

Report of the Meeting on community initiatives to improve nutrition and physical activity

Berlin, Germany, 21–22 February 2008



Abstract

The World Health Organization Regional Office for Europe and the Directorate-General for Health and Consumers of the European Commission have established a joint three-year project to monitor progress in improving nutrition and physical activity and preventing obesity in the European Union. As part of this project, a meeting on community initiatives to improve nutrition and physical activity, supported and hosted by the Federal Ministry of Health of Germany, was organized by the Regional Office in Berlin, Germany on 21–22 February 2008. Its aims were to share knowledge and experience of successful lifestyle interventions and to discuss a draft concept of a tool to appraise good practice elements of intervention programmes.

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List of abbreviations

The following abbreviations are used in this report:

ACORDA	<i>Adolescentes e Crianças Obesas em Regime de Dieta e Actividade Física</i> (Obese children and adolescents involved in physical activity and diet programme)
AMED	<i>Alimentación Mediterránea</i> (Mediterranean diet)
BIG	<i>Bewegung als Investition in Gesundheit</i> (Movement as investment in health)
DG SANCO	Directorate-General for Health and Consumers (EC)
DOiT	Dutch Obesity Intervention in Teenagers
EC	European Commission
EPODE	<i>Ensemble prévenons l'obésité des enfants</i> (Together let's prevent childhood obesity)
EU	European Union
EUNAAPA	European Network for Action on Ageing and Physical Activity
HAPPY	Hungarian Aqua Promoting Programme in the Youth
HBSC	Health Behaviour in School-aged Children
HEPA	Health-Enhancing Physical Activity
HEPS	Healthy Eating and Physical Activity in Schools project
HOPE	Health promotion through Obesity Prevention across Europe
HPS	Health Promoting Schools
IDEFICS	Identification and prevention of Dietary – and lifestyle – induced health Effects in Children and infants
NFSI	Nutrition-Friendly Schools Initiative
PASSI	<i>Progressi delle Aziende Sanitarie per la Salute in Italia</i> (Italian Behavioural Risk Factor Surveillance System)
PREFFI	<i>Preventie Effect Management Instrument</i> (Health promotion effect management instrument)
RCT	randomized controlled trial
RIVM	Dutch National Institute for Public Health and the Environment
SAT	Self-Appraisal Tool
SHE	Schools for Health in Europe network
WHO	World Health Organization

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Introduction

The WHO European Action Plan for Food and Nutrition Policy 2007–2012 (1) highlights the importance of health promotion activities carried out at the local level such as “promoting healthy lifestyles such as outdoor recreation in the community, especially among vulnerable groups and providing local environments that support physical activity”. The design of such activities, the context in which they are implemented and the different actors involved are all key factors for success. The assessment of such public health initiatives in the European Region can teach us important lessons for the future.

The aim of the meeting was to share knowledge and experiences of successful lifestyle interventions at the local level. The meeting focused on the concept of community interventions. It incorporated information on how national governments can facilitate and encourage local programmes and at the same time consider the socioeconomic determinants of lifestyle and health. A series of selected community programmes, covering a wide spectrum of settings and approaches, was presented and discussed. The meeting also discussed the concept of good practice in intervention programmes, taking into consideration the main programme characteristics, the monitoring and evaluation processes, quality of implementation and achievement of programme objectives.

The meeting was attended by a total of 80 public health experts and representatives of nongovernmental and intergovernmental organizations (see Annex 1).

The meeting was opened by Karin Knufmann-Happe of the German Federal Ministry of Health and Francesco Branca of the WHO Regional Office for Europe. There then followed four sessions on national and local action to promote diet and physical activity, examples of community interventions and the concept of good practice. The first day ended with discussion groups about programme design, monitoring and evaluation, implementation, and the role of media and communication. The second day opened with a feedback session from the discussion groups, followed by a session about achievements and missed targets. The closing session consisted of a lecture on a good practices database and another on elements of successful community intervention. See Annex 2 for the detailed programme.

A separate meeting on the Nutrition-Friendly Schools Initiative (NFSI) was organized on the afternoon of the second day and attended by country representatives. The minutes of this meeting are given in Annex 3.

WHO European Action Plan for Food and Nutrition Policy 2007–2012

Europe is facing an epidemic of obesity: half of all adults and one in five children in the European Region are overweight. Another alarming issue is the double burden of child malnutrition, meaning that undernutrition and obesity occur simultaneously in children in some countries, especially in eastern Europe. Anaemia among preschool children is also a challenge in the Region.

The overall fat intake is too high and the supply of fruit and vegetables is below the recommendation minimum of 400 g a day. Changes in the modern food system, such as a higher consumption of processed food and an increased use of fast food outlets, influence food consumption patterns. Globalization dramatically reduces local food supplies, and the supplier as well as the consumer needs to be influenced in order to make a real impression and re-establish a better balance. An integrated approach including all relevant sectors (agriculture, fiscal and urban planning) is essential.

Nevertheless there is also some good news and success to report. For example, Sweden (2) can show that a combination of policy, local action and long-term investment has led to a halt or even a decrease in the prevalence of obesity in children, while Finland reports a significant reduction in salt intake (3).

The Action Plan translates political concepts into action areas involving governments, civil society, professional networks, economic operators and international actors. The Action Plan translates the political commitments of the European Charter on Counteracting Obesity (4) into operational goals through six action areas:

1. supporting a healthy start
2. ensuring a safe, healthy and sustainable food supply
3. providing comprehensive information and education to consumers
4. taking integrated action to address related determinants
5. strengthening nutrition and food safety in the health sector
6. monitoring, evaluation and research.

National and local actions to promote diet and physical activity

This session included three presentations on three different countries outlining the actions that have been undertaken at the national and local level to promote a healthy diet and physical activity.

Italy

Italy is divided into 19 regions and 2 autonomous provinces. The health care system is decentralized: the Government defines essential levels of care but implementation is through 210 local health units. The role of the Ministry of Labour, Health and Social Policies is to build a consistent framework of constitutional legislation and agreements with the main actors and to form partnerships to tackle the issues. Other key responsibilities are related to mobilization, monitoring and surveillance, and advocacy.

The Government has issued a national prevention plan in which counteracting obesity is one of the 11 priorities. Recommended actions include the promotion of breastfeeding, improving eating habits and enhancing physical activity at schools and the workplace, promoting and facilitating physical activity in urban areas, improving information and knowledge on nutrition, making healthy nutritional choices available and identifiable, and collaborating with food producers to avoid misleading advertising.

In May 2007, a plan called *Guadagnare Salute (5)* was launched by the Ministry of Labour, Health and Social Policies. It serves as a coordinated intersectoral action plan for tackling the four leading risk factors for noncommunicable diseases: physical activity, nutrition, alcohol use and tobacco consumption. It is based on institutional alliances between ministries and with regions and municipalities and partnerships with the food industry, distribution networks and consumer associations.

Italy uses the following monitoring and surveillance systems:

- *Progressi delle Aziende Sanitarie per la Salute in Italia (PASSI)* is a multipurpose surveillance system for adults covering the following areas: perceived quality of life, smoking, physical activity, nutritional status, cardiovascular risk factors, alcohol use, car safety, mental health,

cancer screening and vaccination (<http://www.ulss7.it/magnoliaPublic/istituzionale/notizie-e-comunicazione/notizie/passi.html>, accessed 11 March 2010).

- *The Health Behaviour in School-aged Children (HBSC) survey (6)* has the overall goal of gaining new insights into and increasing our understanding of health.
- *OKkio alla SALUTE* involves cluster sampling of pupils in their third year of primary school and is designed to produce local or regional estimates of dietary habits, overweight and physical activity (<http://www.epicentro.iss.it/okkioallasalute/default.asp>, accessed 11 March 2010). As part of the project, Italy is participating in the WHO European childhood obesity surveillance initiative.

The advocacy role of the Ministry aims at counteracting negative views on obesity or on obesity prevention policies.

Switzerland

The Swiss Federal Government's Concept for a National Sports Policy has existed since 2000 and defines as its main objective an increase in the proportion of physically active people in the Swiss population. A national programme on nutrition and physical activity is in preparation, one of its main objectives being the promotion of physical activity and sport. Another document entitled *Physical activity at every age* is being developed and will describe the factors/determinants influencing sport and physical activity behaviour for different age groups, such as personal factors and the social and physical environment.

Since 1999, organizations interested in health promotion through physical activity and sports have met through the HEPA (Health-Enhancing Physical Activity) network in Switzerland (<http://www.hepa.ch/>, accessed 11 March 2010). Recommendations for health-enhancing physical activity in adults were issued in 1999 and those for children and adolescents in 2006.

However, the biggest and most important intervention for physical activity and sports promotion has existed much longer: the national *Youth+Sport* programme was started in 1972 and by 2005 involved 550 000 children and adolescents aged 10–20 years of age with activities primarily oriented towards sport for all and developing sporting skills. Existing bodies such as schools, sports clubs, sports federations and youth organizations are subsidized in order to promote and increase physical activity among youth by offering sports activities (<http://www.jugendundsport.ch/internet/js/fr/home.html>, accessed 11 March 2010).

In view of growing concerns about overweight and physical inactivity in children, the need to reach out to younger children and underserved populations is increasingly recognized. That is why, in 2007, a pilot project entitled *Youth+Sport Kids* was launched in 247 school classes for girls and boys aged 5–10 years. Primary school teachers were trained and reimbursed

for offering an additional physical education lesson per week and for integrating physical activity into their classes and schools. An evaluation is currently being carried out, consisting of interviews with all teachers and detailed measurement in 15 intervention and 15 control classes.

