Supporting the mid-term evaluation of the EU Action Plan on Childhood Obesity

The Childhood Obesity Study

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The Childhood Obesity Study

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The authors analysed and presented the information provided and collected from different sources to the best of their knowledge. However, information from different sources sometimes contained conflicting information. Furthermore, the situation may have changed after the data have been collected and not all country representatives responded to the stakeholder feedback. Therefore, we cannot exclude the possibility that there are some mistakes in reported figures or status of policies or initiatives undertaken.

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EXECUTIVE SUMMARY

Introduction

The EU Action Plan on Childhood Obesity 2014-2020 (hereafter named Action Plan) was launched in February 2014. The overarching goal of this Action Plan is to contribute to halting the rise in overweight and obesity in children and young people by 2020. The Action Plan consists of eight areas for action, being:

1) Support a healthy start in life
2) Promote healthier environments, especially in schools and pre-schools
3) Make the healthy option the easier option
4) Restrict marketing and advertising to children
5) Inform and empower families
6) Encourage physical activity
7) Monitor and evaluate
8) Increase research

To support the European Commission with the mid-term (2014-2017) evaluation of the Action Plan, the Childhood Obesity Study was carried out. This study aimed to provide the European Commission and the EU Member States with an overview of the efforts during the first-half period of the Action Plan as well as the prevalence of childhood obesity in 33 countries, being the 28 EU Member State as well as Iceland, Norway, Switzerland, Serbia, and Montenegro.

Four tasks were included in this study. The first provides an overview on the prevalence of childhood overweight and obesity in the participating countries as well as an overall assessment of the main activities. The second provides a mapping of the activities carried out, on-going and/or planned in each of the Member States. Task 3 provides an overview of the engagement of EU Member States, the European Commission and international organisations in EU wide initiatives, projects, and Joint Actions in the field of nutrition and physical activity. The last task tries to give some insight into strengths and weaknesses for the implementation of the Action Plan.

Information basis for this report

For each area for action several indicators have been included for measuring country actions. In total 39 indicators were assessed, including the 18 indicators that were identified in 2015 for immediate operationalisation by the Member States, the European Commission and the WHO Regional Office for Europe. The additional indicators were included to cover Area 5 of the Action Plan and additional policies and initiatives that are of interest to the European Commission and the Member States.

Information on these indicators was obtained through a variety of sources. Telephone interviews were carried out with representatives of 29 countries between mid-December 2016 and February 2017. The other countries filled out the interview forms on paper. These interviews were used as primary source of information on the availability of national policies and other initiatives initiated, coordinated or supported by national authorities for the first seven areas for action. The representatives were members of the High Level Group on Nutrition and Physical Activity, a group of government representatives dealing with the topics of nutrition and physical activity from all 28 EU Member States plus Iceland, Norway, and Switzerland, or other competent authorities they appointed. Several additional sources of information were used: some first results from the second Global Nutrition Policy Review Survey (GNPRS2 data collected in 2016) provided by WHO Regional Office for Europe; consultation of experts in 25 of the 33 participating countries; information that has been collected by Directorate General for Health and Food Safety (DG SANTE) in 2014 and 2015 and desk research. Data on quantitative indicators, such as the percentage of obesity in children or the percentage of schools participating in the EU School Fruit and Vegetable Scheme, were obtained by desk research, through the consulted experts, and from WHO Regional Office for Europe who provided the latest available information on the Childhood Obesity Surveillance Initiative (COSI).

The data were analysed and the results provide insight into the into the fulfilment of an action mentioned in the Action Plan at the level of all participating countries together, the 28 EU Member States and the individual countries. The evaluation of the effectiveness of an action was beyond the scope and resources of the study. Fulfilment of an action can imply:

a) (partial) fulfilment of an action, dating back from before the introduction of the action plan (2014)
b) (partial) fulfilment of an action, since the introduction of the action plan
c) action in preparation, possibly still be contingent on the outcomes of policy processes
d) no action is initiated or supported by national authorities

Furthermore, an overview about the engagement of the European Commission, the Member States, and international organisations in common EU initiatives, projects, and Joint Actions in the field of childhood obesity, nutrition and physical activity is provided in this report. Data was collected by searching websites and databases of Pilot projects funded by the European Parliament, the EU Health Programme, the 7th Framework and Horizon 2020 Programmes, the Erasmus+ Programme, the EU Sport Programme and the Joint Programming Initiatives. Relevant projects that were ongoing in or after 2014 were mapped against the areas for action and the operational objectives of the Action Plan. Furthermore, we consulted the websites of the World Health Organisation (WHO), WHO Regional Office for Europe, the European Association for the Study of Obesity (EASO), the World Obesity Federation (WOF) and the Organisation for Economic Co-operation and Development (OECD) to get insight into their EU-wide activities that could contribute to halting the rise in childhood obesity.

Finally, a short questionnaire was sent out mid-2017, addressing the policies and other initiatives that the recipient considered 'most successful' and 'least successful' in their countries, the Action Plan and the efforts of the European Commission. No specific definition of the term successful was provided, so 'success' has been referred to by authorities in various ways and should be interpreted in that light. Recipients were the members of the High Level Group on Nutrition and Physical Activity, the Competent Authorities of Montenegro and Serbia and eight of the consulted experts, in order to provide additional information on their country. Information was available for 25 countries.

Prevalence of overweight and obesity

The results of the first task show that published data on the prevalence of overweight and obesity in children under 5 years of age are scarce. In addition, different surveys use different criteria to define overweight and obesity, and studies differ in the age-ranges of children studied. As a result, the available data are difficult to compare. Therefore a clear picture on the prevalence of overweight and obesity among young children cannot be provided.

Results of COSI from the 2009/2010 and 2013/2014 school year for 15 countries and published literature for another 5 countries show that the prevalence of overweight (including obesity) among primary school children (6-9 years) is high, but varies considerably, i.e. from 18% in 6-year-old boys in Belgium to 57% in 9-year-old boys in Greece. Data from the 2013/2014 round of the Health Behaviour in School-aged Children (HBSC) among adolescents (11, 13 and 15 years) showed that also among this age group the prevalence varies considerably, from 7% in 15 year old Polish girls to 39% in 11-year old Greek boys. With some exceptions the prevalence of overweight among primary school children and adolescents was higher in boys than in girls. It should, be noted, however that in HBSC height and weight were self-reported and not measured as in COSI. This probably results in an underestimation of the prevalence of overweight and obesity in HBSC.

Projections from the WOF envision an increase in the prevalence of overweight and obesity among 2-19.9 year olds between 2010 and 2025 for most countries, assuming that no effective intervention is implemented to significantly change the trend (linear projection). Systematically collected data to determine actual trends in the prevalence of overweight and obesity since the adoption of the Action Plan are not yet available. Data from the most recent (2015/2016) and the next (2018/2019) round of COSI and of a next round of the HBSC survey (2017/2018) will provide more insight after the expiry of the Action Plan.

Activity in the first seven areas for action of the Action Plan
Results of the second task showed that all countries are active in more than one of the areas for action of the Action Plan, plus a number of countries is moving from having plans to implementation.

Area 1: support a healthy start in life
The majority of countries have policies, strategies or actions relating to Area 1 of the Action Plan. In almost all countries, guidance on nutrition and physical activity is provided to women, during and immediately after pregnancy. This is often part of regular maternity care. Information on breastfeeding is provided and/or breastfeeding is advised or promoted in all countries, while 82% of the countries have implemented the Baby-Friendly Hospital Initiative, a global effort launched by WHO and UNICEF to implement practices that protect, promote and support breastfeeding. Eleven countries mentioned that guidelines, strategies or action plans were renewed since 2014 or will be renewed in 2017. How this may impact the percentage of exclusively breastfed children has still to be evaluated. Before the adoption of the Action Plan, the percentage of infants exclusively breastfed for the first six months of life ranged from 0.7% to 54.2%. In the majority of countries (91%) guidelines on complementary feeding are available and/or young mothers are advised on this issue through child health care.

Area 2: Promote healthier environments, especially in schools
Area 2 is one of the areas for action that is addressed by most countries. Policies to improve the school environment are in place or planned in all countries, whereas policies on supplying easily accessible free drinking water in schools are available in 64% of the countries. In another 21% of the countries tap water is safe, so free drinking water is considered to be available in schools also. Most school food policies include policies on vending machines and energy drinks. Only in Spain and Portugal do policies on vending machines also apply to settings other than the school environment, such as the National Service of health (PT) and hospitals (ES). Policies on energy drinks are not restricted to the school setting in six countries (18%). For example, by law energy drinks cannot be sold to children below the age of 18 years in Lithuania and Latvia. All but three EU Member States participated in the EU School Fruit and Vegetable Scheme in the 2015/2016 school year. The percentage of schools that received school fruit ranged from 21% (secondary schools in Austria) to 97% (Malta). In almost 80% of the countries the percentage of schools receiving school fruit was higher than in the 2013/2014 school year. All EU Member States participate in the new School Fruit, Vegetable and Milk Scheme, that applies since the 2017/2018 school year. In all countries physical education is included in the school curriculum. The minimum number of hours to be devoted to physical education ranges from 1 to 10 hours per week. Nutrition education is also included in school curricula in all but one of the participating countries. However, it is voluntary in 27% of the countries and is often part of ‘biology’, ‘home economics’ or other lessons without specification of the number of hours to be provided.

Area 3: making the healthy option the easy option
Area 3 is the area for action that experiences the most progress across Europe. Recent activity is especially seen for food reformulation/food product improvement, as a way to improve dietary intake that does not require the consumer to drastically change their diet. Several countries recently started reformulation initiatives for salt (12%),

sugar (39%), saturated fatty acids (15%) and/or calories/portion sizes (27%). Other countries are planning to do so (15%, 15%, 24% and 15% respectively). Countries that entered the EU in or after 2004 (EU13) are clearly catching up on EU15 Member States. In 21 countries (64%) legislation or other measures and initiatives are in place to limit the levels of trans fatty acids; in almost half of them it is based on voluntary agreements from/with industry. Easy to understand labelling, such as front-of-pack labelling, is used in 11 countries (33%) to help consumers make healthier food choices. In one country it will end in 2017, while it is planned in another. Taxation of nutritionally unbalanced products is also becoming more common, but is not widely used (existing in 9 of the 33 countries). Another three countries (9%) have plans for a levy on sugar-containing beverages. Lowered VAT rates for some specific food products as a subsidy is implemented in Hungary and Latvia only.

Area 4: restriction of marketing and advertising to children
Almost 90% of the countries have initiatives (n=27) to restrict marketing and advertising of foods and beverages that are high in salt, sugars or fat (HFSS) or that otherwise do not fit national or international nutritional guidelines to children, or have plans (6%) in this area. In about half of the countries nutrient criteria are used to reduce marketing of HFSS foods to children. Two thirds of the initiatives concern (voluntary) codes issued by the private sector. Competent Authorities of several countries mentioned that their countries will take a further position on this topic after the conclusions of the discussion on the EU's Audiovisual Media Services Directive have been published.

Area 5: inform and empower families
Food-based dietary guidelines are used to inform consumers about a healthy diet. They are available in 31 of the participating countries and one is working on them (RS). At least 15 countries (45%) have separate guidelines for children. Twenty-three countries (70%) are currently running national campaigns to inform and educate the population on healthy diet and the importance of physical activity and one (3%) is planning a campaign. Fewer countries (n=19, 58%) mentioned to have or plan policies to support community-based interventions. Community-based-interventions often fall under the responsibility of subnational authorities, such as municipalities. Community-based interventions according to the EPODE-methodology are implemented in almost half of the countries. Screening for overweight and obesity takes place or is planned in 20 countries (61%) and is quite often seen as one of the tasks of child health care providers and general practitioners. In many countries, the general practitioner is also the one who is responsible for the management of an obese child. The majority of countries (82%) provide management services for children who are already overweight or obese, either by the general practitioner, or by other health care providers or through specific programmes.

Area 6: Encouraging physical activity
Area 6 seems to be well covered, with respect to policies (in 94% of the countries), the presence of or planning of national guidelines (in 24% of the countries) and available data on weight and height of children (in 94% of the countries). In about half of the countries national or subnational schemes to promote active travel to school are present or plans exist to develop such schemes. Self-reported physical activity levels among adolescents are assessed through the HBSC study in 30 countries. In general, the percentage of boys and girls reporting to reach the WHO's physical activity recommendation was higher among 11-year olds than among 15-year olds, and higher among boys than girls. In 2013/2014, the percentage of boys reaching the recommendation ranged from 11% to 47%. Among girls the percentage ranged from 5% to 34%. A new round of the HBSC survey could provide more insight into the changes in the percentage of children that reach WHOs physical activity recommendations since the adoption of the Action Plan.

Area 7: *monitoring and evaluation*
National representative nutrition surveys are available in 82% of the countries. However, in several countries children are not included and in not all countries they are executed at a regular basis. Seventy-six percent of the countries have national food composition tables or databases, but in only two of them (FR, BE) they are at the brand level. Data at the brand level would enable monitoring of the achievements of food reformulation/food product improvement. Monitoring of self-reported physical activity, height and weight and several health behaviours is covered by HBSC and in several countries by other projects. All but 3 of the 33 countries (CY, ME, RS) participate in HBSC. Participation in COSI is the indicator that experienced the second largest growth since 2014. In the 2015/2016 round 26 of the 33 countries participated (79%), of which ten countries (30%) participated for the first time. At least two countries make use of other surveys to monitor the prevalence of overweight and obesity among children.

Engagement in EU wide initiatives
The third task, i.e. to provide an overview of engagement of the European Commission, EU Member States and international organisations in EU-wide initiatives, provided the following results.

Engagement of the European Commission in EU-wide Initiatives
The European Commission had several instruments at its proposal to support the Member States with the implementation of the Action Plan. These include amongst others the coordination of working groups, the publication of reports to provide information to Member States and financial tools, such as research programmes.

The European Commission amongst others coordinates the High Level Group on Nutrition and Physical Activity and the EU platform for action on diet, physical activity and health. The High Level Group seeks European solutions to obesity-related health issues in several ways. For example, they help governments share policy ideas and practice. The EU platform is a forum for European-level organisations ranging from the food industry to consumer protection organisations that are willing to commit to tackling current trends in diet and physical activity.

The Joint Research Centre (JRC) is the science and knowledge service of the European Commission, supporting EU policies with independent research. Amongst others, the JRC has published reports on school food policies, on public procurement of food for health in the school setting and on nutrient profile models, as well as a set of toolkits on promoting water, fruits and vegetables in schools.

Through funding, the European Commission supports (indirectly) the implementation of its health strategies and policies. The European Parliament provides the European Commission with additional funding for pilot projects, which are initiatives of an experimental nature designed to test the feasibility and usefulness of action.

EU funded projects
In total five relevant pilot projects and 162 relevant projects funded through EU-funding programmes were identified on the websites and in the databases that were searched in March 2017. Of these, 138 were funded through the Erasmus+ Programme. The projects mapped to all but one of the areas for action of the Action Plan. No project mapped to Area 4 (restrict marketing and advertising to children). However, the JRC was recently asked to produce a mapping of initiatives to reduce marketing pressure in order to identify best practices that Member States may wish to adapt or on which they may build. Furthermore, in October 2017, a tender was published for a study on the exposure of children to marketing of foods high in fat, salt or sugar. Relatively few projects mapped to Area 3. Many projects, especially from the Erasmus+ Programme mapped to areas 2 and 6. Area 5 was mostly addressed by Pilot Projects and projects funded by the Health Programme. The latter programme contributes considerably to the exchange of knowledge and best practices among

countries. Two Joint Actions funded by the Health Programme are worth mentioning specifically in more detail below.

The first is **CHRODIS.** Its objective was to promote and facilitate exchange and transfer of good practices addressing chronic conditions, such as obesity, between European countries and regions. Thirteen EU Member States and Norway co-funded this Joint Action. CHRODIS-Plus is the successor of CHRODIS and involves 18 EU Member States plus Norway, Serbia and Iceland. It will contribute to the reduction of the burden of chronic diseases in Europe by promoting the implementation of policies and practices with demonstrated success.

The second is The Joint Action on Nutrition and Physical Activity "**JANPA**". It is fully dedicated to childhood obesity and therefore maps to several operational objectives of the Action Plan. Its general objective is to contribute to halting the rise in overweight and obesity in children and adolescents by 2020. Through the identification, selection and sharing of best data and practices, JANPA allows for improvement of the implementation of integrated interventions to promote nutrition and physical activity for pregnant women and families with young children, improvement of actions within school settings and an increase in the use of nutritional information on foods by public health authorities, stakeholders and families for nutrition policy purposes. Furthermore, JANPA evaluated the cost of overweight and obesity in children to raise awareness and encourage public actions. All but 3 (DK, NL, UK) of the 28 EU Member States, as well as Norway, participated in JANPA.

Joint Programming Initiatives (JPIs) are strategic frameworks with high-level commitment from Member States. The overall aim of the Joint Programming process is to pool national research efforts in order to make better use of Europe's public research and development resources and to tackle common European challenges more effectively. JPI "A Healthy Diet for a Healthy Life" (JPI-HDHL) started in 2011 and is most relevant with respect to the topic of childhood obesity.

Engagement of the countries in EU-wide initiatives
Participation in JPI-HDHL and activities that come forward from this initiative especially show the engagement of Member States' authorities, as they are voluntary partnerships of the Member States with high-level commitment and (co-)funding. Currently, 20 EU Member States, plus Norway and Switzerland participate in JPI-HDHL.

Participation in projects and activities funded by the EU Health Programme, FP7/H2020 and the Erasmus+ Programme also provides some insight in the engagement of Member States. By submitting research proposals, organisations in the Member States show their interest in the topics of childhood obesity, nutrition and physical activity. Furthermore it may be an indicator of awareness about childhood obesity among many stakeholders in society, such as researchers, teachers, and sports organisations. Organisations from Italy, Spain and Poland are involved in >60 EU-funded projects, due to a large participation rate in Erasmus+ projects. These are, however, large countries, which also may have resulted in participation in many projects, as there are more organisations that may apply for funding than in smaller countries, such as Luxembourg, Malta, Estonia or Cyprus. Organisations from these latter countries are involved in <10 projects.

Engagement of international organisations
In 2014, WHO established the Commission on Ending Childhood Obesity that presented its final report in 2016, describing a comprehensive, integrated package of recommendations to address childhood obesity. In 2014, WHO Regional Office for Europe issued the WHO European Food and Nutrition Action Plan 2015-2020, which is intended to significantly reduce the burden of preventable diet-related non-communicable diseases, obesity and all other forms of malnutrition still prevalent in the WHO European Region. In order to support activities at country and international

level for implementation of this action plan WHO Regional Office for Europe has set up action networks consisting of groups of Member States. Furthermore, they are the host, as well as member, of the European network for the promotion of health-enhancing physical activity, coordinate the WHO European Healthy Cities Network, and provide technical support in implementing COSI. Besides these activities WHO Regional Office for Europe carries out various surveys, such as the Global Nutrition Policy Review survey (GNPR2 survey). The data from these surveys is made available, for example through the NOPA database.

EASO is a federation of professional membership associations from European countries, while the WOF represents members from over 50 regional and national obesity associations. Organisations from all but five countries included in this study are member of EASO and/or the WOF. EASO has several task forces and working groups, such as the Childhood Obesity Task Force and Nutrition Working Group. WOF launched the World Obesity Action Initiative in 2015 that promotes a comprehensive view of tackling obesity. Furthermore, WOF has an official obesity education programme for health professionals and publishes country profiles with information on obesity prevalence, management and prevention.

The OECD provides a forum in which governments can work together to share experiences and seek solutions to common problems. It published their most recent obesity update in 2017, which focused on communication policies designed to empower people to make healthier choices. OECD has also announced a new series of reviews of public health, covering e.g. the topics obesity and unhealthy diets.

Strengths and weaknesses of activities to prevent childhood obesity

The opinions expressed by the respondents to the questionnaire on strengths and weaknesses provide some insight to the 'more successful' activities and those that need additional action and support (Task 4). In the framework of this exercise the term 'success' was not specifically defined and has been referred to by authorities in various ways. Therefore, the results need to be seen as a first indication and not as an objective evaluation of the strengths and weaknesses.

In total, the respondents reported 57 'most successful' activities and 34 activities that could be considered 'most difficult to work on'. None of the reported activities pertained to Area 6 of the Action Plan (encourage physical activity). By far the most reported 'most successful' activities (n=23, 40%) lie in area for action 2 of the Action Plan, i.e. promote healthier environments, especially at schools and pre-schools. Among these, setting standards for foods provided or sold in schools is mentioned the most, followed by nutrition education, enabling active breaks, and provision of free healthy meals. Activities to restrict marketing and advertising to children (Area 4) were mentioned least often among the 'most successful' (n=2, 4%). Most of the activities reported to be 'most difficult to work on' lie in Area 3 (n=10, 30%). Activities on food reformulation/food product improvement, easy to understand labelling and taxation policies were mentioned most often. It should be noted that some of the activities were reported to be among the 'most successful' in one country and among the 'most difficult to work on' in another.

The questionnaire also asked for the factors that contributed to 'successful' development and/or implementation of activities and factors that hampered them. Political commitment and stakeholder involvement and collaboration are among the factors that were mentioned for activities in more than one area for action. Lack of these factors was also mentioned as hampering factors for activities 'most difficult to work on'. These can therefore be considered to be highly important.

Interviewees reported that the Action Plan provided awareness, inspiration, example and guidance, or facilitated policy-making, implementation of initiatives or discussions with health and other stakeholders (including with industry). For countries that already have many policies, strategies or actions in the areas of action that are

mentioned in the Action Plan, it mainly serves as a justification or reference document for their national policies. Eight respondents to the questionnaire on strengths and weaknesses (32%) thought all relevant areas of action were covered. Others have made several suggestions for areas that could be strengthened or added. One point raised was that the Action Plan could be more focussed on cross-country activities. Common priorities could be stated as well as simultaneous actions in the EU and in Member States. Another point raised was the need for evaluation of each of the areas for action itself and as a comprehensive approach, to identify which areas are more/less effective or are required as companion areas. Promoting a healthier environment in schools (Area 2) is seen as a positive action. More importance could, however, be given to the promotion of a healthier environment outside school. The majority of activities and actions are part of regular class activities, so leisure time activities for children could be more emphasized. Furthermore, creating a healthy environment in communities, for example through urban planning, is considered to be important.

Initiatives of the European Commission, such as support for and reinforcement of national actions, sharing of information and facilitating collaborative actions of Member States are highly appreciated. The Commission's efforts help to obtain political commitment for actions in the field of childhood obesity. JANPA is seen as a good example of collaborative action. The area of food reformulation/food product improvement and marketing are areas where collaborative action and support from the European Commission is deemed necessary. Companies are active on the EU internal market and beyond, and without collaborative action and support from the European Commission it is very difficult to achieve results on a national level.

Main conclusions

The results of this study showed that all countries are active in more than one of the areas for action of the Action Plan and most countries are active in all eight action areas. A lot of activities originate from before 2014, the year the Action Plan was published. In addition, in all areas for action a number of countries are moving from having plans to implementation of actions. Particularly in Area 3 (make the healthy choice the easier choice) a considerable number of initiatives were implemented after 2014. This does not necessarily mean, however, that the implementation was a result of the Action Plan.

Area 2 (promote healthier environments, especially in (pre-)schools) seems to be one of the areas for action that is best addressed, since a lot of activity is seen in Area 2 and 40% of the reported 'most successful' activities pertain to this action area. Additionally, many of the EU-funded projects address operational objectives in this action area. Area 6 also seems to be well covered, with respect to the presence of policies, the presence or planning of national guidelines and available data on weight and height of children.

Area 3 (make the healthier option the easy option) and Area 4 (restrict marketing and advertising to children) seem to be action areas that need additional action and support. This despite the (increased) activity and appreciated support provided by the European Commission and other organisations, such as WHO.

Due to the shortness of the period of 2014-2017 covered by this report, it is unlikely that policies and activities implemented since 2014 can be causally related to a decrease in or a halt in the rise of childhood obesity. Furthermore, systematically collected data to determine trends in the prevalence of childhood obesity since the adoption of the Action Plan are not yet available.

RÉSUMÉ

Le plan d'action de l'UE sur l'obésité infantile 2014-2020 (ci-après nommé Plan d'action) a été lancé en février 2014. L'objectif global de ce plan d'action est de contribuer à enrayer l'augmentation du surpoids et de l'obésité chez les enfants et les jeunes. Le Plan d'action comprend huit domaines d'action, à savoir:
1) Permettre un début de vie en bonne santé
2) Promouvoir des environnements plus sains, en particulier dans les écoles et les établissements préscolaires
3) Faire de l'option saine une option facile
4) Restreindre le marketing et la publicité aux enfants
5) Informer et autonomiser les familles
6) Encourager l'activité physique
7) Surveiller et évaluer
8) Augmenter la recherche

L'étude sur l'obésité infantile visait à fournir à la Commission européenne et aux États membres de l'UE un aperçu des efforts déployés dans la première moitié du Plan d'action dans chaque État membre, ainsi qu'en Islande, Norvège, Suisse, Serbie et Monténégro, et au niveau de l'UE. Il offre également des informations sur la prévalence de l'obésité infantile dans les pays précités. Cet aperçu vise à soutenir la Commission européenne dans l'évaluation à mi-parcours (2014-2017) du Plan d'action.

Quatre tâches ont été incluses dans l'étude sur l'obésité infantile. La première fournit un aperçu de la prévalence du surpoids et de l'obésité chez les enfants dans les pays participants ainsi qu'une évaluation globale de l'état d'avancement des activités. La seconde fournit une cartographie des activités réalisées, en cours et / ou planifiées dans chacun des États membres. La tâche 3 donne un aperçu de l'engagement des États membres de l'UE, de la Commission européenne et des organisations internationales dans des initiatives, des projets et des actions communes à l'échelle de l'UE dans le domaine de la nutrition et de l'activité physique. La dernière tâche tente de donner un aperçu des forces et des faiblesses de la mise en œuvre du Plan d'action.

Base d'informations pour ce rapport
Pour chaque domaine d'action, plusieurs indicateurs ont été inclus pour mesurer les actions des pays, conformément aux objectifs du Plan d'action. Ils incluaient les 18 indicateurs identifiés en 2015 opérationnels directement pour le Etats membres, la Commission européenne et le Bureau régional de l'OMS pour l'Europe. Des indicateurs supplémentaires ont été inclus, à la fois pour couvrir le domaine 5 du Plan d'action et pour couvrir d'autres politiques et initiatives présentant un intérêt pour la Commission européenne et les États membres.

Les informations sur ces indicateurs ont été obtenues à partir de diverses sources. Des entrevues téléphoniques ont été réalisées avec des représentants de 29 pays entre la mi-décembre 2016 et février 2017. Les autres pays ont rempli les formulaires d'entrevue sur papier. Ces entretiens ont été utilisés comme principale source d'information sur la disponibilité des politiques nationales et d'autres initiatives lancées, coordonnées ou soutenues par les autorités nationales pour les sept premiers domaines d'action. Les représentants étaient membres du groupe de haut niveau sur la nutrition et l'activité physique, un groupe de représentants des gouvernements des 28 États membres de l'UE, plus l'Islande, la Norvège et la Suisse, ou d'autres autorités compétentes qu'ils ont nommées. Plusieurs autres sources d'information ont été utilisées: quelques résultats préliminaires de la deuxième enquête sur la révision de la politique nutritionnelle mondiale (données GNPRS2 collectées en 2016) fournies par le Bureau régional de l'OMS pour l'Europe; la consultation d'experts dans 25 des 33 pays participants; les informations collectées par la direction générale de la santé et de la sécurité alimentaire (DG SANTE) en 2014 et 2015 et de la recherche documentaire.

Les données sur les indicateurs quantitatifs, tels que le pourcentage d'obésité chez les enfants ou le pourcentage d'écoles participant au programme européen en faveur de la consommation de fruits et légumes à l'école, ont été obtenues grâce aux experts consultés et au Bureau régional de l'OMS pour l'Europe qui ont fourni les dernières informations disponibles sur l'Initiative de surveillance de l'obésité infantile (COSI).

Les données ont été analysées et les résultats donnent un aperçu de la réalisation d'une action mentionnée dans le Plan d'action au niveau de tous les pays participants, des 28 États membres de l'UE et de tous les pays individuels. L'évaluation de l'efficacité d'une action dépassait la portée et les ressources de l'étude. L'accomplissement d'une action peut impliquer:

a) La réalisation (partielle) d'une action datant d'avant la mise en place du Plan d'action (2014)
b) l'exécution (partielle) d'une action, depuis l'introduction du Plan d'action
c) des mesures en préparation, éventuellement encore subordonnées aux résultats des processus politiques
d) aucune action initiée ou soutenue par les autorités nationales

De plus, un aperçu de l'engagement de la Commission européenne, des États membres et des organisations internationales dans les initiatives, projets et actions communes de l'UE dans le domaine de l'obésité infantile, de la nutrition et de l'activité physique est présenté dans ce rapport. Les données ont été recueillies en recherchant des sites Web et des bases de données de projets pilotes financés par le Parlement européen, le programme de santé de l'UE, le 7e programme-cadre et les programmes Horizon 2020, le programme Erasmus + et les initiatives de programmation conjointe. Les projets pertinents en cours ou après 2014 ont été mis en correspondance avec les domaines d'action et les objectifs opérationnels du Plan d'action. En outre, nous avons consulté les sites Web de l'OMS, du Bureau régional de l'OMS pour l'Europe, de l'Association européenne pour l'étude de l'obésité (EASO), de la Fédération mondiale de l'obésité (WOF) et de l'Organisation de coopération et de développement économiques (OECD) pour avoir un aperçu de leurs activités à l'échelle de l'UE qui pourraient contribuer à freiner l'augmentation de l'obésité infantile.

Enfin, un court questionnaire a été envoyé à la mi-2017 pour examiner les politiques et autres initiatives que le répondant considérait comme «les plus réussies» et «le moins réussies» dans leur pays, des questions concernant aussi le Plan d'action et l'implication de la Commission européenne. Aucune définition spécifique du terme «réussi» n'a été fournie, de sorte que le «succès» a été mentionné par les autorités de diverses manières et devrait donc être interprété dans cette optique. Les répondants étaient les membres du groupe de haut niveau sur la nutrition et l'activité physique, les autorités compétentes du Monténégro et de la Serbie et huit des experts consultés, afin de fournir des informations supplémentaires spécifiques à leur pays. Des informations étaient disponibles pour 25 pays.

Prévalence du surpoids et de l'obésité

Les chiffres publiés sur la prévalence du surpoids et de l'obésité chez les enfants de moins de 5 ans sont rares. En outre, les différentes enquêtes utilisent des critères différents pour définir le surpoids et l'obésité, et les études diffèrent concernant les tranches d'âge des enfants étudiés. Les données disponibles sont donc difficiles à comparer. En conséquence, une image claire de la prévalence du surpoids et de l'obésité chez les jeunes enfants ne peut être fournie.

Les résultats du COSI de l'année scolaire 2009/2010 et 2013/2014 pour 15 pays et la littérature publiée pour 5 autres pays montrent que la prévalence du surpoids (y compris l'obésité) chez les enfants du primaire (6-9 ans) est élevée, mais varie considérablement, de 18% chez les garçons de 6 ans en Belgique à 57% chez les garçons de 9 ans en Grèce. Les données de 2013/2014 sur le comportement en matière de santé des enfants d'âge scolaire (HBSC) chez les adolescents (11, 13 et 15 ans) ont montré que la prévalence variait également considérablement chez ces

adolescentes, de 7% chez les filles polonaises de 15 ans à 39% chez les garçons grecs âgés de 11 ans. À quelques exceptions près, la prévalence du surpoids chez les enfants et les adolescents du primaire était plus élevée chez les garçons que chez les filles. Il convient toutefois de noter que pour HBSC, la taille et le poids étaient auto déclarés et non mesurés comme pour COSI. Cela entraîne probablement une sous-estimation de la prévalence du surpoids et de l'obésité.

Les projections du WOF supposant qu'aucune intervention efficace n'est mise en œuvre pour modifier significativement la tendance (projection linéaire) prévoient une augmentation de la prévalence du surpoids et de l'obésité chez les 2-19,9 ans entre 2010 et 2025 pour la plupart des pays. Les données systématiquement recueillies pour déterminer les tendances actuelles de la prévalence du surpoids et de l'obésité depuis l'adoption du Plan d'action ne sont pas encore disponibles. Les chiffres provenant des plus récentes études pour les années scolaires 2015/2016 de COSI et d'une autre série de sondages HBSC (2017/2018) fourniront plus de détails après la date d'expiration du Plan d'action.

L'Activité dans les sept premiers domaines d'action du Plan d'action
Les résultats de la première tâche ont montré que tous les pays sont actifs dans plus d'un des domaines d'action du Plan d'action, et un certain nombre de pays sont en train d'avancer vers l'implantation de leur plan.

Domaine 1: permettre un début de vie en bonne santé
La majorité des pays dispose de politiques, de stratégies ou d'actions en lien avec le domaine 1 du Plan d'action. Dans presque tous les pays, des conseils en matière de nutrition et d'activité physique sont donnés aux femmes pendant et directement après la grossesse. Cela fait souvent partie des soins maternels ordinaires. Des informations sur l'allaitement sont fournies et/ou l'allaitement est conseillé ou encouragé dans tous les pays tandis que 82% des pays ont implémenté la Baby-Friendly Hospital Initiative, une initiative mondiale lancée par l'OMS et UNICEF visant à implanter des pratiques qui protègent, promeuvent et soutiennent l'allaitement. 11 des pays ont mentionné que leurs conseils, stratégies ou plans d'action avaient été renouvelé depuis 2014 ou seront renouvelé en 2017. L'impact sur le pourcentage d'enfants exclusivement allaités doit encore être évalué. Avant l'adoption du plan d'action, le pourcentage d'enfants exclusivement allaité au sein maternel lors des premiers 6 mois de vie variait de 0.7 à 54.2%. Dans la majorité des pays (91%), les recommandations sur l'allaitement complémentaire sont disponibles et/ou les jeunes mères sont avisées sur cette problématique au court des soins de l'enfant.

Domaine 2: promouvoir des environnements plus sains, en particulier dans les écoles
Domaine 2 est l'un des domaines d'action abordés par la plupart des pays. Des politiques visant à améliorer l'environnement scolaire sont en place ou prévues dans tous les pays, tandis que des politiques visant à fournir gratuitement de l'eau potable facilement accessible dans les écoles sont disponibles dans 64% des pays. Dans 21% des pays, l'eau du robinet est potable et l'eau potable est donc considérée comme disponible dans les écoles. Dans tous les cas sauf quelques-uns, les politiques alimentaires scolaires comprennent des politiques sur les distributeurs automatiques et les boissons énergisantes. Ce n'est qu'en Espagne et au Portugal que les politiques relatives aux distributeurs automatiques s'appliquent également à d'autres contextes que l'environnement scolaire, tels que le Service national de la santé (PT) et les hôpitaux (ES).Les politiques sur les boissons énergisantes ne sont pas limitées au milieu scolaire dans d'avantage de pays (18%). Par exemple, selon la loi, les boissons énergisantes ne peuvent pas être vendues aux enfants de moins de 18 ans en Lituanie et en Lettonie. Tous les États membres de l'UE, sauf trois, ont participé au programme européen en faveur de la consommation de fruits et légumes à l'école (EU School Fruit and Vegetable Scheme) au cours de l'année scolaire 2015/2016. Le pourcentage d'écoles ayant reçu des fruits à l'école variait de 21% (écoles secondaires en Autriche) à 97% (à Malte).Dans près de 80% des pays, le pourcentage d'écoles recevant des fruits à l'école était supérieur à celui de l'année scolaire 2013/2014. Tous les États

membres de l'UE participent au nouveau programme pour les fruits, légumes et lait à l'école (new School Fruit, Vegetable and Milk Scheme), qui s'applique depuis l'année scolaire 2017/2018. Dans tous les pays, l'éducation physique est incluse dans le programme scolaire. Le nombre minimum d'heures consacrées à l'éducation physique varie de 1 à 8-10 heures par semaine. L'éducation nutritionnelle est également incluse dans les programmes scolaires dans tous les pays participants sauf un. Cependant, elle est facultative dans 27% des pays et fait souvent partie de la «biologie», de l '«économie domestique» ou d'autres leçons sans préciser le nombre d'heures à suivre.

Domaine 3: faire de l'option saine une option facile
Le domaine 3 est le domaine d'action qui connaît le plus de croissance en Europe. La croissance est surtout observée concernant la reformulation des aliments / l'amélioration des produits alimentaires, comme un moyen d'améliorer l'apport alimentaire qui ne nécessite pas de changement radical du régime alimentaire du consommateur. Plusieurs pays ont récemment lancé des initiatives de reformulation pour le sel (12%), le sucre (39%), les acides gras saturés (15%) et / ou les calories / portions (27%). D'autres pays prévoient de le faire (15%, 15%, 24% et 15% respectivement).

Les pays entrés dans l'UE en 2004 ou après (UE13) rattrapent clairement les États membres de l'UE15. Dans 21 pays (64%), une législation ou d'autres mesures et initiatives sont en place pour limiter les niveaux d'acides gras trans. Dans presque la moitié d'entre eux, il s'agit d'un accord volontaire de / avec l'industrie. Un étiquetage facile à comprendre, tel que l'étiquetage sur le devant de l'emballage, est utilisé dans 11 pays (33%) pour aider les consommateurs à faire des choix alimentaires plus sains (dans un des pays cela prendra fin en 2017), tandis que cela est prévu dans un autre pays. De plus, la taxation des produits déséquilibrés sur le plan nutritionnel est également de plus en plus courante, mais elle n'est pas largement utilisée (elle existe dans 9 des 33 pays). Trois autres pays (9%) prévoient une taxe sur les boissons contenant du sucre. La baisse des taux de TVA pour certains produits alimentaires spécifiques servant de subside est appliquée uniquement en Hongrie et en Lettonie.

Domaine 4: restriction de la commercialisation aux enfants
Près de 90% des pays ont des initiatives (n = 27) ou des plans (6%) pour restriction de la commercialisation des aliments et des boissons riches en sel, en sucres ou en graisses (HFSS) ou qui sinon ne correspondent pas aux directives nutritionnelles nationales ou internationales pour les enfants. Dans environ la moitié des pays, les critères nutritionnels sont utilisés pour réduire la commercialisation des aliments HFSS aux enfants. Les deux tiers des initiatives concernent des codes (facultatifs) émis par le secteur privé. Les autorités compétentes de plusieurs des pays ont indiqué que leur pays prendra d'autres positions sur ce sujet après la publication des conclusions de la discussion sur la directive de l'UE sur les services de médias audiovisuels.

Domaine 5: informer et autonomiser les familles
Les directives diététiques basées sur l'alimentation sont utilisées pour informer les consommateurs sur une alimentation saine. Elles sont disponibles dans 31 des pays participants et un d'eux travaille dessus (RS). Au moins 15 pays (45%) ont des directives distinctes pour les enfants. Vingt-trois pays (70%) ont actuellement des campagnes nationales pour informer et éduquer la population sur une alimentation saine et l'importance de l'activité physique, et un pays (3%) planifie une campagne. En revanche, d'autant moins de pays (n = 19, 58%) ont mentionné avoir ou planifier des politiques pour soutenir les interventions communautaires. Les interventions au niveau communautaire relèvent souvent de la responsabilité des autorités infranationales, telles que les municipalités. Les interventions communautaires selon la méthodologie EPODE sont implantées dans près de la moitié des pays. Le dépistage du surpoids et de l'obésité a lieu ou est prévu dans 20 pays (61%) et est souvent considéré comme étant l'une des tâches des médecins généralistes et des prestataires de soins de santé pour les enfants. Dans de nombreux pays, le médecin généraliste est également responsable de la prise en charge d'un enfant obèse. La majorité des

pays (82%) fournissent des services de prise en charge pour les enfants déjà en surpoids ou obèses, soit par le médecin généraliste, soit par d'autres prestataires de soins ou par le biais de programmes spécifiques.

Domaine 6: encourager l'activité physique
Domaine 6 semble être bien couvert, en ce qui concerne les politiques (dans 94% des pays), la présence ou la planification de directives nationales (dans 24% des pays) et les données disponibles sur le poids et la taille des enfants (dans 94% des pays). Dans environ la moitié des pays, des programmes nationaux ou infranationaux visant à promouvoir les trajets actifs à l'école existent ou alors des plans existent pour développer de tels programmes. Les niveaux d'activité physique auto-déclarés chez les adolescents sont évalués dans le cadre de l'étude HBSC dans 30 pays. En général, le pourcentage de garçons et de filles déclarant atteindre les recommandations de l'OMS en matière d'activité physique était plus élevé chez les garçons de 11 ans que chez ceux de 15 ans, et de façon générale plus élevé chez les garçons que chez les filles. En 2013-2014, le pourcentage de garçons atteignant la recommandation variait de 11% à 47%. Chez les filles, le pourcentage variait de 5% à 34%. Un nouveau cycle de l'enquête HBSC pourrait fournir davantage d'informations sur les changements dans le pourcentage d'enfants qui atteignent les recommandations d'activité physique de l'OMS depuis l'adoption du plan d'action.

Domaine 7: Surveiller et évaluer
Des enquêtes à l'échelle nationale sur la nutrition sont disponibles dans 82% des pays. Cependant, dans plusieurs pays, les enfants ne sont pas inclus et ce type d'enquêtes ne sont pas exécutés régulièrement dans tous les pays. Soixante-seize pour cent des pays disposent de tableaux sur la composition des aliments ou de bases de données nationales (sur la composition des aliments), mais seulement deux d'entre eux (FR, BE) le sont au niveau de la marque. Les données au niveau de la marque permettraient de suivre les résultats de la reformulation des produits alimentaires et de l'amélioration des produits alimentaires. La surveillance de l'activité physique auto-déclarée, de la taille et du poids et de plusieurs comportements liés à la santé (tous auto-déclarés) est prise en compte par l'HBSC et dans plusieurs pays par le biais d'autres projets. Tous sauf 3 des 33 pays (CY, ME, RS) participent à l'HBSC. La participation à COSI est l'indicateur qui a connu la deuxième plus forte croissance depuis 2014; dix pays (30%) ont participé pour la première fois au cycle 2015/2016. Dans cette ronde 26 des 33 pays ont participé (79%). Au moins deux pays utilisent d'autres enquêtes pour surveiller la prévalence du surpoids et de l'obésité chez les enfants.

Engagement dans des initiatives à l'échelle de l'UE
La troisième tâche, donner un aperçu de l'engagement de la Commission européenne, des États membres de l'UE et des organisations internationales dans les initiatives à l'échelle de l'UE, a donné les résultats suivants.

Engagement de la Commission européenne dans des initiatives à l'échelle de l'UE
La Commission européenne dispose de plusieurs instruments pour aider les États membres avec la mise en œuvre des activités du plan d'action. Ceux-ci comprennent la coordination de groupes de travail, publication des rapports destinés à fournir des informations aux États membres et des outils financiers, tels que des programmes de recherche.

La Commission européenne, entre autres, coordonne le groupe de haut niveau sur la nutrition et l'activité physique et la plate-forme d'action de l'UE sur l'alimentation, l'activité physique et la santé. Le groupe de haut niveau recherche des solutions européennes aux problèmes de santé liés à l'obésité de plusieurs façons. Par exemple, ils aident les gouvernements à partager leurs idées et leurs pratiques. La plate-forme de l'UE est un forum pour les organisations européennes allant de l'industrie alimentaire aux organisations de protection des consommateurs qui sont prêts à

s'engager pour faire face aux tendances actuelles dans l'alimentation et l'activité physique.

Le Centre commun de recherche (JRC) est le service des sciences et des connaissances de la Commission européenne, qui soutient les politiques de l'UE grâce à des recherches indépendantes. Entre autres, le JRC a publié des rapports sur les politiques alimentaires scolaires, sur les marchés publics de produits alimentaires pour la santé en milieu scolaire et sur les modèles de profils nutritionnels, ainsi qu'un ensemble d'outils sur la promotion de l'eau, des fruits et des légumes dans les écoles.

Grâce au financement, la Commission européenne soutient (indirectement) l'implémentation de ses stratégies et politiques de santé. Le Parlement européen fournit à la Commission européenne un financement supplémentaire pour des projets pilotes, qui sont des initiatives de nature expérimentale visant à tester la faisabilité et l'utilité de l'action.

Projets financés par l'UE
Au total, cinq projets pilotes pertinents et 162 projets pertinents financés par des programmes de financement de l'UE ont été identifiés sur les sites Web et dans les bases de données consultées en mars 2017. Parmi ceux-ci, 138 ont été financés par le programme Erasmus +. Les projets reprennent ont été recensés dans tous les domaines d'action du Plan d'action, excepté pour le domaine 4 (restreindre le marketing et la publicité aux enfants). Toutefois, le JRC a récemment été invité à établir une cartographie des initiatives visant à réduire l'insistance du marketing afin d'identifier les meilleures pratiques que les États membres pourraient désirer d'adapter ou de développer. Toutefois, en octobre 2017, un appel d'offres a été lancé pour une étude sur l'exposition des enfants au marketing/à la commercialisation linéaire, non linéaire et en ligne d'aliments riches en graisses, en sel ou en sucre. Relativement peu de projets pouvaient être recensés dans le domaine 3. De nombreux projets, en particulier du programme Erasmus +, correspondaient aux domaines 2 et 6. Le domaine 5 a été principalement traité par des projets pilotes et des projets financés par le programme de santé. Ce dernier programme contribue considérablement à l'échange de connaissances et de bonnes pratiques entre les pays. Deux actions conjointes financées par le programme de santé méritent d'être mentionnées spécifiquement.

Le premier étant **CHRODIS**. Son objectif était de promouvoir et de faciliter l'échange et le transfert de bonnes pratiques en matière de maladies chroniques, telles que l'obésité, entre les pays et les régions d'Europe. Treize États membres de l'UE et la Norvège ont cofinancé cette action commune. CHRODIS-Plus est le successeur de CHRODIS et implique 18 États membres de l'UE ainsi que la Norvège, la Serbie et l'Islande. Il contribuera à la réduction du fardeau des maladies chroniques en Europe en encourageant l'implantation de politiques et de pratiques ayant fait leurs preuves.

La deuxième est l'action commune sur la nutrition et l'activité physique "**JANPA**". Elle est entièrement dédiée à l'obésité infantile et correspond par conséquent à plusieurs objectifs opérationnels du plan d'action. Son objectif général est de contribuer à stopper l'augmentation de surpoids et d'obésité chez les enfants et les adolescents d'ici 2020. Grâce à l'identification, la sélection et le partage des meilleures données et pratiques, JANPA permet d'améliorer la mise en œuvre d'interventions intégrées pour promouvoir la nutrition et l'activité physique pour les femmes enceintes et les familles avec de jeunes enfants, ainsi que l'amélioration des actions dans les établissements scolaires et l'augmentation de l'utilisation des informations nutritionnelles sur les aliments par les autorités de santé publique, les parties prenantes et les familles à des fins de politique nutritionnelle. De plus, JANPA a évalué le coût du surpoids et de l'obésité chez les enfants pour sensibiliser et encourager les actions publiques. Tous sauf trois (DK, NL, UK) des 28 États membres de l'UE, ainsi que la Norvège, ont participé à JANPA.

Les initiatives de programmation commune (JPI) sont des cadres stratégiques avec un engagement de haut niveau de la part des États membres. L'objectif global du processus de programmation commune est de mettre en commun les efforts nationaux en matière de recherche afin de mieux utiliser les ressources publiques de recherche et de développement européen et aussi de s'attaquer plus efficacement aux défis européens communs. JPI "Une alimentation saine pour une vie saine" (JPI-HDHL) a commencé en 2011 et est le plus pertinent en ce qui concerne le sujet de l'obésité infantile.

Engagement des pays dans des initiatives à l'échelle de l'UE
La participation au JPI-HDHL et les activités qui découlent de cette initiative montrent en particulier l'engagement des autorités des États membres, car ce sont des partenariats volontaires des États membres avec un engagement et un (co)financement de haut niveau. Actuellement, 20 États membres de l'UE, plus la Norvège et la Suisse participent au JPI-HDHL.

La participation à des projets et activités financés par le programme de santé de l'UE (EU Health Programme), le FP7/H2020 et le programme Erasmus +, fournit également un aperçu de l'engagement des États membres. En soumettant des propositions de recherche, les organisations des États membres montrent leur intérêt pour les thèmes de l'obésité infantile, de la nutrition et de l'activité physique. En outre, il peut être un indicateur de la sensibilisation à l'obésité infantile parmi de nombreuses parties prenantes de la société, comme les chercheurs, les enseignants et les organisations sportives. Des organisations italiennes, espagnoles et polonaises participent à plus de 60 projets financés par l'UE, ce qui s'explique par un taux de participation élevé aux projets Erasmus +. Il s'agit toutefois de grands pays, ce qui peut aussi avoir entraîné la participation à de nombreux projets, car plus d'organisations ont la possibilité de demander un financement que dans les petits pays, tels que le Luxembourg, Malte, l'Estonie ou Chypre. Les organisations de ces derniers pays sont impliquées dans moins de 10 projets.

Engagement des organisations internationales
En 2014, l'OMS a créé la Commission pour mettre fin à l'obésité chez les enfants (Commission on Ending Childhood Obesity). Celle-ci a présenté en 2016 son rapport final, décrivant un ensemble complet et intégré de recommandations pour lutter contre l'obésité infantile. En 2014, le Bureau régional de l'OMS pour l'Europe a publié le Plan d'action européen 2015-2020 de l'OMS pour l'alimentation et la nutrition, qui vise à réduire considérablement le fardeau des maladies non transmissibles liées au régime alimentaire, l'obésité et toutes les autres formes de malnutrition Région européenne de l'OMS. Afin de soutenir les activités de mise en œuvre de ce plan d'action aux niveaux national et international, le Bureau régional de l'OMS pour l'Europe a mis en place des réseaux d'action composés de groupes d'États membres. Par ailleurs, ils sont l'hôte ainsi que membre du réseau européen de promotion de la santé favorable à l'activité physique, coordonnent le WHO European Healthy Cities Network, et fournissent un appui technique pour l'implémentation de COSI.

Outre ces activités, le Bureau régional de l'OMS pour l'Europe établit diverses enquêtes, telles que la Global Nutrition Policy Review (enquête GNPR2). Les données de ces enquêtes sont disponibles, par exemple à travers la base de données NOPA.

L'EASO est une fédération d'associations professionnelles de pays européens, tandis que la WOF représente des membres de plus de 50 associations régionales et nationales pour l'obésité. Les organisations de tous les pays inclus dans cette étude, sauf cinq, sont membres de l'EASO et/ou de la WOF. L'EASO compte plusieurs groupes de travail, tels que le groupe de travail sur l'obésité infantile (Childhood Obesity Task Force) et le groupe de travail sur la nutrition (Nutrition Working Group). La WOF a lancé l'Initiative mondiale contre l'obésité en 2015, qui promeut une vision globale de la lutte contre l'obésité. D'autre part, la WOF possède un programme officiel d'éducation sur l'obésité destiné aux professionnels de la santé et publie des profils de

pays contenant des informations sur la prévalence, la prise en charge et la prévention de l'obésité.

L'OECD offre un forum dans lequel les gouvernements peuvent travailler ensemble pour partager leurs expériences et chercher des solutions à des problèmes communs. L'OECD a publié sa dernière mise à jour sur l'obésité en 2017, qui mettait l'accent sur les politiques de communication conçues pour permettre aux gens de faire des choix plus sains. L'OECD a annoncé une nouvelle série de revues de santé publique, couvrant par ex. les sujets obésité et mauvaise alimentation.

Points forts et points faibles des activités visant à prévenir l'obésité infantile
Les opinions exprimées par les répondants au questionnaire sur les points forts et les points faibles donnent un aperçu des activités «les plus réussies» et de celles qui nécessitent des mesures et un soutien supplémentaires (tâche 4). Dans le cadre de cet exercice, le terme «succès» n'a pas été défini de manière spécifique et a été mentionné par les autorités de diverses manières. Par conséquent, les résultats doivent être considérés comme une première indication et non comme une évaluation objective des forces et des faiblesses.

Au total, les répondants ont identifié 57 activités comme étant «les plus réussies» et 34 activités pouvant être considérées comme «les plus difficiles à travailler». Aucune des activités identifiées ne concernait le domaine 6 du plan d'action (encourager l'activité physique). Les activités déterminées comme les plus réussies (n = 23, 40%) se situent de loin dans le domaine 2 du plan d'action, à savoir promouvoir des environnements plus sains, en particulier dans les écoles et les établissements préscolaires. Parmi ceux-ci, l'établissement de normes pour les aliments fournis ou vendus dans les écoles est le plus mentionné, suivi par l'éducation nutritionnelle, permettant des récréations actives, et la provision de repas sains gratuitement. Les activités visant à restreindre le marketing et la publicité destinés aux enfants (domaine 4) ont été mentionnées le moins souvent parmi les «plus réussies» (n = 2, 4%). La plupart des activités déclarées «les plus difficiles à travailler» se situent dans le domaine 3 (n = 10, 30%). Les activités sur la reformulation des aliments / l'amélioration des produits alimentaires, l'étiquetage facile à comprendre et les politiques fiscales ont été mentionnées le plus souvent. Il convient de souligner que certaines des activités ont été parmi les «plus réussies» dans un pays et parmi les «plus difficiles à exécuter» dans un autre.

Le questionnaire a également demandé les facteurs qui ont contribué au développement «réussi» et/ou à l'implantation des activités ainsi que les facteurs qui les ont entravés. L'engagement politique et la participation et collaboration des parties prenantes sont parmi les facteurs qui ont été mentionnés pour les activités dans plus d'un domaine d'action. L'absence de ceux-ci a également été mentionnée comme facteurs entravant les activités dites «les plus difficiles à exécuter». Ceux-ci peuvent donc être considérés comme très importants.

Les personnes interrogées ont indiqué que le plan d'action fournissait de la sensibilisation, de l'inspiration, des exemples et des conseils ou facilitait l'élaboration de politiques, la mise en œuvre d'initiatives ou de discussions avec des intervenants de la santé et d'autres intervenants (incluant l'industrie). Pour les pays qui ont déjà de nombreuses politiques, stratégies ou actions dans les domaines d'action mentionnés dans le Plan d'action, il sert principalement de document de justification ou de référence pour leurs politiques nationales. Huit répondants au questionnaire sur les points forts et les points faibles (32%) ont considéré que tous les domaines d'action considérés étaient couverts. D'autres ont émis plusieurs suggestions pour des domaines qui pourraient être renforcés ou ajoutés. Un point soulevé était que le Plan d'action pourrait être davantage axé sur les activités transnationales. De plus, des priorités communes pourraient être définies ainsi que des actions simultanées dans l'UE et dans les États membres.

Un autre point soulevé a été l'évaluation de chacun des domaines d'action et une approche globale pour identifier les domaines qui sont plus ou moins efficaces, ou qui sont nécessaires en tant que compagnons. Promouvoir un environnement plus sain dans les écoles (domaine 2) est considéré comme une action positive. Une plus grande importance pourrait cependant être accordée à la promotion d'un environnement plus sain en dehors des écoles. La majorité des activités et des actions font partie des activités scolaire ordinaires, par conséquent les activités de loisirs pour les enfants pourraient être plus valorisées. De plus, la création d'un environnement sain dans les communautés, par exemple à travers l'aménagement urbain, est considérée comme important.

Les initiatives de la Commission européenne, telles que le soutien et le renforcement des actions nationales, le partage d'informations et la facilitation des actions de collaboration des États membres, sont grandement appréciés. Les efforts de la Commission permettent d'obtenir un engagement politique en faveur d'actions dans le domaine de l'obésité infantile. JANPA est considéré comme un bon exemple d'action collaborative. Le domaine de la reformulation des aliments / l'amélioration et la commercialisation des produits alimentaires sont des domaines dans lesquels une action collaborative et le soutien de la Commission européenne sont jugés nécessaires. Les entreprises sont actives sur le marché intérieur de l'UE et au-delà, mais sans une action collaborative et le soutien de la Commission européenne, il est très difficile d'être actif au niveau national.

Conclusions principales

Les résultats de cette étude ont montré que tous les pays sont actifs dans plus d'un des domaines d'action du plan d'action, et que la plupart des pays sont actifs dans les huit domaines d'action. Beaucoup d'activités proviennent d'avant 2014, année de l'approbation du plan d'action. En outre, dans tous les domaines d'action, un certain nombre de pays passent de la planification à la mise en œuvre. En particulier pour le domaine d'action 3 (faire de l'option saine une option facile), un nombre d'initiatives considérable ont été mises en œuvre après 2014. Cela ne signifie pas nécessairement que la mise en œuvre résulte du plan d'action.

Le domaine 2 (promouvoir des environnements plus sains, en particulier dans les écoles et établissements préscolaire) semble être l'un des domaines d'action les mieux pris en compte car de nombreuse activités sont observées dans ce deuxième domaine et 40% des activités dites «les plus réussies» sont relatives à ce domaine d'action. De plus, de nombreux projets financés par l'UE répondent à des objectifs opérationnels dans ce domaine. Le domaine 6 semble également bien traité, en ce qui concerne la présence de politiques, la présence ou la planification de directives nationales et les données disponibles sur le poids et la taille des enfants.

Le domaine 3 (faire de l'option saine une option facile) et le domaine 4 (restreindre le marketing et la publicité aux enfants) semblent être des domaines d'action qui nécessitent des mesures et un engagement supplémentaires. Cela malgré l'activité accrue et le soutien apprécié de la Commission européenne et d'autres organisations, telles que l'OMS.

En raison de la brièveté de la période 2014-2017 couverte par ce rapport, il est peu probable que les politiques et activités mises en œuvre depuis 2014 puissent être liées de manière causale à une diminution ou à un arrêt de la hausse de l'obésité infantile. De plus, les données collectées systématiquement pour déterminer les tendances de la prévalence de l'obésité chez les enfants depuis l'adoption du Plan d'action ne sont pas encore disponibles.

ZUSAMMENFASSUNG

Einleitung

Der EU-Aktionsplan zu Adipositas im Kindesalter 2014-2020 (nachstehend Aktionsplan genannt) wurde im Februar 2014 gestartet. Übergeordnetes Ziel dieses Aktionsplans ist es, dazu beizutragen den Anstieg von Übergewicht und Adipositas bei Kindern und Jugendlichen bis 2020 zu stoppen. Der Plan besteht aus acht Aktionsbereichen:

1) Einen gesunden Start ins Leben unterstützen
2) Ein gesundes Umfeld, besonders in Schulen und in Vorschulen, fördern
3) Die gesündere Option zur einfachen Option machen
4) Marketing und Werbung zu Kindern einschränken
5) Familien informieren und stärken
6) Bewegung fördern
7) Überwachen und auswerten
8) Forschung fördern

Um die Europäische Kommission bei der Halbzeitbewertung (2014-2017) des Aktionsplans zu unterstützen, wurde die Studie zu Adipositas im Kindesalter durchgeführt. Das Ziel dieser Studie ist, der Europäischen Kommission und den Mitgliedsstaaten der EU einen Überblick, über die Bemühungen von jedem EU-Mitgliedsstaat, Island, Norwegen, Schweiz, Serbien und Montenegro, sowie auf EU-Ebene, während der ersten Hälfte des Aktionsplans zu geben. Zusätzlich sind Informationen über die Prävalenz von Adipositas im Kindesalter in den zuvor genannten Ländern bereitgestellt. Dieser Überblick soll die Europäische Kommission bei der Zwischenbewertung (2014-2017) des Aktionsplans unterstützen.

Vier Aufgaben wurden in der Studie zu Adipositas im Kindesalter behandelt. Die erste verschafft einen Überblick über die Prävalenz von Übergewicht und Adipositas im Kindesalter in den teilnehmenden Ländern sowie eine Gesamtbewertung des aktuellen Standes der Aktivitäten. Die zweite fasst die laufenden oder geplanten Aktivitäten der Mitgliedsstaaten zusammen. Aufgabe 3 gibt einen Überblick über das Engagement der EU-Mitgliedstaaten, der Europäischen Kommission und der internationalen Organisationen in EU-weiten Initiativen, Projekten und gemeinsamen Aktionen im Ernährungs- und Bewegungsbereich. Das Ziel der letzten Aufgabe ist, einen Einblick in die Stärken und Schwächen der Umsetzung des Aktionsplans zu geben.

Informationen für diesen Report

Um die Aktionen der Länder zu messen, wurden für jeden Aktionsbereich bestimmte Indikatoren benutzt, die mit den Zielen des Aktionsplans übereinstimmen. Der Aktionsplan benutzte 18 Indikatoren, die 2015 bestimmt wurden, um die sofortige Operationalisierung der Mitgliedstaaten, der Europäischen Kommission und des WHO-Regionalbüros für Europa sicherzustellen. Zusätzliche Indikatoren wurden ausgewählt um den fünften Aktionsbereich des Aktionsplans und zusätzliche Aktionen und Initiativen, die im Interesse der Europäischen Kommission und der Mitgliedstaaten stehen, mit einzubeziehen. Verschiedene Quellen speisten Informationen zu diesen Indikatoren. Zwischen Mitte Dezember 2016 und Februar 2017 führten Vertreter aus 29 Ländern Telefoninterviews durch. Die anderen Länder füllten den Fragebogen auf Papier aus. Im Bereich der ersten sieben Aktionsbereichen stellten diese Interviews die grundlegende Informationsquelle über die Verfügbarkeit von nationalen Strategien und anderen Initiativen, die von nationalen Behörden eingeleitet, koordiniert oder unterstützt werden, dar. Die Vertreter waren Mitglieder der Hochrangigen Gruppe für Ernährung und Bewegung, welche sich aus Vertreter der Regierung oder anderen zuständigen Behörden, die sich mit dem Thema Ernährung und Bewegung befassen, der 28 Mitgliedstaaten, Island, Norwegen und der Schweiz zusammensetzt. Zusätzlich wurden andere Informationsquellen mit einbezogen: die Ergebnisse der zweiten Umfrage zur globalen Ernährungspolitik (GNPRS2 Daten wurden in 2016 gesammelt), die von dem WHO-Regionalbüro für Europa zur Verfügung gestellt wurden; Informationen, die die Generaldirektion Gesundheit und Lebensmittelsicherheit (DG SANTE) in 2014 und 2015 sammelte, und Deskresearch. Daten über quantitative

Indikatoren, wie zum Beispiel wie viel Prozent der Kinder an Adipositas leiden oder wie viel Prozent der Schulen am EU-Schulobstprogramm teilnehmen, wurden durch sekundäre Forschung, durch die hinzugezogenen Experten und durch das WHO-Regionalbüro für Europa, die die neuesten Ergebnisse der Initiative zur Überwachung von Adipositas im Kindesalter (COSI) bereitstellten, gewonnen.

Die Daten wurden analysiert und die Ergebnisse ermöglichen einen Einblick darin, ob die Aktionen des Aktionsplans auf der Ebene die teilnehmenden Länder, der 28 EU-Mitgliedstaaten und der individuellen Länder, erfüllt wurden. Die Auswertung der Effektivität der Aktionen geht über den Umfang und der Ressourcen dieser Studie hinaus. Die Erfüllung der Aktionen kann folgendes bedeuten:

a) (teilweise) Erfüllung der Aktion bereits vor der Einführung des Aktionsplans in 2014

b). (teilweise) Erfüllung der Aktion seit der Einführung des Aktionsplans in 2014

c). Aktion in Vorbereitung, die Resultate des Prozesses sind möglicherweise noch ungewiss

d.) Keine Aktion wurde durch nationale Behörden eingeleitet oder unterstützt

Darüber hinaus beinhaltet dieser Report einen Überblick über das Engagement der Europäischen Kommission, der Mitgliedstaaten, und der internationalen Organisationen in EU Initiativen, Projekten, und in gemeinsamen Aktionen im Bereich von Adipositas im Kindesalter, Ernährung und Bewegung. Diese Informationen wurden auf den Internetseiten und Datenbanken der vom Europäischen Parlaments finanzierten Pilotprojekten, des EU-Gesundheitsprogramms, des Siebten Rahmenprogramms und Horizont 2020 Programm, des Erasmus+ Programm, des EU-Sport Programm und der Initiative zur gemeinsamen Programmplanung gesammelt. Relevante Projekte, die während oder nach 2014 liefen, wurden nach Aktionsbereichen und Zielen des Aktionsplans geordnet. Zusätzlich wurden die Internetseiten der Weltgesundheitsorganisation (WHO), des WHO-Regionalbüros für Europa, der Europäischen Gesellschaft für die Studie von Adipositas (EASO), der Welt Adipositas Vereinigung (WOF) und der Organisation für wirtschaftliche Zusammenarbeit und Entwicklung (OECD) konsultiert, um einen Einblick in deren EU-weiten Aktivitäten, welche versuchen den Anstieg in Adipositas im Kindesalter zu stoppen, zu erhalten.

Eine kurze Umfrage wurde Mitte 2017 ausgesendet. Sie thematisiert, welche politischen Maßnahmen und andere nationalen Initiativen von den Empfängern als “am erfolgreichsten” oder “am wenigsten erfolgreich” empfunden wurden, den Aktionsplan und die Bestrebungen der Europäischen Kommission. Der Begriff “erfolgreich” wurde dabei nicht definiert, sodass die Behörden “Erfolg” unterschiedlich interpretierten. Somit sind die Ergebnisse der Umfrage vorsichtig zu interpretieren. Befragt wurden die Mitglieder der Hochrangigen Gruppe für Ernährung und Bewegung, die zuständigen Behörden in Montenegro und Serbien und acht hinzugezogenen Experten um zusätzliche Informationen zu deren Länder zu erhalten. Informationen für 25 Länder waren verfügbar.

Prävalenz von Übergewicht und Adipositas

Die Ergebnisse der ersten Aufgabe zeigen das es sind wenige Daten über die Prävalenz von Übergewicht und Adipositas in Kindern unter fünf Jahren veröffentlicht. Unterschiedliche Umfragen benutzten unterschiedliche Kriterien um Übergewicht und Adipositas zu definieren und die Umfragen unterscheiden sich in den Altersbereichen der teilnehmenden Kinder. Deswegen können keine konkreten Angaben zu der Prävalenz von Übergewicht und Adipositas in jungen Kindern gemacht werden.

Die Ergebnisse der COSI-Umfrage für die Schuljahre 2009/2010 und 2013/2014 in 15 Ländern und die veröffentlichte Literatur von weiteren fünf Ländern zeigen, dass die Prävalenz von Übergewicht (einschließlich Adipositas) unter Grundschulkindern (6-9 Jahre) hoch ist, aber sich stark unterscheidet, z. B. 18 % in 6-Jahre alten Jungen in Belgien und 57 % in 9-Jahre alten Jungen in Griechenland. Daten über das Gesundheitsverhalten in Schulkindern in 2013/2014 (HBSC-Umfrage) zeigen, dass

sich auch in der Altersgruppe von Jugendlichen (11, 13 und 15 Jahren) starke Schwankungen aufzeigen lassen, von 7 % in 15-Jahre alten polnischen Mädchen zu 39 % in 11-Jahre alten griechischen Jungen. Die Prävalenz von Übergewicht in Grundschulkindern und Jugendlichen war, mit ein paar Ausnahmen, höher in Jungen als in Mädchen. Allerdings muss man beachten, dass Größe und Gewicht in HBSC selbst eingeschätzt, und nicht wie in COSI gemessen wurde. Das könnte eine Unterschätzung der Prävalenz von Übergewicht und Adipositas zu Folge haben.

Prognosen vom WOF nehmen an, dass derzeit keine effektive Intervention den ansteigenden Trend zwischen 2010 und 2025 (lineare Projektion) in der Prävalenz von Übergewicht und Adipositas in 2-19.9-Jährigen in den meisten Ländern signifikant ändern könnte. Es sind noch keine systematisch gesammelten Daten, die den tatsächlichen Trend in der Prävalenz von Übergewicht nach der Einführung des Aktionsplans bestimmen, verfügbar. Daten aus der neuesten COSI-Umfrage des Schuljahres 2015/2016 und die nächste Runde der HBSC-Umfrage (2017/2018) tragen zu einem weiteren Einblick nach der Einführung des Aktionsplans bei.

Aktivitäten in den ersten sieben Aktionsbereichen des Aktionsplans
Die Ergebnisse der zweiten Aufgabe zeigen das jedes Land ist aktiv in mehr als nur einem Aktionsbereich des Aktionsplans und ein paar Länder bewegen sich von der alleinigen Planung zu der Implementierung.

Aktionsbereich 1: einen gesunden Start ins Leben fördern
Politische Maßnahmen, Strategien oder Aktionen, die sich auf den ersten Bereich beziehen, gibt es in den meisten Ländern. In fast jedem Land werden Ernährungs- und Bewegungsberatungen für Frauen während oder nach ihrer Schwangerschaft angeboten. Dies ist oft Teil der regelmäßigen Schwangerschaftsberatung. In allen Ländern werden Informationen zum Stillen zur Verfügung gestellt und/oder Stillen wird empfohlen oder gefördert, während 82 % der Länder an der Initiative zum Babyfreundlichen Krankenhaus teilnehmen, eine globale Maßnahme von WHO und UNICEF um Methoden zu implementieren, die das Stillen beschützen, bewerben und fördern. Elf Länder erwähnen, dass ihre Richtlinien, Strategien oder Aktionspläne seit 2014 erneuert wurden oder in 2017 erneuert werden. Wie sich das auf die Prozentzahl von Säuglingen, die nur gestillt werden, auswirkt, muss noch ausgewertet werden. Vor der Einführung des Aktionsplans schwankte die Prozentzahl der Säuglinge, die während der ersten sechs Monate nur gestillt wurden, von 0,7 % zu 54,2 %. In der Mehrheit der Länder (91 %) sind Richtlinien zum zusätzlichen Füttern vorhanden und/oder junge Mütter können Beratungen in Anspruch nehmen.

Aktionsbereich 2: Ein gesundes Umfeld, besonders in Schulen und in Vorschulen, fördern
Aktionsbereich 2 ist ein Bereich, der von den meisten Ländern thematisiert wird. In allen Ländern sind Aktionen, die das Schulumfeld verbessern sollen, vorhanden oder geplant, wobei in 64 % der Länder kostenloses und frei zugängliches Trinkwasser verfügbar ist. In weiteren 21 % der Länder ist das Leitungswasser sicher, sodass es als kostenloses und frei zugängliches Trinkwasser betrachtet wurde. In fast allen Ländern beinhaltet die Ernährungspolitik in Schulen auch Maßnahmen über Automaten und Energydrinks. Nur in Spanien und Portugal trafen diese Maßnahmen über Automaten auch in anderen Umfeldern als in der Schule zu, wie zum Beispiel im nationalen Gesundheitsdienst (PT) und in Krankenhäusern (ES). In mehreren Ländern sind Maßnahmen über Energydrinks nicht nur auf das Schulumfeld beschränkt (18 %). Zum Beispiel können Energydrinks in Litauen und Lettland per Gesetz nicht an Kinder unter 18 Jahren verkauft werden. Alle EU-Mitgliedsstaaten, mit der Ausnahme von drei Ländern, nahmen 2015/2016 am EU-Schulobst- und gemüseprogramm teil. Die Prozentzahl der Schulen, die Früchte erhielten, schwankte von 21 % (weiterführende Schulen in Österreich) zu 97 % (in Malta). In fast 80% der Länder war die Prozentzahl der Schulen die Früchte erhielten höher als im Schuljahr 2013/2014. Alle EU-Mitgliedsstaaten nahmen am neuen Schulobst, -gemüse und -milch Programm, welches seit 2017/2018 läuft, teil. In jedem Land ist Bewegung Teil des Lehrplans. Pro

Woche werden mindestens 1 bis 8-10 Stunden für Bewegung zugeteilt. In allen teilnehmenden Ländern, außer einem, ist Ernährungserziehung Teil des Lehrplans. Dies ist jedoch freiwillig in 27 % der Länder und oft Teil des “Biologieunterrichts”, “Hauswirtschaftslehre” oder anderen Fächern, deren Anzahl der Unterrichtsstunden nicht genannt wurde.

Aktionsbereich 3: die gesündere Option zur einfachen Option machen
Der dritte Bereich ist der Aktionsbereich, der den höchsten Anstieg in Europa verspürt hat. Der Anstieg ist besonders hoch in der Reformulierung/ Verbesserung von Nahrungsmitteln, welches die Nährstoffaufnahme verbessern soll, ohne dass der Konsument seine Ernährung drastisch umstellen muss. Manche Länder haben vor kurzem Reformulierungsinitiativen für Salz (12 %), Zucker (39 %), gesättigte Fettsäuren (15 %) und/oder Kalorien/Portionsgrößen (27 %) gestartet. Andere Länder haben dies in der Planung (15%, 15%, 24% und 15% in dieser Reihenfolge). Länder, die der EU 2014 oder später beigetreten sind (EU13) schließen klar auf die EU15-Mitgliedsstaaten auf. In zwanzig Ländern (61 %) sind Gesetze oder andere Maßnahmen etabliert, die das Level gesättigter Fettsäuren regulieren. Dies sind in fast allen Ländern freiwillige Abkommen von/mit der Industrie. Einfach zu verstehende Kennzeichnungen, wie Kennzeichnungen auf der Vorderseite, werden in 11 Ländern (33 %) benutzt um Konsumenten eine gesündere Essenswahl zu ermöglichen (davon endet eine Initiative in 2017), und in einem Land ist dies geplant. Auch Steuern auf Produkte mit unausgewogenen Nährstoffen werden öfter genutzt (existiert in 9 von 33 Ländern), aber noch nicht flächendeckend. Drei andere Länder (9 %) haben Pläne für eine Abgabe für zuckerhaltige Getränke. In Ungarn und Lettland gibt es als Subvention Steuervergünstigungen für bestimmte Produkte.

Aktionsbereich 4: Einschränkung des Marketings und Werbung
Bereich vier handelt von der Einschränkung des Marketings und Werbung von Nahrungsmitteln und Getränken, die viel Salz, Zucker oder Fett (englische Abkürzung: HFSS) enthalten oder die nicht in die nationalen oder internationalen Ernährungsrichtlinien passen, zu Kindern. Fast 90 % der Länder haben Initiativen (n=27) oder Pläne (6 %) in diesem Bereich. In ca. der Hälfte der Länder werden Nährstoffkriterien benutzt, die Marketing von HFSS Produkten einschränken. Zwei Drittel der Initiativen sind (freiwillige) Kodexe des privaten Sektors. Die zuständigen Behörden der jeweiligen Länder erwähnten, dass ihre Länder eine weitere Position zu diesem Thema einnehmen, nachdem die Schlussfolgerungen der Diskussionen um die Richtlinie über audiovisuelle Mediendienste veröffentlicht wurden.

Aktionsbereich 5: Familien informieren und stärken
Lebensmittelorientierte Ernährungsleitfäden informieren Konsumenten über gesunde Ernährung. Sie sind in 31 der teilnehmenden Länder verfügbar und ein Land arbeitet daran (RS). Mindestens 15 Länder (45 %) haben separate Richtlinien für Kinder. In 23 Ländern (70 %) laufen derzeit nationale Kampagnen, die die Bevölkerung über gesunde Ernährung und die Wichtigkeit von Bewegung informieren und bilden, und ein Land (3 %) plant eine Kampagne. Weniger Länder (n=19, 58 %) erwähnen, dass politische Maßnahmen existieren oder geplant sind, die gemeindebasierte Interventionen fördern. Gemeindebasierte Interventionen fallen häufig unter die Verantwortung der örtlichen Behörden, wie der Gemeinde. Gemeindebasierte Interventionen, laut der EPODE-Methode sind in fast der Hälfte der Länder eingesetzt. Übergewicht- und Adipositas-Screening existiert oder ist in 20 Ländern (61 %) geplant und wird oft als Aufgabe des Gesundheitsdienstleisters des Kindes oder der Hausärzte gesehen. In vielen Ländern sind Hausärzte auch für das Management des adipösen Kindes verantwortlich. In der Mehrzahl der Länder (82 %) werden Behandlungen für Kinder, die bereits übergewichtig oder adipös sind, entweder vom Hausarzt oder von anderen Gesundheitsdienstleistern oder anderen spezifischen Programmen durchgeführt.

Aktionsbereich 6: Bewegung fördern
Bereich 6 scheint recht gut abgedeckt zu sein in Bezug auf politische Maßnahmen (in 94 % der Länder), existierende oder geplante nationale Richtlinien (in 24 % der Länder) und vorhandene Daten über Gewicht und Größe der Kinder (in 94 % der Länder). In circa der Hälfte der Länder gibt es nationale oder regionale Pläne, die den aktiven Schulweg fördern. Die HBSC Studie sammelt die selbsteinschätze Bewegung von Jugendlichen in 30 Ländern. Die Prozentzahl der Jungen und Mädchen, die die Bewegungsempfehlung der WHO erreichten, war in 11-Jährigen generell höher als in 15-Jährigen und in Jungen generell höher als in Mädchen. In 2013/2014 schwankte die Prozentzahl der Jungen, die die Empfehlung erreichten, zwischen 11 % und 47 %. Bei den Mädchen lag sie zwischen 5 % und 34 %. Eine neue Runde der HBSC Umfrage könnte mehr Einsicht in die Prozentzahl der Kinder geben, die die WHO Empfehlung seit der Einführung des Aktionsplans erreichen.

Aktionsbereich 7: Überwachen und auswerten
In 82 % der Länder sind repräsentative, nationale Ernährungsumfragen vorhanden. In manchen Ländern schließen diese allerdings nicht Kinder mit ein oder werden nicht regelmäßig befragt. 76 % der Länder erstellten nationale Tabellen oder Datenbanken über Lebensmittelzusammensetzungen, aber in nur zwei Länder passierte dies auch auf Markenebene. Informationen auf Markenebene würde es ermöglichen, Auswirkungen der Reformulierung/ Verbesserung von Nahrungsmitteln zu überprüfen. Das Überwachen von selbst eingeschätzter Bewegung, Höhe und Gewicht und andere Gesundheitsverhalten wird durch HBSC, und in manchen Ländern durch andere Projekte, abgedeckt. Außer drei Länder (CY, ME, RS) nehmen alle Länder an HBSC teil. Teilnahme an COSI ist ein Indikator, der den zweitgrößten Zuwachs seit 2014 verspürte; zehn Länder (30 %) nahmen bei der ersten Runde in 2015/2016 teil. In der letzen Runde nahmen 26 der 33 Länder teil (79 %). Mindestens zwei Länder überwachen die Prävalenz von Übergewicht und Adipositas in Kindern mit Hilfe von anderen Umfragen.

Engagement in EU-weiten Initiativen
Aufgabe 3 gibt einen Überblick über das Engagement der EU-Mitgliedstaaten, der Europäischen Kommission und der internationalen Organisationen in EU-weiten Initiativen.

Engagement der Europäischen Kommission in EU-weiten Initiativen
Im Aktionsplan forderten die Mitgliedstaaten die Europäische Kommission zur Verantwortung für drei oberste Prioritäten auf, und zwar 1) weiterhin Unterstützung und Koordinierung bereitzustellen und den Austausch von Informationen und besten Vorgehensweisen zu ermöglichen, 2) den Gebrauch von verfügbaren Instrumenten, und zwar das EU Gesundheitsprogramm und die Wachstumsstrategie Horizont 2020, besser zu fördern, und 3) ihr Ziel, das Thema Gesundheit besser in andere politische Bereiche der EU zu integrieren, verstärkt zu verfolgen. Die Europäische Kommission hat verschiedene Instrumente um diese drei genannten Ziele zu verfolgen, einschließlich der Koordinierung von Arbeitsgruppen, besonderen Veranstaltungen, etc., Reporte um die Mitgliedstaaten zu informieren und finanzielle Mittel, wie Forschungsprogramme.

Die Europäische Kommission koordiniert unter Anderem die Hochrangige Gruppe für Ernährung und Bewegung und die EU-Plattform für Ernährung, Bewegung und Gesundheit. Die Hochrangige Gruppe sucht europäische Lösungen für Adipositas-relevante Gesundheitsthemen auf verschiedenen Wegen. Zum Beispiel hilft sie den Regierungen, politische Maßnahmen und Ideen auszutauschen. Die EU-Plattform ist ein Forum für europäische Organisationen, von der Lebensmittelindustrie zu Verbraucherschutzorganisationen, die daran interessiert sind, den aktuellen Trend in der Ernährung und Bewegung umzukehren.

Die Gemeinsame Forschungsstelle (JRC) ist eine wissenschaftliche Dienstleistung der Europäischen Kommission und unterstützt politische Maßnahmen der EU mit unabhängiger Forschung. Die Gemeinsame Forschungsstelle veröffentlichte unter Anderem Reporte über Schulessen, über öffentliche Auftragsvergabe von Essen für die Gesundheit in der Schule und über Nährstoff-Modelle, sowie Methoden um Wasser, Früchte und Gemüse in der Schule zu bewerben.

Die Europäische Kommission unterstützt (indirekt) die Implementierung von Gesundheitsstrategien und -maßnahmen durch dessen Finanzierung. Das Europäische Parlament stellt der Europäischen Kommission zusätzliche Gelder für Pilotprojekte, also experimentelle Initiativen, die die Durchführbarkeit und Nützlichkeit der Aktionen testen, zur Verfügung.

EU-finanzierte Projekte
Auf den Internetseiten und in den Datenbanken, welche im März 2017 durchsucht wurden, wurden insgesamt fünf relevante Pilotprojekte und 162 relevante Projekte, die durch EU-Finanzierung finanziert wurden, identifiziert. Von diesen Projekten wurden 138 Projekte durch das Erasmus+ Programm finanziert. Die Projekte passten zu allen Aktionsbereichen des Aktionsplans mit Ausnahme vom vierten *(Marketing und Werbung zu Kindern einschränken).* Das JPR wurde allerdings kürzlich um ein Mapping über Initiativen in diesem Bereich gebeten, um beste Maßnahmen zu identifizieren, welche Mitgliedstaaten übernehmen oder darauf aufbauen könnten. Zudem wurde im Oktober 2017 eine Ausschreibung für eine Studie veröffentlicht, in der es darum geht zu ermitteln, welcher Werbung für Produkte, die hoch in Fett, Salz oder Zucker sind, Kinder ausgesetzt sind. Relativ wenige Projekte passen zu Bereich 3. Viele Projekte, besonders die vom Erasmus+ Programm geförderte, passten zu dem zweiten und sechsten Bereich. Der fünfte Bereich wurde hauptsächlich von Pilotprojekten und vom Gesundheitsprogramm geförderten Projekten bearbeitet. Das Gesundheitsprogramm trägt besonders zu dem Austausch von Informationen und besten Maßnahmen der Länder bei. Zwei Gemeinsame Aktionen, die von dem Gesundheitsprogramm gefördert wurden, sind erwähnenswert. Die erste ist **CHRODIS**, wessen Ziel ist, den Austausch und die Übertragung von guten Maßnahmen gegen chronische Krankheiten, wie Adipositas, zwischen europäischen Ländern und Regionen zu fördern und zu ermöglichen. Dreizehn EU-Mitgliedstaaten und Norwegen finanzieren diese Gemeinsame Aktion mit. CHRODIS-PLUS ist der Nachfolger von CHRODIS und involviert 18-Mitgliedsstaaten, Norwegen, Serbien und Island. Es trägt dazu bei, die Belastungen durch chronische Krankheiten zu reduzieren, weil es die erfolgreiche Einführung von politischen Maßnahmen und Methoden fördert.

Die zweite ist **JANPA**, eine Gemeinsame Aktion über Ernährung und Bewegung. Sie widmet sich voll und ganz Adipositas im Kindesalter und orientiert sich daher an mehreren operativen Zielen des Aktionsplans. Ihr allgemeines Ziel ist es, dazu beizutragen, den Anstieg von Übergewicht und Adipositas bei Kindern und Jugendlichen bis 2020 zu stoppen. Durch die Ermittlung, Auswahl und den Austausch bewährter Daten und Verfahren ermöglicht JANPA die Verbesserung der Umsetzung integrierter Maßnahmen zur Förderung der Ernährung und Bewegung von Schwangeren und Familien mit Kleinkindern, die Verbesserung von Maßnahmen im schulischen Umfeld und die verstärkte Nutzung von Ernährungsinformationen von Lebensmittel durch Gesundheitsbehörden, Interessengruppen und Familien für ernährungspolitische Zwecke. Darüber hinaus ermittelte JANPA die Kosten von Übergewicht und Adipositas bei Kindern, um das Bewusstsein zu schärfen und öffentliche Maßnahmen zu fördern. Bis auf 3 Länder (DK, NL, UK) nahmen die Mitgliedstaaten, sowie Norwegen, an JANPA teil.

Mitgliedstaaten zeigen hohes Engagement in den strategischen Initiativen zur Gemeinsamen Programmplanung (JPI). Übergeordnetes Ziel der Gemeinsamen Programmplanung ist es, nationale Forschungen zu bündeln, um die öffentlichen Forschungs- und Entwicklungsressourcen Europas besser zu nutzen und die gemeinsamen europäischen Herausforderungen besser zu bewältigen. Die JPI "Eine gesunde Ernährung für ein gesundes Leben" (JPI-HDHL) startete im Jahr 2011 und ist für das Thema Adipositas bei Kindern besonders relevant.

Engagement der Länder in EU-weiten Initiativen
Die Teilnahme an JPI-HDHL und an Aktivitäten, die aus dieser Initiative hervorgehen, zeigte insbesondere das Engagement der Regierungen der Mitgliedstaaten, da die Partnerschaften der Mitgliedstaaten freiwillig sind und hohes Engagement und (Mit-)Finanzierung fordert. Derzeit nehmen 20 EU-Mitgliedstaaten, sowie Norwegen und die Schweiz, an JPI-HDHL teil.

Auch die Teilnahme an Projekten und Aktivitäten, die durch das EU-Gesundheitsprogramm, FP7/H2020 und dem Erasmus+ Programm finanziert werden, gibt einen Einblick in das Engagement der Mitgliedstaaten. Mit der Einreichung von Forschungsvorhaben zeigen Organisationen in den Mitgliedstaaten ihr Interesse an den Themen Adipositas bei Kindern, Ernährung und Bewegung. Darüber hinaus kann es ein Indikator für das Bewusstsein über Adipositas bei vielen gesellschaftlichen Akteuren wie Forschern, Lehrern und Sportorganisationen sein. Organisationen aus Italien, Spanien und Polen sind an >60 von der EU geförderten Projekten beteiligt, was auf eine hohe Beteiligung an Erasmus+ Projekten zurückzuführen ist. Es handelt sich jedoch um große Länder, was auch zu der Beteiligung an vielen Projekten geführt haben kann, da es mehr Organisationen gibt, die eine Finanzierung beantragen können als in kleineren Ländern wie Luxemburg, Malta, Estland oder Zypern. Organisationen aus diesen Ländern sind an <10 Projekten beteiligt.

Engagement der internationalen Organisationen
Im Jahr 2014 gründete die WHO die Kommission zur Bekämpfung von Adipositas im Kindesalter, die 2016 ihren Abschlussbericht vorlegte, der ein umfassendes, integriertes Paket von Empfehlungen zur Bekämpfung von Adipositas im Kindesalter enthält. Im Jahr 2014 veröffentlichte das WHO-Regionalbüro für Europa den Europäischen Aktionsplan Nahrung und Ernährung 2015-2020, der vermeidbare ernährungsbedingte, nichtübertragbare Krankheiten, Adipositas und alle anderen Formen der Fehlernährung, die in der europäischen Region der WHO noch immer verbreitet sind, deutlich verringern soll. Das WHO-Regionalbüro koordiniert Netzwerke mit Mitgliedstaaten, um Aktivitäten auf nationaler und internationaler Ebene und die Umsetzung des Aktionsplans zu unterstützen. Darüber hinaus sind sie Gastgeber und Mitglied des europäischen Netzwerks zur Förderung gesunder Bewegung, welches vom Europäischen Gesunde Städte-Netzwerk der WHO koordiniert wird und technische Unterstützung bei der Umsetzung von COSI gibt. Neben diesen Aktivitäten führt das WHO-Regionalbüro für Europa verschiedene Erhebungen durch, wie z. B. die Umfrage zur globaler Ernährungspolitik (GNPR2-Umfrage). Die Daten aus diesen Erhebungen werden zum Beispiel über die NOPA-Datenbank zur Verfügung gestellt.

EASO ist ein Zusammenschluss von Verbänden aus europäischen Ländern, während die WOF Mitglieder aus über 50 regionalen und nationalen Adipositasverbänden vertritt. Organisationen aus allen, außer fünf, teilnehmenden Ländern sind Mitglieder von EASO und/oder WOF. EASO hat mehrere Arbeitsbereiche und Arbeitsgruppen, wie die Arbeitsgruppe zu Adipositas im Kindesalter und die Arbeitsgruppe zu Ernährung. WOF hat im Jahr 2015 die Welt-Adipositas-Aktionsinitiative ins Leben gerufen, die eine umfangreiche Bekämpfung von Adipositas fördert. Darüber hinaus erstellt WOF ein offizielles Programm zur Aufklärung von Gesundheitsfachkräften und veröffentlicht Länderprofile mit Informationen über Adipositasprävalenz, -management und -prävention.

Die OECD bietet ein Forum, in dem Regierungen zusammenarbeiten können, um Erfahrungen auszutauschen und nach Lösungen für gemeinsame Probleme zu suchen. Die OECD veröffentlichte 2017 ihr letztes Update über Adipositas, das sich auf Kommunikationsmaßnahmen konzentrierte, die die Menschen in die Lage versetzen sollen, gesündere Entscheidungen zu treffen. Die OECD hat eine neue Reihe von Überprüfungen der öffentlichen Gesundheit angekündigt, die z.B. die Themen Adipositas und ungesunde Ernährung abdecken.

Stärken und Schwächen der Aktivitäten zur Prävention von Adipositas im Kindesalter

Die Meinungen der Befragten zum Fragebogen über Stärken und Schwächen geben einen Einblick in die "erfolgreicheren" Aktivitäten und diejenigen, die zusätzliche Maßnahmen und Unterstützung benötigen (Aufgabe 4). Im Rahmen dieser Übung wurde der Begriff "Erfolg" nicht spezifisch definiert und von den Behörden auf verschiedene Weise interpretiert. Die Ergebnisse sind daher als erster Anhaltspunkt und nicht als objektive Bewertung der Stärken und Schwächen zu verstehen.

