in the WHO European Region (2013): <http://www.euro.who.int/en/nutrition-country-profiles>
- Marketing of foods high in fat, salt and sugar to children: update 2012–13 <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2013/marketing-of-foods-high-in-fat-salt-and-sugar-to-children-update-20122013>
- European Charter on Counteracting Obesity (2006):
http://www.euro.who.int/__data/assets/pdf_file/0009/87462/E89567.pdf
- European Food and Nutrition Policy Action Plan 2007–12:
<http://www.euro.who.int/en/health-topics/noncommunicable-diseases/cardiovascular-diseases/publications/2009/who-european-action-plan-for-food-and-nutrition-policy-2007-2012>
- White Paper on a Strategy for Europe on nutrition, overweight and obesity-related health issues (2007):
<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0279:FIN:EN:PDF>

Partners

Main Beneficiary:

WHO Regional Office for Europe,
European Centre for Environment and Health
Denmark

(7) WHO European Childhood Obesity Surveillance Initiative: <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/monitoring-and-surveillance/who-european-childhood-obesity-surveillance-initiative-cosi>



Developing monitoring systems

COSI project

3rd round of the European Childhood Obesity Surveillance Initiative

Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height⁽¹⁾. Body mass index (BMI) is a measure used to determine childhood overweight and obesity. It is calculated using a child's weight and height. BMI does not measure body fat directly, but it is a reasonable indicator of body fatness for most children and teens⁽²⁾.

A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults, because children's body composition varies as they age and varies between boys and girls. Usually, overweight is defined as a BMI between the 85th and 95th percentile and obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

The prevalence of overweight and obesity among children appears to be rising rapidly in many countries around the world including countries in Europe. Obesity is linked to serious complications in childhood, and an obese child is at risk of becoming an obese adult with an associated increased likelihood of ill health and premature death⁽³⁾.

In order to combat this emerging epidemic, trends in obesity need to be monitored through population surveys. Such monitoring

Through **the European Charter on Counteracting Obesity**, Member States in the European Region of the World Health Organization (WHO) committed to strengthening action on counteracting obesity through the development of internationally comparable core indicators for inclusion in national health surveillance systems and to placing this issue high on the political agenda of their governments. The Charter was signed at the WHO Ministerial Conference on Counteracting Obesity in Istanbul, Turkey (November 2006).

WHO Regional Office for Europe: European Charter on Counteracting Obesity, Copenhagen; 2006

http://www.euro.who.int/__data/assets/pdf_file/0009/87462/E89567.pdf

needs to be conducted on the basis of agreed standardised definitions⁽⁴⁾ of BMI.

(1) Centers for Disease Control and Prevention: Defining Overweight and Obesity.

(2) Centers for Disease Control and Prevention: Basics About Childhood Obesity.

(3) WHO Global Strategy on Diet, Physical Activity and Health: www.who.int/dietphysicalactivity/childhood/en/

(4) WHO Data and Statistics: <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/data-and-statistics>: 'BMI is calculated as a person's weight (in kg) divided by his or her height (in m²); and it does not distinguish weight associated with muscle from weight associated with fat and therefore provides only a crude measure of fatness'.

The Childhood Obesity Surveillance Initiative (COSI) emphasises the need for harmonised surveillance systems among primary-school children on which policy development within the European Region could be based⁽⁵⁾.

The establishment of the WHO European COSI, co-funded by the European Commission, is a response to the European Charter on Counteracting Obesity (*see box*).

Two COSI data collection rounds took place prior to this action, respectively the first round during the school year 2007/2008 and the second round during the school year 2009/2010.

Objectives

COSI routinely measures overweight and obesity prevalence of primary-school children aged 6–9 years, in order to monitor progress and enable comparisons between countries within the WHO/Europe Region.

This direct agreement between the WHO/Europe and DG SANCO supports the implementation for another two-year period of data collection (school year 2012/2013) and extends the survey to the newly joining EU countries.

Each country is responsible for its national data collection and identifies the institute to be responsible for overall national coordination.

WHO develops the protocols, manages the international coordination of the surveillance initiative and facilitates investigators' meetings.

In relation to the 3rd round, the 6th COSI meeting was convened in Oslo, Norway in November 2012. Earlier meetings with COSI Principal Investigators of the participating countries and Members of the COSI Advisory Board took place in Paris, France (June 2007), Maceira, Portugal (December 2007), Copenhagen, Denmark (June 2009), Rome, Italy (February 2010) and Lisbon, Portugal (July 2011).

Major results so far ⁽⁶⁾

The first data collection took place during the school year 2007/2008 with 13 countries participating⁽⁷⁾. The prevalence of overweight (including obesity) ranged from 19% to 49% among boys and 18% to 43% among girls, and the prevalence of obesity ranged from 6% to 26.6% among boys and from 5% to 17% among girls based on the 2007 WHO Growth Reference⁽⁸⁾. Furthermore, the presence of a north-south gradient was demonstrated with the highest level of overweight found in southern European countries⁽⁹⁾.