It is planned to achieve national coverage with *Youth+Sport Kids*. But, even if this succeeds, further approaches will be necessary to successfully fight the problems of physical inactivity and overweight. This is why discussion on existing interventions and experiences will continue and be intensified, both at national level and at international level through HEPA Europe, the European network for the promotion of health-enhancing physical activity (<http://www.children-on-the-move.ch>, accessed 11 March 2010).

At the same time, a systematic approach to physical activity and sports promotion is under development in the “biographical framework” developed jointly with practitioners and scientists. The framework describes the main determinants of physical activity behaviour in different age groups and illustrates the roles that the different partners in physical activity promotion can take on. Further developments of the framework can be used for guidance in promoting physical activity at the national, regional and local level.

United Kingdom

Nearly a quarter of men and women in England are now obese, with two thirds of all adults overweight or obese. Almost a fifth of 2–5-year-old children are obese, with one third of children overweight or obese. The recently commissioned *Foresight* report (7) predicted this could rise to 9 in 10 adults and two thirds of children by 2050 on current trends. This would have a serious effect on the health of the population, increasing the risk of diabetes, cancer, heart disease and liver disease and costing up to £50 billion per year to the National Health Service and to society as a whole. The *Foresight* report called this the “climate change of public health”.

The report focused on the basic premise of an imbalance between what is consumed through eating and what is used by the body, including the energy used through physical activity. The report said that a multifactorial approach is required, including addressing societal influences, food production, food consumption, individual psychology, individual activity and the activity environment. Tackling obesity was identified as a priority in the Government’s “*Choosing Health*” Public Health White Paper in November 2004 (8). A delivery plan followed in March 2004 and “*Health Challenge England*” (9) in 2006 set out the next steps. Action has been taken to improve food standards in schools, introduce front-of-pack labelling and restrict broadcast advertising on food products high in fat, salt and sugar within programmes targeted at children. A national child measurement programme was introduced in schools for reception year children (aged 4–5 years) and year 6 children (aged 10–11 years).

Recently, the Government published *Healthy weight, healthy lives (10)*, a cross-government strategy, with the ambition to be the first major country to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. The initial focus will be on children with the aim of reducing the proportion of overweight and obese children to 2000 levels by 2020. A number of key actions at national level are being taken, including promoting healthier food choices, building physical activity into everyday lives, creating incentives for better health, and personalized advice and support.

In September 2007, a Childhood Obesity National Support Team was piloted following the successful introduction of a number of other public health national support teams covering areas such as sexual health and teenage pregnancy, tobacco control and health inequalities. Two multidisciplinary national support teams provide expert support and advice to local health organizations and their local government partners in developing and implementing local strategies for tackling obesity, and give advice on specific interventions to improve nutrition and increase physical activity. This process is undertaken through four-day visits to local areas in every region of the country and interviews with key members of staff, at the end of which feedback is given and possibilities of further support are identified. Examples of good practice in relation to local interventions are being collected from these visits for dissemination elsewhere in the country. Experience from these visits is fed back into policy development and local delivery guidance (<http://www.dh.gov.uk/en/PublicHealth/Healthimprovement/NationalSupportTeams/Childhoodobesity/index.htm>, accessed 11 March 2010).

Examples of community interventions – presentations

Representatives of six community interventions from different countries introduced their programmes, including information about the main programme characteristics, implementation, and monitoring and evaluation. A summary of each intervention is provided below.

Shape Up

Shape Up is a project that bridges the gap between health prevention and health promotion. It addresses childhood obesity by focusing on determinants of health rather than solely on individual behaviour and lifestyles (<http://www.shapeupeurope.net/index.php?page=home>, accessed 11 March 2010).

The *Shape Up* methodological approach builds on the experience and research from, among others, the Schools for Health in Europe (SHE) network (<http://www.schoolsforhealth.eu/>, accessed 11 March 2010), and particularly from the international educational project “*Young minds – exploring links between youth, health and culture*”. The approach builds on often

neglected potential relating to collaboration between the school and local community, genuine child participation and international collaboration.

Shape Up was set in motion in 2004 when 21 cities in 21 EU Member States were approached and committed resources to a unique cooperative project to counteract child obesity and influence the determinants of a healthy and balanced growing up. Children aged 4–16 years from 78 schools participated in the project. In 2005, the proposal was submitted to the EC's DG SANCO and was assessed and selected for funding. *Shape Up* relies on an innovative public–private partnership based on strict ethical rules.

The *Shape Up* approach differs from traditional prevention or health-promoting interventions that often focus exclusively on modifying children's behaviour. In contrast, *Shape Up* suggests that it is vitally important to develop the child's capacity to critically explore and improve health-related conditions and practices at different levels: family, school and community. Children collaborate with adults to explore the issues of health, diet and physical exercise and take action to initiate real-life changes at school and local community level. Changes can be, for example, a footpath to school, improvements of the physical environment of the school canteen, improvements in the quality of school meals, or better play and exercise facilities at the local level. The specific changes will always depend on needs identified by or with children in the local setting. Furthermore, the changes will be sustained after the project ends.

Shape Up staff – a local coordinator and a local facilitator who has direct contact with schools – work in each city. Local *Shape Up* promoting groups have been created, consisting of city officials, facilitators and other stakeholders, whose task it is to provide opportunities and support for children and young people, and to provide logistic and strategic support to make sure that children's ideas for action are taken seriously and followed through at community level.

EPODE – Ensemble prévenons l'obésité des enfants (Together let's prevent childhood obesity)

The EPODE programme, implemented in several European countries since 2004, is a community-based intervention methodology to prevent childhood obesity in a sustainable way that involves local stakeholders. The five key factors of EPODE are strong political will, a scientific background, a professional organizational scheme, an ethical public–private involvement and continuous communication (<http://www.epode.fr>, accessed 11 March 2010).

The EPODE model is based on involvement of the community for the community, at the very heart of the “ecological niche”: the town. It is a long-term programme that lies within the framework of daily life and takes the environment and constraints into account. It is a positive, concrete and step-by-step apprenticeship of nutritional balance and physical

activity. EPODE is a behaviour-centred approach, with an educational philosophy prompting fun and the non-stigmatization of any food.

A national coordination team using social marketing and organizational techniques coaches a local project manager nominated by the mayor (or other local leader) to mobilize local stakeholders. This coordination involves network organization techniques, continuous education, approaches relying on group dynamics and modification of social policies, marketing to health professionals, communication with the general public, and press relations on public health issues. The national coordination team operates under the supervision of a committee of independent specialists and in collaboration with professionals in the fields of education, psychology, sociology, sport and nutrition.

The municipality concerned takes responsibility for the programme for at least five years, through the appointment of a project manager who coordinates a municipal multidisciplinary steering committee (education, school catering, sport, health, community life, etc). This methodology permits the entire community (e.g. teachers, school catering staff, health professionals, parents, the media) to become a vector within noncommunicable diseases, including strategies for obesity prevention and creating an environment that facilitates changes close to the family. As of early 2007, 127 towns in France, 2 in Belgium and 5 in Spain were involved, covering more than 2 million people. Within families, the programme is seen as a “healthy lifestyle” programme, a concrete aid that helps to guide and support their educational role towards their children.

The BIG project – Bewegung als Investition in Gesundheit (Movement as investment in health)

With respect to counteracting obesity, socially disadvantaged people are an important target group but they tend to be difficult to reach with health promotion action. Participatory approaches to planning health promotion action appear to be an appropriate means of reaching such people.

The BIG project aimed to improve health outcomes by investing in preventive physical activity. BIG used a multi-level, policy-orientated, participatory approach to reach the target group, with the aim of promoting healthy behaviour (movement) among women in difficult situations, i.e. those on low incomes and/or with an ethnic minority background. The target group was characterized by a comparably low prevalence of physical activity and a high prevalence of diseases related to a sedentary lifestyle. BIG focused on both individual and structural changes. The project developed, implemented and evaluated interventions at the local level in the city of Erlangen in three different settings – neighbourhood, workplace and sports club. It combined the “investment for health” approach with the newly designed “health assets” concept of WHO to conduct research that integrated the action areas of the Ottawa Charter for Health Promotion (11). Focus groups, workshops and social marketing strategies were used as methods in the participatory approach. BIG assessed policy options

and movement possibilities during the assessment phase, and used a collaborative approach to project planning and implementation involving target group members, experts and local policy-makers. Evaluation encompassed health, health behaviour and economic and social impact on health. Qualitative and quantitative methods were used, as well as expert-based and participatory evaluation approaches (<http://www.stmugv.bayern.de/gesundheit/giba/gewicht/big.htm>, accessed 11 March 2010).

In a participatory and collaborative planning process, target group members and other local stakeholders were systematically involved and became co-workers and co-deciders in the process of the project. The multi-level intervention considered the action areas of the Ottawa Charter. Exercise classes, newly-created opportunities for movement, and educational activities reached the target group and developed the women's personal skills. Opportunities for movement also promoted community action. Enabling and improving access to sport facilities contributed to creating supportive environments. Establishing and sustaining infrastructures, developing interventions together with stakeholders, and promoting intersectoral policy-making in health promotion through collaborative planning shifted public policy towards health promotion among vulnerable target groups.

Everything affects us – especially ourselves

“Everything affects us, especially ourselves” is a mutual development project of the Public Health Institute and 25 municipalities in Iceland. It aims to promote healthy lifestyles in children and their families by emphasizing increased physical activity and improved diet. The project is based on a multifactorial, population-based, primary prevention strategy, making an effort to increase people's knowledge of the relevant, influencing factors, in addition to promoting better facilities for public health (<http://www.lydheilsustod.is/english/projects/everything-affects-us-especially-ourselves/>, accessed 11 March 2010).