Insgesamt berichteten die Befragten von 57 "erfolgreichsten" Aktivitäten und 34 Aktivitäten, die als "am schwierigsten zu bearbeiten" angesehen werden. Keine der Aktivitäten betraf den Bereich 6 des Aktionsplans (*Bewegung fördern*). Die mit Abstand “erfolgreichsten" Aktivitäten (n=23, 40 %) liegen im Aktionsbereich 2 des Aktionsplans, d. h. *ein gesundes Umfeld, besonders in Schulen und in Vorschulen, fördern*. Hier wird am häufigsten die Festlegung von Standards für Lebensmittel, die in Schulen angeboten oder verkauft werden, erwähnt, gefolgt von Ernährungserziehung, die aktive Pausen ermöglicht, und die Bereitstellung von kostenlosen, gesunden Mahlzeiten. Aktivitäten zur *Einschränkung von Marketing und Werbung auf Kinder* (Bereich 4) wurden am seltensten unter den "erfolgreichsten Aktivitäten" genannt (n=2, 4 %). Die meisten der als am schwierigsten zu bearbeitenden Tätigkeiten liegen im Bereich 3 (n=10, 30 %). Am häufigsten wurden hier Maßnahmen zur Neuformulierung/Verbesserung von Lebensmitteln, leicht verständliche Etikettierung und Steuerpolitik genannt. Es ist darauf hingewiesen, dass einige der Aktivitäten in einem Land zu den "erfolgreichsten" und in einem anderen Land zu den "am schwierigsten zu bearbeitenden" gehören.

Der Fragebogen fragte auch nach den Faktoren, die zur "erfolgreichen" Entwicklung und/oder Umsetzung von Aktivitäten beigetragen haben, und nach den Faktoren, die sie dies verhinderten. Politisches Engagement und die Einbeziehung und Zusammenarbeit von Interessengruppen gehören zu den Faktoren die für Aktivitäten in mehr als einem Aktionsbereich genannt wurden. Das Fehlen dieser Faktoren wurde wiederum als erschwerender Faktor für Aktivitäten genannt, die "am schwierigsten zu bearbeiten sind". Diese können daher als sehr wichtig angesehen werden.

Die Befragten berichteten, dass der Aktionsplan Bewusstsein, Inspirationen, Beispiele und Anleitungen bot oder die politische Entscheidungsfindung, die Umsetzung von Initiativen oder Diskussionen zwischen dem Gesundheitsbereich und anderen Interessengruppen (einschließlich der Industrie), erleichterte. Für Länder, die bereits über zahlreiche politische Maßnahmen, Strategien oder Aktionen in den im Aktionsplan genannten Aktionsbereichen verfügen, dient er vor allem als Begründung oder Referenzdokument für ihre nationale Politik. Acht Befragte des Fragebogens zu Stärken und Schwächen (32%) waren der Meinung, dass alle relevanten Handlungsfelder abgedeckt sind. Andere haben mehrere Vorschläge für Bereiche gemacht, die verstärkt oder ergänzt werden könnten. Ein Punkt war, dass der Aktionsplan stärker auf länderübergreifende Aktivitäten ausgerichtet werden könnte. Es könnten gemeinsame Prioritäten sowie gleichzeitige Maßnahmen in der EU und in den Mitgliedstaaten festgelegt werden. Ein weiterer Punkt war die Bewertung der einzelnen Handlungsfelder selbst und die Feststellung, welche Bereiche mehr oder weniger effektiv sind oder als Begleiter benötigt werden. Die Förderung eines gesunden Umfeldes in den Schulen (Bereich 2) wird als positive Maßnahme angesehen. Mehr Bedeutung könnte jedoch der Förderung eines gesunden Umfeldes

außerhalb der Schulen zugeteilt werden. Die meisten Aktivitäten und Aktionen sind Teil der regulären Klassenaktivitäten, sodass Freizeitaktivitäten für Kinder stärker betont werden müssen. Darüber hinaus wird die Schaffung eines gesunden Umfeldes in den Gemeinden, zum Beispiel durch die Stadtplanung, als wichtig erachtet.

Initiativen der Europäischen Kommission, wie die Unterstützung und Verstärkung nationaler Maßnahmen, der Informationsaustausch und die Erleichterung von Kooperationsmaßnahmen der Mitgliedstaaten, werden sehr geschätzt. Die Bemühungen der Kommission tragen dazu bei, ein politisches Engagement für Maßnahmen gegen Adipositas im Kindesalter zu erreichen. JANPA wird als gutes Beispiel für gemeinsames Handeln angesehen.
Lebensmittelreformulierung/Lebensmittelverbesserung und -vermarktung sind Bereiche, in denen eine Zusammenarbeit und Unterstützung durch die Europäische Kommission als notwendig erachtet wird. Unternehmen sind auf dem EU-Binnenmarkt und darüber hinaus aktiv und ohne Zusammenarbeit und Unterstützung der Europäischen Kommission ist es sehr schwierig, auf nationaler Ebene tätig zu sein.

Wichtigste Schlussfolgerungen
Die Ergebnisse der Studie haben gezeigt, dass alle Länder sind in mehr als einem der Aktionsbereiche des Aktionsplans aktiv, und die meisten Länder sind in allen acht Aktionsbereichen aktiv. Viele Aktivitäten stammen aus der Zeit vor 2014, dem Jahr der Verabschiedung des Aktionsplans. Daneben bewegt eine Reihe von Ländern sich von der Planung zur Umsetzung. Insbesondere im Bereich 3 (*die gesündere Option zur einfachen Option machen*) wurden nach 2014 eine beträchtliche Anzahl von Initiativen umgesetzt. Dies bedeutet jedoch nicht unbedingt, dass diese Umsetzung ein Ergebnis des Aktionsplans war.

Bereich 2 (*ein gesundes Umfeld, besonders in Schulen und in Vorschulen, fördern*) scheint einer der Handlungsbereiche zu sein, der am besten adressiert wird, da viele Aktivitäten im zweiten Bereich zu beobachten sind und 40 % der gemeldeten "erfolgreichsten" Aktivitäten diesen Bereich betreffen. Darüber hinaus sind viele operative Ziele der von der EU geförderten Projekte auf diesen Bereich ausgerichtet. Auch der Bereich 6 scheint gut abgedeckt zu sein, mit Hinblick auf das Vorhandensein von politischen Maßnahmen, das Vorhandensein oder die Planung von nationalen Richtlinien und verfügbare Daten über Gewicht und Größe von Kindern betrifft.

Die Bereiche 3 (*die gesündere Option zur einfachen Option machen*) und 4 (*Marketing und Werbung zu Kindern einschränken*) scheinen Handlungsfelder zu sein, die zusätzliche Maßnahmen und Unterstützung erfordern, trotz der (verstärkten) Aktivität und Unterstützung durch die Europäische Kommission und andere Organisationen wie die WHO.

Aufgrund der Kürze des Zeitraums 2014-2017, der in diesem Bericht behandelt wird, ist es unwahrscheinlich, dass die seit 2014 durchgeführten politischen Maßnahmen und Aktivitäten ursächlich mit einem Rückgang oder einem Anhalten des Anstiegs der Fettleibigkeit bei Kindern zusammenhängen. Außerdem, systematisch erhobene Daten zur Ermittlung der Prävalenztrends seit der Einführung des Aktionsplans liegen noch nicht vor.

ABSTRACT / ABSTRAIT / ABSTRAKT

The Childhood Obesity Study aimed to provide the European Commission and the EU Member States an overview of the efforts during the first-half period of the EU Action Plan on Childhood Obesity 2014-2020 in every EU Member State as well as Iceland, Norway, Switzerland, Serbia, and Montenegro, and at the EU level. This report provides the basis for a further in-depth reflection process to discuss which areas of action identified under the current Action Plan will need to be strengthened and expanded to halt and reverse obesity in children and youth. All countries are active in more than one of the areas for action of the Action Plan, and a number of countries are moving from having plans to implementation. Area 2 (promote healthier environments, especially in (pre-)schools) seems to be one of the areas for action that is best addressed. Area 6 also seems to be well covered, with respect to the presence of policies, the presence or planning of national guidelines and available data on weight and height of children. The support Area 3 (make the healthier option the easy option) and Area 4 (restrict marketing and advertising to children) seem to be areas for action that need additional action and support. This despite the (increased) activity and appreciated support provided by the European Commission and other organisations, such as WHO.

L'étude sur l'obésité infantile avait pour but de fournir à la Commission européenne et aux États membres de l'UE un aperçu des efforts déployés durant la première moitié du plan d'action sur l'obésité infantile 2014-2020 dans tous les États membres de l'UE ainsi qu'en Islande, Norvège, Suisse, Serbie et Monténégro, et également au niveau de l'UE. Ce rapport fournit la base d'un processus de réflexion approfondi pour discuter les domaines d'action identifiés dans le plan d'action actuel qui devront être renforcés et élargis pour stopper et inverser l'obésité chez les enfants et les jeunes. Tous les pays sont actifs dans plus d'un des domaines d'action du Plan d'action, et un certain nombre de pays passe à l'implantation de leur plan d'action. Le domaine 2 (promouvoir des environnements plus sains, en particulier dans les écoles et établissements préscolaire) semble être l'un des domaines d'action les mieux traités. Le domaine 6 semble également bien cibler, en ce qui concerne la présence de politiques, la présence ou la planification de directives nationales et les données disponibles sur le poids et la taille des enfants. Le domaine (de soutien) 3 (faire de l'option saine une option facile) et le domaine 4 (restreindre le marketing et la publicité aux enfants) semblent être des domaines d'action qui nécessitent des mesures et un appui supplémentaires. Cela malgré l'activité croissante et le soutien apprécié de la Commission européenne et d'autres organisations, telles que l'OMS.

Das Ziel der Studie zu Adipositas im Kindesalter ist der Europäischen Kommission und den Mitgliedsstaaten der EU einen Überblick zu geben, über die Bemühungen von jedem EU-Mitgliedsstaat, Island, Norwegen, Schweiz, Serbien und Montenegro, sowie auf EU-Ebene, während der ersten Hälfte des EU-Aktionsplans zu Adipositas im Kindesalter 2014-2020. Dieser Bericht bietet die Grundlage für weitere Reflexionsprozesse, um zu erörtern, welche im Rahmen des derzeitigen Aktionsplans ermittelten Aktionsbereiche gestärkt und erweitert werden müssen, um Adipositas bei Kindern und Jugendlichen zu stoppen und den Trend umzukehren. Alle Länder sind in mehr als einem der Aktionsbereiche des Aktionsplans aktiv und eine Reihe von Ländern bewegt sich von der Planung zur Umsetzung des Planes. Der Bereich 2 (*ein gesundes Umfeld, besonders in Schulen und in Vorschulen, fördern*) scheint einer der Aktionsbereiche zu sein, der am besten adressiert wird. Auch der Bereich 6 scheint gut abgedeckt zu sein, mit Hinblick auf das Vorhandensein von politischen Maßnahmen, das Vorhandensein oder die Planung von nationalen Richtlinien und verfügbare Daten über Gewicht und Größe von Kindern betrifft. Der dritte Aktionsbereich (*die gesündere Option zur einfachen Option machen*) und der vierte (*Marketing und Werbung zu Kindern einschränken*) scheinen Handlungsfelder zu sein, die zusätzliche Maßnahmen und Unterstützung erfordern trotz der (verstärkten) Aktivität und der geschätzten Unterstützung durch die Europäische Kommission und andere Organisationen wie die WHO.

1 INTRODUCTION

The prevalence of obesity has more than tripled in many European countries since the 1980s. Since more than a decade, action has been undertaken at both national and the European level to reverse this rising trend in overweight and obesity. Nevertheless, the proportion of children who are overweight or obese remains worryingly high. The few available data show that up to 2.7% of children are morbidly obese (1-4). A recent study pooled the results on measured height and weight from many population-based studies between 1975 and 2016 (5). It showed that the trend in children's and adolescents' age-standardized mean body mass index plateaued, albeit at high levels, in North-western and South-western Europe since around 2000. In Central and Eastern European countries mean body mass index was still increasing. The high level of overweight and obesity in children and young people in Europe, and worldwide, is an area of particular concern. See Textbox 1.1 for more background information on childhood obesity.

Textbox 1.1. Background information on childhood obesity

Overweight and obesity are established risk factors for multiple health problems including cardiovascular diseases, many types of cancer, musculoskeletal disorders and type 2 diabetes in particular (6). Compared to normal weight children, those who are overweight or obese are more likely to go on to become obese adults, and are at an increased risk of suffering from associated health problems. In addition to increased future health risks, obese children experience breathing difficulties, and are at increased risk of fractures, hypertension, elevated early markers of cardiovascular disease, insulin resistance and psychological effects (7, 8).

Because of the negative consequences of obesity on the quality of life, associated diseases, etc. and since obesity is difficult to treat once established, prevention is the main priority. Behaviours such as an increased consumption of high energy density beverages and foods, a low consumption of vegetables and fruits, less physical activity and more sedentary leisure time activities are shown to contribute to overweight and obesity (9-11). However, these behaviours are made possible and are sometimes even stimulated within the socio-cultural and physical environment in which people live (12). Children's behaviour depends much on their immediate physical and social environment (13). Obesity can therefore be seen as a normal response to an obesogenic environment. This implies that prevention of overweight and obesity in children should be implemented across the multiple contexts that can influence a child's nutrition, physical activity pattern and weight (e.g. schools, home and family, community and health care settings). Several reviews suggest that the most sustainable and beneficial effect on obesity prevention involves multiple strategies that focus on meals, classroom activities, sports, and play activities, and involve home, school or kindergarten, and community participants (14, 15). Similarly, the World Health Organisation (WHO) argues for the implementation of population-based approaches to childhood obesity prevention (16). The more an environment consistently promotes healthy behaviour, the greater the likelihood that such behaviour will occur.

Towards the Action Plan on Childhood Obesity

In 2007, the European Commission adopted the 'White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity-related Health issues' in response to the challenge of supporting the Member States in this area (17). The purpose of this White Paper was to set out an integrated approach for the European Union (EU) to contribute to reducing ill health due to poor nutrition, overweight and obesity. Children and young people represent a priority group for action. Reducing health inequalities is seen as a horizontal concern. The Strategy encourages action-oriented partnerships across the EU, involving as key stakeholders the Member States and the civil society. These partnerships were implemented primarily via two main instruments, the High Level Group on Nutrition and Physical Activity and the EU platform for action on diet, physical activity and health. The High Level Group is a group of government representatives dealing with the topics of nutrition and physical activity from all 28 EU Member States plus Iceland, Norway, and Switzerland. The EU Platform is a forum for European-level organisations ranging from the food industry to consumer and health non-governmental organisations (NGOs) coordinated by the European Commission.

Following the informal meeting of EU Health Ministers in Dublin in March 2013, the Commission supported the Irish EU Presidency's proposal to mandate the High Level Group on Nutrition and Physical Activity to draw up an action plan to address overweight and obesity in children and young people. As a result, the High Level Group adopted the EU Action Plan on Childhood Obesity 2014-2020 (18). The overarching goal of this Action Plan is to contribute to halting the rise in overweight and obesity in children and young people (0-18 years) by 2020.

Table 1.1. Areas of Action and topics mentioned under these areas for action in the EU Action Plan on Childhood Obesity (18)

Area for action
1 Support a healthy start in life, including e.g.:
• counselling and support on diet and physical activity before, during and immediately after pregnancy • proper information and support on breastfeeding • guidance on complementary feeding • interdisciplinary evidence-based programmes for obese children and young people
2 Promote healthier environments, especially in schools and pre-schools, including e.g.:
• improve the uptake of healthy and high quality school meals and limit access to snacks and other supplementary less healthy food options on school premises • physical education in schools and encouragement of active breaks
3 Make the healthy option the easier option, including e.g.:
• provide appropriate information to consumers that could help them to identify nutritious, affordable and convenient food options • encourage food reformulation/food product improvement • take nutritional objectives into consideration when defining taxation, subsidies or social support policies • active commuting to and from school
4 Restrict marketing and advertising to children, including e.g.:
• restrict marketing and advertising of foods high in fat, sugar and salt to children and young people that includes not only TV but all marketing elements, including in-store environments, promotional actions, internet presence and social media activities
5 Inform and empower families, including e.g.:
• promote and encourage family-based programmes • effectively deliver nutritional information in a more useful and easy to understand way for everyone
6 Encourage physical activity, including e.g.:
• encourage activity as early on as possible in childhood • encourage physical activity as an everyday occurrence
7 Monitor and evaluate, including e.g.:
• monitor the health status and behaviours of children and young people in relation to nutrition and physical activity in order to develop and direct targeted action • evaluate the Action Plan on Childhood Obesity at the end of 2020 • revisit the Action Plan After three years, in order to see whether the operational objectives and actions are still relevant to its main objective
8 Increase research, including e.g.:
• improve systematic data collection • identify gaps in research and eliminate them through the funding of new projects and by improving alignment of national research agendas • disseminate research findings and turn them into innovative actions

To achieve this goal, active participation of a wide range of stakeholders is necessary. The Action Plan is a non-binding instrument and specifies a set of operational objectives that have been designed to guide the actions of stakeholders across eight priority areas (see Table 1.1). The actions were proposed by a number of Member States and provide a basis for countries to develop policy on tackling childhood obesity. Defining national health policies remains the exclusive competence of Member States. Therefore, these actions are voluntary and should be taken forward by each of the Member States according to their own national contexts and priorities.

The Council of the EU welcomed the agreement on the Action Plan and called the EU Member States to use the Action Plan as guidance for effective action on reducing childhood obesity and for promoting good practices. Via the Council Conclusions on Nutrition and Physical Activity of 20 June 2014 [1], the Council of the EU also asked the Commission to report back to the Council on the progress made in implementing the Action Plan midway and again in 2020.

The Childhood Obesity Study

The Childhood Obesity Study aims to provide the European Commission and thereby the EU Member States with an overview of the prevalence of childhood obesity and the efforts initiated or supported by national authorities during the first-half period of the Action Plan (2014-2020) in every EU Member State as well as Iceland, Norway, Switzerland, Serbia, and Montenegro, and at the EU level. Voluntary initiatives undertaken by other stakeholders, including the industry, actively support many of the actions identified in the Action Plan. Nevertheless, it falls outside the scope and resources of the Childhood Obesity Study to include those initiatives in the overview.

The objectives of the Childhood Obesity Study are subdivided into four tasks and formulated as follows:

Task 1: To provide an overall assessment of the state-of-play of activities in the EU addressing childhood obesity, as defined in the eight areas for action of the Action Plan.

This task offers an overall picture of the situation of childhood obesity in the EU and each of the countries included in the study as well as the estimated development of the rates of childhood obesity under the assumption of absence of additional action by extrapolating current trends. It further identifies the relevant related policy developments in each of the countries, resulting in a short description per country.

Task 2: To provide an analysis and mapping of the state of implementation and activities carried out, on-going and/or planned in each of the Member States, in the period 2014-2020.

This task provides a country specific mapping on the state of implementation of areas for action defined in the Action Plan at national level and includes activities that have been carried out, that are on-going as well as those that are planned. The progress in the implementation of the Action Plan in each of the countries included in this study and in the EU is measured against the 2014 baseline.

[1] http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/143285.pdf

Task 3: To provide an overview and analysis of the engagement of EU Member States, the European Commission and international organisations in EU wide initiatives, projects, and Joint Actions in the field of nutrition and physical activity.

This task provides an assessment of the engagement in common EU initiatives/projects for each of the countries included in this study as well as the European Commission and international organisations, such as the WHO. Several initiatives/projects have been carried out at the EU level in the last years under the EU Health Programme, such as projects and Member State Joint Actions. Also other EU funding programmes have provided funding for EU wide projects and initiatives in the field of childhood obesity, nutrition or physical activity. The analysis includes an assessment of how the common initiatives/projects map to the areas for action and their operational objectives.

Task 4: To provide an assessment of the strengths and weaknesses for the implementation of the Action Plan and recommendations for the second half-period of the Action Plan.

This task identifies strengths and weaknesses for each of the eight areas of the Action Plan. The study indicates pending weaknesses, such as if any of the areas for action have not been well addressed yet, and what can be areas of next steps/further improvement.

These four tasks directly relate to the four tasks described - as well as the whole set-up of the service - in the Tender specifications for requesting specific services (N° CHAFEA/2016/Health/01), whereas the general frame for this service is provided for in the Framework contract N° EAHC/2013/Health/01 (lot 1: Health reports).

The methods used in the study are described in Chapter 2. The results for task 1-4 are subsequently described in Chapter 3 to 6. In Chapter 7 the possible impact of the Action Plan is described, while conclusions of the Childhood Obesity Study are provided in Chapter 8.

2 METHODOLOGY

2.1 Countries included in the study

In total 33 countries are included in this study, including the 28 EU Member States, the EFTA/EEA countries of Iceland, Norway and Switzerland, and the candidate countries Montenegro and Serbia. In line with the recommendations of the interinstitutional style guide of the publication office of the European Union[2], ISO 3166-1 Alpha-2 country codes are used as abbreviations in the text and figures, except for Greece and the United Kingdom. All countries and their country codes are provided in Box 2.1.

Box 2.1. Countries included in this study and their country codes

EU15	EU13	Other countries
Austria (AT)	Bulgaria (BG)	Montenegro (ME), candidate
Belgium (BE)	Croatia (HR)	Serbia (RS), candidate
Denmark (DK)	Cyprus (CY)	Iceland (IS), EEA
Finland (FI)	Czech Republic (CZ)	Norway (NO), EEA
France (FR)	Estonia (EE)	Switzerland (CH), EFTA
Germany (DE)	Hungary (HU)	
Greece (EL)	Latvia (LV)	
Ireland (IE)	Lithuania (LT)	
Italy (IT)	Malta (MT)	
Luxembourg (LU)	Poland (PL)	
the Netherlands (NL)	Romania (RO)	
Portugal (PT)	Slovakia (SK)	
Spain (ES)	Slovenia (SI)	
Sweden (SE)		
United Kingdom (UK)		

EU15: EU Member States that were part of the EU in 1995.
EU13: EU Member States that became part of the EU in or after 2004.
EEA: European Economic Area.
EFTA: European Free Trade Association.

2.2 Data collection for Task 1 and 2

The first task was to provide an overview on the prevalence of childhood overweight and obesity in the participating countries as well as an overall assessment of the main activities. The second task was to provide a mapping of the activities carried out, on-going and/or planned in each of the Member States.

The data collection for Task 1 and 2 is based on a combination of desk research and consultations of experts through structured questionnaires and interviews with Competent Authorities of the countries included in this study, carried out by a multidisciplinary project team.

- Firstly, desk research was executed to collect information from available reports summarizing relevant information at the EU level, as well as from country sheets prepared by the WHO Regional Office for Europe and the World Obesity Federation (WOF). In addition, an excel-file containing information that has been collected by Directorate General for Health and Food Safety (DG SANTE) to obtain a baseline snapshot for the Action Plan for 2014 and an update for 2015 was provided to the research team.

[2] http://publications.europa.eu/code/en/en-000100.htm

- Secondly, collaboration was sought with the WHO Regional Office for Europe in order to use the information of the Childhood Obesity Surveillance Initiative (COSI), the 2015-2016 European Physical Activity Focal Points Network Questionnaire (HEPA-Questionnaire) and the second Global Nutrition Policy Review Survey 2016 (GNPR2). COSI data until the 3rd round (2012/2013) are not publically available yet and were provided to the research team. The GNPR2 was conducted in 2016 and the data was provided mid-2017. The factsheets on health-enhancing physical activity – based on the HEPA-Questionnaire in the 28 EU Member States of the WHO European Region are available through the internet[3].
- Thirdly, members of the High Level Group on Nutrition and Physical Activity of the Member States were contacted and invited for an interview focussing on policies related to childhood obesity. A semi-structured interview was developed in consultation with policy officers of the European Commission (see Annex 1). In this semi-structured interview, members of the High Level Group or other representatives they appointed – together named Competent Authorities in the remainder of this document - were asked to provide information on the eight areas of action in the Action Plan, based on their expertise and involvement in activities around the prevention of childhood obesity, nutrition and/or physical activity. Furthermore we asked them for experts in their countries who could provide us with information on more quantitative indicators (see below).
- Finally, subcontractors within the EPHORT-consortium (available in 25 of the 33 countries) were contacted to provide information on selected indicators themselves or provide the name of an expert to contact. These experts as well as the experts given by the Competent Authorities were sent an excel-based data-file to be filled in. Information we had available from the desk research, WHO and DG SANTE was transferred to this data-file with the request to check the data, provide more recent data if available, and add any missing data. Instructions on how to fill in the survey were presented in the data-file.

Interviews

After the kick-off meeting between Chafea/DG SANTE and the research team in November 2016, an announcement letter was prepared and sent on December 7, 2016 by the Commission to prepare the ground for a fruitful information gathering by the Childhood Obesity Study research team. The team carried out interviews with Competent Authorities in 29 of the 33 countries included in the study, predominantly between December 21, 2016 and January 31, 2017. Interview summaries were made by the research team and sent to the interviewees for corrections.

Competent Authorities of four countries (DE, ME, PT, RS) filled out the interview on paper. Germany did this extensively, so information is comparable to that obtained by the interview. Montenegro, Portugal and Serbia provided more limited information than provided in the interviews.

Indicators

WHO, the European Commission and Member States agreed on a longlist of 66 monitoring indicators for all areas of action of the Action Plan in 2014. Of those 18 were considered for immediate operational status as it was expected that they were highly available in the Member States. These indicators are among the indicators included in the Childhood Obesity Study, for measuring country actions, which are in line with goals of the Action Plan. To be able, however, to provide information on a wider range of topics addressed in the Action Plan, additional topics that are of interest to the European Commission and Member States are described in this report. These topics include amongst others: policies on breastfeeding; policies on school

[3] http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/country-work

(and kindergartens and crèches) meals; policies on public procurement of food; policies on energy drinks; policies on vending machines; policies on drinking water and physical activity in schools; initiatives on food reformulation; initiatives on food labelling; the VAT rate on fruit and vegetables; taxation policies. Indicators to cover these topics and to cover Area 5 of the Action Plan ('inform and empower families'), which was not covered by the 18 indicators considered for immediate operational status were inspired by/based on the aforementioned longlist. They were chosen in consultation with and checked by policy officers of the European Commission. A complete list of indicators and the sources of information for these indicators is provided in Annex 2.

2.3 Data handling and reporting: Task 1

This task provides a general assessment of the prevalence of childhood obesity and policy developments in the EU addressing childhood obesity. An overall picture of the situation of childhood obesity in the EU is provided by:

- Describing the available prevalence data among children below the age of 5 years. As little comparable data was available, information has not been summarized in tables or figures.
- Summarizing the prevalence data of COSI round 2 (2009/2010) and round 3 (2012/2013) and measured data obtained from literature in figures according to sex and age.
- Summarizing the prevalence data of HBSC of 2009/2010 and 2013/2014, as well as the difference between these rounds in figures according to sex and age.
- Providing information on the future development of childhood obesity based on linear projections on the prevalence of overweight and obesity in 2025 made by the WOF (19).

Relevant policy developments related to childhood obesity in each of the countries were obtained from the interviews. For each country a summary is provided based on the following interview questions:

- Does your country have a National Action Plan on Childhood Obesity? If not, are there any plans for overweight prevention in general, physical activity promotion, nutrition and/or non-communicable diseases?
- What are the priority topics of the national authorities with respect to childhood obesity in your country?
- Why are these the priority topics in your country?
- Are there any policies in preparation or planned for the (near) future that are relevant for the prevention of childhood obesity?
- How did the Action Plan facilitate development or implementation of any of the policies?
- How are health inequalities addressed in the policies that are relevant to childhood obesity?
- Are there any specific national coordinating mechanism (e.g. working group, task force, advisory body, coordinating institution, and so on) in the area of childhood obesity, nutrition or physical activity promotion in your country?

In addition, per country and at the EU-level a colour-scheme is given illustrating the presence of policies and actions according to seven of the eight areas of the Action Plan (Area 8 is covered in Task 3) for a selection of indicators. The indicators are those covered in the interview and the qualitative indicators of the 18 that were identified in 2015. The interview for Cyprus was not complete. Data was complemented with the information provided by the expert from Cyprus who was consulted. Based on the information obtained from the data sources described above (desk research, WHO Regional office for Europe, interview, experts and information collected by DG SANTE in 2014 and 2015, when other information was lacking), colour codes were given for various indicators that represent the state of implementation for that indicator. When

the data sources were discordant, information from desk research and the interview was leading, as these are most verifiable. Colour coding was as follows:

Light green: (partial, when striped) fulfilment of an action, dating back from before the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated.

Dark green: (partial, when striped) fulfilment of an action, since the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated. This does also not necessarily mean that the action is undertaken as a result of the Action Plan.

Orange: actions in preparation. They may still be contingent on the outcomes of policy processes.

Red: no action is initiated or supported by national authorities. This does not mean, however, that no action is undertaken, e.g. by local authorities, non-governmental organisations (NGOs) or commercial parties.

2.4 Data handling and reporting: Task 2

This task provides a country specific mapping on the state of implementation of the seven key areas for action (see task 1) defined in the Action Plan at national level and includes activities that have been carried out, that are on-going as well as those that are planned. Progress of the Action Plan is evaluated by means of process indicators and outcome indicators. Process indicators refer to the adoption of policies and activities. They give a good overview of the efforts of the relevant states to prevent a further increase in childhood obesity prevalence. Outcome indicators give more insight into possible changes achieved, such as (changes in) the percentage of children with obesity or the percentage of children that are breastfed. The state of implementation of the Action Plan is evaluated through both types of indicators.

Data for task 2 were collected as described in Chapter 2.2. For the indicators included in this study, we provided:

- insight into the percentage of countries that have an activity ongoing, planned or not, for all 33 countries included in the Childhood Obesity Study, plus for the following three subgroups: the 28 EU Member States, the EU15 Member States, and the EU13 Member States.
- graphical representations (maps) of the adoption of policies and actions in all 33 countries included in the study
- a more detailed description of the type of policies and actions undertaken, when appropriate
- baseline information on the qualitative indicators (mainly available through desk research). It became apparent that more recent information on quantitative indicators is very limited. This renders it difficult to systematically include the information, so these scattered data were not included in the report.

Additionally, all policies and other actions mentioned in the interviews, except for those in Area 4, were ranked by their degree of intrusiveness, using the intervention ladder developed by the Nuffield Council of Bioethics (20). On this ladder the least intrusive and most non-committal measures are placed at the bottom, and the most intrusive measures are placed at the top. The ladder goes from doing nothing and monitoring to eliminating certain choices. The intervention ladder illustrates how strongly policy intervenes, but also which possibilities there are to intervene strongly or less strongly. The assumption in this respect is that the most intrusive measures are often, but not always, the most effective measures (21).

2.5 Data collection, handling and reporting: Task 3

This task provides an overview of the engagement of the European Commission, the Member States, and international organisations in common EU initiatives and projects, in the field of childhood obesity, nutrition and physical activity. Next to this, the outcomes of the projects were mapped against the operational objectives of the Action Plan as listed under paragraph 3 of the Action Plan (see Annex 3).

Data collection Task 3
A non-exhaustive list of documents and relevant project-databases was provided by the European Commission. This list was extended by desk research. Websites of the European Commission, a.o. of the Joint Research Centre (JRC), were searched to look for relevant activities, projects and documents to demonstrate their engagement.

To get insight into the engagement of international organisations, their websites were consulted. The following international organisations have been included:

- World Health Organisation (WHO, http://www.who.int/en/)
- WHO - Regional Office for Europe (http://www.euro.who.int/en/)
- European Association for the Study of Obesity (EASO, http://easo.org/)
- World Obesity Federation (WOF, https://www.worldobesity.org/)
- The Organisation for Economic Co-operation and Development (OECD, (http://www.oecd.org/)

Common initiatives and projects funded by the EU were identified by searching several relevant EU programmes and databases in March 2017. They are listed in Box 2.2.
In all databases a search has been performed based on the following search criteria:
(Obesity AND (childhood OR children OR young OR youth OR adolescents))
OR
(Obese AND (childhood OR children OR young OR youth OR adolescents))
OR
(Overweight AND (childhood OR children OR young OR youth OR adolescents))
OR
(Nutrition AND (childhood OR children OR young OR youth OR adolescents))
OR
(Physical activity AND (childhood OR children OR young OR youth OR adolescents))

It was not possible to combine many search terms in the databases consulted, so this long search string could not be used as such. Therefore, the search has been performed using separate combinations of terms (e.g. 1: obesity AND childhood, 2: obesity AND children, etc.). For the Health Programme project database, it was not possible to combine search terms, so separate searches are performed on the terms 'obesity', 'obese', 'overweight, 'nutrition' and 'physical activity' only (and not combined with the children related terms). All records found for each search were downloaded in an excel-file and duplicate records were removed.

We excluded projects that ended before 2014, as their initiation cannot be related to the endorsement of the Action Plan. Because in the Health Programme database only the starting date of projects is provided we excluded projects funded by this programme that started before 2010, assuming that projects would have ended before 2014.

Titles and summaries of projects were screened to judge their relevance with respect to the topic of the prevention of childhood obesity. The first screening has been performed by one researcher (J. Driesenaar). When not sure, the project was discussed with another researcher (J. Boer), who also performed a second screening of all projects. Projects were included if their aims corresponded to the operational objectives of the Action Plan (Annex 3). Furthermore, we only included FP7 and H2020 projects that had a clear implementation component, such as creating toolboxes, platforms for knowledge exchange etc. Projects that primarily aimed at increasing our

understanding, for example on the aetiology of childhood obesity or determinants for childhood obesity, were excluded. Applications for the EU School Fruit, Fruit and Vegetables Scheme and the EU School Milk Scheme were also excluded, as this topic is described in Chapter 4.2. Two projects (IMPALA.net and PASTA, funded by the Erasmus+ Programme and FP7, respectively) were mentioned by Chafea and added to our search. They both concern urban planning to increase physical activity and were not selected based on our search criteria (do not mention obesity). It cannot be excluded that more projects on this topic are funded by the European Commission, e.g. through other programmes.

The following information was extracted per project (if available): title, start and end date, participating countries and country coordinating, amount of funding received, summary.

Box 2.2. EU programmes and databases searched to find relevant EU-funded projects

Pilot projects funded by the European Parliament (https://.ec.europa.eu/health/nutrition_physical_activity/projects/ep_funded_projects_en#fragment4)

Health programmes database that contains the projects funded by the 1st, 2nd and 3rd EU Health Programme (https://webgate.ec.europa.eu/chafea_pdb/health/projects/)

The Projects & Results Service of the Community Research and Development Information Service (CORDIS) for projects funded by the 7th Framework Programme (FP7) and Horizon 2020 under the following relevant subprograms (http://cordis.europa.eu/projects/home_en.html)

- FP7: Health
- FP7: Food, Agriculture and Fisheries, Biotechnology
- FP7: European Research Council
- FP7: Research for the benefit of small and medium-sized enterprises (SMEs)
- FP7: Information and Communication Technologies
- H2020: Excellent Science - European Research Council
- H2020: Industrial Leadership - Leadership in enabling and industrial technologies - Information and Communication Technologies
- H2020: Mainstreaming SME support, especially through a dedicated instrument
- H2020: Societal Challenges - Health, demographic change and well-being
- H2020: Understanding health, wellbeing and disease
- H2020: Methods and data
- H2020: Societal Challenges - Europe In A Changing World - Inclusive, Innovative And Reflective Societies
- H2020: Teaming of excellent research institutions and low performing RDI regions

The Erasmus+ Project Results Platform that contains projects funded by the Erasmus+ programme (http://ec.europa.eu/programmes/erasmus-plus/projects/).
Only the following relevant sub-programmes were included:

- Key Action 2: Innovation and good practices
- Key Action 3: Support for Policy Reform
- Jean Monnet Activities
- Sport

The EU Sport Programme (https://ec.europa.eu/sport/)

Joint Programming Initiative (http://ec.europa.eu/research/era/joint-programming-initiatives_en.html)

The project database for the Creative Europe Programme (http://ec.europa.eu/programmes/creative-europe/projects/)

The general project database "EU for results" (http://ec.europa.eu/budget/euprojects/search-projects_en)

Data handling Task 3
Our search resulted in a total number of 160 projects that were further mapped against the areas of action and operational objectives of the Action Plan 2014-2020. A project can relate to more than one area for action or operational objective. We expect that the impact of projects with partners from only a few countries at the European level will be limited. Therefore, projects funded by the Erasmus+ Programme (n=137) were mapped against the areas of action when partners were based in four or more countries and mapped against the operational objectives when partners were based in at least six countries.

Reporting Task 3
For each programme, except the Erasmus+ programme, the relevant projects are briefly described and the operational objectives that the projects and programme contribute to are presented. Furthermore, it is indicated in what way the project contributes to the operational objectives of the Action Plan. The following categories are used:

1. Knowledge acquisition: projects aimed at gathering knowledge
2. Development of tools: projects aimed at development of guidelines, databases etc.
3. Exchange of knowledge: projects aimed at exchanging existing knowledge and best practices
4. Change: projects that intervene on the current situation
5. Promotion of/support for developing best practices

In addition, for each area for action the number of EU-funded projects that are related to it is determined. This will indicate action areas with more research activity and those with less research activity.

To provide insight in the efforts of the Commission in the different areas for action, the total budget of the EU funded projects as well as the budget according to each area for action of the Action Plan is presented.

Furthermore, for each country included in this study we determine in how many projects it participates and whether it has a coordinating role or not. This provides an indication of the research capacity per country and of their engagement, assuming that countries participating in more projects are more engaged than countries that participate in fewer projects. It should be noted however, that the five countries that are not EU Member States probably have fewer possibilities to join initiatives with EU funding.

2.6 Data collection, handling and reporting: Task 4

To be able to give recommendations to the Commission about the further implementation of the Action Plan for the second half-period (2018-2020), insight was needed into factors that facilitate or hamper successful development (and implementation) of policies and other initiatives. Information for this was gathered with a short questionnaire (see Annex 4). In the beginning of July 2017, this questionnaire was send by DG SANTE to all members of the High Level Group on Nutrition and Physical Activity, with the request to fill it out themselves or forward it to the person that was interviewed for Task 1 and 2. In addition, the questionnaire was sent out to the Competent Authorities we consulted for Serbia and Montenegro as well as to consulted experts of eight countries in order to provide additional information on their country (AT, CY, HU, IE, MT, PT, RO, UK). Reminders were sent on three occasions; two of these were sent by the research team and one by DG SANTE.

The questionnaire asked the respondents what they considered to be the ‘most successful’ and ‘least successful’ activities in their country. The latter will be referred to as activities “most difficult to work on” in the remainder of this document. It should be noted however, that no definition of ‘successful’ was provided. Therefore it

probably has been referred to by authorities in various ways. For instance, the measure of successful can be used to describe the degree of completeness of implementation of a policy or intervention. It can, but does not necessarily, also refer to success in terms of preventing childhood obesity. The questionnaire also asked about the reasons for being successful or not and about activities the respondents tried to develop (or would have liked to develop), but without success. Furthermore the questionnaire contained questions on the Action Plan and the efforts of the European Commission. For each question, the respondents were able to state whether or not the answers had to be reported anonymously.

After the deadline (mid-September 2017), the answers from all received questionnaires were collated. Based on this an overview of the results is given in chapter 6.

2.7 Stakeholder feedback

Preliminary results of the Childhood Obesity Study were presented to the participants of the 'Expert Technical Meeting on Childhood Obesity: halting the rise' that was organised by the Maltese EU Presidency in February 2017. A very first draft version of this report has also been distributed to the participants. This meeting contributed to an improvement of this report.

Furthermore, preliminary results on several areas for action of the Action Plan have been presented at meetings of the High Level Group on Nutrition and Physical Activity. Comments received on these occasions were incorporated in the report.

Finally, a large range of stakeholders were offered the possibility to comment on the draft version of this report. They were given the possibility to correct or update presented information, provide information that was in their opinion lacking and comment on the preliminary conclusions and recommendations. Comments were received from 34 stakeholders and used to improve the report. All stakeholders were provided with individual feedback explaining how their comments were addressed.

The research team analysed and presented the information provided and collected from different sources to the best of their knowledge. However, some of the sources contained conflicting information for a few of the quantitative indicators, such as the VAT rates for vegetables. We tried to validate these data with additional sources as much as possible. Furthermore, not all country representatives responded to the stakeholder feedback. Therefore, we cannot exclude the possibility that there are some mistakes in reported figures or status of policies or initiatives undertaken.

3 GENERAL ASSESSMENT OF THE PREVALENCE OF OBESITY AND POLICY DEVELOPMENTS ADDRESSING CHILDHOOD OBESITY IN THE EU

This chapter provides a general assessment of the state of play of activities in the EU addressing childhood obesity. An overall picture of the situation of childhood obesity in the EU is provided in Chapter 3.1. Chapter 3.2 provides a summary overview of the presence of policies and actions according to Area 1-7 of the Action Plan. Profiles for each country, describing relevant policy developments related to childhood obesity, key data on the prevalence of childhood obesity facts and an overview of the presence of policies and actions is provided in Annex 5.

3.1 Prevalence of childhood overweight and obesity in the EU

3.1.1 Prevalence of overweight and obesity among children <6 years of age

Data on the prevalence of overweight and obesity in children under 6 years of age are scarce in the EU. In addition, different surveys use different criteria to define overweight and obesity, and studies differ in the age-ranges of children studied and the year of data collection. As a result, the available data are difficult to compare. Therefore a clear picture on the prevalence of overweight and obesity among young children cannot be provided.

For 18 countries some data were collected by DG SANTE in 2014 and 2015 (BE, BG, CY, CZ, FR, EL, IE, IT, LT, PT, ES, UK), from personal communication (DE, FI), or published articles and reports (AT (22), HU[4], NL (23), PT (24)). In general, the prevalence of overweight (including obesity) ranged from around 3-5% to 20-30%. In most countries the prevalence of overweight was higher in girls than in boys (see Table 3.1).

[4] http://mdosz.hu/hun/wp-content/uploads/2017/01/UD_2016_5_final.pdf

Table 3.1. Prevalence of overweight (including obesity) among children <6 years.

Country	Year	Definition	Age (years)	Prevalence (%)	
BE-FLA		WHO	3	4.2	
			4	7.3	
			5	8.5	
BE-WAL			2-5	7.0	
BG		WHO	2	6.4	
			3	3.4	
			4	12.9	
			5	33.3	
CY		WHO	3	10.8	
CZ		WHO	2	5.5	
DK					
FI	2014-2015	WHO	2	Boys: 4.7	Girls: 5.7
			3	Boys: 4.5	Girls: 5.2
			4	Boys: 4.9	Girls: 4.2
			5	Boys: 24.1	Girls: 21.0
FR		WHO	3	11.4	
EL		WHO	4	Boys: 16.2	Girls: 21.2
			5	Boys: 21.7	Girls: 24.1
IE		WHO	4	27.5	
IT		WHO	4	10.2	
LT		WHO	3	5.1	
PL		WHO	2	14.3	
UK-ENG		WHO	3	21.9	
UK-WLS		WHO	3	26.5	
UK-SCT	2013	>85th centile	2-6	Boys: 27.3	Girls: 25.8
AT	2009-2011	IOTF	4-6	Boys: 11.5	Girls: 15.1
DE	2014-2017	IOTF	3	Boys: 4.3	Girls: 9.5
			4	Boys: 4.8	Girls: 19.9
			5	Boys: 12.0	Girls: 18.1
NL	2009	IOTF	2	Boys: 8.0	Girls: 8.3
			3	Boys: 7.8	Girls: 12.8
			4	Boys: 9.1	Girls: 16.3
			5	Boys: 12.8	Girls: 18.1
PT	2009/2010	IOTF	3	Boys: 16.8	Girls: 17.8
			4	Boys: 17.8	Girls: 26.2
			5	Boys: 22.1	Girls: 30.3
ES	2011-2012	IOTF	2-4	Boys: 31.1	Girls: 28.9

3.1.2 *Prevalence of overweight and obesity among children aged 6-9 years old*

For primary school children (6-9 years) more, and more comparable data are available, mainly from the Childhood Obesity Surveillance Initiative (COSI) initiated by WHO Regional Office for Europe (25). Data from the surveys in 2009/2010 and 2012/2013 were used, except for Bulgaria (2007/2008 and 2012/2013). For countries that did not take part in these COSI surveys, nationally representative data are included, where available (AT (22), CY (26), FI[5], NL (23). While WHO criteria (27) were used for countries participating in COSI, these other countries used the cut-off points of the International Obesity Task Force (IOTF) (28, 29). The latter mostly result in lower prevalence figures (30).

In 2009/2010, the prevalence of overweight (including obesity) was among the lowest in Austria, Finland and the Netherlands, which may be due to the use of IOTF criteria instead of WHO criteria. Among counties participating in COSI the prevalence ranged from around 18% in 6-year-olds from Belgium to 50-57% in 9-year-olds from Greece (see Figure 3.1). The highest prevalences (40% or higher) were found in Greece, Spain[6] and Italy. In several countries the prevalence exceeded 30% in some age groups (SI, MT, CY, IE). In most of the other countries the prevalence of overweight was between 20% and 30%. In boys, the prevalence of obesity ranged from 5-6% in 6-year olds from Belgium to 30.5% in 9 year old boys from Greece. In a pooled analysis of cross-sectional studies between 2006 and 2015 in Romania (32), the prevalence of overweight (including obesity) ranged from 25% in 6-year old to 36% in 9-year old children (not in the figure). With some exceptions the prevalence of overweight was higher in boys than in girls.

In Denmark the prevalence of childhood obesity (including obesity) according to IOTF criteria among 7-year olds was 9.8 in boys and 13.5 in girls in 2013[7]. COSI data for 2012/2013 are presented in Figure 3.2. The prevalence of overweight (including obesity) was more than 2% lower in the 2012/2013 survey than in the 2009/2010 survey for some groups of 7-year old girls (IE, LT) and boys (SI), 8-year old boys (NO, SI) and 9-year old girls (SI). In 7-year old boys from Lithuania and 9-year old Belgian girls, the prevalence of overweight (including obesity) increased more than 2%. A difference of -0.5% to +0.5% between the two surveys, indicating no change, was observed in several age and sex subgroups: 6-year old boys (BE) and girls (BE, SI), 7-year old boys (BE, LV) and girls (PT), 8-year old boys (BE, IT, ES) and girls (BE), 9-year old boys (IE, IT, IS) and girls (IT). It should be noted, however, that no formal statistical testing has been done, so we cannot exclude the possibility that any of the differences are rather due to chance. Data on the fourth COSI round (2015/2016) will provide more insight into any further trends after the implementation of the Action Plan. At the time of writing this report, these data had been submitted to WHO Regional Office for Europe but were not yet available for research.

[5] http://www.terveytemme.fi/lastenterveys/raportti/atlas.html?select=1001&data=l_ylipaino_cole_ika
[6] In Spain, the ALADINO study contributes to COSI. In the publication on COSI (25), the prevalence of overweight (including obesity) among 8-year old boys is 45.3%. In the publication on the ALADINO study (31) the prevalence is 48%. We used the latter figure.
[7] http://esundhed.dk/sundhedsregistre/BDB/Sider/BDB01.aspx

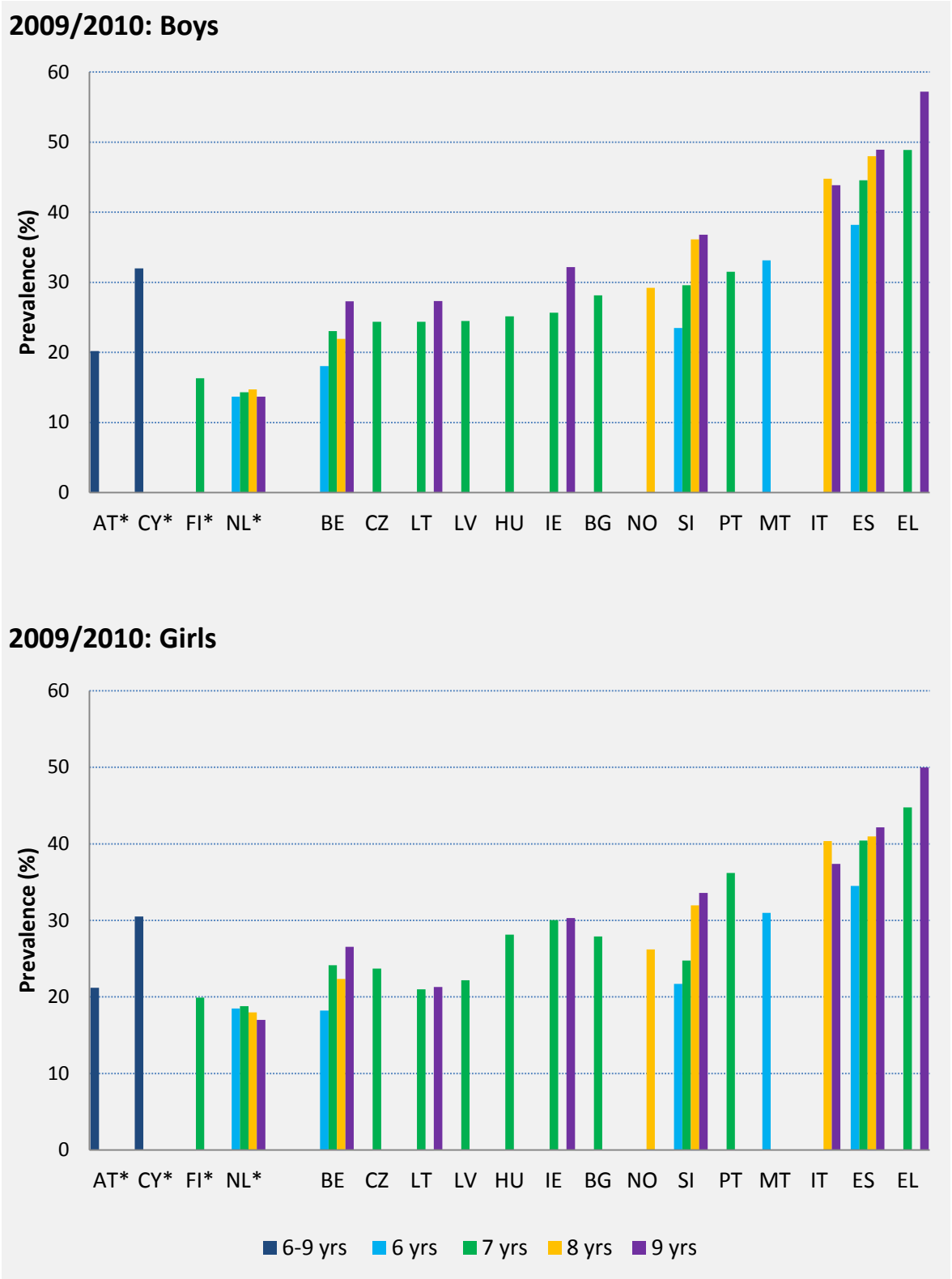


Figure 3.1. *Prevalence of overweight (including obesity) according to WHO child growth curve standards among 6-9 year old children in 2009/2010. * IOTF criteria used and year is around 2009/2010.*

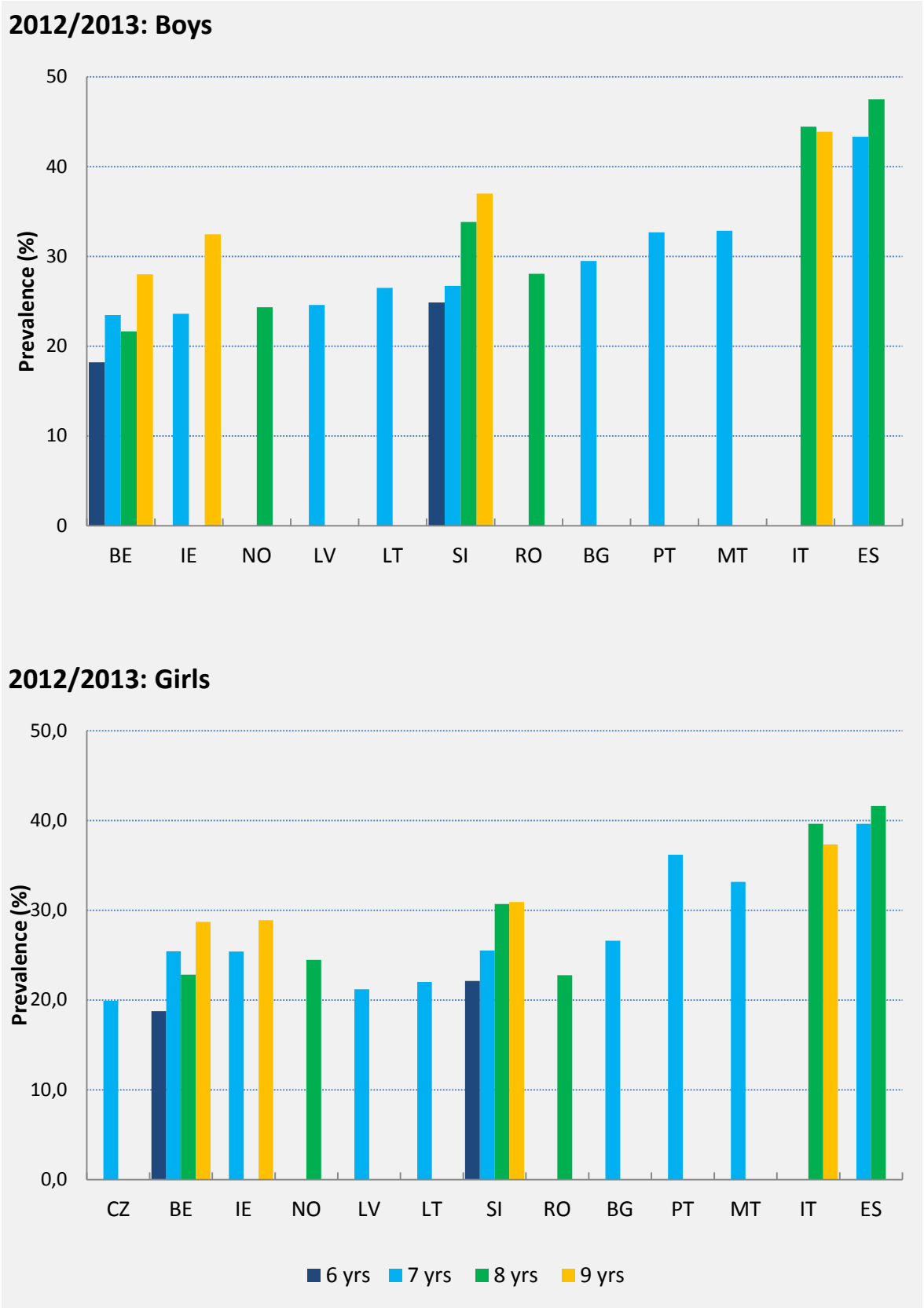


Figure 3.2. *Prevalence of overweight (including obesity) according to WHO child growth curve standards among 6-9 year old children in 2012/2013.*

3.1.3 Prevalence of overweight and obesity among adolescents

Intercountry comparable prevalence data on overweight including obesity in 11-, 13-, and 15-year-old adolescents are derived from the 2009/2010 and 2013/2014 Health Behaviour in School-aged Children (HBSC) surveys (33, 34). In contrast to the data of COSI, the data for HBSC are based on self-reported height and weight. Self-reported body weight is often underreported. A longitudinal study among US students in grades 8-12 found that the level of underreporting increased with age in girls (35). It should further be noted that in some countries data was missing for > 30% of the sample (for BE-WAL (Wallonia), IE, LT, UK in both surveys and for MT and RO in 2013/2014). Therefore, prevalences of overweight and obesity are likely underestimated and firm conclusions about trends cannot be drawn from these data.

According to the WHO child growth curve standards (27), in the 2013/2014 survey, the prevalence of overweight including obesity ranged from 13-39% in 11-year old boys and from 9-33% in 11-year old girls (see Figure 3.3). The prevalence of overweight including obesity for 13-year old and 15-year old boys ranged from 11% to 36% and from 13% to 34%, respectively (see Figures 3.4 and 3.5). For girls these percentages were 8-33% and 7-26%. Just as in the younger age group (6-9 years) described above, in almost most all countries the prevalence was higher in boys than in girls at all ages. In general, the prevalence is highest among the 11-year old and lowest among the 15-year olds. These may be real differences, but may in part also be explained by an increase in underreporting with age.

In the HBSC surveys socioeconomic position at the individual level was measured by the family affluence scale, a summary index of four items: does your family own a car, van or truck? (0-2 points); do you have your own bedroom? (0-1 points); during the past 12 months, how many times did you travel away on holiday with your family? (0-2 points) and how many computers does your family own? (0-2 points). In the 2009/2010 survey in general boys and girls with a low family affluence had a higher prevalence of overweight including obesity, but differences where not always statistically significant. Only in Slovakia, the prevalence was significantly lower in boys with a low family affluence. Similar trends (but not statistically significant) were seen in Poland, Ireland and Romania (33). In the 2013/2014 survey the association between low family affluence and the prevalence of overweight including obesity was more pronounced, with more countries showing statistically significant higher prevalence among children with a low family affluence (34).

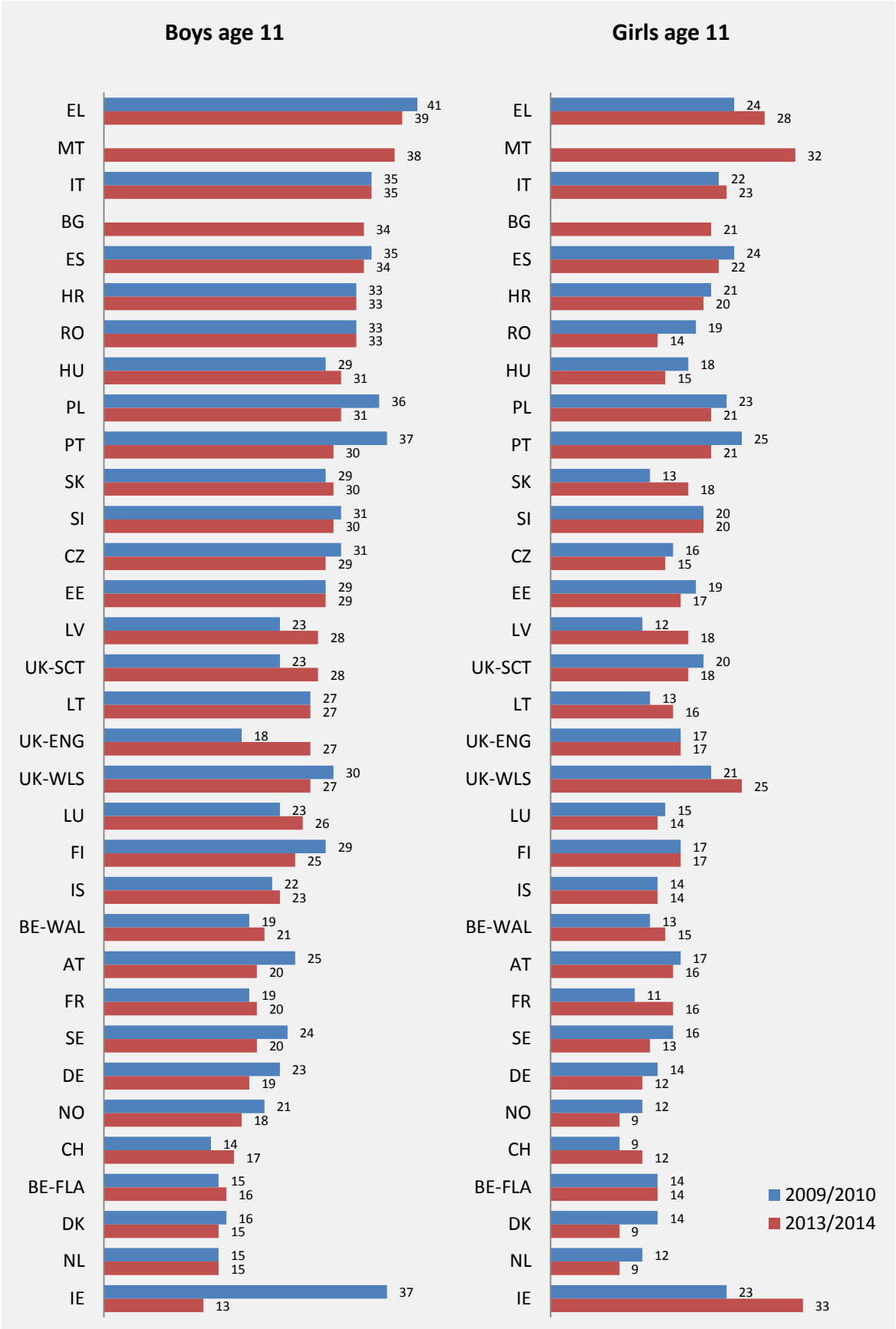


***Figure 3.3**. Prevalence of overweight including obesity in 11-year old boys and girls, according to WHO child growth curve standards in the HBSC survey.*

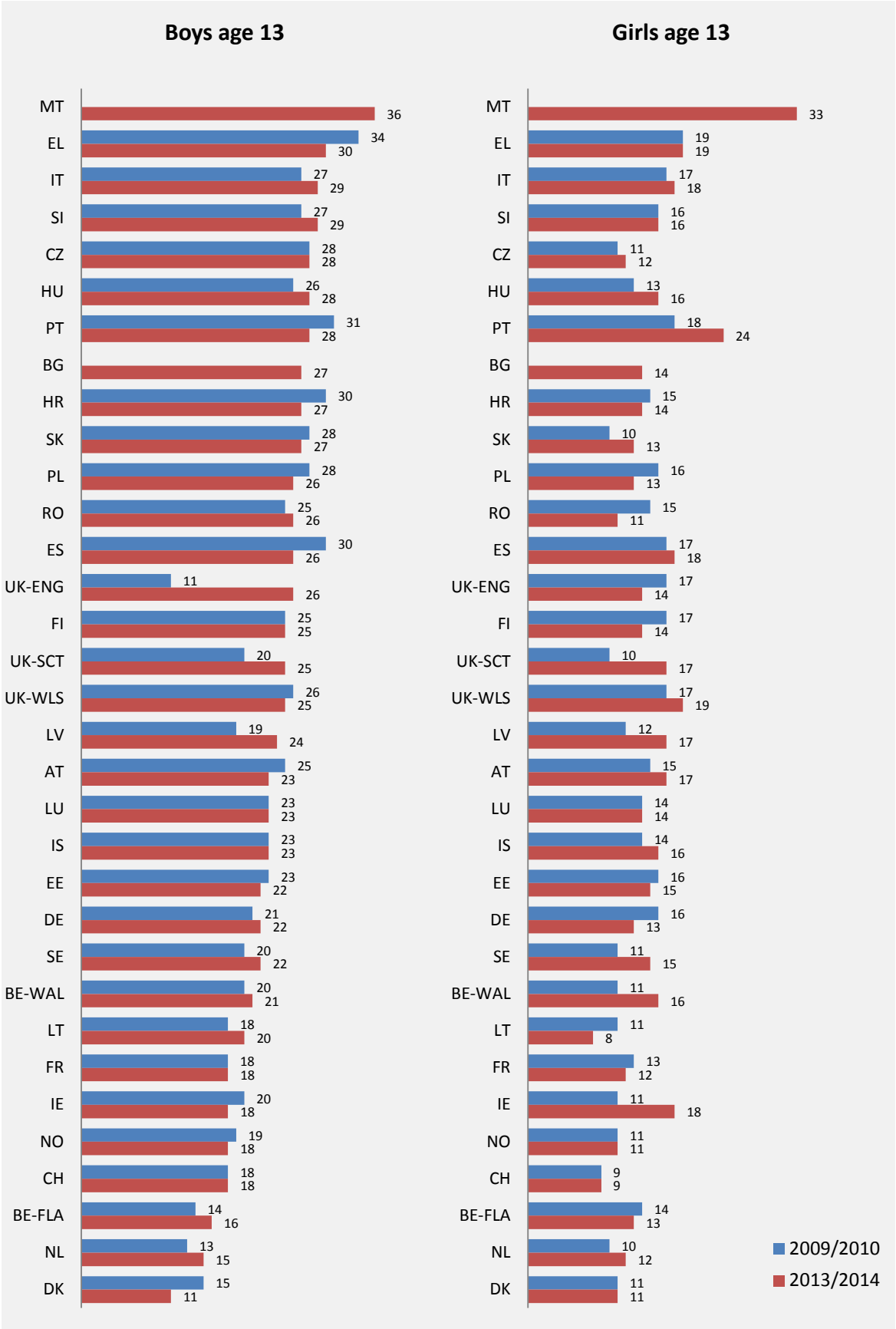


***Figure 3.4**. Prevalence of overweight including obesity in 13-year old boys and girls, according to WHO child growth curve standards in the HBSC survey.*

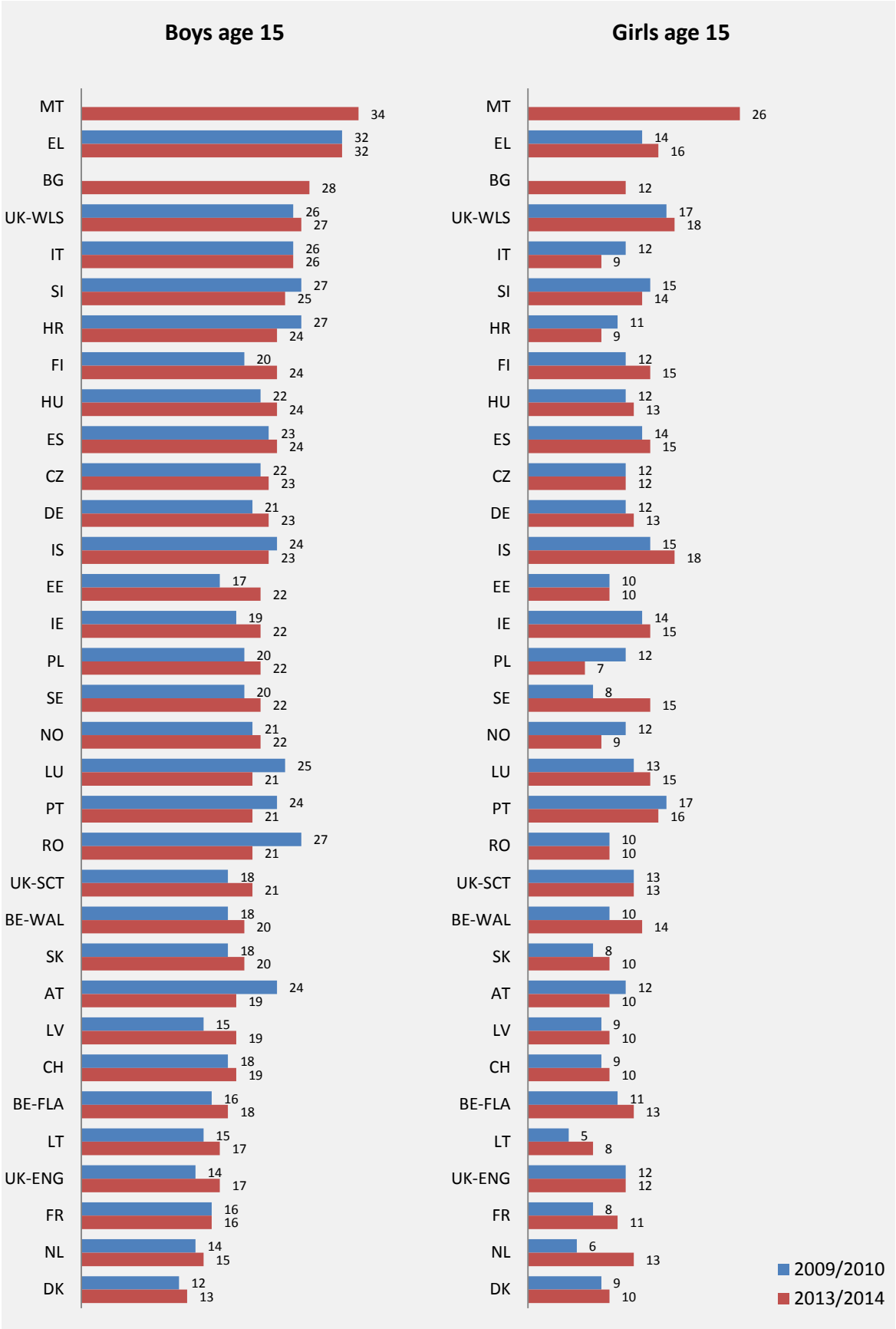


***Figure 3.5**. Prevalence of overweight including obesity in 15-year old boys and girls, according to WHO child growth curve standards in the HBSC survey.*

For 11 of the 31 countries that participated in both surveys the prevalence of self-reported overweight including obesity among boys was lower in the second survey than in the first (Figure 3.4). Irish 11-year old boys even reported a 24%-point lower prevalence of overweight including obesity (37% versus 14%), while Irish girls reported the largest increase. This may be in part due to the fact that self-reported data are used in HBSC, resulting in possible misreporting. Moreover, for Ireland data on body weight and height were missing for more than 30% of the sample. In 12 countries the prevalence of overweight including obesity among 11-year old girls was lower in the second survey than in the first survey. The largest decrease was 5%-points in Denmark and Romania. In the remaining countries the prevalence remained stable or was higher in the 2013/2014 survey.

Only for a few countries, for both boys and girls aged 13 and 15 years, the prevalence of overweight including obesity was lower in the 2013/2014 survey than in the 2009/2010 survey (Figures 3.7 and 3.8). In about half of the countries the prevalence was higher both for 15-year old boys and girls.

In 2017, WHO Regional Office for Europe published a report on the trends in overweight and obesity from the HBSC 2001/2002 to the 2013/2014 survey (36) with the following conclusions:

- While levels of obesity have stabilized in some countries and regions, prevalence has increased in over half of those involved in HBSC surveys since 2002. These increases are nevertheless inconsistent across age and gender groups.
- The most marked increases have been observed in eastern European countries, where levels of obesity were relatively low in 2002.
- Only 13-year-old boys in Norway and 11-year-old girls in Spain experienced a significant decrease in obesity prevalence.
- Inequalities in obesity have persisted in most countries and regions over time.

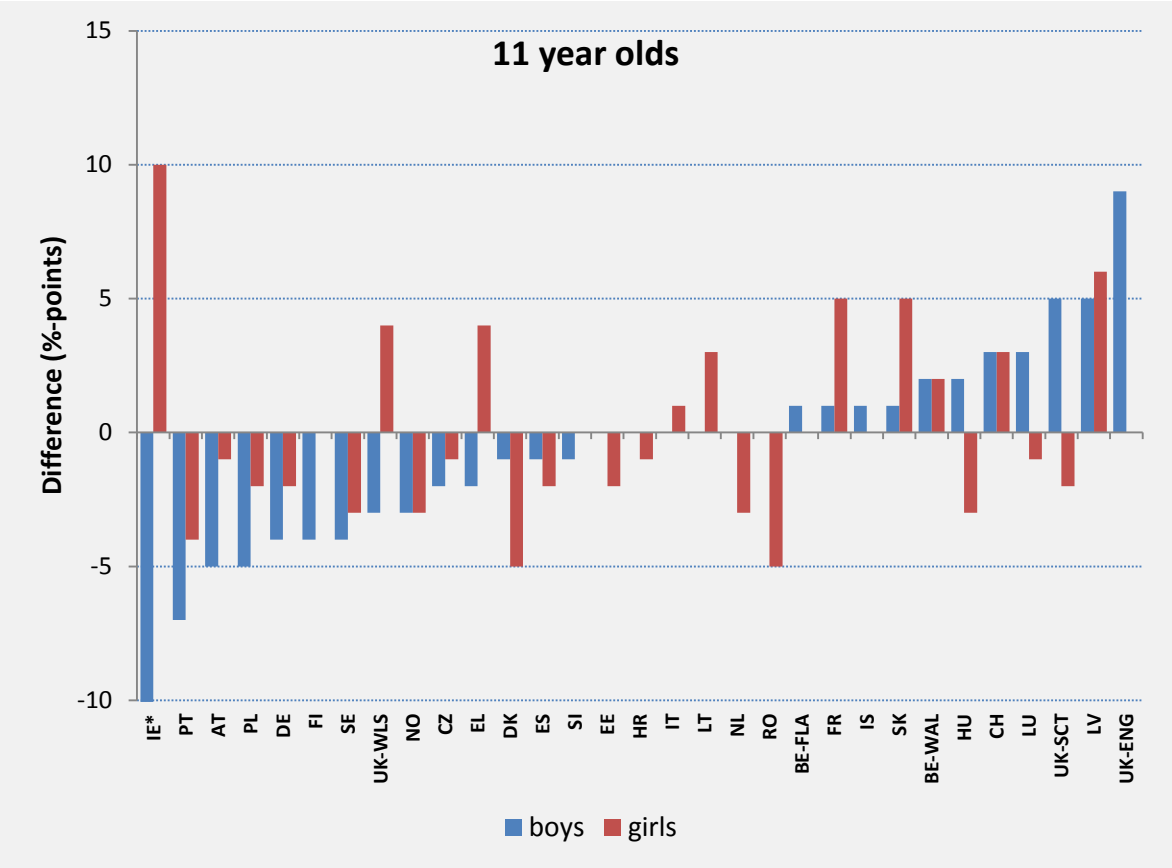


Figure 3.4. *Difference in the prevalence of overweight including obesity between the 2013/2014 and 2009/2010 HBSC surveys among 11-year old boys and girls.*

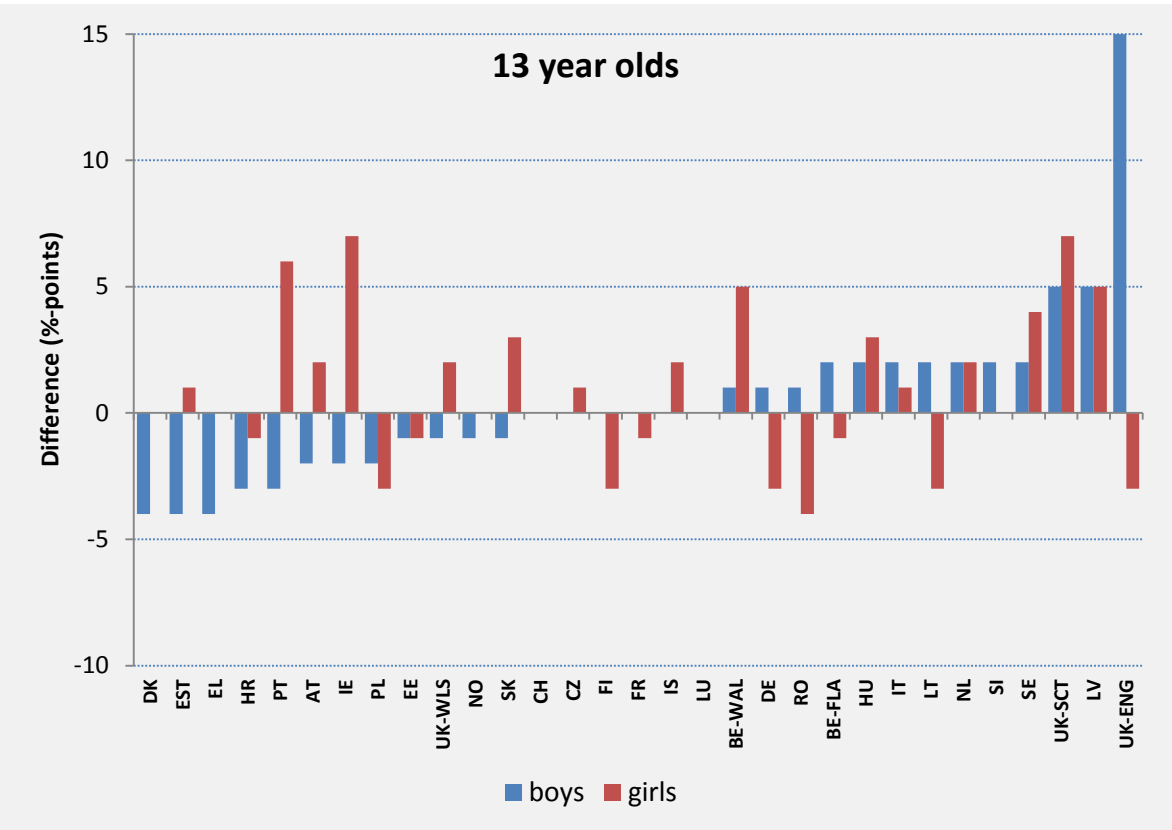


Figure 3.7. *Difference in the prevalence of overweight including obesity between the 2013/2014 and 2009/2010 HBSC surveys among 13-year old boys and girls.*

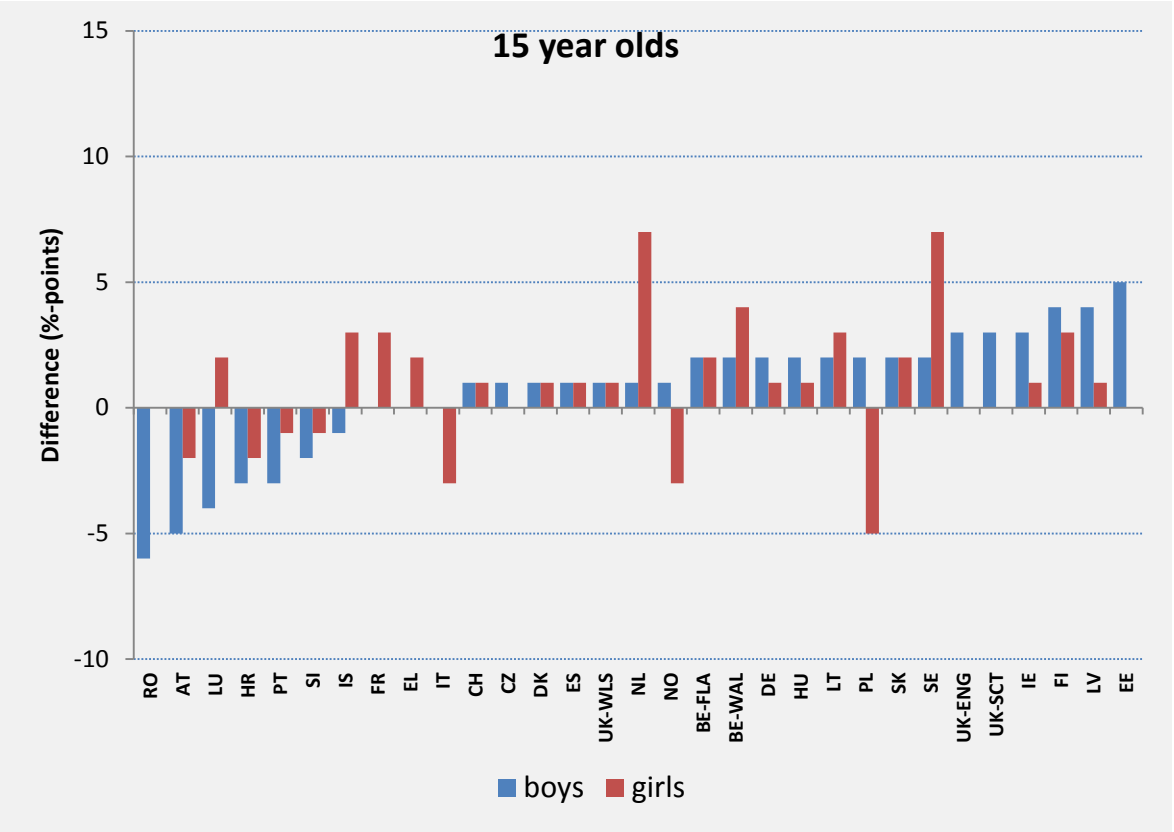


Figure 3.8. *Difference in the prevalence of overweight including obesity between the 2013/2014 and 2009/2010 HBSC surveys among 15-year old boys and girls.*

3.1.4 Projections on overweight and obesity prevalence for 2025

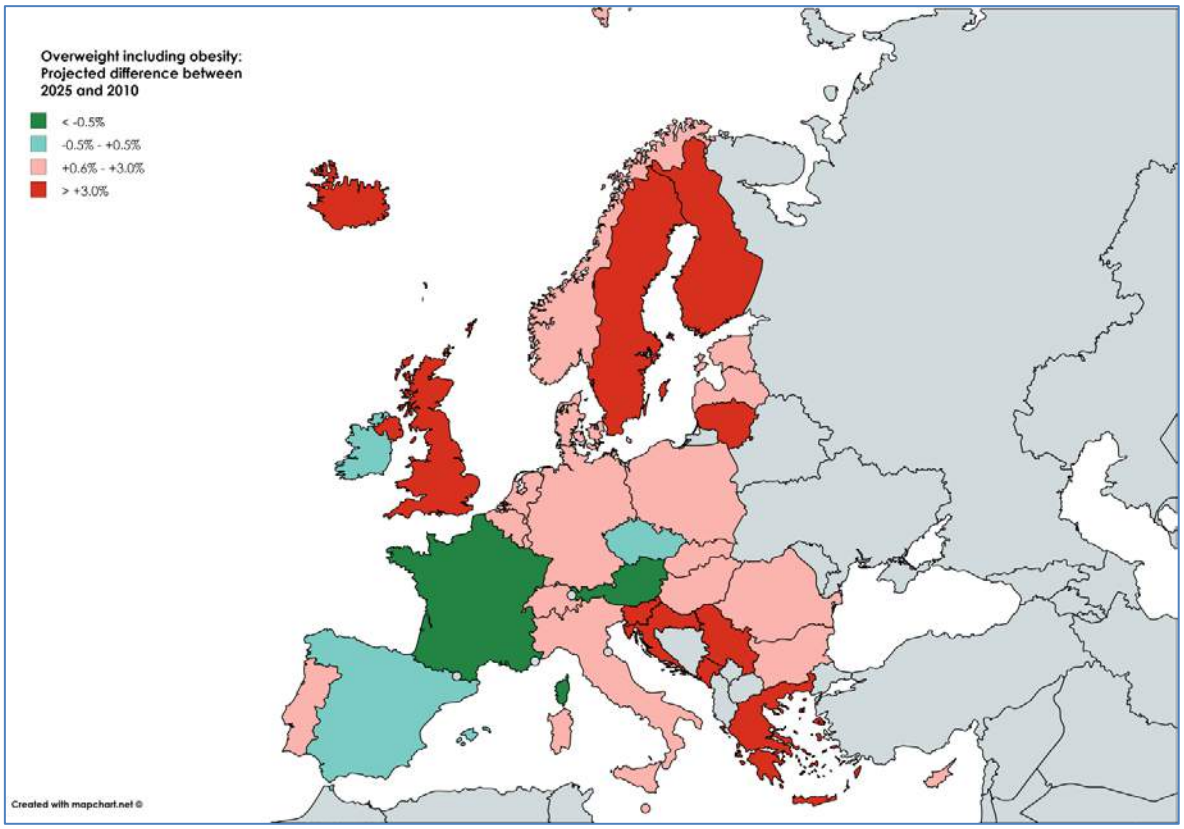
The WOF has made projections on the prevalence of overweight and obesity among school-aged children and adolescents (2-19.9 years) in 2025 (19). This was done for 184 countries, including European countries, in order to assess the scale of the problem of overweight and obesity in the light of one of the targets that WHO's member states adopted in the 65th and 66th World Health Assembly. This target was 'no increase in obesity levels by 2025'. For evaluating achievement of a 'halt' in the rise in obesity 2010 was considered as the baseline.

Lobstein et al. (19) used estimates of overweight and obesity from the Global Burden of Disease (GBD) programme for 2000 and 2013 to make estimates for 2010 (to match the WHO baseline year). Overweight and obesity were defined according to the IOTF criteria. Subsequently, these estimates were projected forward to 2025 on the basis that no effective intervention was implemented to significantly change the trend (linear projection).

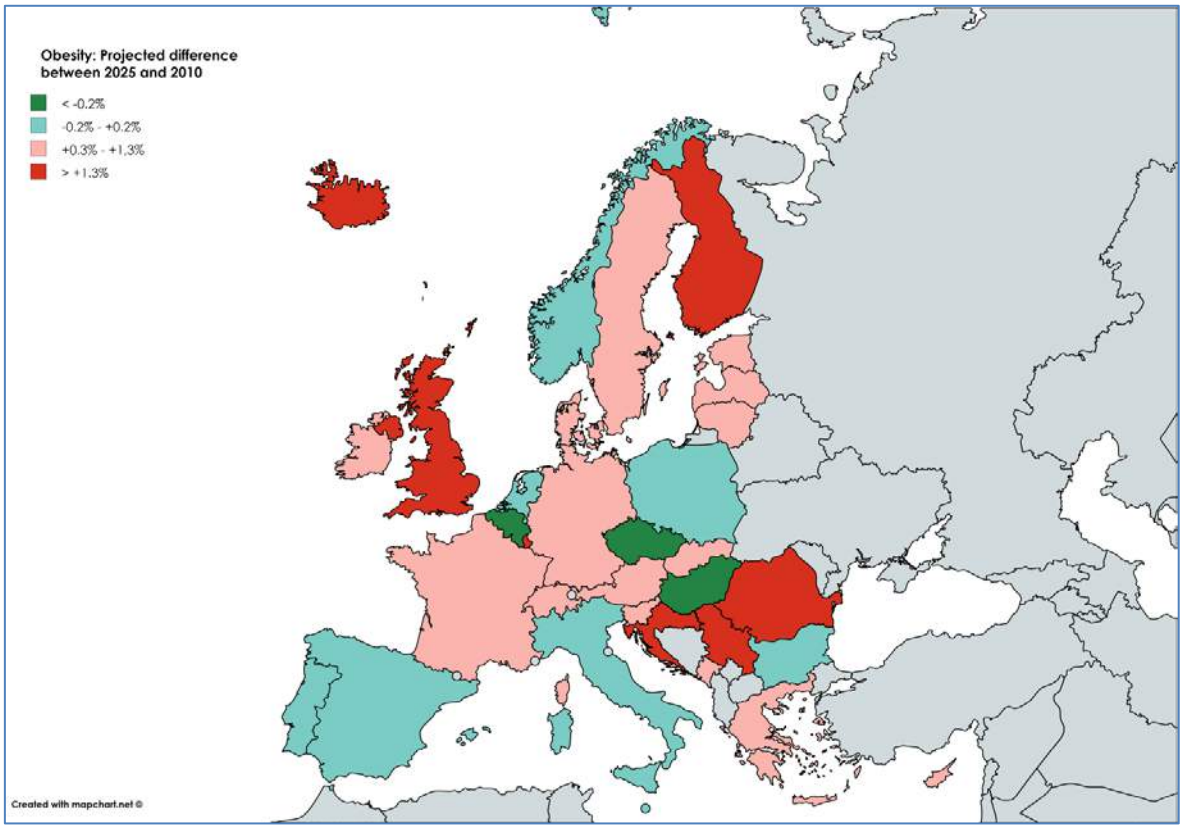
Map 3.1 presents the predicted changes in the prevalence of overweight including obesity in 2010-2025 based on the linear projections for school-aged children and adolescents for all 28 countries of the European Union, and Iceland, Montenegro, Norway, Serbia and Switzerland. For most countries the projections show an increase in the prevalence of overweight and obesity between 2010 and 2025. Only for two countries (AT and FR) the prevalences were expected to be slightly lower in 2025 compared to 2010 and in three countries the prevalence of overweight and obesity remained more or less stable, i.e. predicted difference between -0.5% and +0.5% (CZ, IE and ES). The projected increase is more than 3% in 10 countries.

The predicted prevalence of obesity (without overweight) was also higher in 2025 compared to 2010 for most countries (see map 3.2). These projections show a small decrease in the prevalence of obesity in three countries (BE, CZ and HU), rather stable prevalences (-0.2% to +0.2%) in eight countries and increases in the remaining countries.

The projections only give an indication of the expected change in the prevalence of overweight and obesity between 2010 and 2025 assuming no effective intervention. They represent the situation if the trend from 2000 to 2013 continues. The figures are not to be interpreted as truly expected prevalences in 2025. In Germany, for example, there was a steep increase in overweight and obesity prevalence from the beginning of 1990 to 2003-2006. The projections show an increase in the prevalence until 2025. However, data from the second wave (2014-2017) of the Health Interview and Examination Survey for Children and Adolescents (KiGGS) indicate no further increase in the prevalence of overweight and obesity between 2003-2006 and 2014-2017 (personal communication).



Map 3.1. *Projected difference in the prevalence of overweight including obesity between 2025 and 2010 among 2 to 19.9 year old children and adolescents (19). Based on IOTF criteria under the assumption that that no effective intervention is implemented to significantly change the trend.*



Map 3.2. *Projected differences in the prevalence of obesity between 2025 and 2010 among 2 to 19.9 year old children and adolescents (19). Based on IOTF criteria under the assumption that that no effective intervention is implemented to significantly change the trend.*

3.2 Overall assessment of policy developments in the EU

This overall assessment is mainly based on the information provided in the interviews with the Competent Authorities. Figure 3.9 and Table 3.1 provide a birds-eye overview of policies/strategies in the 33 countries according to the areas of action. The following indicators are included and the numbers of the indicators correspond to the numbers in the table. Indicators with an asterisk (*) are part of the set of 18 indicators that was identified by the Member States, European Commission and WHO Europe in 2014 as indicators that were considered for immediate operational status.