The second round took place during the school year 2009/2010 with four new participating countries: Greece, Hungary, Spain and the former Yugoslav Republic of Macedonia. In this round, the prevalence of overweight (including obesity) was a bit higher, ranging from 18% to 57% among boys and from 18% to 50% among girls⁽¹⁰⁾. Southern European countries still had the highest prevalence.

An additional four countries (Albania, Republic of Moldova, Romania and Turkey) joined the third data collection round, which took place during the school year 2012/2013.

In conclusion, results from the first two rounds showed that with the present COSI data it is possible to detect relevant changes. A period of two years, with just two rounds of data collection, is, however, inadequate for identifying clear trends within countries. Hence, continuation of the surveys will be important for evaluating the currently observed changes over a longer period.

(5) WHO Regional Office for the European Childhood Obesity Surveillance Initiative: <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/monitoring-and-surveillance/who-european-childhood-obesity-surveillance-initiative-cosi>

(6) WHO COSI Presentation by Dr J. Breda: http://ec.europa.eu/health/nutrition_physical_activity/docs/ev20120209_co03_en.pdf

(7) Belgium (Flemish region), Bulgaria, Cyprus, Czech Republic, Ireland, Italy, Latvia, Lithuania, Malta, Norway, Portugal, Slovenia and Sweden.

(8) WHO Growth Reference 5–19 years for school-aged children and adolescents to construct growth curves for school-aged children and adolescents that align with the WHO Child Growth Standards for preschool children and the BMI cut-offs for adults: <http://www.who.int/growthref/en/>

(9) WHO European Childhood Obesity Surveillance Initiative 2008: weight, height and body mass index in 6–9 year-old children: <http://onlinelibrary.wiley.com/doi/10.1111/j.2047-6310.2012.00090.x/abstract>

(10) Preliminary results from the study group.



**World Health
Organization**

Useful links

- WHO Regional Office for Europe: European Charter on Counteracting Obesity, Copenhagen; 2006: http://www.euro.who.int/__data/assets/pdf_file/0009/87462/E89567.pdf
- WHO European Childhood Obesity Surveillance Initiative (COSI): <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/monitoring-and-surveillance/who-european-childhood-obesity-surveillance-initiative-cosi>
- WHO European Action Plan for Food and Nutrition Policy 2007–12. <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/pre-2009/who-european-action-plan-for-food-and-nutrition-policy-2007-2012>
- The challenge of obesity in the WHO/Europe region and the strategies for response. http://www.euro.who.int/__data/assets/pdf_file/0010/74746/E90711.pdf

COSI core measurements:

‘A final sample size of 2 800 children per age group (6.0–6.9; 7.0–7.9; 8.0–8.9; 9.0–9.9) is determined for each round.

Core measurements are body weight and body height; waist and hip circumference are optional, along with associated co-morbidities, dietary intake and physical activity/inactivity patterns. The anthropometric

measurements are done by trained examiners and standardised according to WHO standardised techniques.’

COSI project <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/monitoring-and-surveillance/who-european-childhood-obesity-surveillance-initiative-cosi>

Partners

Main Beneficiary:

WHO Regional Office for Europe,
European Centre for Environment and Health
Denmark

List of Abbreviations

BMI	Body mass index
CAP	Common Agricultural Policy
CBI s	Community-based initiatives
CIAA	Confederation of the Food and Drink Industries in Europe
CHAFEA	Consumers, Health and Food Executive Agency, formerly EAHC
COM	Commission Communication
CVD	Cardiovascular disease
DG EAC	Directorate-General for Education and Culture
DG RTD	Directorate-General for Research and Innovation
DG SANCO	Directorate-General for Health and Consumers
EC	European Commission
EU	European Union
EFIC	European Food Information Council
FAO	Food and Agriculture Organization of the United Nations
HBSC	Health Behaviour in School-Aged Children
HEAT	Health Economic Assessment Tool
HEPA	Health-enhancing physical activity
HLG	High Level Group on Nutrition and Physical activity
IASO	International Association for the Study of Obesity
IOTF	International Obesity Task Force
LTPA	Leisure-time physical activity
NCDs	Non-communicable diseases
NEET	Not in education, employment or training
NGO	Non-governmental organisation
OECD	Organisation for Economic Cooperation and Development
PA	Physical activity
PHP	Public Health Programme
PPP	Public-private partnership
SDG	Socially disadvantaged groups
SES	Socio-economic status
SFA	Saturated fatty acids
SMEs	Small and medium-sized enterprises
SWD	Staff Working Document
TFA	Trans fatty acids
WHO	World Health Organization
WHO/Europe	World Health Organization Regional Office for Europe
WP	Work Package

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