The participating municipalities formulate their own policy and action plans for increasing physical activity and improving nutrition in children in their home areas in accordance with their own needs and circumstances. In each municipality, an interdisciplinary task force is formed to keep track of the progress of the project in its area. In each school and preschool institution, working groups are linked with the task force's activities. In addition, the primary health care service in each location collaborates with the task force. The Public Health Institute plays a consultative and advisory role in the project.

The project formally began in the autumn of 2005. The first part of the project ended in 2007 and the second part will be finalized in 2010. For the last two years, the municipalities participating in the programme have been responding well. Increased knowledge and changing attitudes by all involved has led to a more strategic focus on physical activity and nutrition.

The Public Health Institute is responsible for evaluating the project. The baseline was taken during the spring of 2005. An assessment was made in 2007 and will be made again in 2010.

Indicators have been defined focusing on structure, process and impact. These are considered to be the critical factors for successfully reaching the goals of the programme.

Programme on nutrition prevention and health of children and adolescents in Aquitaine

The *French National Programme on Nutrition and Health* was initiated by the Ministry of Health in 2001. Its main objective is to stop the increase in childhood obesity rates. Various public health actions were therefore implemented to improve dietary habits and physical activity during childhood (<http://www.nutritionenfant.aquitaine.fr>, accessed 11 March 2010).

In the Aquitaine region in south-west France, a regional programme for preventing obesity in children and adolescents was introduced in November 2004. The programme aims at improving the behaviour of children and adolescents regarding healthy diet and physical activity and at stabilizing the prevalence of childhood obesity. It targets children aged 3–18 years and also involves their families and health and education professionals. Special attention is given to vulnerable groups such as those on low incomes.

Actions focus on the following three areas:

1. early screening, prevention and management of obesity during childhood by mobilizing school doctors and nurses throughout Aquitaine, using clinical guidance in screening and treating those already overweight and providing training for health professionals;
2. improving the availability of healthy food at school and at leisure time facilities; and
3. implementation of health promotion activities in the fields of nutrition and physical activity for children and families, together with training sessions for health and education professionals.

The programme is managed by URCAM for Aquitaine (a public health care insurance organization working at regional level) in collaboration with local branches of the Ministry of Health, Education and Sport. An intersectoral committee has been established, including public health professionals such as doctors, nurses and health educators, nongovernmental organizations in the field of health promotion, and local authorities. To evaluate the programme, several surveys are planned for measuring food intake in children under 6 years of age, weight and food intake of children aged 7–9 years, weight, physical activity and food intake in middle- and high-school pupils, and food supply in middle- and high-schools.

Food cooperatives

Consumption of fruit and vegetables in Wales is considerably lower than the United Kingdom recommended level of five portions a day. In 2004, only 41% of all adults in Wales reported

eating five or more portions of fruit and vegetables a day and this level was only 37% for manual workers and 30% for the long-term unemployed.

In April 2004, as part of a range of initiatives to address this issue, a two-year pilot scheme was begun to develop community food cooperatives in north and south-east Wales. The pilot area covered a diversity of rural and urban areas, including a significant proportion of the South Wales Valleys. The key focus of the pilot was to supply, from locally produced sources as far as possible, affordable fruit and vegetables of good quality to disadvantaged communities through the development of sustainable local food distribution networks. A partnership was formed between the Welsh Assembly Government and the Rural Regeneration Unit. A grant from the Welsh Assembly Government funded two Community Food Development Officers to develop a minimum of 26 sustainable food cooperatives (<http://www.physicalactivityandnutritionwales.org.uk/page.cfm?orgid=740&pid=29570>, accessed 11 March 2010).

The pilot focused on socially disadvantaged communities. The project aimed to develop and introduce sustainable practices to improve health through collaborative action and direct efforts at a local level linking farmers to consumers. The food cooperatives work by linking local volunteers, who run the cooperatives, to a local supplier, who is a grower and/or local wholesaler. A simple payment and delivery system is agreed, which enables the volunteers to order and pay weekly in advance for the fruit and vegetables. Customers then collect their fruit and vegetables at an agreed venue during cooperative opening times and place their orders and pay for the following week. A total of 77 food cooperatives were set up in the two-year period.

The successful development and sustainability of cooperatives depends in large measure on the extent to which they are networked into a broad range of community interventions or programmes. Contact with outside agencies is important for sustaining momentum and the morale of those associated with the cooperatives, and offers mutual practical support. Many cooperatives benefited particularly from working in tandem with other agencies, often located within the same premises.

The pilot was evaluated by Cardiff Institute of Society, Health and Ethics and the North East Wales Institute, who concluded that most people buying from the cooperatives were eating more fruit and vegetables. Other benefits highlighted included changes to the quality of social lives and connections to other people, perceived improvements to health, and understanding of health-related issues. Changes in attitudes to fruit and vegetables were reported for other beneficiaries: in families, in schools and in the community as a whole.

Examples of community interventions – short briefings

In this session, representatives of various programmes had the opportunity to briefly present their main aims and key activities.

Miniature golf comes to you – Austria

The “*Miniature golf comes to you*” programme takes place in Vienna. The aim is to enhance physical activity among older people aged ≥ 75 years living in residential homes. Indoor miniature golf courses, training and championships are offered. To evaluate the programme, the participants are interviewed and asked to complete questionnaires, the organizers and the contact persons of the residential homes are interviewed, and the participants are kept under observation. The results show that the project complies ideally with the requirements of the elderly. It encourages participation by people up to 95 years of age as well as physically handicapped people and those who have never participated in sport before. The participants seem to mainly appreciate the social aspects and they begin to go out again regularly to participate in competitions or visit other teams. The project shows how elderly people can gain sense of purpose and confidence by engaging in sport, in spite of physical limitations (<http://www.minigolfcompany.com/>, accessed 11 March 2010).

Promoting physical activity with an activity monitor in pre-diabetic adults – Austria

DE-PLAN (*Diabetes in Europe – Prevention using Lifestyle, Physical Activity and Nutritional intervention*) is an EU-funded project involving 25 institutions from 17 countries between 2005 and 2008. It aimed at promoting physical activity in pre-diabetic adults in the Salzburg area. To show that the use of an activity monitor (Polar AW200 Activity Watch™, Polar Electro Oy, Kempele, Finland) will improve physical activity, dietary behaviour and clinical data in pre-diabetic adults, 150 participants were enrolled in a 2-year lifestyle programme and were followed by means of an activity monitor (watch). The 150 participants were assigned randomly to a low fat education group, to a low glycaemic index load education group and to a control group. Both intervention groups attended the programme, including 13 sessions on how to achieve the 5 lifestyle goals (5% reduction in body weight, < 30% total fat intake, < 10% saturated fat intake, ≥ 15 g fibre intake per 1000 kcal and ≥ 240 minutes of moderate-intensity physical activity per week) and a sports fair. One half of both intervention groups received the activity monitor. The control group received two educational sessions only, did not participate at the sports fair and did not receive the activity monitor. All participants were followed up six-weekly and six-monthly to keep them motivated to achieve the goals and to assess changes in physical activity and clinical parameters (<http://www.de-plan.at/>, accessed 11 March 2010).

Equality in active living – Denmark

In the city of Horsens, a 2-years project aiming at providing equality in active living has been launched at 21 schools. The project targets lower socioeconomic groups and aims

at supporting families who cannot afford to pay for the activities. It creates social networks and integrates the parents in the activities. It focuses on understanding and feeling the importance of physical activity, health and experiences with good friends. The expected outcome is to create sustainable habits and a solid network.

Fit for Life Programme – Finland

The *Fit for Life* Programme inspires adults over the age of 40 to include physical activity in their daily routines, and provides physical activity services that are easily available around the country. One goal is to strengthen cooperation and networking among organizations operating in the field of HEPA (at national, regional and local levels). Local projects (nearly 800) are organized in cooperation with different organizations, such as municipal sports and health services, workplaces, occupational health care, sports clubs, associations and health organizations. Local projects can apply for funding from the national programme, which is funded by the Ministry of Education and Ministry of Social Affairs and Health. *Fit for Life* is also supported by the Ministry of Transport and Communications, the Ministry of the Environment and the National Board of Forestry (<http://www.kki.likes.fi/pages/content/Show.aspx?id=31>, accessed 11 March 2010).

The programme developed several exercise and weight control campaigns such as “*Have a Chance*” and “*The Adventures of Joe Finn*”. It provides middle-aged people with tools to help them towards permanent weight control, a more active lifestyle and healthier eating habits.

The development of the IDEFICS Community intervention for obesity prevention in young children – Germany

The IDEFICS (*Identification and prevention of Dietary – and lifestyle – induced health Effects in Children and infants*) study (2006–2011) is coordinated by the Bremen Institute for Prevention Research and Social Medicine at the University of Bremen. The study is funded by the EC and its focus lies in exploring the risks for overweight and obesity in children as well as the associated long-term consequences. In addition, it offers a unique possibility to measure how far sensory perception and children’s preferences influence the development of overweight. Besides research, IDEFICS will offer activities for prevention and health promotion in kindergartens and schools. The results of the study will be incorporated into various guidelines on nutritional, behavioural, lifestyle and ethical aspects in all participating countries (<http://www.idefics.eu/idefics/>, accessed 11 March 2010).

European Network for Action on Ageing and Physical Activity (EUNAAPA) – Germany

EUNAAPA is a network fostering exchange between researchers and policy-makers in the field of sedentary lifestyles and population ageing, in order to improve the health, well-being, and independence of older people. A total of 24 institutions from 18 European countries take part in the network, which is funded by the EC’s DG SANCO and whose primary goal is to support the political implementation of evidence-based interventions promoting physical

activity among elderly people throughout Europe. In close cooperation with experts from all relevant fields (sport, health care and social care) and levels (national, regional and local), the EUNAAPA group identified successful and evidence-based programmes and strategies for promoting physical activity (<http://www.eunaapa.org/>, accessed 11 March 2010).