Area 1: Support a healthy start in life
1.1 Policies or strategies to ensure that women receive guidance on nutrition and nutritional status before, during and immediately after pregnancy*
1.2 Policies, strategies, initiatives or actions to promote and protect breastfeeding
1.3 Policies or guidance on complementary feeding

Area 2: Promote healthier environments, especially in schools and pre-schools
2.1 Policies on improving the children's school environment
2.2 Policies, strategies etc. on energy drinks for children
2.3 Policies, strategies etc. on vending machines
2.4 Mandatory nutrition education included in school curricula
2.5 Mandatory physical activity education included in school curricula

Area 3: Make the healthy option the easy option
3.1 Policies or initiatives on food reformulation/food product improvement for:
a: salt*
b: saturated fat*
c: sugar
d: calories or portion size*
3.2 Policies or initiatives to (virtually) eliminate trans fat*
3.3 System to monitor the level of nutrients (and thus the effect of strategies for food reformulation/food product improvement)
3.4 Mandatory or voluntary easy to understand labelling, e.g. front of pack labelling
3.5 (Policies on) food taxation for products/nutrients that are high in fat, sugar or salt or do otherwise not fit nutritional guidelines ('unhealthy' foods)
3.6 (Policies on) subsidies for healthier options ('healthy' foods), other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme

Area 4: Restrict marketing and advertising
4.1 Policies on marketing of foods to children*
4.2 Use of nutrient profiles or criteria to restrict marketing of foods to children*

Area 5: Inform and empower families
5.1 National campaigns to promote healthy diet and/or increase physical activity
5.2 Policies or initiatives to support community based interventions
5.3 Screening programmes for childhood overweight and obesity (in primary care)
5.4 Management services (e.g. interventions or weight loss programmes) for overweight and obese children

Area 6: Encourage physical activity
6.1 Policies on physical activity promotion for <18 year olds*
6.2 National physical activity guidelines
6.3 Data on height and weight in children*

Area 7: Monitoring and surveillance
7.1 National representative diet/nutrition surveys*
7.2 National representative surveys on physical activity
7.3 Participation in COSI*

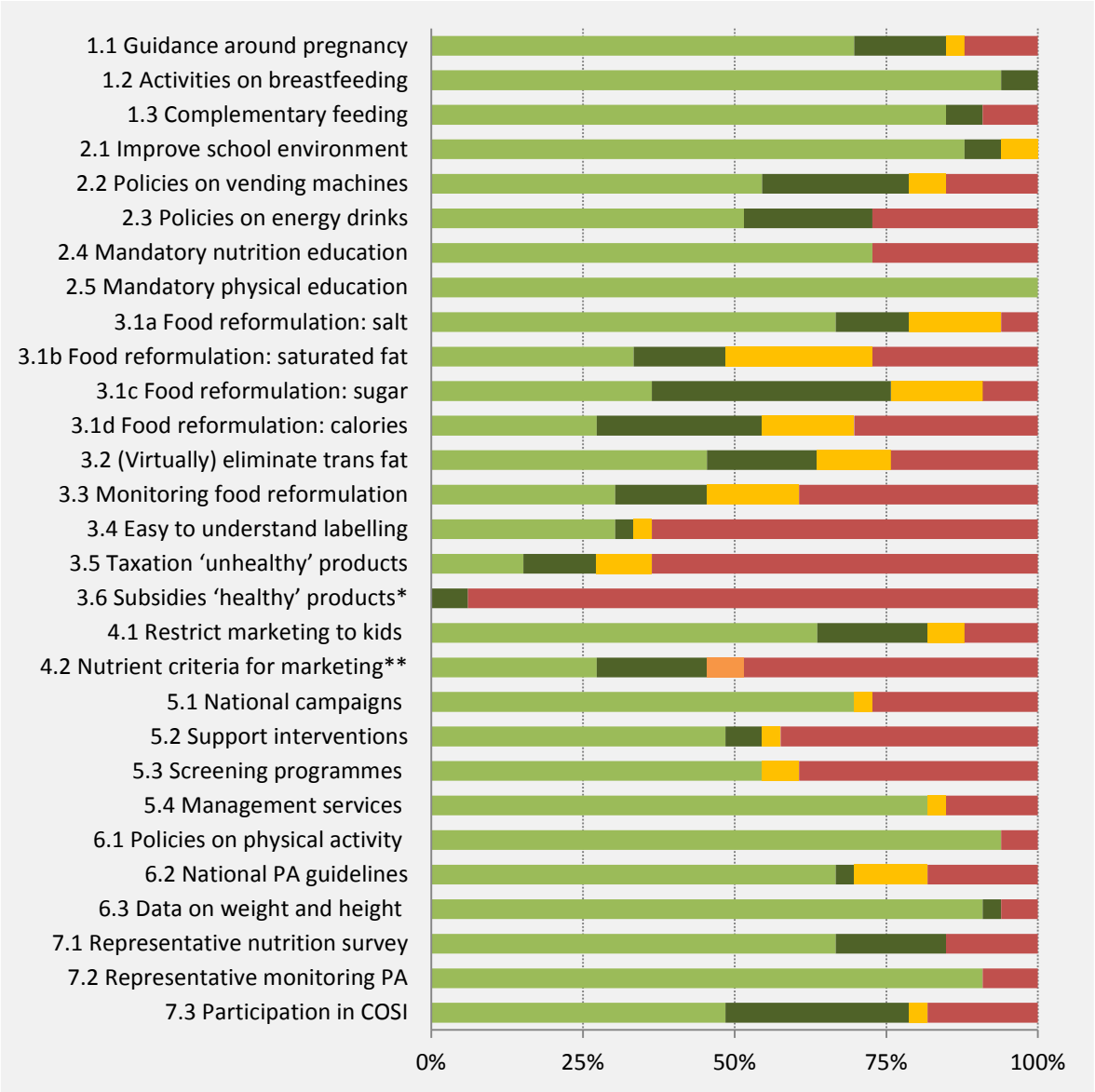
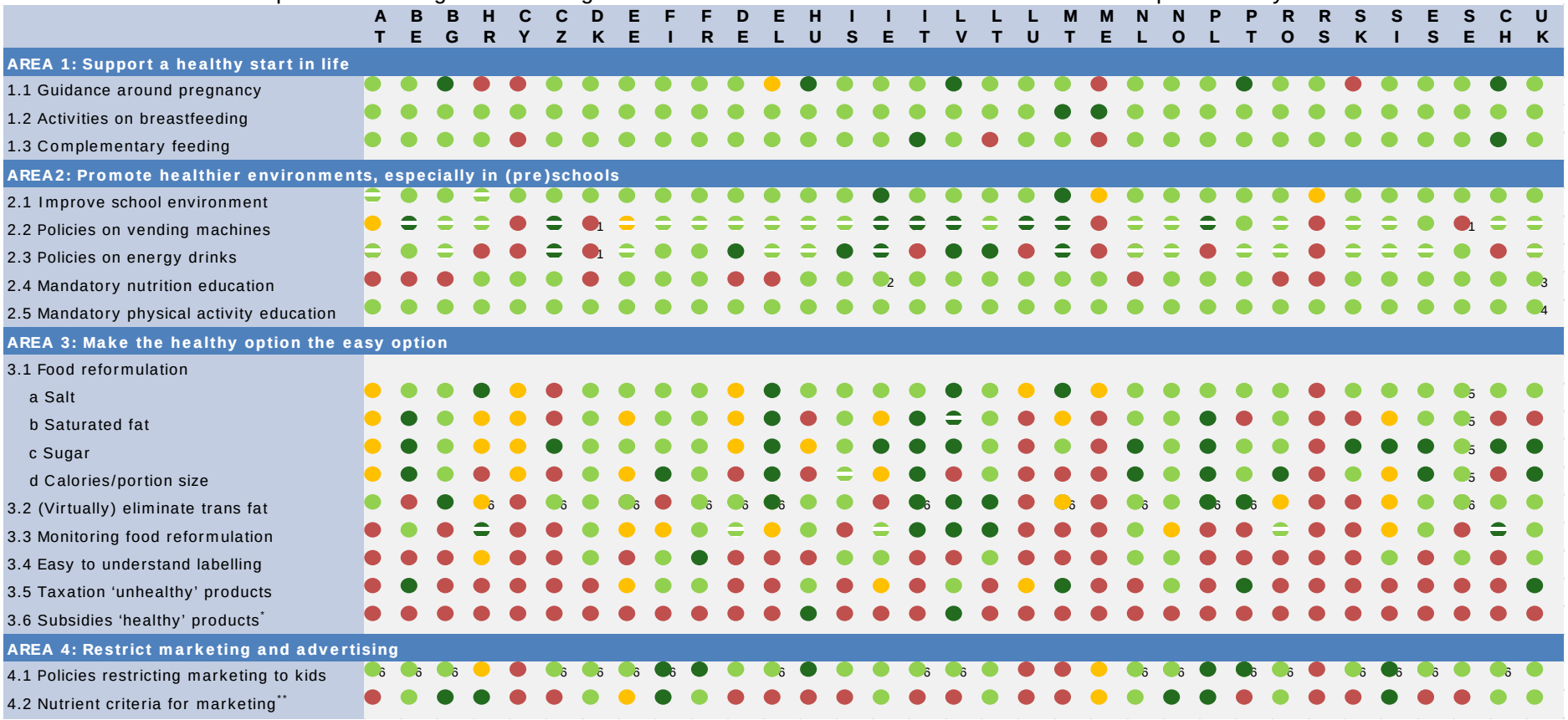


Figure 3.9. *Summary of implementation of the EU Action Plan expressed as percentage of all countries having activities in the mentioned areas.*

* other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme
** other than included in school policies

Light green: fulfilment of an action, dating back from before the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated.
Dark green: fulfilment of an action, since the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated. It does also not necessarily mean that the action is undertaken as a result of the Action Plan.
Orange: actions in preparation. They may still be contingent on the outcomes of policy processes.
Red: no action is initiated or supported by national authorities. This does not mean, however, that no action is undertaken, e.g. by local authorities, non-governmental organisations (NGOs) or commercial parties.

Table 3.1. Overview of policies/strategies according to the areas of action included in the Action Plan per country.



Light green: (when striped: partial, for example in certain settings or certain regions) fulfilment of an action, dating back from before the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated.
Dark green: (when striped: partial, for example in certain settings or certain regions) fulfilment of an action, since the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated. It does also not necessarily mean that the action is undertaken as a result of the Action Plan.
Orange: actions in preparation. They may still be contingent on the outcomes of policy processes.
Red: no action is initiated or supported by national authorities. This does not mean, however, that no action is undertaken, e.g. by local authorities, non-governmental organisations (NGOs) or commercial parties.
* Other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme, ** Other than included in school policies
Footnotes 1-8 can be found on the next page

Table 3.1 continued. Overview of policies/strategies according to the areas of action included in the Action Plan per country.

	AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IS	IE	IT	LV	LT	LU	MT	NL	NO	PL	PT	RO	SK	SI	ES	SE	CH	UK
AREA 5: Inform and empower families																															
5.1 National campaigns	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
5.2 Support interventions	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
5.3 Screening programmes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
5.4 Management services	●	●	◓	●	●	●	●	●	●	●	●	●	●	●	●	◓	●	●	●	●	●	●	◓	●	◓	●	●	●	●	●	●
AREA 6: Encourage physical activity																															
6.1 Policies on physical activity	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
6.2 National PA guidelines	●	●	●	●	●	●	●	● [7]	●	●	●	●	●	●	●	● [7]	●	●	●	●	●	●	●	●	●	●	●	●	◓	●	●
6.3 Data on weight and height	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	● [8]
AREA 7: Monitoring and surveillance																															
7.1 Representative nutrition survey	●	●	●	●	●	●	●	●	● [9]	●	●	●	● [9]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	● [9]	●
7.2 Representative monitoring PA	◓	◓	◓	◓	●	◓	◓	◓	●	◓	●	◓	●	●	●	●	◓	●	◓	◓	●	●	●	◓	●	◓	●	◓	◓	●	◓	●
7.3 Participation in COSI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

[1] There are few vending machines and it is a cultural phenomenon that foods high in sugar, salt and fat, including energy drinks, are not sold in schools. Therefore, there is no need for specific policies addressing vending machines and/or energy drinks.
[2] In secondary school, not in primary school
[3] In Scotland only
[4] Except in England
[5] Indirect through Keyhole logo, not seen as explicit policy
[6] Voluntary agreement with/of industry
[7] New guidelines planned
[8] Children are not included

The results presented in Figure 3.8 and Table 3.1 as well as additional information from the interviews suggest that:

- The majority of countries have policies, strategies or actions relating to Area 1 of the Action Plan. In general, guidance is provided to women during and immediately after pregnancy. Information on breastfeeding is provided and/or breastfeeding is advised or promoted in all countries. In the majority of countries (91% of all countries; 93% of all EU Member states) guidelines on complementary feeding are available.
- Also the majority of countries have policies that promote healthier environments, especially in schools (Area 2). Policies to improve the school environment are in place or planned in all countries. In all except a few cases, policies on vending machines and energy drinks in schools are included. Only in two countries policies on vending machines also apply to settings other than the school environment. For policies on energy drinks this the case in eight countries. In all countries, except in England (UK) physical education is mandatorily included in the school curriculum. In the majority of countries, a minimum number of hours is specified. Mandatory nutrition education is included in school curricula in 73% of the countries (71% of the EU Member States). In all but one of the other countries nutrition education is voluntarily included. However, being mandatory or not, it is often part of 'biology', 'home economics' or other lessons without specification of the number of hours to be provided.
- Food reformulation/food product improvement, which falls under Area 3, experiences growth across Europe. This is most apparent for sugar. Thirteen countries (39%) recently started reformulation initiatives, while others are planning to do so (n=5, 15%). Easy to understand labelling, such as front-of-pack labelling, is used in 11 countries (33%) to make the healthy option the easy choice (in one it will end in 2018), while planned in one other. Taxation of 'unhealthy' products is used in a similar number of countries (n=9, 27%; 29% of all EU Member States), but another three countries (9%) have plans for a levy (additional legal charge) on sugar-containing beverages. A subsidy on 'healthier' options – other than provision of school meals, the EU Fruit and Vegetable Scheme or the EU School Milk Scheme - is not implemented, except by Hungary and Latvia.
- Area 4 concerns restriction of marketing of foods and beverages that are high in salt, sugars or fat or that otherwise do not fit national or international nutritional guidelines (HFSS foods) to children. Almost 82% of the countries (n=27; 86% of the EU Member States) have initiatives in this area, two thirds being voluntary codes issued by the private sector. Two countries have plans in this area for the near future. About half of the countries use nutrient criteria to restrict marketing of foods to children or have plans for it (50% of the EU Member States).
- Twenty-three countries (70%; 71% of the EU Member States) use (national) campaigns to inform and educate the population on healthy diet and the importance of physical activity (Area 5). Somewhat fewer countries (n=19, 58%; 54% of the EU Member States) mentioned to have or plan policies to support community-based interventions. Community-based interventions often fall under the responsibility of subnational authorities, such as municipalities. Screening for overweight and obesity takes place or is planned in 20 countries (61%) and is quite often seen as one of the tasks of child health care providers and general practitioners. The majority of countries (82%) provide management services for children who are already overweight or obese. In many countries, the general practitioner is the one who is responsible for the management of an obese child.
- Encouraging physical activity (Area 6) seems to be well covered, with respect to policies (in 94% of the countries; 100% of the EU Member States), the presence of or planning of national guidelines (in 82% of the countries) and available data on weight and height of children (in 94% of the countries).

- National representative nutrition surveys are available in 85% of the countries (82% of the EU Member States). However, in at least three countries children are not included in these surveys. All but three countries participate in the Health Behaviour in School-aged Children (HBSC) surveys and 26 countries participate in COSI. However, several countries measure certain age groups within the 6-9 year olds (COSI) and data in HBSC are self-reported. Monitoring of childhood obesity is therefore covered in part of the primary-school children and adolescents. Monitoring of self-reported physical activity among adolescents is covered through the HBSC-study in all but three countries. Thirteen of them also have additional surveys on physical activity in children.

To see whether there was any possible association between the presence of policies/activities in countries and the prevalence of childhood obesity we ordered the countries in table 3.1 according to increasing prevalence of overweight (including obesity). No clear pattern was apparent, except that countries with a high prevalence of overweight seem to show more recent activity on food reformulation/food product improvement (see Annex 6, table A6A). When the countries were ordered according to their population size at 1-1-2016, it seems that smaller countries have somewhat fewer initiatives on food reformulation/food product improvement ongoing (Annex 6, table A6B).

4 MAPPING OF POLICIES AND ACTIONS AIMED AT REDUCING CHILDHOOD OBESITY IN THE EU

This chapter presents a further description and several maps of the indicators included in the present study (see Annex 2) according to the first to seventh area for action of the Action Plan. Area 8: "Increase research" is covered in the next chapter.

4.1 AREA 1: Support a healthy start in life

4.1.1 Policies or strategies to ensure that women receive guidance on nutrition and nutritional status before, during and immediately after pregnancy

Twenty-eight countries (24 EU Member States) (85%) provide nutritional guidance before, during and after pregnancy (see Figure 4.1 and Map 4.1). Guidance is usually provided by health professionals in the context of maternity care, but also by issuing guidelines for pregnant women. Four Member States (BG, HU, LV, PT) and Switzerland (15%) have implemented (new) guidance since 2014. More EU13 Member States (n=3, 23%) implemented guidance after 2014 than EU15 Member States (n=1, 7%). Few countries do not provide guidance yet (all EU13). In Greece, new national nutritional guidelines are expected to be adopted. They will include recommendations for pregnant women, based on the scientific evidence and with a special focus on the Mediterranean diet.

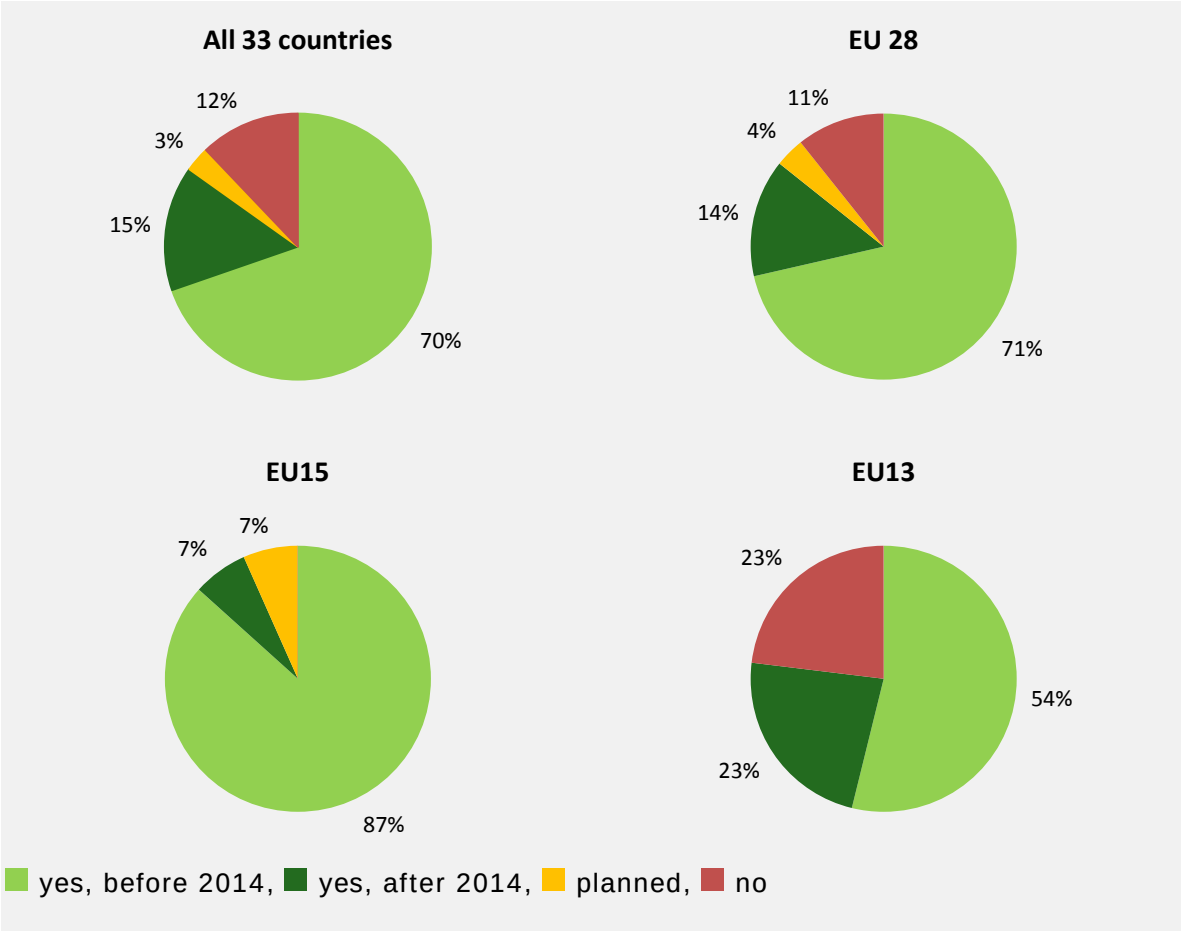
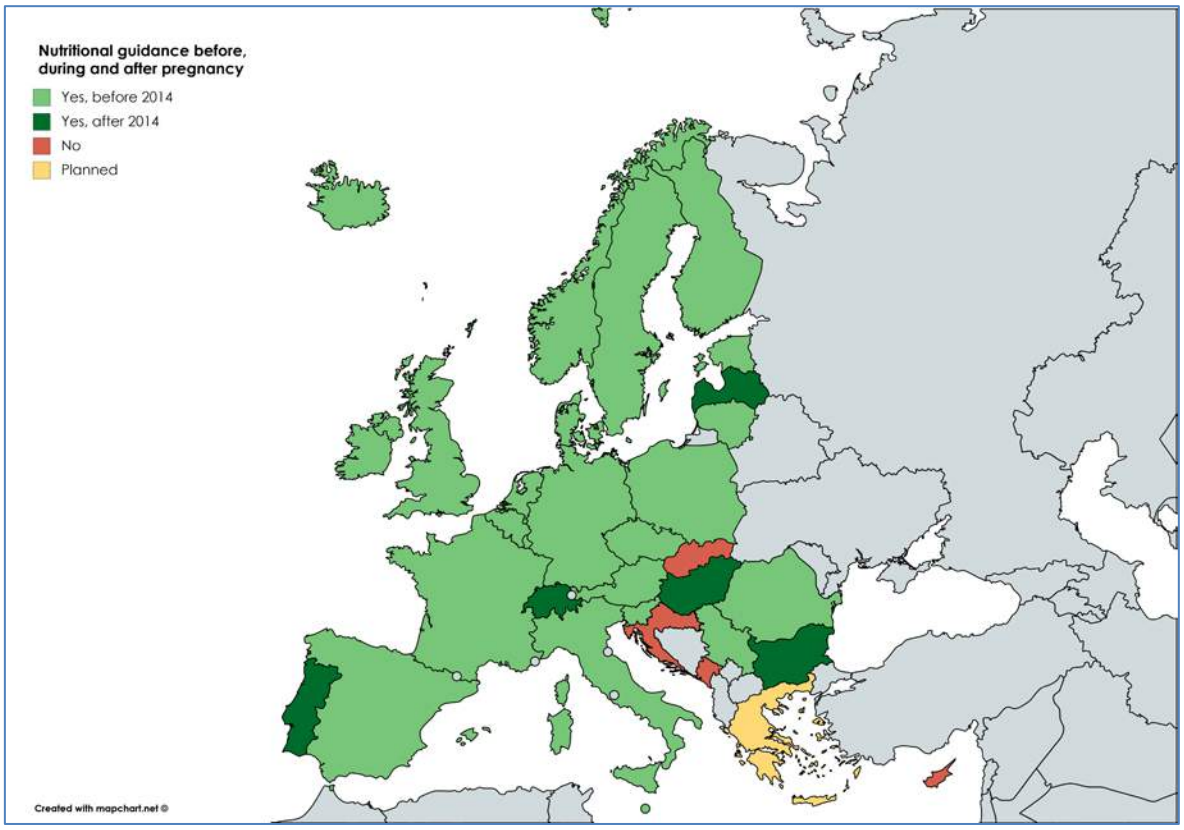


***Figure 4.1**. Provision of nutritional guidance before, during and after pregnancy. EU13: Member States that joined the EU in/after 2004.*



***Map 4.1.** Provision of nutritional guidance before, during and after pregnancy in 28 EU Member States plus Montenegro, Norway, Iceland, Serbia, and Switzerland.*

4.1.2 Policies, strategies, initiatives or actions to promote and protect breastfeeding

Breastfed infants are at lower risk of obesity and this association appears to be confined to exclusive breastfeeding (37). In all countries, mothers are somehow informed on the beneficial effects of breastfeeding or breastfeeding is actively promoted. This may be in the form of breastfeeding policies, national committees on breastfeeding or actions on breastfeeding included in other policies or action plans. Four countries (CY, FR, PL, UK) mentioned that there are no breastfeeding policies from national authorities, but that women receive information about breastfeeding, either through health professionals or NGO's. For the large majority of the countries, breastfeeding activities have been ongoing (long) before the introduction of the Action Plan. However, eleven countries mentioned that guidelines, strategies or action plans were renewed since 2014 (MT, ME, IS, IT, NO, PL, CH) or will be renewed (EE, FI, IE, ES). According to the GNPR2 survey of WHO, breastfeeding promotion and counselling is being implemented in the hospital, clinic as well as in the community in 14 countries. In another 10 countries it is implemented in one or two of these settings (no data are available for six countries).

The Baby Friendly Hospital Initiative was launched in 1991 by WHO and UNICEF as a global programme to incentivize maternity facilities throughout the world to adhere to the Ten Steps to successful Breastfeeding and comply with the International Code of Marketing of Breast-milk Substitutes. According to a recent report of WHO (38), 27 of the 33 countries (82%) currently have implemented the initiative, one since 2015 (CY) (Figure 4.2). Twenty-three EU Member States (82%) have implemented the initiative. Four countries have implemented it previously but not anymore (DK, EE, LV, RO) and two never implemented it (IS, MT). In Malta, the ten steps are integrated into national quality standards.

In the countries that implemented the Baby Friendly Hospital Initiative, the percentage of hospitals and maternities that have ever been designated baby-friendly ranges from 0 to 100%. In three countries no hospitals and maternities were ever designated as baby-friendly (BG, CY, CH) and in 5 countries none have been re-designated in the last 5 years (ME, NO, RS, ES, SE). Therefore the percentage of births in hospitals and maternities designated as baby friendly is 0 in these countries. In the other countries from which information is available, the reported percentage ranges from 4.7% in Greece to 94.6% in Croatia (Figure 4.3).

Although in all countries breastfeeding is somehow promoted and in many countries the Baby Friendly Hospital Initiative is currently implemented, the percentage of infants exclusively breastfed ranged from 0.7% in Greece to 54.2% in Croatia (figure 4.4). National representative data on exclusive breastfeeding were obtained from WHO's Global Health Observatory data repository[8], and WHO's country profiles on nutrition, physical activity and obesity[9] for 30 countries. According to the country profile, no national representative data on exclusive breastfeeding are available for Estonia. For two countries with missing data in both data sources (FR, PL), information collected by DG SANTE in 2014 and 2015 was used. Data for Finland were obtained from ref (39). All surveys originate before introduction of the Action Plan (ranging from 1999 to 2014). It should be noted, however, that numbers are derived from national data which have varying degrees of accuracy, consistency and completeness. Different breastfeeding definitions are used causing inconsistencies. Therefore the numbers should be interpreted cautiously. In the majority of cases, exclusive breastfeeding was defined as exclusive breastfeeding at six months: infants who have been exclusively fed breast milk from birth to six months of age. For some countries exclusive breastfeeding under six months of age was used, i.e. the proportion of

[8] http://apps.who.int/gho/data/view.main.NUT1730?lang=en
[9] http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/country-work

infants aged 0–5.9 months who are fed exclusively on breast milk. Alternative definitions were used in Bulgaria (at 4-5 months), Finland (at 5-6 months), Norway (at 5.5 months) and Croatia (3-6 months). The alternative definition in Croatia probably partly explains the high percentage of exclusively breastfed children.

There are many factors that may influence the percentage of children that are exclusively breastfed until the age of six months. One of them is the duration of maternity leave. Data on the duration of maternity leave were obtained from the experts or the European Parliamentary Research Service (40) (for BE, CZ, FR, DE, LV, LU, PT, SI). No data are available for Switzerland. The length maternal leave ranges from 10 weeks in Portugal to 156 weeks in Estonia and Slovakia. The percentage of children exclusively breastfed was not clearly associated with the duration of maternity leave (figure 4.5), but this does not imply that longer maternity leaves are not improving breastfeeding outcomes, as for many countries maternity leave is shorter than 26 weeks.

Representatives of 11 countries (AT, BE, BG, CY, DE, IS, IT, LU, NL, SI, SE) told us that women have the legal right to breastfeed at work, while this is not regulated by law at least in Denmark, Greece and the United Kingdom. For the remaining countries it is unknown.

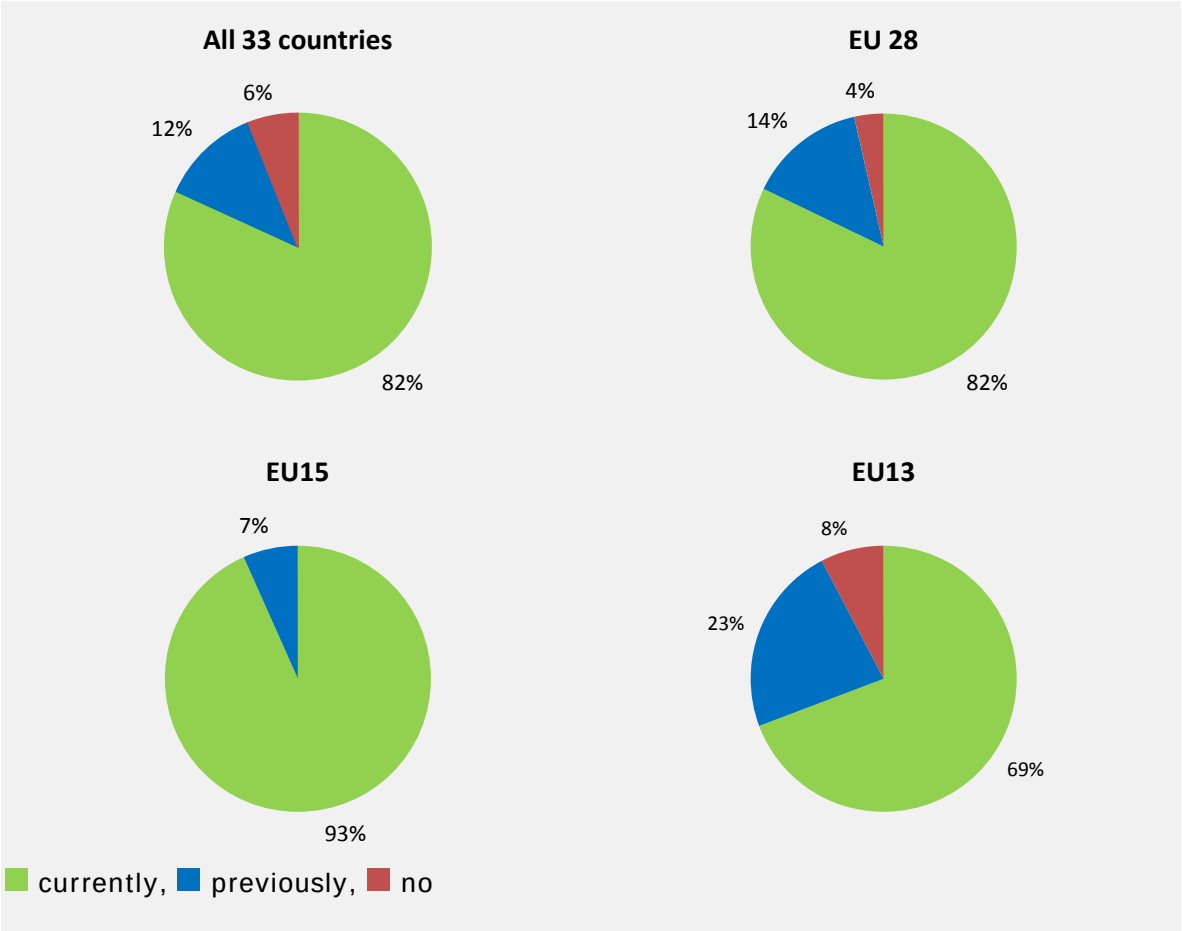


***Figure 4.2**. Implementation of the Baby-Friendly Hospital Initiative. Situation in 2016 (38). EU13: Member States that joined the EU in/after 2004.*

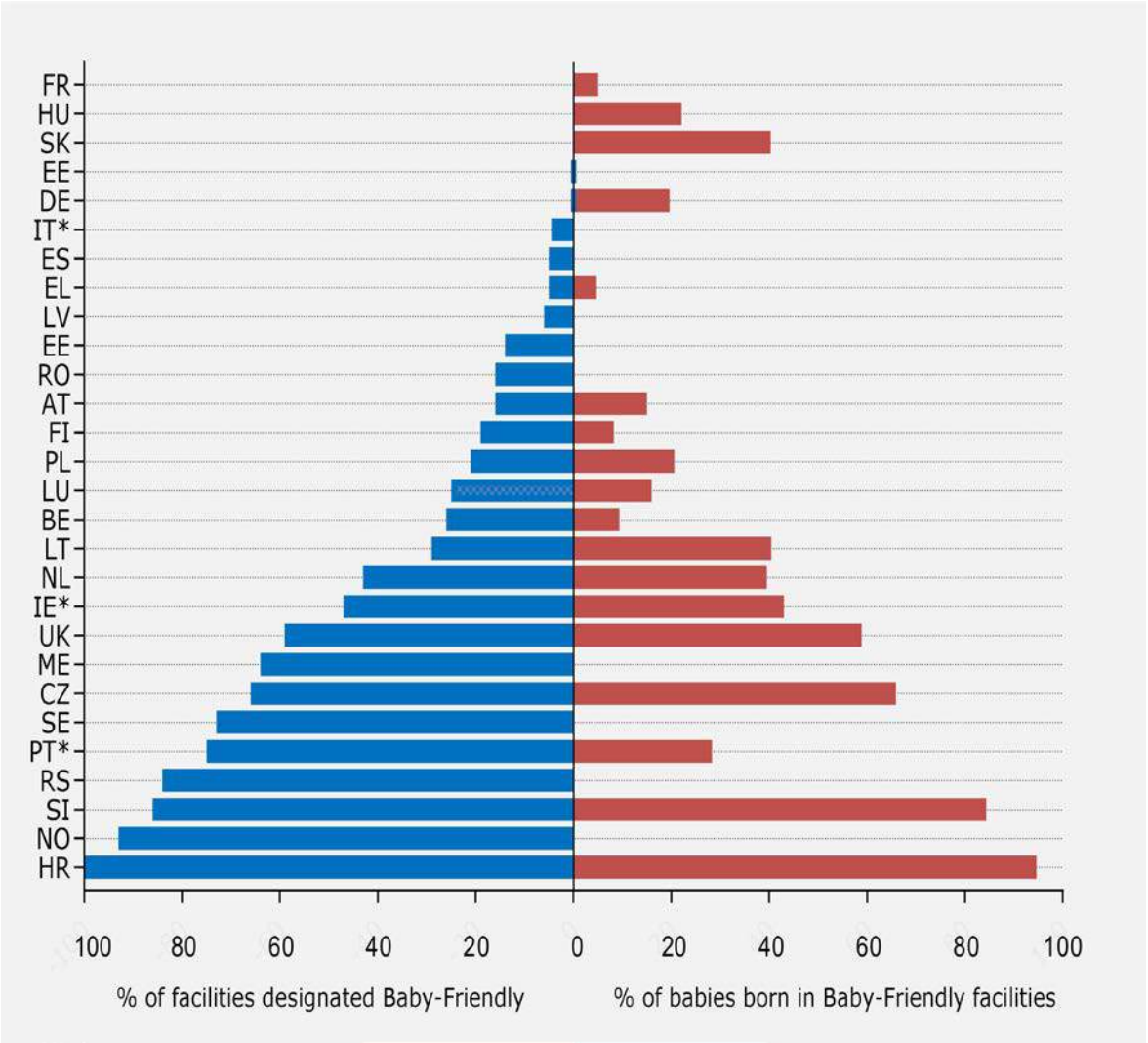


***Figure 4.3**. Percentage hospitals and maternities designated as baby friendly according to the Baby Friendly Hospital Initiative (left) and the percentage of babies born in such facilities (right). Situation in 2016 (38). Empty lines represent missing data. * Data on % of facilities designated obtained from experts (for IT and PT).*

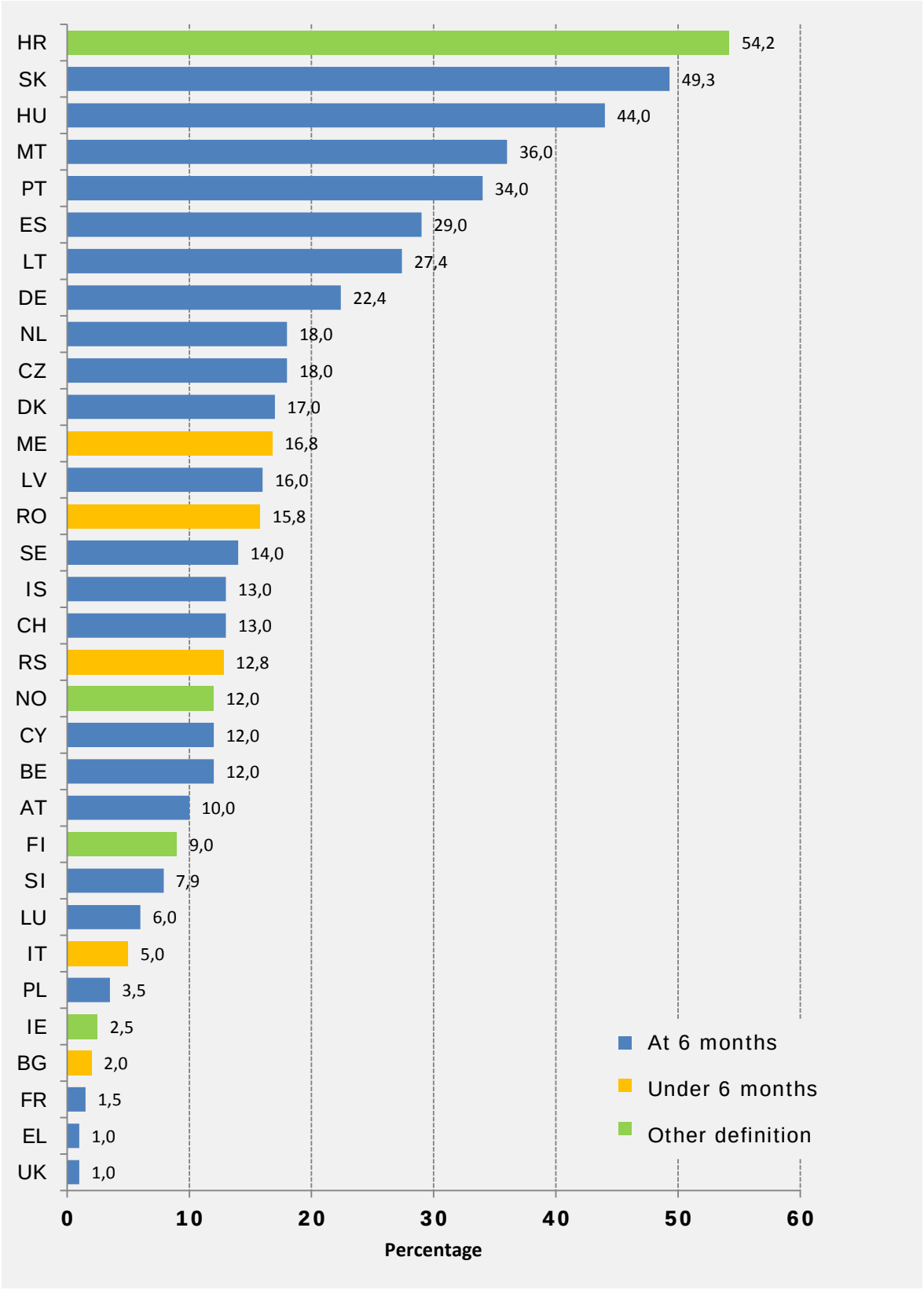


***Figure 4.4**. Percentage of children exclusively breastfed in 28 EU Member States, plus Montenegro, Norway, Iceland, Serbia, and Switzerland.*

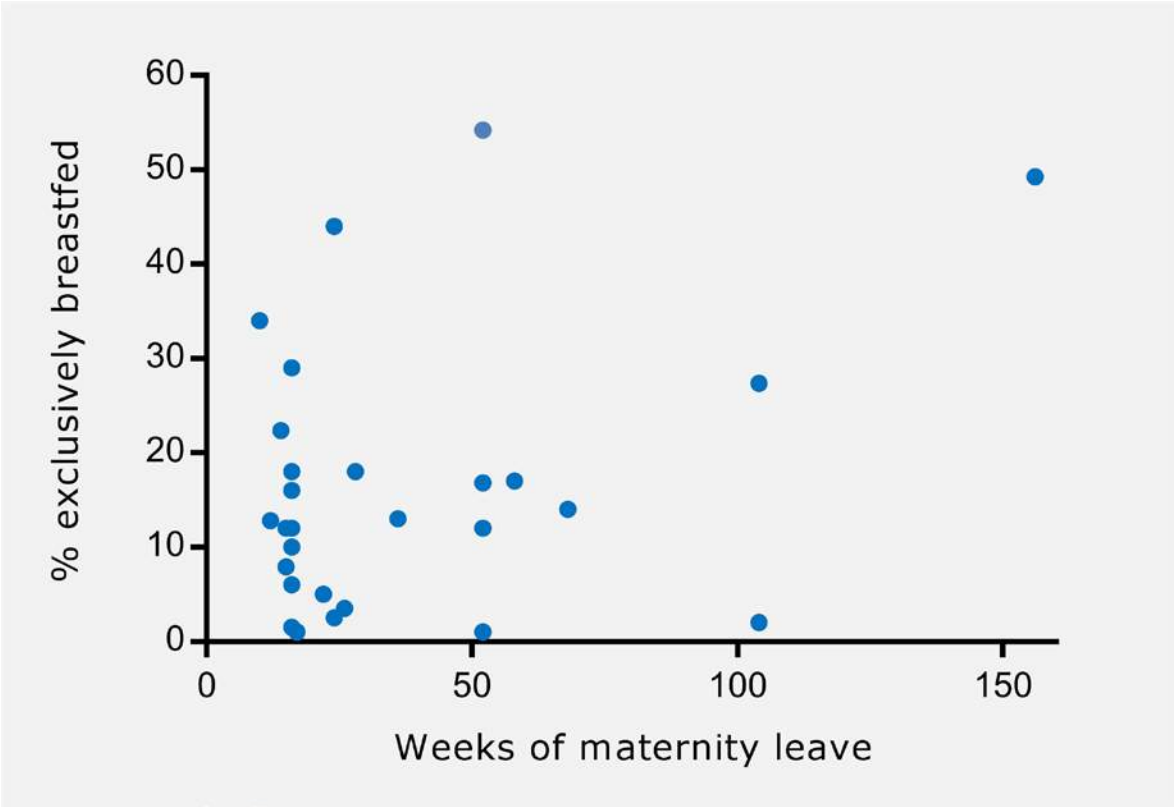


***Figure 4.5**. Relation between the duration of maternity leave and the percentage of children exclusively breastfed for 6 months.*

4.1.3 Policies or guidance on complementary feeding

Guidance on complementary feeding, usually in the form of national or international guidelines, is provided by almost all countries (91% of all countries and 93% of EU Member States; figure 4.5 and map 4.3). When the interviewee mentioned that gynaecologists or paediatricians provide guidance based on international guidelines, this was coded green (actions undertaken). When countries mentioned that health professionals might provide information, but that there are no guidelines, we coded them as having no actions. The percentage of countries providing guidance on complementary feeding is higher in EU15 (100%) than in EU13 Member States (85%).

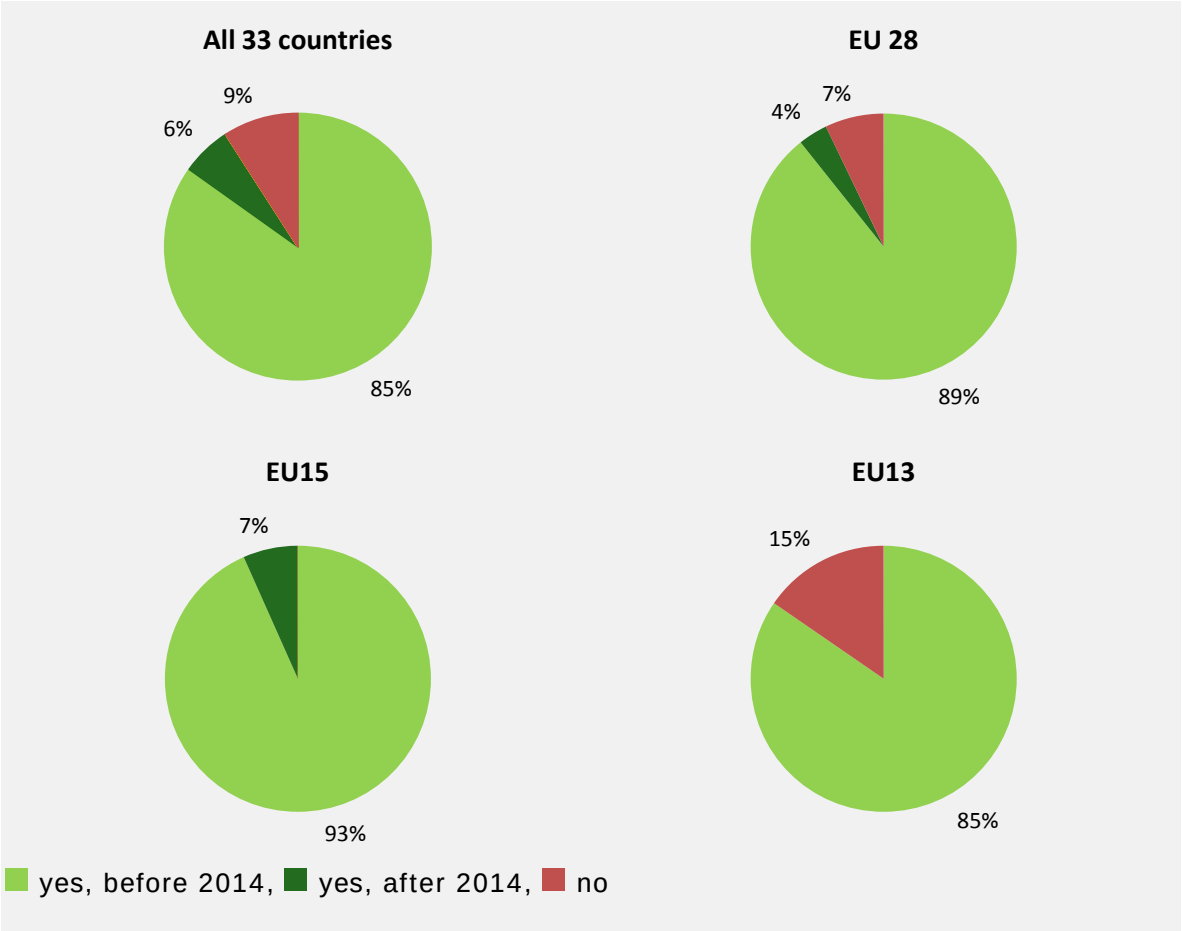
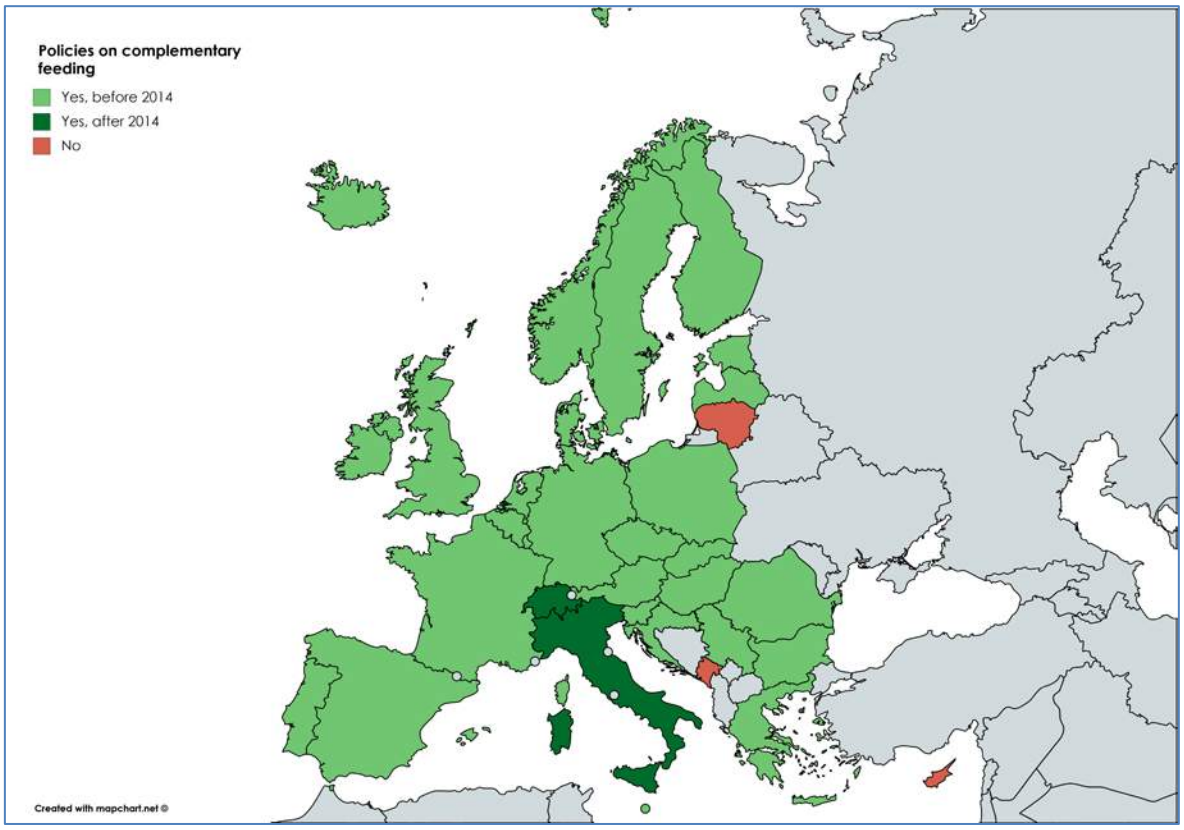


***Figure 4.6**. Guidance on complementary feeding. EU13: Member States that joined the EU in/after 2004.*



***Map 4.2.** Guidance on complementary feeding in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

4.2 AREA 2: Promote Healthier environments, especially in schools and pre-schools

Children and young people spend much of their day at school, typically consuming at least one meal a day there, either brought from home or provided by the school. Schools are therefore an essential environment to consider when tackling overweight and obesity in children and young people.

4.2.1 Policies on improving the children's school environment

All competent authorities interviewed mentioned to have policies to improve the school environment in their country (IE and MT after 2014) or that they are being prepared (ME, RS). These include at least mandatory or voluntary standards that are specified for school meals and other foods provided or sold at schools. Map 4.3 shows whether or not schools provide free or subsidized meals. More detailed information can be found in the school food policy country sheets of the Joint Research Centre (JRC)[10].

Public procurement of food in the school setting
In 2017, JRC together with the Maltese EU Presidency and DG SANTE issued a report on public procurement of food for health, focussing on the school setting (41). According to the report, the implementation of school food policies through a procurement process for school food that is health sensitive can have several benefits, such as improved student health and increased societal awareness about the role of healthy nutrition for health. Of the EU Member States plus Norway and Switzerland 77% have issued guidance on food-related public procurement. Most of them are targeted at schools. However, many guidelines also exist for other settings, such as hospitals, workplace canteens and sports clubs. The report shows examples of public procurement initiatives, guidance and legislation from 17 EU Member States (AT, BE, BG, CZ, DK, DE, EL, FI, FR, IT, LV, LT, HU, SK, SE, ES, UK).

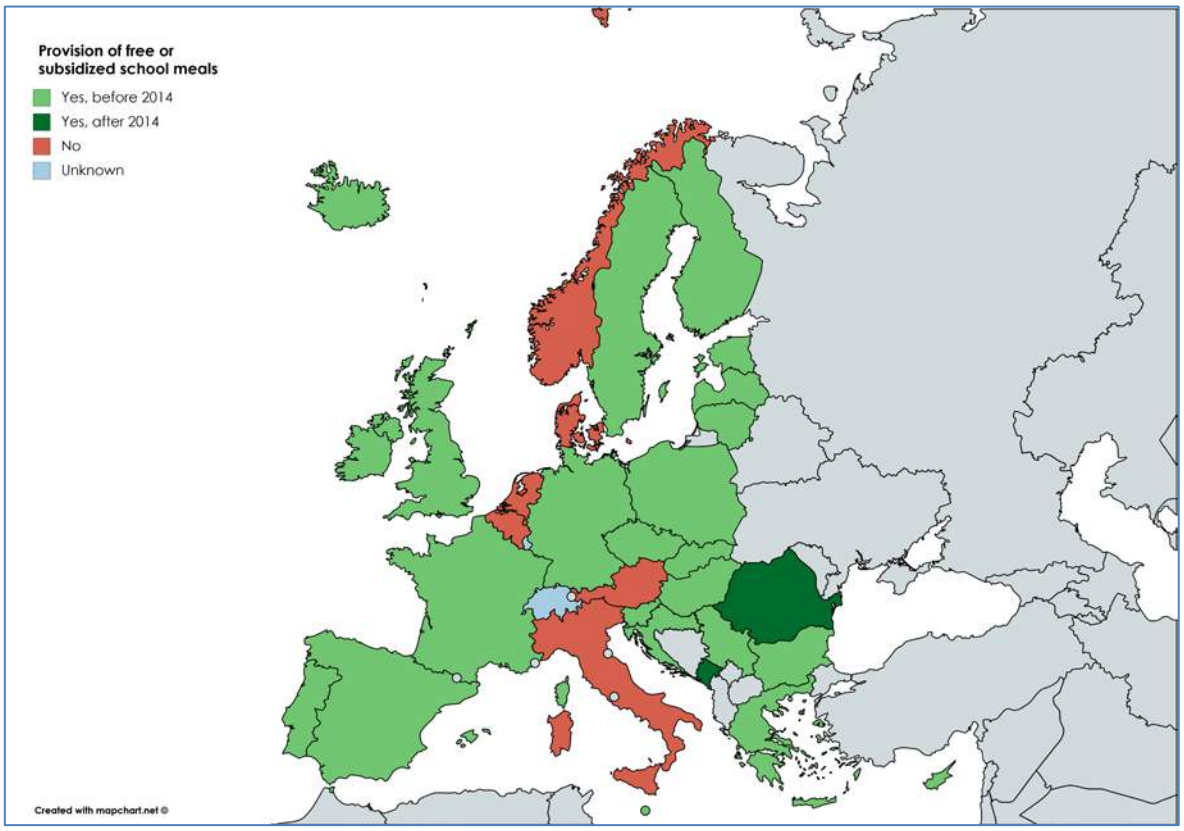
Participation in the EU School Fruit and Vegetable Scheme
The EU-wide School Fruit and Vegetable Scheme, applicable from the 2009/2010 to the 2016/2017 school year, provided school children with fruit and vegetables to encourage good eating habits in young people. In addition to providing fruit and vegetables, participating EU Member States set up educational and awareness-raising initiatives. In the 2015/2016 school year, Finland, Sweden and the UK, which have similar schemes running at national level, did not participate as well as Greece due to implementation issues. Norway also has a programme providing fruit and vegetables in schools. National evaluations of the EU School Fruit and Vegetables scheme, submitted in March 2017, provide conclusions and recommendations for improvement. They are available in the EU School Fruit and Vegetables Scheme webpage[11], under each participating country.

In the 2015/2016 school year 11.7 million children in 79.903 schools were reached by the Scheme[12]. The main target group was children aged 6-10 years, but in several member States the target group was wider. The duration of the scheme varied from some weeks to the whole school year and the frequency of provisions ranged from once a week to daily. On average 53 portions per schoolchild were provided, but portion sizes varied widely across Member States (from 66 to 218 grams). The percentage of schools that received school fruit in the 2015/2016 school year ranged from 21% in Austrian secondary schools to 97% in Malta and Latvia (see Figure 4.9). In many countries the percentage of schools that received school fruit was higher than in the 2013/2014 school year. The increase was largest (>15 percent points) in

[10] https://ec.europa.eu/jrc/en/publication/school-food-policy-country-factsheets
[11] https://ec.europa.eu/agriculture/sfs_en
[12] https://ec.europa.eu/agriculture/sites/agriculture/files/sfs/documents/sfs-facts-figures-2015-2016_en.pdf

Slovakia, Bulgaria, Luxemburg and Austria (primary schools). A large decrease was observed in Romania only.

A new EU School Fruit, Vegetables and Milk Scheme under a single legal framework applies from 1 August 2017. This is expected to increase efficiency, enable more focused support and enhance the educational dimension of the scheme. All 28 EU Member States participate in this new Scheme, with Sweden and the UK only implementing the milk part.



Map 4.3. *Provision of free or subsidized school meals in 28 EU Member States plus Montenegro, Norway, Iceland, Serbia and Switzerland.*

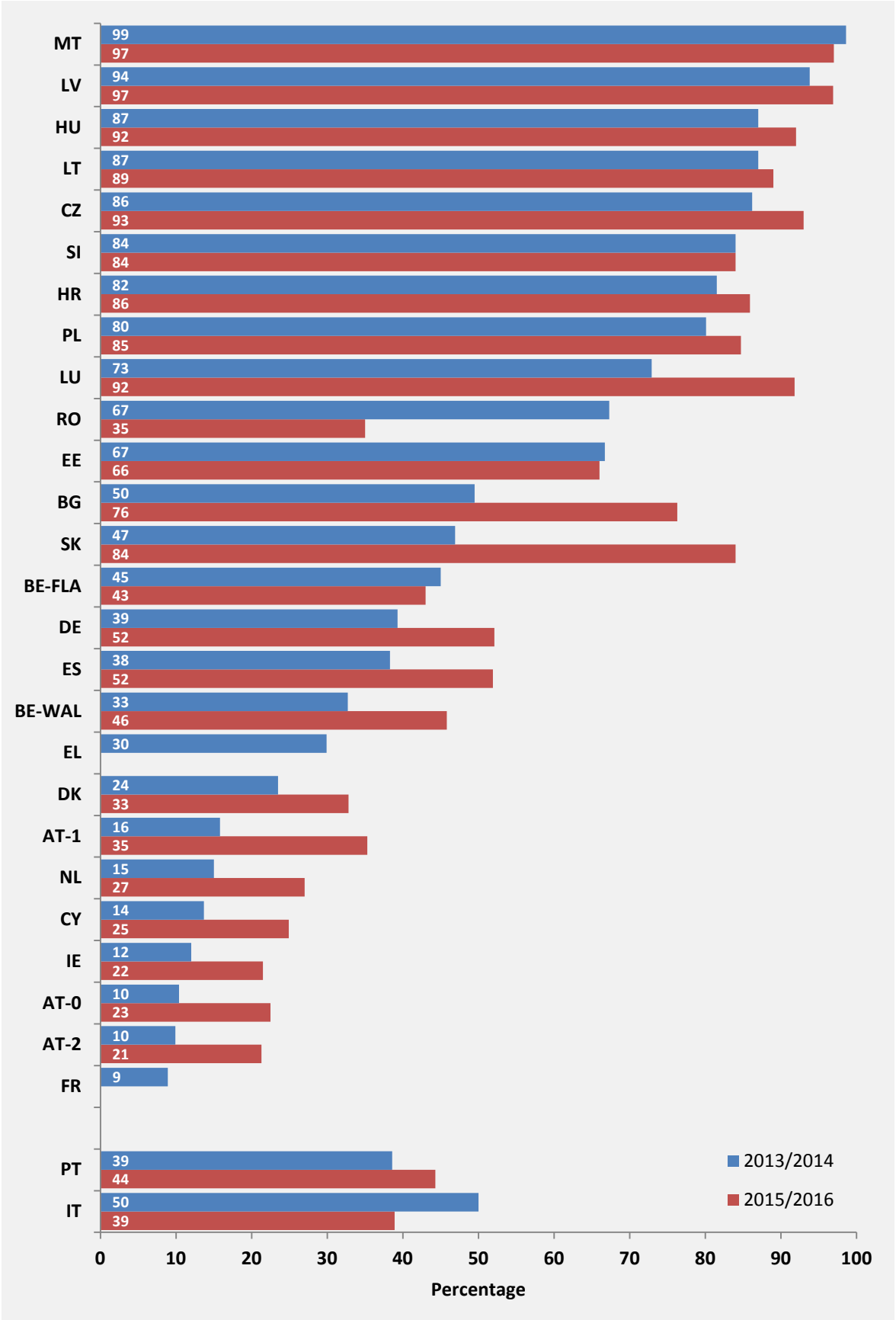


Figure 4.9. *Percentage of schools participating in the EU School Fruit and Vegetable Scheme in school year 2013/2014 and 2015/2016. For PT and IT, the percentage of children reached by the Scheme is presented.AT-0: Austrian kindergartens, AT-1: primary schools, AT-2: secondary schools.*

Availability of fresh drinking water in schools

In 21 of the 33 countries (64%) policies on safe drinking water in schools are available or safe drinking water is available free of charge in schools as part of school food policies. Representatives or experts of seven other countries (21%) reported that the quality of tap water is secured, so students also have access to safe free drinking water in schools. The above is the case in 19 and 5 of the 28 EU Member States, for policies and quality of tap water respectively (68% and 18%). Therefore, in total policies on free fresh drinking water or fresh drinking water are available in schools in 85% of the countries (86% of the EU Member States; Figure 4.7 and Map 4.4). The percentage is somewhat lower in the EU13 Member States (77%). For 13 countries information about the percentage of schools supplying free fresh drinking water (e.g. through tap points) is available (AT, BE, BG, HR, FI, IS, LT, MT, NL, NO, RS, SK, ES). The reported percentage is lowest in Malta (29%) and the Food and Nutrition Policy and Action Plan for Malta 2015-2020 identified the improvement of availability and accessibility of drinking water in schools as a key priority. In the other countries the reported percentage of schools supplying free fresh drinking water are 78% (BE), 90% (RS), 99% (HR) and 100% in the rest.

Based on a study from 2012 (42), in the Action Plan it was recognized that young people in the EU consume substantial amounts of sugar-sweetened beverages. The HBSC surveys showed that the percentage of adolescents that reported to consume sugar-sweetened beverages on a daily basis decreased from 29% in 2002 to 18% in 2014 across 32 countries in the WHO European Region (36). A decline was observed among boys and girls in almost all countries, except in France, Luxembourg, Malta and Poland. In none of the countries there was an increase in the self-reported daily soft-drinks consumption.

However, in the 2013/2014 HBSC survey (34) the percentage of adolescents that daily consume sugar-sweetened is still high in many of the 33 countries included in the present study. There are large differences between countries. In boys, the percentage ranged from 3% to 39% among 11 year-olds, from 4% to 41% among 13 year-olds and from 5% to 40% among 15 year-olds (Figure 4.8). In general, a smaller percentage of girls daily consumed sugar-sweetened beverages (1% to 34% among 11 year-olds, 1% to 34% among 13 year-olds and 1% to 39% among 15 year-olds). In Belgium, Bulgaria, Malta, and Hungary, 20% or more of the boys *and* girls in all age categories consumed sugar-sweetened beverages on a daily basis. In Finland and Greece, less than 10% of the boys and 5% of the girls in all age categories consumed sugar-sweetened beverages daily. The largest increase from 11 to 15 years of age is seen in the Netherlands (from 16% to 39% in boys and from 17% to 29% in girls). None of the experts provided more recent information.

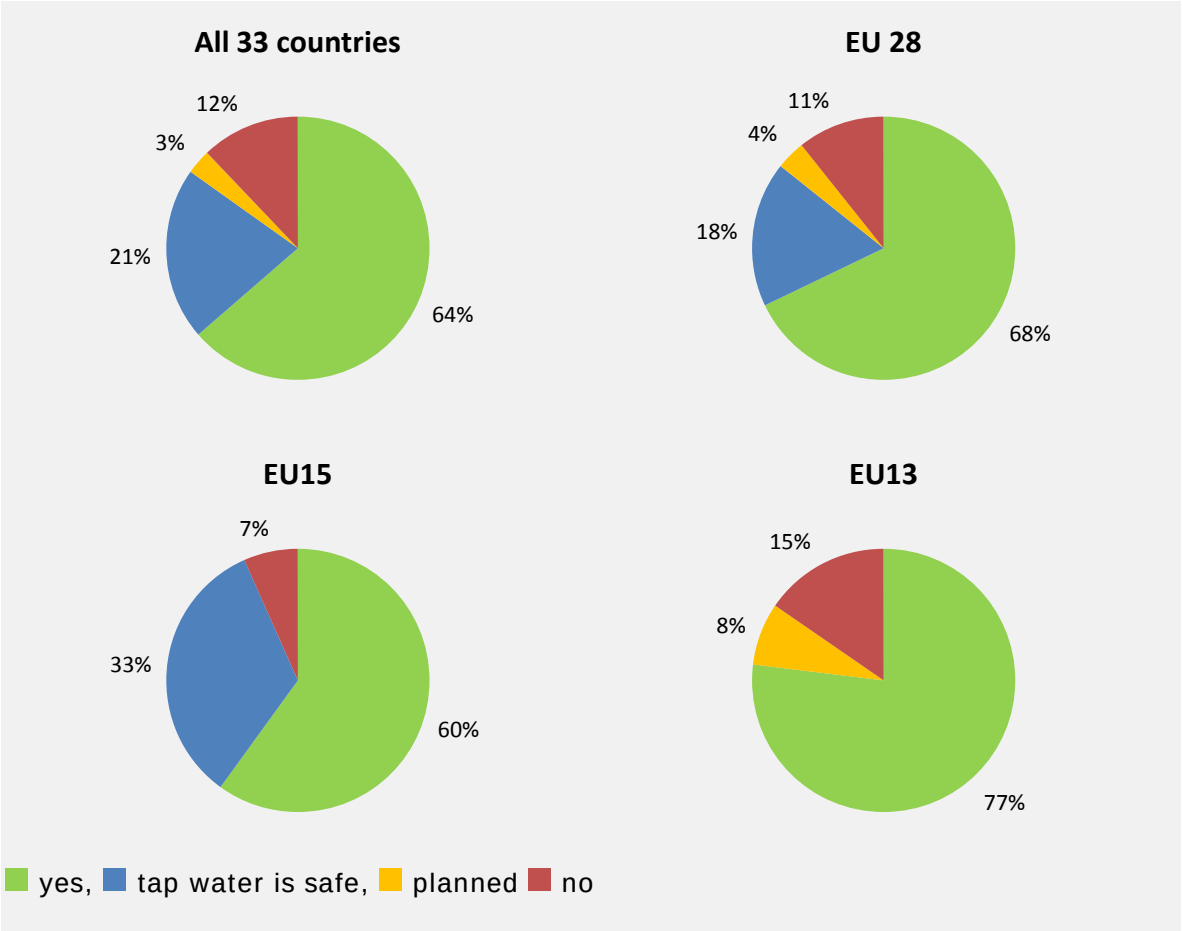
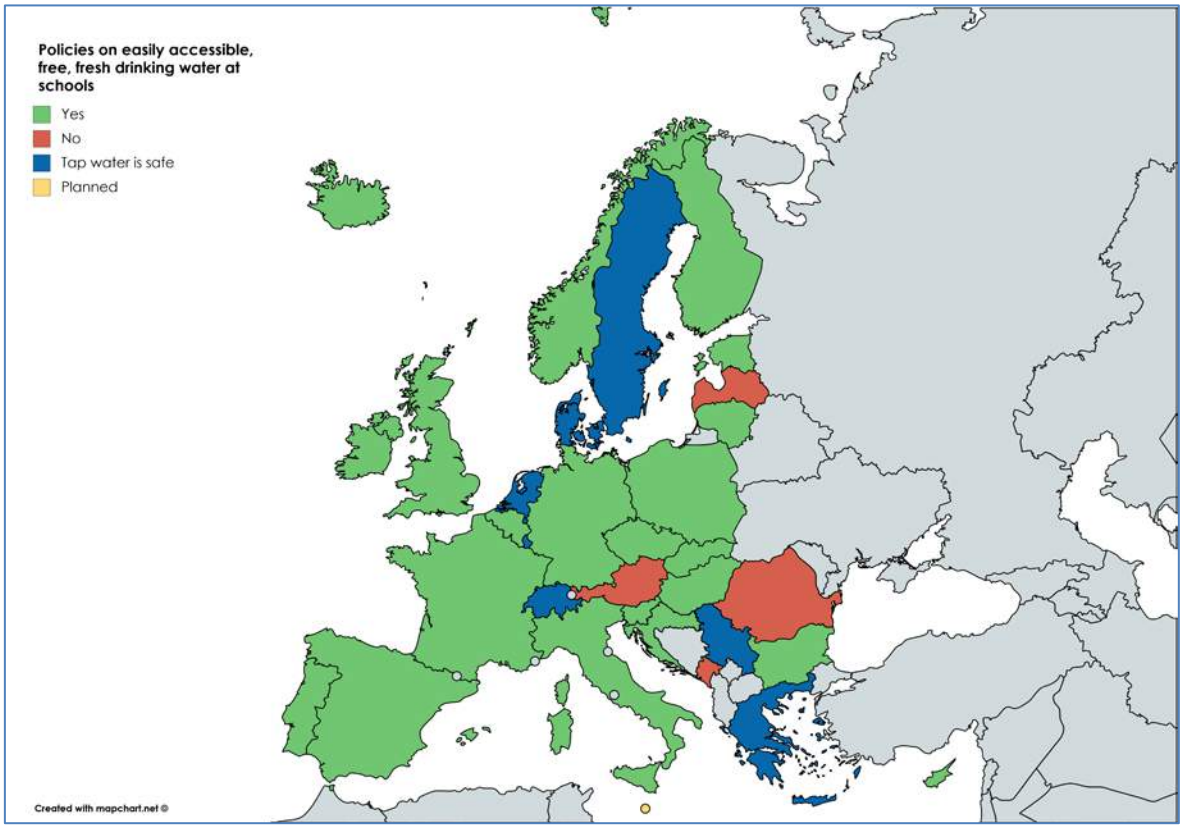


Figure 4.7. *Policies or guidelines on supplying easily accessible, free fresh drinking water at schools. EU13: Member States that joined the EU in/after 2004.*



Map 4.4. *Easily accessible, free, fresh drinking water at schools in 28 EU Member States plus Montenegro, Norway, Iceland, Serbia and Switzerland.*

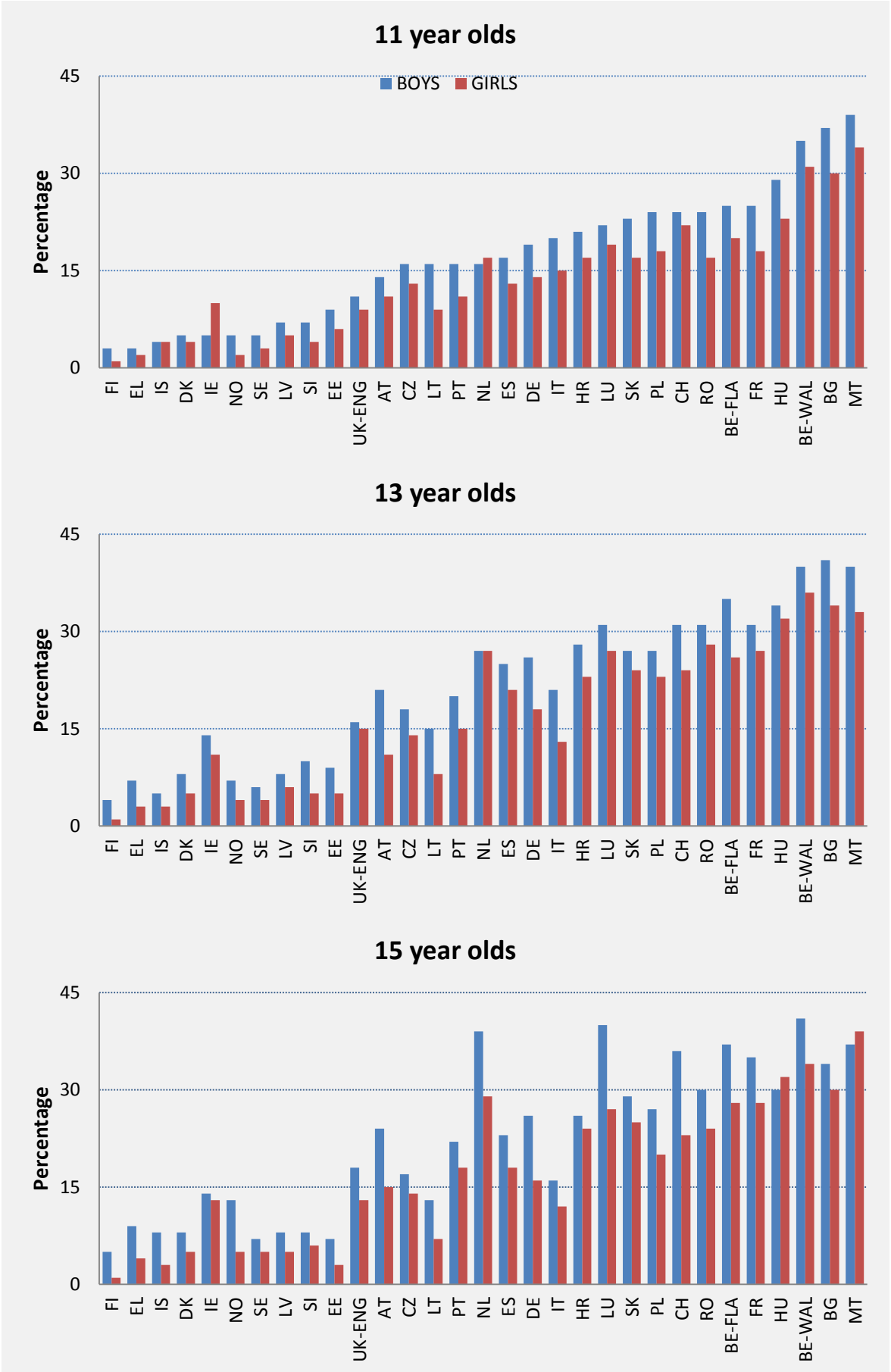


Figure 4.8. *Percentage of children daily consuming sugar sweetened beverages in 2013/2014 (HBSC). No data are available for Cyprus, Montenegro and Serbia.*

4.2.2 Policies, strategies etc. on vending machines

The standards for school meals and other foods provided at schools often include regulations for vending machines. Therefore 88% of the countries (89% of the EU Member States) have policies on vending machines in schools. They can be banned in total from the school premises (FR, SI, ES (pre-school and primary education) or can contain only certain products. Croatia managed to ban vending machines from schools, mainly in the capital, but not in all regions of the country. In several countries there are no vending machines in primary schools (NO), public schools (CY), or primary and secondary schools (IS, EL, RS). Vending machines in other schools have to comply with standards in Iceland, Greece and Norway. For Cyprus and Serbia the absence of vending machines in schools is the reason not to have policies on this topic. In Denmark and Sweden there are also few vending machines and it is a cultural phenomenon that foods high in sugar, salt and fat, including energy drinks, are not sold in schools. Therefore, there is no need for specific policies addressing vending machines.

In Portugal policies on a healthier offer in vending machines also apply to the National Service of Health. In Spain initiatives from different stakeholders are ongoing to facilitate a healthier supply in vending machines at other places than schools, like hospitals and the workplace.

4.2.3 Policies, strategies etc. on energy drinks for children

School food policies do not allow beverages high in sugar, so they also cover energy drinks. In several countries there are policies or initiatives on energy drinks for children that go beyond school policies. In 2015, Lithuania was the first country in the world to ban energy drinks for children below the age of 18 years by law. In Latvia the parliament approved a law prohibiting the sale of energy drinks to people under the age of 18 that came into force on 1 June 2016.

In Sweden, since 2009, there is voluntary agreement on a 15-year limit for the trading of energy drinks through the Swedish Retail Trade. All stores that are part of this Trade, which is the majority, follow this agreement. In some Finnish municipalities and cities there are voluntary agreements with families, schools and retailers close to school that energy drinks should not be sold to children below the age of 15. Furthermore the National Parents Association has issued guidelines at the community and city level saying that energy drinks are forbidden, but this is not official policy. Also in Iceland some shops have decided on a voluntary basis to set an age limit for the sale of energy drinks.

In addition, it is mandatory since November 2017 in Iceland to label energy drinks with a high amount of caffeine (40-56 mg/100 ml) front-of-pack with “this product is not to be sold to children under 18 years”, “very high content of caffeine” as well as with the amount of caffeine per can and per 100 ml. In Germany, the industry association for alcohol-free drinks has agreed to a Code of conduct for the labelling and marketing of energy drinks. This code is effective as of January 1, 2017

Due to taxation policies, in France all energy drinks are below a certain level of caffeine. Furthermore, the free refill system is not allowed in restaurant settings for beverages with added sugars, which include energy drinks. This also applies for beverages with sweeteners.

4.2.4 Nutrition and physical activity education in school curricula

Nutrition education in school curricula

All but one country (RS) have nutrition education included in the school curricula. In 24 countries (73%) nutrition education is mandatory. This percentage is 71% in EU Member States. In Ireland nutrition education is mandatory in secondary school, but not in primary school. In the United Kingdom, nutrition education is mandatory in Scotland but not in England and Wales. However, nutrition education is often included in broader topics, such as home economics or biology and therefore little insight can be obtained in the exact amount of nutrition education to be provided to school children. In the eight other countries (24%, AT, BE, BG, DK, DE, EL, NL, RO) nutrition education is voluntary. Sometimes there are guidelines and/or education materials for nutrition education, for example in Greece and the Netherlands.

Physical activity education in school curricula

Physical education is mandatorily included in the school curricula of all countries. Only in England (UK) there are no mandatory requirements. There is statutory guidance and as part of 'Childhood Obesity: a plan for action' 30-60 minutes of physical activity at schools is recommended. In most countries 2-3 hours or lessons of physical education are required per week (see Table 4.1). Daily physical education is mandatory in Denmark and Hungary, while the requirements in Slovakia are highest (8 and 10 hours per week in primary and secondary schools, respectively). In Spain, minimum requirements are set by the autonomous regions. Only in the Netherlands and Wales (UK) the minimum number of hours to be dedicated to physical education is to be determined by the schools themselves. In the Netherlands, traditionally, physical education is more firmly rooted in secondary education than in primary education. A discussion is ongoing on whether or not to set a minimum of mandatory hours, but it is unclear whether a minimum will be set in the near future.

Table 4.1. Minimum requirements of physical education

Minimum time to be spent	Applies to:
Primary education	
2 x 30-40 minutes per week	IE
90 minutes per week	CY, MT, SE
2 hours/lessons per week	AT, BE, CZ, FR, IT, LV, LT, ES, FI, PT, UK-SCT, HR (grade 5-8), LU (grade 5-6), RO (grade 1-2, 5-6)
2-3 hours/lessons per week	EE, FI, EL
2-4 lessons per week	SI
3 hours/lessons per week	IS, CH, RS, BG (grade 1, 2), HR (grade 1-4), LU (grade 1-4), RO (grade 3, 4)
3.5 hours per week	BG (grade 3-6)
3-5 hours per week	DE (varies by Laender)
4 hours/lessons per week	FR, PL
45 minutes per day	DK, HU
8 hours per week	SK
478 hours in total	NO
Secondary education	
1 hour per week	LU (year 7, 8)
2 x 30-40 minutes per week	IE
90 minutes per week	MT
1-2 times per week	HR
2 hours/lessons per week	AT, BE, CZ, EL, IT, PT, ES, UK-SCT, FR (high school), LU (year 2-6), RO (grade 7)
2-3 lessons per week	EE
135 minutes	CY (on average)
3 hours/lessons per week	RS, BG (grade 7-12), FR (college), IS (lower secondary), LU (year 1)
3-5 hours per week	DE (varies by Laender)
4 x 45 minutes per week	PL
45 minutes per day	DK, HU
10 hours per week	SK
Course of 38 weeks total	FI
223 hours in total	NO

4.3 AREA 3: Make the healthy option the easy option

4.3.1 Food reformulation/Food product improvement

Food reformulation/food product improvement is considered to be an important strategy to improve the nutrient intake that does not require the consumer to modify drastically his or her habitual dietary pattern. Initiatives on food reformulation/food product improvement primarily focus on commonly eaten processed foods that contribute to high intakes of salt, trans- and saturated fatty acids, salt and added sugar. The Council of Europe, in its Council Conclusions on Food Product Improvement of 17 June 2016, called upon the Member States to "have a national plan for food product improvement in place by the end of 2017, either as a new plan or integrated into an existing plan, in cooperation with the relevant stakeholders, to make the healthy choice easier for consumers by 2020, through an increased availability of food with lower levels of salt, saturated fats, added sugars, energy value and, where appropriate, through reduced portion sizes and to provide information on the nutritional composition of processed foods".

Food reformulation/food product improvement initiatives are becoming more common and are often voluntary agreements with industry. Initiatives on food reformulation/food product improvement for salt are most common. They are in preparation or planned in five countries (AT, CY, DE, LU, ME), while 26 countries (79%) already have initiatives ongoing (see Figure 4.10 and Map 4.5). All but one EU Member States have initiatives for salt or have them planned. The EU13 Member States are catching up; in three EU13 Member States (23%) initiatives have been implemented since 2014.

After salt, most food reformulation/food product improvement initiatives concern sugar reduction. It gets a lot of recent attention (see Figure 4.10 and Map 4.6) with initiatives since 2014 in 13 countries (39%) and in preparation or planned in another 5 countries (15%). Initiatives were already ongoing before 2014 in 12 countries (36%). All EU13 and all but one EU15 Member States have initiatives ongoing or planned.

In fewer countries food reformulation/food product improvement initiatives include activities on the reduction of saturated fat and calories/portion sizes (see Figure 4.10, Map 4.7 and Map 4.8). In almost half of the countries (48%) there are initiatives or agreements to reduce the level of saturated fat in foods and in 55% there are initiatives to reduce calories or portion sizes. The number of countries where initiatives are still in the planning phase is higher than for sugar (eight countries for saturated fat (24%) and 5 countries for calories/portion sizes (15%)). Also a larger number of countries have no initiatives ongoing or planned (27% and 30% respectively). In EU13 Member States initiatives on calories are less often included in the agreements, but this may be achieved indirectly through the reduction of sugar and fat.

Several countries mentioned that they use the Keyhole logo (front-of-pack labelling) as strategy for food reformulation/food product improvement (DK, FI, IS, LT). A product has to meet several nutrient criteria for the level of salt and sugar, saturated fat, and fibre. This indirectly influences reformulation because it is attractive to get a label on a product. Sweden also has the Keyhole logo, but it is not considered as a reformulation strategy. For consistency reasons, however, we used similar colour coding for Sweden as for the other countries. In addition to this indirect strategy, Denmark has a partnership with different stakeholders on salt since 2015, while Finland has additional initiatives on all nutrients since 2017. The competent authority of Hungary mentioned that the public health product tax (see 4.3.3) also facilitates food reformulation/food product improvement, as the industry improves products, to avoid tax. This seems to be successful for sugar and salt. Manufacturers made up for the loss in sweet taste in soft drinks with artificial sweeteners.

Fifteen countries (45%), reported to monitor the level of food reformulation/food product improvement in their country (BE, DK, FR, HU, IT, LV, LT, NL, ES, UK, DE (for trans fats only), HR and IE (for salt only), and RO and CH (sugar)). Five of them (HR, IT, LV, LT, CH) started with monitoring after the introduction of the Action Plan. Another four countries (12%) are planning for a monitoring system (EE, FI, EL, NO). When looking at EU Member States only, fourteen (50%) reported to monitor food reformulation/food product improvement and three are planning to do so (11%).

4.3.2 Specific measures to limit industrially derived trans fatty acids

According to the GNPR2 survey from WHO Regional Office for Europe and additional information from the interviews, 11 countries (33%) have specific measures to ban or (virtually) eliminate trans fatty acids. Among EU Member States the percentage is 29%. This often concerns legislation on the maximum level of industrially derived trans fatty acids in foods. In 10 other countries (30%, 36% of the EU Member States) there are voluntary agreements with industry to reduce the level of trans fatty acids in foods (see Figure 4.11 and Map 4.9). In Romania and Slovenia legislation is in preparation, while Croatia and Malta are working on voluntary agreements. Also on this topic EU13 Member States are planning to catch up on EU15 Member States.

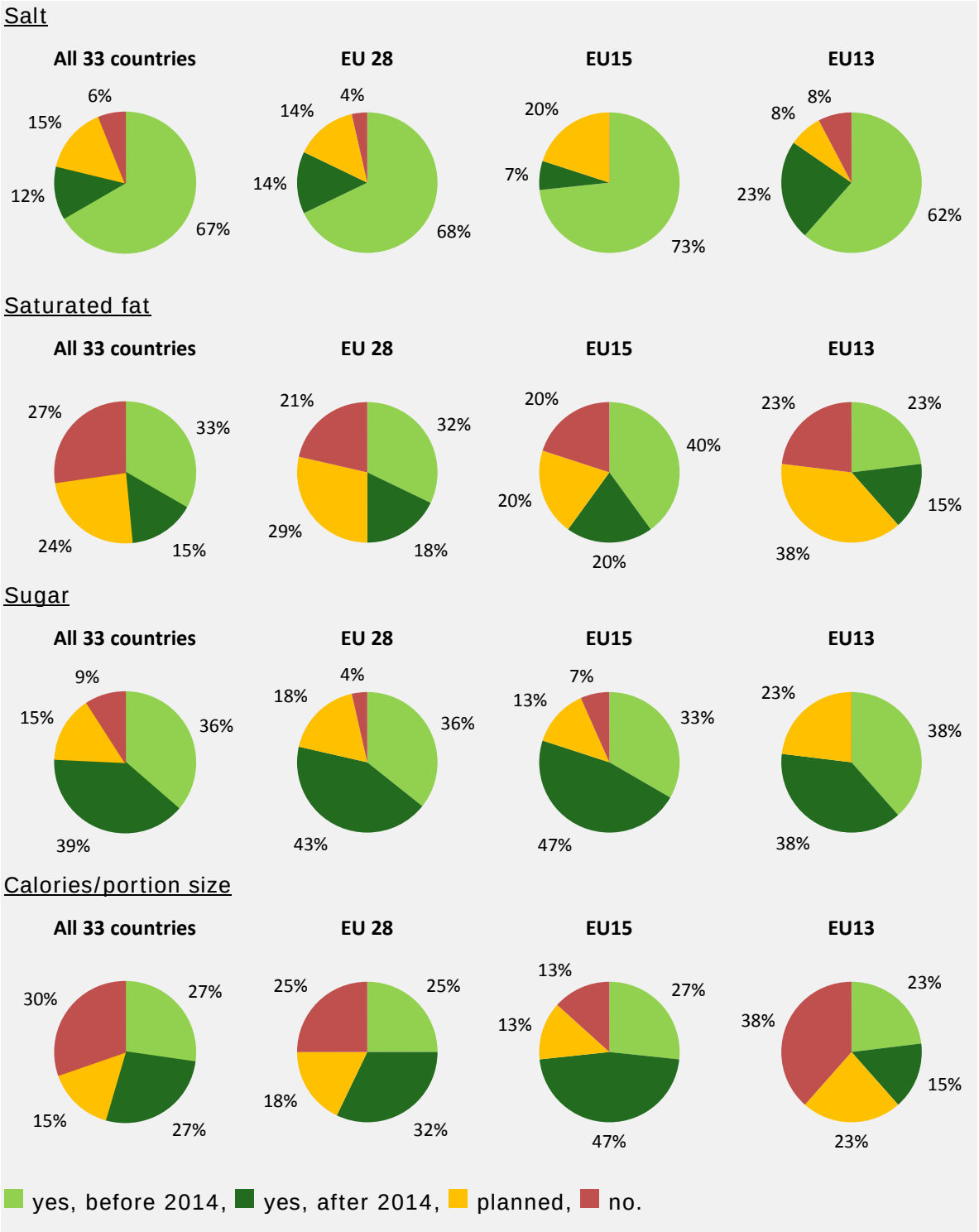
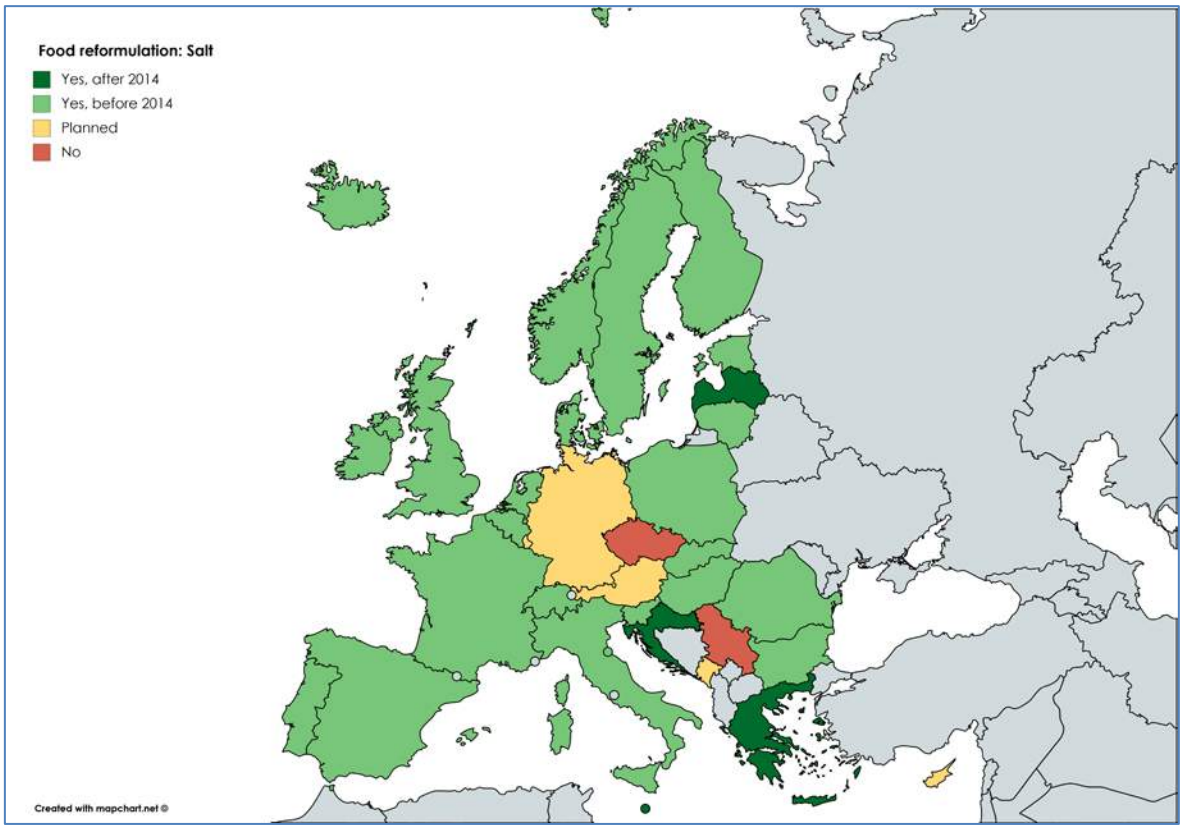
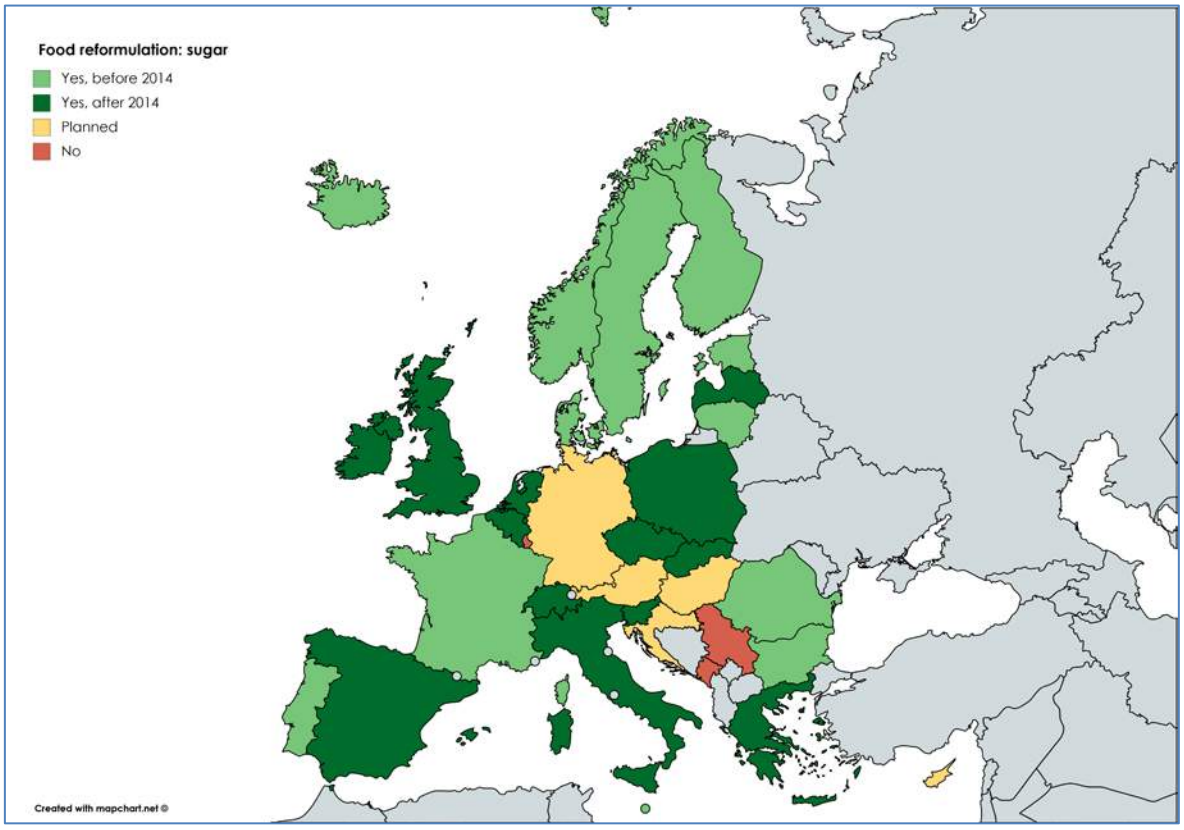


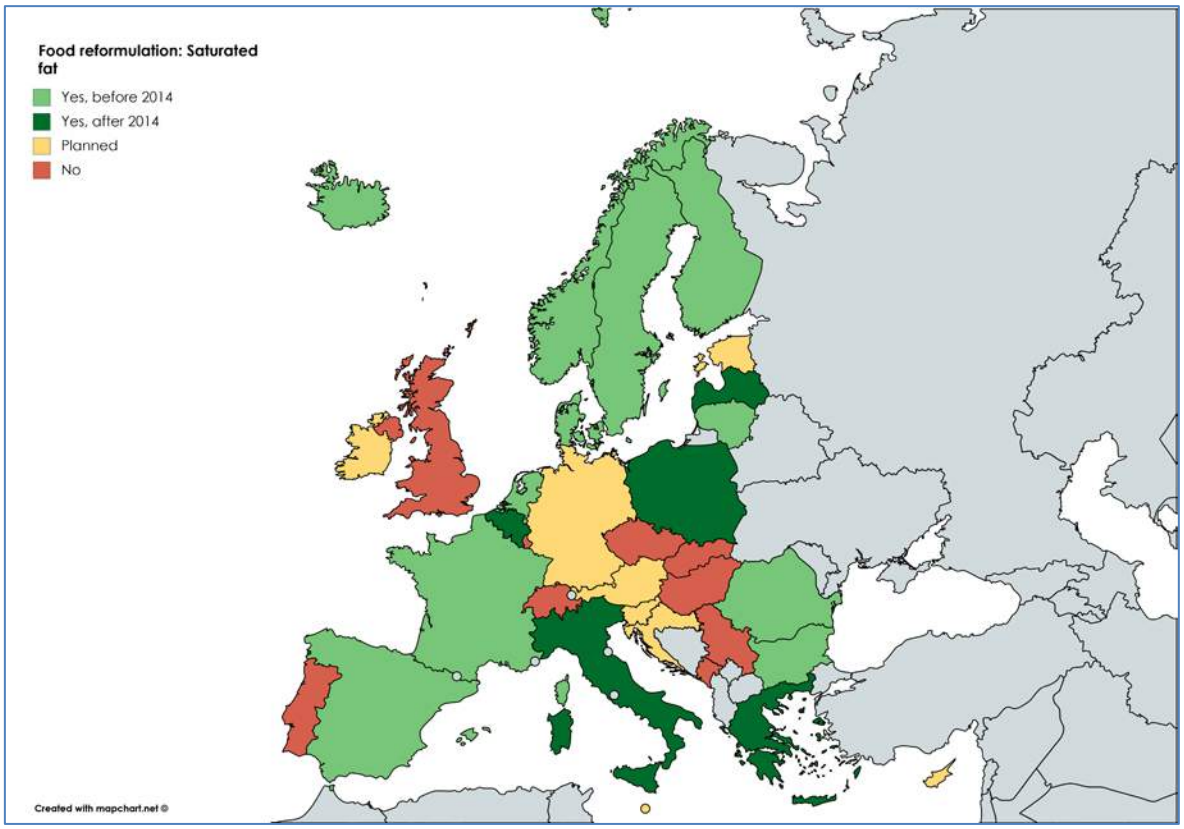
Figure 4.10. *Activities on food reformulation/food product improvement. EU13: Member States that joined the EU in/after 2004.*



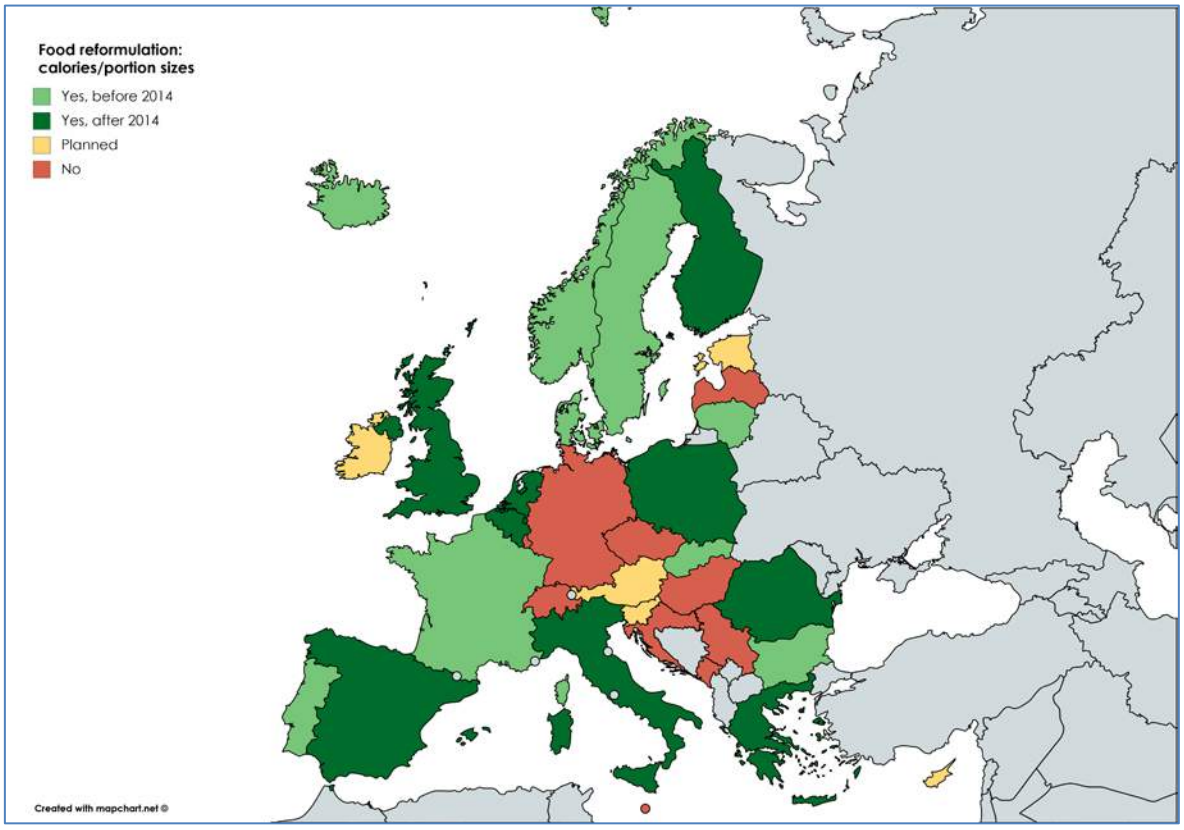
Map 4.5. *Food reformulation/food product improvement initiatives for salt in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*



Map 4.6. *Food reformulation/food product improvement initiatives for sugar in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*



Map 4.7. *Food reformulation/food product improvement initiatives for saturated fat in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*



Map 4.8. *Food reformulation/food product improvement initiatives for calories/ portion sizes in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

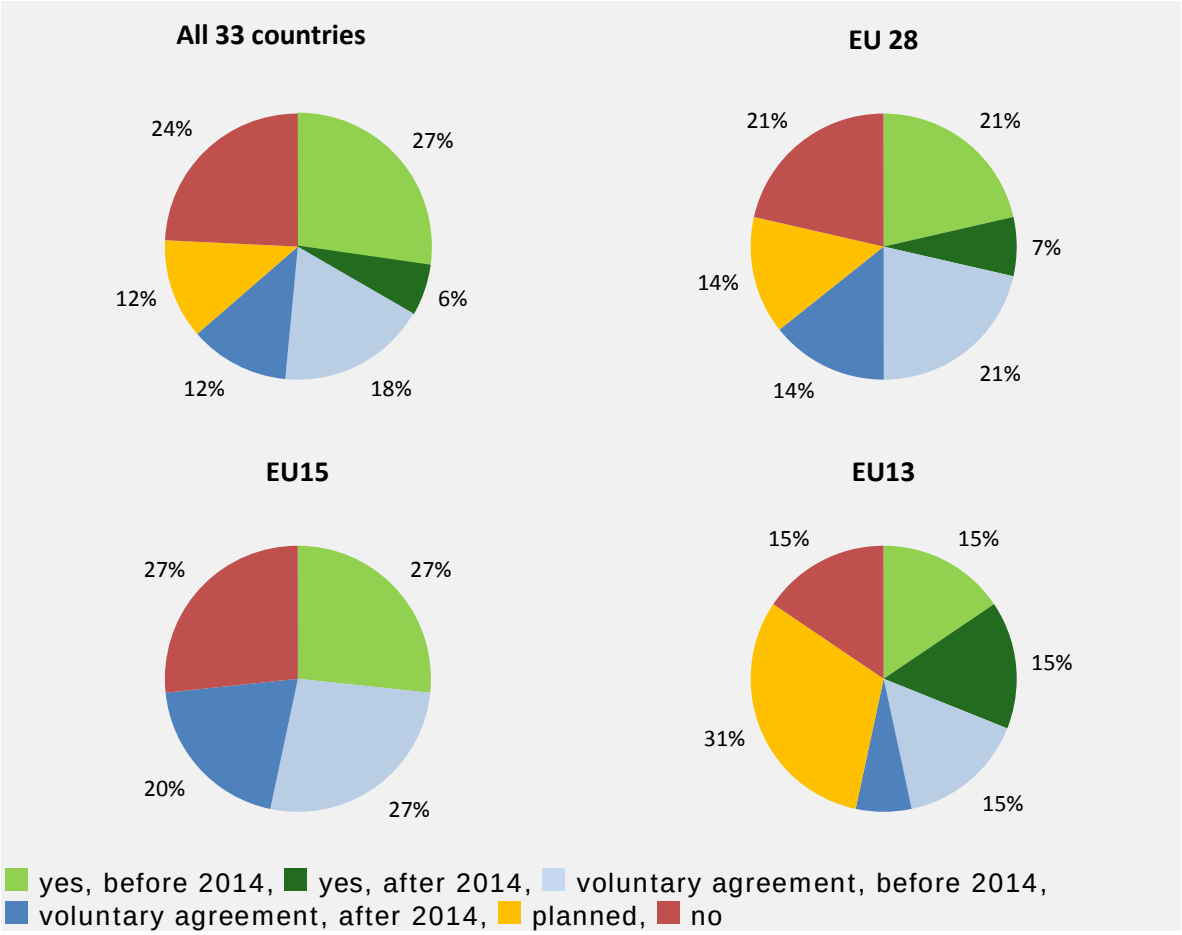
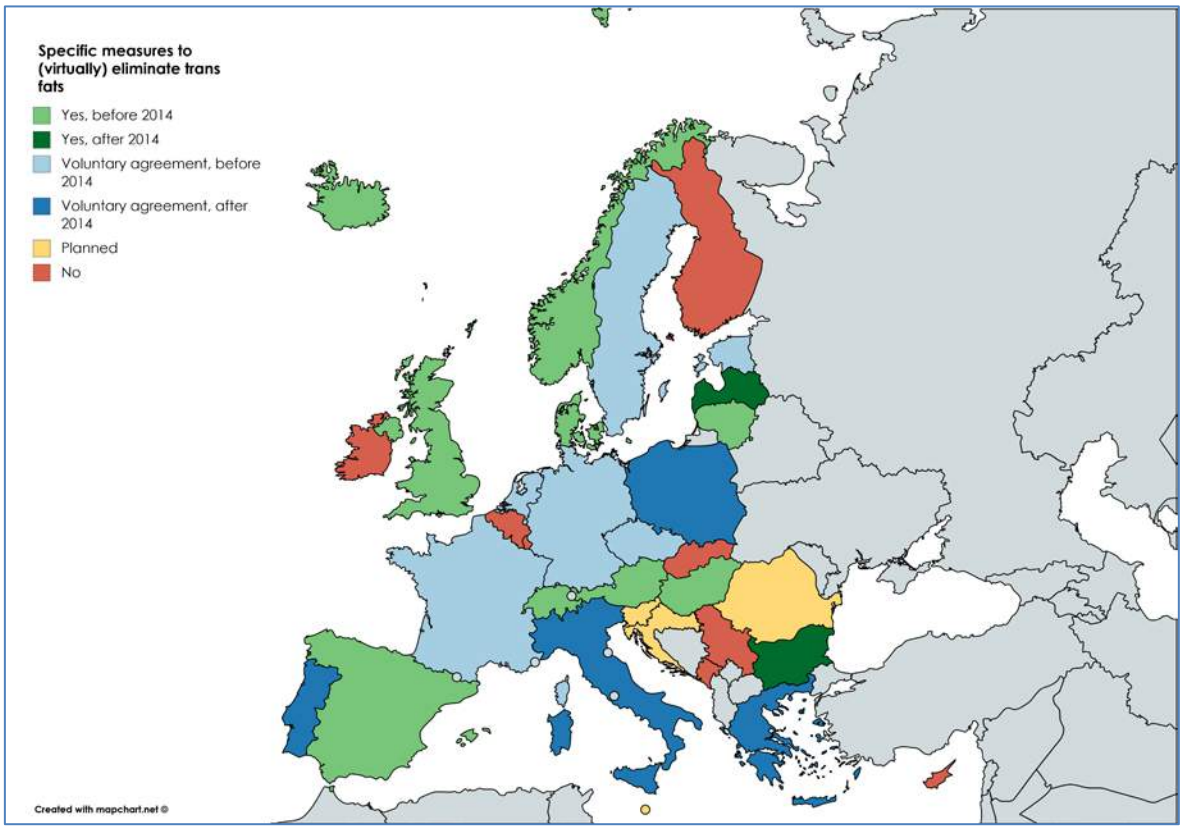


Figure 4.11. *Specific measures to ban or (virtually) eliminate trans fatty acids from foods. EU13: Member States that joined the EU in/after 2004.*



Map 4.9. *Specific measures to ban or (virtually) eliminate trans fatty acids in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

4.3.3 Easy to understand labelling

Easy to understand labelling, such as front-of pack logo's, can facilitate consumer understanding of the nutritional content of foods, and could help them make healthier food choices (43). Moreover, front-of-pack labelling can provide incentives to the food industry to reformulate their products to improve nutritional quality.

Eleven countries (33%; 9 EU Member States (32%)) use voluntary easy to understand labelling to help consumers make healthier food choices (DK, FI, FR, IS, IE, LT, NL, NO, SI, SE, UK). Several countries use positive endorsement logos. Such logos tell consumers which products within a food group are better choices with respect to the level of certain nutrients, such as fat, saturated fatty acids, sodium and sugar. Choosing foods with a logo can make it easier to find healthier products in food stores. The Keyhole is used in Denmark, Iceland, Lithuania, Norway and Sweden. Foods labelled with the Keyhole symbol contain less fat, sugars and salt and more dietary fibre than food products of the same type not carrying the symbol. The Finnish Heart Association and the Finnish Diabetic Association launched the Heart Symbol in 2000. It shows which products within a food group are better choices regarding fat, saturated fatty acids, and sodium content. In some product groups, also added sugar and fibre contents are taken into account. The Dutch Healthy Choices logo has been abandoned in 2017. From October 2018 products with the logo can no longer be produced. However, products with the logo can be sold until their expiration date.

Since October 2017, a front-of-pack labelling system named Nutri-Score is being implemented in France after comparison tests against several other labels. It classifies foods and beverages according to five categories of nutritional quality, indicated via a colour scale and letters ranging from green (grade A) to red (grade E).

In Slovenia the 'Protect Health' logo is granted by the Slovenian Heart Foundation to pre-packaged manufactured foods, which meet specified criteria, since 1995.

In the UK and Ireland, multiple traffic light systems are used, that score foods on individual nutrient content. This means that a product can get a green score for one nutrient and a red score for another. Such schemes also communicate information on the levels of nutrients in a product, related to reference intakes.

As part of the national programme Healthy Living Croatia is planning to introduce labelling according to nutrient criteria. Analyses of products is planned and based upon the results products will receive a label or not. This goal is expected to be achieved in 5 to 6 years.

4.3.4 Taxation policies

Fiscal measures, such as taxes or subsidies, are increasingly considered to be an important measure to limit consumption of unhealthy foods and increase the consumption of healthy foods (44). Such strategies are based on the economic theory that an increase in price will result in a decrease in quantity sold and thereby leads to healthier consumption patterns. Evidence suggests that taxation of sugar-sweetened beverages and subsidies on fruit and vegetables are the most effective pricing strategies (45). Furthermore, taxation policies may stimulate food reformulation/food product improvement, as recently observed in the UK[13].

Nine countries (27%) use taxation policies. Three other countries are planning to do so (EE, IE, LU, see Figure 4.12 and Map 4.10). All but one are EU Member States, so 11 EU Member States (39%) have introduced or planned taxation policies as one of the measures that may contribute to limiting the consumption of foods that do not meet certain nutrition criteria. Most often it concerns a levy on sugar (NO) or sugar sweetened beverages (BE, EE, FI, FR, IE, LU, NO, PT, UK). In France the tax additionally affects artificially-sweetened beverages. In Latvia excess tax is levied on non-alcoholic beverages, except on water and 100% juice, while in Malta it concerns non-alcoholic beverages, except milk and water. Next to the taxation of sugar-sweetened beverages, Portugal is planning an excess tax on salty snacks. The Hungarian Public Health Product Tax is aimed at products for which healthier options are available. The categories of goods impacted by the tax are sugar-sweetened beverages, energy drinks, confectionery, salted snacks, condiments, flavoured alcohol and fruit jams. The revenue generated from the tax is hypothecated for the health care budget and is currently used to supplement the salaries of health care professionals. Also in England (UK) the revenue from the levy is dedicated to a specific aim. It will be invested in programmes to reduce obesity and encourage physical activity and balanced diets for school age children.

In Estonia a law proposing an excess tax on sugar-sweetened beverages was adopted by the Parliament in June 2017. The president did not promulgate the law and sent it back to Parliament. The government decided to postpone implementation and improve the law. Denmark had a tax on soft drinks in place for 80 years and introduced a wide-ranging tax on saturated fat in 2011. Both were abandoned. While the tax on saturated fat was introduced with public health arguments, it was repealed for suggested economic reasons, such as cross-border shopping, job losses and negative profit impacts for producers (46). The tax has been associated with a 4% reduction in saturated fat intake (47). Since 2011, Finland had a levy on sweets, such as candy, chocolate, and ice cream. The Finnish Financial Parliamentary Committee decided to end the levy on sweets in 2015 because of the ongoing legal proceedings in the EU. The new decision took effect on January 1, 2017. Since then all beverages are taxed, and the amount of the tax is based on the sugar content of the product.

Hungary introduced lowered VAT rates for some specific food products (fresh milk, poultry meat, and eggs) in 2017 and 2018 (fish) as subsidy. Since 1 January 2018 there are also subsidies on several products in Latvia. Latvia applies 5% VAT instead of the general 22% to typical Latvian fruits, berries and vegetables.

The VAT rates on fruit and vegetables are presented in Figure 4.13. Three countries have a zero-vat rate (IE, MT, UK). For the other countries VAT-rates on fruit and vegetables range from 2.5% (CH) to 27% (HU). In the Netherlands the government has plans to raise the VAT-rate from the current 6% to 9%.

[13] https://www.theguardian.com/society/2017/mar/08/sugar-tax-will-raise-less-money-than-expected

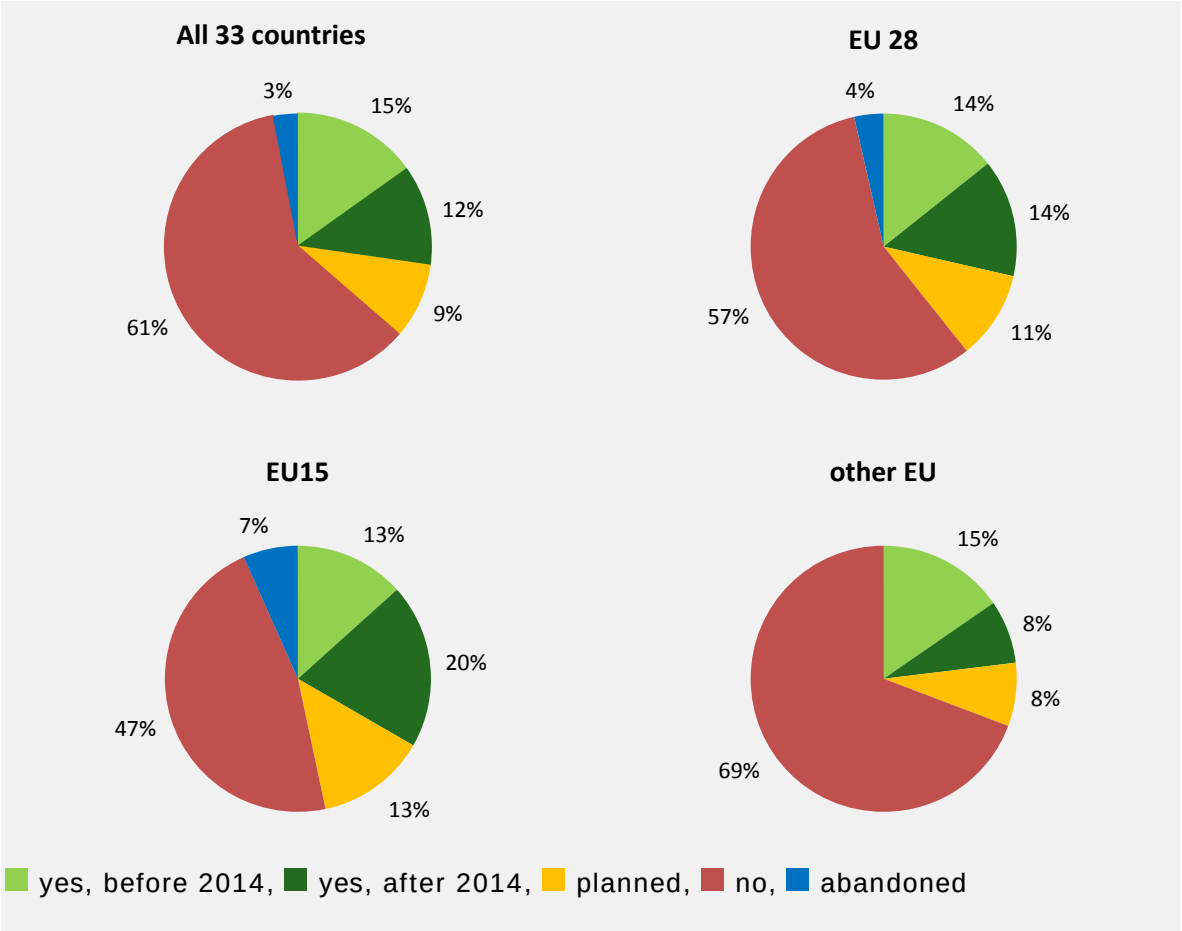
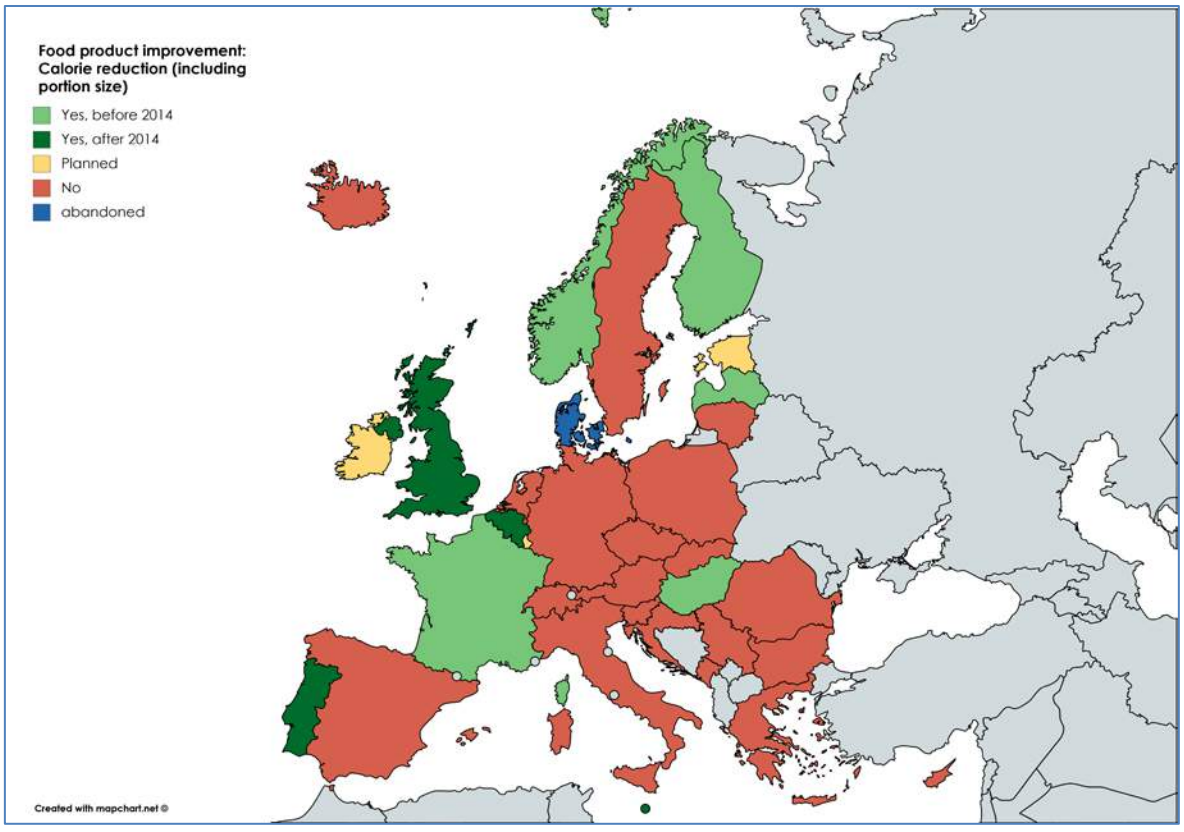


Figure 4.12. *Taxation policies. EU13: Member States that joined the EU in/after 2004.*



Map 4.10. *Taxation policies in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

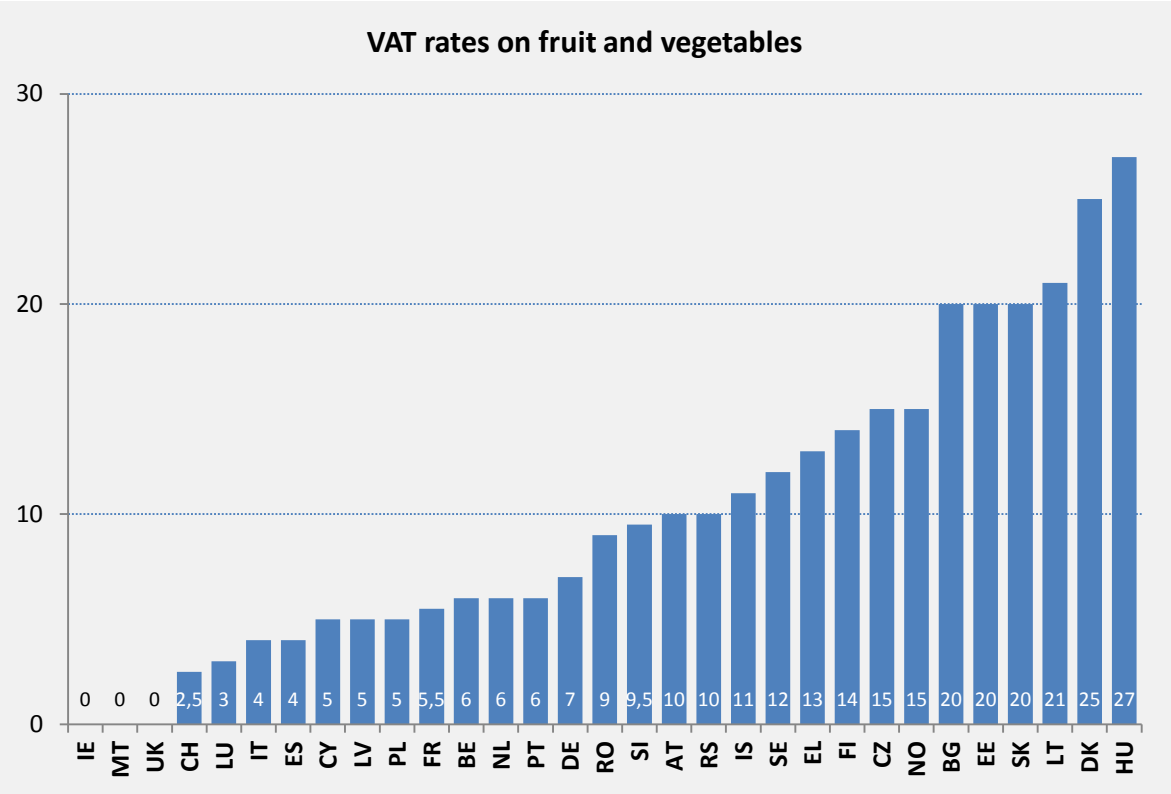


Figure 4.13. *VAT rates on fruit and vegetables. No data for HR and ME.*

4.4 AREA 4: Restrict marketing and advertising

In order to tackle overweight and obesity in children and young people, it is necessary to address the issue of marketing of foods and beverages that are high in salt, sugars or fat or that otherwise do not fit national or international nutritional guidelines (HFSS foods) targeting those age groups (48). In Europe, the Audiovisual Media Services Directive for the marketing of food and beverages to children has been active since 2010. This Directive addresses the advertising of unhealthy food and beverages in children's programmes. It sets out a goal that all EU Member States must achieve, but it is up to the individual countries to decide how to do this. A new legislative proposal amending the Audiovisual Media Services Directive has been adopted by the European Commission on 25 May 2016. The directive is currently open for review in the trilogue between the Commission, the European Parliament and the European Council. Several countries mentioned that they will take a further position on this topic or that probably new self-regulatory codes will be implemented after the conclusions of the discussion on the EU's Audiovisual Media Services Directive are known (MT, HR, FI, SE).

According to the interviews and the Ex-post REFIT evaluation of the Audiovisual Media Services Directive 2010/13/EU[14], in all but three of the 33 countries included in this study initiatives are undertaken or planned to reduce marketing of HFSS foods to children (see Figure 4.14 and Map 4.11). In nine countries by law there are specific restrictions on marketing and advertising to children (FR, DE, HU, IS, IE, LT, PL, SE, UK). For example, marketing is not allowed at children's channels or in and around children's programmes. At least in Hungary, Ireland and Poland these regulations are combined with voluntary commitments or self-regulatory agreements. In nine countries (AT, CY, EE, EL, IT, LV, MT, SI, ES) statutory instruments require or recommend the development of codes of conduct, and they are available in most of them (except in CY and MT). According to the Ex-post REFIT evaluation Cyprus has drafted a code of conduct, but it is unclear whether it is implemented. The Healthy Lifestyle Act in Malta enables further regulation of marketing of products which may have adverse effects on healthy lifestyles. In Slovenia and Spain the codes of conduct must be in line with guidelines developed by government. In another 10 countries (BE, BG, CZ, DK, NL, NO, PT, RO, SK, CH) there are self-regulatory agreements or codes of conduct. In Romania the EU Pledge has been adopted, a voluntary initiative by leading food and beverage companies to change food and beverage advertising to children under the age of 12 in the European Union (www.eu-pledge.eu). Several other countries have pledges that are derived from it, such as the Belgian Pledge, the Swiss Pledge and the Portuguese Pledge. The Finnish Food and Drink Federation issued recommendations for marketing to children. Initiatives are planned in Croatia and Montenegro.

Another objective with respect to marketing to children mentioned in the Action Plan (18) is to define nutrition criteria to use in a framework for marketing of foods to children. According to the interview information and the consulted experts, 15 countries (45%), of which 13 are EU Member States use nutrient profiles or criteria to reduce marketing to children (Figure 4.15 and Map 4.12). For six of them this was after the introduction of the Action Plan. Slovenia has adopted the criteria set by WHO. Two countries are currently working on this topic (EE, ME), meaning that 48% of the countries (and 50% of the EU Member States) do not have nutrient criteria to reduce marketing to children. The percentage of countries with nutrient criteria to reduce marketing to children is comparable between EU15 Member States and EU13 Member States. The EU13 Member States have caught up since 2014.

[14] https://ec.europa.eu/digital-single-market/en/news/ex-post-refit-evaluation-audiovisual-media-services-directive-201013eu

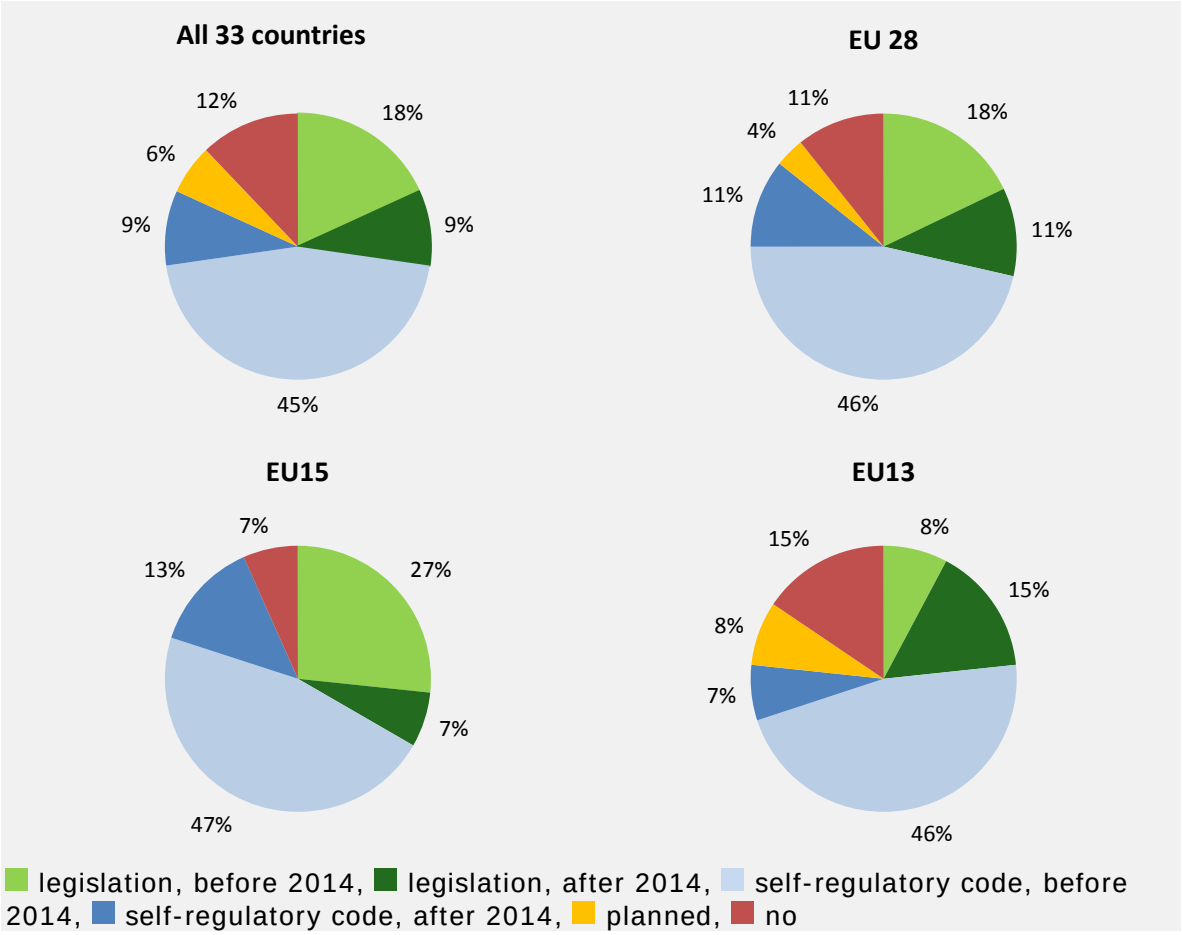
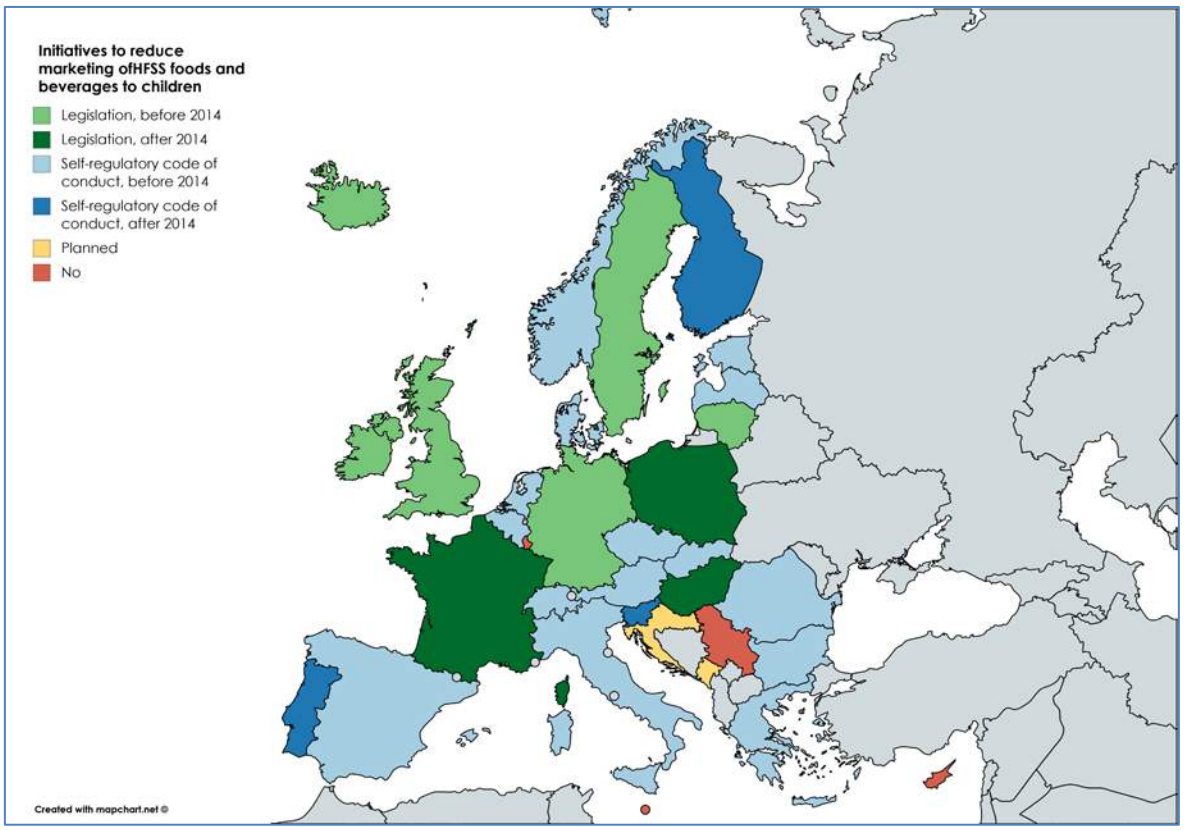


Figure 4.14. *Initiatives to reduce marketing and advertising to children. EU13: Member States that joined the EU in/after 2004.*



Map 4.11. *Initiatives to reduce marketing of HFSS foods and beverages to children in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

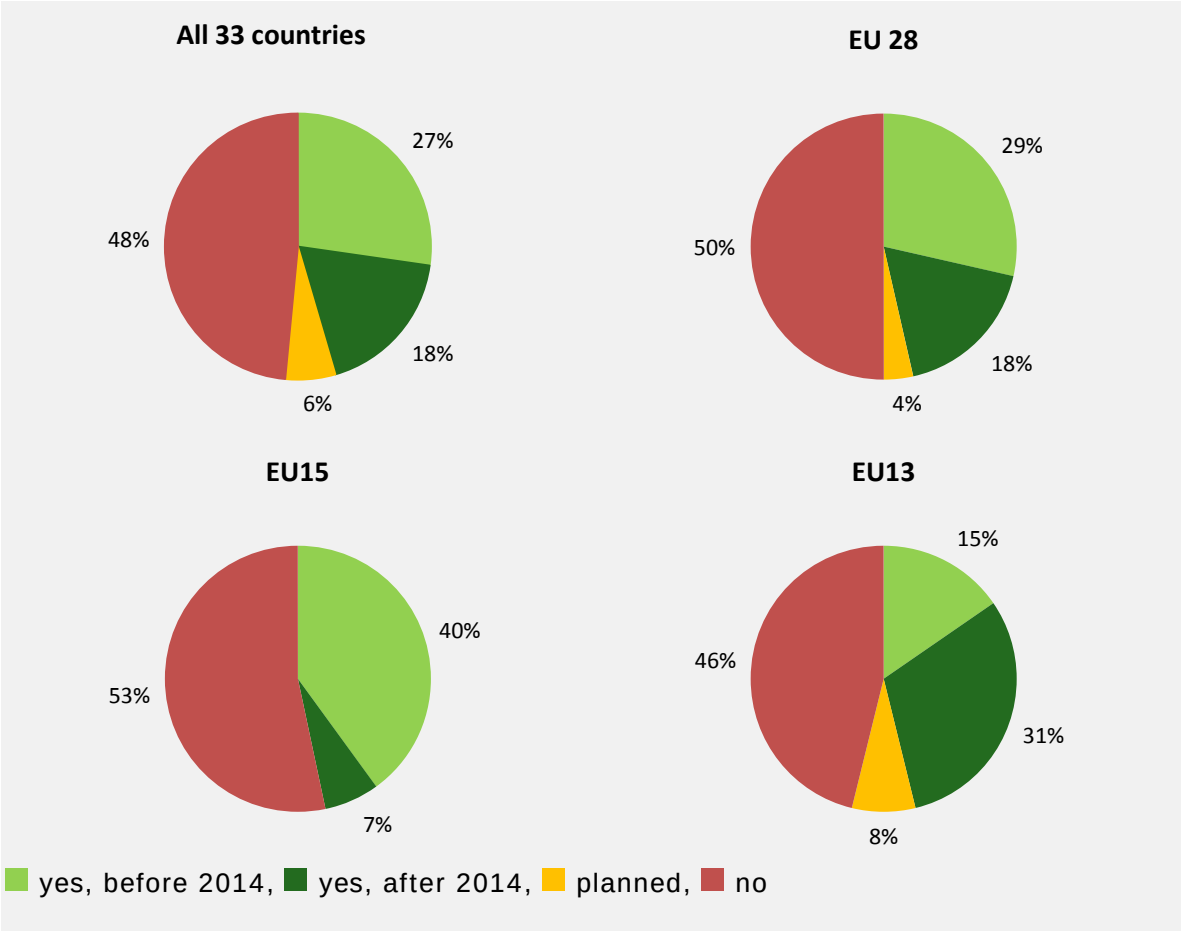
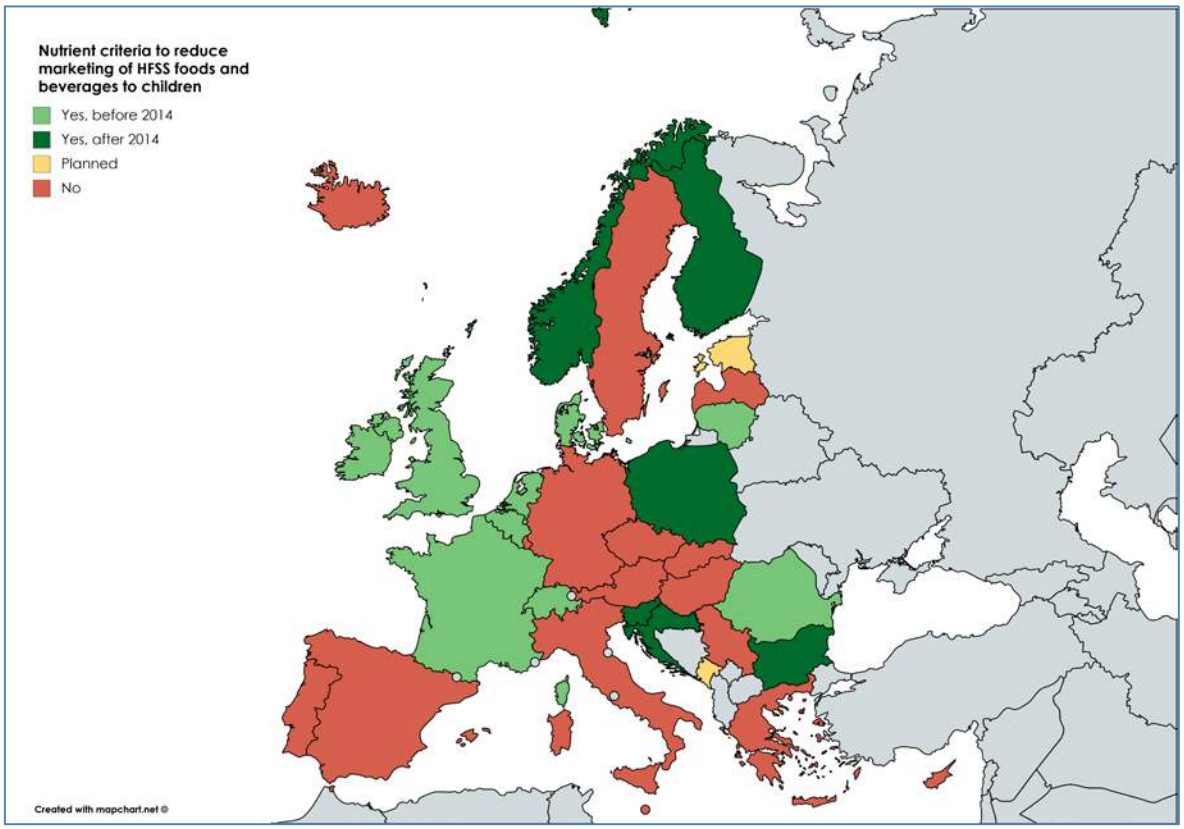


Figure 4.15. *Nutrient profiles to reduce marketing for HFSS foods and beverages to children. EU13: Member States that joined the EU in/after 2004.*



Map 4.12. *Use of nutrient criteria to reduce marketing of HFSS foods to children in 28 EU Member States, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

4.5 AREA 5: Inform and empower families

Parents are the primary individuals responsible for children's and young people's health and development. They play an influential role in the formation of eating and activity habits. Furthermore, tools or initiatives that can help parents and carers to recognise when their child may be becoming overweight or obese and that can guide their response can prove useful in the prevention of further weight gain of their child.

Food-based dietary guidelines

Food-based dietary guidelines provide advice on foods, food groups and dietary patterns to the general public in order to promote overall health and prevent chronic diseases. Thirty-one countries (94%) have food-based dietary guidelines (Figure 4.16 and Map 4.13) and Serbia is planning for them. All EU Member States have food-based dietary guidelines. Nine countries published updated guidelines after 2014 (FI, IE, IS, MT, NL, NO, SI, SE, UK). At least 15 of them have specific recommendations for children (AT, BE, HR, CY, EE, FI, HU, FR, LV, NO, PL, PT, ES, SE, CH). The guidelines of three countries (BG, EL, MT) are aimed at the adult population only, but Malta will be launching the "Dietary Guidelines for Maltese Children – The Mediterranean Way: 3 – 12 years" in 2018.

National campaigns

National campaigns are tools to inform individuals about nutrition and physical activity. Of the 33 countries that provided information in the interview or on paper, 23 (70%; 20 EU Member States (71%) have some form of campaign running and one is planning campaigns (SI) (see Figure 4.17). Nine countries (BE, CY, CZ, EL, ME, NL, PL, SE, CH) reported currently not having national campaigns running. However, some of them had national campaigns in the past (BE, CY, CZ, NL, SE). There is no clear geographical pattern to be seen.

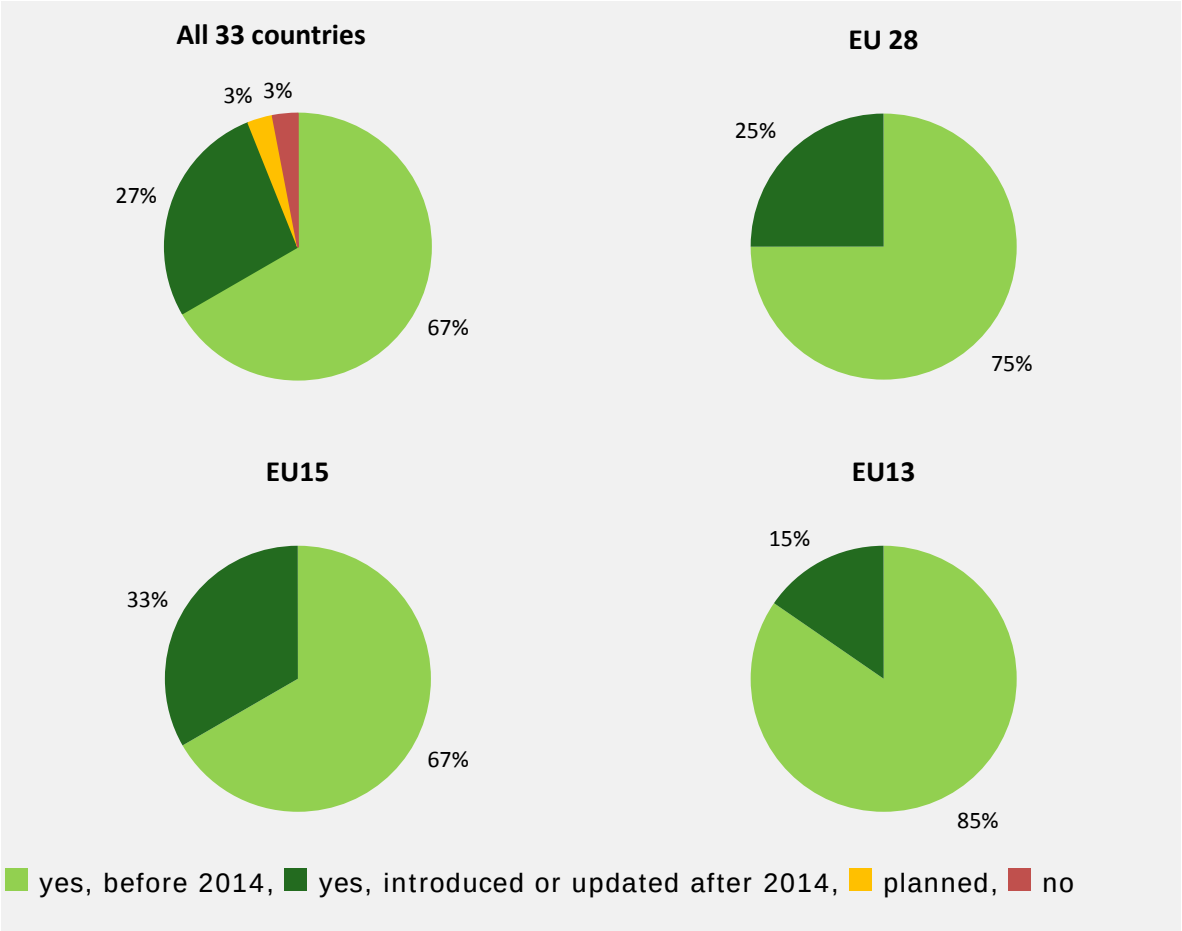
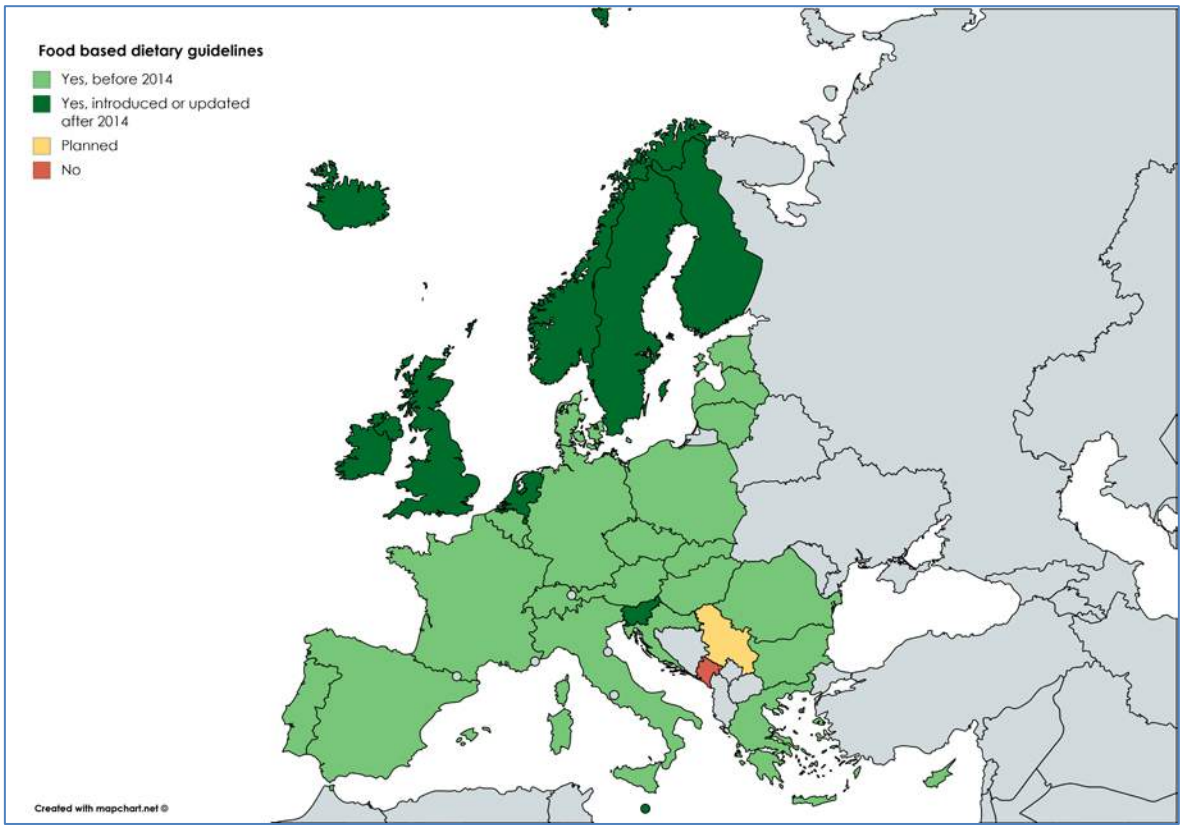


Figure 4.16. *Availability of food based dietary guidelines. EU13: Member States that joined the EU in/after 2004.*



Map 4.13. *Availability of food based dietary guidelines in 28 EU Member States plus Montenegro, Iceland, Norway, Serbia and Switzerland.*

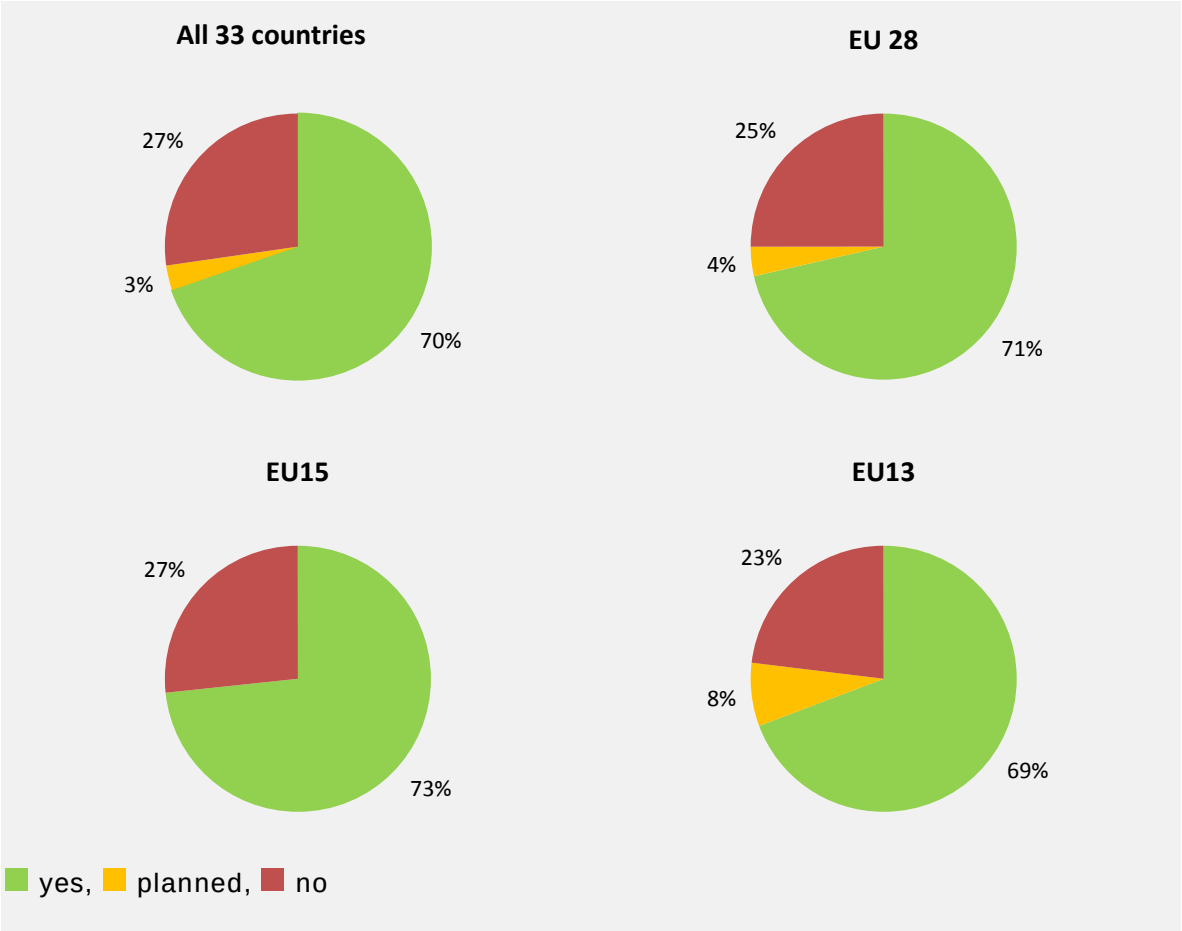


Figure 4.17. *National campaigns. EU13: Member States that joined the EU in/after 2004.*

Community-based interventions according to the EPODE-methodology

In 2003, the EPODE model was designed as a coordinated, capacity-building approach to help communities change the local environment, behaviours and social norms to encourage healthy lifestyles. EPODE enables community stakeholders to implement effective and sustainable strategies to prevent childhood obesity and non-communicable diseases at the local level. It's community approach step by step changes the micro and macro environment, behaviours and social norms using social marketing, scientific evaluation, ensuring political support and the involvement of all sectors, particularly the public and private sectors.

The EPODE International Network was launched in 2008 to facilitate the implementation of community-based interventions that use the EPODE methodology in European countries, regions and cities. For a programme to be classified as a community-based programme, the programme must be securely embedded in the community and should benefit from local political and private support. Furthermore, it should mobilise multiple stakeholders within the community and must adhere to all four pillars of the EPODE methodology:

- Scientific and multidisciplinary evaluation
- Strong political commitment
- Support services and communication inspired from social marketing techniques
- Mobilization of resources including Public-Private Partnerships

Healthy Active Initiatives are specific interventions that take place within a school, community or family and aim to improve health by promoting an active healthy lifestyle. Initiatives should encompass both nutritional and physical activity aspects of healthy living. Support from families as well as from local politicians is essential.

In 10 countries (AT, BE, HR, FR, EL, HU, IT, NL, PL, RO) community-based programmes are implemented, either at a small or at a larger scale. In seven countries, Healthy Active Initiatives are implemented (BG, IE, PT, RO, SK, ES, UK). Community-based interventions and Healthy Active Initiatives activities are somewhat more prevalent in EU15 Member States than in the other Member States. (see Figure 4.18 and Map 4.14).

Community-based interventions according to the EPODE-methodology, Healthy Active Initiatives and other interventions to prevent overweight, promote physical activity and/or healthy nutrition often fall under the responsibility of subnational authorities, such as municipalities or regions. Eighteen countries mentioned to support such community-based interventions in several ways, for example by providing funding, while Serbia has plans to do so (see Figure 4.19 and Map 4.15).

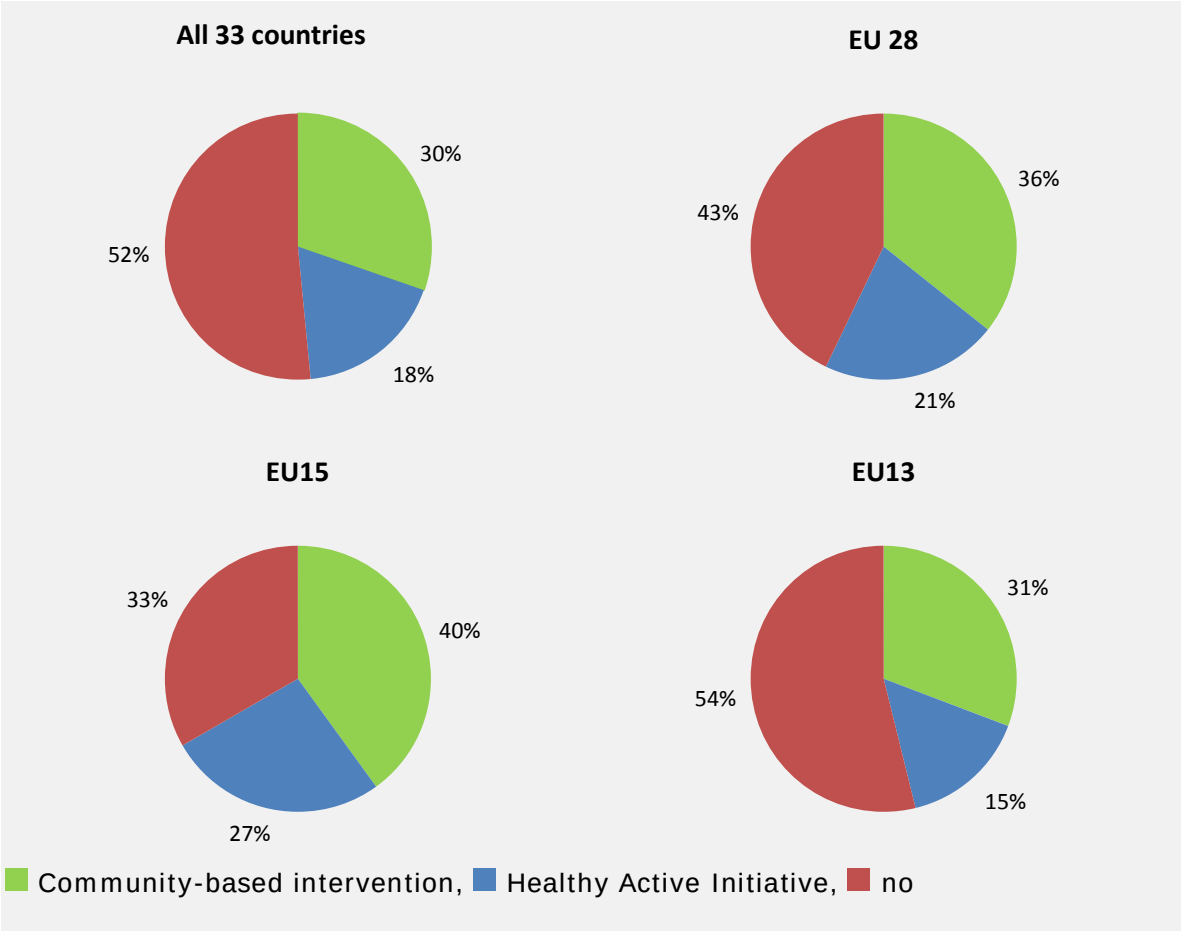
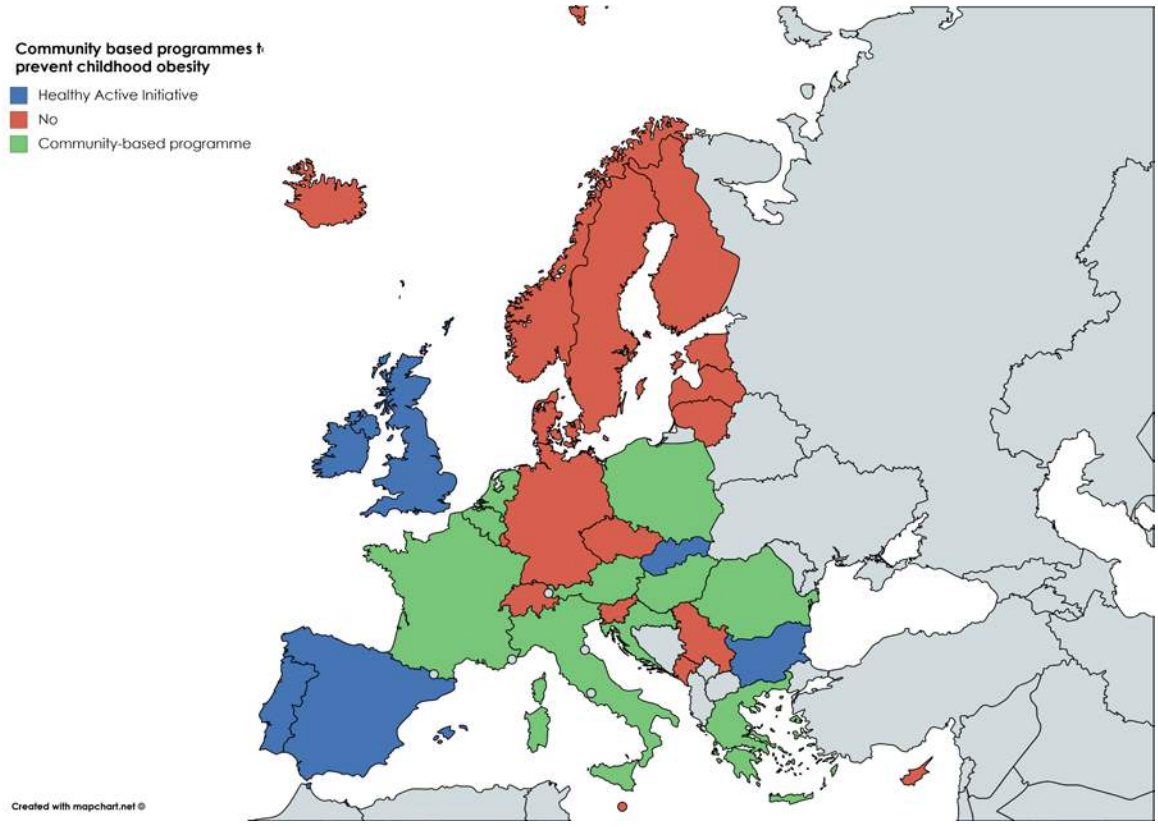


Figure 4.18. *Community-based programmes according to the EPODE-methodology. EU13: Member States that joined the EU in/after 2004.*



Map 4.14. *Community-based interventions according to the EPODE-methodology in 28 EU Member States Montenegro, Norway, Iceland, Serbia, and Switzerland.*

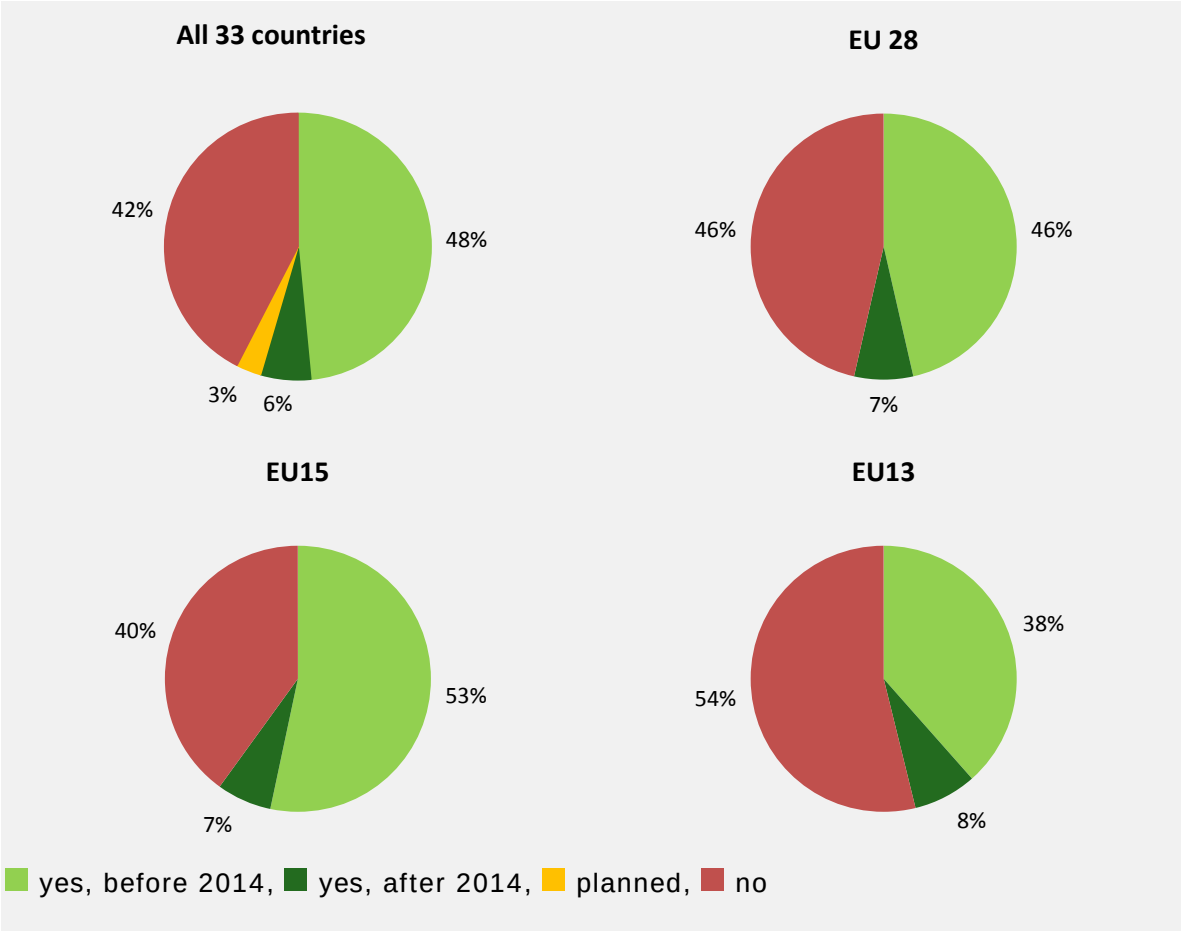
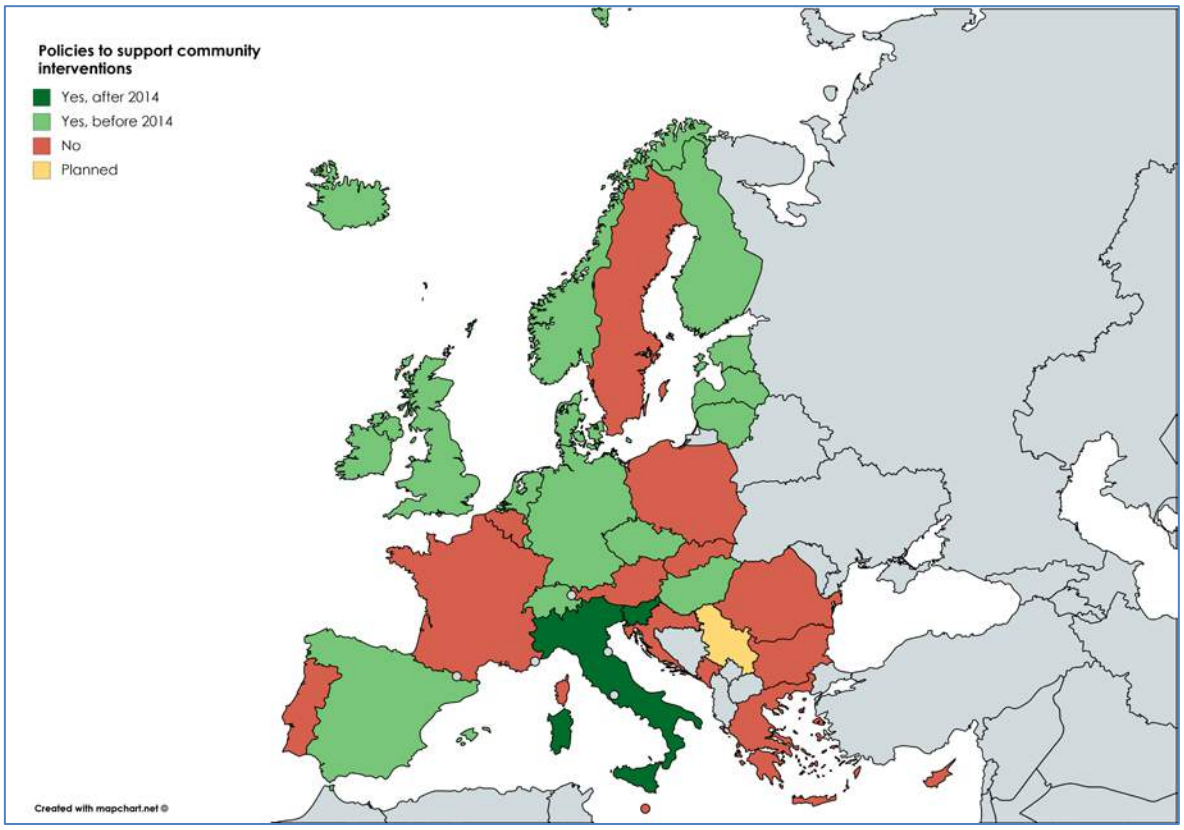


Figure 4.19. *Supporting community based interventions. EU13: Member States that joined the EU in/after 2004.*



Map 4.15. *Policies to support community based interventions in 28 EU Member States Montenegro, Norway, Iceland, Serbia, and Switzerland.*

Screening for overweight and obesity in children

Screening for overweight and obesity is in place in 18 countries (55%) often implemented in systems of school health care, child health care or primary care (see Figure 4.20 and Map 4.16). Among these countries are 15 EU Member States, so in 54% of them screening activities are carried out. When countries mentioned in the interview that general practitioners are expected to take action if a child is overweight or obese, but that there are no regular health checks in primary care, we concluded that no screening programmes are offered. Malta is investigating whether they can use a monitoring study in all schools as a way to identify obese children and offer them help. A pilot for this was expected in 2017, after which the programme can be rolled out in 2018. Also in Estonia there are plans for screening for overweight and obesity in children.

Management services for overweight and obese children

Management services, such as interventions and weight loss programmes, are offered to children who are overweight or obese in many countries, usually embedded in the health care setting (Figure 4.21). In some countries, for example Ireland and Slovenia, there are national programmes. Several countries, such as the Netherlands, Finland and the United Kingdom have national clinical guidelines for the treatment of childhood obesity. In Malta weight management courses are available for adults. In 2017, a training course focusing on childhood obesity was organised for general practitioners and health professions in collaboration with EASO. Furthermore there is a small scientific working group to identify and pilot successful weight loss programmes for children that may be implemented at a larger scale. The competent authorities of five countries reported that there are no management services in their county (LT, PL, RO, SE).

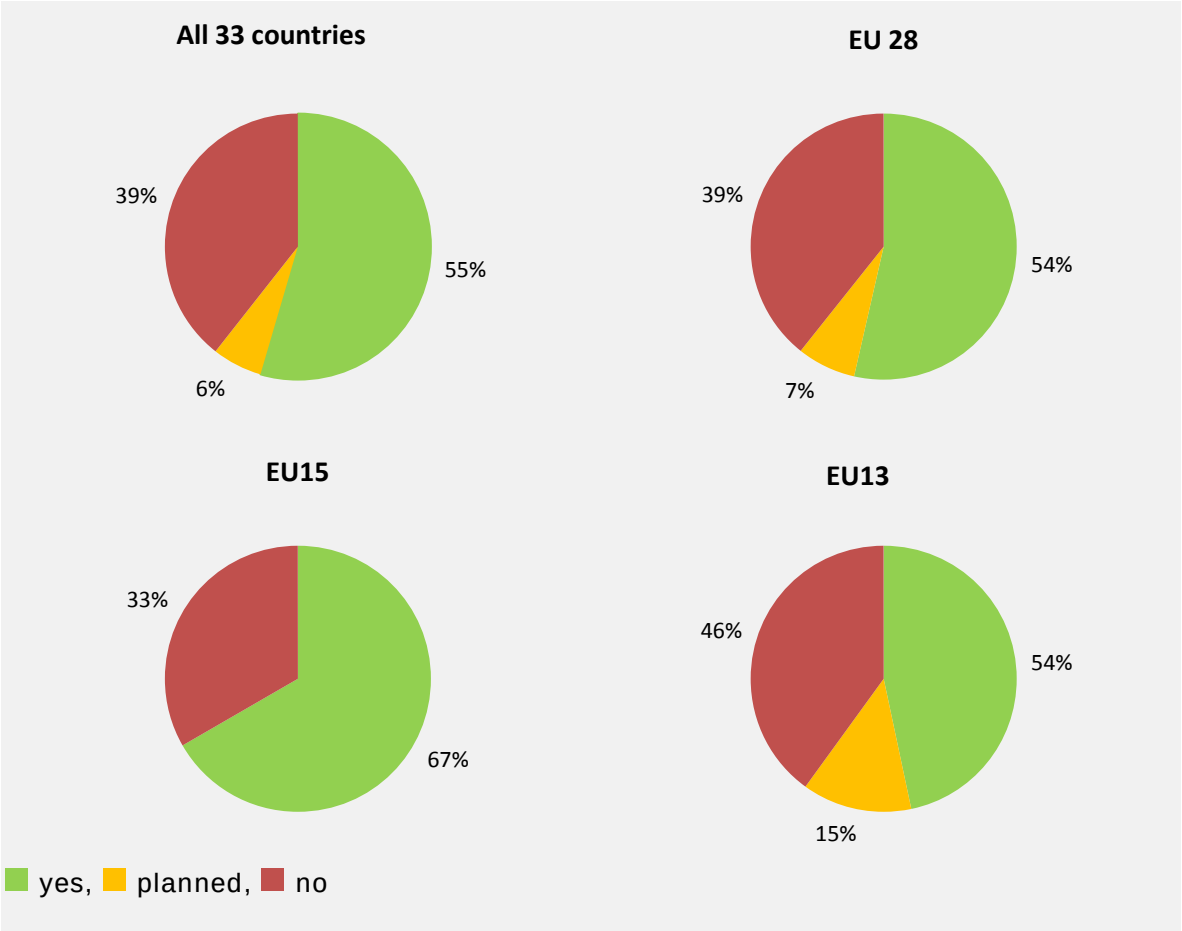
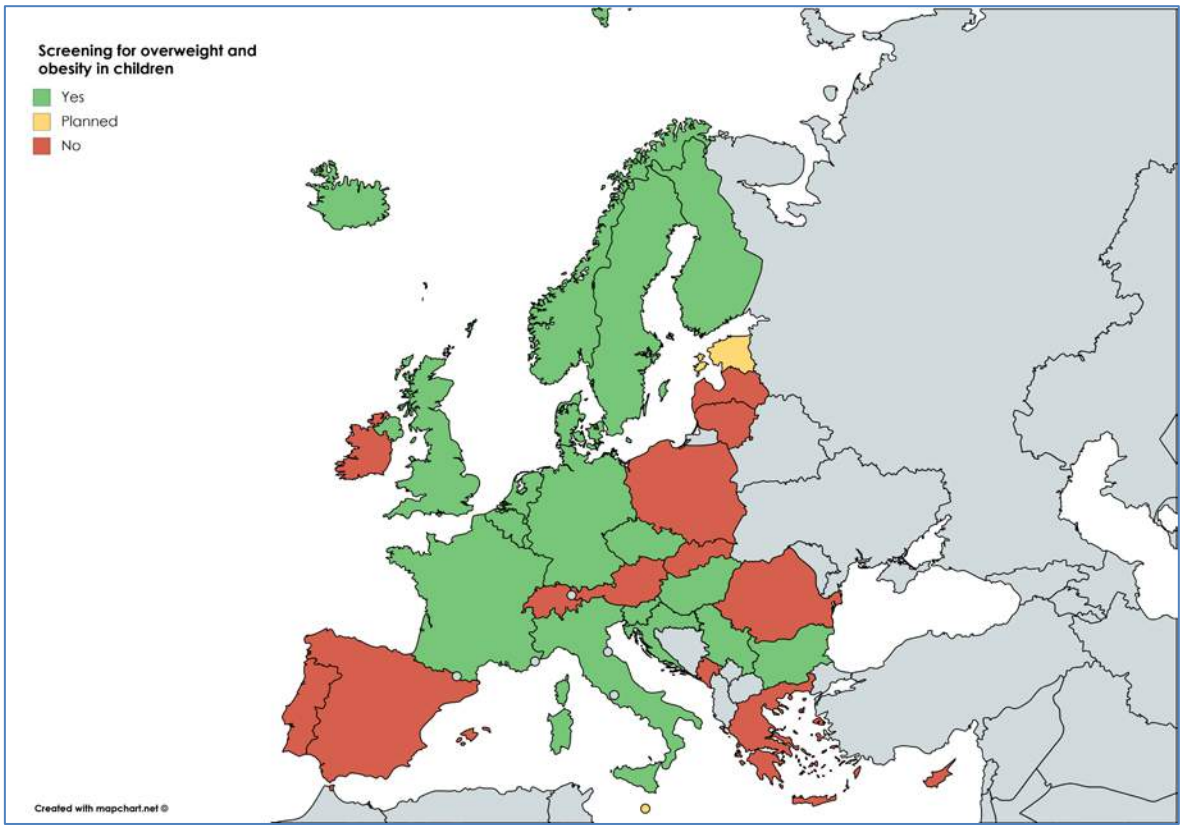


Figure 4.20. *Screening for overweight and obesity in children. EU13: Member States that joined the EU in/after 2004.*



Map 4.16. *Screening for overweight and obesity in children in 28 EU Member States Montenegro, Norway, Iceland, Serbia, and Switzerland.*

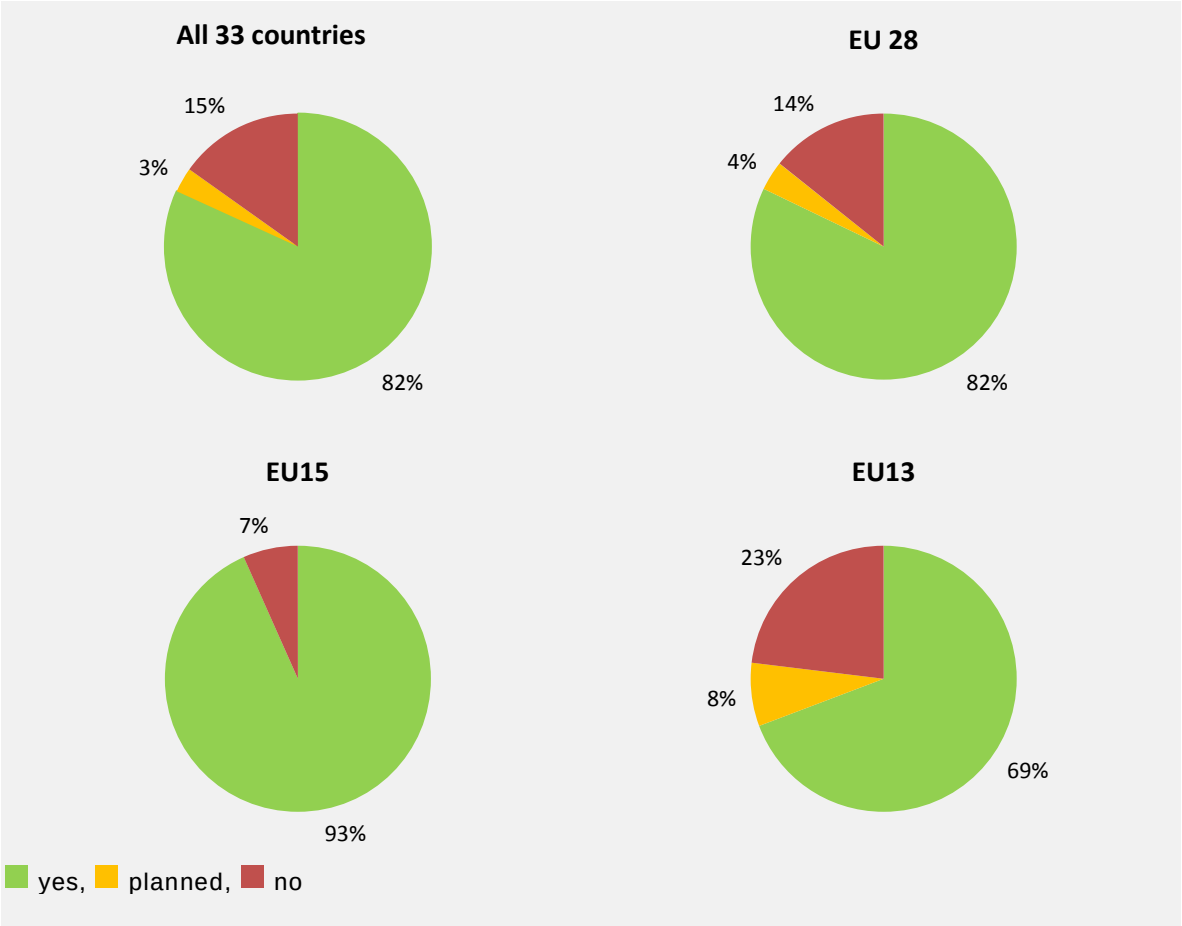


Figure 4.21. *Management services, such as interventions or weight loss programmes, for overweight and obese children. EU13: Member States that joined the EU in/after 2004.*

4.6 AREA 6: Encourage physical activity

Physical activity plays a vital role in maintaining health. The Council of Europe, in its 'Council Recommendation on promoting health-enhancing physical activity across sectors' of 25 November 2013, recommended the EU Member States amongst others to "Work towards effective HEPA policies by developing a cross-sectoral approach involving policy areas including sport, health, education, environment and transport, taking into account the EU Physical Activity Guidelines, as well as other relevant sectors and in accordance with national specificities". Following these Council Recommendation, the European Commission and the WHO Regional Office for Europe have been cooperating to develop and scale-up monitoring and surveillance of health-enhancing physical activity in the EU Member States. A network of national HEPA focal points was launched in Rome in October 2014. Its main role, in line with the Recommendation, was to coordinate the national collection of information for the monitoring framework. This paragraph provides an overview of the situation on selected physical activity indicators in children and adolescents. Most of the data come from the factsheets on health-enhancing physical activity (HEPA) of the WHO European Region[15] that contain information collected through the HEPA focal point network complemented with information from the interviews.

All countries except two (ME, RS) mentioned to have policies on physical activity promotion that (also) aims at children under the age of 18 years. The majority has national guidelines on physical activity. Four countries reported to be working on national recommendations on physical activity for children (CY, HR, EL, SI). Two countries mentioned that they are working on an update of their current recommendations (EE, IT). Only six countries, of which 4 are EU Member States, indicated that they do not have guidelines on physical activity (CZ, ME, PL, RO, RS, SK). However, for some of them their aims are in accordance with WHO's Global Recommendations on Physical Activity for Health (CZ, PL, SK).

In 30 countries (except for CY, ME and RS) self-reported data on physical activity levels among adolescents is available through the HBSC surveys. By using self-reported data, physical activity levels are likely to be overestimated. In general, at the age of 11, 13 and 15 years, boys more often report to reach WHO's physical activity recommendation than girls (Figure 4.22 (2009/2010) and Figure 4.23 (2013/2014)). The percentage among boys ranged from 10% (IT) to 43% (IE) in 2009/2010 and from 11% (IT) to 47% (FI) in 2013/2014. Among girls it ranged from 5% (IT) and 35% (IE) among girls in 2009/2010 and from 5% (AT, IT, PT) to 34% (FI) in 2013/2014. In general, the percentage of boys and girls reaching the WHO's physical activity recommendation was higher among 11-year olds than among 15-year olds. Generally, 13-year old boys and girls have intermediate values.