Healthy children in healthy communities – Germany

This project serves as a multisectoral cross-border network strategy at the community level (family, school, sports club and community administration offices for education, public health and sports, environmental planning and development) to counteract the development of overweight and obesity and to promote an active lifestyle in childhood. The strategy employs a comprehensive approach for intervention: co-curriculum physical activities in the morning before school lessons start (“walking bus”), health-enhanced physical education at school (three lessons per week) in conjunction with health education and nutrition information as a part of “science” at primary school level, co-curriculum physical activities between school lessons, and sports-based physical activity and sports courses for selected target groups of pupils regarding motor development and health status (obesity, lack of motor control, coordination, aerobic endurance, etc.). A total of daily physical activities of about 90 minutes are provided by a sound combination of different school and sports-based physical activity programmes, supplemented by teaching on healthy lifestyles. Each community network is linked with others in the cross-border region of Germany and the Netherlands (http://www.gk-gk.de/index.php?page_id=1, accessed 11 March 2010).

Hungarian Aqua Promoting Programme in the Young (HAPPY) – Hungary

The HAPPY programme was the first intervention to promote water consumption in Hungarian children. The intervention aimed to assess the drinking pattern (quantity and quality) of participating students and evaluate the effectiveness of the programme over a 2-month period. A total of 397 children from 6 different primary schools (202 boys and 195 girls aged 7–10 years) were recruited for the HAPPY programme. Written informed consent from all parents was sought prior to starting the study. The 2-month-long intervention consisted of promoting water consumption by (a) education and leaflets about adequate fluid consumption, and (b) providing free bottled mineral water (natural low-sodium mineral water containing 728 mg/l minerals). Dieticians prepared standard educational materials for the oral presentations and gave 40-minute lessons for each participating class as a part of the curriculum. At baseline and after the programme, all the children filled out questionnaires about their knowledge of fluid consumption and about beverage consumption habits overall. At the end of the programme, an additional questionnaire was produced for their parents. At baseline, most students (83%) reported bringing drinks to school but rather tea or ice tea (41%) or carbonated soft drinks (30%) than mineral water (12%). Water consumption increased significantly, with 92 % of the children drinking the mineral water provided at least once per day; and water consumption at home increased at the expense of soft drinks.

Communities on the move – Netherlands

“Communities on the move” was launched by the Netherlands Institute for Sports and Physical Activity in 2003. Since then, 20 pilot projects have been initiated aimed at improving physical activity in low socioeconomic groups, obese children, the elderly and people with a handicap. The objective is to reach this goal in a sustained manner by having fun. Each community is invited to actively participate, and this may differ among groups. If the participants have fun during the activities, there is a better chance that their changed behaviour is sustainable. The conditions for “having fun” may differ from group to group, and some other conditions also play a role.

- Whether groups of people are encouraged to pursue an active lifestyle largely depends on their surroundings. The group can also influence that environment.
- Collaboration among various organizations leads to more effective results and creates more support from and policy change within the organizations involved. Funding and a sufficient number of qualified people are essential for disseminating and consolidating the approach.

Further significant investment by the national government aims at involving 40 more “Communities on the move” projects by the end of 2010 (http://www.communitiesinbeweging.nisb.nl/cat/1438/Communities_on_the_move, accessed 11 March 2010).

Dutch Obesity Intervention in Teenagers (DOiT) – Netherlands

The purpose of the study was to develop and evaluate a school-based programme aimed at preventing excessive weight gain among adolescents. The intervention was developed according to the Intervention Mapping protocol, a structured approach for designing theory- and evidence-based health programmes. Eighteen prevocational secondary schools were randomly assigned to either the experimental group or a control group. Data were collected at baseline and after eight months’ intervention and included height, weight, skin fold thickness, hip and waist circumference and aerobic fitness. The development of the intervention resulted in a comprehensive, school-based programme tailored to the needs of Dutch adolescents from a low socioeconomic background. The intervention consisted of an adapted curriculum for 11 lessons in biology and physical education and environmental change options, including additional lessons in physical education and advice on the choice of foods in the school canteen. The intervention focused on improving sedentary behaviour and physical activity patterns and reducing the consumption of sugar-containing beverages and high-calorie snacks. The DoiT programme showed a beneficial effect on body composition and behaviour related to preventing weight gain among adolescents (mean age 13 years), in both the short and the long term (<http://www.onderzoekinformatie.nl/en/oi/nod/onderzoek/OND1293890/>, accessed 11 March 2010).

Obese children and adolescents involved in physical activity and diet programme (ACORDA) – Portugal

The ACORDA interdisciplinary project is led by the Faculty of Sports at the University of Porto. It aims at integrating emotional, intellectual, social and spiritual areas for a balanced lifestyle. It includes several interventions in the area of physical activity. The physical activity programme is based on activities designed to provide children with a wide range of fun-type skill-learning experiences in order to improve physical fitness and confidence with sports and exercise. The programme also helps to provide an active environment (http://ciafel.fade.up.pt/lang/en/p_acorda.php, accessed 11 March 2010).

School dining halls and promotion of healthy nutrition in the Valencia region – Spain

A total of 121 000 schoolchildren aged 3–16 years make daily use of school dining halls in the Valencia Region. It is becoming more and more important that these services take part in an efficient strategy to provide a healthy diet and health education, in order to improve schoolchildren's health and prevent emerging health problems such as obesity. This intergenerational project aims to promote healthy habits in 10–12-year old children in the Valencia Region. The project involves families and educational centres in encouraging the community to reflect on healthy eating habits. A one-hour school introduction to healthy habits with an older instructor has been designed, and other school activities include working groups, debates and games. An evaluation form has been prepared, which provides easy and quick assessment in terms of food portions and the nutritional suitability of the menu. This document allows a better range of food than the catering company offers, as well as an evaluation of the menus served throughout the school year. The form is completed every month and at the end of the school year is attached to the school dining hall report.

The physical activity, sports and health plan – Spain

The Department of Health in Catalonia has launched a plan for physical activity, sport and health that focuses on the primary health care setting. It aims to promote physical activity in adults by introducing the concept of physical activity on prescription in the practice of physicians and nurses. One of the project's main objectives is to provide primary health care staff with the right skills and tools to be able to adequately prescribe physical activity. Patients receive either general or specific advice or are referred to a supervised exercise programme after a health evaluation. The implementation phase began in 2008 in 75 health centres and will progressively be extended to the rest of Catalonia by 2010. Primary health care teams (physicians and nurses), sports physicians and sports professionals at the community level receive training in physical activity by physicians and nurses that have previously participated in a "training for trainers" programme (<http://www.gencat.cat/salut/depasalt/html/ca/premsa/pafes09.pdf>, accessed 11 March 2010).

Restaurants promoting the Mediterranean diet (AMED) – Spain

The AMED project is led by the Catalonian Department of Health. It is based on the assumption that diet and physical activity influence people's health, that the Mediterranean diet is a very healthy diet, and that restaurants have become very important in today's food pattern (35% of the adult population have lunch in restaurants). The aim is to facilitate healthy eating choices in restaurants. An accreditation is given according to a compulsory list of criteria. The programme is carried out in collaboration with cities and various partners and provides for special advertising of the participating restaurants (<http://www.amed.cat/>, accessed 11 March 2010).

Exercise Looks After You – Spain

This programme has been running since 2006 in the Estremadura region in order to increase health in the elderly. General practitioners refer elderly people who are overweight, are hypertensive, have diabetes type 2 or are moderately depressed to primary care centres, where they are assessed and provided with a structured walk-based programme in groups, including talks and some exercises four days a week. Each participant is evaluated at baseline and after three and six months. The main assessment areas are sociodemographic issues, the referral process, health status, nutritional assessment, health-related quality of life, use of the health system and fitness. After the first two years, more than 4000 elderly people living in 100 municipalities were participating. Significant improvements have been observed in fitness and agility, together with a reduction in the prevalence of depression (<http://www.ejerciciotecuida.es/>, accessed 11 March 2010).

European Health Stadia Programme – United Kingdom

The *Healthy Stadia* programme is an EU-funded programme that uses stadiums to promote public health. The idea is that sports stadiums can promote the health of visitors, fans, players, employees and those who live in the surrounding community. The programme seeks to address the social determinants of health using sports stadiums to promote community health and support the exchange of good practice across Europe. The programme represents an innovative approach to tackling social determinants of health by supporting sports stadiums in promoting community health (<http://www.healthystadia.eu/>, accessed 11 March 2010).

Sustrans Active Travel Consortium – United Kingdom

Sustrans is the leading sustainable transport charity in the United Kingdom, bringing together 6 charities to deliver 50 community-level physical activity and well-being projects. It is experienced in successfully delivering walking and cycling interventions. Projects range from infrastructural changes to activities that encourage people on a community level to (re)integrate walking and cycling into their lives and lead a healthier life. Sustrans' current community projects are of three types: school projects that encourage children to cycle

and walk to school; work with inactive adults in deprived communities, encouraging them to cycle and walk more; and individual travel planning projects that aims to find personal alternatives to car travel. Sustrans monitors the project aims and the number of people benefiting. It furthermore evaluates the effect of the project, at individual and community level, on physical activity, general well-being and travel behaviour (<http://www.sustrans.org.uk/>, accessed 11 March 2010).