For 28 of the 30 countries participating in the HBSC surveys, (except BG and MT) data was available from 2009/2010 as well as from 2013/2014. Four-year differences in the percentage boys and girls reporting to reach WHO's physical activity recommendation are presented in Figure 4.24. Differences ranged between -8% (UK: England) and +11% (NO). In seven countries, for all age and sex groups the prevalence of children reaching the recommendations was higher in 2013/2014 than in 2009/2010 (HR, IS, HU, LT, PL, RO, CH). In two countries (AT and UK: Wales) the percentage in 2013/2014 were lower than in 2009/2010 for all age and sex groups. For all other countries higher as well as lower percentages were observed depending on the age and sex group.

[15] http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/country-work

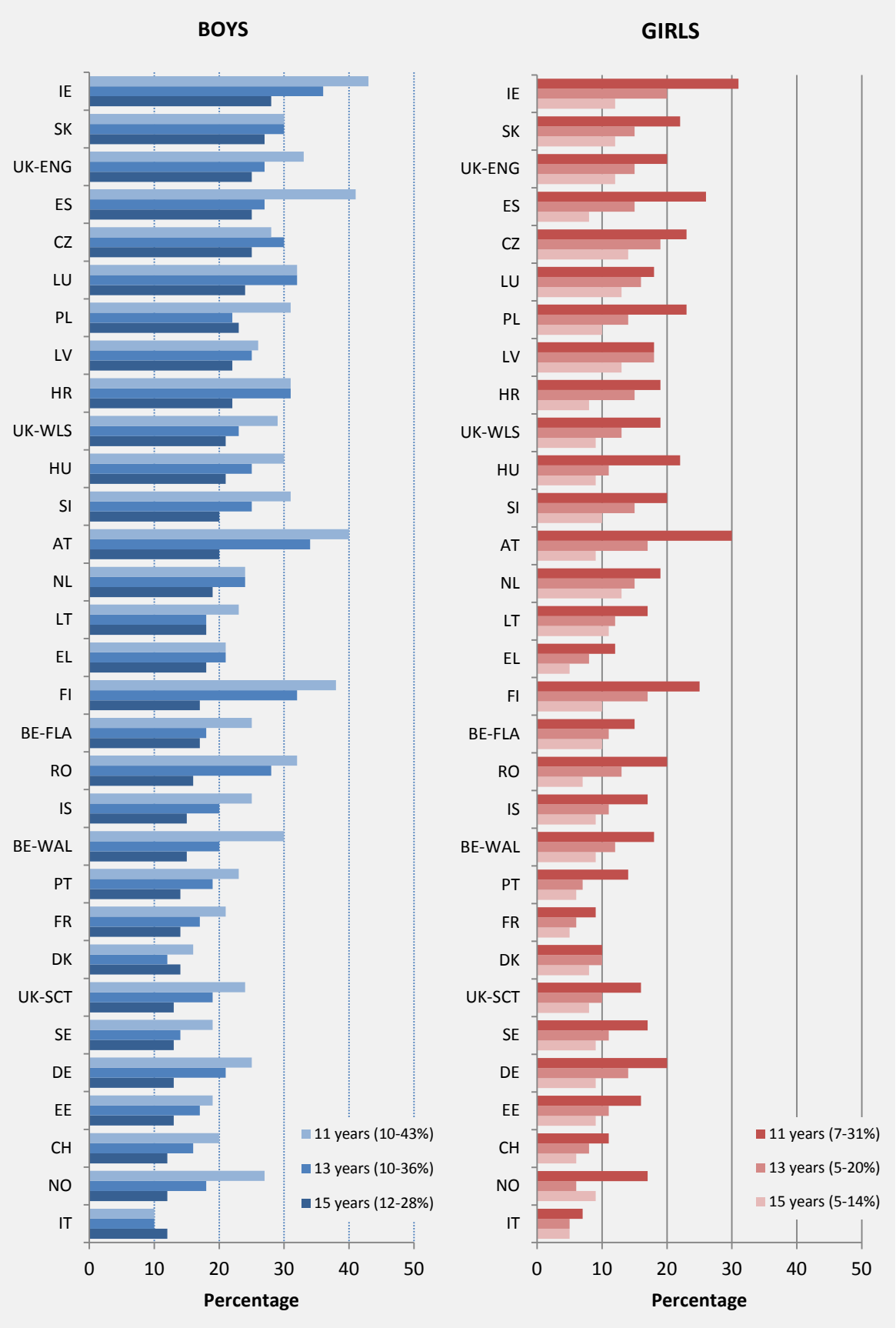


Figure 4.22. *Percentage boys and girls aged 11, 13 and 15 years reaching WHO's physical activity recommendations in* ***2009/2010*** *by county (HBSC).*

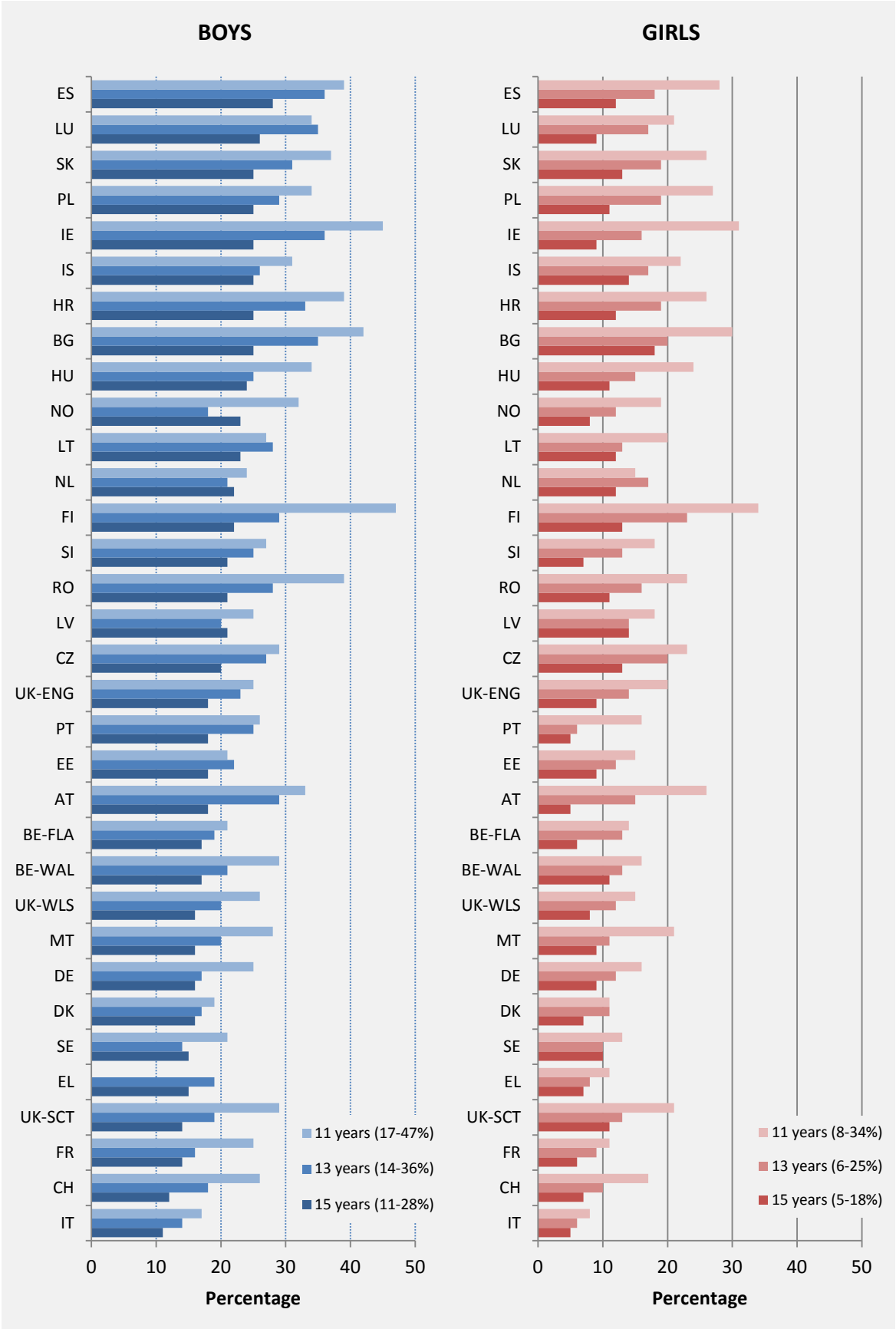


Figure 4.23. *Percentage boys and girls aged 11, 13 and 15 years reaching WHO's physical activity recommendations in* ***2013/2014*** *by country (HBSC).*

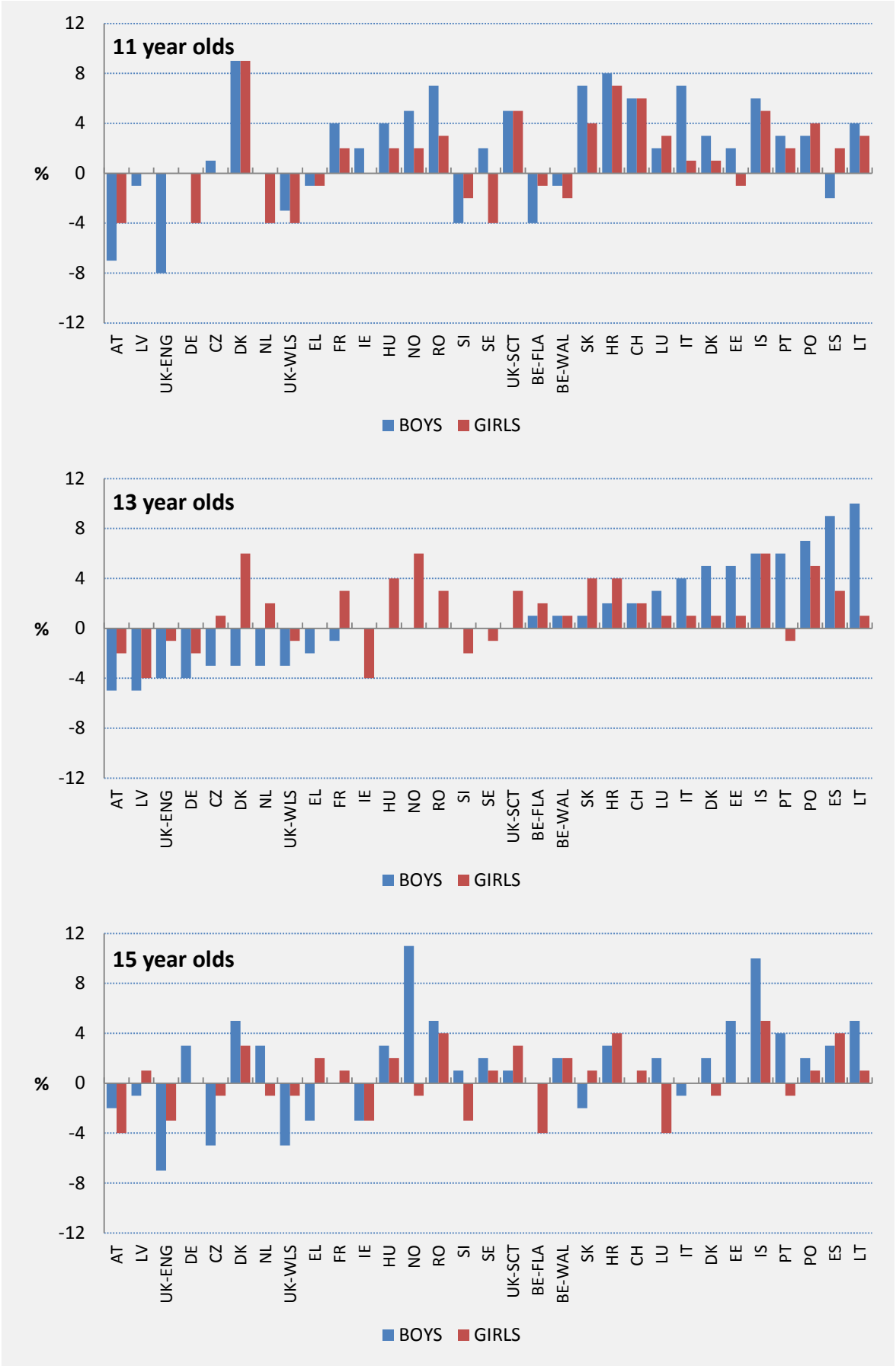


Figure 4.24. *Four-year differences in the percentage boys and girls aged 11, 13 and 15 reaching WHO's physical activity recommendations in 2013/2014 as compared to 2009/2010 by country (HBSC).*

For the 28 EU Member States, information on the implementation of national or subnational schemes promoting active travel to school was available from the NOPA database of WHO (www.whonopa.eu). These data were updated with information received from the consulted experts. According to this information, in 45% of the countries (or 50% of the EU Member States) such schemes are implemented (see Figure 4.25 and Map 4.17). At least in the Netherlands these are mostly small-scale local initiatives. Three countries reported that schemes for active travel to school are foreseen (BG, LV, SI).

The number of countries that have data on weight and height is also among the 18 indicators selected for immediate operationalisation by WHO, EU Member States and the European Commission. It is included for Area 6, and is therefore described here, but might as well fall under Area 7 (Monitoring and surveillance). In all but two countries (LU, and CH) data on weight and height are collected. From the sources available it is not possible to evaluate how representative and comparable those surveys are across countries, and whether or not data are available for monitoring or research purposes.

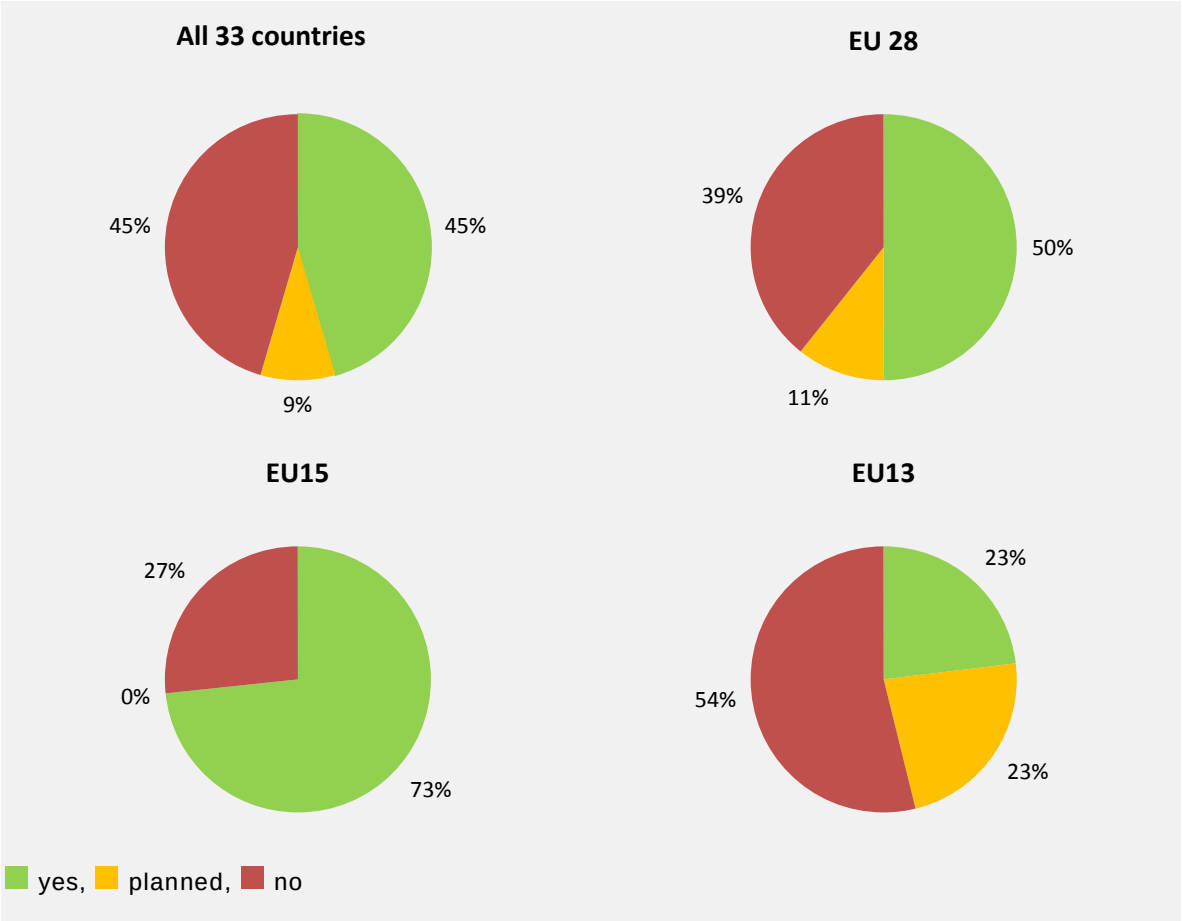
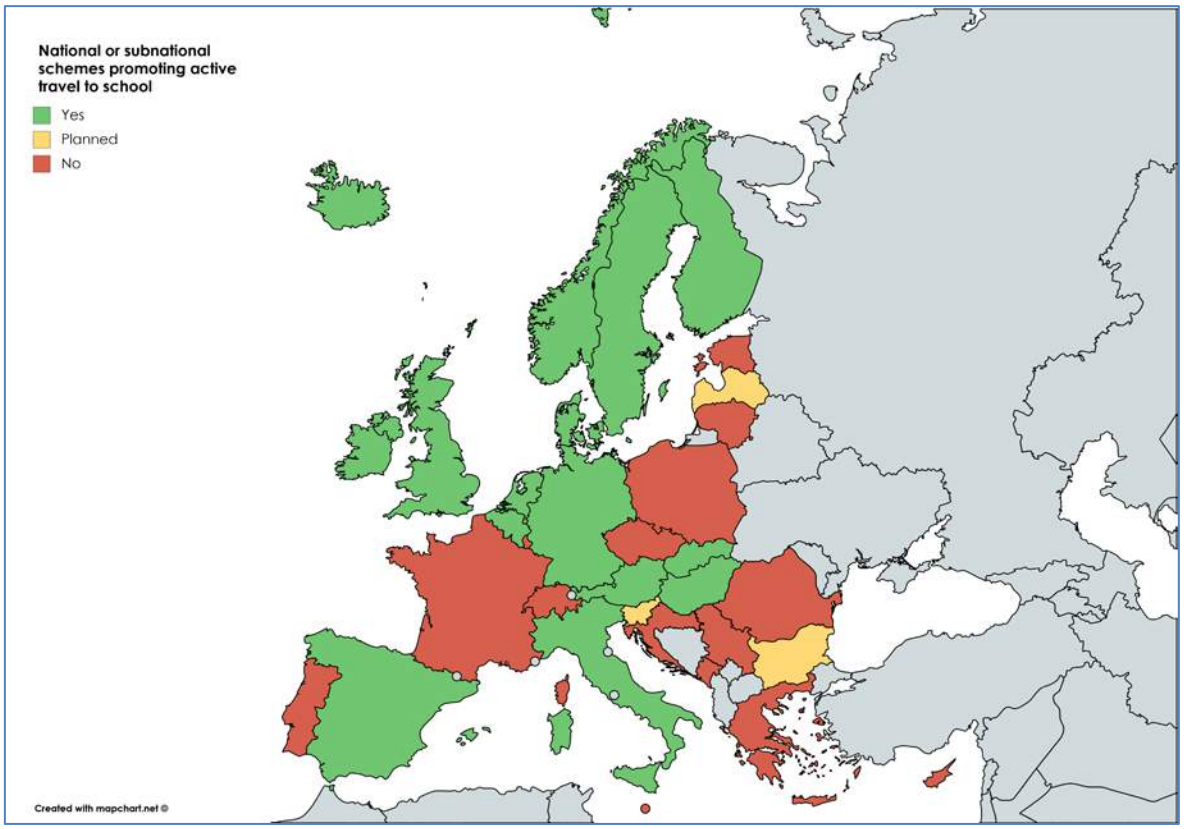


Figure 4.25. *National or subnational schemes to promote active travel to school. EU13: Member States that joined the EU in/after 2004.*



Map 4.17. *National or subnational schemes promoting active travel to school in 28 Member States Montenegro, Iceland, Norway, Serbia and Switzerland.*

4.7 AREA 7: Monitoring

It is important to monitor obesity, nutrition and physical activity in children and young people in order to develop and direct targeted action. Monitoring procedures tend to vary by country, however, making it difficult to compare results directly.

Participation in the Childhood Obesity Surveillance Initiative
The WHO Regional Office for Europe has established the Childhood Obesity Surveillance Initiative (COSI) that aims to routinely measure overweight and obesity in a representative sample of primary school children (6-9 years) according to a standard protocol. This enables the evaluation of trends and comparison between countries within the European Region. In the 2015/2016 round of the Childhood Obesity Initiative (COSI) 26 countries (79%) participated (see Figure 4.26 and Map 4.18), 12 more than in the round before (2012/2013). For ten countries, the 2015/2016 round was the first time they participated in COSI. Participation rate of EU Member States is 82%. All countries that entered the EU in or after 2004 (EU13) currently participate in COSI. The Netherlands is exploring the possibility to join COSI.

In Germany and England (UK), other programmes are running. In Germany a health interview and examination survey for children and adolescents (KiGGS) was conducted 2003-2006 for the first time and included 17640 children and adolescents aged 0-17 years. From 2014 to 2017 the next examination survey was conducted. Results will be published in 2018. The Health Survey for England takes physical measures such as height, and weight and also the National Child Measurement Programme measures the height and weight of children in reception class (age 4 to 5 years) and year 6 (age 10 to 11 years) to assess overweight and obesity levels in children.

Representative diet and nutrition surveys
Figure 4.27 and Map 4.19 show whether countries have representative diet and nutrition surveys. The information is obtained from WHO's GNPR2 survey, consulted experts (for BG, DE, HU, IT, MT, PT, RO, SE. UK) and the information collected by DG SANTE in 2014 and 2015 (HR, LU, SI) when no data from GNPR2 were available. Twenty-eight countries (85%) - 24 EU Member States (86%) - have representative diet and nutrition surveys. However, the Competent Authorities of Finland, Switzerland and Hungary mentioned that children are not included in their surveys. This may apply also to some other countries. Furthermore, from the available data it is not always clear whether the surveys are performed on a regular basis. The surveys take place every 8-10 years in Estonia, Germany, Montenegro and Norway; every 4-5 years in Bulgaria, Denmark, Hungary and the Netherlands, and more frequently in the United Kingdom and Serbia. For the other countries we don't know. In addition, a study from WHO regional Office for Europe showed that it is not always clear which methods are used to assess dietary intake (and body composition) in European surveys (49).

According to the GNPR2 survey and the information collected by DG SANTE in 2014 and 2015 (for BG, DE, HU, LU, MT, PT, RO, SI), national food composition tables or databases are available in 25 of the 33 countries (76%; not in HR, LV, LU, MT, ME, RO, SK, ES). This means that 25 EU Member States have national food composition tables (86%). Slovenia has national tables for meat, fruit and vegetables and uses values from foreign dietary tables for their own national context. Malta uses US food composition data. It should be noted, however, that most food composition tables are at the food level. Only France and Belgium have food composition databases at the brand level. The French table (Oqali) is more extensive than the Belgian table (Nubel).

Monitoring of physical activity in children
Physical activity levels are being assessed through the questionnaires of the HBSC study among adolescents, in all but three countries (CY, ME, RS). These are thus, self-reported data. In addition, experts of 13 countries reported to also have other surveillance systems that include measures of physical activity among children (FI, DE, HU, IS, IT, IE, LT, NL, NO, PT, ES, SE, UK).

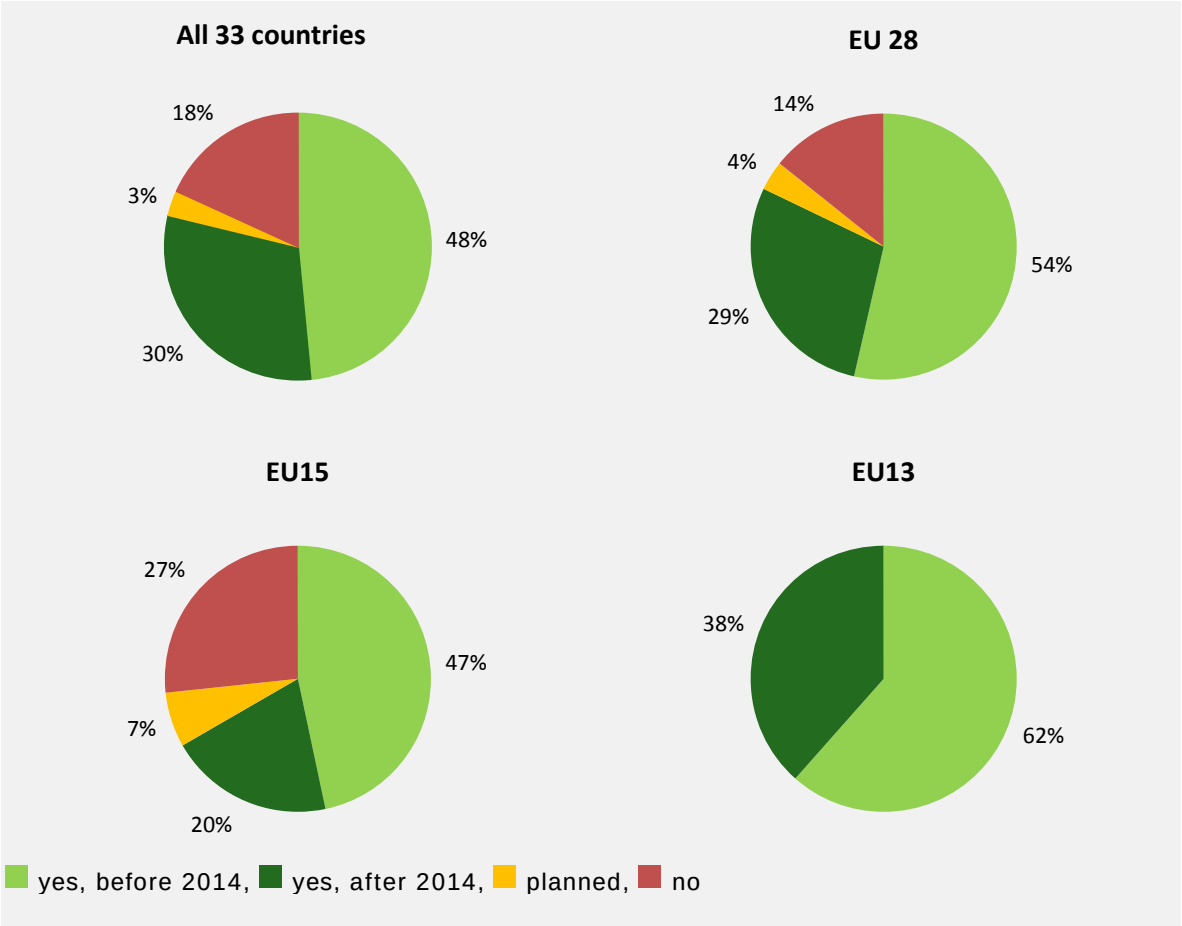
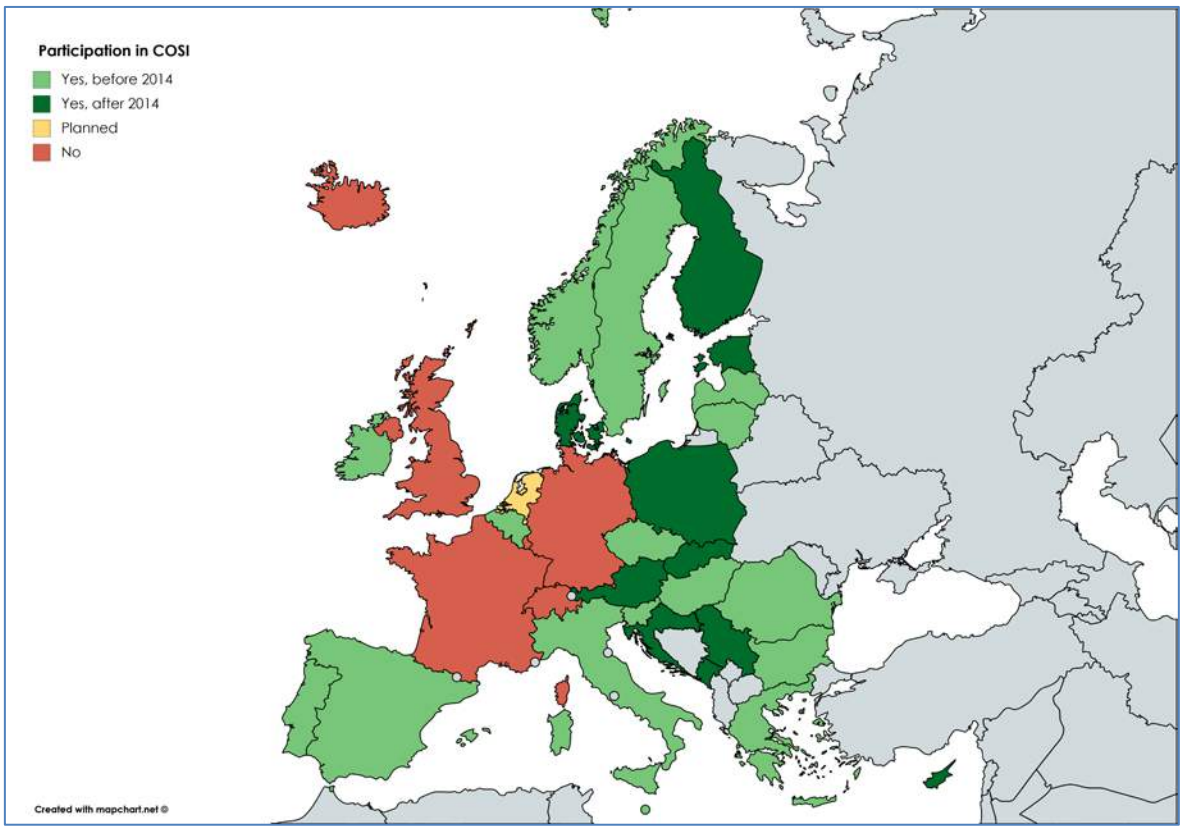


Figure 4.26. *Participation in the Childhood Obesity Surveillance Initiative. EU13: Member States that joined the EU in/after 2004.*



Map 4.18. *Participation in the Childhood Obesity Surveillance Initiative in 28 EU Member States Montenegro, Iceland, Norway, Serbia and Switzerland.*

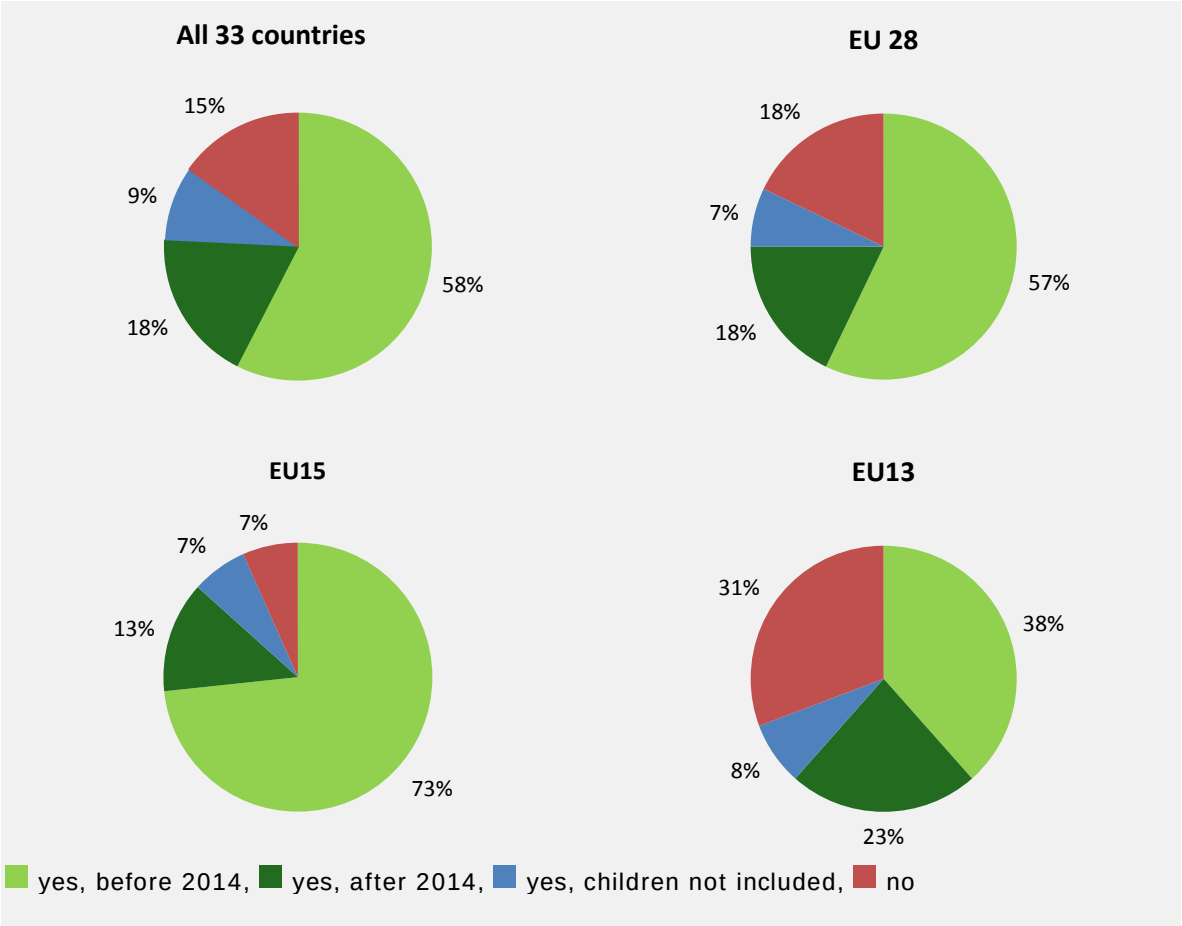
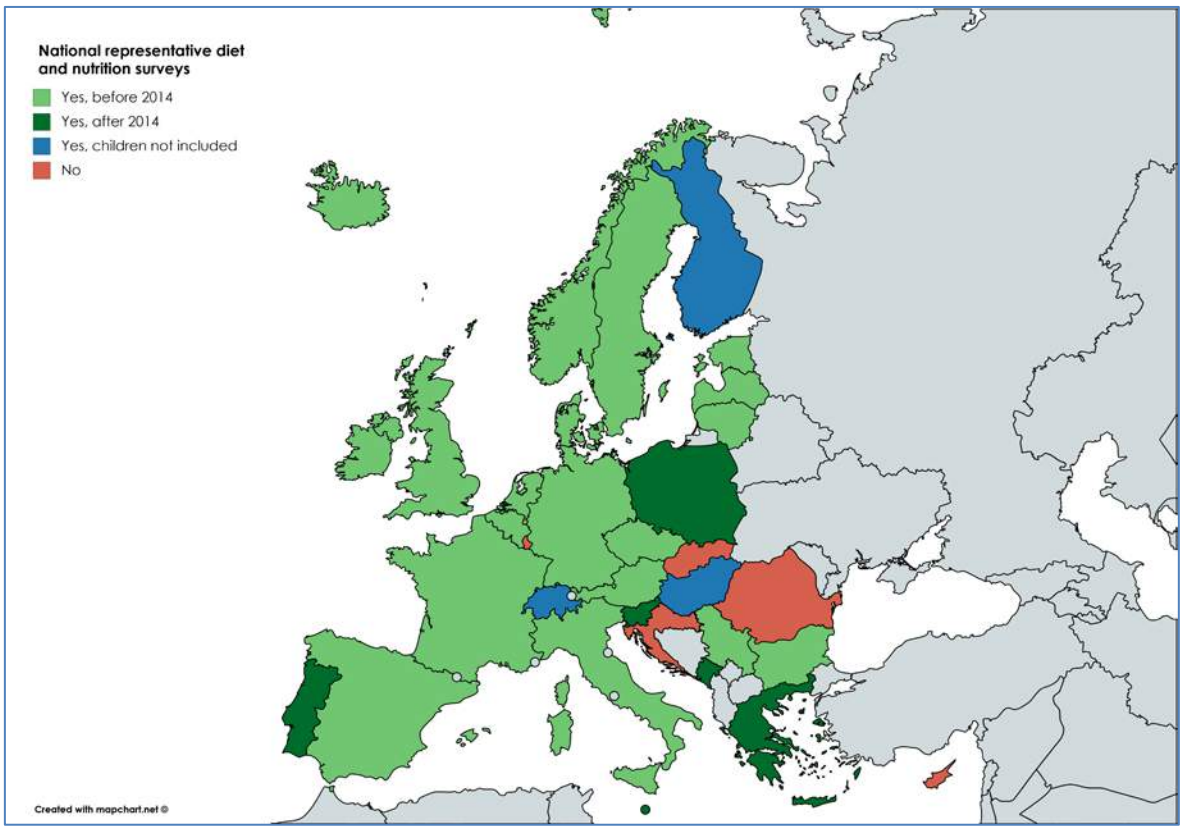


Figure 4.27. *Representative diet and nutrition surveys. EU13: Member States that joined the EU in/after 2004.*



Map 4.19. *Representative diet and nutrition surveys in 28 EU Member States Montenegro, Iceland, Norway, Serbia and Switzerland.*

4.8 Intrusiveness of policies using the Intervention ladder

Policy measures and interventions can be ranked by their degree of intrusiveness. The more intrusive a policy measure or intervention is, the greater are the restrictions on people's freedom of choice. To assist in thinking about the acceptability and justification of different policy initiatives to improve public health, the UK-based Nuffield Council on Bioethics developed an 'intervention ladder' (20). On this ladder the least intrusive and most non-committal measures are placed at the bottom, and the most intrusive measures are placed at the top. The ladder goes from doing nothing and monitoring to eliminating certain choices. The intervention ladder not only illustrates how strongly policy intervenes, but also which possibilities there are to intervene strongly or less strongly. The assumption in this respect is that the most intrusive measures are often the most effective measures (21).

Most of the actions that were listed through the interviews are at the lower steps of the intervention ladder ('provide information' and 'enable choice'). Examples of the first step are guidelines for breastfeeding, physical activity and nutrition. The creation of sports facilities, and providing the possibility to engage in weight-loss programs are examples of the second step (see Figure 4.28).

Relatively many of the actions in Area 2 can be found high on the intervention ladder. These include, for example, the mandatory school food policies and legislation that prohibits the sale of energy drinks to children. By nature, taxation policies (Area 3) are also at the higher steps of the intervention ladder. Food reformulation/food product improvement initiatives are usually in the lower middle part of the intervention ladder. Usually not all products in a product category that are available on the market will be reformulated, so there is still room for individual choices. It might be higher on the intervention ladder when, for example, the bakery sector as a whole agrees to reduce salt in bread. However, then all individual bakers have to comply with the agreement and no bread should be sold from bakeries that originate from other countries that did not sign the agreement.

INTERVENTION LADDER
Eliminate choice. Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.
2.1 Mandatory nutrient- or food –based standards for meals or other foods provided by school 2.3 Legislation that prohibits sale of energy drinks to children 2.5 Mandatory physical activity education in schools
Restrict choice. Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.
1.2 Regulations on breast milk substitutes (e.g. EU Directive 2006/141) 2.1 Mandatory nutrient- or food –based standards for meals or other foods sold at school 2.2 Ban on vending machines in schools (and other public places) 2.2 Mandatory restriction of products that can be offered in vending machines 2.3 Legislation that forbids free refill system for beverages with added sugars or sweeteners, in all restaurant settings 2.3 Legislation that forbids the sale of energy drinks in schools 3.3 Legislation on limitation of industrial trans fats
Guide choice through disincentives. Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes.
3.4 Taxation of sugar sweetened beverages 3.4 Taxation of products for which healthier alternatives are available 3.4 Taxation of sugar
Guide choices through incentives. Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax breaks for the purchase of bicycles that are used as a means of travelling to work.
3.5 Decreased tax levels for specific products 6.1 Provide grants to buy a bicycle 6.1 Provide funds to (partly) finance sports for poorer families
Guide choices through changing the default policy. For example, in a restaurant, instead of providing chips as a standard dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).
2.1 Voluntary nutrient- or food-based standards for meals or other foods sold at school 2.2 Voluntary restriction of products that can be offered in vending machines 2.3 Voluntary initiatives to restrict sale of energy drinks to children
Enable choice. Enable individuals to change their behaviours, for example by building cycle lanes, or providing free fruit in schools.
1.2 Policies or legislation that enable women to breastfeed at work 1.2 Providing payed maternity leave for 6 months or longer 1.2 Create breastfeeding spaces at public places 2.1 Provision of free fruit and vegetables in schools (e.g. EU School Fruit and Vegetable Scheme) 2.1 Provision of free drinking water in schools 3.1-3.5 (Voluntary) agreements on food reformulation/food product improvement 5.1 Provide possibility to exercise (as part of National Campaigns) 5.2 Provide (support for) community based interventions 5.4 Provide interventions or weight loss programmes to overweight/obese children 6.1 Improve infrastructures (such as cycle paths, play grounds, and routes to school) 6.1 Provide interventions and programmes to encourage physical activities 6.1 Construction of sports facilities 6.1 Provide accompanied 'walking bus' to school 6.1 Prescription of physical activity to patients by health care professionals

INTERVENTION LADDER (continued)
Provide information. Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.
1.1 Information or guidelines on nutrition and/or physical activity before, during and after pregnancy 1.1 Counselling/support on nutrition and/or physical activity before, during and after pregnancy 1.2 Information on breastfeeding, e.g. through brochures or guidance by health professionals 1.3 Information or guidance on complementary feeding 2.3 Advice children to avoid consumption of energy drinks 2.4 Voluntary or mandatory nutrition education in schools 3.3 Voluntary or mandatory easy to understand labelling 5.1 National campaigns to promote healthy diet and/or increase physical activity 6.1 Advice on/promotion of active travel to school 6.1 Provide information on the need for physical activity 6.2 Provide guidelines for physical activity
Do nothing or simply monitor the current situation.
7.1 Representative surveys on dietary intake 7.2 Representative surveys on physical activity 7.3 Participation in COSI

Figure 4.28. *Policies, measures and activities that were mentioned in the interviews according to their intrusiveness using the intervention ladder (20).*

5 ENGAGEMENT IN EU WIDE INITIATIVES IN THE FIELD OF NUTRITION AND PHYSICAL ACTIVITY

This chapter provides an overview of the engagement of the European Commission, the Member States, and international organisations in common EU initiatives and projects in the field of nutrition and physical activity. First, the efforts of the European Commission are described (Chapter 5.1). Second, attention is paid to EU funded programs (Chapter 5.2) and last, engagement of international organizations is discussed (Chapter 5.3).

5.1 Efforts by the European Commission

According to the Action Plan, "*the Member States ask the European Commission to be responsible for three key priorities. Firstly, the European Commission's main task will be to continue providing support and coordination through the High Level Group on Nutrition and Physical Activity and the EU platform for action on diet, physical activity and health, and to further facilitate exchange of information and guidance on best practice. Secondly, the European Commission will promote better utilisation of the existing instruments at its disposal, namely the EU Health Programme and the Horizon 2020 growth strategy. Thirdly, the European Commission will strengthen its aim to integrate the issue of health in other EU policy areas such as those relating to urban mobility, media, education, physical activity, sport and the Common Agricultural Policy (CAP).*" The first two priorities can be addressed by the results of the Childhood Obesity Study.

The European Commission has several instruments to fulfil the tasks described above. These include:

- The coordination of working groups, special events, etc. (see 5.1.1)
- Providing scientific and technical guidance to support EU policy-making (see 5.1.2)
- Financial tools, such as research programmes (see 5.1.3)

5.1.1 Coordination

The European Commission coordinates the High Level Group on Nutrition and Physical Activity and the EU platform for action on diet, physical activity and health.

The **High Level Group on Nutrition and Physical Activity** seeks European solutions to obesity-related health issues in several ways. They offer an overview of all government policies on nutrition and physical activity. They help governments share policy ideas and practice and improve liaison between governments and the EU platform for action on diet, physical activity and health, as a result of which relevant public-private partnerships can be quickly identified and agreed on. The High Level Group meets usually two to three times a year and regularly has joint meetings with the EU platform for action on diet, physical activity and health. In addition, the High Level Group can ask the European Commission to call together experts for preparing the grounds for its initiatives.

The **EU platform for action on diet, physical activity and health** is a forum for European-level organisations ranging from the food industry to consumer and health non-governmental organisations (NGOs) coordinated by the European Commission. Its members make voluntary commitments relevant to tackling current trends in diet and physical activity. Progress is marked by annual self-reporting of commitments. Trends in the type of commitments introduced and their implementation are analysed by an external contractor and made public in annual reports. In 2016, a revised methodology was adopted for the platform to increase the level of ambition of commitments. Therewith the commitments better support the Member States in reaching the targets agreed to in the Action Plan on Childhood Obesity and in the WHO context on reducing non-communicable diseases.

The **Steering Group on Promotion and Prevention**, composed of representatives from all EU and EEA countries, was set up by the European Commission to support Member States in meeting the WHO/UN 2025 global voluntary targets on non-communicable diseases[16]. The Steering Group first met in November 2016. It takes positions on priority actions to be implemented in all areas of health promotion and non-communicable disease prevention. This includes addressing health inequalities, nutrition, physical activity, reduction of tobacco use and alcohol-related harm, screening and management of non-communicable diseases, such as cancer, cardiovascular diseases, and diabetes. The activities of the Steering Group are intended to facilitate the implementation of evidence-based best practices by EU countries, in order to ensure that the most up-to-date findings and knowledge are being put into practice.

The European Commission also has two initiatives that aim to encourage people to get involved in sport and to support physical activity: the **European Week of Sport** (EWoS) and the **European Sport Forum**. EWoS is a Commission-led initiative to raise awareness of the benefits of sport practice and regular physical activity. The implementation of EWoS across Europe is largely decentralised and takes place in close cooperation with national coordinating bodies and European partners. The first EWoS was organised in 2015 and from 2017 onwards it will take place every year. The event has millions of participants. Besides sport activities accessible to the public, some centralised events have been organised by the European Commission. These consisted of conferences and seminars to raise further awareness about the EWoS. Furthermore, the Commission translated key documents (one-page information sheet, key messages for the Focus Themes, template for press releases) and developed guidance materials to ensure that the same messages are passed Europe-wide during the EWoS. Under the EU Health Programme (see 5.2.2) funding for the EWoS has been provided to several Member States. Coinciding with the 2017 EWoS, Commissioners Hogan (agriculture and rural development), Navracsics (education, culture, youth and sport) and Andriukaitis (health and food safety) launched the **Tartu call for a healthy lifestyle**[17] that sets out a roadmap for promoting healthy lifestyles in Europe, particular amongst children, over the next two years. The **European Sport Forum**, organized by the European Commission, is an annual meeting of representatives from international and European sport federations, European and national sport umbrella organisations, the Olympic movement, and other sport related organisations. Its main objective is to take stock of progress achieved in implementing the EU agenda for sport and to seek stakeholders' views on current, planned or possible future activities. In 2017 the ninth European Sport Forum since the adoption of the White Paper on Sport in 2007 took place in Malta.

The European Commission also finances **Eltis**. Eltis was created more than 10 years ago, and is now Europe's main observatory on urban mobility. It facilitates the exchange of information, knowledge and experiences in the field of sustainable urban mobility in Europe. It is aimed at individuals working in transport as well as in related disciplines, including urban and regional development, health, energy and environmental sciences. Eltis provides information, good practices, tools and communication channels to help cities turn into models of sustainable urban mobility.

Finally, the support that the European Commission provides to reach the United Nations' Sustainable Development Goals (SDGs)[18], can contribute to the prevention of childhood obesity. This especially applies for support related to the second SDG (end hunger, achieve food security and improved nutrition and promote sustainable agriculture) and the third SDG (ensure healthy lives and promote well-being for all at all ages). Not only will the Commission include the SDGs into EU policies and initiatives across the board, they will also support EU governments with the

[16] http://www.who.int/nmh/ncd-tools/definition-targets/en/
[17] https://ec.europa.eu/sport/sites/sport/files/ewos-tartu-call_en.pdf
[18] http://www.un.org/sustainabledevelopment/sustainable-development-goals/

implementation of initiatives that support the SDGs. In May 2017, the high-level **Multi-stakeholder platform on SDGs** was launched, supporting the exchange of best practices on implementation across sectors at national and EU level.

5.1.2 Providing scientific and technical guidance to support EU policy-making

Support for EU policy making with independent research is provided by the JRC. They also stimulate innovation and develop new methods, tools and standards. Know-how is shared with the Member States, the scientific community and international partners. JRC works in several science areas, one of them being 'health and consumer protection'. School-aged children are an important group of focus within this science area.

To assess the situation of school food provision frameworks in Europe, JRC, in close collaboration with the High Level Group on Nutrition and Physical Activity and DG Health & Consumers, has produced an overview and content analysis of national school food policies in the EU Member States plus Norway and Switzerland (50). Other examples of their work in this area are the report on school food and nutrition in Europe (51) and school food policy country factsheets (52). In 2016, the JRC published a set of toolkits on promoting water as well as fruit and vegetables in schools (53, 54), to support the European Commission, the Member States and schools in general in their efforts to raise healthier children. The toolkits combine practical information on education, environment and parental involvement with guidance on process and outcome monitoring and evaluation. Together with the Maltese EU Presidency team and DG SANTE, JRC published a technical report on public procurement of food for health in the school setting in 2017 (41).

JRC also published a report comparing the nutrient profile model recently developed by WHO Regional office for Europe with the voluntary industry-devised EU Pledge, both intended to restrict food and drink advertising to children (55). The WHO model can be considered stricter than the EU Pledge system in that it would permit fewer products to be advertised to children under 12 than is the case under the EU Pledge. Reducing the marketing of foods high in energy, certain fats, sugar, or salt to children is a key area for action in the Action Plan. Nutrient profiling can be used as a tool to define food and drink products eligible for marketing to children. Very recently, JRC started to produce a mapping of initiatives to reduce marketing pressure to identify best practices that the Member States may wish to adapt or build on.

The Joint Research Centre was further asked to produce a collection of targeted briefs for policy makers responding to the Member States' need for having short, user-friendly, scientifically accurate summaries of the latest evidence, data and implementation examples. These have now evolved into a Health Promotion and Disease Prevention Knowledge Gateway[19]. Dozens of examples of validated best practices have been collected from Member States to support implementation in general and the Steering Group on Prevention and Promotion in particular.

Other reports and projects worth mentioning in the context of childhood obesity are:

- the report "Trans fatty acids in Europe: where do we stand?" published by JRC in 2014 in response to the request of the European Parliament and the Council as part of Regulation (EU) No1169/2011 on the provision of food information to consumers to report on 'the presence of trans fats in foods and in the overall diet of the Union population' (56).

[19] https://ec.europa.eu/jrc/en/health-knowledge-gateway

- the 'Peer Active' project. This project ran in 2014 and looked at the impact of different forms of social incentives (i.e. reciprocity, group cooperation, etc.) in order to ascertain which incentives work best in motivating children to be more active.
- The 'Social Biking' project[20], using social media to motivate European citizens to cycle in urban spaces. People can form interactive groups through an app and track their rides to collectively earn points and prizes.

5.1.3 Financial tools

The European Commission uses financial tools as a coordinating mechanism. The European Commission provides funding for EU wide projects and initiatives via several EU programmes (e.g. EU Health Programme, FP7 and H2020, Erasmus+). Through funding, the Commission supports (indirectly) the implementation of its health strategies and policies. In addition, the European Parliament provides the European Commission with additional funding for pilot projects. A pilot project or preparatory action is an initiative of an experimental nature designed to test the feasibility and usefulness of action. More detailed information on the projects that are funded through the above mentioned programmes is provided in Chapter 5.2.

5.2 EU funded projects

As shortly described in Chapter 5.1, several EU programmes have provided funding for EU-wide projects and initiatives. Through funding, the EU supports (indirectly) the implementation of health strategies and policies. At the same time, participation of Member States (or their institutions) in these activities and projects gives an indication of their engagement. Furthermore the European Parliament initiates and funds Pilot projects and preparatory actions that are meant to provide policy guidance for possible future initiatives. This paragraph will take a closer look at the Pilot projects (5.2.1) and EU-funded projects in the field of nutrition and physical activity funded under the EU Health programme (5.2.2), the 7th Framework Programme and Horizon 2020 (5.2.3) and the Erasmus+ programme (5.2.4), as well as Joint Programming Initiatives (5.2.5). The activities of the projects are also mapped against the 35 operational objectives of the Action Plan (see Annex 3 for a complete list of operational objectives as formulated in the action plan). Operational objectives referred to in this chapter are described in Box 5.1. A summary of the engagement of the European Commission is provided in 5.2.6, followed by a description of the engagement of the countries involved in this study (5.2.7).

5.2.1 Pilot projects initiated and funded by the European Parliament

Pilot projects and preparatory actions, are initiated and funded by the European Parliament and implemented by the European Commission. They are meant to try different approaches, develop evidence-based strategies to address a problem, identify good practices, and provide policy guidance for the benefit of possible future initiatives. Since 2014, five projects have been funded in the area of nutrition and physical activity. They map to seven of the 35 operational objectives in the Action Plan (Table 5.1, Figure 5.1 and Figure 5.2). Each of the five pilot projects is described in more detail below Figure 5.2.

[20] https://socialbiking.jrc.ec.europa.eu/

Box 5.1. Operational objectives of the EU Action Plan on Childhood Obesity referred to in Chapter 5.2

Area for action 1: Support a healthy start in life

1.1. Increase the prevalence of children that are breastfed.

1.2. Promote timely introduction of complementary foods.

1.3. Encourage healthier food habits and physical activity in pregnant women, infants, toddlers and preschool children; include vulnerable groups and respect ethnic minority background.

1.4. Further improve the effective response of the health care sector.

Area for action 2: promote healthier environments, especially in schools and pre-schools

2.1. Provide the healthy option and increase daily consumption of fresh fruit and vegetables, healthy food and water intake in schools (with a targeted focus on schools in underprivileged districts).

2.2. Improve the education on healthier food choices and physical activity at schools.

2.3. Develop and manage initiatives to care for overweight children and prevent them making the transition to obesity. This has to be linked with the clinical work.

2.4. Improve a physical activity friendly kindergarten and school environment.

Area for action 3: Make the healthy option the easier option

3.1. Make the healthy choice the easy choice.

3.2. Increase food reformulation actions in order to achieve the objectives in the EU Framework for National Initiatives on Selected Nutrients.

Area for action 5: Inform and empower families

5.1. Educate and support families to make healthy changes to their diets and promote physical activity including related issues with specific focus on lower socio economic groups.

5.2. Promote the importance of spending time together either in a family or as friends.

5.4. Increase the intake of healthy foods (especially fruits and vegetables, milk and water) in parents and children in local communities, with a special focus on disadvantaged regions and communities.

5.5. Support disadvantaged communities, families, children and adolescents, by making the healthy choice more easily available, accessible and affordable.

5.6. Support disadvantaged communities to help reduce food poverty.

5.8. Encourage/support families, professionals and day-care centres to integrate physical activity in the children's daily routine.

Area for action 6: Encourage physical activity

6.1. Strengthen the promotion of physical activity policies.

6.2. Supportive role of urban design and planning in order to reduce afterschool sedentary behaviour.

6.3. Increase the awareness of and participation in the European Week of Sport

Area for action 7: Monitor and evaluate

7.1. Improve the reporting on the availability, nutritional status, food quality, food consumption habits, and levels of physical activity in different age and socioeconomic groups.

7.2. Share good ideas and practices regarding the monitoring of policy initiatives

7.3. Monitor in order to strengthen obesity prevention.

Area for action 8: Increase research

8.2. Ensure quality and conformity of research projects to existing EU policy objectives and approaches.

Table 5.1 Pilot projects and preparatory actions initiated and funded by the European Parliament with an end date in 2014 or later.

Title	Start and end date	Participating countries	Action Plan operational objectives
Taste booster	2012-2014	BG, RO, SK	1.3, 2.1, 5.1, 5.4, 5.5
My healthy family	2014-2015	HU, PL	1.3, 2.1, 5.1, 5.4, 5.5, 5.6
We love eating	2014-2015	ES, SK, UK, RO, NL, PL, FR	1.3, 5.2, 5.6, 6.1
Together	2015-2016	BG, CZ, DK, ES, UK	1.3, 5.1, 5.6, 6.1
SciView	2016-2017	AT, BE, UK	8.2

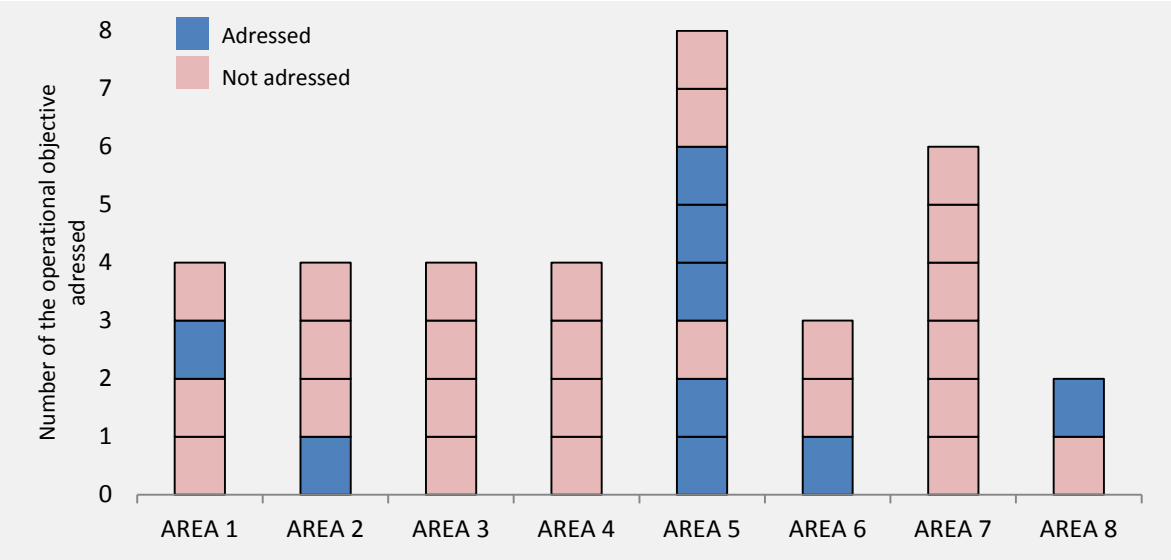


Figure 5.1. *Mapping of the five Pilot projects to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 5.1 for a description of the operational objectives.*

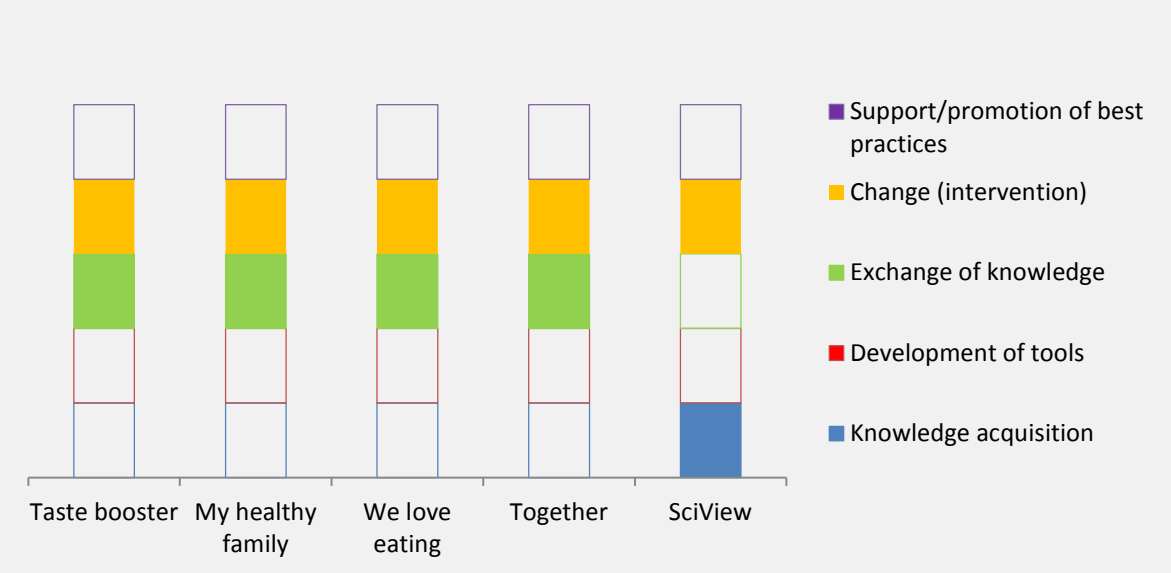


Figure 5.2. *Way in which the five Pilot projects contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

In 2012, the European Commission launched the "**Taste Booster**" pilot project that was carried out in Bulgaria, Slovakia and Romania. The project tested how to best encourage pregnant women, children and older people to eat more fresh fruit and vegetables in regions with primary household income below 50% of the EU average. The target audiences were reached and involved in partnership with local stakeholders (schools, community centres, hospital maternity wards, etc.). The project entailed a series of monthly cooking sessions, where the participants prepared recipes containing fresh fruit and vegetables under the guidance of chefs and nutritionists. At the end of each session they were provided with a kit containing ingredients and recipes, allowing them to recreate the experience at home. Between 2012 and 2014:

- An estimated 5,000 participants were reached through almost 1,000 cooking sessions and events
- 92% of participants declared to have eaten more fruit and vegetables since participating in the cooking sessions
- 97% of participants said they felt more informed about nutrition
- 98 tons of fruit and vegetables were consumed on location and distributed for further cooking at home.

"**My healthy family**" encouraged pregnant women, children and older people in Hungary and Poland to eat more fruit and vegetables. Particular attention was given to vulnerable groups. The idea was to get people to truly enjoy the tastes, textures and colours of fresh fruit and vegetables. This was done by distributing free fruit and vegetables and, with the help of well-known chefs, by providing recipes and cooking lessons (alongside information on the nutritional value of food). More than 23.500 people took part in the project. The project has increased the consumption of fresh fruit and vegetables, but people's cooking and eating habits are still deeply rooted in traditions that are not always healthy.

"**We Love Eating**" encouraged conscious eating in pregnant women, children, and older people from seven European cities. It focused on the pleasure food brings through tools such as games, recipes, leaflets, posters and a website. It also promoted more physical activity in daily life, offering realistic ways to adopt a healthier and more active lifestyle. After the project:

- 3 out of 4 pregnant women were triggered to think about their lifestyle, though their actual behaviour still remained largely unaffected.
- Pregnant women were more aware that it is good for their unborn child if they enjoy eating balanced, home-cooked meals with fruit and vegetables, and are physically active.
- Parents were more aware that their children enjoy eating healthily. Fewer young children ate vegetables less than twice a week or drank water less than once a day.
- Fewer youngsters (10-15 years) ate fruit less than twice a week.

"**Together**" promoted healthier diets and regular physical activity before, during and after pregnancy in six European cities. It targeted mothers and mothers to be, especially from disadvantaged groups. The actions taken were designed to empower women to choose a healthier lifestyle, for themselves and for their families. This meant involving all kinds of community actors and forming Local Promoting Groups to design and implement activities considering the target groups' specific needs. The project stimulated more than half of the women to eat more home-cooked meals, drink more water and eat more fruit and vegetables. They also intended to keep up or increase their regular physical activity.

For all four closed projects mentioned above, a guide with experiences and lessons learnt from the project is available for the wider public, including others wishing to carry out similar initiatives[21,22,23,24].

"**SciView**" is a preparatory action that reviewed scientific evidence and policies to create a comprehensive evidence-base for more effective and efficient action to tackle challenges related to nutrition and physical activity and to help prevent non-communicable diseases. A consortium of four European partners from three countries (UK, BE, AT) carries out the project under the responsibility of the European Commission. The following eight topics have been reviewed:

- Preconceptions and behaviours contributing to positive energy balance
- Health interventions effectiveness and efficiency, in the domain of nutrition and physical activity
- Sources of calories consumed and physical activity undertaken by EU citizens
- Consumption, energy intake and impact of fruit juices and of artificially and sugar sweetened beverages on health
- Consumption, energy intake and impact of High Fructose syrups on health
- Links between school and work performance and achievement, and overweight and obesity and/or inadequate physical activity
- Possible early warning indicators for changes in population overweight and obesity
- Nutrition and physical guidelines for specific population groups

5.2.2 EU Health Programme

The Third EU Health Programme (2014-2020) is the main instrument of the European Commission to implement the EU health strategy. The programme is prepared in close cooperation with the Member States and then adopted by the Commission. It is managed with the assistance of the Consumers, Health, Agriculture and Food Executive Agency (Chafea) and of National Contact Points in the 28 EU Member States and other participating countries. The third EU Health Programme has four overarching objectives.

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle
- Protect EU citizens from serious cross-border health threats
- Contribute to innovative, efficient and sustainable health systems
- Facilitate access to better and safer health care for EU citizens

The programme amongst others supports actions jointly undertaken by Member State health authorities, cooperation projects at the EU level, and the functioning of non-governmental organisations and networks. Joint Actions especially show the engagement of Member States' competent authorities, as they provide co-funding. The Third EU Health Programme was preceded by the first (2003-2008) and second Health Programme (2008-2013).

Table 5.2 shows the Joint Actions, projects and operational grants funded by the second and third Health Programme that are relevant to the prevention of childhood obesity. They are described in more detail below.

[21] https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2015_tastebooster_howtoguide_en.pdf
[22] https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2015_myhealthyfamily_replicationguide_english.pdf
[23] https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2016_weloveeating_replicationguide_english.pdf
[24] https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2017_together_replicationguide_en.pdf

Joint Actions

The Joint Action on health inequalities **"Equity Action**" aimed to strategically engage with key players to develop evidence and knowledge of what works to reduce health inequalities. They did this by developing knowledge for action on health inequalities, supporting the engagement of Member States, regions and other stakeholders in action to tackle socio-economic and geographic health inequalities, shared learning between Member States and other actors and by supporting the development of effective action to tackle socio-economic health inequalities at the European policy level (http://www.health-inequalities.eu/projects/past-projects/equity-action/). Fifteen EU Member States and Norway co-funded this Joint Action, in which 25 partner organisations participated. Childhood obesity, nutrition and physical activity are not among the main topics. Therefore it was not possible to map this activity to the operational objectives of the Action Plan. However, this Joint Action is considered relevant as the project included early years, being a key determinant for health.

Table 5.2. Joint Actions, projects and operating grants funded under the EU Health Programme with an end date in 2014 or later.

Title	Start and end date	Participating countries	Action Plan operational objectives
Joint Actions			
Equity Action	2011-2014	UK*, IT, EL, DE, IE, BE, NO, SE, ES, CZ, NL, PL, FI, HU, FR, LV	Area 1
CHRODIS	2014-2017	ES*, EL, IT, DE, PT, IS, BE, IE, LU, NO, SI, NL, LT, BG	7.2
CHRODIS plus	2017-2020	ES*, HR, FR, DE, EL, HU, IS, IE, IT, BE, LT, MT, NL, RS, SK, SI, BG, FI, PT, PL	7.2
JANPA	2015-2017	FR*, AT, BE, BG, HR, CZ, EE, FI, DE, EL, HU, IE, IT, LV, LT, LU, MT, NO, PL, PT, RO, SI, SK, ES	1.3, 2.1-2.4, 3.1, 7.1, 7.2
Projects			
MOVE	2011-2014	DK*, ES, BE, DE, IT	6.1
SALUS	2011-2014	IT*, FR, HU, UK, BG, SI, RO, FI, LT, DE, ES, AT	3.2
EPHE	2012-2015	FR*, PT, NL, RO, BE, ES, UK, BG, EL	5.1
EYTO	2013-2015	UK*, ES, PT, CZ	5.1, 6.1
HEPCOM	2013-2015	NL*, DK, NO, BE, HR, EL, IT, DE, AT, LT, IE, ES, PT, FR, UK, FI	5.1
OPEN	2014-2016	FR*, ES, PT, NL, RO, UK, MT, EL, SK, PL, BE, DE, CY, SE	5.1
Operating grants			
SHE network	2013-2017	NL*	2.1-2.3
SOEEF	2014-2016	IE*	6.1
OBTAINS-E	2014-2017	WOF (UK*)	1.4

* coordinator

"**CHRODIS**" is a Joint Action addressing chronic diseases and promoting healthy ageing across the life cycle (http://chrodis.eu/). The objective of CHRODIS was to promote and facilitate exchange and transfer of good practices addressing chronic conditions between European countries and regions. There was a specific focus on health promotion and prevention of chronic conditions, multi-morbidity and diabetes. One of the key deliverables was a 'Platform for Knowledge Exchange', which includes both an online help-desk for policy makers and a clearinghouse providing an up to date repository of best practices and the best knowledge on chronic care. On this platform, for example an overview can be found of 41 good practices in health promotion, that include good practice on (the prevention of) childhood obesity, and on promotion of healthy nutrition and physical activity. Thirteen EU Member States. Iceland and Norway co-funded this Joint Action. '**CHRODIS-Plus**' is the successor of CHRODIS and involves 18 EU Member States plus Norway, Serbia and Iceland. The Joint Action will contribute to the reduction of the burden of chronic diseases in Europe by promoting the implementation of policies and practices with demonstrated success. These will be based on the collection of policies, strategies and interventions that started in CHRODIS. Health promotion and primary prevention as a way to reduce the burden of chronic diseases is considered to be one of the cornerstones. CHRODIS and CHRODIS-Plus fit best with operational objective 7.2 of the Action Plan.

The Joint Action on Nutrition and Physical Activity "**JANPA**" was a Joint Action that ran from 2015-2017 (http://www.janpa.eu/). It was fully dedicated to childhood obesity and therefore maps to several operational objectives of the Action Plan. Its general objective was to contribute to halting the rise in overweight and obesity in children and adolescents by 2020. All but 3 (DK, NL, UK) of the 28 EU Member States, as well as Norway, participated in the Joint Action. Two of them (CY, SE) are collaborative stakeholders that contribute on a voluntary basis. Also WHO Regional office for Europe and the JRC were involved in JANPA. Through the identification, selection and sharing of best data and practices, JANPA allows for:

- improvement of the implementation of integrated interventions to promote nutrition and physical activity for pregnant women, and families with young children
- improvement of actions within school settings
- an increase in the use of nutritional information on foods by public health authorities, stakeholders and families for nutrition policy purposes

Furthermore, JANPA evaluated the cost of overweight and obesity in children to raise awareness and encourage public actions. The aim of one of the work packages was to improve the quality of public policies and interventions that promote healthy diets and physical activity and diminish sedentary behaviour. JANPA did this by developing information on models of good practice, with special attention to social inequality aspects. The overarching goal of another work package was to help Member States to create healthier environments in kindergartens and schools by providing guidance on policy options and initiatives on different levels. There was also a work package that shared best practices from nine EU countries on how nutritional information on food and diet is gathered and used for nutritional policy by different stakeholders. A summary of the main results and recommendations from JANPA is given in Box 5.2.

Box 5.2. Summary of main results and recommendations from JANPA

A position paper[25] and a brochure[26] describe the main conclusions and recommendations resulting from the Joint Action on Nutrition and Physical Activity (JANPA).

JANPA has published an evidence paper[27] and developed a model to evaluate the cost of overweight and obesity in children to raise awareness and encourage public actions. It was concluded that the increase in the prevalence of childhood obesity appears to be slowing in some, but not all, European countries, mostly in younger age groups. The prevalence is, however, high. For Ireland final results of the costing model are available, estimating that the total lifetime costs of childhood obesity amount to 4.5 billion Euros. The largest part (79.1%) consists of societal costs, such as costs from lifetime productivity loss due to premature mortality. The other 20.9% of the costs are lifetime direct health care costs. If the mean BMI of Irish children would be reduced by 5%, the lifetime costs could fall by 1.1 billion Euros. JANPA recommends that the model should become available in open source software for use by all research teams. Furthermore, co-ordination of national health information systems across the EU should be improved in order to obtain results from the model that are reliable and comparable between countries. This concerns obesity surveillance in various age groups, surveillance of obesity-related diseases and information on healthcare costs. Finally, the JANPA costing model should be extended by incorporating psychosocial impacts of childhood obesity.

JANPA shared best practices on how nutritional information on food is gathered and used for nutritional policy by different stakeholders. Information campaigns are widely developed in the participating countries. They raise awareness but have a low impact on consumers' behaviour. Work on the food environment, such as serving sizes and advertising, has a more direct impact and should be encouraged. Food reformulation/food product improvement has been shown to be quite efficient to improve nutritional quality of the food on offer and has the advantage of benefiting the entire population. However, its impact is often too limited to have a public health impact. In a pilot study, the French "Oqali" approach for monitoring changes in the supply of processed foods available on the French market at the brand level was tested in two other countries. This approach measures the nutritional composition and labelling information over time. The results show that the methodology used in "Oqali" was adaptable to other European countries with minor modifications. Within several families of products among breakfast cereals and soft drinks, the macro-nutrient content varied largely. This suggests that there are real possibilities for food reformulation/food product improvement. JANPA recommends public authorities in each European country to develop this monitoring tool, allowing comparison between countries and the nutritional food improvement asked by the European Council.

JANPA also identified, with the use of 9 rigorous criteria, 39 best practices with an objective to prevent childhood obesity that contained actions at kindergarten and/or school level (primary and secondary schools). Easy access to these good practices was organised through a toolbox (https://www.janpa-toolbox.eu/) to facilitate programme planners and decision makers to design and implement effective interventions. This toolbox is accompanied by a Guide specially written on the "what and how" to create healthier environments in kindergartens and schools[28]. JANPA recommends that school-wide messages delivered through the curriculum, school programmes, the school environment and physical activity facilities must be coherent, consistent and mutually reinforcing to reach children and their families. To obtain the greatest impact, actions need to be undertaken in multiple settings in parallel, incorporating a variety of approaches and involving a wide range of stakeholders.

JANPA identified programmes for overweight and obesity prevention in the early stages of life, and thus targeting families during pregnancy, lactation and early childhood. From a total of 50 initiatives submitted by 11 participating countries, 20 different practices were identified as best practices. Analysis of these good practices showed that guidelines, recommendations and regulations are powerful tools for implementing policies. To ensure sustainability, follow-up and monitoring of actions through a strong public authority's commitment at regional and/or local level is essential. Campaigns and one-off measures have limited impact. Expansion of the JANPA toolbox with early interventions, particularly those addressing social inequalities, is recommended.

[25] http://www.janpa.eu/outcomes/Deliverables/2_scheda_inform%20POSITION%20PAPER_4p_210x297_JANPA.pdf

[26] http://www.janpa.eu/outcomes/Deliverables/1_%20brochure_LAYMAN_20p_170x210_JANPA.pdf

[27] http://www.janpa.eu/outcomes/Deliverables/JANPA%20DELIVERABLE%20D4.1.pdf

[28] http://www.janpa.eu/outcomes/Deliverables/D6.3_janpa_guide_online-Oct31.pdf

Projects

"**MOVE**" (European Physical Activity Promotion Forum) was a project that aimed to identify, qualify and implement good practices in cross-cutting community initiatives to promote health-enhancing physical activity in socio-economically disadvantaged areas. Amongst others MOVE collected 109 good practices. Based on these the MOVE handbook for physical activity promotion in socially disadvantaged groups was developed.

"**SALUS**" is a European network to follow-up the reformulation of food in terms of reduction of the levels of fat, saturated and trans fats, salt and sugar in manufactured foods. The collaborators in the project analysed the EU context, and identified and exchanged best practices, especially among new EU Member States. They also followed-up reformulation of manufactured foods among SMEs and performed a cost-effectiveness analysis of the major reformulations identified. They established a European Clearing House (http://www.salux-project.eu/sez/clearinghouse) that focusses on topics related to food reformulation and consumer's awareness for SMEs and consumers.

"**EPHE**" (EPODE for the Promotion of Health Equity, http://www.ephestory.eu/) aimed to reduce socio-economic inequities linked to health-related behaviour of families in seven European countries over three years (2012-2015). With its operational approach and a mix of tools and expertise, EPHE has offered an example of how community-based programmes promoting health are a solution when tackling health inequities. The project concluded that a programme at local level only can influence the behaviours and habits of families, independent of their socio-economic status, when all key stakeholders in a community are involved.

European Youth Tackling Obesity "**EYTO**" developed peer-led social marketing campaigns in a range of settings in four countries to promote healthy eating and physical activity amongst young people aged 13-16 who are vulnerable to obesity (http://www.eyto.org.uk/). More than 16,000 young people engaged in a range of paper based, face to face and web-based activities.

The overall objective of promoting Healthy Eating and Physical activity in local COMmunities "**HEPCOM**" was to increase the quality and level of local community and school interventions on promoting healthy eating and physical activity among children and young people all over Europe. The project developed the HEPCOM Learning Platform (http://hepcom.eu) to serve local authorities, local communities and professional practitioners, working on the prevention of obesity and overweight among children and young people.

The "**OPEN**" project (Obesity Prevention through European Network) aimed to strengthen the methodology of community based programmes and initiatives or public organizations, willing to implement sustainable strategies and actions to prevent obesity at local and national level. The project increased the capacity of coordination teams, organised best-practice sharing workshops and provided tailored coaching. Methodological and communication documents used by coordinating teams are classified and shared in a toolbox, that also includes other documents related to the project (http://openprogram.eu/toolbox).

Operational grants

Operational grants have been provided to:

- the **SHE-network** (Schools for Health in Europe) that supports its members to further develop and sustain school health promotion by providing a European platform for school health promotion.
- The Special Olympics EU Eurasia Foundation (**SOEEF**) that is dedicated to providing critical services to children and adults with intellectual disabilities through ongoing training and competition, physical activities, inclusive sport, social inclusive initiatives and health services in all 28 EU Member States.
- The OBesity Training and INformation Services for Europe (**OBTAINS-E**) of the WOF that offers web-based training for professional obesity treatment and weight management to practitioners across health services. It also provides data and policy dissemination activities for the development of obesity prevention strategies in the European region.

Mapping to the operational objectives of the EU Action Plan

The Joint Actions and projects of the EU Health programme often comprehend identification and sharing of good practices. This type of work is not explicitly mentioned as one of the operational objectives of the Action Plan. We therefore mapped the projects to the most relevant topic. Figure 5.3 shows that the activities funded under the EU Health Programme that are relevant to childhood obesity contributed to operational objectives in all areas of action, except for Area 4: Restrict marketing and advertising to children, and Area 8: Increase research. The Joint Actions and projects funded under the EU Health Programme mainly used the development of tools and exchange of knowledge as means to contribute to these operational objectives (Figure 5.4).

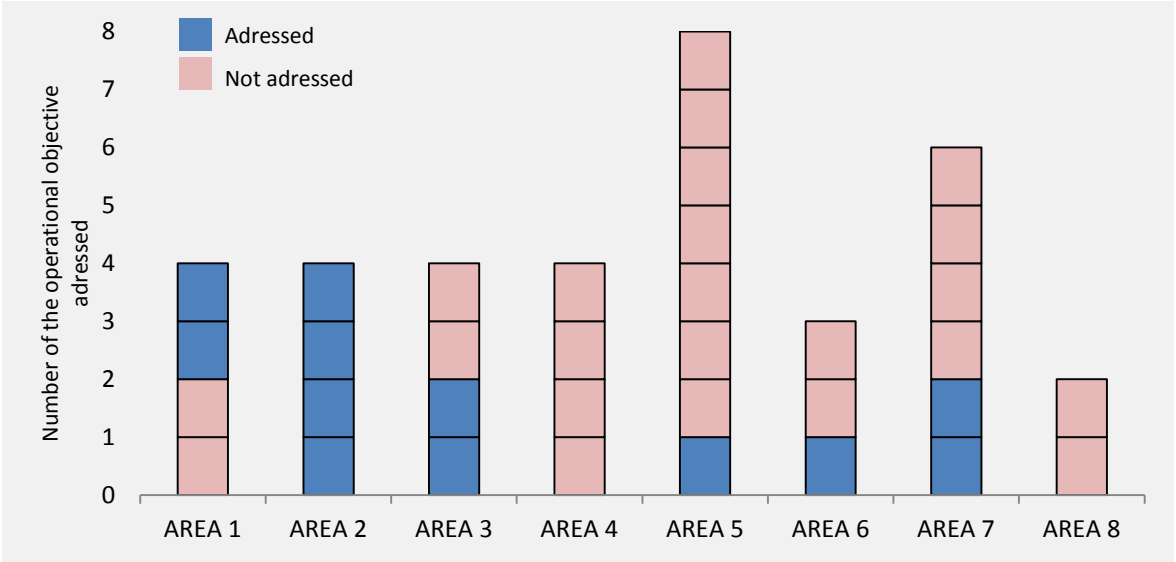


Figure 5.3. *Mapping of the 12 Joint Actions, projects and operational grants of the EU Health Programme to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 5.1 for a description of the operational objectives.*

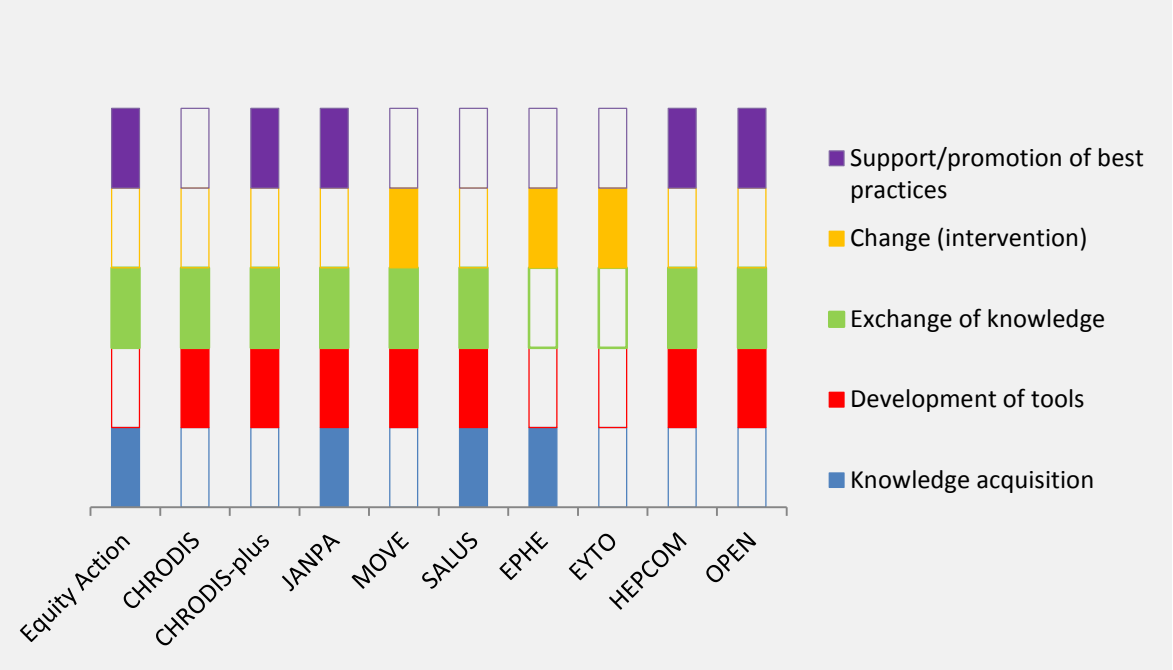


Figure 5.4. *Way in which the 12 Joint Actions and projects funded under the EU Health programme contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

5.2.3 7Th Framework Programme and Horizon 2020

The 7th Framework Programme for Research and Technological Development (FP7: 2007-2013) and Horizon 2020 (H2020: 2014-2020) are the European Union's main instruments for funding research and innovation in Europe. They aim to secure Europe's global competitiveness by ensuring Europe produces world-class science, removing barriers to innovation and enabling the public and private sectors to work together in delivering innovation. The focus is not so much on applied research and implementation of policies and interventions, but nevertheless some projects contribute to the operational objectives of the Action Plan (see Table 5.3 and Figure 5.5).

Seven projects that linked to the topic of childhood obesity complied with our inclusion criteria, i.e. did not end before 2014 and had a clear implementation arm in the project. They contributed to the operational objectives by knowledge acquisition, change (implemented interventions) and/or development of tools (produced material for children, parents or teachers) (see Figure 5.6). The projects are described below.

The project "**HabEat**: Determining factors and critical periods in food habit formation and breaking in early childhood: a multidisciplinary approach" (https://www.habeat.eu/) investigated the formation of eating habits in children aged 6 months to 6 years through epidemiological as well as experimental studies. It has incorporated the results and evidence from previous literature into a booklet "Vegetables and fruit: help your child to like them" and a web-based guide to parents of infants and young children on how to help children to like vegetables and fruit. This guide includes recommendations on breastfeeding, complementary feeding, feeding young children, and parental feeding practices, such as offering food as reward and snacking.

The "**ToyBox**" project is a multifactorial evidence based approach using behavioural models in understanding and promoting fun, healthy food, play and policy for the prevention of obesity in early childhood (http://www.toybox-study.eu/). The project developed a kindergarten-based, family-involved intervention to promote healthy food and fun and active play in kindergarten settings throughout Europe. The intervention was implemented in 6 European Countries in the school year 2012/2013 and the CHRODIS-project (see 5.2.2) identified it as "best practice intervention". Materials are available in different languages.

The project "**REPOPA**" (REsearch into POlicy to enhance Physical Activity) found practical ways to support policymakers in their use of research evidence in developing physical activity policies (http://www.repopa.eu/). REPOPA researchers worked hand-in-hand with policymakers to learn how best to co-create policies so that research evidence is taken into account. In other words, REPOPA used the evidence-informed policymaking approach, meaning that research evidence is not the primary driver of decision making. Instead local contexts, resources and needs are taken into account as well.

"**PEGASO**" stands for PErsonalised GuidAnce Services for Optimising lifestyle in teen-agers through awareness, motivation and engagement. The project developed a multi-dimensional cross-disciplinary ICT system that will exploit sophisticated game mechanics to motivate behavioural changes towards healthier lifestyles and prevent overweight and obesity in the younger population. The system is co-designed with adolescents and in the first phase involved approximately 400 adolescents from three European countries. On the website information and e-courses for teens, parents and teachers is provided (http://www.pegasof4f.eu/web/guest/training).

The "**PASTA**" project (Physical Activity through Sustainable Transport Approaches) focused on the systematic promotion and facilitation of active mobility (i.e. walking and cycling including the combination with public transport use) as an innovative approach to integrate physical activity into individuals' everyday lives. The project provided an updated version of the World Health Organization's Health Impact Assessment (HIA) tool designed to help urban planners, transport and health practitioners make the case for new investment in active mobility. A compendium of good practices of active mobility promotion aimed at decision makers, implementing authorities, businesses, civil society organizations and end users, will be published in 2018 on the website of the project (http://pastaproject.eu/).

"**BigO**: Big data against childhood Obesity" will develop a platform, allowing the quantification of behavioural community patterns through Big Data provided by wearables and eHealth-devices (https://bigoprogram.eu/). School and age-matched obese children and adolescents will be the sources for community data. Comprehensive models will be created, allowing data-driven effectiveness predictions about specific policies on a community and real-time monitoring of the population response. This will allow Public Health Authorities to evaluate their communities based on their obesity prevalence risk and to take local action, based on objective evidence.

"**SmartLife**: Smart Clothing Gamification to promote Energy-related Behaviours among Adolescents" will develop an exercise game (exergame) that requires movement to be played (http://www.smartlifeproject.eu/). The game will provide immediate physiological feedback from smart textile to ensure exercises are performed at a moderate-to-vigorous intensity level.

Table 5.3. Projects funded under FP7 and H2020 with an end date in 2014 or later.