Appetite for Life – United Kingdom (Wales)

The *Appetite for Life* strategy examines how to improve the quality and nutritional standards of school foods and highlights the benefits of nutritious school food in helping to reduce diet-related health problems. It also sets out how to ensure consistency and coherence to drive forward improvements through a whole school approach in Wales. The innovative aspect of this programme is the development of central software for analysing menus and sharing good practice, recipes and ideas. This approach highlights the central public health role that caterers and school meals supervisors play in supporting the implementation of healthy eating programmes based in the school environment. The work is managed by a school food coordinator, whose main function is to provide practical support to local authorities, caterers and schools on implementing the recommendations set out in “*Appetite for Life*”. The coordinator also oversees the running of the food analysis software, collating and analysing user reports, identifying key issues and, where appropriate, recommending action within agreed timescales (<http://wales.gov.uk/topics/educationandskills/publications/guidance/appetiteforlife/?lang=en>, accessed 11 March 2010).

The concept of good practice

When is a programme successful?

Best practice implies that there are approaches or practices to prevent, treat or cure that are the best or at least better than others. The term evidence-based practice has been adopted to determine best practice. Evidence-based practice means that there is evidence to support a particular practice or intervention. The idea has been raised that levels of evidence could be based on study design. There is a hierarchy in study designs, some approaches being more consistent with scientific methods and thus providing more robust evidence than others. Systematic randomized controlled trials (RCTs) are placed at the top in defining evidence and are followed by four other study designs (ranked from best to worst in the hierarchy of evidence): (a) quasi experimental designs without randomization; (b) controlled observations; (c) observational designs; and (d) experts opinion.

The RCT procedure has limitations in identifying evidence for population health. For various reasons, RCT is barely applicable in the open field: it is best applied when the causal chain between intervention and outcome is short and simple and results are easily extrapolated. An alternative is the “portfolio approach”, which uses a matrix to classify strategies from least to most promising or successful. It examines the intervention or programme effectiveness

and the potential for population impact. Effectiveness is evaluated based on an assessment of quality of evidence, by judging internal validity and by examining programme outcomes on the basis of programme assessment. Potential for population impact can be evaluated by identifying the level of impact based on the logic of the theoretical basis of the programme, the reach and breadth of the population, and the utility and feasibility.

Tools are needed to identify best practices. Those tools can be beneficial for clinicians, programme planners and decision-makers in order to facilitate their choice of interventions to adopt. Such tools should aim to evaluate the certainty of effectiveness and the potential for population impact.

A health promotion effect management instrument (PREFFI) has been developed by the National Institute for Public Health and the Environment (RIVM) in the Netherlands and is being regularly improved in order to assess public health programmes effectiveness. It serves as a diagnostic quality tool that offers starting points for increasing effectiveness of health promotion projects. In connection with this tool, RIVM has also developed a pilot tool and a certification system for appraising interventions (<http://www.preffi.nl/>, accessed 11 March 2010).

Good practice in health promotion

Health promotion is the process of enabling individuals, communities and organizations to increase control over the determinants of health and thereby improve their health. It embraces not only actions directed at strengthening the skills and capabilities of individuals, but also those directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.

Health promotion actions are influenced by the complexity of social and political settings, by various stakeholders and community sectors and by their level of accountability. Effective actions are strongly linked to a specific context and conditioned by settings and the level at which local communities begin capacity building.

Further, health promotion actions can be classified into at least three distinct categories:

1. single interventions aimed at particular behaviours and settings;
2. programmes and plans including multiple interventions in the same setting or in a community; and
3. local and national policies supporting and involving institutional and public actors.

In defining what is meant by good practice, some important elements need to be considered.

- Which action levels are to be evaluated: intervention, programme/plan, policy? Have they some characteristics in common? How do they differ from each other? What is targeted?
- Are defined quality criteria and a good description of the action sufficient to identify and describe good practice?
- Which ingredients of a project make it a good practice and ensure that it responds to the needs of the target group and/or is adjusted to the local setting and its social context of the project's intervention?

The WHO good practice evaluation tool

The Regional Office has developed a tool to evaluate good practice elements of the planning and implementation of preventive interventions and programmes. The tool has been pilot tested and is in its final stages. The aim of the tool is to assess the quality of interventions to see whether they can be considered as good practice and can serve as an example for future initiatives. The tool consists of two parts.

1. The appraisal form, with 43 criteria statements, serves as a template for reviewers to assess the information gathered in the questionnaire. The appraisal form comprises three sections.
 - *Main intervention characteristics.* This section consists of items such as aim of the intervention, the main objectives, planned activities, target group and involved stakeholders.
 - *Monitoring and evaluation.* Items in this section address indicators, statistics and measurements.
 - *Implementation.* This comprises performance, programme management and target group participation.

An indication of good practice can be obtained for each section as well as for the intervention as a whole. This makes it possible to highlight interventions that may, for example, have a very good design but poor evaluation and implementation, or initiatives that are well evaluated but struggle with design and implementation or projects and programmes that are not well designed and evaluated but have an excellent implementation. For ongoing interventions, only the first section can be appraised.

A score is calculated for each section independently. The score for one section is divided by the maximum section score, which leads to section scores less than or equal to unity. A score of 0.8 in a section certifies an intervention as "good practice" in the respective section.

2. The questionnaire serves as the information-gathering form for the tool. Project managers answer 43 questions and provide reference materials, such as a project description, Internet links, an evaluation report and an overview of budget and time-line.

WHO is establishing a roster of experts to assist in the appraisal of programmes. Each programme will be reviewed independently by two of these experts.

Discussion groups

To facilitate a more in-depth discussion on different aspects of community interventions, the participants were divided into four groups. Each group received questions for discussion (highlighted below in italics) and a summary of the responses expressed is listed below.

1. Programme design: the essential elements

a. How can we ensure the relevance of an intervention for a certain region/problem?

- Get the aims and objectives right by involving the project target groups and users in the development of the intervention and by performing a needs assessment.
- Carry out a stakeholder analysis and assess their interests and needs.
- Ensure that the programme objectives are well designed and specific in nature.
- Carry out a pilot test.
- Take a step-by-step approach; achieve small objectives first then increase targets.

b. How should we choose the intervention activities?

- Interventions and their sub-activities should be underpinned with theoretical models.
- Make the framework for the programme activities flexible; set core activities first and make the activities more concrete and specific at a later stage.

c. How can we ensure that intervention activities target the goals and the population group?

- Ask the population group what their needs and interests are.

d. When is a programme sustainable?

- A programme is sustainable when its users are convinced that it works and when the necessary funds are available.

e. To what extent should stakeholders be involved in programme design?

- Stakeholders should become involved during the development of the programme and they should remain involved throughout the implementation phase.

2. Monitoring and evaluation

a. *What role do indicators play in monitoring and evaluation (process, output and outcome)?*

- Indicators help to quantify the goals and measure the achievement of the targets.
- Indicators are crucial for an objective evaluation.
- Indicators evaluate the process, outputs and outcomes independently.
- Indicators can help to describe even unintended effects of the intervention.

b. *What are the main barriers to evaluation and how have they been addressed or how could they be better addressed in the future?*

- Indicators are not entirely in line with or are irrelevant to the goals.
- Evaluation is not done by monitoring and evaluation experts but by the people involved in the project or organizations that have funded the project.
- Baseline data are missing.
- There is a lack of technical capacity to conduct the monitoring or difficulties with putting the scientific monitoring and evaluation methods into practice.
- Mobilization of stakeholders to collect the required information is poor.
- The check list for monitoring project quality is lacking before the intervention has started.
- There are difficulties in capturing the influences that are beyond the intervention and difficult to control.
- Indicators do not always explain why a change has occurred.
- The focus is only on the final outcome and not on intermediate objectives of the intervention.

c. *What are the experiences with internal versus external evaluations? Is there a gold standard or is the approach dependent on the project?*

- External valuation is needed to objectively display the effectiveness of the intervention to the public.
- Internal evaluation can better discover additional achievements.
- External evaluation may be seen as an intrusion or threat, especially if roles and power are not clearly defined, while internal evaluation is often understood as being useful.
- External evaluation should be seen in a more positive light.

Continued

- Combination of internal and external evaluation is essential, because each provides specific information.
- d. *How should evaluation data be reported?*
- Evaluation data should be in the public domain, especially when the project is publicly funded.
- e. *What impact did the evaluation results have on follow-up projects/future funding?*
- Positive evaluation results do not always result in continuation of funding possibilities.
 - It is important to invest in those interventions that have proven to be effective.
 - Evaluation and evidence-based projects get more attention and interest from funding organizations.
- f. *Which cost–effectiveness measurements are used and how important are they?*
- Use of cost–effectiveness measurements are considered as important elements of evaluation.
 - Not all components of the effectiveness of an intervention can be expressed in economic terms.
 - Outcomes such as quality of life and happiness are difficult to measure in terms of cost–effectiveness.
 - Some projects may not be able to fully assess cost–effectiveness because the full effects may occur much later.

3. Implementation

a. What is good programme management?

- Making the best use of the resources available in the community (e.g. using relevant stakeholders).
- Developing a theory-based programme with clear objectives but flexible as the project proceeds.

b. What are the main barriers to implementation and how have they been addressed or how could they be better addressed in the future?

- Sustainable funding.
- Intersectoral programmes: different cultures/ideologies in organizations/ ministries can make it difficult to work together.
- Strategies to overcome barriers may include: raising awareness of the general benefits that the project will offer to the public/community; being creative with limited resources; and intersectoral cooperation (e.g. trying to create a win-win situation and trying to share resources between sectors).

c. How can we ensure sufficient target group participation?