Title	Start and end date	Participating countries	Action Plan operational objectives
FP7			
HabEat	2010-2014	FR*, NL, UK, DK, PT, EL,	1.1, 1.2, 1.3
ToyBox	2010-2014	EL*, DE, BE, NL, ES, NO, UK, PL, BG, LU	2.4, 5.1, 5.8
REPOPA	2011-2016	DK*, FI, IT, NL, RO, UK	6.1
PEGASO	2013-2017	IT*, CH, DE, ES, RO, UK	5.1, 6.1
PASTA	2013-2017	AT*, BE, DE, IT, ES, SE, CH, UK	6.2
H2020			
BigO	2016-2020	EL*, SE, NL, IE, ES	7.3
SmartLife	2017-2018	PT*, ES, DE, BE	6.1

* coordinator

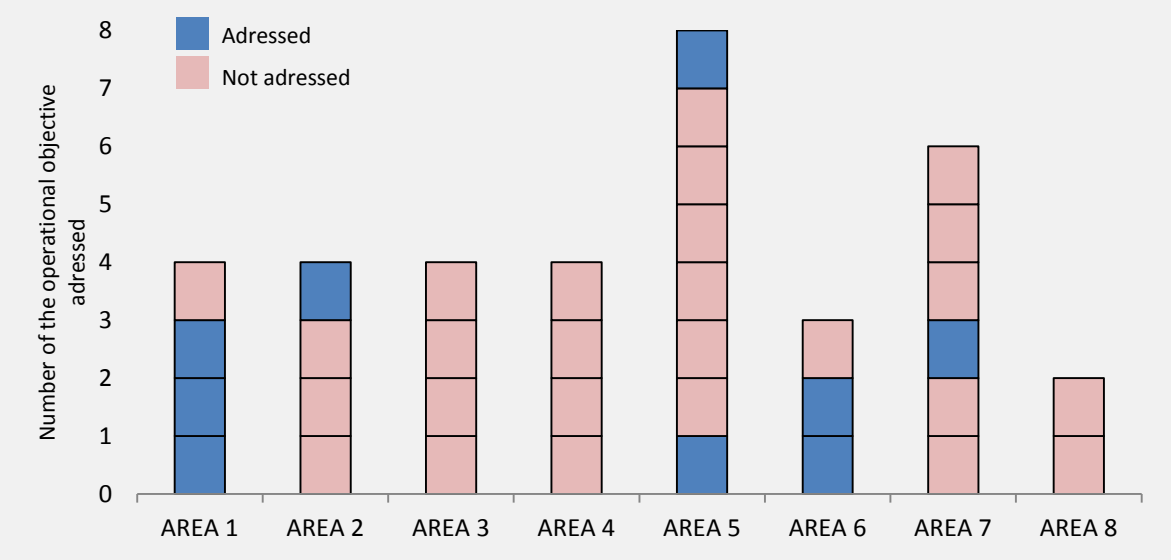


Figure 5.5. *Mapping of the seven projects funded by FP7 and H2020 to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 5.1 for a description of the operational objectives.*

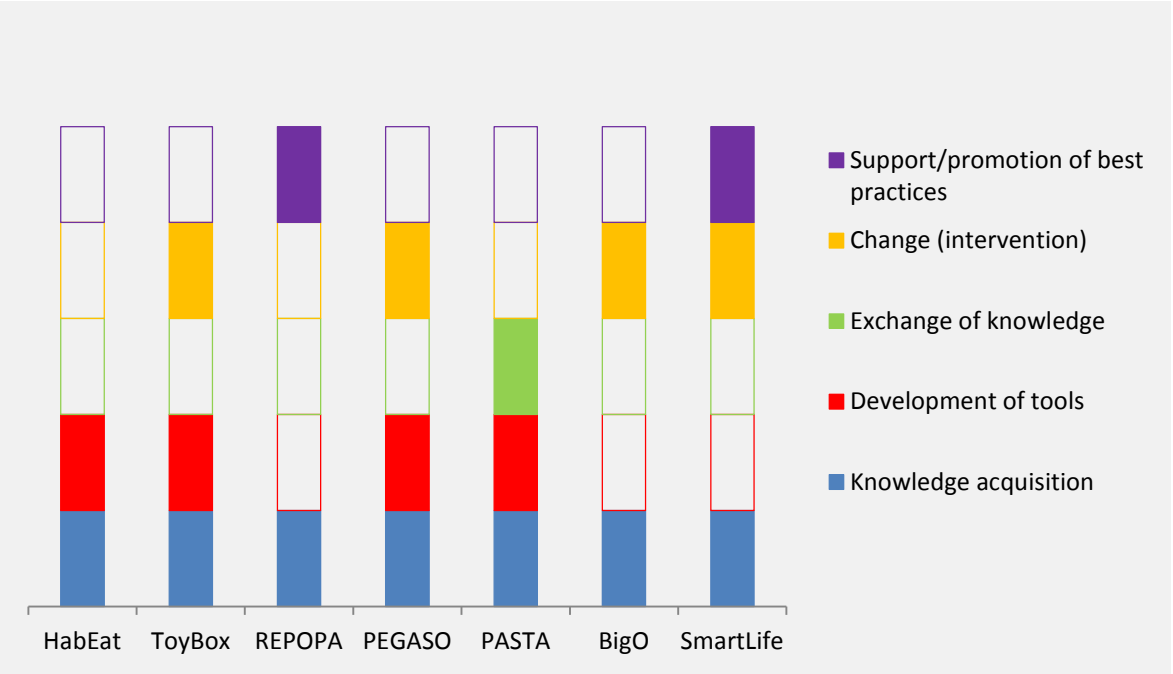


Figure 5.6. *Way in which the seven projects funded under FP7 and H2020 contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

5.2.4 Erasmus+ Programme

Erasmus+ is the EU's programme to support education, training, youth and sport in Europe. The aim of Erasmus+ is to contribute to the Europe 2020 strategy for growth, jobs, social equity and inclusion, as well as the aims of ET2020, the EU's strategic framework for education and training. Among the specific issues tackled by the programme are: supporting innovation, cooperation and reform, and promoting cooperation and mobility with the EU's partner countries.

In total 138 projects have been identified that are relevant to childhood obesity: 84 from the sub-programme "cooperation for innovation and the exchange of good practices", 47 from the sub-programme "sport" and seven from other sub-programmes. Annex 6 lists all relevant projects funded under the Erasmus+ Programme. Projects that had collaborators from >3 countries (n=96) were mapped against the areas of action mentioned in the Action Plan. These 96 projects contributed to the following areas of action:

- Area 2: Promote healthier environments, especially at schools and pre-schools (55% of the projects)
- Area 6: Encourage physical activity (56% of the projects)
- Area 5: Inform and empower families (4% of the projects)
- Area 3: Make the healthy option, the easier option (1% of the projects)
- Area 7: Monitor and evaluate (1% of the projects)

Projects with collaborators from >5 countries and projects in the context of the European Week of Sport (n=48) were also mapped against the operational objectives. The projects are mostly practice-based and contribute to the prevention of childhood obesity by organising activities at the local level, i.e. through change: projects that intervene on the current situation. Since the operational objectives of the Action Plan are predominantly tailored to policy making and initiatives from (public health) authorities, it is not always easy to map the projects to its operational objectives. Projects that were organised to increase physical activity were therefore mapped to operational objective 6.1: Strengthened promotion of physical activity policies. The projects can be linked to 13 of the 35 operational objectives (see Figure 5.7).

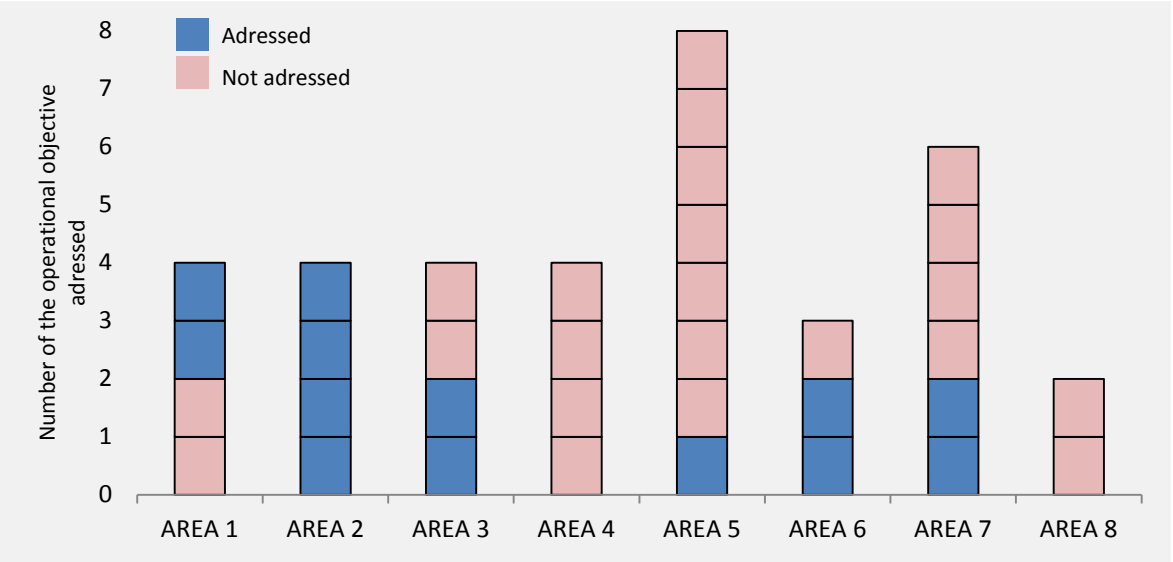


Figure 5.7. *Mapping of 96 of the 138 projects funded by the Erasmus+ programme to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 5.1 for a description of the operational objectives.*

5.2.5 Joint Programming Initiatives

Joint Programming Initiatives (JPIs) are a strategic framework, a bottom-up approach with high-level commitment from Member States. The overall aim of the Joint Programming process is to pool national research efforts in order to make better use of Europe's public research and development resources and to tackle common European challenges more effectively in a few key areas. Member States voluntarily commit to Joint Programming Initiatives (JPIs) where they implement together joint strategic research agendas leading to partnerships composed of variable groups of countries. The European Commission facilitates the Joint Programming process and, if they so wish, support Member States for Joint Programming by, for instance, financing support actions to their management and launching possible complementary measures to actions undertaken jointly by participating countries as identified in each JPI strategic research agenda.

Ten Joint Programming Initiatives have been launched. “A Healthy Diet for a Healthy Life” (**JPI-HDHL**) started in 2011 and is most relevant with respect to the topic of childhood obesity (https://www.healthydietforhealthylife.eu/). Currently, 20 EU Member States, plus Norway and Switzerland participate in JPI-HDHL either as a full member or as observer (see Map 5.1).

The vision of the JPI-HDHL is that by 2030 all citizens will have the motivation, ability and opportunity to consume a healthy diet from a variety of foods, have healthy levels of physical activity and that the incidence of diet-related diseases will have decreased significantly. The JPI-HDHL provides a roadmap for harmonised and structured research efforts in the area of food, nutrition, health and physical activity and offers defined priorities. The Strategic Research Agenda contains three key interacting research areas:

- Determinants of diet and physical activity: ensuring the healthy choice is the easy choice for all consumers. The challenge is to understand the most effective ways for improving public health through interventions targeting motivation, ability and opportunity to adopt and maintain healthy dietary and physical activity behaviours.
- Diet and food production: developing healthy, high-quality, safe and sustainable foods. The challenge is to stimulate the European consumers to select foods that fit into a healthy diet and to stimulate the food industry to produce healthier, high-quality foods in a safe, sustainable and affordable way.

- Diet-related chronic diseases: preventing diet-related, chronic diseases and increasing the quality of life. The challenge is to prevent or delay the onset of diet-related chronic diseases by gaining a better understanding of the impact of nutrition and lifestyle across Europe on human health and diseases.

For each of these research areas, primary initiatives and research challenges are described for the periods 2012-2014 and 2015-2019. Several activities are relevant for the topic of childhood obesity and they contribute to four of the 35 operational objectives of the Action Plan (see Table 5.4 and Figure 5.8).

Within JPI-HDHL several projects have been launched that are relevant in the context of childhood obesity.

"DEDIPAC" (DEterminants of DIet and Physical ACtivity) was the first Joint Action of JPI-HDHL that started in December 2013 and ran for 3 years (https://www.dedipac.eu/). Its objective was "*To understand the determinants, at both the individual and group levels, regarding dietary, physical activity and sedentary behaviours using a broad multidisciplinary approach, and to translate this knowledge into a more effective promotion of these health behaviours.*" For this purpose, DEDIPAC developed a knowledge hub, i.e. a network and infrastructure, for future monitoring, research and translation of research to policy and practice regarding determinants of dietary, physical activity and sedentary behaviours. The network consists of more than 300 European researchers from many different disciplines. An online toolbox summarizes an overview of the quality of measurement methods for diet, physical activity, and sedentary behaviours. There is also a toolbox to assist in the development, implementation and evaluation of interventions and policies. Furthermore, first steps were taken towards cross-European surveillance with a detailed roadmap. Sixty-eight research organisations from 13 countries participated in the project.

Mid of December 2014, European Nutritional Phenotype Assessment DAta Sharing Initiative ("**ENPADASI**") officially started its work programme (http://www.enpadasi.eu/). The main objective of ENPADASI was to deliver an open access research infrastructure that contains data from a wide variety of nutritional studies. This infrastructure will facilitate combined analyses in the future. ENPADASI developed a database and integrated existing databases in it. Furthermore it organised training sessions for young researchers to learn how to work with the system. Fifty-one research groups from nine EU Member States were involved in ENPADASI.

"**FOODBALL**" (FOOD Biomarker ALLiance), launched at the end of 2014, may contribute to better monitoring of dietary intake in Europe and therefore is considered to contribute to the operational objectives of the Action Plan (http://foodmetabolome.org/). The FOODBALL consortium includes research organisations from 11 European countries, Canada and New Zealand. The project includes a systematic exploration and validation of biomarkers to obtain a good coverage of the food intake in different population groups within Europe.

In 2017 there were two calls within JPI-HDHL that probably will result in projects that contribute to the operational objectives of the Action Plan.

1. The aim of the first call, the Joint Funding Action "Effectiveness of existing policies for lifestyle interventions – Policy Evaluation Network" (**PEN**), is to establish a multi-disciplinary research network for the monitoring, benchmarking and evaluation of policies that affect dietary and physical activity as well as sedentary behaviour with a standardized approach across Europe. A proposal was submitted in September 2017by 26 research groups and has been funded.
2. The second call concerned the establishment of working groups on diet related diseases. Herewith the JPI-HDHL aims to support transnational cooperation and communication between individual researchers, research groups and research organisations in order to merge knowledge, data and research results. Three topics

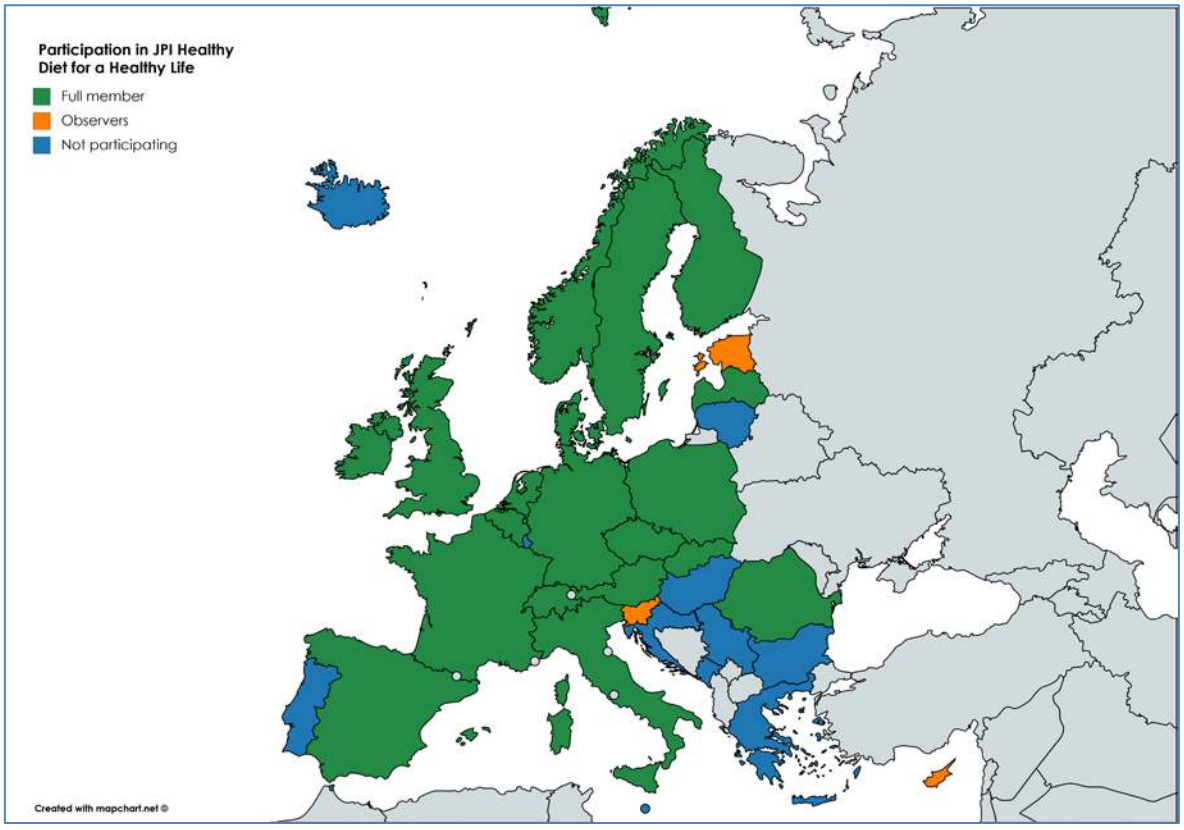
are to be addressed in the Working Groups, i.e. 1) economic evaluation of dietary interventions and/or physical activity interventions, 2) integrated chronic disease prevention and management and 3) scouting exercise for existing intervention studies and explore the possibilities of merging. The output of the working groups will be white papers, prospective views, guidelines, or best practice frameworks of value to the wider research community and with societal impact.

Until now, JPI-HDHL uses knowledge acquisition, development of tools, exchange of knowledge and promotion of/support for developing best practices as ways to achieve its goals (see Figure 5.9).

Table 5.4. Relevant activities of the Joint Programming Initiative "A Healthy Diet for a Healthy Life (JPI-HDHL)"

Title	Start and end date	Participating countries	Action Plan operational objectives
Overall programme			
JPI-HDHL	2011-2021	NL*, AT, BE, CZ, DK, FI, FR, DE, IE, IT, LV, NO, RO, PL, SK, ES, SE, CH, UK, CY, EE, SI	8.2
Activities initiated by JPI-HDHL			
DEDIPAC	2013-2016	NL*, AT, BE, DK, FI, FR, DE, IT, IE, NO, PL, ES, UK	6.1, 7.1, 7.2, 8.2
ENPADASI	2014-2016	NL*, BE, DK, EE, FR, DE, IE, ES	7.1, 8.2
FOODBALL	2014-2017	NL*, BE, DK, FR, DE, IE, IT, NO, ES, CH	7.1, 8.2

* coordinator



Map 5.1. *Participation in the Joint Programming Initiative "A Healthy Diet for a Healthy Life".*

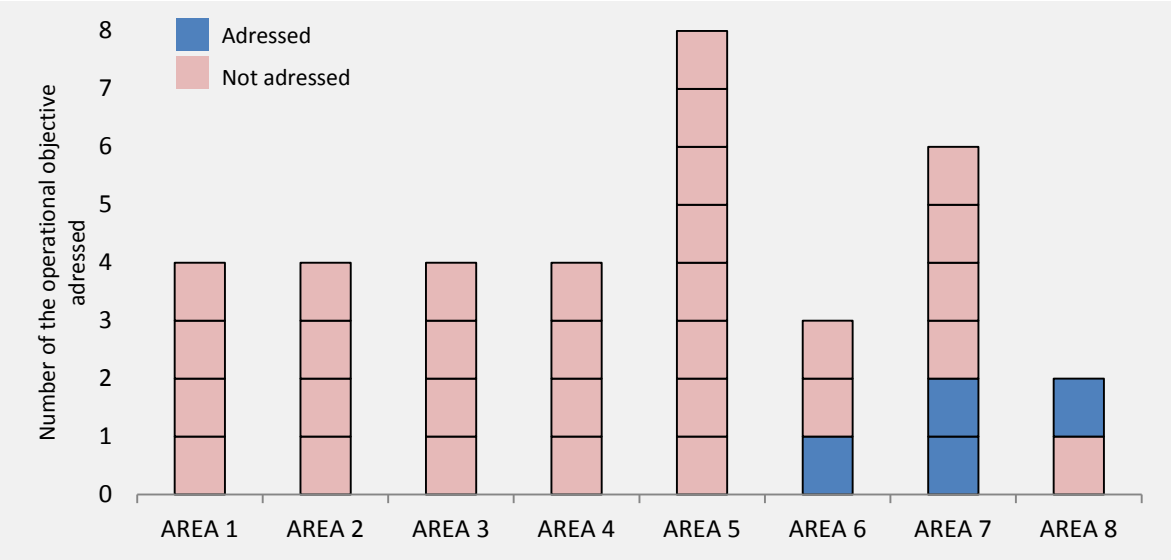


Figure 5.8. *Mapping of JPI-HDHL to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 5.1 for a description of the operational objectives.*

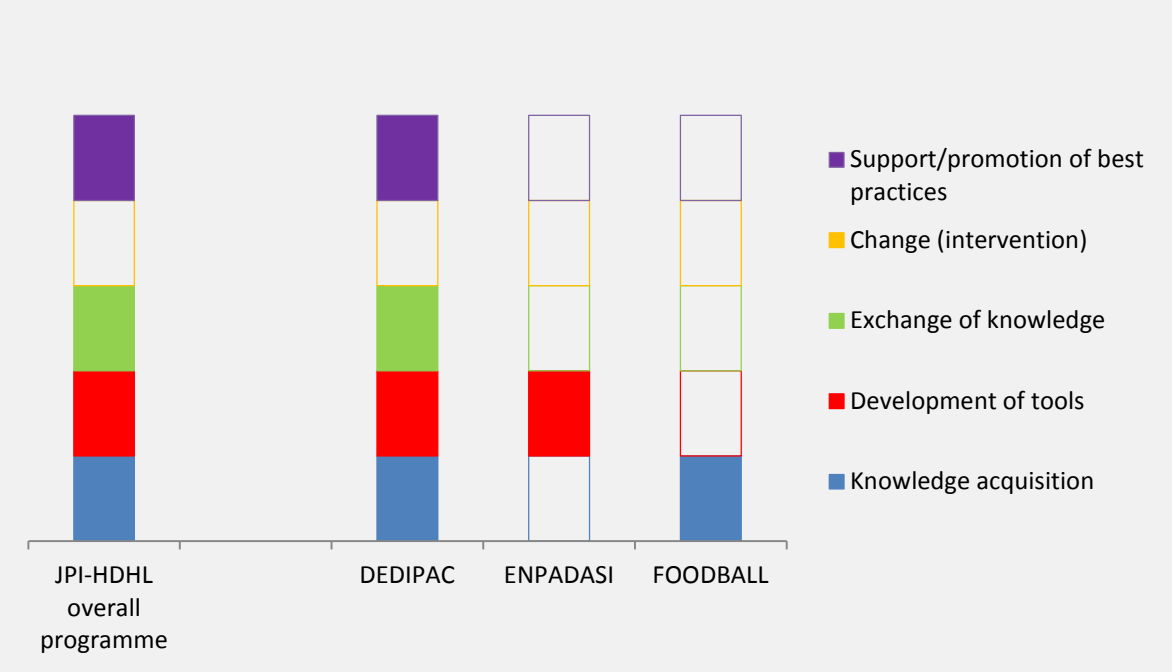


Figure 5.9. *Way in which JPI-HDHL and the projects that resulted from it contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

5.2.6 *Summary of the engagement of the European Commission*

One of the operational objectives under Area 8 of the Action Plan is to increase the support by EU research programmes. Engagement of the European Commission in the EU programmes is therefore assessed by the amount of funding the Commission provided for the projects that are described in the preceding paragraphs, excluding pilot projects. The total funding for the projects amounted to more than 70 million euros (see Figure 5.10). It should be noted that JPI HDHL activities are funded through a virtual common pot model. This means that funding organisations of the participating countries contribute considerably to the projects, while the EC then co-funds a certain share.

Funding according to area for action of the Action Plan is presented in Figure 5.11. When the projects activities address an area for action, the complete funding is allocated to that area for action. Therefore this figure should be seen as a rough indicator for the attention each area for action gets in the funding programmes. Projects funded by the Erasmus+ programme that involved organisations from less than four countries involved in the Childhood Obesity Study were not mapped. Area 6 seems to be addressed the most. It is apparent that areas of action that require (voluntary) agreements with industry, i.e. Area 3 (make the healthy option the easy option) and Area 4 (restrict marketing to children), are not much addressed through EU-funding. It should be noted, however, that on 23 December 2017 the European Commission issued a call to tender for a feasibility study on a monitoring system on food reformulation initiatives for salt, sugars and fat[29]. The study intends to pilot test the functioning of the monitoring system in key areas. With this initiative, funded under the third Health Programme, the European Commission meets one of the recommendations of JANPA, i.e. deploying the tested monitoring system based on "Oqali" in several European countries in the framework of a network including at least 15 to 20 countries. In total a budget of €1.4 million is available for this initiative. Furthermore, October 2017, a call to tender for a study on the exposure of children to marketing of foods high in fat, salt or sugar, with a budget of €770.000[30] has been published. This study aims to provide an overview of the amount and types of marketing of HFSS foods to which children are exposed.

[29] http://ted.europa.eu/udl?uri=TED:NOTICE:516944-2017:TEXT:NL:HTML&tabId=1
[30] http://ted.europa.eu/udl?uri=TED:NOTICE:339176-2017:TEXT:EN:HTML

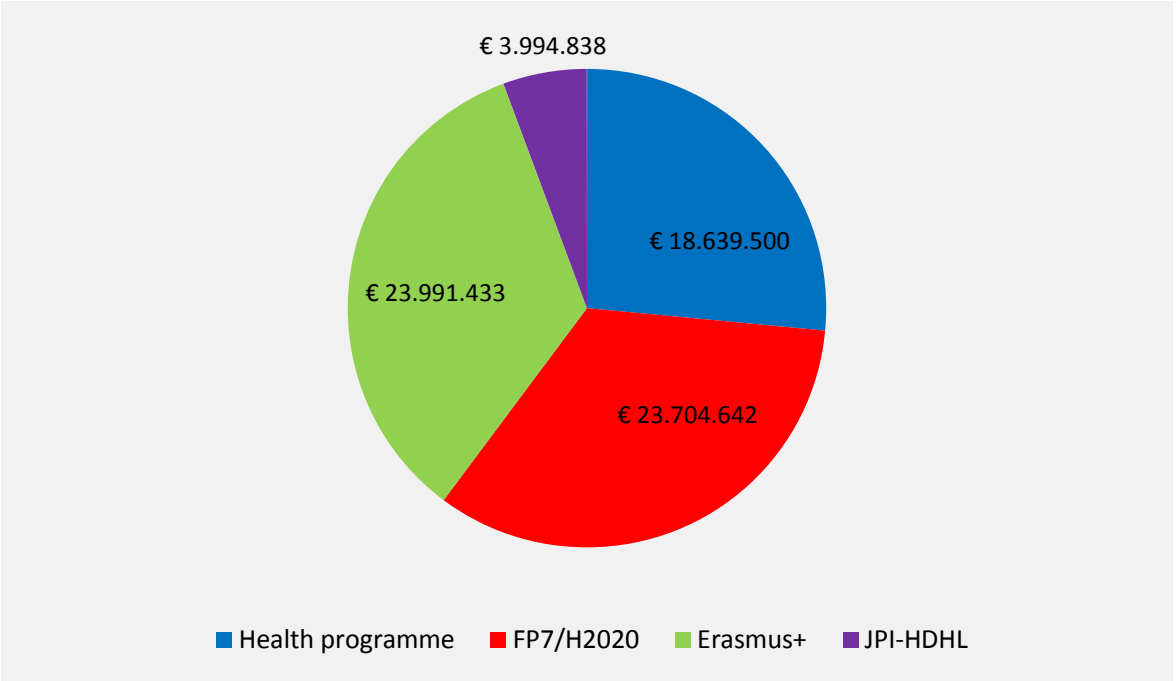


Figure 5.10. *EU-funding of projects relevant to childhood obesity according to the funding programme.*

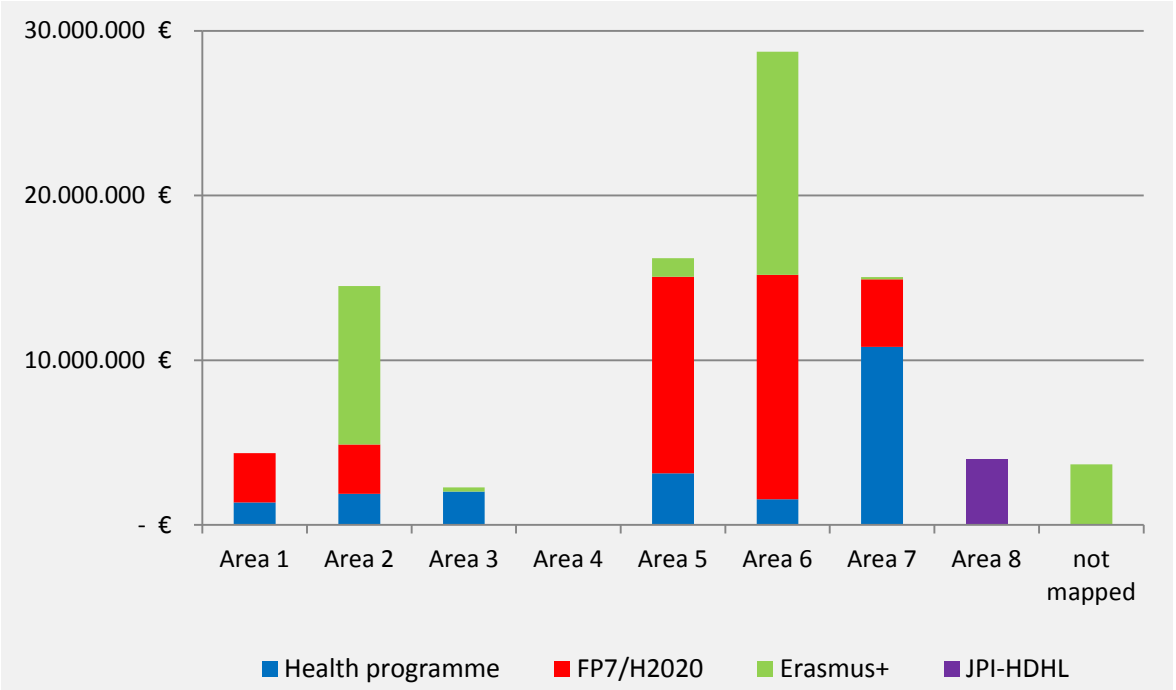


Figure 5.11. *Allocation of funding by EU programmes to areas of action of the EU Action Plan on Childhood Obesity 2014-2020.*

5.2.7 Assessment of the engagement of Member States

Participation in JPI-HDHL and activities that come forward from this initiative especially show the engagement of Member States' authorities, as the JPI-HDHL is a voluntary partnership of the Member States with high-level commitment and (co-)funding. Participation in projects and activities funded by the EU Health Programme, FP7/H2020 and the Erasmus+ Programme also provides some insight in the engagement of Member States. By submitting research proposals, organisations in the Member States show their interest in the topic of childhood obesity, nutrition and physical activity. Furthermore it may be an indicator of awareness about and capacity dedicated to childhood obesity among many stakeholders in society, like researchers, teachers, and sports organisations. When awareness and/or capacity is low, these stakeholders would likely not participate in such projects.

Organisations from Italy, Spain and Poland are most often involved in EU-funded projects, and this is due to a large participation in Erasmus+ projects (see Figure 5.12). These are, however, large countries, which also may have resulted in participation in many projects, as there are more organisations that may apply for funding than in smaller countries, such as Luxembourg, Malta, Estonia or Cyprus. Lower participation rates in non-EU countries, especially Montenegro and Serbia, are likely due to a limited access to the funding programmes. The percentage of projects EU Member States coordinate may be an additional indicator of engagement, as coordinators often (but not always) take the initiative for funding and the lead in writing the proposal. Organisations from nine EU Member States (AT, FR, IT, NL, ES, UK, HR, CZ, PL, RS) coordinated more than 20% of the projects they participated in, while organisations from 12 countries coordinated 10-20% (BE, DK, FI, DE, EL, IE, SE, BG, EE, LT, MT, RO). Organisations from the other seven Member States coordinated less than 10% of the projects.

Engagement from Norway and Iceland can also be demonstrated by the fact that they fund projects relevant for childhood obesity through the Norway and EEA Grants. The Norway Grants are financed solely by Norway and available in 13 EU Member States that joined in 2004, 2007 and 2013. The EEA Grants are jointly financed by Iceland, Liechtenstein and Norway. They are additionally available in Greece and Portugal. Through these funds Hungary and Romania received funding for public health initiatives related to childhood obesity, nutrition and/or physical activity. In Hungary the programme includes projects to raise awareness on physical activity among vulnerable and disadvantaged groups, e.g. projects targeting Roma inclusion. In Romania a project is ongoing that aims to reach out to youth with preventive services for adopting healthier lifestyles (through community based interventions in schools and kindergartens). Portugal received funding for three projects, one for eliminating dietary inequality in schools, one to promote nutritional and social equity and one to improve health literacy on nutrition in families with low income and children between 5-10 years old.

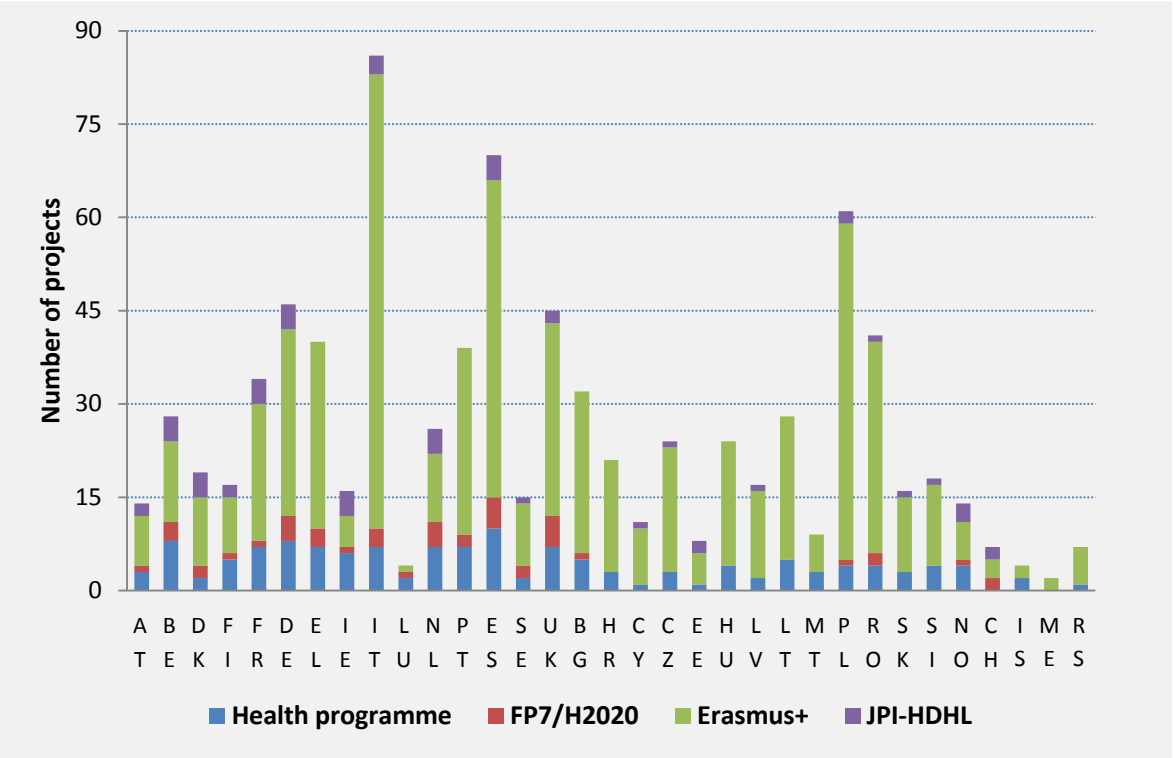


Figure 5.12. *Participation of EU Member States, Norway, Switzerland, Iceland, Montenegro and Serbia in projects funded by EU programmes.*

5.3 International organisations

Several international organisations initiate, coordinate or participate in activities that could help countries with the development of policies and activities for their fight against childhood obesity. These activities are described below.

5.3.1 The World Health Organization (WHO)

WHO is the authority responsible for public health within the United Nations system. In 2014, the Commission on Ending Childhood Obesity was established to review, build upon and address gaps in existing mandates and strategies. In 2016 the WHO presented the final report of this Commission, describing a comprehensive, integrated package of recommendations to address childhood obesity (57). Several other documents have been published to inform and help policy makers to address childhood obesity. The list below is not meant to be exhaustive, but gives examples of relevant documents.

- A set of recommendations on the marketing of foods and non-alcoholic beverages to children (58)
- Global recommendations on physical activity for health (59), which contain recommendations for the age group of 5 - 17 year olds
- An overview of the types of childhood obesity prevention interventions that can be undertaken at national, sub-national and local levels (60).
- A set of tools for Member States to determine and identify priority areas for action in the field of population-based prevention of childhood obesity (61).
- Guidelines to support primary health care workers identify and manage children who are overweight or obese (62).
- Guidelines on the protection, promotion and support of breastfeeding in facilities providing maternity and new-born services (63).

Furthermore, WHO together with the United Nations Children's Fund (UNICEF) launched the Baby Friendly Hospital Initiative (BFHI) in 1992. This initiative is to implement practices that protect, promote and support breastfeeding. BFHI aims to give every baby the best start in life by creating a health care environment where breastfeeding is the norm, thus helping to reduce the levels of infant morbidity and mortality in each country. Participation in this initiative is described in Chapter 4.1.1.

The WHO Regional Office for Europe is one of six regional offices around the world. It serves the WHO European Region, which comprises 53 countries, including the 33 countries included in this study. A number of its activities contribute to reversing the obesity epidemic in Europe, including those focusing on physical activity and diet. They issued, for example, the WHO European Food and Nutrition Action Plan 2015-2020 (64), which was adopted unanimously by the WHO Regional Committee for Europe. This action plan is intended to significantly reduce the burden of preventable diet-related non-communicable diseases, obesity and all other forms of malnutrition still prevalent in the WHO European Region. It calls for countries to act, using a whole-of-government, health-in-all-policies approach. WHO Regional Office for Europe supports activities at country and international level to implement the action plan. For this purpose, action networks have been set up consisting of groups of Member States that have taken the lead in addressing particular challenges, such as reducing marketing pressure on children. WHO Regional office for Europe is also involved in several other networks:

- It is the host, as well as member, of HEPA Europe (European network for the promotion of health-enhancing physical activity). This is a network that works for better health through physical activity among all people in the WHO European Region, by strengthening and supporting efforts to increase participation and improve the conditions for healthy lifestyles. WHO Regional Office for Europe closely collaborates with the network, consistently with the goals of its programme on transport and health that include the promotion of physical activity as a healthy means for sustainable transport. All activities of HEPA Europe are based on WHO policy statements, such as the Global Strategy for Diet, Physical Activity and Health (65), the European Charter on Counteracting Obesity (66), the Global action plan for the prevention and control of NCDs 2013-2020 (67) and on corresponding documents from the European Commission.
- It also coordinates the WHO European Healthy Cities Network. This network consists of nearly 100 cities and towns from 30 countries around the WHO European Region that are committed to health and sustainable development. They are also linked through national, regional, metropolitan and thematic Healthy Cities networks. Each five-year phase focuses on core priority themes and is launched with a political declaration and a set of strategic goals. The overarching goal of the current Phase VI (2014–2018) is implementing Health 2020 at the local level. Recently WHO Regional Office for Europe published a report on transforming public spaces to promote physical activity (68).

Besides the activities described above WHO Regional Office for Europe sets out and/or supports various surveys that are relevant with respect to childhood obesity.

- It provides technical support in implementing the Childhood Obesity Surveillance Initiative (COSI), with assistance in sampling, equipment and training, and continues to organize COSI network meetings every year.
- It adopted HBSC as a collaborative study in 1983.
- It conducts surveys, such as the Global Nutrition Policy Review survey (GNPR2 survey) in 2016. The data from these surveys are made available, for example through the Nutrition Obesity Physical Activity (NOPA) database. The database comprises surveillance data on national and subnational level, as well as policy related information. As a monitoring tool, the NOPA database can stimulate policy-makers to identify gaps and needs in data collection and policy development, or to show progress in their fight against obesity. The database will be continuously updated and expanded with policy documents, data on

nutritional status, food consumption, nutrient intake, physical-activity levels and policy implementation in each Member State.

WHO Regional Office for Europe's public health journal, Public Health Panorama, dedicated its issue of December 2017 to obesity and unhealthy diets in the European Region (69). This issue, "Turning the tide on obesity and unhealthy diets", gives a snapshot of challenges governments face in making policies for improving public health. It examines the rapid increase in overweight and obesity among children and adolescents, as well as the need for transforming both service delivery and the scope of practice of health professionals. Several articles in this issue describe concrete and effective solutions that have been implemented in the Region. It presents lessons learned on topics such as taxation on sugary drinks; clear, consumer-friendly front-of-package labelling; marketing restrictions on the promotion of fatty, salty and sugary foods to children; school food policies; and public procurement. WHO Regional Office for Europe also published a report on Incentives and disincentives for reducing sugar in manufactured foods (70).

5.3.2 European Association for the Study of Obesity (EASO)

The European Association for the Study of Obesity is a federation of professional membership associations from 32 European countries. Organisations from 27 countries included in this study are members. Six countries have no organisations represented (LU, CY, EE, LV, LT, MT). Malta is in the process of setting up an obesity association which will be a member of EASO. The mission of EASO is to decrease the burden of unhealthy weight. It represents the European obesity community, including scientists, health care practitioners, physicians, public health experts and patients. EASO is in official relations with WHO Regional Office for Europe and a founding member of the EU platform for action on diet, physical activity and health. It has several task forces and working groups, such as the Childhood Obesity Task Force and Nutrition Working Group.

The Childhood Obesity Taskforce published a position statement on childhood obesity (71) and has developed a series of educational podcasts on childhood obesity related issues. The Nutrition Working Group is a network of European nutrition experts, offering expert opinion and input to EASO activities. The working group also delivers nutrition education via workshops at the European Congress on Obesity and teaching courses.

5.3.3 World Obesity Federation (WOF)

The WOF represents professional members of the scientific, medical and research communities from over 50 regional and national obesity associations. Organisations from three countries are member of the EASO, but not of the WOF (ES, SE, ME). For Malta the Malta Nutrition and Obesity Research Unit is on the list of active national association members of the WOF. The WOF creates a global community of organisations dedicated to solving the problems of obesity. WOF's mission is to lead and drive global efforts to reduce, prevent and treat obesity. Through a global network of experts and other NGOs,

WOF-Policy&Prevention advocates for action and change at a global, regional, national and local level, targeting both the public and private sectors. They do this in a number of ways, such as advising governments, responding to consultations, publishing position statements, and convening high-level meetings of experts.

In 2015 WOF launched the World Obesity Action Initiative to drive awareness and understanding of practical and effective actions that can be taken to combat the obesity crisis. The Action Initiative promotes a comprehensive view of tackling obesity covering a range of individual, environmental, social and physiological issues that can

have an impact – from diet to physical activity, from infrastructure to sport, from public health interventions to medicine.

Furthermore, WOF has an official obesity education programme, designed for all health professionals: SCOPE (Specialist Certification in Obesity Professional Education). Its mission is to develop a coherent approach to obesity management through education, and recognition of professional expertise in obesity and its management.

WOF also publishes country profiles that provide information on obesity prevalence, management and prevention, as well as the interactive World Obesity Atlas, a database on obesity statistics and related data on drivers of obesity, the impact of obesity and actions being taken to prevent and manage obesity (https://www.worldobesity.org/data/).

5.3.4 The Organisation for Economic Co-operation and Development (OECD)

The mission of the Organisation for Economic Co-operation and Development is to promote policies that will improve the economic and social well-being of people around the world. It provides a forum in which governments can work together to share experiences and seek solutions to common problems. Amongst others, they analyse and compare data to predict future trends. These data and real-life experience are used to recommend policies designed to improve the quality of people's lives.

In 2013, OECD published a working paper on the role of fiscal policies in health promotion (72). In 2015 results of a study on the economics of public health and health promotion was published (73). The study was primarily focused on interventions addressing behavioural risk factors, such as diet and physical activity. Besides these, OECD has published several Obesity Updates. The most recent one was published in 2017 (74). This Obesity Update focusses on communication policies designed to empower people to make healthier choices, which are increasingly used in OECD countries. In October 2017, OECD announced a new series of reviews of public health (http://www.oecd.org/health/public-health-reviews.htm). These provide in-depth analysis and policy recommendations to strengthen priority areas of countries' public health systems, highlighting best practice examples that allow learning from shared experiences, and the spreading of innovative approaches. Obesity and unhealthy diets are among the topics covered within this series of health reviews.

6 STRENGTHS AND WEAKNESSES OF ACTIONS RELATED TO THE ACTION PLAN

This chapter describes the results of the questionnaire on strengths and weaknesses. Seventy percent (n=23) of the Competent Authorities returned this questionnaire. In total, 61% (n=20) was able to provide the requested information. In addition, seven of the eight contacted experts (88%) returned the questionnaire (AT, CY, HU, IE, MT, PT, UK). In total, information on 25 of the 33 countries (76%) is available from 27 respondents. For two countries (HU and MT), information was provided both by the Competent Authority and the expert.

First a general overview of the number of reported 'most successful' activities and activities 'most difficult to work on' is given (Chapter 6.1), followed by a more detailed description of the activities per area for action in Chapter 6.2. The completeness of the Action Plan is described in Chapter 6.3.

It should be noted that 'successful' has been referred to by the respondents in various ways and should be interpreted in that light. For instance, the measure of successful has sometimes been used to describe the degree of completeness of implementation of a policy or intervention. It can, but does not necessarily, also refer to success in terms of preventing childhood overweight (including obesity). It was not always easy for the respondents to identify the policies/activities 'most difficult to work on' in their country. Reasons given are that initiatives are to be seen as a broad spectrum of activities – some targeting nutrition, some physical activity and some overweight and obesity, some targeting specific groups, some universal – that in combination work towards a common goal. More than less 'successful'/effective policies, there are less developed actions and policies that therefore have not yet led to important results. In Spain for example, the prevalence of childhood obesity is high, but a decrease is being achieved. All policies contribute to this decrease, to a greater or lesser extent, although the impact takes time to be visualized. The results described in this chapter therefore should be interpreted only as indicative for areas that are relatively well-addressed and areas that require additional action and support.

Respondents were asked to report the two 'most successful' activities and the two activities 'most difficult to work on' in their country. In a separate question they could report whether there were any policies they tried or would have liked to develop, but without success yet. Often respondent mentioned the same activities as the 'most difficult to work on', so these are described in the paragraphs for each area for action following the activities 'most difficult to work on'.

6.1 General overview

In total, the respondents reported 57 'most successful' activities and 34 activities 'most difficult to work on'. The number of reported activities per area for action is shown in Figure 6.1, whereas the relative contribution of the areas for action to the total number of 'most successful' activities and the total number of activities 'most difficult to work on' is presented in Figure 6.2. One of the activities reported as 'most difficult to work on' concerned a whole national action plan ("Gesond Iesen Mei Bewegen" (GIMB) in Luxembourg) and not to a specific activity that falls under one of the areas for action of the Action Plan. It is therefore not further included. The respondent reported that funds and human resources are lacking to develop tools to increase visibility of the program and to develop activities in ways other than through the internet. Other factors hampering the program mentioned were a lack of examples of good practice and a lack of European common policies.

None of the activities reported as 'most successful' or 'most difficult to work on' pertained to Area 6 of the Action Plan (encourage physical activity). By far the most reported 'most successful' activities (n=23, 40%) lie in Area 2, i.e. promote healthier environments, especially at schools and pre-schools. Among these, setting standards

for foods provided or sold in schools is mentioned the most, followed by nutrition education, enabling active breaks, and provision of free healthy meals. Also quite some of the reported 'most successful' activities pertain to Area 5: inform and empower families (n=11, 19%) and Area 7: monitor and evaluate (n=10, 18%). Activities to restrict marketing and advertising to children (Area 4) were mentioned least often among the 'most successful' (n=2, 4%). More activities 'most difficult to work on' were reported for this action area. Also for Area 3 (make the healthy option the easier option) there were more activities reported to be 'difficult to work on' than 'most successful'. In absolute terms and as a percentage of the total number of activities, most reported activities 'most difficult to work on' lie in Area 3 (n=10, 30%). Activities on food reformulation/food product improvement, easy to understand labelling and taxation policies were mentioned most often. Relatively few of the activities 'most difficult to work on' lie within Area 1 (support a healthy start in life) and Area 7 (monitor and evaluate). It should be noted that some of the activities were reported to be among the 'most successful' in one country and among the 'most difficult to work on' in another.

The questionnaire also asked for the factors that contributed to 'successful' development and/or implementation of activities and factors that hampered them. Political commitment and stakeholder involvement and collaboration are among the factors that were mentioned for activities in more than one area for action. Lack of it was mentioned as hampering factors for activities 'most difficult to work on'. Political commitment and stakeholder involvement can therefore be considered highly important. Figure 6.3 provides an overview of the succesfactors and hampering factors that were mentioned for activities in more than one area for action, irrespective of the number of times they were mentioned. These may be considered as general factors to take into account when developing or implementing activities.

More information on the reported 'most successful' activities and activities 'most difficult to work on' and the factors that contributed to this can be found in the paragraphs per area for action.

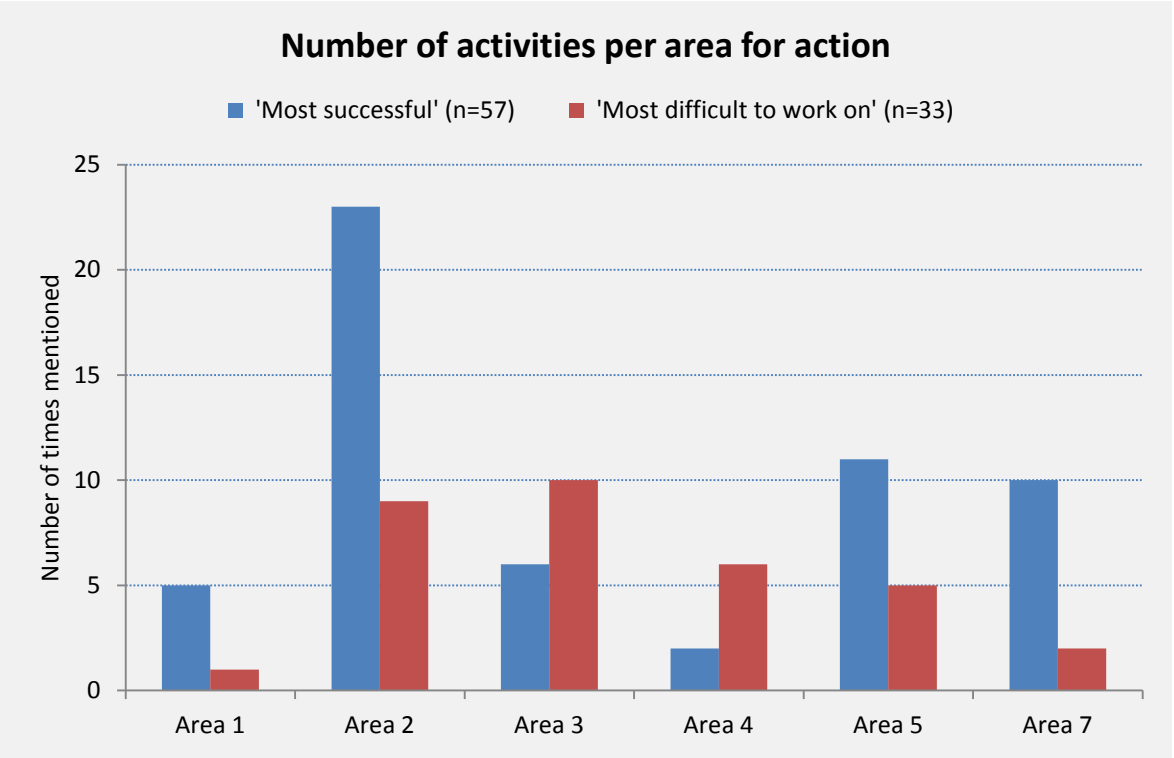


Figure 6.1. *Number of activities reported as 'most successful' and 'most difficult to work on' per area for action of the EU Action Plan on Childhood Obesity 2014-2020.*

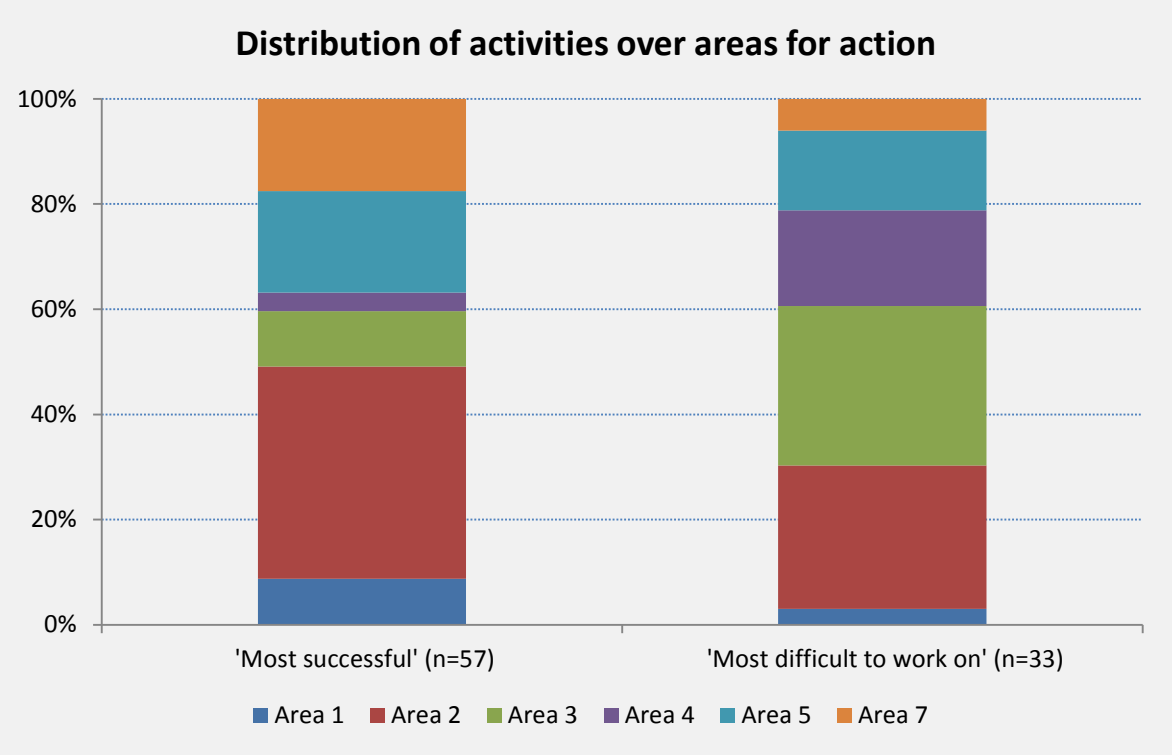


Figure 6.2. *Relative contribution of the areas for action of the EU Action Plan on Childhood Obesity 2014-2020 to the total number of activities reported as 'most successful' and 'most difficult to work on'.*

Succes factors	Hampering factors
Political commitment	Lack of political commitment
Wide stakeholder involvement and collaboration	Insufficient stakeholder involvement and collaboration
Support of central and regional institutions	Lack of funding
Good working relationship between Ministries of Health and Education	Lack of EU regulation
Uniform systematic practice or structured way of working	Lack of expertise of professionals (education, clinicians)
Inclusion of all children regardless of socioeconomic status	
Easy implementation (e.g. when regulated by legislation)	
Evidence-based, reliable information	
Coherent, understandable, practical messages/activities adjusted to specific needs of target groups (socio-economic, language, culture)	
Personal and individualised feedback or advice	
Free access to activities	
Direct involvement of both children and their parents	

Figure 6.4. *Factors that contributed to 'most successful' activities (success factors) and factors that contributed to activities 'most difficult to work on' (hampering factors) that were mentioned for more than one area for action.*

6.2 Strengths and weaknesses per area for action

Area for action 1: Support a healthy start in life
Representatives of five countries reported activities in Area 1 among their 'most successful' for the prevention of childhood obesity. Three of them mentioned their **guidelines for (early) nutrition** (NO, BG, EL). The following success factors were mentioned. The guidelines were developed in cooperation with many experts, resulting in wide acceptance. Furthermore, they were understandable, adjusted to the specific needs of the target groups, consistent across different age-groups and available in several languages.

The **promotion of breastfeeding** (EL) and a **long maternity leave** (RO) resulted in an increase in breastfeeding and were therefore considered to be 'successful'. The fact that the policies to promote breastfeeding in Greece contain parts that are regulated by legislation, made them relatively easy to implement. More details on the 'most successful' activities and their achievements are provided in Box 6.1.

Representatives of two countries reported activities in the first area for action to be among their activities 'most difficult to work on' or among activities they tried or would like to develop but were unsuccessful yet. In Slovakia experts from regional public health authorities carry out educational activities before, during and after pregnancy in a framework of so called maternity centres. According to the Slovak representative, a broader involvement of clinical professionals (gynaecologists, neonatologists) is needed. The majority of them are private workers and are hesitant about cooperation in international projects without financial reimbursement. The respondent from Poland would have liked to increase the number of centres where obese children along with their families could receive treatment and education. However, medical or physical activity professionals do not receive enough didactic hours devoted to the prevention and treatment of childhood obesity.

Box 6.1. 'Most successful' policies as reported by country representatives.
Area 1: support a healthy start in life

Promotion of breastfeeding

EL: Promotion of breastfeeding by legislative actions and education/support for mothers increased the prevalence of children that are breastfed in Greece. Furthermore, the population and health professionals are more aware of the importance of breastfeeding.

Maternity leave

RO: A long maternity leave of 2 years, paid with a very high percentage of the former income of the mother, is encouraging breastfeeding and a better monitoring of infant `s development. This resulted in an increase in breastfed children.

Guidelines on (early) nutrition

NO: Enhancing breastfeeding and education and providing information on healthy nutrition and physical activity during pregnancy and childhood. Hereunder fall national guidelines for preventing overweight and obesity, guidelines for diet and physical activity and guidelines for healthy meals in kindergartens and schools. These activities reach practically all children during their childhood and raised consciousness on these issues among parents, local authorities (municipalities) responsible for local planning, and personnel in health care, kindergartens and schools.

BG: Dietary guidelines for healthy nutrition of targeted groups like pregnant women, infants, toddlers, children 3-7 years old, and children 7-19 years old. These guidelines cover all age groups targeted in the prevention of childhood obesity - from preconception to 19 years of age-, adjusted to the specific needs of each age group. They are easily understandable and consistent. This has led to raised awareness for the principles of balanced nutrition and healthy lifestyle.

CH: With the brochures "Nutrition during pregnancy and breast-feeding period" and "Nutrition for infants and toddlers" Switzerland provides guidance for parents/tutors to a healthy eating routine for children. The latter is developed most recently with the cooperation of many experts in nutrition as well as paediatrics and is based on a scientific report from a Swiss commission for nutrition. It provides science-based information and examples of healthy meals/eating during this very important phase of life. The brochures are available in the 3 official languages (French, German, Italian). Shorter versions of the brochure on nutritional guidance during pregnancy and breastfeeding period (flyers) are available in 14 different languages. Flyers in different languages will also be created for the other brochure in order to reach as many people as possible, including those with a low socio-economic status.

Area for action 2: Promote healthier environments, especially at schools and pre-schools

The large number of 'most successful' activities and the considerable number of activities 'most difficult to work on' in Area 2, suggest that this area for action in general sees a lot of activity, which is in line with the findings described in chapter 3 and 4. Activities in the school environment are amongst others considered 'successful' because a healthier environment in schools reaches children nation-wide, independent of their socio-economic background. It also provides the possibility for succession along the different developmental periods in childhood, from pre-school to secondary education. Box 6.2 shortly describes the activities in different countries that were reported to be among the 'most successful'.

Setting **standards for foods** provided or sold in schools is mentioned the most (by respondents from BG, EL, LT, HU, SK, ES, HR). It improved the quality of the foods offered in schools. Furthermore, providing healthier food endorses nutrition education. A high political commitment (for example by provision of budget), an extended dialogue with stakeholders and a firm cooperation between local and national players were mentioned as success factors. This may contribute to a widely accepted collaborative agreement, which was also mentioned. For one of the respondents the easy implementation, because it is regulated by legislation, was one of the reasons to consider it as a 'successful' activity. Another mentioned that the activity is comparatively straightforward and less costly to implement compared to other initiatives. Although in Slovakia the activities improved the quality of served meals and drinking regime in school boarding facilities they would like to intensify the cooperation with the Ministry of Education, Science, Research and Sport in the field of educating workers of boarding facilities at schools. Furthermore, there has been an effort to improve the assortment offered in school buffets by revising current legislation. This was, however, not met with understanding by all stakeholders, such as entrepreneurs. The respondent mentioned the latter therefore as an activity 'most difficult to work on'.

Respondents of four countries (FI, HU, 2x anonymous) mentioned the **provision of free healthy meals** among their 'most successful' activities. In two countries this is especially targeted to disadvantaged children. It ensures that the children have adequate nutrition during the preschool/school days and increases socio-economic equality in nutrition.

None of the respondents mentioned the **provision of fruit and vegetables** in schools as one of the 'most successful' activities. Several respondents, however, reported it as one of the 'most difficult to work on' (NO, anonymous) or activities they would like to develop further (HR). In Norway the provision of fruit and vegetables is initiated and subsidised by the government, but parents must pay most of the cost of the fruit and vegetables. Therefore, participation rate is low. In the other country the effects of this school-based intervention did not carry over into the home environment. The former EU School Fruit and Vegetable Scheme was lacking interest among schools in Croatia, partly because of its unrecognizability within schools. Especially school representatives and members of local communities needed to be motivated better.

According to four respondents (BE-WAL, FI, LU, PL), **nutrition education** was among the 'most successful' activities in their country. It increases knowledge and skills about healthy nutrition. In Luxembourg a national awareness and education tool for healthy eating in school-aged children has been implemented. This resulted in the use of coherent messages and knowledge, and the tool was pre-tested. In addition, a gentle, positive approach was used. These factors were seen as contributors to its success. In Poland the educational activities in the "Keep the balance" project not only focussed on pupils, but also on employees of educational institutions. Furthermore, annual evaluation of activities mobilized institutions to ensure a solid implementation of pro-health activities. The project was nationwide but involved only 1600 kindergartens and

schools. Financial constraints prevented expansion of activities to a wider group of children, and was therefore also mentioned as one of the activities 'most difficult to work on'. Respondents of two other countries (LT, anonymous) also mentioned nutrition education to be among their activities 'most difficult to work on'. In Lithuania, the Children Health Education Programme has been integrated into a variety of other subjects. According to the respondent, this caused weakness and fragmentation of the knowledge provided. In the other country nutrition education is difficult to work on because curricula are already filled with other topics, a lack of funding and specialised teachers, and a lack of interest of schools. A better collaboration between the Ministry of Health and the Ministry of Education is needed to make it more successful.

Two respondents (LU, IT) reported more in general **that promotion of a healthy lifestyle at schools** was among the 'most successful' initiatives in their country. In Luxembourg this concerns the promotion of the GIMB Label (Healthy eating, more physical activity) in day care centres, which encouraged them to promote healthy eating and physical activity in their facilities. Working groups were created with label-partners for specific missions. For example, one working group has elaborated a tool with national guidelines for healthy eating in day care centres. The firm cooperation between local and national players and the bottom-up step-by-step approach were mentioned as success factors. In Italy a healthy lifestyle is promoted as part of the cross-sectoral national programme 'Gaining Health', which follows a health in all policies approach. Related to this topic is one of the activities 'most difficult to work on' mentioned by the respondent of one of the countries (anonymous). In this country, the number of schools currently participating in the Schools for Healthy Education (SHE–) Network is less than the initial number and the network is not being developed further to a larger number of schools in the country.

Enabling active brakes or after school sports was mentioned by respondents of five countries to be among the 'most successful' activities (HR, CY, MT, PT, SK). Free access to the activities is mentioned as one of the success factors for such activities, as it allows also the less privileged children to participate. In Croatia, additional physical activity and the distribution of polygones to enable physical activity in the classroom or hall is part of a comprehensive health promotion programme, which contributes to its success. In Cyprus, children could exercise together with their parents, followed by a different health topic addressed each week. This not only allowed all children, including those who are less privileged, to be physically active, but also provided quality time with their parents. Because children and their parents participated in the same educational or empowering activities, the lessons learned could be translated to the home situation

In Hungary **daily physical activity** has been incorporated in the school curricula since 2012. This was accompanied by financial support to improve the facilities. This is considered as one of the 'most successful' activities as it contributes to the achievement of recommendations for physical activity in children. Although mandatory physical activity education is included in school curricula in all countries, some respondents see this activity as 'most difficult to work on'. Respondents of two countries (LT, anonymous) mentioned that the amount of time allocated to physical education in schools should be increased. In one country there are initiatives to increase physical activity in schools, but these are voluntary. In Lithuania the curriculum does not allow an increase in physical education. Also in Norway, many schools find it difficult to find time for physical activity during the school day, despite the clear ambition of the Norwegian government to increase the level of physical activity in schools to one hour per day. Education authorities and school owners and leaders need more knowledge to be convinced of the benefit of daily physical activity for the learning environment. Furthermore, good examples and methods on how physical activity can be included in the education programme are important. An ongoing project, in which middle school pupils in 30 schools will get about two extra hours a week for physical activity and physical exercise, may give some answers.

Box 6.2. 'Most successful' policies as reported by country representatives.
Area 2: Promote healthier environments, especially in schools and pre-schools

Guidelines/standards for foods offered in schools

BG: A legislative framework for healthy nutrition of children aged 0-19 years in public facilities (Ordinance for healthy nutrition in schools in school canteens and cafeterias – 2009, Ordinance for healthy nutrition in kindergartens - 2011, Ordinance for healthy nutrition in crèches – 2013) resulted in regulation of the food environment in crèches, kindergartens and schools with improvement of the available food. Recipes used for the preparation of meals in schools and crèches were improved. The framework creates healthier environments for the children on a nationwide scale and along the different developmental periods in childhood. It resulted in an increase in the availability of fruits, vegetables, milk and milk products, and water, whereas it decreased the availability of sugar sweetened drinks and some foods with high fat, sugar and salt content. The framework is built upon the expertise in a traditionally successful model for organized nutrition in public facilities like schools and kindergartens.

EL: Legislative actions set standards for foods that are offered in school canteens and food aid programs. This resulted in more healthy foods offered in school canteens.

LT: According to the Order of the Minister of Health for the organization of catering services at pre-schools, general education schools and children's social care institutions, schools are not allowed to provide foods high in fat, sugar, salt, trans fats and caffeine, such as potato chips, fat-cooked, roasted or puffed products, candies, chocolate, glazed confectionery, cream or chocolate, carbonated and energy drinks. The Regulation recommends the supply of vegetables, fruits, milk and dairy products, lean meat, poultry, fish, bread, eggs and drinking water. This stopped the supply of energy-dense and nutrient-poor foods to schools. Furthermore, it educates youth about healthy nutrition.

HU: Legislation on healthy public catering (Ministerial decree 37/2014. (IV.30)) sets standards for foods in schools. By eliminating nutritional risk factors it promotes a healthy diet of children and contributes to the prevention of non-communicable diseases. Government funding enables the improvement of technical facilities of kitchens. A long preparatory process preceded the implementation. This process included an extended dialogue with stakeholders, especially food industry.

SK: Promotion of healthier environment in schools resulted in an improved quality of served meals in school boarding facilities. In cooperation with the Ministry of Education, Science, Research and Sport new recipes with reduced content of salt were developed. Furthermore, as a part of the drinking regime in school boarding facilities, sweetened beverages were limited and drinking water preferred. The Public Health Authority of the Slovak Republic in cooperation with 36 regional public health authorities carries out the state health supervision at schools and school boarding facilities.

ES: Law 17/2011 on Food Safety and Nutrition includes special measures aimed at minors, particularly in the school environment. These include nutrition education, promotion of physical activity and prohibition of marketing and sale of unhealthy foods. Food that is served or can be acquired in educational centres has to fulfil criteria of nutritional balance. Moreover, schools and kindergartens are declared as advertising-free spaces, so that promotions or campaigns carried out in schools only take place when educational authorities, in coordination with health authorities, understand that the activity is beneficial to the interests of minors. The "Consensus document on food in educational centres" was approved by the Spanish Health System's Inter-Territorial Board. With this document the commitment to promote a balanced diet, ensuring an adequate food environment is reinforced. It regulates the diet of schoolchildren by food-based standards for lunch and non-lunch, nutrient-based standards for lunch and establishes nutritional criteria for food and drinks offered at educational centres. This collaborative agreement is widely accepted by school and health authorities.

HR: The national programme "Healthy Living" has 5 components including "health and education", "health and physical activity", "health and nutrition" and "health and the environment". The programme is co-financed by the European Union from the European Social Fund. At the moment implementation of "Healthy Living" is started in 11 out of 21 Croatian Counties. In all counties there is communication and collaboration with schools. Healthy menus are developed and communicated to schools. This programme is the only one dealing with comprehensive health promotion, with respect to the prevention of obesity, education on physical activity, nutrition, and mental and sexual health. The project connects many non-governmental organizations and was recognized by nine governmental institutions.

Box 6.2 continued

Free provision of healthy meals

FI: Healthy meals are served free of charge for all children in kindergartens and schools. These public catering services have to comply with national food recommendations for meals and snacks, and nutritional criteria set for the quality of meals. The meals served at kindergartens and schools ensure adequate nutrition during the school days for most of the child population. Provision of meals also increases the equality in nutrition between groups with different socio-economic backgrounds. Served meals are the model of good and healthy choices for the whole life. It also enables long-lasting and concrete food education during the school years. The served meals and snacks are not only meals but function as food education included in the curriculum. Teachers and the kindergarten staff are recommended to eat together with the children (role modelling). In general, this resulted in better nutrition and disappearance of malnutrition in children. At the population level the effects are seen in the incidence of non-communicable diseases, especially cardiovascular diseases.

HU: Allocating governmental funds for free catering for children living in families with low socio-economic status. Providing fruits, vegetables and dairy products in some schools, mainly in low SES areas.

Anonymous: Providing free healthy meals in schools resulted not only in children receiving at least one healthy meal a day, but also in better knowledge about healthy nutrition.

Anonymous: Increased funding for a food programme for disadvantaged schools contributed to healthy habit formation at a younger age. This programme provides a range of state sponsored meals to disadvantaged schools. New technical standards for the foods provided have been developed. With its reach of 250,000 disadvantaged children, the programme has a big impact on health inequalities. Information can also be passed to families of schoolchildren.

Nutrition education in school curricula

BE-WAL: Since there is a perpetual exchange between children and parents, nutrition education for parents depends on the nutritional education of children in school. In the family nucleus food choices for children and teenagers are made by adults, influenced by society (doctor, family, neighbours, etc.).

FI: In primary school home economics is included as a subject in the curricula (as independent lessons in grade 7-9 and integrated in other subjects in the lower levels of primary school). Furthermore, health education is in the curricula of primary school as an independent subject for all pupils. Kindergarten and school as settings comprehensively improve children's and adolescents' eating habits, skills related to food and health, and finally nutrition literacy.

LU: In collaboration with the Ministry of Education, school directors and school health services a national awareness and education tool for healthy eating in school-aged children has been implemented. It encompasses training sessions for teachers and school health services and is available for all children in primary school. The collaboration results in coherent messages and knowledge (all children obtain the same correct messages and knowledge about healthy nutrition and physical activity). This facilitates the credibility of the messages.

PL: One of the tasks in the project "Keep the Balance" was education and implementation of the principles of nutrition in kindergartens and primary, middle and secondary schools. This project on the prevention of overweight and obesity as well as chronic non-communicable diseases through education of the society about nutrition and physical activity (Project KIK/34 in the Swiss-Polish Cooperation Programme) was co-financed by the Ministry of Health. The impact of education on nutrition, nutritional status and the level of knowledge among children and adolescent was evaluated. There was an improvement in selected dietary behaviours and selected physical activity indicators. It also increased knowledge of children and adolescents about the role of nutrition and physical activity for health. An additional achievement was a 1% decline of overweight and obesity among students from primary and lower secondary schools participating in the project. This task was a certification project and project activities were evaluated annually which mobilized the institutions to ensure a solid implementation of pro-health activities that were directed not only to children and adolescents but also to the employees of educational institutions and parents of students. Based on the methodology, a certification process for the whole country has been suggested to the Ministry of Health by the Institute of Food and Health. A decision has not been made yet.

Box 6.2 continued

Promotion of healthy lifestyle at schools

LU: The GIMB Label encourages day care centres to promote healthy eating and physical activity in their facilities. Many day care centres have opted for the Label GIMB and it thus strengthens health promotion activities in the sector. The label uses a step-by step bottom-up approach in collaboration with national and local stakeholders. For specific missions working groups are created with Label-Partners. One working group has elaborated a tool with national guidelines for healthy eating in day care centres.

IT: The national program "Gaining Health" aimed to promote healthier environments, especially in schools. It is a coordinated action plan for counteracting the four leading risk factors for non-communicable diseases, including poor nutrition. The program follows the health in all policies approach. As part of this programme a healthy lifestyle is promoted among children and adults.

Enabling active breaks or after school sports

HR: As part of the national programme "Healthy Living", additional education on physical activity has been provided as well as equipment (polygons) to schools that have no gym or sports hall. Children can be active in the hall or the classroom.

CY: In the 'Open School Programme' municipalities arranged for schools to remain open in the afternoons for extra-curricular activities. These included archery, taekwondo, gymnastics, dancing and the 'Healthy Children program' where parents and their children can exercise together followed by a different health education topic addressed each week. What started out as an initiative of one municipality, quickly spread to other municipalities and districts. The program allowed for underprivileged children to participate in sports activities and provided all children the possibility to socialize with children outside of school hours. One of the activities of the Open School Programme allowed for children to spend quality time with parents in enjoyable activities. Both parents and children participating in the same health education/empowerment activities enables to translate what was learnt into behaviour at home. Preliminary findings showed great improvement in health behaviours such as increased fruit and vegetable consumption and physical activity.

MT: The programme "Mass Movement in action: schools on the move" was launched to encourage more physical activity during schools hours especially during the break time. The programme aimed at girls, because Maltese adolescents have low level of physical activity, girls showing to be less active than boys. The programme was supported by community initiatives around Malta in collaboration with the sports sector. Of the participating adolescents 16.6% were not doing any physical activity and started doing physical activity during and after the project.

PT: Physical activity practice in national public schools is integrated in curricula from 5th grade to secondary level. The 2nd and 3rd grades and secondary public schools also offer free school sports after classes within the school building. Municipalities offer extracurricular activities for 5 to 7.5 hours per week in thr 1st and 2nd year and 3 to 5.5 hours weekly in the 3rd and 4th year of public primary education. The reach of this activity is large as there is universal and free access to the public school from pre-school to secondary school (12th year inclusive).

SK: The promotion of physical activity resulted in monitoring of the possibility to utilize physical education facilities at schools also for out-of-school activities. Based on evaluation of physical education facilities at schools, different measures and education activities were taken. They contributed to increased interest of children in physical activities. In addition, pedagogues of physical education classes try to make classes of physical education more attractive in a way that they are accessible to pupils with limited motion capability.

Mandatory daily physical activity lessons

HU: Mandatory daily physical activity lessons were built into the national curricula in 2012 (Act CXC of 2011 on National Public Education). Furthermore, financial resources were provided to improve the infrastructure in schools (building gym, access to swimming pools). The regulation provides a good framework to fulfil the WHO recommendation of at least 60 minutes daily physical activity for the children. Development of a National Student Fitness Test (NETFIT®) makes standardized monitoring and evaluation of the effectiveness of everyday physical education classes possible.

Area for action 3: Make the healthy option the easy option

Activities in Area 3 were among the activities that were considered 'most successful' by respondents of 6 countries (see Box 6.3). More respondents (n=10) reported activities in this area to be among the 'most difficult to work on'.

The respondents from Norway, Spain and Switzerland considered the achievements on **food reformulation/food product improvement** as one of their 'most successful'. Several success factors were mentioned, such as political agenda setting (stressing the importance of supporting a healthy lifestyle and cooperation with industry and retailers), collaboration with different food sectors, and commitment of a whole sector. In Spain, the support through the Council Conclusions on Reformulation was very important as well as the interaction and discussion in the High Level Group on Nutrition and Physical Activity. Furthermore, the proposed reductions of nutrients have been stablished according to the 'European framework on salt and selected nutrients' and take into account the nutrient content of the foods analysed by laboratory and labelling studies. This evidence-based approach is also seen as one of the success factors. The respondent from Spain reported that it is important to be transparent and communicate all agreements, which need to be evaluated on their progress. Nevertheless, activities on food reformulation/food product improvement were also among the reported activities 'most difficult to work on' (LU, PT, anonymous). Reformulation was not a priority in Luxembourg's first action plan "Healthy eating, more physical activity" (GIMB 2006-2016), because most food products are imported limiting their possibilities to reformulate these products. Furthermore, there was some resistance and concern from the private sector. However, Luxembourg wishes to contribute to the increase in efforts that Member States and stakeholders have committed to. Therefore, food reformulation/food product improvement is one of the priorities in the new action plan 2017-2025. In Portugal, policies to eliminate trans-fat, to reduce saturated fat and to reduce salt intake received resistance of the food industry, restaurants and catering companies. In the third country voluntary food reformulation/food product improvement is not very actively pursued by industry, although it seems to be facilitated by regulatory measures on other topics. An independent organisation is not involved in monitoring of the activities of the food industry, making the activities less transparent. The Ministry of Health of Lithuania signed an agreement on food reformulation with 10 major food production companies. It would, however, have liked to further develop their activities on food product improvement, but encountered a lack of interest from the food industry. A broader commitment with national and international stakeholders in the food chain was considered needed. The representative reported that EU regulation or European support to achieve agreements with industry at the European level could facilitate this process.

The respondent from Denmark considered multi component initiatives developed in partnership with various relevant stakeholders, which result in sustained efforts that include both information/communication and structural components, as most successful policies. The Keyhole and Wholegrain **logos** as well as the Meal Label "Måltidsmærket" - official guidelines on healthy eating for day care, schools and workplaces – were reported as examples of this type of initiatives. Respondents from several other countries considered easy to understand labelling, such as front of pack labelling (BE-WAL, CH, anonymous), or menu labelling (IE) as being one of the activities 'most difficult to work on'. One of the reasons given is that it is difficult to place a food in a certain category with respect to its nutritional value. This makes it difficult to develop a label that is understandable and usable by all (BE-WAL). In Switzerland support could not be obtained from both industry and consumer organisations. In the other country there was also industry resistance to the introduction of food labelling. This related amongst others to concerns about the costs, which labelling and chemical analysis of foods may infer. Calorie posting on menus is at present a voluntary activity in Ireland. Implementation varies, so it is difficult to determine its effect. Norway would like to implement mandatory labelling of added sugar but did not get support for their proposal that the EU Food Information

Regulation should include labelling requirements for added sugar. Labelling of added sugar would allow more accurate application of the three different taxes on sugar in Norway.

The representative of Hungary considered the introduction of the Public Health Product **Tax** in 2011 as one of the 'most successful' activities in Hungary. A tax is levied on food products that contain unhealthy levels of sugar, salt and other ingredients in an effort to reduce their consumption, to promote healthy eating and create an additional mechanism for financing public health services. An impact assessment carried out with technical support of WHO Regional Office for Europe showed not only effects on sales of products subject to the tax, but also changes in manufacturers' recipes, and health literacy of consumers. Implementation of taxation was reported among the activities 'most difficult to work on' by respondents of three countries (BG, 2x anonymous). In Bulgaria, a plan for taxation for certain foods and drinks with a high content of salt, sugar and trans fats was ready in 2015, but has now been completely abandoned. The respondent form Bulgaria reported that there has been growing resistance to this measure, starting from industry, spreading to the public and members of the executive power, such as ministers of finance and agriculture. Also in one of the other countries there was political and public resistance to introducing taxation and a strong industry lobby. In the other country some taxation measures have recently been abandoned. Several issues have been reported that would enable successful implementation of taxation. These include firm governmental commitment as well as cooperation between EU Member States and clear guidance regarding what is permissible in terms of taxation/subsidies without falling foul of EU regulation. In addition, monitoring data on consumption of unhealthy products will allow assessment of the effects of taxation policies. Furthermore, the public should be informed about the effectiveness of the measure and their fears for increased financial burden need to be addressed.

For the Lithuanian representative the **ban on the sale of energy drinks** to children under 18 years old is one of the 'most successful' policies.

Box 6.3. 'Most successful' policies as reported by country representatives.
Area 3: make the healthy option, the easier option

Food reformulation/food product improvement

NO: By cooperation with the industry and retailers healthier foods are developed and promoted in stores, canteens, and schools. As a result the intake of sugar has decreased and the intake of fruit and vegetables has increased in the latest decade.

ES: In Spain, reformulation initiatives and activities have been promoted since 2005. Already before then an agreement to reduce salt in bread was signed between the Spanish Confederation of Bakers, the Spanish Association of Manufacturers of Frozen Dough and the Ministry of Health. At the end of 2008 the NAOS strategy launched the Plan for the Reduction of salt Intake, that included an agreement to reduce salt and fat in artisan meat and charcuterie products (commitment with the Spanish Confederation of Meat Retailers, 2012) and an agreement to reduce the salt content of potato chips and savoury snacks (commitment with the Association of Snack Manufacturers, 2015). Within the framework of the Observatory for Nutrition and the Study of Obesity several studies were carried out to evaluate and monitor the reformulation voluntary agreements. These showed that there has been a significant reduction in the amount of salt used in bread production and an important reduction in other food groups such as breakfast cereals, broths and ready meals. Moreover, observed decreases in the content and percentage of trans fatty acids in different food groups between 2010 and 2015 lead to the conclusion that the TFA content in food currently does not represent a public health problem in Spain. February, 2018 the Minister of Health presented the Collaboration Plan for the improvement of the composition of food and beverages and other measures 2017-2020 (PLAN). The PLAN contains reformulation commitments of the manufacturing and retail sectors on the reduction of added sugars, salt and saturated fats for several types of food and beverages regularly consumed by children, young people and families. It also includes agreements with the Contract Catering, Modern Restaurant and Vending sectors. These transversal and synergistic agreements (commitments of all companies of the sector and in several groups of food and food related sectors) are expected to have an impact on the shopping basket in different environments.

CH: In 2015 a Memorandum of Understanding was signed between the Federal Councillor and the Swiss food producers and retail trade representatives on reducing sugar in breakfast cereals and yogurts. A round table took place in 2017 and the results have shown that the average added sugar content in yoghurts has fallen around 3% and in breakfast cereals around 5%. Until 2018, a further reduction of 2.5% for yoghurts and 5% for breakfast cereals should be achieved. With these new targets, Swiss food producers and retailers are sending a clear signal. Because cooperation with food producers has proved successful, the food reformulation/food product improvement activities are to be continued after 2018 as part of the action plan for the Swiss nutritional strategy until 2024. Further food groups will be addressed and the work on salt and fats will be intensified.

Easy to understand labelling

DK: The most successful policies are multi stakeholder and multi component initiatives developed in partnership with relevant stakeholders that result in sustained efforts that include both information/communication and structural components. Examples of this type of initiatives are the Keyhole and Wholegrain logos as well as the official guidelines on healthy eating for day care, schools and workplaces – most recently in the form of the Meal Label "Måltidsmærket". The Keyhole has made the healthy choice the easier choice through the availability of more than 3000 Keyhole labelled products. The Keyhole logo has furthermore lead to the reformulation of products in a healthier direction. Today 9 out of 10 consumers recognize the Keyhole logo, while 71% of the Danes is familiar with the Wholegrain logo. The whole grain intake in Danes has significantly increased from 36 to 63 grams per day in the period 2004-2015.

Box 6.3 continued.

Taxation

HU: The Public Health product Tax (PHPT) in association with ministerial decree 20/2012 (VIII. 31) of the Ministry of Human Capacities, which does not allow the provisions of food categories subject to PHPT to be sold in school settings and sport events organized by schools. After the introduction of the PHPT, supply and sales of products containing ingredient(s) proved to be harmful to health decreased (40% of the responding manufacturers changed the formula; manufacturers' sales of products subject to PHPT decreased by 27%). The population reduced the consumption of products subject to PHPT (25-35% of people consumed less of these products than one year before). The decrease in the consumption was not only caused by the increase in price, but also by positive changes in the population's attitude. The health literacy of the consumers has improved over the first impact assessment. Another positive development is that the attitude of the food industry has started to change slowly and willingness to reformulate is slowly increasing.

Ban on energy drinks

LT: The Law on Food (Article 6(1)) bans the sale of energy drinks to children below 18 years old. This measure helps to prevent young people from excessive consumption of sugar and caffeine.

Box 6.4. 'Most successful' policies as reported by country representatives.
Area 4: restrict marketing and advertising to children

BE: Policies on marketing of food and beverages that are high in salt, sugars or fat or that otherwise do not fit national or international nutritional guidelines (HFSS foods) to children (Belgian Pledge). It was strengthened in June 2017 to align it with the EU Pledge. The media are part of the social relays that influence the behaviour of individuals, especially children and teenagers. Adults find themselves alone facing food choices with constraints such as budget, delighting children, time, etc. The influence of the media affects them also through children.

LT: The Law on Advertising (Article 14) bans the advertising of energy drinks to children below 18 years old. This helps to prevent young people from excessive consumption of sugar and caffeine.

Area for action 4: Restrict marketing and advertising to children

Representatives of two countries (BE, LT) considered the restriction of marketing and advertising to children to be among their 'most successful' activities (see Box 6.4). This refers to the Belgian Pledge and the Lithuanian Law on advertising that bans advertising of energy drinks to children. Success factors were not reported.

Five respondents reported the current voluntary restrictions on marketing and advertising of foods and beverages that are high in salt, sugars or fat or that otherwise do not fit national or international nutritional guidelines (HFSS foods and beverages) as one of the activities 'most difficult to work on' (BG, RO, CH, 2 anonymous). The respondents of Bulgaria and another country reported that the existing code of conduct is not followed or supported by all companies. The Bulgarian respondent would like to see more obligatory measures and capacity building for improved control on the implementation of measures taken. The nutrient profile used by the Swiss Plegde, which is similar as the EU Plegde, is considered to be not restrictive enough. Furthermore, the marketing and advertising industry discovers and uses new ways to reach children and moves from visible channels to hidden ones. The three reasons mentioned above leave room for exposure of children to all kinds of advertisement for HFSS foods and beverages. Another respondent reported that national measures do not work for multinational products. Therefore, common policies and measures are needed across EU Member States. Although in Hungary there are some voluntary actions on restricting marketing to children, and the National children channel became free of any kind of advertisement from the first of June 2107, the respondent would like to update and further develop the policies in this area. Priority

to other preventive measures/policies was the reasons for not having (yet) done so. The respondent of another country would also have liked that the current voluntary restrictions would be stricter.

The respondent from Greece sees the fact that the country has not elaborated action to set nutritional criteria to reduce marketing to children as one of the activities 'most difficult to work on'. This would demand cooperation between many public and private sectors. The respondent from Lithuania would like to set criteria for all foods addressed to children, e.g. by claims, titles or drawings. Preferably this would be in the form of clear, sound and mandatory EU regulation.

Area for action 5: Inform and empower families

Respondents from eight countries reported eleven activities in area 5 to be among the 'most successful' in their country. This refers to multi-faceted community-based interventions (n=5), campaigns (n=4) and other activities to inform and educate people (n=2, see Box 6.5).

In Belgium and the Netherlands, **prevention programmes** based on the EPODE methodology are reported as 'most successful'. The fact these are integrated programmes at the local level working in a structural way for a longer period of time contributes to their success. The programme in another country is also a holistic, evidence –based approach. It combines information on healthy nutrition and physical activity, helps parents to develop confidence and skills and helps behavioural change for the whole family. The respondent from Italy referred not to specific intervention programmes, but the integrated approached developed at the regional level to facilitate multi-sectorial policies and initiatives. The plans involve different settings and not only the health system, but also other stakeholders to achieve the objectives. A progressive increase in interventions has been seen in the last year. This is amongst others due to a significant improvement in the capacity to engage different sectors and a stronger support for health promoting policies from central and regional institutions. An **intervention programme** for children who are already overweight or obese was also reported to be among the 'most successful' activities in the Netherlands. Another respondent would have liked to develop management services for overweight or obese children also, but the costs for such an initiative are high. Related to this topic is an activity 'most difficult to work on' mentioned by one of the respondents (anonymous). This is HEPCOM – the Learning Platform for Preventing Childhood Obesity in Europe, an initiative to increase the quality and level of local community and school interventions on promoting healthy eating and physical activity among children and young people all over Europe. According to the respondent, problems of funding play a role herein.

Campaigns were among the 'most successful' activities of four respondents. This concerned campaigns to promote healthy diet and physical activity (IT, anonymous), on portion sizes (MT), and on salt and sugar reduction and promotion fruits and vegetables (anonymous). Several factors were considered to be success factors for the latter campaign. First, the programme began with over six months of engagement with all actors and stakeholders, so that the public would encounter an informed and supportive local environment when the campaign started. Secondly, a network of commercial sector organisations was developed to ensure that many of the biggest companies pledged to support the programme. Thirdly, the campaign used user-friendly, memorable language and included local people telling stories of how they managed to change their families' behaviours. For the respondents of three countries (BE-WAL, DK, EL) national campaigns to promote healthy diet and physical activity are among the activities 'most difficult to work on'. In Belgium, with the division of powers, a national campaign is very difficult to develop. There is a need to agree on the priority themes but also on the way to communicate them to the public. The information needs to be understandable to the general public and science-based. The respondent of Denmark feels that without stakeholder support and involvement, one-off campaigns (limited to a single time, occasion of instance) and initiatives like for

instance the sugar campaign "max en halv liter" (only 0.5 litre of sugar sweetened drink per week) will not have the desired effect and therefore will not result in long term behavioural change. For Greece national campaigns are 'most difficult to work on' because they are demanding in terms of financial support.

The newly established National Centre for Nutrition Education in Poland has success with society, whereas the new guidelines for healthy eating in another country provide very useful practical information for different target audiences. They include daily meal plans for adults and children and a range of different information sheets.

Among the activities 'most difficult to work on' reported by the respondent of Portugal are policies to reduce social inequalities. There are no structured programs to reduce them. In recent years the economic and financial crisis has aggravated the social inequalities that were already evident, reflected in population food security, reduced food choices and adherence to a healthy diet.

Box 6.5. 'Most successful' policies as reported by country representatives.
Area 5: inform and empower families

Multi-faceted community based interventions

BE: Some municipalities and cities, both in the Flemish and French part, engaged in the ViaSano program based on the original French initiative EPODE. The initiative (financed by private partners) aims to reduce childhood obesity by the enrolment of all actors and stakeholders of the municipality. It includes medical doctors, paediatricians, schools, families, and retailers. Different tools exist to help families to adopt healthier food habits and lifestyle. At this time, the program is active in 18 different places and still ongoing.

NL: Youth at a Healthy Weight (Jongeren Op Gezond Gewicht, JOGG) is a local, integral approach that works on the prevention of childhood obesity, and the care for overweight children in a structural way for a longer period of time. It is the Dutch version of EPODE. One third of all Dutch municipalities are now partner of JOGG. School canteens and sport canteens became healthier and in 14 municipalities a decrease in BMI has been observed.

NL: Care for Obesity is a programme to stimulate better care for children with overweight or obesity and to develop a model on integrated care, in order to make the quality of care and cooperation between professionals optimal for child and family. The model specific is based on the practice in two municipalities (Amsterdam and 's-Hertogenbosch) where it led to a decrease in BMI and is under further development.

Anonymous: A holistic, evidence-based approach for behaviour change that helps parents to gain the confidence, knowledge and tools as well as the parenting skills they need to adopt a healthier and happier family lifestyle has resulted in several positive changes. Among these are increased consumption of fruit, vegetables and water; reduced consumption of sugary drinks and foods high in fat and/or sugar such as cakes, biscuits and chocolate; more frequent family mealtimes; reduced screen time; and increased physical activity for the whole family. In a city where the approach is part of the city-wide obesity strategy and delivered in children's centres across the city, obesity rates at reception stage have fallen from 10.3% to 8.7% over a 7-year period. The national trends have remained almost stable. Also, the gap between obesity rates at age 5 in the least deprived and most deprived areas is narrowing, with obesity rates dropping from 13.8% to 9.7% in the most deprived areas over the last 5 years. The programme also provides training courses for practitioners working with families of young children.