- Have sufficient knowledge about the target group.
- Inform the target group about the benefits of participating in the project.
- Involve the target group from the beginning of the project (participatory approach) and give them ownership.
- Make sure that the project is designed and implemented through a democratic process.
- Provide incentives to target groups that are difficult to reach for their contribution.

d. To what extent should stakeholders be involved during the implementation phase?

- Stakeholders should be involved in order to ensure sustainability and ownership.

e. To what extent and how should we collaborate with other relevant projects during the implementation phase?

- It may be difficult to cooperate with projects that have already been formulated, but it is important to learn from each other's experiences.
- Determine the benefits for each collaborator: the project, the local community, politicians and the private sector.
- A network of many project collaborators might hamper implementation and achievements if each one has a different public health agenda.

4. The role of the media and communication

- a. *What importance should the promotion of the programme have?*
 - The media and communication play an important role in promoting health programmes.
 - There should be good branding of the programme and its products to familiarize the target group with it.
- b. *How should we communicate the public health message of the intervention?*
 - The public health message of an intervention should be communicated to the audience as well as to the stakeholders.
 - Communication tools can be leaflets, web sites and guidelines for stakeholders to use
 - A good public health message is one that is culturally adapted.
- c. *How should we expand and scale up a project?*
 - The media can be a good tool for disseminating and scaling up the project.
 - It is essential to ensure a well-designed and well-implemented communication strategy and transferable study design.
 - Use the results and lessons learned from other projects.
 - Develop a communication strategy.
- d. *How much dissemination of project information and results should be guaranteed?*
 - This is considered to be difficult to determine, but a minimum amount can be decided at baseline.

Achievements and missed targets

The two keynote lectures given at the meeting presented successes, missed targets and recommendations for further action. The lectures are summarized below.

Sweden: the first sign of and possible reasons for a reversal of the trend in childhood obesity

Evidence from independent surveys across Sweden indicates that trends in childhood obesity may be levelling off, and possibly reversing in girls. In all studies, anthropometric measurements were abstracted from school records of fourth-grade (10–11-year-old) pupils, based on which secular trends could be documented.

In Gothenburg, 8876 records were available for fourth-grade pupils examined in 2000 or 2004. Prevalence of overweight in girls decreased from 19.6% to 15.9% ($P < 0.01$) while obesity decreased from 3.0% to 2.5% (not significant). There were non-significant changes in boys:

17.1% to 17.6% overweight and 2.9% to 2.8% obesity. Compared to an earlier cohort examined in 1984, 2-fold increases in overweight and 3–4-fold increases in obesity were observed.

In Stockholm, 4599 schoolchildren were sampled from different socioeconomic districts in 1999 or 2003 and prevalence estimates were weighted to reflect the true distribution of socioeconomic status. In girls, overweight decreased from 22.1% to 19.2% and obesity decreased from 4.4% to 2.8% (both not significant). In boys, the prevalence of overweight was 21.6% and 20.5% on respective years while obesity increased from 3.2% to 3.8% (both not significant). The opposing secular changes in obesity observed in Stockholm among boys vs girls were found to differ significantly ($P = 0.05$ for interaction by gender).

In Malmö, preliminary data are available describing overweight and obesity among 7238 10-year-olds examined in 2003/2004, 2004/2005, 2005/2006 or 2006/2007. The most recent rates of obesity in boys and girls were 7.5% and 5.7%, respectively. There have been no clear trends in Malmö suggesting either decreasing or increasing prevalence estimates since 2003. Further, the Swedish National Institute of Public Health released figures from 9288 10-year-olds in Karlstad, Umeå, Västerås and Ystad from 2003 to 2005 indicating that the prevalence of obesity decreased significantly, from 4.9% to 3.6%.

In summary, no increases in obesity have been observed recently in Swedish 10-year-olds. Continuing surveillance will be needed to see if this stabilization can be sustained.

Dietary surveys and total food consumption statistics indicate some positive changes in food habits during the same period, and these could have contributed to the observed trends in obesity. The consumption of soft drinks and sweets decreased while that of fruit and vegetables increased. The Swedish data on overweight and obesity indicate differences between socioeconomic groups and various studies of food habits confirm such differences. The reasons for the observed changes in overweight and food habits are largely unknown. However, since 2003/2004, there has been enormous media attention to overweight, healthy food habits and physical activity, which have resulted in a common awareness of the problem. Local activities have started in child health care centres, preschool facilities, schools and sports clubs. Sweden has a long tradition of public health activities, official nutrition recommendations and food-based dietary guidelines, free child health care, free school meals and school nurses located in every school, and this probably formed a solid basis for the recent activities. However, Sweden does not have a national action plan for healthy dietary habits and physical activity, and no national campaigns have been launched yet. Therefore, the positive signs are probably a result of the various regional and local actions that have taken place in many sectors and levels in society rather than one specific measure or national political commitment. To bring the obesity trend down to decent levels and to reach the lower socioeconomic groups, concerted, multisectoral, long-term action is needed in combination with a much larger political determination.

Obesity and socioeconomic groups in Europe: evidence and implications for action

Obesity and overweight in Europe are associated with socioeconomic status. Women in lower socioeconomic groups may be most vulnerable to developing obesity because they are subject to different environmental pressures, including less physical activity, pregnancy, discrimination in employment and income, family responsibilities, and lower self-esteem associated with a failure to meet societal norms. There are very few controlled interventions that have targeted lower socioeconomic groups. Where evidence is available, it shows that participants from lower income groups are likely to show less response to health promotion programmes and have higher drop-out rates.

The evidence suggests that educational information alone is relatively ineffective among lower income groups and may even increase inequalities. However, there is evidence that breastfeeding support programmes can be effective for women in less affluent groups. More focused interventions should be offered through maternal and child services. However, services must be carefully designed to engage these women, and evaluations of such interventions are needed to gain stakeholder support and to develop models of social development that include reductions in health inequalities. New dietary and physical activity guidelines are needed so that maternal and child care services can provide appropriate support for disadvantaged women of reproductive age, especially during and around pregnancy.

It is likely that the rate of return from investing in health promotion while a child is young is higher than that from the same financial investment made at a later age. Early investment is harvested over a longer period, and the nature of early learning and early cognitive development can also facilitate later learning. Implementation of comprehensive preschool, school and health policies, including access to healthy meals and physical activity, are shown to improve children's health and learning potential. Girls in particular show a marked decrease in physical activity at school, and school policies should therefore ensure physical education lessons are attractive to girls, especially those from lower socioeconomic and ethnic minority backgrounds.

More evidence is needed concerning the mechanisms of how food and nutrition insecurity and obesity co-exist within the same groups in society. For example, the percentage of disposable income and the absolute amount spent on food by members of different socioeconomic groups should be calculated. This amount can be compared with both the cost of a healthy food basket and the level of obesity within different socioeconomic groups.

There is a need for better monitoring of measured heights and weights across the lifespan and of the determinants of obesity, such as analysis of food and physical activity indices. These surveillance data provide the basis for setting targets and will enable the evaluation of interventions. More evidence on the reach and penetration of interventions in lower-income

groups is needed. The cost of interventions also needs to be reported in order to estimate the cost-effectiveness of health improvement strategies.

Summary and conclusions

The meeting was concluded with two presentations that addressed a database of good practice under development and the key elements for the design and implementation of a successful community intervention.

A database of good practice

As part of the joint WHO/EC project to monitor progress in improving nutrition and physical activity and preventing obesity in the EU, a database of good practice in interventions and programmes on nutrition, diet, physical activity and obesity prevention will be developed. The project runs from 2008 to 2010 and aims to develop an Internet-based information and reporting system to describe progress in strengthening the promotion of healthy nutrition and physical activity, to reduce obesity and to illustrate good practices in Europe. The objectives of the project are to evaluate the stage of policy development and the actions carried out in the EU Member States to implement policies with regard to key commitments contained in the three main policy documents: the European Charter on Counteracting Obesity (4), the EC White Paper entitled *A Strategy for Europe on nutrition, overweight and obesity related health issues* (12) and the WHO European Action Plan for Food and Nutrition Policy 2007–2012 (1). Key areas that will be covered are, for instance, a healthy and sustainable food supply, advertising and appropriate marketing practices, product reformulation, labelling of food products, surveillance systems, physical activity promotion and the built environment.

The database output will allow a visible profile of regional and country information, showing surveillance data on nutritional status, physical activity, food consumption and nutrient intake as well as national policy documents on nutrition, physical activity and/or obesity, statutory and voluntary regulations, public–private partnerships and voluntary action carried out by economic actors.

The collection of examples of good practice in interventions and programmes will be based on an existing case collection issued from WHO meetings and programmes. The current international inventory of policies on physical activity promotion will also be a source, as it already includes 150 case studies ranging from health policy to national programmes for physical activity promotion (<http://data.euro.who.int/PhysicalActivity/>, accessed 11 March 2010). An online submission system for projects will be put in place, in addition to the conducting of Internet and literature searches. Collaboration with relevant initiatives or projects and partners will be used (e.g. with HEPA Europe, the European Association for the Study of Obesity and the HOPE project (Health Promotion through Obesity Prevention across Europe)).

Elements for successful community interventions

The starting point needs to be a clear definition of the aims and objectives. Psychosociological aspects must be taken into consideration with equal importance, and have to be achievable and acceptable for the target population. The project leadership and staff have to be enthusiastic and dynamic. Users should have the feeling that they are the owners of the programme, which should be underpinned by a strong theoretical background.

Being aware of other current programmes and being in touch with national policy is essential. A multisectoral approach must be pursued to ensure common priorities among different agendas, such as health and education.

Stakeholders need to be involved from the very conception of the project. Pilot evaluation should not be mandatory but performed as often as possible when money and time are available. The right target needs to be tackled: weight loss is likely to be the consequence of a main goal, such as increasing physical activity. Choosing a target group on which the effect is likely to be greatest may be a better starting point than focusing initially only on the most vulnerable group. Some pitfalls need to be avoided, such as stigma about obesity. A mixed programme combining prevention and a focused intervention on a subgroup of participants can enhance interest.

Funding should likewise be adequately planned from the beginning. The use of incentives should be considered in order to allow the inclusion and participation of the most vulnerable groups of stakeholders. There is no evidence that more expensive projects work, best but short-term funding is often difficult to find and to manage.

Effective communication includes the use of media that can help recruitment and retention, as well as social marketing to promote the expected advantages for both users and community.

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Annex 2. Programme

Thursday, 21 February 2008

08.00 – 09.00 **Registration**

09.00 – 09.15 **Opening**

*German Ministry of Health
WHO Regional Office for Europe*

09.15 – 09.30 **WHO European Action Plan on Food and Nutrition Policy 2007-2012** (*Francesco Branca*)

09.30 – 10.15 **Session 1**

National and local actions to promote diet and physical activity

- The role of national governments in promoting local actions with examples from the United Kingdom and Italy (*Cathy Hamlyn, United Kingdom and Paolo D'Argenio, Italy*)
- National guidelines on physical activity and local projects in Switzerland (*Brian Martin, Switzerland*)

10.15 – 10.30 **Coffee, tea and fruit**

10.30 – 13.00 **Session 2**

Examples of community interventions

- Shape Up (*Europe, Spain*) (*Tatiana Mora*)
- EPODE (*France*) (*Sandrine Raffin*)
- Bewegung als Investition in Gesundheit, BIG (*Germany*) (*Alfred Rütten*)
- Everything affects us, especially ourselves (*Iceland*) (*Jorlaug Heimisdottir*)
- Programme for Nutrition, Prevention and Health of Children and Teenagers in Aquitaine (*France*) (*Hélène Thibault*)
- Food Cooperatives (*United Kingdom*) (*Maureen Howell*)

13.00 – 14.00 **Lunch**

14.00 – 15.15 **Session 3**

Examples of community interventions

Each programme will make a brief 3-minute presentation

15.15 – 16.00

Session 4

The concept of good practice

- When is a programme successful? (*Joop van Raaij*)
- Good practices in health promotion (*Claudio Tortone*)
- WHO tool to evaluate good practice (*Katerina Vrtikapa*)
- Discussion

16.00 – 16.30

Coffee, tea and fruit

16.30 – 18.30

Discussion groups

Participants will be divided into 4 discussion groups

- Programme design – what are the essential elements?
Facilitator: *Carolyn Summerbell*
- Monitoring and evaluation – how to perform?
Facilitator: *Lisa Muller*
- Implementation – what are the actors, barriers and success factors?
Facilitator: *Alfred Rütten*
- The role of media and communication.
Facilitator: *Christophe Roy*

19.30 – 20.30

Reception hosted by the German Ministry of Health and the WHO Regional Office for Europe

Friday, 22 February 2008

- 09.00 – 10.30 **Session 5**
Feedback from discussion groups
- Programme design
 - Monitoring and evaluation
 - Implementation
 - The role of media and communication
- General discussion
- 10.30 – 11.00 **Coffee, tea and fruit**
- 11.00 – 12.15 **Session 6**
Achievements and missed targets
- 11.00 Sweden – the first signs and possible reasons for a reversed childhood obesity trend (*Lauren Lissner and Annica Sohlström*)
- 11.30 Discussion
- 11.45 Obesity and socioeconomic groups in Europe: evidence and implications for action (*Aileen Robertson*)
- 12.00 Discussion
- 12.15 – 13.00 **Session 7**
Summary and conclusions
- A database of good practices (*Sonja Kahlmeier*)
 - Elements for successful community interventions (*Carolyn Summerbell*)
- Close of the meeting**
- 13.00 – 14.00 **Lunch**
- 14.00 – 18.30 **Meeting on the Nutrition-Friendly Schools Initiative**
(separate programme) for country delegates

Annex 3. Minutes of the first meeting on the Nutrition-Friendly Schools Initiative

Participants

Country representatives

Austria, Dr Fritz Wagner; Cyprus, Ms Eliza Markidou; Czech Republic, Dr Zuzana Brazdova; Denmark, Ms Maria Bruselius-Jensen and Dr Bent Egberg Mikkelsen; Georgia, Dr Levan Baramidze; Hungary, Dr Viktoria Anna Kovacs and Dr Eva Martos; Italy, Dr Margherita Caroli and Dr Lucia Guidarelli; Latvia, Dr Iveta Pudule and Dr Ilze Straume; Lithuania, Professor Apolinaras Zaborskis; Poland, Dr Miroslaw Jarosz and Ms Katarzyna Wolnicka; Portugal, Mr Miguel Angelo Rego; Russian Federation, Dr Igor Kon; Serbia, Dr Jelena Gudelj Rakic; Sweden, Dr Annica Sohlström; Switzerland, Dr Per Bo Mahler and Dr Awilo Ochieng Pernet.

Technical advisers

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WHO Regional Office for Europe

Dr Francesco Branca; Dr Sonja Kahlmeier; Ms Lideke Middelbeek; Ms Trudy Wijnhoven.

Scope and Purpose

The NFSI is a school-based programme that addresses the double burden of malnutrition –undernutrition, including micronutrient deficiencies, and overweight/obesity. It is a tool for developing a school environment that promotes the nutritional well-being of school-age children and increases their physical activity levels. Since autumn 2006, the NFSI framework has been pilot tested in 21 countries worldwide, among them 11 countries in the WHO European Region: Croatia, the Czech Republic, Denmark, Finland, Georgia, Greece, Italy, Latvia, Lithuania, Slovenia and Switzerland. This phase involved consultation with schools selected via opportunistic sampling methods and a review of the appropriateness and feasibility of the content of the draft NFSI framework document. It contributed to the enhancement, revision and evaluation of the framework and self-appraisal tool, its effectiveness and the methods required for effective implementation.

The main purpose of this first NFSI meeting with country representatives was to review and discuss the outcomes of the first pilot testing phase and to share experiences. The scaling up of the initiative at national level and the strengthening of the NFSI network in countries was also discussed.

NFSI rational and objectives

The NFSI is based on the principle that effectively addressing the increasing global public health problem of the double burden of malnutrition requires common policy options. Developed originally as a follow-up to the WHO Expert Meeting on Childhood Obesity (Kobe, 20–24 June 2005), the NFSI provides a framework for implementing integrated intervention programmes to improve the health and nutritional status of school-age children and adolescents, targeted in the school setting (including preschool facilities such as nurseries and kindergartens).

School settings offer many opportunities to promote healthy diet and physical activity habits for children. They act as access points for engaging parents and community members in the prevention of diseases associated with poor child nutrition. The universality of educational institutions makes them highly relevant in combating the increasing public health problems of the double burden of nutrition-related ill health. Healthy nutrition improves child well-being and learning ability, leading to better academic performance. The NFSI builds on the experience of Health Promoting Schools (HPS) and ongoing school programmes in several countries, and brings together the ongoing efforts and work of concerned agencies and partners to develop integrated intervention programmes to improve the health and nutrition of school-age children and adolescents. It also employs the concept and principles of the Baby-Friendly Hospital Initiative.

The objectives of the NFSI are to:

- provide a framework for designing school-based intervention programmes that address the double burden of nutrition-related ill health; and
- serve as a stimulating mechanism for interconnecting the various ongoing school-based intervention programmes addressing malnutrition in all its forms.

The expected outcome of the NFSI is to increase the number of schools that:

- provide an enabling physical, social and educational environment that contributes to the health and nutritional well-being of children, and also their improved learning and academic achievement; and
- have close links with parents, the local community and the health services for promoting the health and nutritional well-being of children.

The NFSI will provide the following possible benefits to schools by:

- helping them build an enabling environment for promoting the overall health and nutritional well-being of children, which in turn contributes to improvements in learning and academic achievement;

- strengthening their capacity to address the health and nutritional problems of their children, their families and communities through a “whole school” approach that acts both within and beyond the classroom;
- strengthen the capacity of and networking within the school community, including school personnel, students, parents, the local community and local health and education authorities, to tackle the increasing double burden of nutrition-related ill-health being faced by both industrialized and developing countries; and
- enabling schools to be accredited as “nutrition-friendly schools”, which will increase their reputation for making an effective investment in children’s health, nutrition and development.

Outcomes of the NFSI pilot testing in the WHO European Region

Seven countries were able to present the results of the pilot testing of the NFSI framework in a selected number of schools and their presentations included: comments/concerns expressed by the schools on the NFSI Self-Appraisal Tool (SAT); essential NFSI criteria that were difficult for schools to meet; and follow-up actions undertaken by the pilot schools in order to meet these criteria.

Croatia

The NFSI was tested in five schools, three rural and two urban. In these schools, two workshops were organized as part of the pilot project, one for the headmasters and other relevant stakeholders and the other for the teachers. The schools were interested in participating, since they consider nutrition and physical activity key areas to work on. The main barrier was funding. One of the criteria difficult to meet was food preparation skills. There was a high involvement at community level, and the programme raised awareness and motivation among parents and local communities. The established core action groups in each pilot school still exist and they are still very important for daily implementation. The NFSI influenced policy and the political agenda at the national level.