IT: The National Prevention Plans 2014-2018 implemented at the regional level, develop an integrated approach to facilitate multi-sectoral policies and processes which impact on public health and promote health. All the Italian regions have implemented projects for non-communicable disease prevention, with particular emphasis to prevention of childhood overweight and obesity and related health problems, unhealthy diet, physical inactivity, harmful consumption of alcohol and tobacco use. In the last years there has been a progressive increase in interventions and, above all, a significant improvement in the capacity to involve different sectors, both public and private, in order to converge towards a health objective, according to a whole-society approach.

Box 6.5 (Continued)

Campaigns

IT: National campaigns to promote healthy diet and physical activity together with policies to support community-based interventions have, at the national level, contributed to a decrease in overweight from 23% in 2008 to 21.3% in 2016, and in obesity from 12% to 9.3% among children aged 8-9. This has been concluded from data of the 2016 surveillance system "Okkio alla Salute".

MT: A portion size campaign through a family based approach was launched focusing on the food portion one needs to consume.

Anonymous Campaigns, e.g. on salt, sugar reduction and fruits and vegetable promotion resulted in better nutrition-related awareness, attitude and skills.

Anonymous: A public health programme/national social marketing campaign that encourages people to both eat better and move more was evaluated after the first year. This evaluation showed that:

- Three in 10 mothers who were aware of the campaign claimed to have made a change to their children's behaviours as a direct result of the campaign.
- The number of mothers claiming their children do all eight behaviours, which parents should encourage their children to adopt if they are to achieve and maintain a healthy weight, increased from 16% to 20%.
- The proportion of families having adopted at least four of the behaviours has increased, suggesting the campaign has persuaded people with much less healthy lifestyles to make an effort to improve their health.

Basket analysis found differences in the purchasing behaviour of 10,000 families who were most engaged with the campaign relative to a control group. In particular, there were changes in the purchases of beverages. The programme began with over six months of engagement with partners and workforces, local service providers, potential local supporters and non-governmental organisations, so that when national marketing started, the public would encounter an informed and supportive local environment. The potential competition from food retailers was also anticipated and a network of commercial sector organisations was developed to ensure that many of the biggest companies pledged to support the programme. Also, the campaign used user-friendly, memorable language for describing the desired behaviours to modify, supplied tips that translated each behaviour into real situations to which target audiences could relate, and created a mechanism for promoting the behaviours as a set. The campaign also included local people telling stories of how they managed to change their families' behaviours.

Informing people

PL: The National Centre of Nutritional Education (www.ncez.pl) has been developed and financed in the frame of the Polish National Health Programme. This centre is powered by the Institute of Food and Nutrition and began its activity in January 2017. The centre is a reliable source of scientific information on obesity and overweight, nutrition, recommendations on healthy diet and physical activity as well as on nutrition in health and disease. Success within society can be demonstrated by the fact that since the launch of the portal there have been nearly 28,000 users and over 285,000 page views. Over 56% are new users which means wider education with expert content about nutrition and physical activity.

Anonymous: The new healthy eating guidelines and updated food pyramid form a new suite of resources that provides very useful practical nutrition advice for the population including children, health care professionals and for those working in other sectors, such as education, social protection and industry. They now include daily meal plans for children and adults as well as a range of information sheets on different parts of the food pyramid.

Area for action 7: Monitor and evaluate

Evaluating the magnitude of the problem of obesity is a fundamental element in improving knowledge about the situation in a country and stimulating an appropriate response from health authorities. Respondents of several countries (MT, PL, RS, ES) considered their achievements in the field of **monitoring** among the 'most successful' activities (see Box 6.6). When filling out the questionnaire, the surveys were still in the planning phase in Poland, while respondents of Serbia and Spain explicitly referred to COSI. Factors that contributed, according to the respondents, to the success of these initiatives include its relatively easy implementation in schools and the good inter-sectoral working relationships between the Ministries of Health and Education.

Six other respondents mentioned the **evaluation of height and weight in the child health care system** (BE, DK, FI, PT, RO) or at **school** (CY), followed by appropriate action if needed. By regular follow-up of children from a young age, early intervention is possible. In Denmark guidelines have ensured more uniform practice across the nation. In Finland special support is provided targeting the whole family based on their needs. Also the programme in Cyprus, which has ended in 2002, directly involved both parents and children. Schools, parents and teachers request for its return but this is currently unfeasible due to the high costs. Almost all respondents mentioned the fact that their system reaches practically all children, irrespective of their socio-economic status, as one of the success factors. Other success factors that were mentioned were free access, enhancement of anticipatory care, the high professional skills of the involved staff members, long experience with the system and individualized personal feedback.

Two respondents mentioned another topic in this area for action to be among the activities 'most difficult to work on' (AT, CY). They reported that most often **evaluation** of policies or activities pertaining (at least partly) to childhood obesity is not carried out. Therefore, assessment of achievements is lacking. The respondent of Malta reported that they would like an increase in workforce to monitor the current activities in the areas of action.

Box 6.6. Most successful policies as reported by country representatives.
Area 7: monitor and evaluate

Monitoring (general)

PL: In the National Health Programme for period 2016—2020 national surveys on nutritional status (including obesity) and food consumption are mentioned. This will be the base for a national monitoring system on overweight and obesity and health inequalities in all demographic groups. Preparation of the surveys is pending.

MT: Collection of data on weight and height in children within schools confirmed the scale and extent of the problem of overweight and obesity in schoolchildren. This provided to policymakers evidence of the need for action.

RS: The Childhood Obesity Surveillance Initiative (COSI) has been conducted for the first time, supported by WHO Regional office for Europe and recognized by the Ministry of Health. Many children and elementary schools were recruited and COSI results have been promoted to stakeholders, the professional community and the public. This increased public awareness on children obesity.

ES: The Observatory of Nutrition and the Study of Obesity was created in January 2013. The ALADINO Study, part of the COSI Initiative, monitors overweight and obesity trends between the ages of 6 and 9. During this age range there is a reduction in potential differences attributable to the onset of puberty. It is also considered an age during which intervention and education are possible to prevent the onset of obesity and to achieve healthy lifestyles.

Box 6.6 (continued).

Monitoring and follow-up in child health care

BE: At the community level, there is mandatory preventive care for children and adolescents. Every 2 years, starting from the age of 3 years up to 18 years, children are followed to check their general wellbeing, height, weight, hearing awareness and visual acuity. This is done in the school setting in dedicated centres for school medicine. With this activity we are able to follow the growth curve of the child and adolescent population. In addition, we can sensitize parents to take actions to reduce the excess weight of their child and to adopt better food habits and lifestyle if needed.

DK: Height and bodyweight of pre-school and school children is monitored regularly by general practitioners, health visitors and school health nurses according to the Danish Health Act. This is combined with the development and implementation of national guidelines on healthy growth and early intervention for children at risk of overweight and obesity. Regular monitoring ensures focus on overweight and obesity, identification of children at risk as well as early intervention. National guidelines ensure more uniform practices across the nation, not only for the identification of children at risk but also for the development of supporting electronic BMI-charts for the health professionals. Because this system includes children regardless of socioeconomic status they help to reduce inequalities related to overweight and obesity in children.

FI: Child health care covers >99% of families in Finland. It includes not only growth follow up by measurement of height and weight but also counselling on breast feeding, timely introduction of complementary feeding, family meals, snack consumption, physical activity and weight management if at risk of overweight or obesity. Counselling is targeted to the whole family and based on the needs of the family. It continues in school health care. The child health care system also enables allocation of services and special support to those who need it the most. New tools have been developed and implemented, such as “Smart Family”: a self-assessment tool for food intake/meals, physical activity, and inactivity (sitting time/media time). The involved staff has high professional skills in family counselling and is offered continuous education.

PT: Screening activities are integrated in the Child and Youth National Health Program, operationalized by health consultations/examinations in the National Health Service. This programme universally covers the child and adolescent population. Anthropometric evaluation (weight, height, body mass index) takes place at key ages, corresponding to important events in the child or adolescent’s life. In addition it enhances anticipatory care, providing parents and other caregivers with knowledge for the best performance in a number of areas, including nutrition (a.o. promotion of exclusive breastfeeding up to 6 months, restriction of sugary and/or fried foods, juices, and fats). The Child and Youth National Program is free for all children up to the age of 18, both in primary health care and in hospital health care.

RO: Monitoring and advice by family doctors enables early identification of unhealthy weight gain and subsequent measures to stop and reverse it. Appointments are free of charge and extreme cases are managed in hospitals also free of charge. This implies that all children, whatever their socio-economic position, are covered.

Monitoring of height and weight in schools, followed by action when needed

CY: In the ‘Healthy Children Program’, carried out by the Research and Education Institute of Child Health between 1995 and 2002, each year all 6th grade primary school children were examined. The examinations included anthropometric tests, blood analyses, and assessment of physical fitness and nutrition. Results for each child were handed to the parents by experts, who they could discuss the results with and ask questions. In the paediatricians part of the programme parents were alerted that their children’s body mass index, for example, was above normal. They would then evaluate their diet records and explain to parents the benefits of a Mediterranean diet. Also seminars on health behaviours were arranged for parents throughout the island. The individualised feedback given to each family made it personal to them, so alerting them to the issue of obesity. Childhood obesity is then not just something they heard of on television or the radio. Results showed a decrease in total cholesterol levels of 11-12 year old children over successive years. Additionally, a greater increase in obesity in primary school children was observed upon cessation of this programme in subsequent prevalence studies.

6.3 Completeness of the EU Action Plan on Childhood Obesity 2014-2020

The questionnaire on strengths and weaknesses also asked whether the respondents thought there was any area for action that could contribute to the prevention of childhood obesity but was missing in the Action Plan. Eight respondents (32%) thought all relevant areas of action were covered. Slovakia recognized the efforts of the European Commission by stating "Source materials for creation of Action Plan were elaborated very professionally from the side of the European Commission, on high expert level with sufficiently broad scope. It covers all eventual areas and activities which will contribute to reduction of occurrence of obesity in childhood and adolescent population". Others have done several suggestions for areas that could be strengthened or added.

- One point raised was that the Action Plan could be more focussed on commonalities across countries. The common priorities could be stated as well as simultaneous actions in the EU and in Member States, such as common lobbing. Examples are marketing and advertising to children, where EU Member States can work together on (for example) how to address advertising on social media, YouTube, etc. Reformulation is another example, if the implementation is successful and happens simultaneous.
- Another point raised was evaluation of each eight areas of action as itself and as a comprehensive approach, to identify which areas are more/less effective or are needed as companion. This would need data to assess the effectiveness of actions, but there are little.
- One of the respondents thought that the action plan should not only encompass recommendations but should be of more obligatory nature including overall stewardship, clear distribution of responsibilities, and scientific evidence based supervision. Another respondent plead for reinforcement of planned actions in areas 2, 3, 4 and 6.

Promoting a healthier environment in schools is a positive action. More importance could, however, be given to the promotion of a healthier environment outside of schools. The majority of activities and actions are part of regular class activities, so free time activities for children could be more emphasized. Furthermore, creating a healthy environment in communities through urban planning is important. The development of policies for the construction of Healthy Cities could contribute to this issue. In Healthy Cities, health development is not about the health sector only. It includes health considerations in economic, regeneration and urban development efforts. Inter-sectoral strategies are strengthened in order to have physical environments that contribute to health, wellbeing, security, social interaction, and easy mobility.

Furthermore, it was mentioned that more emphasis could be put on several other topics in the Action Plan.

- Labelling of foods could be further strengthened.
- Prevention on childhood obesity can be more successful when working on proper care for children with obesity.
- Helping families to (be able to) make right choices and have a good quality of life is an element somewhat lacking in the EU Action Plan.
- Tackling socio economic determinants of health.

7 Impact of the Action Plan and related national activities

A formal evaluation of the impact of the action plan or the policies and activities for which indicators are included in the Childhood Obesity Study falls outside the scope of the project. Nevertheless, in this chapter, some anecdotal insights are provided based on the interviews and information described in the forgoing chapters.

7.1 Impact of the Action Plan as a whole on policy development and implementation

The Action Plan serves mainly as a guidance document that provides directions and ideas for national policies. For countries that already have many policies, strategies or actions in the areas of action of the Action Plan, it serves as a justification or reference document for their national policies. Six Member States (HR, EE, EL, LV, LU, PT) credited the Action Plan (and the support of the Commission) with directly having sparked or facilitated the adoption of a specific national plan on nutrition. In Croatia it also facilitated participation in COSI. Two other Member States (AT, RO) further noted that the Action Plan supported the allocation of financial resources to the area of nutrition. One Member State (EL) revised its public procurement procedures following discussions of the Action Plan at the High Level Group. Twenty-three Member States and also Switzerland have noted that the Action Plan helped to implement or strengthen national policies, or provided awareness, inspiration, example and guidance, or facilitated policy-making, implementation of initiatives or discussions with health and other stakeholders (including with industry).

Furthermore, Member States mentioned some positive remarks, such as (see Figure 6.6 for a graphical representation):

- Several respondents (AT, DK, HU) find it very useful that the European Commission started the **discussion** on childhood obesity.
- Setting of a uniform framework with European standards and reference **recommendations** supports Member States and regions/communities with their priorities (LT, BE-WAL). Also **monitoring of the implementation** is seen as useful (LT).
- European initiatives are seen as **support** and reinforcement of **national actions**, which is the most beneficial support for Members States. For example, support for COSI and surveillance actions (ES, NO, anonymous).
- **Collaborative action**, as a comprehensive whole, is seen as useful (FI). In this respect the instalment of the **High Level Group** on Nutrition and Physical Activity can be mentioned. Its activities (recommendations, opinions, interventions, support) that are the result of collaboration between its members are seen as valuable (HR).
- An example of such collaboration with support of the European Commission is the activity in the field of food **reformulation**/food product improvement. With the globalization of the production of foods, the actions of the European Commission in the field of reformulation are very important and support efforts at the national level (FI, NO, RO, CH). The **stakeholder dialogue** with other sectors, in particular food industry mentioned by Italy is related to this.
- Another example is the Joint Action on Nutrition and Physical Activity (**JANPA**) (HU, IT, RO). **Research** in different areas of the Action Plan is important for the countries (CH) and **funding projects** through Joint Actions or through several tenders is seen as useful (AT, HU).
- Other actions that were considered to be useful were: relevant **Council Conclusions** (HU), **cooperation with WHO** (IT) and reduction of **marketing** pressure on children (CH). The latter topic should be tackled especially on the European level, because companies can be active in many countries. Without support from the European Commission it is very difficult to be active on a national level.

Figure 7.1. *Wordcloud illustrating the useful actions of the European Commission that were mentioned by the respondents. The larger the word, the more often it was mentioned.*

7.2 Impact of the individual national actions included in the Action Plan

The Action Plan has been launched in 2014. It provided inspiration for the creation of some national policies (as described under 7.1) in this policy area while others would have been initiated also without the Action Plan. For both categories, due to the shortness of the period of 2014-2017 covered by this report, it is unlikely that policies and activities implemented since 2014 can be causally related to a decrease in or a halt in the rise of childhood obesity. These policies and activities can be rather seen as an outcome to a higher or lesser extent resulting from the Action Plan or supporting the aims of the Action Plan.

Nevertheless there are some examples of certain policy areas related to childhood obesity that saw some important progress during this short period of time. As shown in Chapter 4.3.1, food reformulation/food product improvement is the area that showed a lot of new activity since the launch of the Action Plan. The largest increase in reformulation initiatives was observed for sugar. The number of countries that have reformulation/food product improvement initiatives for sugar increased from 12 countries (36%) to 25 countries (75%). In Switzerland, for example, a memorandum of understanding with food producers was signed in 2015. It resulted in a 3% reduction of added sugar in yoghurts and a 5% reduction in breakfast cereals.

Several of the other activities originate from before 2014, but are still ongoing. These policies and other initiatives could have been adapted or strengthened, using the Action Plan as inspiration and guidance. Examples of achievements for ongoing policies are the following.

- There has been an increase in the number of breastfed children in Greece and Romania.
- In some countries (BG, EL, LT, SI, FI) an improved quality of school food and a better knowledge about healthy nutrition has been observed. In other countries the interest of children in physical activity has grown (SK). Some community-based programmes (NL) resulted in healthier school and sports canteens and a reduction in BMI in several municipalities. Also in other countries programmes have shown effects.

- In Spain, reformulation activities resulted in a reduction of salt in bread, breakfast cereals, broths and ready meals and a reduction in trans fatty acids in different food groups.
- The use of a front-of-pack logo (the keyhole logo and wholegrain logo in DK) and the use of a Public Health Product Tax (HU) lead to reformulation of food products. In the latter case, the supply and sales of products subject to the tax decreased, 25-35% of the people consumed less of these products, and health literacy in the general population increased. In Denmark, the average wholegrain intake increased from 36 grams per day before the introduction of the wholegrain logo to 63 grams per day in 2015.
- The development and promotion of healthier foods in stores decreased the intake of sugar and increased the intake of fruit and vegetables in Norway over the last decade.
- Dietary guidelines for healthy nutrition for different ages groups (BG) raised awareness of balanced nutrition and a healthy lifestyle. In some other countries, campaigns on salt, sugar reduction and promotion of fruits and vegetable consumption resulted in better nutrition-related awareness, attitude and skills or improved lifestyles and purchasing behaviour.

In total 39 indicators were used in this report to assess to which extent countries have policies or activities in place for the eight areas for action of the Action Plan. Assessment of the individual national actions in terms of these 39 indicators gave the following results (see Figure 7.2 with countries with the most activities (NO, ES, UK) on top and those with the least activities (CY, ME, RS) at the bottom). Although, none of the countries had activities for all of the indicators, most countries were active in all eight areas for action. There were only six countries that had, for one or two of the action areas, none of the activities fulfilled. This included the two candidate countries (ME, SR), which have not validated the Action Plan.

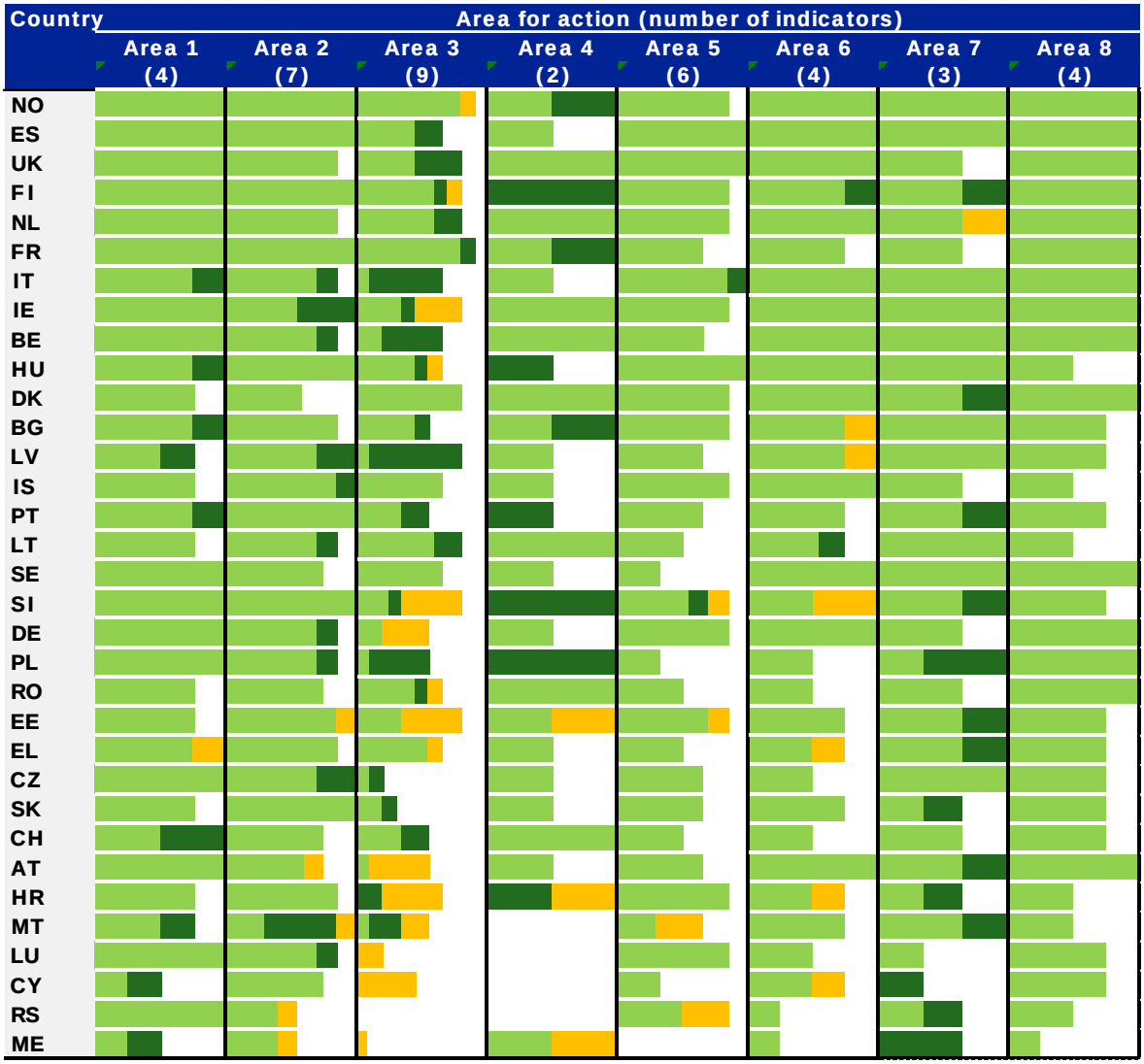


***Figure 7.2**. Percentage of policies or activities implemented per area for action per country.* For each area for action a different number of indicators has been included in the study. In total 39 indicators have been studied.
yes, before 2014 yes, after 2014, planned.

Box 7.1. The 39 indicators used for figure 7.2

Area 1: Support a healthy start in life

- Policies or strategies to ensure that women receive guidance on nutrition and nutritional status before, during and immediately after pregnancy
- Policies, strategies, initiatives or actions to promote and protect breastfeeding
- Participation in the Baby-Friendly-Hospital Initiative
- Policies or guidance on complementary feeding

Area 2: Promote healthier environments, especially in (pre-) schools

- Policies on improving the children's school environment
- Participation in the EU fruit and vegetable scheme (or similar programme)
- Availability of fresh drinking water in schools
- Policies, strategies etc. on energy drinks for children
- Policies, strategies etc. on vending machines
- Nutrition education included in school curricula
- Physical activity included in school curricula

Box 7.1 continued

Area 3: Make the healthy option the easy option

- Policies or initiatives on food reformulation/food product improvement for salt
- Policies or initiatives on food reformulation/food product improvement for saturated fat
- Policies or initiatives on food reformulation/food product improvement for sugar
- Policies or initiatives on food reformulation/food product improvement for calories/portion size
- Policies or initiatives to (virtually) eliminate trans fat
- System to monitor the level of nutrients (and thus the effect of strategies for food reformulation
- Mandatory or voluntary easy to understand labelling, e.g. front of pack labelling
- (Policies on) food taxation for products/nutrients that are high in fat, sugar or salt or do otherwise not fit nutritional guidelines ('unhealthy' foods)
- (Policies on) subsidies for healthier options ('healthy' foods), other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme

Area 4: Restrict marketing and advertising

- Policies on marketing of foods to children
- Use of nutrient profiles or criteria to restrict marketing of foods to children

Area 5: Inform and empower families

- Food-based dietary guidelines
- National campaigns to promote healthy diet and or increase physical activity
- Policies or initiatives to support community based interventions
- Multi-factorial (community-based) intervention programmes
- Screening programmes for childhood overweight and obesity (in primary care)
- Management services (e.g. interventions or weight loss programmes) for overweight and obese children

Area 6: Encourage physical activity

- Policies on physical activity promotion for <18 year olds
- National physical activity guidelines
- Data on height and weight in children
- National or subnational schemes to promote active travel to school

Area 7: Monitoring and surveillance

- National representative diet/nutrition surveys
- National representative surveys on physical activity
- Participation in COSI

Area 8: Increase research

- Participation in projects funded by the Health Programme
- Participation in projects funded by FP7 or H2020
- Participation in projects funded by the Erasmus+ Programme
- Participation in the Joint Programming Initiative 'Healthy Diet for a Healthy Life'

7.3 Impact of the Action Plan on childhood obesity in Europe

The 2015/2016 data collection round of COSI may provide some insight in the impact of the Action Plan on childhood obesity, based on preliminary data recently published by WHO[31]. These data were not available in time to be extensively studied and included in this report. Results on trends are available for only those 12 countries that participated in three or more rounds since the start of COSI in 2007.

These results indicate "a significant decrease" in the prevalence of childhood overweight and obesity in Italy, Greece, Portugal and Slovenia (see Figure 7.3). A similar tendency was observed for Spain and Ireland. These were also the six countries with the highest initial levels of overweight and obesity. In addition, the prevalence was stable in three of the 12 countries (NO, BE, CZ). Less definite patterns were observed in the remaining countries (BG, LV, LT). None of the countries consistently showed an increase in childhood overweight and obesity.

Four of the above six countries with decreasing trends (67%) have policies or activities for 30 or more of the 39 indicators used in this report (see Figure 7.4). Most of the policies and activities originate from before the Action Plan. This is, however, also the case for the six other countries where the prevalence was stable or the pattern was less definite.

In addition, 10 countries (AT, HR, CY, DK, EE, FI, ME, PL, SK, RS) joined COSI for the first time in 2015/2016. The participation rate increased with each round, from 36% in the first round (12 countries), 39% in the second round (13 countries), 42% in the third round (14 countries) and 79% in the last round (26 countries). This is an important increase in participation. The increased participation in COSI shows that the promotion of this Initiative has increased among stakeholders the awareness about childhood obesity and the interest in having factual data on it. In Malta, for example, the results confirmed the scale of the childhood obesity problem and provided evidence to policy makers of the need for action.

[31] http://www.euro.who.int/__data/assets/pdf_file/0006/372426/wh14-cosi-factsheets-eng.pdf?ua=1

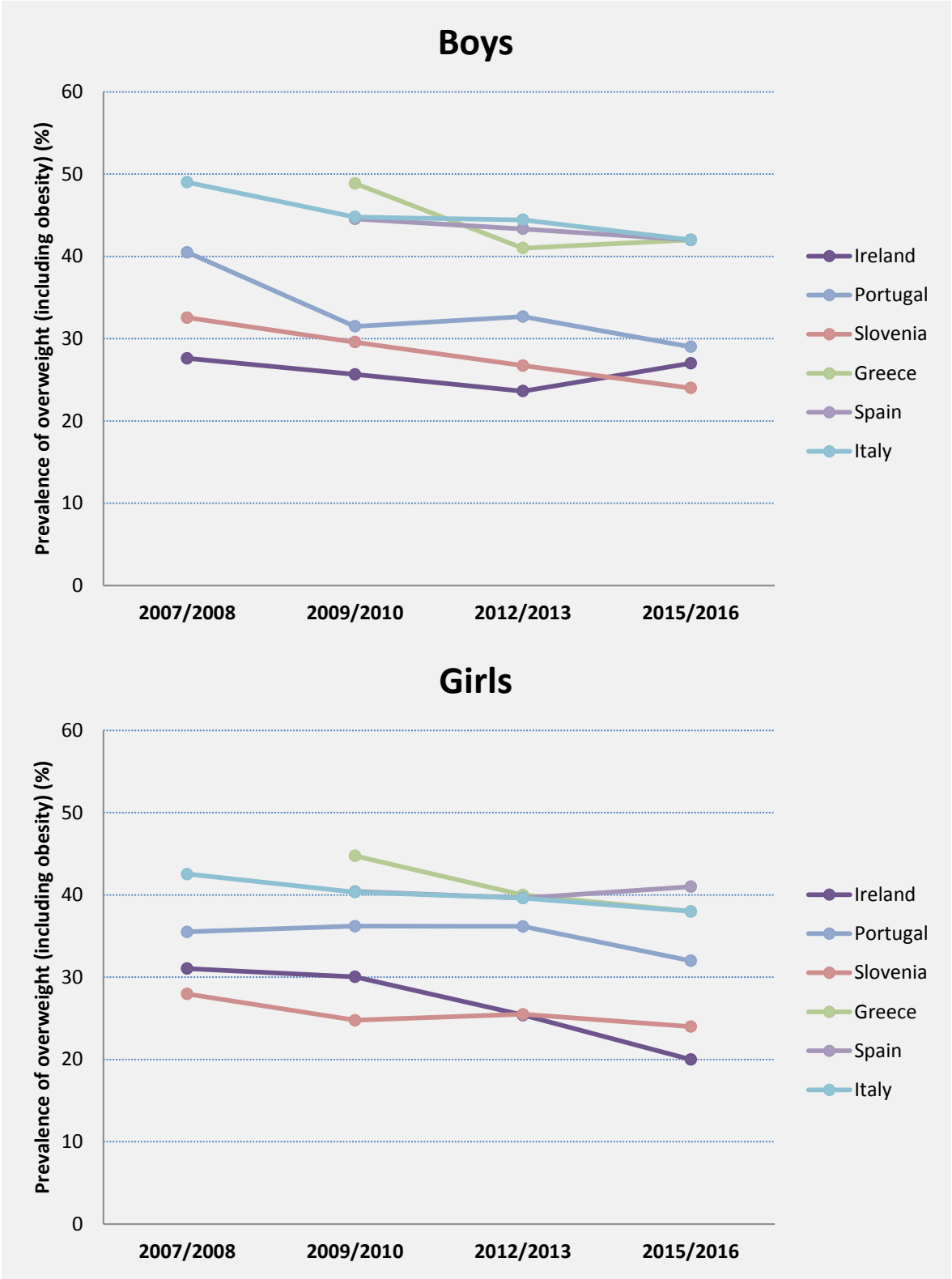


Figure 7.3. *Prevalence of overweight among 7-year old (IE, EL, PT, SI, ES) or 8-year old (IT) boys and girls in subsequent rounds of the Childhood Obesity Surveillance Initiative for countries that showed a decrease in the prevalence.*

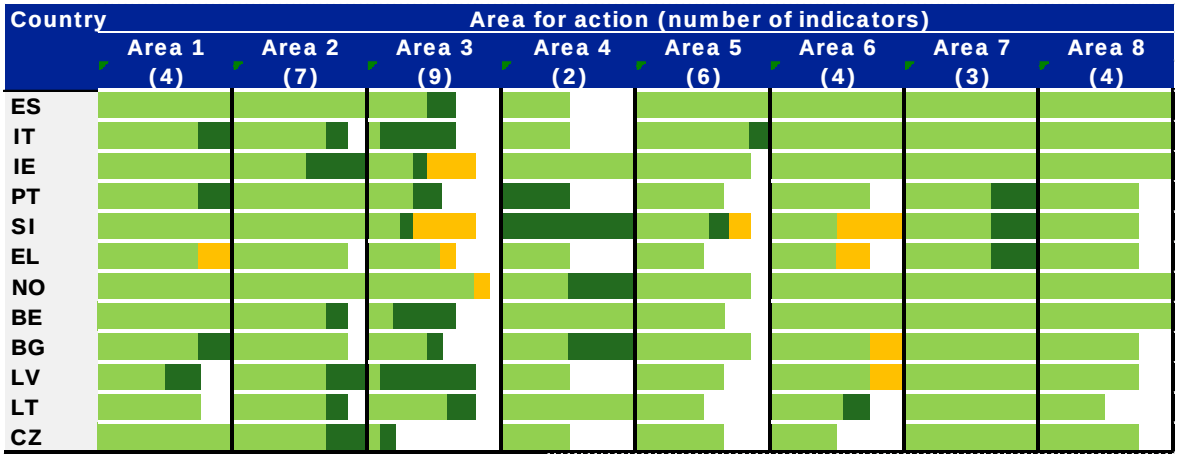


Figure 7.4. *Number of policies or activities implemented per area for action for countries that participated in three or more rounds of COSI.* For each area for action a number of indicators has been included in the study. The number varies between areas for action. The wider the column for the area, the more indicators have been included. yes, before 2014 yes, after 2014, planned.

8 CONCLUSIONS

The Childhood Obesity Study aimed to provide the European Commission and the EU Member States an overview of the efforts during the first-half period of the EU Action Plan on Childhood Obesity 2014-2020 in every EU Member State as well as Iceland, Norway, Switzerland, Serbia, and Montenegro, and at the EU level. It also offers information on the prevalence of childhood obesity in the aforementioned countries.

Prevalence of childhood obesity
A clear picture on the prevalence of overweight and obesity among young children (under 5 years of age) cannot be provided, because published data on children in that age group are scarce and the available data are difficult to compare. More comparable data on the prevalence of overweight and obesity across countries are available for primary schoolchildren (6-9 years) and adolescents based on COSI and HBSC, respectively. The prevalence of overweight (including obesity) in these age groups differs considerably between countries.

Systematically collected data to determine trends in prevalence since the adoption of the Action Plan are not yet available. Data from the most recent round (2015/2016 school year) of COSI and a next round of the HBSC survey (2017/2018) will provide more insight. It should be noted, however, that the effects of all actions undertaken, especially those initiated after the adoption of the Action Plan, on the prevalence of childhood obesity may not be visible yet in those data. Such changes take time.

In COSI height and weight are measured using standard protocols. In HBSC, however, data are self-reported, which may lead to an underestimation of the prevalence of overweight and obesity. In a study among Welsh HBSC participants the prevalence of overweight based on self-reported data was almost 5% lower than the prevalence based on measured height and weight (75). A study among adults found that underestimation increased over a ten-year period (76). This may imply that increasing trends in the prevalence of overweight and obesity in adolescents may also be underestimated.

Area 1: Support a healthy start in life
The majority of countries have policies, strategies or actions relating to Area 1 of the Action Plan (support a healthy start in life). In 85% of the countries, guidance on nutrition and physical activity is provided to women, during and immediately after pregnancy. This is often part of regular maternity care. Information on breastfeeding is provided and/or breastfeeding is advised or promoted in all countries, while 82% of the countries have implemented the Baby-Friendly Hospital Initiative, a global effort launched by WHO and UNICEF to implement practices that protect, promote and support breastfeeding. However, the percentage of hospitals and maternities that have ever been designated baby-friendly ranges widely. In 91% of the countries guidelines on complementary feeding are available and/or young mothers are advised on this issue through child healthcare.

Eleven countries mentioned that guidelines, strategies or action plans were renewed since 2014. How this may impact the percentage of exclusively breastfed children is to be evaluated. Before the adoption of the Action Plan, the percentage of infants exclusively breastfed for the first six months of life ranged from 0.7% to 54.2%. Not all countries, however, used the same definition for exclusive breastfeeding.

The questionnaire on strengths and weaknesses showed no particular issues for this area for action. Only one activity of the 37 that were reported to be ‘most difficult to work on’ was related to Area 1. The aims of nine percent of the EU funded studies we included (ongoing after 2014, situation in March 2017) related to operational objectives of this area for action.

Area 2: Promote healthier environments, especially in (pre-)schools
This action area seems to be one of the areas for action that is best addressed across the countries included in this study, since a lot of activity is seen in Area 2. This is illustrated by several findings of the current study. Firstly, all countries have policies to improve the school environment or have them planned. In most policies vending machines and energy drinks are addressed. Eight countries have policies to restrict the sale of energy drinks to children that go beyond the school setting. Secondly, mandatory physical education is included in the school curriculum in all countries. The number of hours allocated to physical education ranges from 1 hour per week to 10 hours per week. Two to three lessons or hours per week is most common. Thirdly, nutrition education is included in the school curricula of all but one country. However, it is mandatory in only 75% of them. Furthermore, nutrition education is often included in topics like 'biology' or 'home economics'. Therefore it is hard to estimate the amount of time allocated to nutrition education or the exact information that is provided.

Moreover, 40% of the reported 'most successful' activities pertain to this action area. Of these activities setting standards for foods provided in schools, provision of free healthy meals and promoting active breaks are mentioned most. Finally, many of the EU-funded projects address operational objectives in this area for action.

Area 3: Make the healthy option the easier option
Area 3 is the action area that experiences the most growth across Europe. The growth is especially seen for food reformulation/food product improvement. Of all indicators in this report reformulation for sugar is the one that increased the most since 2014. In 13 countries (39%) reformulation initiatives for sugar have been initiated since 2014. In five other countries (15%) there are plans for this. It is likely that the Roadmap for action on food product improvement and the Council Conclusions on food product improvement from 2016 boosted such activities. Specific measures to (virtually) eliminate trans fatty acids from foods, such as laws on maximum levels, are in place in one third of the countries, while in almost another third of the countries there are voluntary agreements to reduce trans fatty acids from industry. Also taxation of nutritionally unbalanced products is becoming more common. It is, however, not widely used, existing in 9 of the 33 countries. In four of them such taxation was introduced after 2014. Three other countries have plans for a levy on sugar-containing beverages.

It is also the case that relatively few of the reported 'most successful' activities (11%) and relatively many of the reported activities that were considered to be 'most difficult to work on' (30%) lie in this area for action. The activities 'most difficult to work on' equally concerned food reformulation/food product improvement, taxation and easy to understand labelling. In many cases, resistance from industry, as well as political and public resistance was reported as one of the hampering factors.

Voluntary cooperation of countries and the subsequent products (recommendations, opinions, interventions, support) can be of value for all, but possibly in particular for (smaller) countries with limited resources or those more dependent on food imports. Food reformulation/food product improvement is one of the topics for which countries can learn a great deal from each other's experiences.

Area 4: restriction marketing and advertising

In 82% of the countries (n=27) initiatives exist to reduce marketing of HFSS foods to children and in 45% of the countries nutrient criteria are used for this purpose. The initiatives are predominantly (voluntary) codes issued by the private sector. However, the Action Plan covers children and adolescents up to 20 years of age, while several of the voluntary pledges are directed at children under 12 years of age. Furthermore, a recent study from the European Commission[32] concluded that "children are exposed to a number of problematic marketing practices in online games, mobile applications and social media sites, which are not always understood by the child consumer".

Only one of the 57 activities that were reported to be 'most successful' (4%) pertained to Area 4 of the Action Plan, whereas 18% of the activities that were considered to be 'most difficult to work on' fall within this action area. The existing codes of conduct or nutrient criteria were seen as not restrictive enough and some considered the adherence to the codes in their country as suboptimal. Furthermore, food industry often operates in many European countries and beyond. In this respect establishing the dialogue with stakeholders has been mentioned as positive action from the European Commission. Competent Authorities of several countries mentioned that their countries will take a further position on this topic after the conclusions of the discussion on the EU's Audiovisual Media Services Directive have been published.

None of the operational objectives of the EU-funded studies that were included in this study related to Area 4. However, the JRC was recently asked to produce a mapping of initiatives to reduce marketing pressure in order to identify best practices that Member States may wish to adapt or build on. Furthermore, in October 2017, a tender was set out by the European Commission for a study on the exposure of children to linear, non-linear and online marketing of foods high in fat, salt or sugar.

Area 5: Inform and empower families

Several indicators were included to assess activity in Area 5 of the Action Plan. The presence of food-based dietary guidelines to inform consumers about a healthy diet is covered best, with all but two countries having such guidelines. In at least 15 countries (45%) separate guidelines for children are available. The indicator 'policies to support community-based interventions' seems to be addressed the least. Such policies are available or planned in almost 60% of the countries. Community-based-interventions often fall under the responsibility of subnational authorities, such as municipalities. Nineteen percent of the reported 'most successful' activities are related to Area 5. Almost half of them concerned multi-faceted interventions. The fact that these are integrated programmes at the local level, involving different stakeholders and settings, and that they are conducted for a longer period of time are seen to contribute to their success.

The majority of countries (82%) provide management services for children who are already overweight or obese, by the general practitioner, other health care providers or through specific programmes. In many countries, the general practitioner is the one who is responsible for the management of an obese child.

[32] https://ec.europa.eu/info/sites/info/files/online_marketing_to_children_factsheet_web_en__0.pdf

Area 6: Encouraging physical activity
Area 6 seems to be well covered, with respect to the presence of policies, the presence or planning of national guidelines and available data on weight and height of children. In about half of the countries national or subnational schemes are present to promote active travel to school or plans exist to develop such schemes. Also the largest part of the budget allocated to projects included in this study by EU programmes was for projects that mapped to this action area. Remarkably, none of the activities that were reported to be 'most successful' or 'most difficult to work on' pertain to this action area.

In the HBSC study, the percentage of boys and girls who reported reaching WHO's physical activity recommendation was higher among 11-year olds than among 15-year olds, and higher among boys than girls. In 2013/2014, the percentage of boys reaching the recommendation ranged from 11% to 47%. Among girls the percentage ranged from 5% to 34%.

Area 7: Monitoring and evaluation
In the most recent round of COSI 26 countries (79%) participated, while at least two countries make use of other surveys to monitor the prevalence of overweight and obesity among children. Participation in COSI is the indicator that experienced the second largest growth since 2014; ten countries (30%) participated for the first time in the 2015/2016 round. Monitoring of height and weight, physical activity and other health related behaviours in adolescents is covered by HBSC. All but 3 of the 33 countries participate in HBSC. Although HBSC provides country-comparable data, it should be noted that they are self-reported. A considerable part of the activities that were 'most successful' relate to this area for action (18%). This concerns monitoring of childhood obesity, for example through COSI, or monitoring/screening in child health care. In many countries height and weight are measured as part of child health care. This data could provide more insight into the prevalence among the youngest age groups. Harmonisation of data of other indicators, such as exclusive breastfeeding, across European countries is important.

National representative nutrition surveys are available in 85% of the countries. However, children are not always included. Furthermore, the methodology differs, making it difficult to compare data across countries. Many countries have national food composition tables or databases. As a source of data for monitoring the achievements of food reformulation/food product improvement, they should be at the brand level. This is only the case in France and Belgium.

The evaluation of policies is the only activity relating to Area 7 that was mentioned as one of the activities 'most difficult to work on' (6%).

Area 8: Increase research
The studies funded by EU programmes that related to childhood obesity, physical activity and/or nutrition and where ongoing in or after 2014 received a considerable amount of funding (around €70 million). We did not investigate whether the total funding for studies on childhood obesity, nutrition or physical activity has increased as compared to a similar period before the Action Plan. However, after our search ended in March 2017 more budget has been allocated, also for topics where relatively few of the operational objectives mapped to (Area 3 and 4). Examples are to study exposure of children to marketing and to elaborate on a monitoring system on food reformulation. In addition, very recently €20 million has been dedicated to the programme 'How to tackle childhood obesity? Two proposals have been selected for funding.

Impact of the Action plan

The Action Plan covers most, if not all, action areas that are relevant to halting the rise in childhood obesity. Suggested actions in each area for action are, however, presented separately and not as a comprehensive approach. Defining national health policies remains the exclusive competence of Member States. Therefore, the actions proposed in the Action Plan are voluntary and should be taken forward by each of the Member States according to their own national contexts and priorities. The Action Plan provided awareness, inspiration, example and guidance, or facilitated policy-making, implementation of initiatives and discussions with stakeholders (including with industry). For countries that already have many policies, strategies or actions, it mainly serves as a justification or reference document for their national policies. Activities of the European Commission support Member States with their priorities, by setting a uniform framework with European standards and reference recommendations.

Sharing of information, experiences and good practices is important for voluntary cooperation or collaborative action between countries, such as in the field of food reformulation/food product improvement and public procurement. Some representatives found that more simultaneous action could be undertaken by the Member States, for example in Area 3 (make the healthy option the easier option) and Area 4 (restriction of marketing to children).

All countries are active in more than one of the action areas of the Action Plan and most countries are active in all eight action areas. For several action areas, a considerable number of initiatives were implemented after 2014, the year the Action Plan was endorsed. In addition, in all areas for action a number of countries are moving from having plans to implementation of actions. Particularly in Area 3 (make the healthy choice the easier choice) a considerable number of initiatives were implemented after 2014. This does not necessarily mean, however, that the implementation was a result of the Action Plan.

Due to the shortness of the period of 2014-2017 covered by this report, it is unlikely that policies and activities implemented since 2014 can be causally related to a decrease in or a halt in the rise of childhood obesity. Furthermore, systematically collected data to determine trends in the prevalence of childhood obesity since the adoption of the Action Plan are not yet available.

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ANNEX 1. SEMI-STRUCTURED INTERVIEW

Interview High Level Group Members

Evaluation of the Action Plan on Childhood Obesity 2014-2016

A study by the EPHORT consortium, consisting of:
RIVM, National Institute for Public Health and the Environment, the Netherlands
NIVEL, Netherlands institute for health services research
EPHA, European Public Health Alliance

National Institute for Public Health and the Environment
Ministry of Health, Welfare and Sport

nivel

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Introduction

Thank you for talking to us about the implementation of the EU Action Plan on Childhood Obesity in your country. As you know, the High Level Group adopted Action Plan in February 2014. A mid-term revision of the objectives was scheduled for three years after the endorsement of the Action Plan. Therefore, we provide support to the European Commission by establishing an overview of the state of implementation of the Action Plan on Childhood Obesity, as well as on relevant related actions on nutrition and physical activity.

This interview has the purpose of collecting information for this overview. Is it Ok for you that we audiotape this interview so we can listen to this when summarizing your response when needed?

Note. It is not necessary to fill it this survey in before the interview. We will do so during the interview and send it afterwards for your review.

Interview

1) Does your country have a National Action Plan on Childhood Obesity?

- ❑ No
- ❑ Yes

If yes -> When was it adopted?

If no -> Does your country have a plan for Overweight prevention in general?

- ❑ No
- ❑ Yes

If yes -> Does it include specific actions for children <18 years?

Does your country have an Action Plan on Physical Activity Promotion?

- ❑ No
- ❑ Yes

If yes -> When was it adopted?

Does it include specific actions for children <18 years?

Does your country have an Action Plan on Nutrition?

- ❑ No
- ❑ Yes

If yes -> When was it adopted?

Does it include specific actions for children <18 years?

Does your country have an Action Plan on prevention of Noncommunicable diseases?

- ❑ No
- ❑ Yes

If yes -> When was it adopted?

Does it include specific actions for children <18 years?

We would now like to go into more detail about the policies related to the prevention of Childhood Obesity in your country. There are, as you know, many possible policies that may be in place in order to prevent childhood obesity, directly or by improving diet and stimulating physical activity. We first would like to know what the priority topics of the National authorities are in your country with respect to Childhood Obesity. Later we will come back into more detail to specific policies and actions.

2) What are the priority topics of the national authorities with respect to childhood obesity in your country?

3) Why are these the priority topics in your country?

4) Are there any policies in preparation or planned for the (near) future that are relevant for the prevention of childhood obesity?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these planned policies *(initiatives, or other)*?
What kind of policies are these?
What kind of actions or guidelines are part of these policies?
When are these policies expected to be implemented?

5) How did the action plan on Childhood obesity facilitate development or implementation of any of the policies?

6) How are health inequalities addressed in the policies that are relevant to childhood obesity?

7) Are there any specific national coordinating mechanism (e.g. working group, task force, advisory body, coordinating institution, and so on) in the area of childhood obesity, nutrition or physical activity promotion in your country?

- ❑ No
- ❑ Yes

If yes -> could you please explain these mechanisms?
What are the competent authority(ies) with regards to the prevention or management of childhood obesity?
Is there a centre of excellence or scientific reference institution for children?

Below, the possible areas are mentioned that are relevant for the prevention of childhood obesity. We will ask some questions about all areas, even though we might have discussed them before, to ensure no relevant information is omitted. We will focus on policies that have recently been implemented (after 2014) or that are currently being developed or planned.

AREA 1: Support a healthy start in life

a) Are there any policies, strategies, initiatives or actions to promote and protect breastfeeding?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
What kind of actions or guidelines are part of these policies?
Do they include policies on breastfeeding at work?
Are these voluntary agreements, legislation or in another way organised?
Since when are these policies…in place? (if you don't know exactly, was it was before or after 2014?)

b) Are there any policies or is there any guidance on complementary feeding?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?
What kind of policies or guidelines?
Since when are these policies/guidelines…in place? (if you don't know exactly, was it before or after 2014?)

c) Are there policies or strategies to ensure that women receive guidance on nutrition and nutritional status before, during and immediately after pregnancy?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?)

d) Are there any management services (e.g. interventions or weight loss programmes) for overweight and obese children in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?)

AREA 2: Promote healthier environments, especially in schools and pre-schools

e) Are there any policies, strategies etc. on energy drinks for children in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Are there specific policies on energy drinks in schools?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?)

f) Are there any policies, strategies etc. on vending machines in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Are there specific policies on vending machines in schools?
Are there any restrictions on energy dense nutrient poor foods and beverages in school vending machines?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?)

g) Are there any policies on improving the children's school environment in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?

- *Do children get any meals at school in your country?*
  - *Are there any food-based or nutrient-based standards for these meals?*
  - *Who sets these standards?*
  - *Are there any food based or nutrient-based standards for other foods in schools (either provided by schools outside meals of taken from home)*
- *Is there any form of provision of free or subsidized school fruit and vegetables in your country?*

h) Is nutrition education included in school curricula in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?)

i) Is physical activity included in school curricula in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about these policies *(initiatives, or other)*?
Since when are these policies…in place? (if you don't know exactly, was it before or after 2014?)

AREA 3: Make the healthy option the easy option

j) What are the policies or initiatives on reformulation in your country?

- ❑ No
- ❑ Yes

- what kind of actions or guidelines are part of these policies?
- *Are these voluntary agreements, legislation or in another way organised?*
- *What are the nutrients these policies focus on? (Salt, Sugar, Saturated fat, Calorie reduction (incl. portion size)*

Since when are they in place?

k) Is there any system in place in your country to monitor the level of these nutrients (and thus the effect of the reformulation strategies) in your country?

- ❑ No
- ❑ Yes

l) Is there any mandatory or voluntary easy to understand labelling, for example front of pack labelling, to help consumers buy healthier products?

- ❑ No
- ❑ Yes

m) Do you have (policies on) food taxation for 'unhealthy' products/nutrients in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?
Do they focus on specific foods or nutrients?

n) Do you have (policies on) subsidies for 'healthy' foods in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?
Do they focus on specific foods or nutrients?

AREA 4: Restrict marketing and advertising

o) Do you have policies on marketing of foods to children?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?
Do they focus on specific foods or nutrients?
To which media do they apply?
At this moment the Audiovisual Media Services Directive is discussed in the European Parliament. Marketing to children is part of this directive. Are there any plans to change any policies on marketing of foods to children due to these negotiations?

AREA 5. Inform and empower families

p) Does your country have implemented policies on the integrated management of childhood obesity?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?

q) Does your country have screening programmes for childhood overweight and obesity in primary care?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?

r) Are there any national campaigns to promote healthy diet and or increase physical activity?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?

s) Are there policies or initiatives to support community based interventions?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this?

AREA 6. Encourage physical activity

t) What are the policies on physical activity promotion for <18 year olds in your country?

- ❑ No
- ❑ Yes

If yes -> Can you tell us more about this? are there any national or subnational schemes promoting active travel to school?

u) Are there any National physical activity guidelines?

- ❑ No
- ❑ Yes

If yes -> Can you tell us what these guidelines are?

We have now almost come to the end of the interview. We have two final questions.

8. Do you have any other issues that you would like to mention with respect to the prevention or management of childhood obesity or about the implementation of the Action Plan in your country?

- ❑ No
- ❑ Yes

If yes -> Please feel free to mention anything you would like to add?

9. Can you provide contact details of an expert in Childhood Obesity in your country that could provide information on outcome indicators, like prevalence of obesity, % children reaching guidelines for physical activity, etc.?

We thank you very much for your time and efforts to provide this valuable information to us. We will send you a filled data sheet for review as soon as possible.

We wish you a pleasant day.

ANNEX 2. INDICATORS USED IN THE STUDY AND THEIR SOURCES

Childhood Obesity Study indicators	Source[1]
Overarching surveillance indicator	
% overweight and obesity among children aged <5 years*	Information collected by DG SANTE in 2014 and 2015, Literature
% overweight among children aged 6-9 years*	COSI
% obesity among children aged 6-9 years*	COSI
% overweight and obesity among children years*	HBSC
Area 1: Support a healthy start in life	
Guidance on nutrition and nutritional before, during and immediately after pregnancy?*	Interview
Actions to protect and promote breastfeeding	Interview, WHO: GNPR2 survey
Implementation of the Baby-Friendly Hospital Initiative	WHO report (38)
% of maternity health facilities and services which are certified WHO baby-friendly	WHO report (38)
% of infants exclusively breastfed for the first six months of life*	WHO: Country profiles on nutrition, physical activity and obesity, WHO: Global Health Observatory data repository, Information collected by DG SANTE in 2014 and 2015
Guidance on complementary feeding	Interview
Area 2: Promote healthier environments, especially in schools and pre-schools	
% population <18 years consuming sugar-sweetened beverages on a daily basis*	HBSC
National school food policies	Interview, Country sheets on school food policies, WHO: GNPR2 survey
Provision of free or subsidized school meals	Experts WHO: GNPR2 survey
Provision of free or subsidized school fruit and/or vegetables	Annual monitoring reports 2013/2014 and 2015/2016, WHO GNPR2 survey
% of schools participating in the EU School Fruit and Vegetable Scheme *	Annual monitoring reports 2013/2014 and 2015/2016
Policies/guidelines on supplying easily accessible, free, fresh drinking water at schools	WHO GNPR2 survey Expert
% of schools supplying free fresh drinking water (e.g. through tap points)	Experts
Policies on vending machines	Interview
Policies on energy drinks	Interview
Mandatory nutrition education in school curricula	Interview
Mandatory physical activity education in school curricula	Interview, WHO: factsheets on health-enhancing physical activity
Area 3: Make the healthy option the easy option	
Food based dietary guidelines	FAO website food-based dietary guidelines, Expert
National food reformulation strategies* on salt, sugar, saturated fat, calorie reduction (including portion size reduction)	Interview, Information collected by DG SANTE in 2014 and 2015
Policies to (virtually) eliminate trans fats *	WHO: GNPR2 survey, Information collected by DG SANTE in 2014 and 2015, Interview
System to monitor the level of nutrients in foods (and thus effect of reformulation)	Interview
Easy to understand or interpretative labelling, such as front of pack labeling	Interview
Taxation on food and drinks in order to promote healthy eating	Interview
Subsidies on food and drinks in order to promote healthy eating	Interview
VAT rates on fruit and vegetables	Several websites
Area 4: Restrict marketing and advertising	

Childhood Obesity Study indicators	Source[1]
Policies and other initiatives to reduce the impact (power and exposure) on children of all forms of marketing of HFSS foods (incl. TV, Internet, social media, sponsorship)*	Interview, WHO: GNPR2 survey
Adopted national nutrient profile model or other explicit nutritional criteria for the purpose of reducing marketing of HFSS foods to children?*	Expert, Interview, Information collected by DG SANTE in 2014 and 2015
Area 5: Inform and empower facilities	
National campaigns to promote healthy diet (e.g. increase fruit & vegetables) and/or physical activity	Interview
Multilevel community based interventions to prevent and/or manage childhood obesity (like 'EPODE', 'JOGG', or 'THAO')	EPODE International Network
Policies/initiatives to promote and/or support community based interventions	Interview
Policies on the integrated management of childhood obesity	Interview, excluded**
Management services (e.g. interventions or weight loss programmes) for overweight and obese children < 18 years	Interview
Screening programmes for childhood overweight and obesity	Interview
Area 6: Encourage physical activity	
% of children reaching WHO recommendations for physical activity*	HBSC
Policies on physical activity promotion for < 18 years*	Interview, WHO: factsheets on health-enhancing physical activity
National physical activity guidelines	Interview, WHO: factsheets on health-enhancing physical activity
Data on weight and height in children*	Expert, Information collected by DG SANTE in 2014 and 2015
National or subnational schemes promoting active travel to school	WHO: European database on nutrition, obesity and physical activity (NOPA), Expert, Some interviews
Area 7: Monitor and evaluate	
Participation in COSI?*	WHO/COSI
Routine representative monitoring of overweight and obesity (or weight and height) that includes the population < 18 years	Expert
Nationally representative diet and nutrition surveys (that include the population < 18 years)*	WHO: GNPR2 survey Expert APCO
National or regional food composition databases?*	WHO GNPR2 survey APCO
National physical activity monitoring and surveillance system (that includes the population < 18 years)	Expert WHO: factsheets on health-enhancing physical activity

[1] See 'Data sources used' for links to websites

* One of the 18 indicators that were identified by the European Commission and WHO Europe in 2015

** This question appeared to be very difficult to answer for interviewees, especially because we already asked whether management services existed. Therefore we did not include this indicator in the report.

ANNEX 3. OPERATIONAL OBJECTIVES AND SUGGESTED ACTIONS ACCORDING TO AREA FOR ACTION OF THE EU ACTION PLAN[33]

Area for action 1: Support a healthy start in life
Main priority: to ensure an effective approach at an early stage as possible.

Operational objectives

1. Increase the prevalence of children that are breastfed. The WHO Baby Friendly Hospital Initiative and the Innocenti Declaration can serve as inspiration.
   Suggested Actions:
   - Promote early childhood services and maternity care practices that empower new mothers to breastfeed.
   - Promote Breastfeeding through national health strategies.
   - Training of health care professionals to help raise awareness among parents of the importance of breastfeeding.
   - Monitoring of the implementation of the provisions of the WHO International Code of marketing of breast milk substitutes in Member States in line with Directive 2006/141.
2. Promote timely introduction of complementary foods.
   Suggested actions:
   - Development of guidelines for complementary feeding of infants, including timely introduction of complementary feeding.
   - Offer updated informational material on infant and young child nutrition (for example: vitamin D, Folic Acid (for pregnant women)).
   - Training of health care professionals, teachers and parents to foster healthy food taste development in children.
3. Encourage healthier food habits and physical activity in pregnant women, infants, toddlers and preschool children; include vulnerable groups and respect ethnic minority background.
   Suggested actions:
   - Increase awareness of the importance of maternal nutrition (e.g. folic acid for pregnant women), physical activity and healthy birth weight range. Increase awareness regarding the importance of obtaining and maintaining a healthy weight preconception.
   - Development of the gestational weight gain guidelines.
   - Provide clear messages on healthy diets, physical activity promotion and sedentary behaviour to families. Enhancement of parental skills by support for the implementation of recommendations (e.g. early childhood support, family midwives, kindergarten).
   - Organise cooking group activities especially for low income families.
   - Promote the consumption of fruit and vegetables as the basis for a healthy diet taking into account the price:
     - Especially fruit and vegetables as snack food alternatives
     - Reduce the number of servings of less healthy food options
   - Implementation of a pilot project on the promotion of healthy diets targeting pregnant and breastfeeding women. This project has further tested field work initiatives through various settings and channels, such as paediatric doctors, nurses, midwives, nutritionists, health oriented NGOs and national and regional health authorities, to deliver targeted education about nutrition, independently of the food industry, to both parents and children. (Commission)
   - Provide physical activity measures for pregnant women and young mothers including the promotion of physical activity for babies and infants by creating an environment which encourages pregnant women as well as children in early childhood to be physically active, e.g. local authorities and sport clubs can offer special play- and movement offers.

[33] As phrased in the EU Action Plan on Childhood Obesity 2014-2020

4. Further improve the effective response of the health care sector.
   Suggested actions:
   - Education of health care staff on issues related to childhood obesity.
   - Create a healthy environment in hospitals and primary health care facilities.
   - Development and updating of treatment programmes for prevention and therapy of overweight and obese children based on the inter-professional approach including paediatric doctors, public health service nurses, general practitioners, nutritionists, physical activity therapists and psychologists.

Area for action 2: Promote healthier environments, especially at schools and pre-schools

Main priority: to establish children's health as a priority at schools

Operational objectives

1. Provide the healthy option and increase daily consumption of fresh fruit and vegetables, healthy food and water intake in schools (with a targeted focus on schools in underprivileged districts). Focus should also be on making the school environment attractive to eat in.
   Suggested actions:
   - Develop a framework on preschool and school meals including the distribution of fruit and vegetables and drinking milk, e.g. via the existing EU School Fruit Scheme, EU School Milk Scheme and the proposal for a New School Scheme. The Joint Research Centre mapping of school meals in the Member States can be an inspiration (Member States / Commission).
   - Extension of the national implementation of the School Fruit Scheme, e.g.:
     - to more schools, or
     - to increase the number/amount of fruit & vegetables per child,
     - to increase the duration (length) of fruit and vegetable distribution in schools
     - Accompanying the School Fruit Scheme with education on healthy eating habits and combating food waste.
   - Promote the intake of tap water whilst reducing the intake of sweetened beverages, e.g. by installing water fountains and assessing daily water intake compared to a reference standard.
   - Implementation of pilot projects on the distribution of healthy foods including fruit and vegetables to vulnerable groups, including children, in the populations of EU NUTS2 regions in Romania, Bulgaria and Slovakia as well as in Poland and Hungary (Commission).
2. Improve the education on healthier food choices and physical activity at schools.
   Suggested actions:
   - Educate children about nutrition and healthy lifestyle (the whole food approach), including the importance of a sustainable diet, reducing food waste etc. This could be done by integrating the nutrition education aspects as part of the school curriculum (social sciences, health education, household etc.) both in primary and secondary school. This can be combined with practical cooking classes. It is important and necessary that teachers, catering staff, school managers and school health care providers cooperate to create a healthy school environment that promotes healthy eating and sufficient physical activity.
   - Awareness raising activities such as establishing school-based food gardens and/or food preparing kitchens.
   - Providing nutritional training to school kitchen staff in order to provide healthy food choices and on portion sizes, e.g. by a "driver's license" to prepare school food.

3. Develop and manage initiatives to care for overweight children and prevent them making the transition to obesity. This has to be linked with the clinical work. It is important that the health promoting work in schools not only focuses on overweight and that overweight children are not stigmatized. Promoting healthy eating and physical activity should be stimulated regardless of body size and appearance.
   Suggested actions:
   - Adopt and apply evidence-based guidelines on overweight and obesity screening and management for children, including their families.
   - Ensure adequate obesity treatment centres for children.
   - Ensure opportunistic screening and early intervention when visiting general practitioner, paediatric doctors, other health professionals or school health nurses.
4. Improve a physical activity friendly kindergarten and school environment.
   Suggested actions:
   - Encourage active commuting to and from school.
   - Provide infrastructures for active breaks according to students' age (e.g. playgrounds, schoolyards), so that physical activity promotion can become an integral part of the school day.
   - Integrate physical activities in the curriculum.
   - Use the interior equipment for kindergarten and schools to offer different possibilities to be active, e.g. open spaces for movement in and outside, so that physical activity becomes part of the structure and the routines of kindergarten and schools.

Area for action 3: Make the healthy option, the easier option
Main priority: to ensure a wide availability of healthy food choices to children

Operational objectives
1. Make the healthy choice the easy choice.
   Suggested actions:
   - Develop a voluntary sign posting scheme promoting the healthy options at preschools and schools (e.g. the Green Keyhole), including healthier food/drinks in vending machines in preschools and schools or restrictions on (certain foods and beverages sold in) vending machines. Such initiatives should be carried out in the legal framework designed by both Regulation (EC) No 1924/2006 on nutrition and health claims and Regulation (EU) No 1169/2011 on food information to consumers.
   - Provide quality standards (e.g. a products catalogue) for the foods included in school meals to be sold in preschool and school canteens. Meals and foods must comply with e.g.:
     - The national nutrient recommendations
     - Guidelines on portion sizes could be included in these quality standards
   - Free supply of fresh drinking water in schools through e.g. installation of water fountains.
2. Increase food reformulation actions in order to achieve the objectives in the EU Framework for National Initiatives on Selected Nutrients.
   Suggested actions:
   - Continue to encourage all food producers to enhance their reformulation actions in line with public health goals, recommendations and guidelines and especially those
     - Providing foods for school meals or being responsible for school meals
     - Providing foods and drinks in sports halls & venues & community activity/centres (Member States, Stakeholders (for implementation))

3. Promoting water intake.
   Suggested actions:
   - Promote free water in public areas like administrations, hospitals, schools (e.g. via installing water fountains).
4. Continue to address the issue of portion sizes.
   Suggested actions:
   - Continue to encourage food and drink producers to reduce portion sizes for pre-packed foods and beverages. Portion size guidelines could be provided.
   - Restaurants, caterers and all providers of meals eaten by children should improve menus, including portion sizes, provide nutritional information for parents and make healthy options the default choice whenever possible.
   - Encourage nutritional training for staff working in restaurants and cafes particularly in suitable portion sizes for children and avoiding less healthy food options recipes and servings. (Stakeholders).

Area for action 4: Restrict marketing and advertising to children
Main priority: to limit the exposure of children to advertisement of food/drinks high in fats, sugars and salt.

Operational objectives
1. Ensure that schools are free from marketing of less healthy food and drink options.
   Suggested actions:
   - Protect from marketing practices that promote these food and drinks at preschools and schools and other places for children, e.g. sport clubs/halls, recreation places in order to ensure that these facilities are protected environments and free from marketing.
   - Develop or improve schemes that limit marketing of energy-dense foods to children also beyond the school environment. This could be done via public private partnerships, e.g. including healthy vending fresh fruit, flavoured water & snacks that are not considered to less healthy food options. (Stakeholders)
2. Define nutrition criteria to use in a framework for marketing of foods to children.
   Suggested actions:
   - Building on existing schemes, develop appropriate nutrition criteria to use in marketing of foods to children. This could be implemented in collaboration with Stakeholders.
3. Set recommendations for marketing foods via TV, internet, sport events etc.
   Suggested actions:
   - Focus on children, especially under 12 years. This could be implemented in collaboration with Stakeholders (e.g. as part of the EU Pledge).
4. Encourage media service providers to set up stricter codes of conduct on audiovisual commercial communications to children regarding foods which are less healthy food options.
   Suggested actions:
   - Actions to strengthen implementation of Article 9.2 of the Directive on Audiovisual Media Services (Directive 2010/13/EU). (Commission / Member States)
   - Ensure effective enforcement of the codes of conduct on audiovisual commercial communications of less healthy food options to children. (Stakeholders)

Area for action 5: Inform and empower families
Main priority: to inform and educate parents with children on their daily food and health choices

Operational objectives

1. Educate and support families to make healthy changes to their diets and promote physical activity including related issues with specific focus on lower socio economic groups.
   Suggested actions:
   - Provide consumer advice, including recipes/cooking skills and information on portion sizes. In order to be inclusive, these classes should address cooking with affordable and yet nutritious ingredients. This could e.g. be done via smart phone apps or by other means for less well of families on healthier food choices and lifestyles: daily tips, menu of the day, computer apps, etc.
   - Offer cooking classes and provide advice on healthy and affordable foods, portion sizes and healthy cooking methods. It will be important to take into account that cooking practices differ across the EU depending on the different cultures.
   - Promote preconception planning for overweight and obese women prior to the conception of their child.
   - Support of families in order to integrate physical activity and healthy diet in everyday life. This action could be covered by a Joint Action work package.
   - Promote adequate sleep duration via information material.
   - Provide information about the importance of physical activity for healthy development, the negative consequences of a sedentary lifestyle/excessive media use and the importance of parental role modelling and social support for the development of an active lifestyle. Integrate new medias, e.g. smart phone to spread the information.
2. Promote the importance of spending time together either in a family or as friends.
   Suggested actions:
   - Promote eating together ("family meals")
   - Promote active weekends (e.g. joint outdoor activities)
   - Promote active travel for all the family
3. Make the healthy choice the easy choice for the families.
   Suggested actions:
   - Improve nutrition labelling through the implementation of EU Regulations and guidelines on labelling and on nutrition and health claims. Initiatives should be carried out in the legal framework designed by both Regulation (EC) No 1924/2006 on nutrition and health claims and Regulation (EU) No 1169/2011 on food information to consumers.
     - Educate consumers about these new labelling schemes
     - Recommendations on portion sizes
     - Develop a voluntary sign posting framework that is easy to understand for consumers and easy to use for stakeholders including supermarkets and restaurants (e.g. also including calorie information on menus).
   - Implement on a voluntary basis a clear signposting scheme for foods and meals that promotes healthier choice (e.g. the Green Keyhole) at
     - Supermarkets
     - Restaurants, including take away menus (e.g. also including calorie information on menus)
   - Encourage restaurants to offer all items on their menu as half portions for children
   - Encourage the development of award schemes for healthy food promotions and good practise examples in the community catering.
   - Prioritise disadvantaged communities when developing food-related support schemes (e.g. co-ops and food banks).

4. Increase the intake of healthy foods (especially fruits and vegetables, milk and water) in parents and children in local communities, with a special focus on disadvantaged regions and communities.
   Suggested actions:
   - Increase the intake of fruit and vegetables, within a variety of settings, e.g. encourage the establishment and use of direct–to consumer marketing outlets such as farmers' markets and community supported agricultural subscriptions.
   - Encourage home food production through the following schemes:
     - Rooftop/balcony gardens
     - School raised bed gardens
   - Planting fruit trees in parks, schools grounds, urban streetscapes and waste ground areas to encourage free picking & consumption of fresh fruit.
   - Establish health partnerships between local governments and supermarkets and retailers and other relevant stakeholders to promote the intake of fruits and vegetables and raise awareness (e.g. the on-going 6 a day or 5 a day campaigns).
5. Support disadvantaged communities, families, children and adolescents, by making the healthy choice more easily available, accessible and affordable. (Commission)
   Suggested actions:
   - Implementation of pilot projects on the promotion of healthy diets and distribution of fruit and vegetables targeting children, pregnant women and older people, with a special focus on EU regions, where the household income is very low (on-going till 2015).
6. Support disadvantaged communities to help reduce food poverty. (Commission)
   Suggested actions:
   - Implementation of pilot projects on the promotion of healthy diets targeting children, pregnant women and older people (2012-2015).
   - Provide nutrition guidelines for the health experts working on targeted food programmes for socially disadvantaged communities and disadvantaged children.
7. Encourage professional health bodies to develop guidelines to strengthen their nutrition and (daily) physical activity training.
   Suggested actions:
   - Work with health professionals to develop a module on nutrition and physical activity for inclusion in training and continuing education programmes on nutrition and physical activity and health promotion as part of the WHO Healthy hospital/health care centres initiative.
8. Encourage/support families, professionals and day-care centres to integrate physical activity in the children's daily routine.
   Suggested actions:
   - Provide recommendations and guidelines on physical activities for children, tailored to age groups e.g. by working together with sport clubs
   - Give best practices examples to integrate physical activity in the daily routine, especially for local authorities, e.g. holiday programs for disadvantage groups.

Area for action 6: Encourage physical activity
Main priority: to increase the regular participation of children in sports or other physical activity

Operational objectives

1. Strengthened promotion of physical activity policies. (Member States / Commission)
   Suggested actions:
   - Commitment to support Health-Enhancing Physical Activity through:
     - Further promotion of the EU Physical Activity Guidelines to raise awareness of and participation in adequate physical activity
     - Strengthened policy coordination and dialogue with Member States, in particular in the context of the implementation of the Council Recommendation on HEPA across sectors
     - Support for HEPA activities, networks and studies under the Sport Chapter of the new Erasmus+ programme (2014-2020)
   - Develop and implement national physical activity guidelines.
   - Increase/Ensure the quality of sequential, age and developmentally appropriate physical education for all preschool and school children, taught by certified physical activity teachers.
2. Supportive role of urban design and planning in order to reduce afterschool sedentary behaviour.
   Suggested actions:
   - Develop and implement a 'Health in all Policies' mechanism/framework for cross-sectoral work to promote physical activity by governments and key stakeholders to promote physical activity.
   - European Guidelines for improving Infrastructures for Leisure-Time Physical Activity being applied systematically to plan, build and manage infrastructures.
   - Facilitate urban environments and infrastructure to reduce sitting and increase opportunities to be active for all children and adults.
   - Extensive and well maintained walking and biking infrastructure so that children can either walk or bike to school and can also bike in their free time.
   - Ensure an adequate presence of free/low cost sports facilities within local and regional communities to facilitate sports activities during and after school.
   - Increase the number of safe and accessible parks and playgrounds, particularly in underserved and low income communities.
   - Give children the possibility to participate in school, city and neighbourhood planning in order to create spaces to move.
3. Increase the awareness of and participation in the European Week of Sport (EWoS, expected start: 2015).
   Suggested actions:
   - Promote actions in the context of this initiative specifically targeted towards children/schools. (Commission)
   - Develop and implement actions in the context of this initiative specifically targeted towards children/schools. (Member States)

Area for action 7: Monitor and evaluate
Main priority: Better monitoring and evaluation of children's nutritional status and behaviours

Operational objectives

1. Improve the reporting on the availability, nutritional status, food quality, food consumption habits, and levels of physical activity in different age and socioeconomic groups.
   Suggested actions:
   - Improve monitoring and reporting of initiatives.
   - Develop and/or improve national food composition databases, e.g. an observatory on the composition of the available foods.
   - Develop and/or improve national physical activities and sports databases.
   - Collecting data from the Member States on the monitored initiatives, e.g. via the WHO European Childhood obesity Surveillance Initiative (COSI), the WHO NOPA database and the WHO Health Behaviour among Schoolchildren and for Health-Promoting Schools (HBSC) surveys. (WHO)
     - Increase the number of Member States being part of the COSI project.
2. Sharing of good ideas and practices regarding the monitoring of policy initiatives
   Suggested actions:
   - Facilitate the sharing of good practices between Member States regarding national policies on diet and physical activity. This will include monitoring nutritional changes to food. This can e.g. be done via a Joint Action:
     - Implement indicators/tools to monitor the relevant policies
     - Review priority actions on an annual basis
3. Monitoring in order to strengthen obesity prevention.
   Suggested actions:
   - Increased childhood screening and surveillance, in particular by identifying overweight children and preventing them from making the transition to obesity, e.g. via WHO European Childhood Obesity Surveillance Initiative (COSI).
   - Paediatricians should be encouraged to routinely calculate children's BMI and measure fat fold and provide information to parents about how to help their children achieve a healthy weight and body composition.
4. Develop a database on childhood obesity.
   Suggested actions:
   - Establish a national data base, using the WHO Childhood Obesity Surveillance Initiative, national and local childhood nutrition surveys.
   - Develop a data base of good practice at local, national and European level using the WHO NOPA 'scoring' tool.
5. Establish harmonized monitoring of school nutrition in EU (in primary and secondary schools).
   Suggested actions:
   - Agreement on the EU sustainable and harmonized data source on school nutrition.
   - Identification of Eurydice as the possible monitoring tool.
   - Definition and implementation of the school nutrition indicators to the Eurydice.
6. Establish annual monitoring of the physical activity of the students as a part of regular sports curricula in primary and secondary schools.
   Suggested actions:
   - Agreement on the EU sustainable and harmonized data source on physical fitness of children.
   - Identification of Eurydice as the possible monitoring tool.
   - Definition and implementation of the physical activity indicators of the children to the Eurydice.

Area for action 8: Increase research
Main priority: Up-to-date and comparable information and data

Operational objective

1. Increase the financial support by national and EU research programmes.
   Suggested actions:
   - Promotion of existing financial support to programmes and further improve financing possibilities. (Commission)
   - Better promote the availability of existing programmes and further improve national financing possibilities.
2. Ensure quality and conformity of research projects to existing EU policy objectives and approaches. (Commission)
   Suggested actions:
   - Take account of the priorities of the EU Nutrition Strategy and Action Plan
   - Take account of gaps in policy formulation
   - Deliver clear added value and ensure coherence and synergy
   - Avoid duplication with research under other programmes and bodies
   - Take account of the importance of behavioural research
   - Take account of socioeconomic disparities and cultural background
   - Prioritise research to understand the health conditions associated with obesity

ANNEX 4. QUESTIONNAIRE ON STRENGTHS AND WEAKNESSES

Childhood Obesity Study
to support the mid-term evaluation of the Action Plan on Childhood Obesity 2014-2016

Questionnaire on strengths and weaknesses

A study by the EPHORT consortium, consisting of:
RIVM, National Institute for Public Health and the Environment, the Netherlands
NIVEL, Netherlands institute for health services research
EPHA, European Public Health Alliance

Service contract N° CHAFEA/2016/HEALTH/01 for the implementation of Framework contract N° EAHC/2013/Health/01 – lot 1 Health reports

National Institute for Public Health and the Environment
Ministry of Health, Welfare and Sport

nivel

epha
european public health alliance

Introduction

Last December or January you informed us about policies and activities that are in place to support the prevention of childhood obesity in your country. This was part of the Childhood Obesity Study, a study commissioned by the European Commission and conducted by the EPHORT consortium. It provides support to the European Commission for the mid-term evaluation of the EU Action Plan on Childhood Obesity, 2014-2016.

Besides providing an overview of the policies and activities in the eight areas of action of the EU action plan, one of the aims of the study is to identify strengths, weaknesses, opportunities and threats for the implementation of the action plan. This questionnaire aims to collect your input for this part of the project. First, a short summary of the interim results of the study is given, followed by an overview of the available policies and activities in your country. Then we kindly ask you to fill out 11 questions. This will take about 15 minutes. For each question you can indicate whether we have to report your response anonymously in the final report of the study or that we can mention your countries name.

If you have any questions you can contact:
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Summary of interim results in all countries

From interviews with the members of the High Level Group on Nutrition and Physical Activity[34] of the 28 EU Member States, plus Iceland, Norway, Switzerland, Montenegro and Serbia we learned that in areas 1 (support a healthy start in life), 2 (promote healthier environments, especially in schools and pre-schools) and 6 (encourage physical activity) the majority of countries have policies, strategies or actions for most indicators. The following three areas are relatively less developed, with a greater share of countries indicating that no action is initiated or supported at national level: areas 3 (make the healthy option the easier option), 4 (restrict marketing and advertising to children) and 5 (inform and empower families. Participation in COSI is the one indicator that has increased the most, since the year 2014, with 9 countries participating for the first time in the last 2015/2016 survey. Many countries reported that the EU Action Plan on Childhood Obesity 2014-2020 serves as a guidance document that provides directions and ideas for national policies. For countries that already had many policies, strategies or actions in the areas of action that are mentioned in the action plan, it also served as a justification or reference document for their national policies.

[34] or representatives they appointed

Situation in your country

Here a country specific summary is provided based on the descriptions in the country-level overviews (see Annex .5)

Overview according to the various areas of action mentioned in the EU action plan

yes, already before EU action plan* partially, for example in certain settings or certain regions*
yes, since EU action plan*
no, but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
in preparation or planned. Adoption may still be contingent on policy process
unknown

* Indicates that an action is (partially) undertaken, but does not contain an evaluation of effectiveness from our part.

Questionnaire

1. What are the two *most* successful policies or activities with respect to the prevention of childhood obesity in your country?

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

Policy/Activity 1:

Policy/Activity 2:

2. What has been achieved (or what they have contributed to) with these policies or activities?

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

Policy/Activity 1:

Policy/Activity 2:

3. Why are they the most successful policies or activities with respect to the prevention of childhood obesity in your country*? (Please mention all factors that make the policy or activity successful)*

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

Policy 1:

Policy 2:

4. What are the two *least* successful policies or activities with respect to the prevention of childhood obesity in your country?

- ❑ Please report anonymously
- ❑ The name of my country can be mentioned in the final report of the study

Policy 1:

Policy 2:

5. Why are they the least successful policies or activities with respect to the prevention of childhood obesity in your country*? (please mention all factors/challenges that keep the policy or activity from being successful)*

- ❑ Please report anonymously
- ❑ The name of my country can be mentioned in the final report of the study

Policy 1:

Policy 2:

6. Are there any policies or initiatives that you would like to develop (further) or tried to develop but without success? *(if yes, please describe all policies/activities)*

- ❑ Please report anonymously
- ❑ The name of my country can be mentioned in the final report of the study

- ❑ No
- ❑ Yes, *please describe all policies/activities*

7. What were the reasons for the development of these policies/activities not being successful? *(please describe separately for each policy/activity)*

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

8. What is needed to successfully develop these policies or activities?

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

9. There are eight areas of action in the EU Action Plan on Childhood Obesity 2014-2020. Are there, in your opinion, any areas of action lacking that could contribute to the prevention of childhood obesity*? (if yes, please describe areas not covered by the action plan)*

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

❑ No
❑ Yes

If yes, please describe any areas of action that are currently lacking in the EU Action Plan on Childhood Obesity 2014-2020

10. What were, in your opinion, the most useful actions of the European Commission with respect to the implementation of the EU Action Plan on Childhood Obesity?

❑ Please report anonymously
❑ The name of my country can be mentioned in the final report of the study

11. What kind of support would you like to see from the European Commission in order to improve the implementation of the EU Action Plan on Childhood Obesity in your country?

❑	Please report anonymously
❑	The name of my country can be mentioned in the final report of the study

Thank you very much for your time and efforts to provide this valuable information to us.

ANNEX 5. COUNTRY LEVEL OVERVIEWS ON THE IMPLEMENTATION OF THE EU ACTION PLAN

A5.1. Austria (AT)

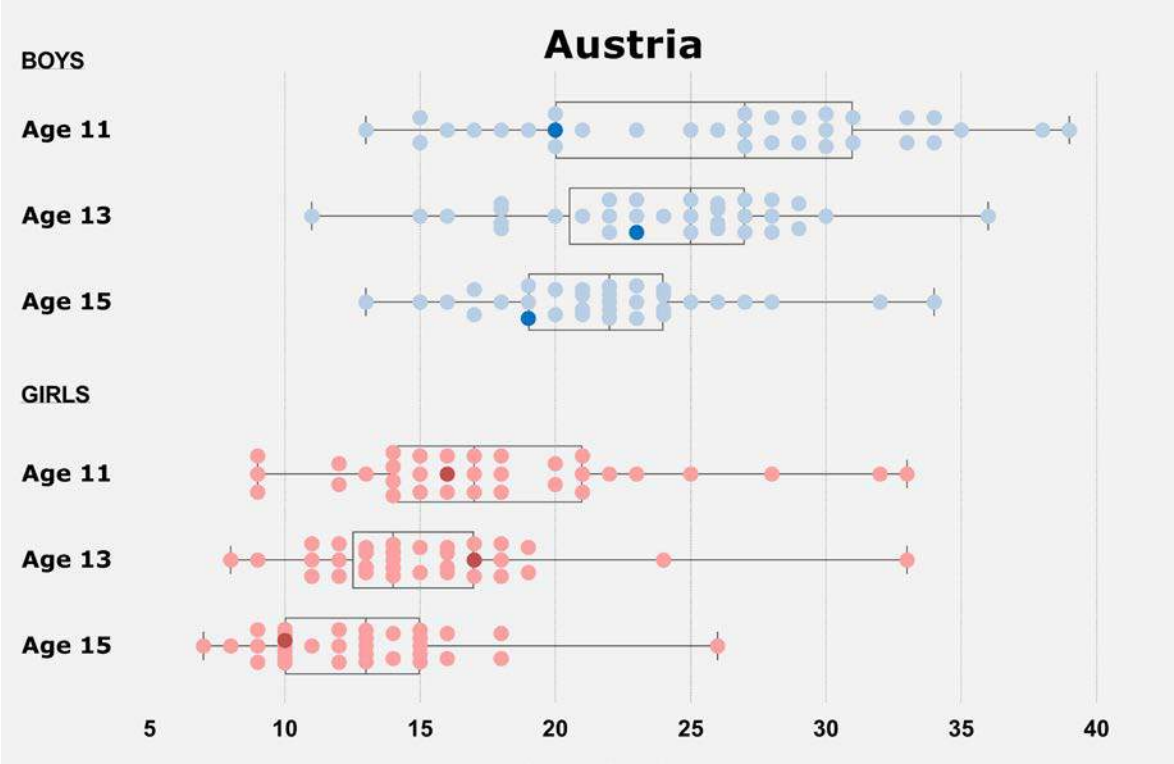
Based on the interview conducted with the Austrian Competent Authority we learned that Austria has no separate action plan for childhood obesity. Policies for (childhood) obesity prevention, as well as those for non-communicable diseases are covered by the National Action Plan Physical Activity, adopted in 2013 and the National Action Plan on Nutrition, adopted in 2010. The latter is updated every few years (i.e. 2013 and 2018).

The National Action Plan Physical Activity contains strategies on promotion of physical activity, sports and health for everyone. There are no specific actions for children below 18 years of age. The National Action Plan on Nutrition does include special initiatives for children <18 years. One is a health promotion program for pregnant and lactating woman and children until 3 years ('Healthy eating from the start', 2008- until now). The project 'Healthy eating from the start' had its first focus on pregnant and lactating women and young families with babies and toddlers. Austria has a recommendation for healthy kindergarten lunches since March 2017. In October 2018 food based dietary guidelines for children aged 4 to 10 years old will be published. Future work of the project will also address this age group. Another project called 'our school cafeteria' (2011- until now) is about providing healthy school snacks. It is going on in 4 regions and it probably will go on for years. Socioeconomic differences in (childhood) obesity and health are addressed by trying to reach all groups with the policies by behavioural measures and information. Information should be easily accessible (via ministries). Information materials are provided free of charge in different languages (e.g. English, Turkish, ex-Yugoslavian languages) and are written in easy to understand language.

For nutrition, there is the Austrian nutrition committee with different working groups. There is one on pregnant and lactating women, and small children. Experts are from different organizations like ministries, the Austrian Health and Nutrition Agency, health care professionals, consumer organisations, and interest groups. They develop guidelines and information materials (e.g. for hospitals on breastfeeding, baby food). They also developed the Pyramid for lactating women and guidelines for the breast milk bank in hospitals.

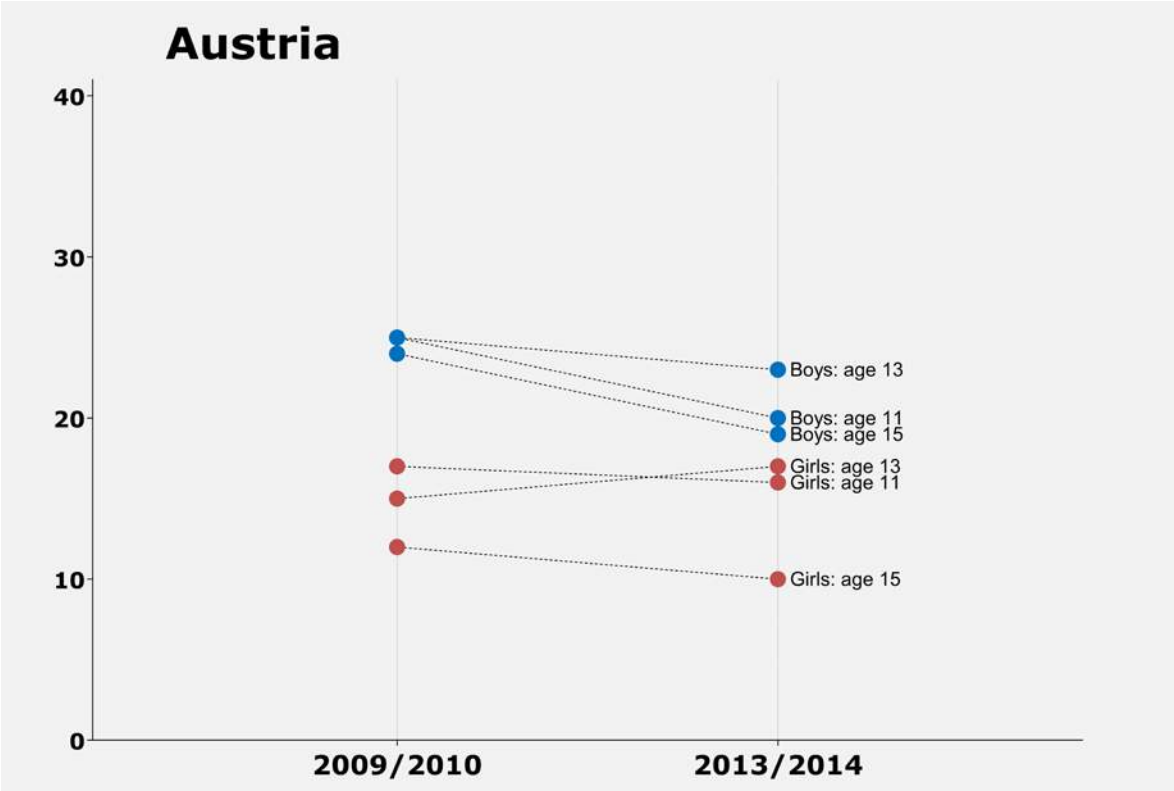
The EU Action Plan on Childhood Obesity 2014-2020 helps Austria with argumentation to get funding for projects from the regions (e.g. School cafeteria project which has no fixed budget). Furthermore it gives directions and ideas about actions that can be implemented and how.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Austria. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Austria

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
● no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
● in preparation or planned; adoption may still be contingent on policy process.

* indicates that an action is undertaken, but does not contain an evaluation of effectiveness from our part.