Denmark

The overall opinion was that it was interesting and informative to participate in the test. In Denmark, there is a high level of interest in improving practices and structures related to healthy eating, and WHO has a good reputation as a result of launching the initiative. On the other hand, there are many competing initiatives in Denmark. The main barriers to implementation were a lack of time and facilities. The involvement of political actors was considered to be important. There is still interest in the NFSI in Denmark, but the concept should be adjusted to a European or maybe even Nordic framework since many questions do not make sense in their current context. Moreover, some of the questions were very complicated for the schools to answer. Another point was that the framework might be too broad – it should perhaps focus more on nutrition-related issues and on integrating

nutritional learning into the curriculum. Finally, it was recommended that certification procedures be supported by guidance on how to make the changes.

Georgia

Nutrition-related health problems in children are increasingly significant in Georgia. As with many health-related problems, children at greatest risk of malnutrition are those in low socioeconomic groups. In Georgia, 12 secondary schools were involved in pilot testing the NFSI. All schools were located in an urban setting and the size varied from 300 to 1000 pupils. The schools found some NFSI criteria difficult to achieve. Also, not all questions were applicable to the Georgian situation and it was difficult to translate some of the questions into Georgian. The results showed that, in general, school services were indicated as being poor and that health services were reported in only three schools. Six schools reported that growth and development were monitored. The results from Georgia indicated a great need for assistance and guidance for planning and implementing school food and nutrition policies.

Italy

The NFSI was tested in 4 institutions: one public nursery and kindergarten, one private kindergarten, one public primary school and one public high school. The NFSI was perceived in a positive light, since schools see nutrition as an important topic, but was considered time-consuming and in some aspects difficult to achieve and maintain. Nevertheless, advocacy for the protection of children's health was perceived as a school task. In general, the schools appreciated the background information and the SAT, although the instructions for completing the SAT were not always clear. This was also the case for some of the questions. Further, some of the criteria were difficult to meet by the schools. Implementation of the initiative will be easier at primary school level than in high schools. Nutrition was considered more important than physical activity. The school's core action groups no longer exist because they were only considered to be part of the pilot study. However, three of the schools asked for follow-up in order to receive accreditation as being nutrition-friendly. Italy has a positive expectation of the NFSI implementation and sees it as one of the tools to promote good health. It can function as a strong umbrella framework for implementing nutrition policies at school.

Latvia

A total of 12 schools participated in the NFSI pilot testing. It was a mix of urban/rural and primary/secondary schools and the number of pupils varied from 200 to 1000. There was a lot of uncertainty about the questions, some of which were difficult to translate while others were not relevant to the Latvian situation. In the urban areas, it was hard to establish contact with the schools because there was less or no community involvement. On the other hand, the schools took the initiative seriously, were interested in continuing, and agreed that nutrition and physical activity were important areas. Three schools have asked to continue. There is currently no central monitoring system in place at Latvian schools.

Lithuania

Four schools – two rural, two urban – participated in the pilot test. Unfortunately, the time allowed for pre-testing was very short. Schools faced problems in understanding the questions, and experienced difficulties in implementing the programme because of financial restrictions, low salaries and lack of teachers. Nutrition is generally included in the (biology) curriculum but not in written school policies. There are no anthropometric measures carried out in schools. Lithuania is willing to participate, but the question is how the country would benefit from it. It was seen by teachers to be extra work and of less importance to them than their concerns over their jobs and salaries.

Switzerland

Schools do not consider nutrition and physical activity as their main priorities. Nevertheless, the NFSI is seen as an important, innovative and well-documented initiative. In Geneva, the NFSI would be in competition with the Green Fork, another school-based nutrition programme. Moreover, the NFSI was considered to be a complex and time-consuming initiative that was difficult for schools to implement without help. Money and a coordinator would also be required to monitor implementation. The schools in Geneva questioned the credibility and sustainability of the programme, and suggested simplifying the design and making it more attractive and user friendly. Another idea put forward was to create an Internet-based NFSI community.

Synergies with the Schools for Health in Europe (SHE) Network

The NFSI will in many cases be implemented in countries where it is not the only school-based programme of health promotion but runs with or alongside related initiatives such as the WHO's Global School Health Initiative (http://www.who.int/school_youth_health/gshi/en/, accessed 11 March 2010) or the SHE network (formerly the European HPS network, which started in 1991; <http://www.schoolsforhealth.eu/>, accessed 11 March 2010). To maximize synergy between all school-based programmes, a few points would be useful for planners to consider.

NFSI and SHE share common values and action areas.

- Both NFSI and SHE focus on a comprehensive participatory approach by the entire school community, with activities centred on policy, community action, formal curricula, environments and strengthened health services.
- Both NFSI and SHE involve the community (teachers, management, students, parents and the community at large) in a coordinated situation analysis, a community diagnosis and an agreed action plan.
- In many countries, SHE has an accreditation process. The SHE process is open and often takes the form of award systems that reward good practice. The NFSI includes a

standardized accreditation process for each participating school to ensure the validity of the entitlement and regular re-evaluation for quality assurance.

- Both NFSI and SHE encourage the formation of networks and it is to be encouraged that school-based health networks at regional or national level work to harmonize the approaches locally so the complementary strengths of the two will be utilized to the full.
- Both NFSI and SHE make an effort to reach the surrounding community of the school and can thus have fundamental long-term effects, not only on child health but on the health of the whole neighbouring population through improved nutrition. This synergy will be optimized by ensuring that the open-ended SHE framework and the comprehensive nutrition- and physical-activity-focused framework of the NFSI are integrated and make the best use of existing processes and networks.

The SHE network, consisting of 43 Member States, is coordinated by the Dutch Institute for Health Promotion. SHE has launched a new school project on healthy eating and physical activity (HEPS). The overall objective of HEPS is to work towards national policy and sustainable practices on healthy eating, obesity and physical activity in schools in all EU Member States. The project runs from 2008 to 2011 (<http://www.hepseurope.eu/index.cfm>, accessed 11 March 2010). At the meeting, the possibility of joint efforts and collaboration between NFSI and SHE was discussed. As SHE already has a good network of schools, it could be used to disseminate the NFSI.

NFSI capacity building

National NFSI committees and school core action groups would need to be established to facilitate NFSI implementation. Key components of a NFSI capacity-building training might comprise training, sharing good practice and offering a network opportunity. The challenges addressed will be to try to create a minimal level of participation in more countries. A sufficient number of countries would lead to interest in others, for whom it then will be easier to step in. Ideally, the NFSI would like to achieve the development of nutrition policies in schools, underpinned with national policies. The resources and facilities of the countries should be mapped and the elements that are missing and the actions that are needed brought together. Further, discrepancies between countries should be addressed and priority given to certain actions.

Discussion

The following issues were discussed at the end of the meeting.

- Will the initiative change behaviour? The first step will be to create awareness for the problems related to poor nutrition and physical inactivity.

- How should the initiative be scaled up? It will be important that political commitment be created; countries cannot work on the initiative if there is no support from the government. It needs to be carried out within an international approach.
- How would countries that were not involved in the pilot test become involved? Cyprus, Hungary, Ireland, Portugal and Serbia expressed their interest and would be most willing to be involved in the next pilot phase, whereas Austria clearly indicated that they would not like to do this since the Austrian Government has just launched its own initiative. Portugal added that the NFSI might be implemented through the SHE network, as this is currently a good network and the schools in Portugal are eager to have self-appraisal tools.

Conclusion

General feedback from the European countries indicated that the NFSI had been well-received, with the majority of countries responding positively to the programme. Nevertheless, there appeared to be widespread concern regarding the practical application and implementation of the initiative, especially in countries where limited resources are a barrier to further health and educational development. This included both financial and non-financial factors, i.e. social, cultural, political and logistical, that prevent some of the fundamental aspects of the initiative being achieved.

A further matter addressed was the information and clarity of the instructions and methodology for the SAT. Several of the pilot countries experienced difficulties in translating the documentation so that it could be understood by the participating schools and struggled with many of the expressions and terminology used. Feedback also suggested that the questionnaires be validated and made more applicable to the context of the country to which they are sent. For example, questions referring to malaria were not generally well-received in European countries, where there is only a minor risk of infection. An alternative would be to ensure that the instructions for completion clearly indicate which questions are mandatory. This was a major issue for consideration, especially bearing in mind that the long-term plans for the initiative are that it be an internationally recognized accreditation system.

The feedback from completed questionnaires was generally positive and encouraging, clearly indicating that there is a need and scope for the initiative. Most of the completed questionnaires indicated commitment to the initiative. Any resistance that was mentioned appeared to result from lack of information, poor communication or a misunderstanding of what was required, suggesting that a support network would be beneficial to those involved.

With regard to the way forward after this first European NFSI network meeting, it was agreed that the Regional Office would continue with dissemination and discussion with countries at national level and that countries would need to point out their needs. An idea for scaling up

was to work with SHE-HEPS, as they already have a well-established network that can be used for the dissemination of the NFSI across Europe.

The Regional Office will develop and organize a capacity-building training course in collaboration with Professor Carolyn Summerbell.

Joint WHO/EC DG SANCO project: Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union (EU), 2008-2010

Report series

No. Title

- 1 Report of the 1st Meeting of National Information Focal Points, Brussels, Belgium, 23–24 September 2008
- 2 Report of the 2nd Meeting of National Information Focal Points, Copenhagen, Denmark, 23–24 June 2009
- 3 Report of the Meeting on community initiatives to improve nutrition and physical activity, Berlin, Germany, 21–22 February 2008
- 4 Report of the Workshop on integration of data on physical activity patterns, Zurich, Switzerland, 25–26 February 2009
- 5 Report of the Workshop on integration of data on household food availability and individual dietary intakes, Copenhagen, Denmark, 28–29 April 2009
- 6 Review of physical activity surveillance data sources in European Union Member States
- 7 Review of dietary intake surveillance data sources in European Union Member States
- 8 Review of obesity surveillance data sources in European Union Member States
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