A5.2. Belgium (BE)

Based on the interview conducted with the Belgian Competent Authority we learned that Belgium has no separate action plan for childhood obesity. At the federal level, Belgium has a "Federal nutrition and health plan" (2006- no end date). This plan aims to reduce the prevalence of overweight, obesity and the prevalence of non-communicable diseases. General recommendations on actions for children or age groups are included in the plan, but there are no specific recommended actions on childhood obesity. Since 2014, actions of the Federal Nutrition and Health plan that focus on the promotion of healthy food and the primary prevention of non-communicable diseases were transferred to Communities and Regions (Flemish, French, German communities/regions and Brussels (with two different governments)). The Federal plan focuses on federal competencies, such as the quality of health care, food norms, food labelling, food reformulation, and food surveys. The "Federal Nutrition and Health Plan" includes several domains, for example:

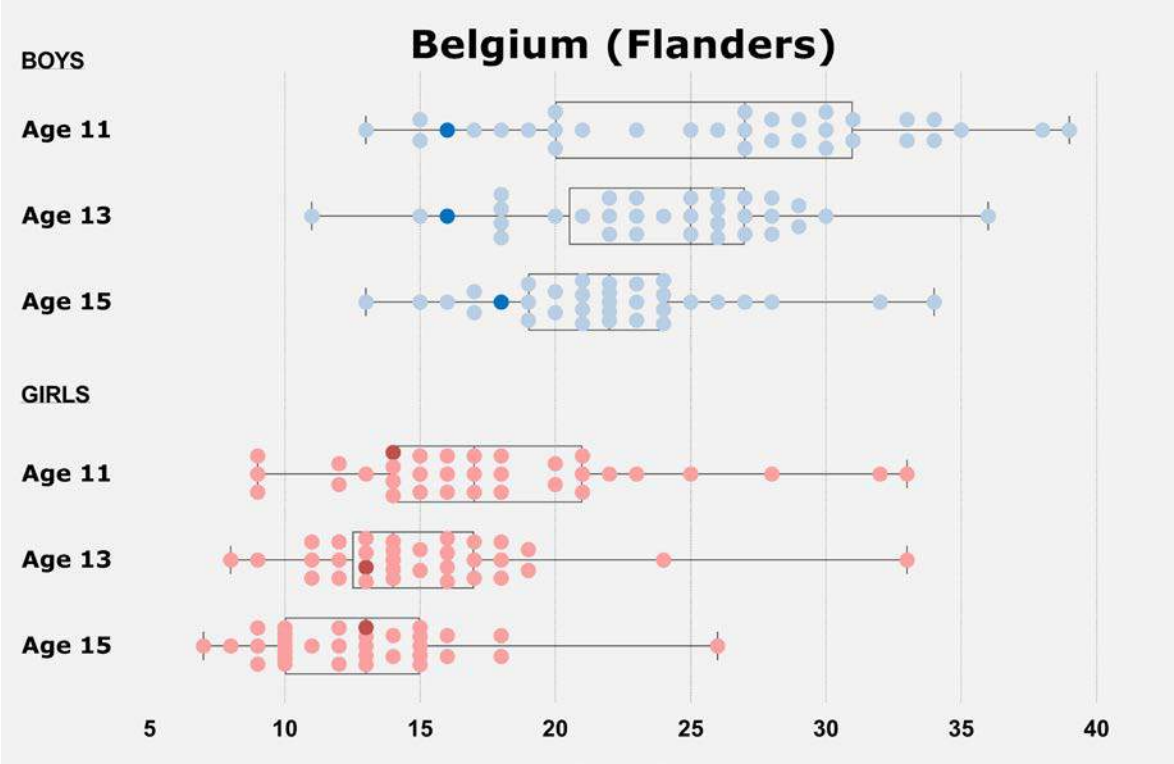
- Engagement of the private sector (e.g. improve the quality of food, food labelling and marketing of food products)
- Breastfeeding and nutrition of young infants
- Scientific research on nutrition and food surveys

At the federal level, Belgium's priority topics include 1) improving the nutritional value of the food supply, 2) improving health status by a better quality of care, including breastfeeding promotion, 3) maintaining the food consumption survey to gather information on behaviour, body mass index and food patterns of the Belgian population, including children (3-17 years), and 4) development of nutrition research (performed by universities and research centres). At the federal level, Belgium wants to improve the food supply for persons in need, i.e. the "food bank"/food aid for deprived persons. Therefore, food procurement procedures will be improved. Furthermore, by food reformulation, all people including those with a lower socio-economic status will benefit from product improvement. There is a task force at federal level on food reformulation, nutrition and the food survey.

The other levels of government manage other topics. The Flemish government has recently launched a new programme on health prevention, which includes a specific objective concerning better food habits, physical activity, schools and food at work. The French region and Brussels are currently preparing an action plan on (healthy) nutrition. At the community or regional level, health inequalities are addressed in projects and programmes. There are regional bodies which are in charge of the health of babies and children in the French part (National Office for Birth and Childhood: Office national de la naissance et de la petite enfance), in the Flemish part (Child and Family: Kind en Gezin) and in the German part (Child and Family: Kind und gezin). They are responsible for the pre- and post-natal care of the mothers and babies and for the health surveillance of the children. This includes promotion of a healthy diet for mother and child during pregnancy, and after birth and following the prevalence of overweight and obesity at regional level.

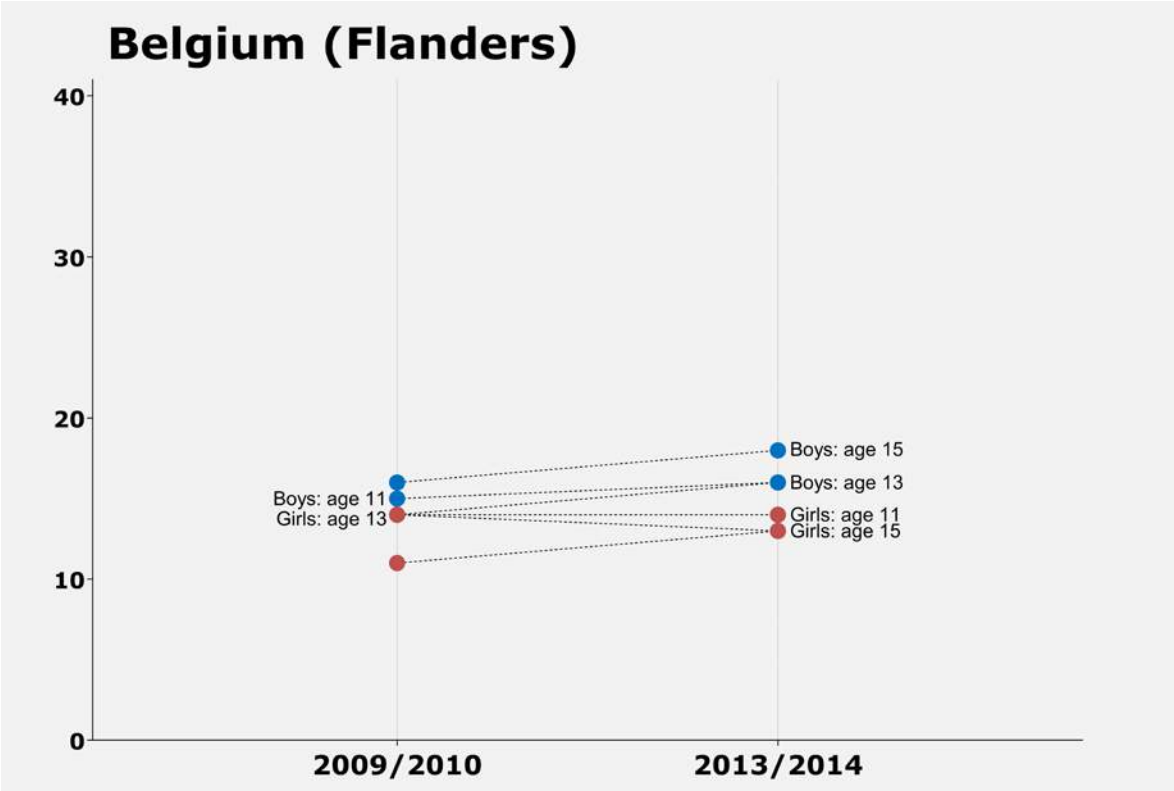
The EU Action Plan on Childhood Obesity 2014-2020 consolidates and justifies the Belgian policies. The actions defined in the Action Plan are for the great majority included at federal or regional level since the publication of the "Federal Health and Nutrition Plan" in 2006.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)

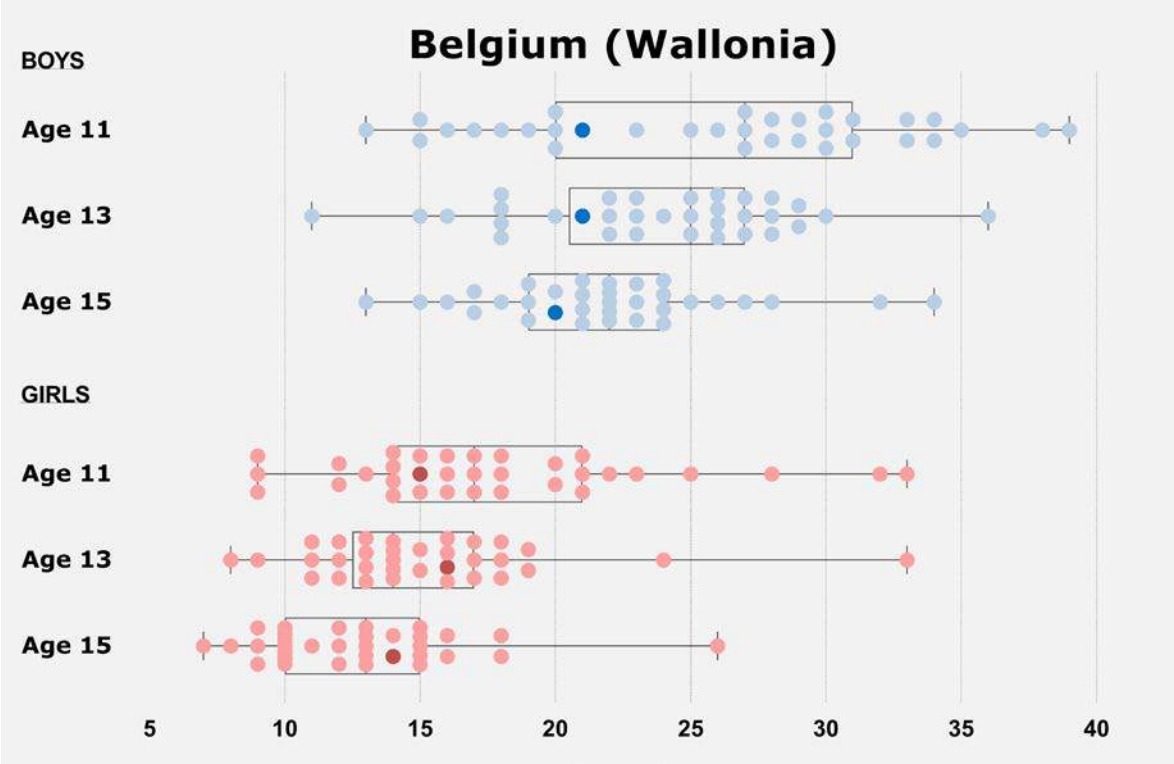


The dark dots represent the prevalence in Flanders (BE). The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014

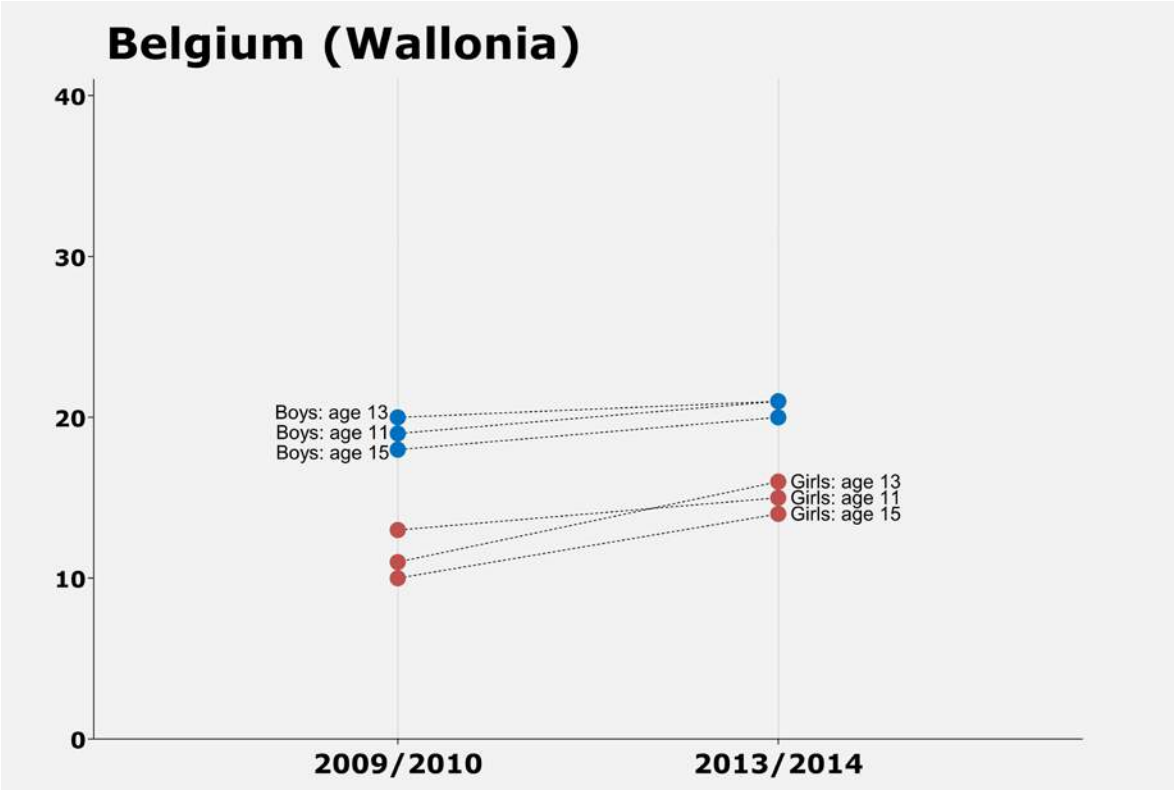


Prevalence of overweight including obesity (%) (HBSC)



The dark dots represent the prevalence in Wallonia (BE). The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Belgium

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
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A5.3. Bulgaria (BG)

Based on the interview conducted with the Bulgarian Competent Authority we learned that Bulgaria has no separate action plan for childhood obesity, but a "National programme for prevention of non-communicable diseases (2014-2020)". It includes the areas of nutrition, physical activity, tobacco and alcohol and non-communicable diseases. Prevention of childhood obesity is part of it. This programme includes several strategies:

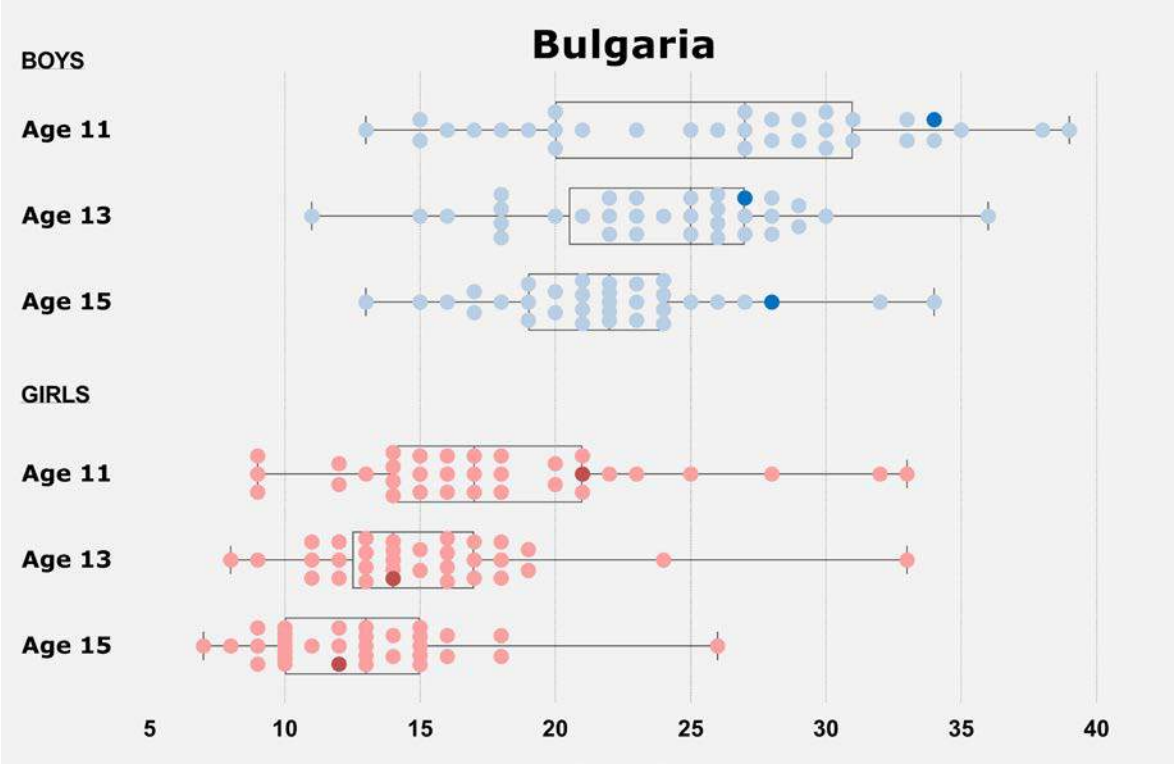
- Increasing awareness and education on nutrition, with the aim to develop healthy nutrition.
- Capacity building of medical professionals, such as medical doctors and dieticians. This includes providing training courses to professionals so they can provide appropriate nutrition information and education in kindergarten and schools.
- Collaboration with relevant stakeholders, such as schools, food industry and communities.
- Inclusion of social structures in different activities.
- Implementation and supplementation of regulations and compliance with regulations.
- Monitoring in the nutritional area (dietary intake and overweight).

The policies that are relevant to childhood obesity do not really address health inequalities, but there are actions targeting the Roma population, which will include the topic of nutrition in the future. In Bulgaria, the prevalence of childhood obesity is high and the priority is to apply national regulations and to adjust them to European regulations. For example, a document on food procurement for healthy nutrition at school has been prepared under the Maltese EU presidency. If this document includes other guidelines than the current Bulgarian regulations, the Bulgarian regulations will be revised. Further plans are to develop nutrition profiles and food standards and to issue a new guideline on infant nutrition for health care providers who give advice on breastfeeding.

The 'National programme council', including representatives from involved Ministries (e.g. the Ministry of Health, Ministry of Education, Ministry of Economy, Ministry of Food and Agriculture) decides on the implementation of the National programme, evaluation of results, structure of the programme, etc. All activities in the nutrition area and activities under the national programme are developed in the National Centre of Public Health and Analyses, approved by the Ministry of Health, and then implemented in the field. In addition, in each region, there are regional programme councils, that represent people from local governmental bodies, regional inspectorates, district hospitals, regional health insurance funds etc. They choose regional coordinators for different risk-factors. The government works close together with the regional coordinators about the policies and plans.

The EU Action Plan on Childhood Obesity 2014-2020 is a guidance document for Bulgarian work and plans for the future.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Bulgaria. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014

No HBSC data for 2009/2010 are available in Bulgaria.

Overview of policies / activities according to the various areas of action of the EU Action Plan in Bulgaria

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.4. Croatia (HR)

Based on the interview conducted with the Croatian Competent Authority we learned that the Ministry of Health (Ministry of Health and Social Care at that time) issued a "National Action Plan for Overweight Prevention and Treatment" in 2010. The Action Plan aimed to encourage the extension and intensity of the activities related to health promotion and prevention of chronic diseases, and the complexity of the causes and consequences of excess body weight in the period 2010-2012. In 2012 the National Strategy for the development of Health 2012-2020 was published. This strategy included nutrition and physical activity. July 2015 Programme "Healthy Living" was adopted as national health promotion programme by the Government and nine responsible ministries. This programme lays out actions for the whole population, from infants to elderly. This programme includes several topics, relevant for the prevention of childhood obesity:

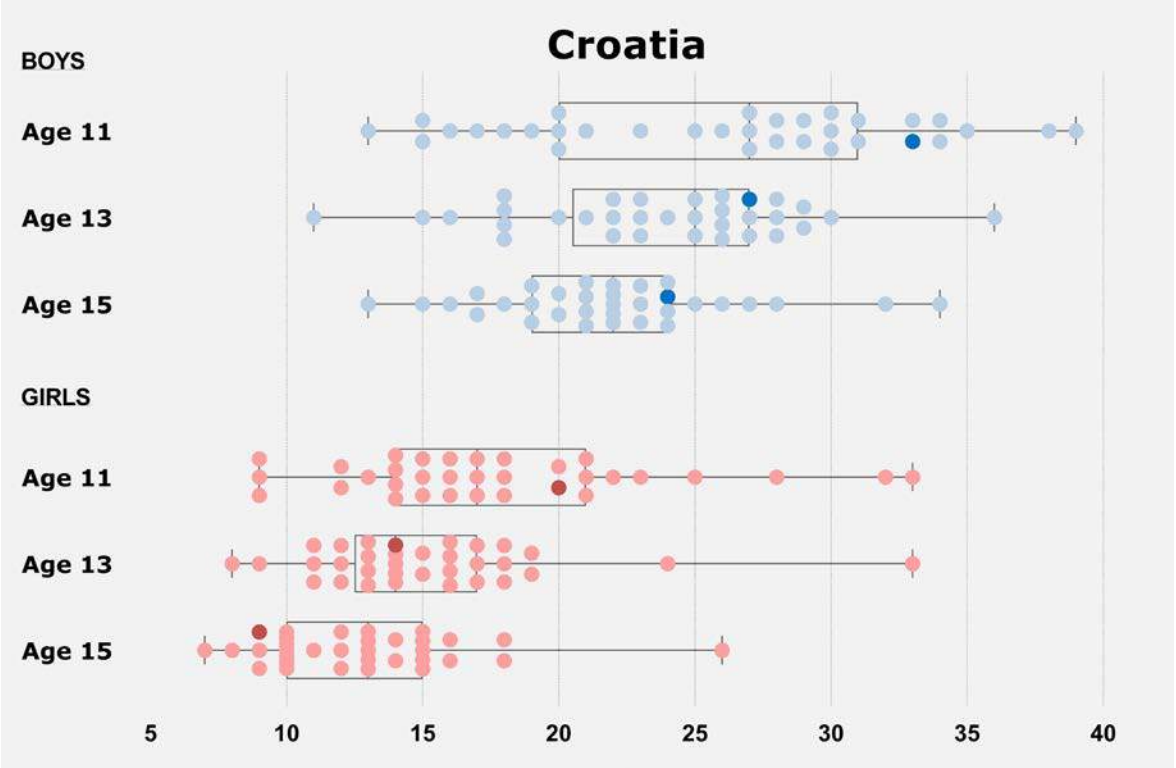
- "Health Education" includes education on physical activity, nutrition, mental and sexual health, mainly directed at children. It also includes provision of "Polygons" and school menus. "Polygons" provide equipment to schools that have no gym or sports hall, so children can be active in the hall or classroom. School menus, developed in line with the "National Nutritional Guidelines for Elementary School Children" are delivered to all national schools as an extra support in preparing school meals.
- "Health and physical activity" is directed to the whole population, including children. Activities are meant to be implemented locally, but across all counties of the nation. This topic includes the activity "Walking towards health" that introduces walking as a cheap way to be physically active.
- "Health and nutrition" Introduces easy to understand labelling to enable consumers to make healthier choices.
- "Health and environment" includes the activity "Volunteers in parks" in order to try to mould how families spent their leisure time, raising awareness about healthy nutrition and increasing physical activity through organization of health-oriented free-time activities in parks in all counties.

Activities in the National Programme are adapted to all socioeconomic groups. They should not infer any additional costs. This enables Croatians with lower socioeconomic status to participate. For all areas of the National Programme, multisectorial working groups exist. No formal coordination mechanism exists for childhood obesity.

In 2013, the Ministry of Agriculture issued the "National Strategy for the Implementation of the School Fruit and Vegetable Scheme". The strategy aims to permanently increase the share of fruit and vegetables in the nutrition of school children in order to prevent early-onset obesity and other diseases caused by inadequate nutrition. In 2015 the Croatian Ministry of Health developed the "Action Plan for Prevention of NCD 2017-2025" and adopted a strategy on the reduction of salt. Plans for the reduction of trans fats and sugar are in preparation, but not yet adopted. Furthermore, in 2016 a new working group on good marketing practices was installed in the Ministry of Health. Intention of this working group is to have a policy document on marketing within the coming years.

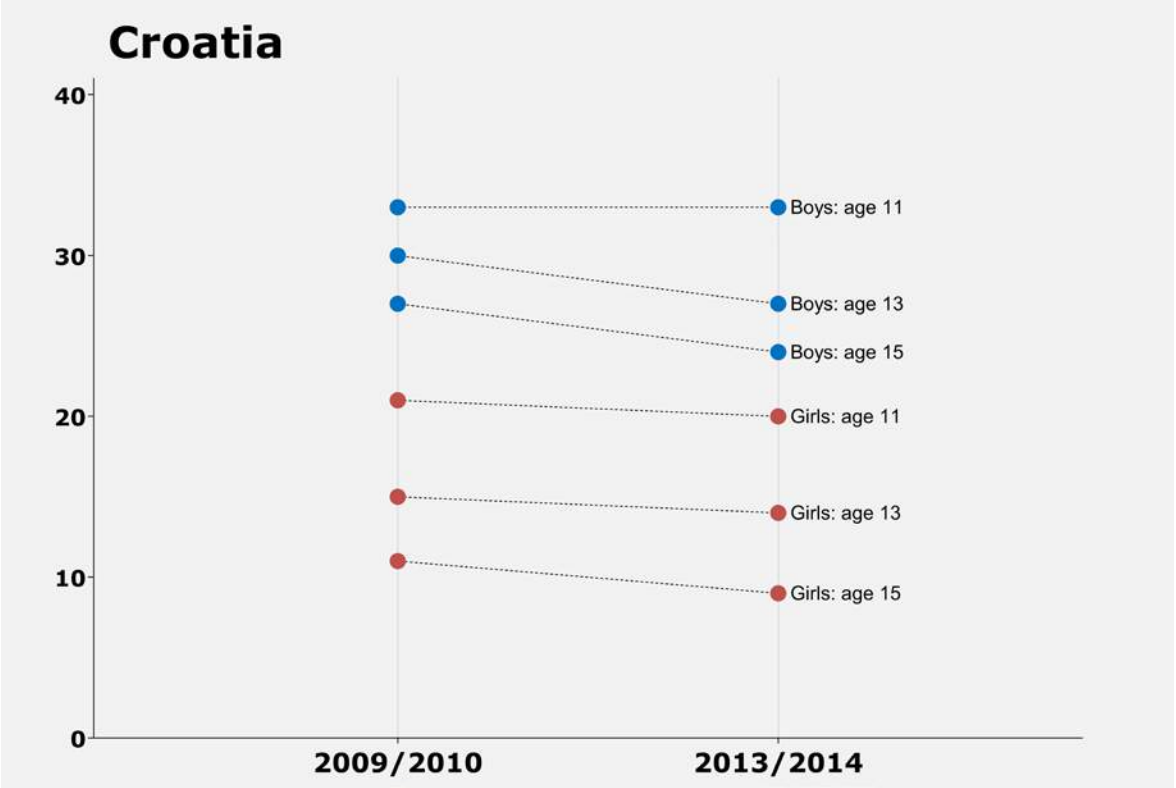
The EU Action Plan on childhood Obesity 2014-2020 is considered to be an important document for Croatia. Since the publication, the Ministry of Health has shown increased awareness. Croatian government sees childhood obesity as an issue, but it is not very high on the agenda yet. The EU Action Plan facilitated participation in the Childhood Obesity Surveillance Initiative (COSI) since 2015 and adoption of the national programme "Healthy Living". Depending on the results of COSI it is expected that a document on childhood obesity will be developed, putting all relevant activities under one umbrella.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Croatia. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Croatia

1 Voluntary agreement with or from industry

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
● no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
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A5.5. Cyprus (CY)

Based on the interview conducted with the Cypriote Competent Authority we learned that around 2011, Cyprus in collaboration with stakeholders made a draft (summary of an) action plan on nutrition, targeting the whole population. This draft nutrition plan included the prevention of non-communicable diseases. However Cyprus does not have a nutrition department or any specific national coordinating mechanisms in the area of childhood obesity, nutrition or physical activity promotion. Therefore the area of the prevention of childhood obesity is underdeveloped. The Ministry of Health is working on the following topics:

- School canteens and school environment
- Diabetes, which is related to childhood obesity
- Monitoring and surveillance by participation in the most recent round of the Childhood Obesity Surveillance Initiative (COSI). The results from COSI might be used for implementation of further actions.

In 1985, the Cyprus Sports Organisation adopted a Sports for All policy. This specifically addresses Sports for All promotion. The programme involves more than 300 sports centres. It is intended to encourage people to become more involved in sports, to promote health “for joy, sensibility, recreation, fitness and health purposes”. Much of the work of the programme is carried out in preschools to encourage fitness from an early age. There is also provision for preschool education, adults, older adults and individuals with special needs.

The EU Action Plan on Childhood Obesity 2014-2020 was used for a draft summary on childhood obesity. It provided a very important basis for it. However, at the moment, few policies are implemented.

For Cyprus, no data on the prevalence of overweight including obesity is available from HBSC.

Overview of policies / activities according to the various areas of action of the EU Action Plan in Cyprus

yes, already before EU Action plan*
partially, for example in certain settings or certain regions*
yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
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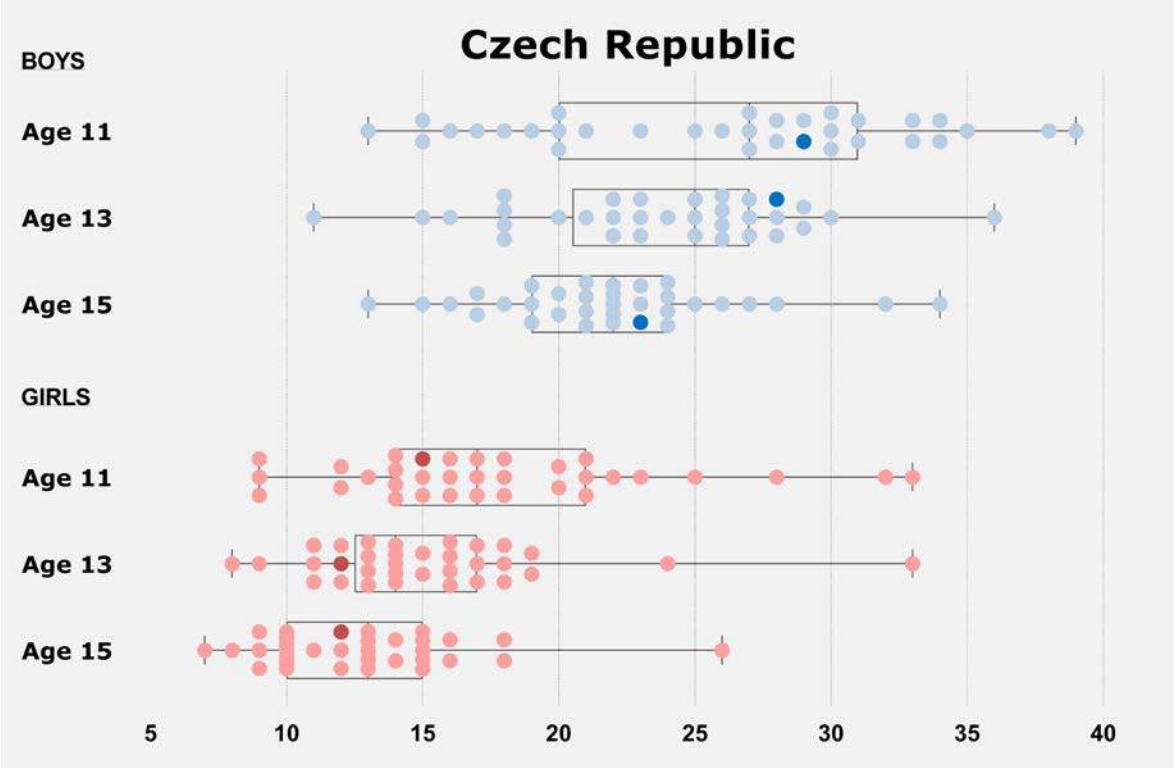
A5.6. Czech Republic (CZ)

Based on the interview conducted with the Czech Competent Authority we learned that the Czech Republic has a long term strategy on public health and health promotion. This framework has been amended and approved in 2014 by the government. Several action plans fall under this strategy entitled “Health 2020: National Strategy for Health Protection and Promotion and Disease Prevention” They are approved in 2015. One of them focusses on physical activity, another on nutrition and healthy diet. The latter action plan is subdivided in two sub-plans; one on obesity prevention and one on healthy diet. The plans do include specific actions for children below 18 years of age. Traditionally, school meals and the school environment are Czech Republic’s priority topics. Every child at school can get a cooked school meal at lunch, which is the main meal of the day in the Czech Republic. By decree there are standards for these meals since the early 1990’s. For several years now, there is public discussion in the media about the quality of the school meal and the school meal system. The National Institute of Public Health provide support to school canteens to fulfil the criteria and has performed a survey on the school meals. Topics included not only the nutritional content of the meals, but also for example expectations of parents and children about school meals. Currently, there are activities from the National Institute of Public Health to improve the school meals by (educational) programmes and by publishing recipes on the website. NGOs, supported by the Ministry of Education, are involved in subsidy programs for school lunches for parents who have difficulty to pay the school lunch. Although the Czech Republic does not have an official framework or strategy on diminishing health inequalities, they consider it important to include all children from all social subgroups.

The main body responsible for health promotion and provision of scientific background in the Czech Republic is the National Institute of Public Health. Furthermore, there are teaching hospitals and medical societies for research and developing guidelines.

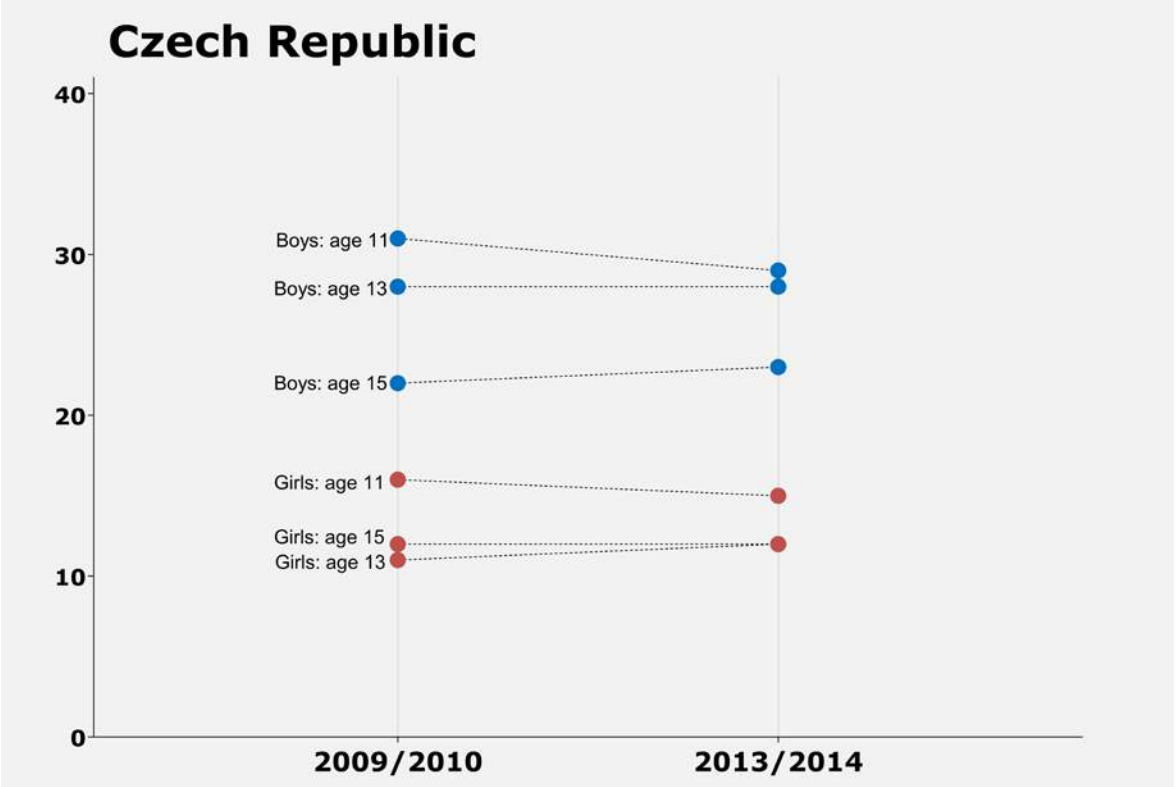
The EU Action Plan on Childhood Obesity 2014-2020 was used as a source of inspiration for national activities in the Czech Republic. It has no direct influence on the implementation of policies.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in the Czech Republic. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in the Czech Republic

1 Voluntary agreement with or from industry

- yes, already before EU Action plan*
- partially, for example in certain settings or certain regions*
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A5.7. Denmark (DK)

Based on the interview conducted with the Danish Competent Authority we learned that Denmark adopted a national action plan on obesity in 2003 (no end date). This action plan provides recommendations for the prevention and treatment of overweight and obesity. It presents practical perspectives on what can be done in relation to various target groups on respectively the private level, municipality level (i.e. schools and workplaces) and in the public sector. It includes all age groups and is not only aimed at obesity but also on overweight. There are specific actions for children and adults. Many recommendations in the plan have been followed, but Denmark does not evaluate progress and initiatives up against each of the 66 recommendations in the plan. Since 2013 Denmark also has a health promotion package on overweight. This does not focus on obesity. This package gives recommendations for municipalities to support and qualify their work in the field of overweight prevention. The package addresses all age groups, and therefore also includes recommendations for actions targeted to children, i.e. recommendations for the school environment. Because of the size of the problem of obesity, the severe consequences for individuals and society, and because obesity is not covered well in the Health promotion Package on overweight, the Danish Health Authority decided in 2014 to further focus on obesity. Also for e.g. physical activity, food and meals, mental health, alcohol and tobacco health promotion packages exists (since 2012). The implementation of all 11 packages in municipalities is monitored every second year and all packages are updated and new versions published in 2018.

An action plan on nutrition was adopted in 2016. It includes specific actions for children under the age of 18 years, next to actions for adults and elderly. It contains guidelines for the work of the Danish Veterinary and Food Administration, and comprises a lot of activities with respect to nutrition, such as salt reduction, dietary recommendations and recommendations for food in school canteens. It takes a multi stakeholder approach for all activities, in which civil society, government institutions, NGO's and the private sector work together. The Danish Ministry of Health/Danish Health Authority have the following priority topics with respect to obesity:

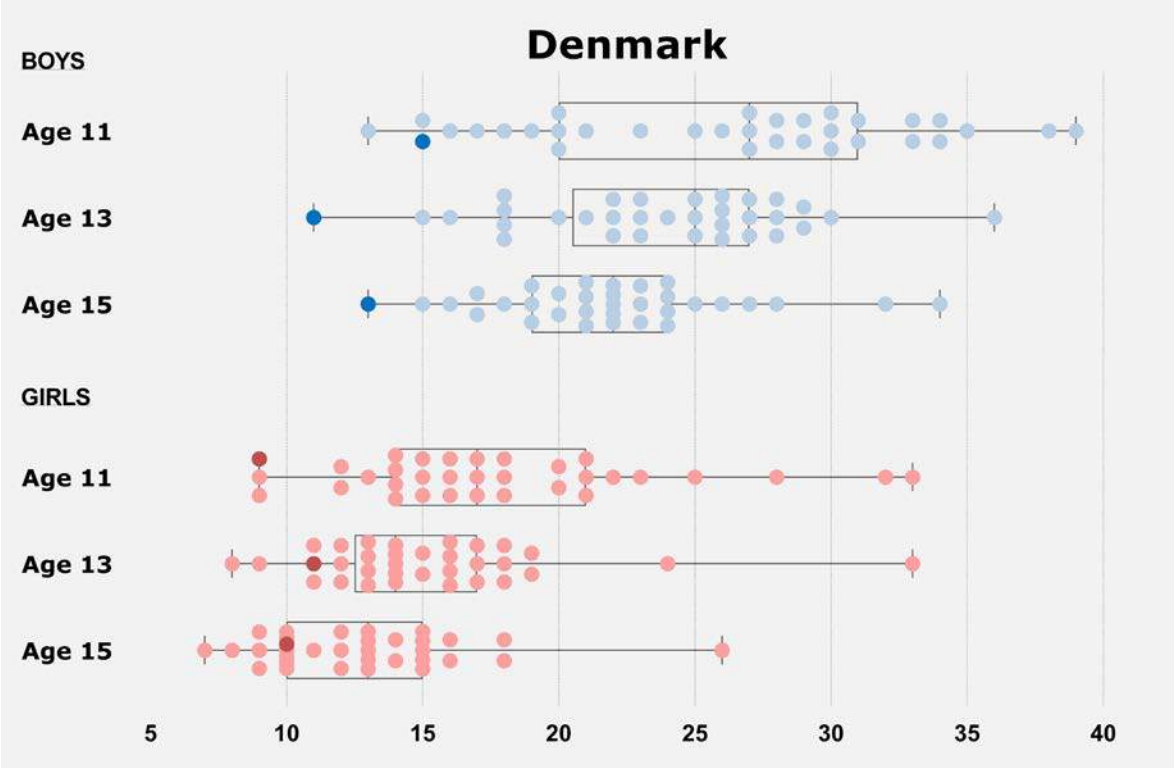
- Monitoring the level of prevalence of overweight and obesity to get insight into the problem at the national level and to compare it with other countries.
- Identification and early intervention.

With respect to nutrition, priority topics focus on two groups. These are children and vulnerable groups. For children, nutrition education is considered to be important as well as the availability of healthy foods. The focus on vulnerable groups is meant to address health inequalities.

In 2016, interventions in municipalities and regions (hospital setting and GPs) on tackling obesity in children and adults were mapped. In 2017 a literature review was produced to get insight into effective interventions. Subsequently, recommendations for municipalities will be developed that describe important elements of interventions that they can implement (planned in 2018). Furthermore, new guidelines for school canteens have been developed. They are voluntary and there will be a labelling system for schools that follow the recommendations. New mandatory recommendations on nutrition will be issued for day care in 2018.

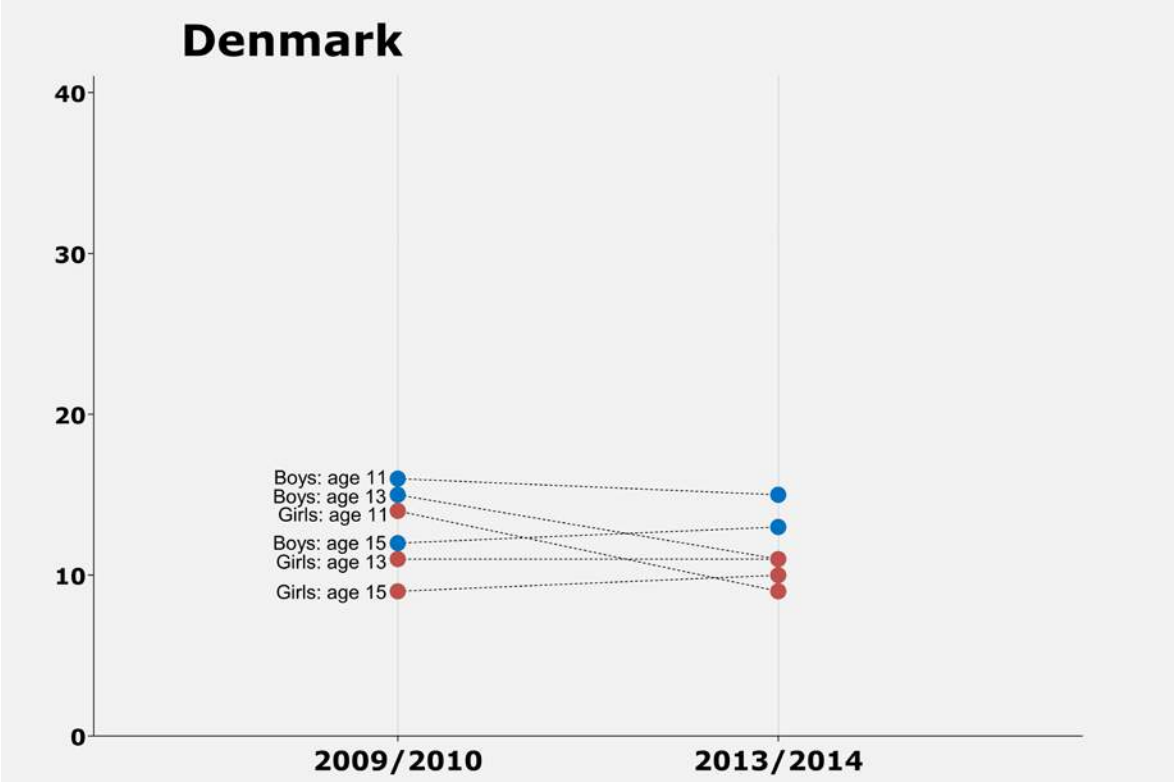
Denmark stands behind the EU Action Plan on Childhood Obesity 2104-2020. Danish' actions and policies are and were already in line with the action plan goals. The action plan did not have direct influence on Danish policy making, but indirectly it provides more focus and awareness on the topic of childhood obesity when you have an international or European focus on a national problem. It is supportive and it creates discussion.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Denmark. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Denmark

- **AREA 1: Support a healthy start in life**
  - Guidance before and during pregnancy
  - Promote and protect breastfeeding
  - Guidance on complementary feeding
- **AREA 2: Promote healthier environments**
  - Improving the school environment
  - Policies on vending machines[1]
  - Policies on energy drinks[1]
  - Mandatory nutrition education
  - Mandatory physical activity education
- **AREA 3: Healthy option the easy option**
  - Food reformulation: salt
  - Food reformulation: saturated fat
  - Food reformulation: sugar
  - Food reformulation: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food reformulation
  - Easy to understand labelling
  - Taxation
  - Subsidies
- **AREA 4: Restrict marketing & advertising**
  - Marketing of (HFSS) foods to children
  - Nutrient criteria to reduce marketing
- **AREA 5: Inform & empower families**
  - Campaigns on diet & physical activity
  - Support community-based interventions
  - Screening programmes childhood obesity
  - Management services for obese children
- **AREA 6: Encourage physical activity**
  - Physical activity promotion for children
  - National physical activity guidelines
  - Data on weight and height in children
- **AREA 7: Monitoring & surveillance**
  - Diet and nutrition surveys
  - Monitoring of physical activity
  - Participation in COSI

1 No need as it is culturally determined that the few vending machines there are do not contain unhealthy products and energy drinks are not sold to children

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◒ partially, for example in certain settings or certain regions*
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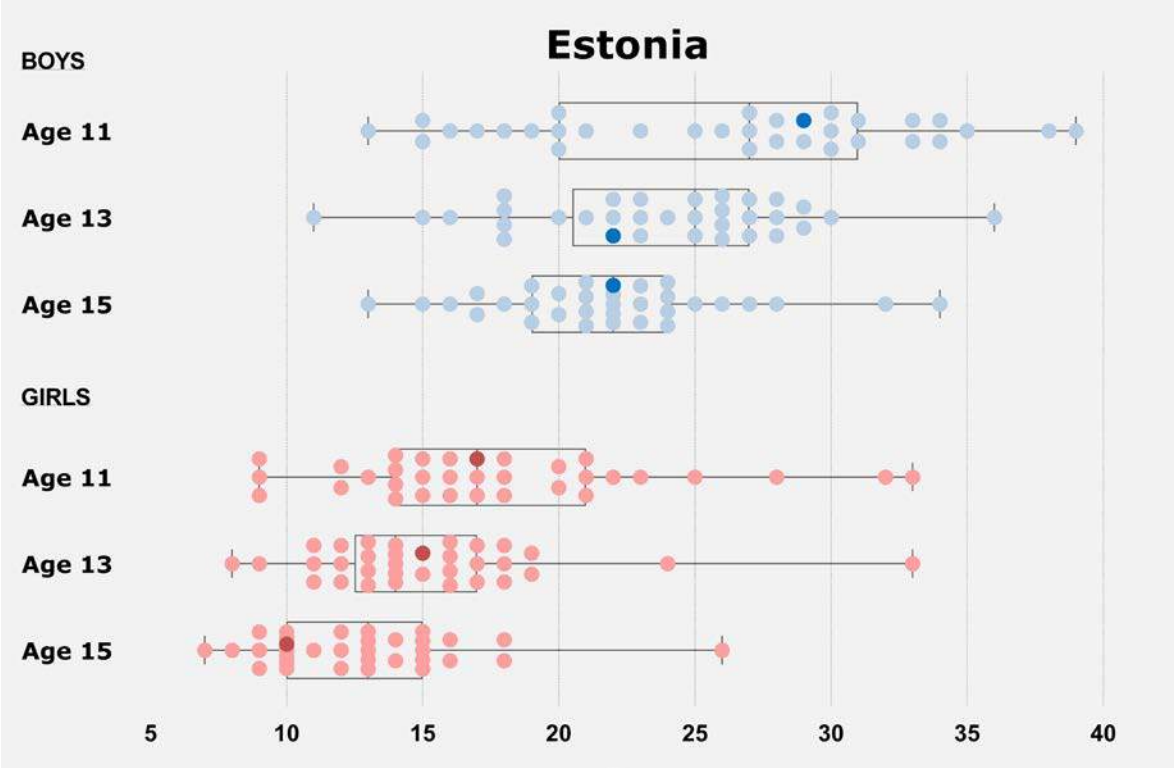
A5.8. Estonia (EE)

Based on the interview conducted with the Estonian Competent Authority we learned that Estonia is working on a Green paper on nutrition and physical activity that will be completed in the spring of 2017. It includes specific chapters about children, called 'promotion of balanced nutrition and physical activity among infants and toddlers', and 'promotion of balanced nutrition and physical in kindergartens and schools'. February 2015, Estonian Parliament has passed a policy entitled "The general principles of Estonian sports policy until 2030", which broadly outlines Estonian sports policy over the next 15 years. This policy was devised through extensive consultation with the sports community and focuses specifically on ensuring that the majority, if not all, of the population are regularly and safely exercising, with the aspiration to ensure at least two thirds of the population are regularly engaged in sports activities. Emphasis is placed on physical activity throughout the life-course, from physical education in preschools through to physical activity later in life, supported by a strengthened sports infrastructure. With respect to the prevention of non-communicable diseases, Estonia has a "National Health Development Plan". Examples in this plan of actions targeting children are renewing the school curriculum on physical and nutrition education, and renewing legislation of food services in schools, but also other children's institutions, like camps. Estonia is planning to restrict snacks that have low nutritional value and are high in salt, sugar and fat in school cafeterias, buffets and vending machines. With respect to physical activity, Estonia piloted in 2016 the project 'School inviting to move' in 10 schools. The project aims to reduce sitting time of children in the school, and to create an environment for children and student to be more physical active. Estonia is planning to include more schools in 2018. In general, Estonia tries to reach all children and all social groups with their policies and actions. For example, there are environmental measures on physical activities which are free and accessible for all children.

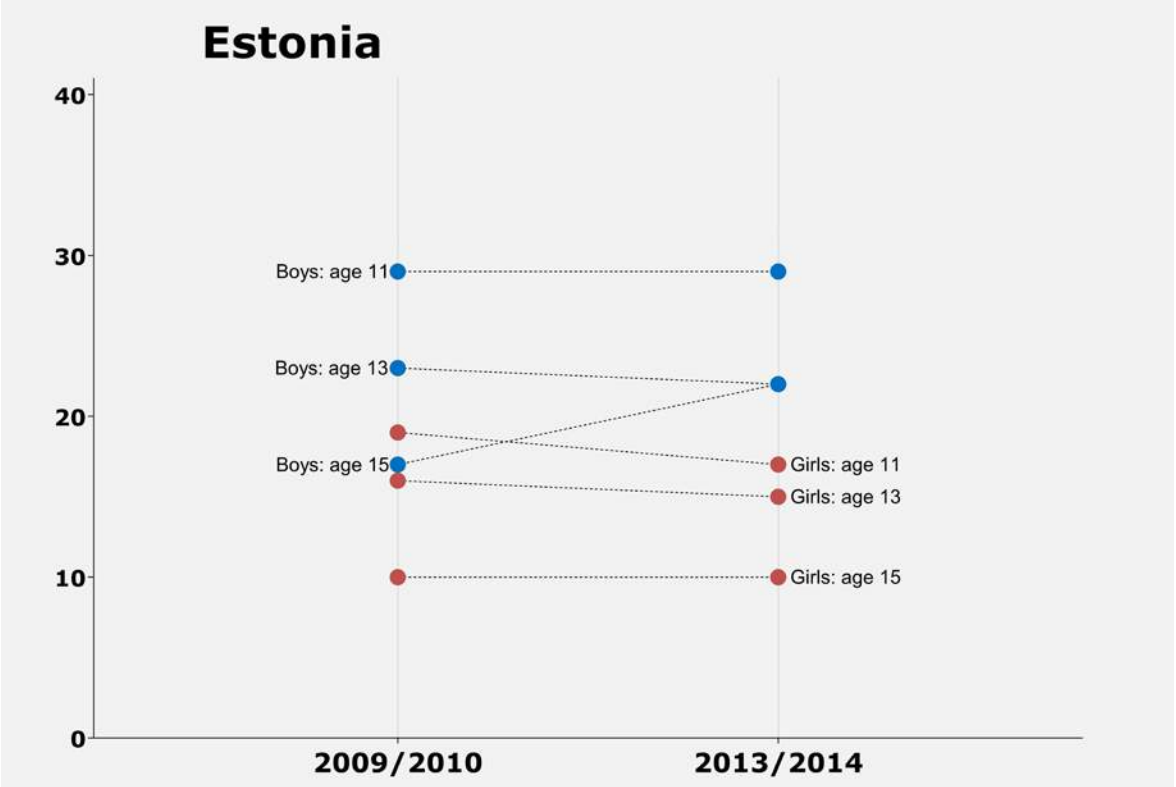
The EU Action Plan on Childhood Obesity 2014-2020 at the beginning helped the development of the Green paper on nutrition and physical activity. A lot of actions addressing childhood obesity in this document are inspired by the EU Action Plan.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Estonia. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Estonia

1 Voluntary agreement with or from industry

2 New guidelines planned

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.9. Finland (FI)

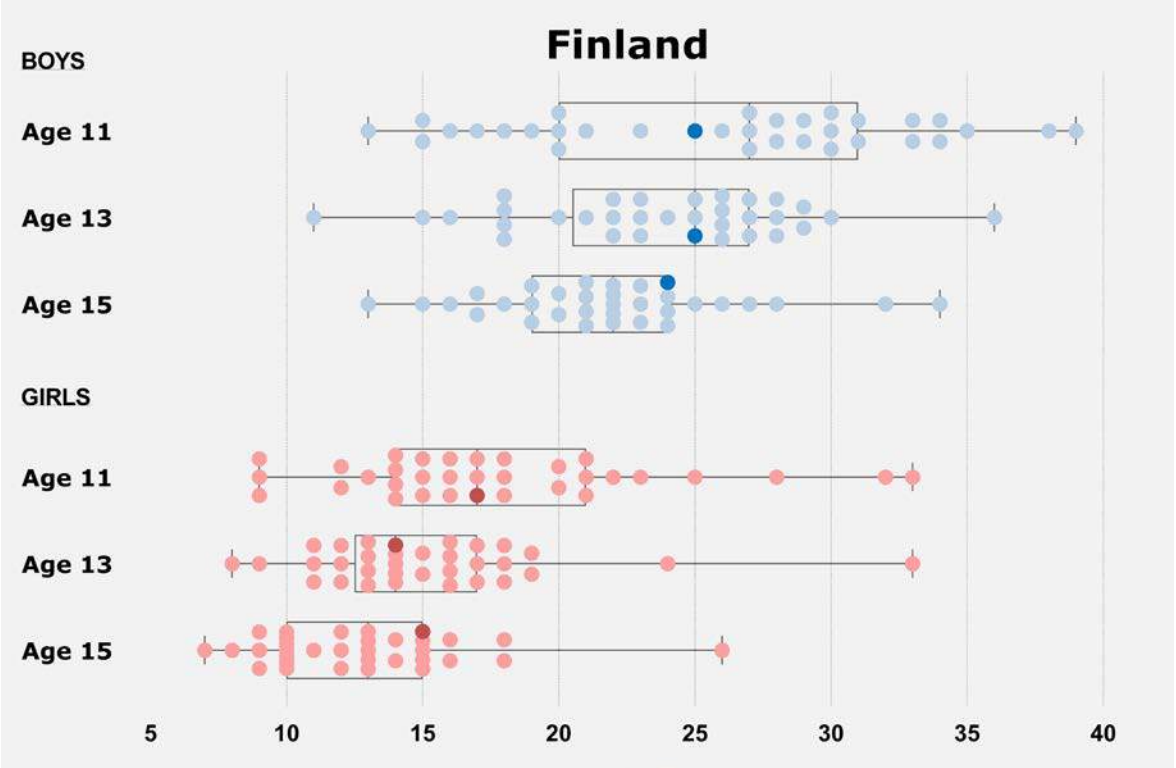
Based on the interview conducted with the Finnish Competent Authority we learned that the National Institute for Health and Social Welfare launched “The National Obesity Programme 2012–2018” in 2012. This is a collaboration network challenging and bringing together different actors and stakeholders. The programme covers an action plan on the prevention of overweight in children and programmes on physical activity promotion. It aims to achieve a downward trend in overweight and obesity in order to improve health and welfare and to maintain the population’s functional and work ability. Among the main programme targets are: 1) reduce the number of children and young people who grow up as obese adults and 2) reduce the differences in obesity prevalence among population groups. There are nutrition recommendations for all age groups in Finland, for example “Eating together- food recommendations for families with children”. “Eating together” addresses the whole lifespan, from pre-pregnancy to the age of 16-18 and thus include guidelines for pregnant and lactating women, infants, small children and school children. The National Institute for Health and Welfare is the coordinating centre for the “National Obesity Programme”. Advisory groups and groups of stakeholders have regular meetings. The National Nutrition Council coordinates the implementation for dietary recommendations and collects data on the implementation of guidelines in public catering (like schools).

Because the first 1000 days and early childhood are considered to be important for the development of obesity, Finland focusses on early prevention. Therefore, the major topic is lifestyle counselling in families with children, including among others counselling on nutrition, physical activity, and sleep. Many other topics are, however, also important, such as catering and free of charge meals in schools and day care, reformulation and restricting marketing of unhealthy foods at children and adolescents. In the Finnish health policies one of the main goals is to decrease inequalities in non-communicable diseases and related risk factors. Especially at the community and city level, quite many actions address specific target groups.

The Ministry of Social Affairs and Health is working on a government resolution “Towards Health and Welfare with Cooperation” that encompasses the implementation of the nutrition and physical activity recommendations and measures. It also includes reformulation issues, and other topics such as mental health and alcohol consumption. This programme is expected to be launched in 2018. Furthermore the Ministry is funding governmental key projects on health promotion for 2 years (2017-2018). One of these is “Smart Family”, a practice-based method for counselling families with children on the topic of nutrition and physical activity. The program is part of a wider national health promotion programme ”One Life” run together by the Finnish Diabetes Association and the Finnish Brain Association. Another important governmental project is the Finnish Schools on the Move, a national action programme aiming to establish a physically active culture in Finnish comprehensive schools. The Finnish Heart Association runs the programme to implement the nutrition recommendations in child health care and school health care.

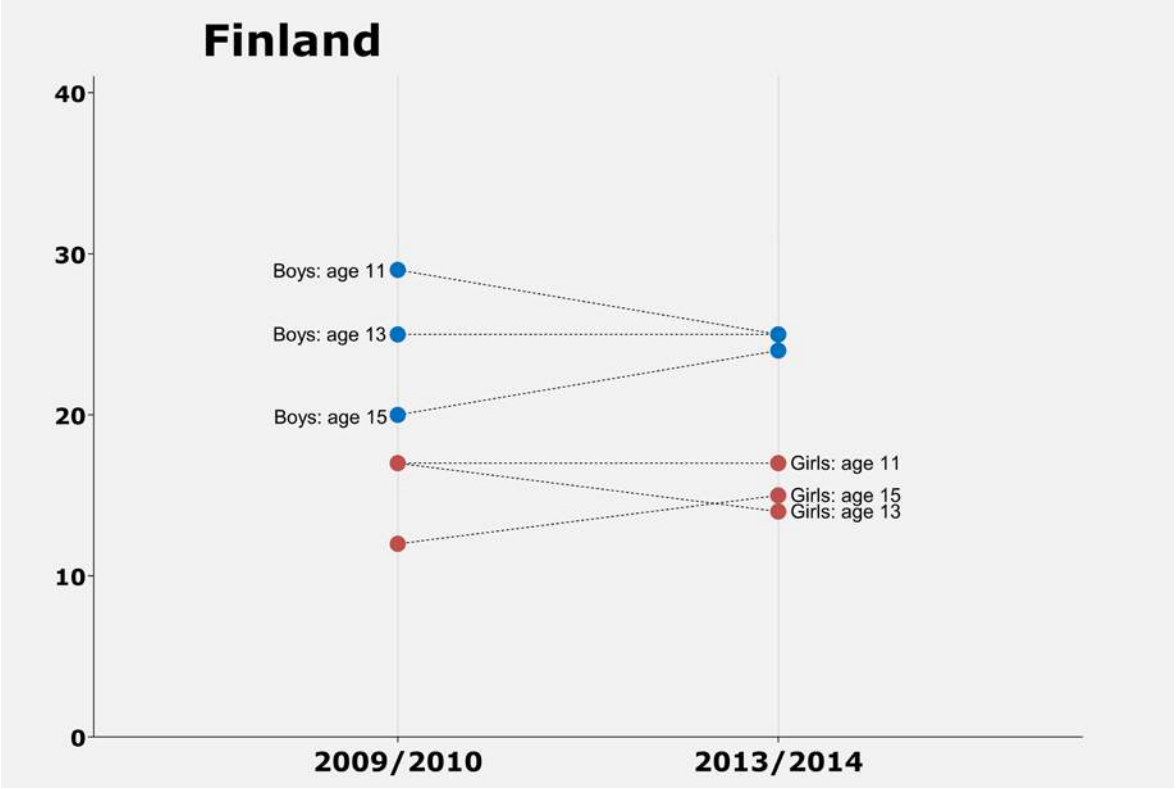
The topic of prevention of childhood obesity has been already on the Finnish agenda for 10-15 years. Nevertheless, the EU Action Plan on Childhood Obesity 2014-2020 stimulates policy makers to go further with their actions on the prevention of childhood obesity. It serves as an important background document to negotiate within the Ministry and stakeholders. Besides this, it provides a net for benchmarking, and good examples from other countries and facilitates development of policies, monitoring and evaluation together with other countries. This is very important for some areas, such as reformulation. Finland has also good and effective practices in prevention of childhood obesity that serve as good examples for others.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Finland. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Finland

[1] Children are not included
[2] Data from Finnish primary health care visits

yes, already before EU Action plan*
partially, for example in certain settings or certain regions*
yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
in preparation or planned; adoption may still be contingent on policy process.

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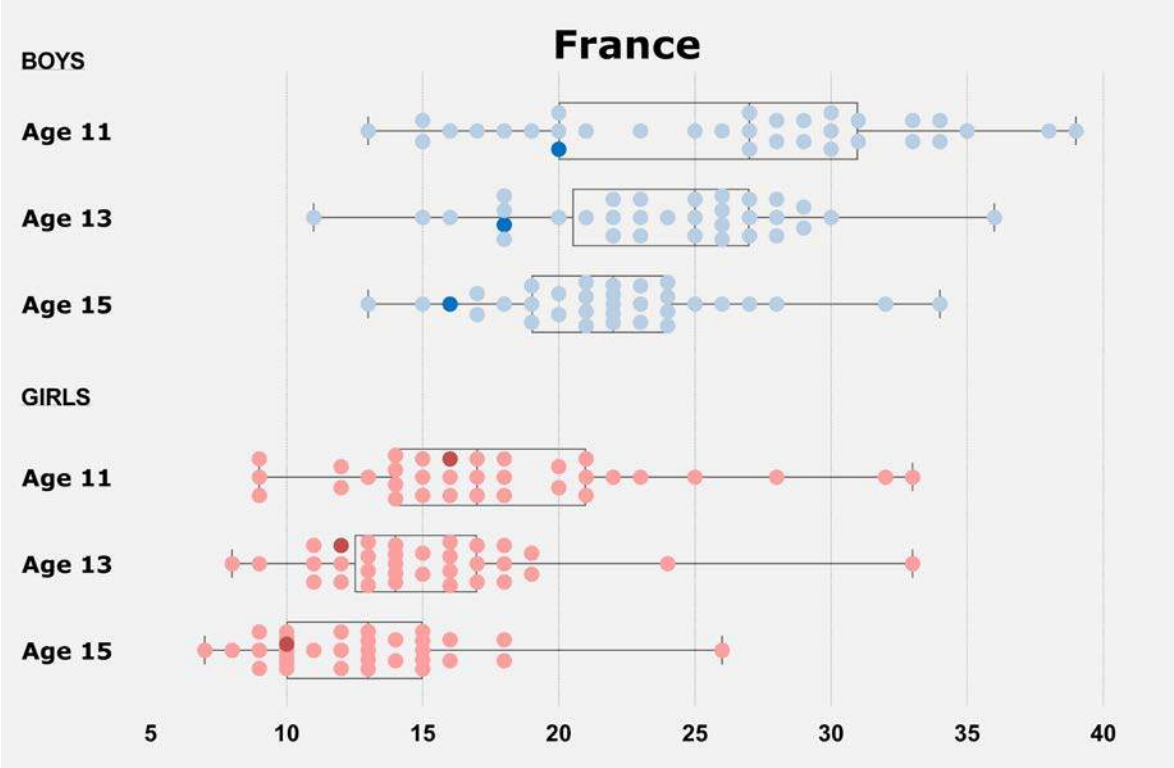
A5.10. France (FR)

Based on the interview conducted with the French Competent Authorities we learned that there is no separate action plan on childhood obesity in France. Since 2001 France has a "National Nutrition and Health Programme" (PNNS). In December 2012, the Ministry of Health published the 2011-2015 Programme. Policies on childhood obesity are covered by the PNNS and include strategies for nutrition and physical activity. Prevention of non-communicable diseases is covered by this and other programmes. Among the objectives of the PNNS is to decrease by 15% the prevalence of overweight and obesity in children and adolescents 3 to 17 years old, also in those from underprivileged families. For the prevention of childhood obesity a diversity of synergic and complementary strategies is needed (health in all policies approach). Each one is important but cannot achieve the results without the other. Some need legislation, other education and communication by public agencies, other some voluntary actions by NGO's or the private sector within the frame given by the PNNS. The PNNS involves the ministries in charge of health, national education, sports, consumer affairs, social cohesion, and higher education and research to promote healthy eating as part of nutritional prevention. The PNNS has a steering-commission that is formed by representatives of all relevant ministries, and public health agencies (for food security, health monitoring, and health promotion). Within a "follow up committee" involving also local authorities, economic actors, NGO's, the sports sector the strategies and actions are discussed regularly (around 4 times a year). Development and implementation of specific actions lies within health agencies, such as the National Institute for Prevention and Health Education. Everyone can develop and implement intervention programmes. However, if you want to have national impact you can go through a system of validation from national authorities. In January 2016, a health law was adopted in France. This law is now being implemented and prevention of obesity is an important focus.

France is now rethinking new objectives for the PNNS, based on - among others –data of a national survey in 2015. These new objectives have been defined in 2017. Additionally, in 2017 Nutri-Score was introduced as a means of front of pack labelling. Also new national food based dietary guidelines will be issued. These will apply to the general population. Also specific guidelines for children are expected. At the national level there is no specific action to diminish the gradient of socio-economic differences in health. It is expected that all policies adopted or to be adopted altogether have some response to the issue of socioeconomic differences. For example, taxing sugar-sweetened beverages is intended to have some effect, because they are consumed more by lower socioeconomic groups and because at the same time education is done on the health impact of overconsumption of sugars. Regulation of marketing unhealthy foods to children may also help, as children with lower socioeconomic status are known to watch more television. Generally speaking there is much more focus on health inequalities at the local level. For the group of deprived families France is working on improving the quality of the foods provided in the National food aid programmes.

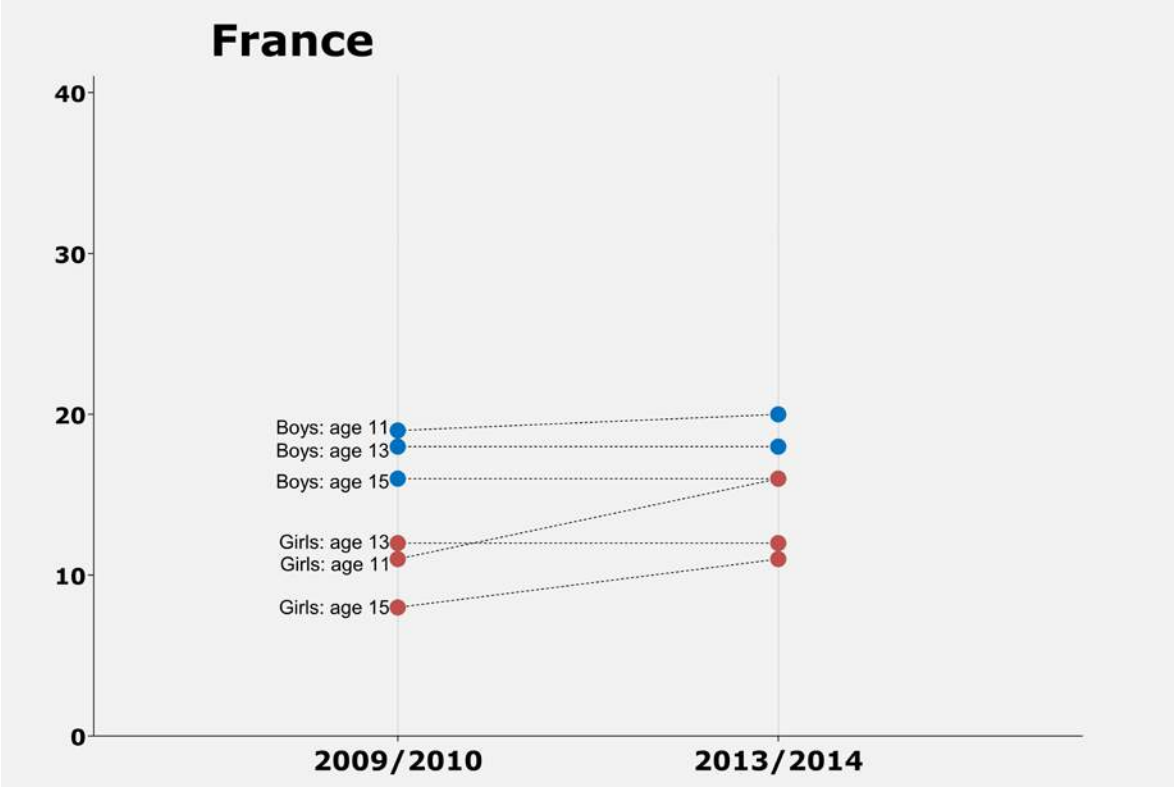
In France, the EU Action plan on Childhood Obesity 2014-2020 serves as useful guideline with proposals for action. Depending on the situation, Parliament or the Ministry will decide to do more than suggested in one area or less in another. Furthermore, the Action Plan serves as general endorsement of the importance of tackling childhood obesity that can be used in negotiations at the national and regional level, but also in discussions with other international organisations like WHO.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in France. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in France

1 Voluntary agreement with or from industry

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.11. Germany (DE)

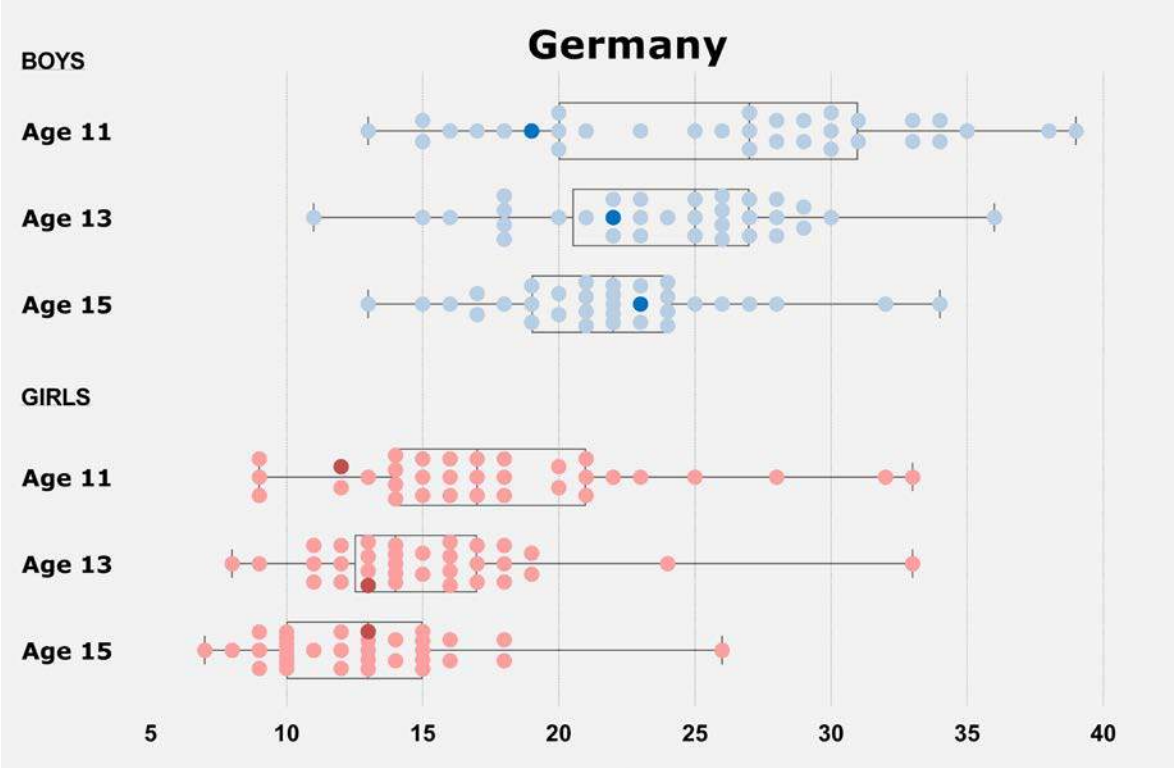
Based on the information provided by the German Competent Authorities we learned that Germany adopted The National Action Plan "IN FORM – German national initiative to promote healthy diets and physical activity" in 2008. “IN FORM” is about promoting a healthy lifestyle. It aims to bring lasting improvements in dietary and exercise habits in Germany by 2020 for the whole population. Children and adolescents are an important target group and health promotion and prevention of childhood obesity are integral parts of “IN FORM”. Prevention of non-communicable diseases is also covered. With “IN FORM”, in particular, children and adolescents in facilities of daily life - kindergartens and schools – are addressed. It contains a host of activities that address young families, children and adolescents with adapted target-group oriented communication. To date more than 200 projects have been supported by the Federal Ministry of Food and Agriculture (BMEL) and the Federal Ministry of Health (BMG) under the “IN FORM” initiative. These two ministries are the lead ministries of this national action plan. Other Federal and Länder ministries and various partners from civil society participate in “IN FORM”. There are many stakeholders such as the IN FORM Secretariat, the IN FORM work groups (with a focus on different topics) and task force (with all relevant stakeholders of the civil society), the national departments and the task force consisting of the national departments and the Länder (Bund-Länder-Gruppe).

The priority topics are healthy upbringing (the first 1000 days) and a healthy diet and dietary education in childcare facilities and schools, because they seem to represent key aspects according to the current state of scientific knowledge in the field of childhood obesity. Activities focus on health promotion and prevention, the creation of healthy environments and settings (particularly focusing on the family, day-care centre, school, and community), setting-based prevention, promotion of research, as well as the dissemination of evidence-based knowledge about these topics. Next to this, activities will also concentrate on establishing and stabilising measures and projects supported under the “IN FORM” initiative in the longer term, disseminating findings and results, and promoting both the exchange of experiences and networking between actors within the projects. The successful transfer of knowledge into practice is an important goal. By promoting a healthy diet, dietary education and physical activity in childcare facilities and schools, we reach almost all children irrespective of their parents' origin and income. By doing so health inequalities are addressed.

From 2017 – 2019, “IN FORM” will be evaluated in order to assess the effectiveness of the projects as well as the overall structure of the programme. In this context, further need for action will be identified in the years to come.

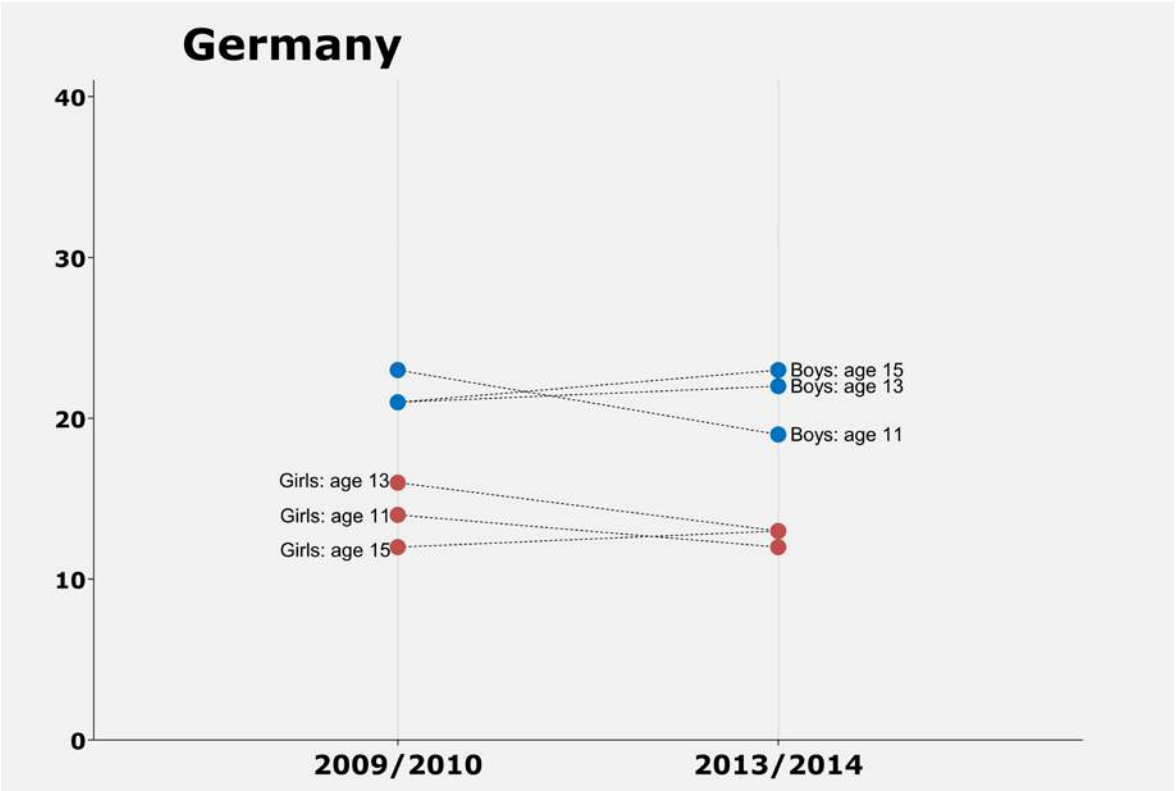
Besides “IN FORM”, the Preventive Health Care Act entered into force on 25th July 2015. It strengthens the basis for enhanced co-operation among the social security institutions, the Laender, and the local authorities in the areas of prevention and health promotion for all age-groups and in multiple life settings. With the assistance of this law, early detection and screening among children, young persons and adults will continue to be developed. The Federal Ministry of Health (BMG) established in 2015 a funding priority in order to promote research in the field of childhood obesity.

Prevalence of overweight including obesity (%) (HBSC)



The dark dots represent the prevalence in Germany. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Germany

1 For salt

2 Voluntary agreement with or from industry

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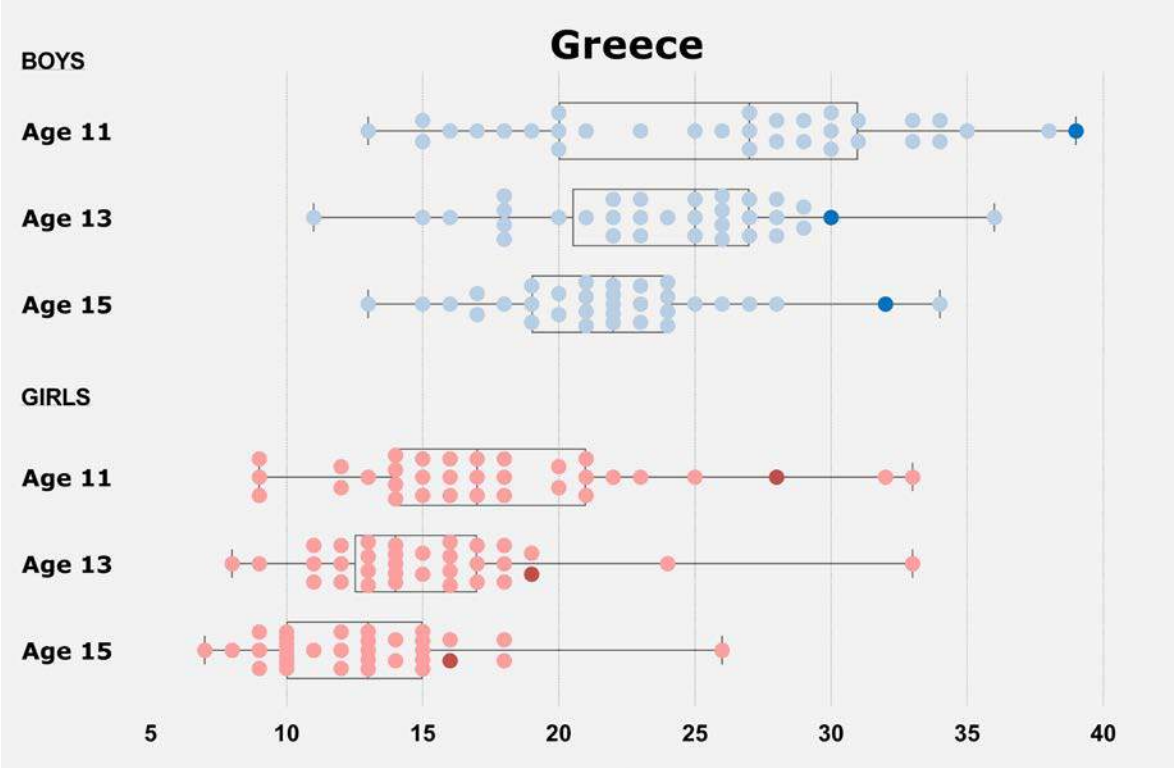
A5.12. Greece (EL)

Based on the interview conducted with the Greek Competent Authorities we learned that Greece does not have a national action plan on childhood obesity, physical activity, nutrition or non-communicable diseases. On the internet a national nutrition policy document can be found, but this document has not been officially approved in terms of action planning and implementation. The newly introduced National Nutrition Policy Committee is planning to work in this area. The committee is planning to cooperate with other ministries (e.g. Ministry of Education), national authorities (e.g. National Food Authority) and other stakeholders such as the food industry. In addition, the Institute of Childs' Health is responsible for some programmes, such as breastfeeding promotion.

For 2017 and upcoming years main activities of the National Nutrition Policy Committee will be education for women (e.g. during pregnancy and parents), for children and elderly on nutrition, food reformulation, and updating of the national nutrition guidelines from 1999. With this focus, the Ministry of Health continues to work on the priority topics it already had before 2014, which are 1) the promotion of a healthy start of life, especially breastfeeding and 2) the promotion of healthy environment in schools (pre-, primary and secondary schools). Greece has no specific policies addressing health inequalities relevant to childhood obesity, except for a programme in which healthy school meals are provided in especially lower socio economic areas.

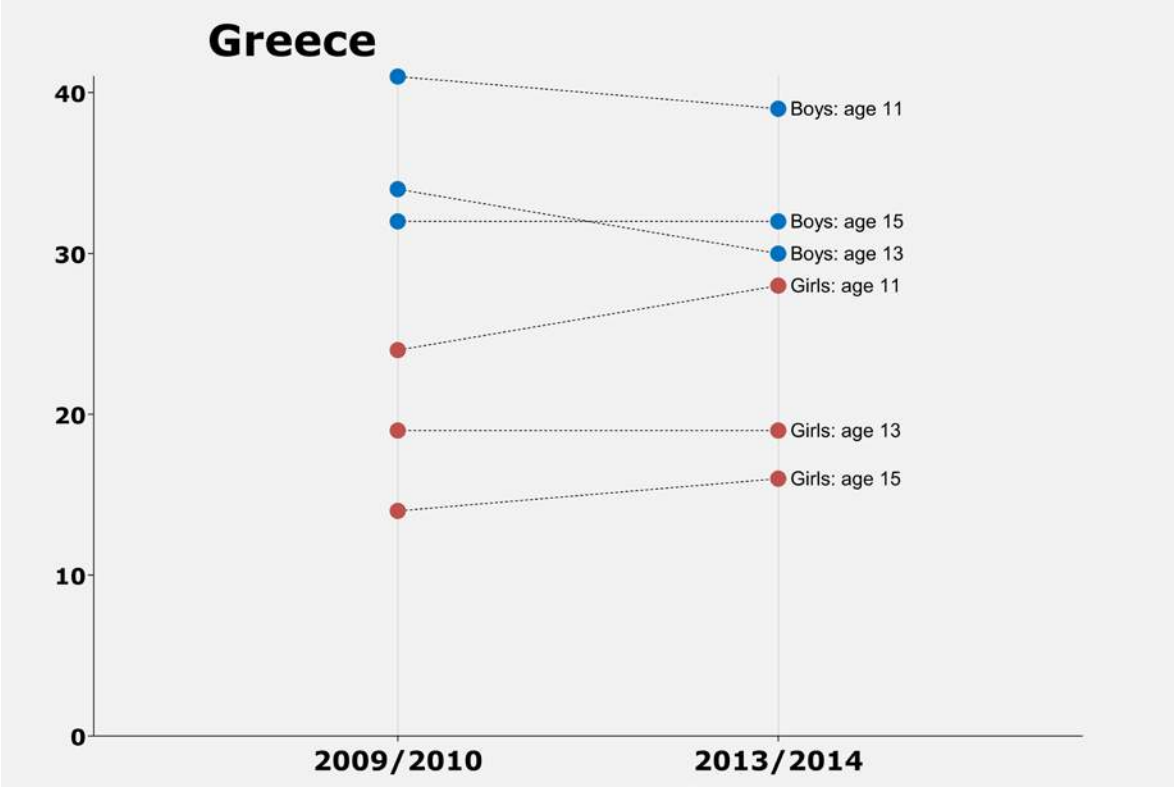
The EU Action Plan on Childhood Obesity 2014-2020 helps to set priorities for the national nutrition policy commission and to indicate the best practices that can be used in the context of Greece.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Greece. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Greece

1 Voluntary agreement with or from industry

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A5.13. Hungary (HU)

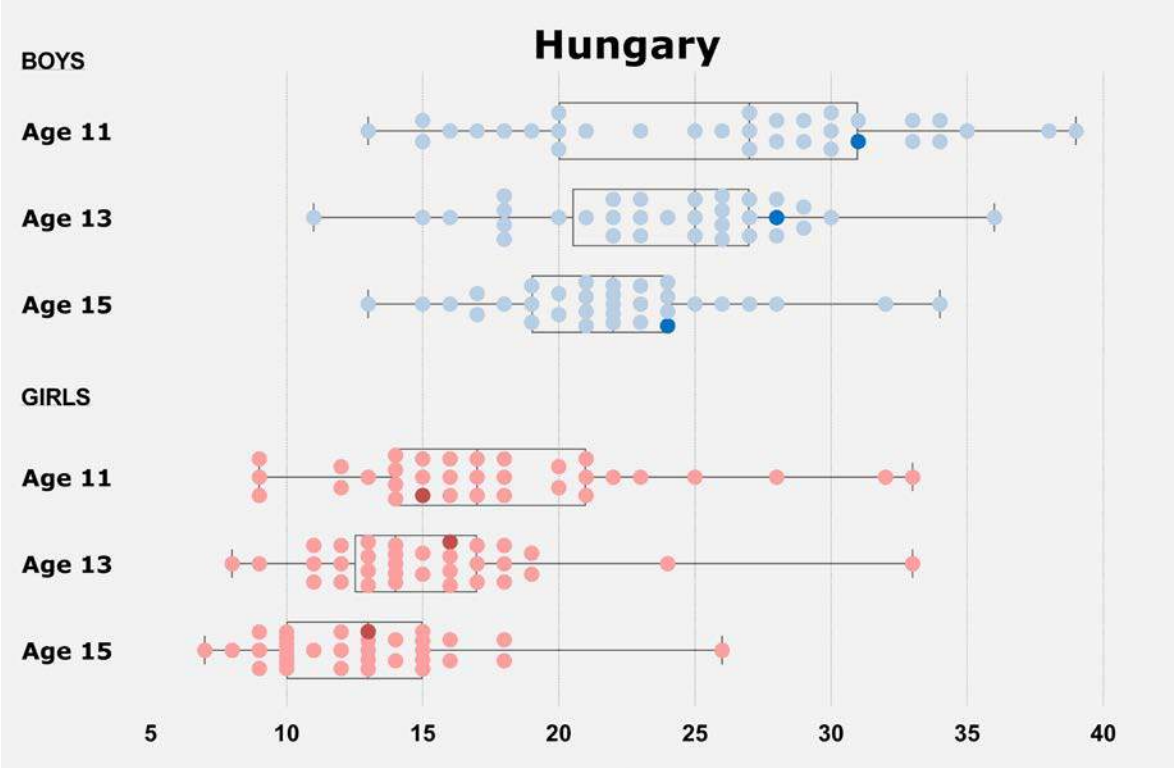
Based on the interview conducted with the Hungarian Competent Authorities we learned that a national plan on nutrition has been drafted several years ago. Some parts of this plan have been implemented (e.g. actions on salt reduction, trans fatty acid regulations and healthy public catering). The national health strategy “Healthy Hungary (2014-2020)” contains a national plan on the prevention of non-communicable diseases. The main priority for this plan is to prevent circulatory diseases and early mortality. Both plans target the whole Hungarian population; there are no specific actions for children below the age of 18 years. In addition, Hungary has a National Sports Strategy (2007–2020) and a National Youth strategy (2009-2024), including biannual action plans. Among the objectives is good physical activity for children and students, providing possibilities for physical activities out of school, and raising awareness of healthy lifestyles. Mandatory daily physical education classes were introduced into the national curricula in a step-up implementation system as of school year 2012/2013.

Central coordination for these plans is the Ministry of Human Capacities. Under this ministry the National Institute of Pharmacy and Nutrition covers the topic of childhood obesity and nutrition. This institute serves as a centre of excellence in the area of nutrition. It performs, implements and evaluates all the national surveys on nutrition and provides summaries of the data to government and stakeholders.

Based on earlier studies, especially in schools, it was concluded that dietary habits and physical activity are not optimal in Hungary and form a risk for children’s’ development. Therefore, healthy diet and physical activity are priority topics together with mental health. Schools are an important setting, because schools are proven to be the most common settings in which behaviours can be changed. The government supports “healthy catering” in nurseries, kindergartens and schools. For children with a low socioeconomic status, the government financially supports healthy catering – with 3 free meals per day. The public health product tax is expected to have an effect on decreasing childhood obesity trough the taxation of sugar-sweetened beverages and pre-packaged sweets.

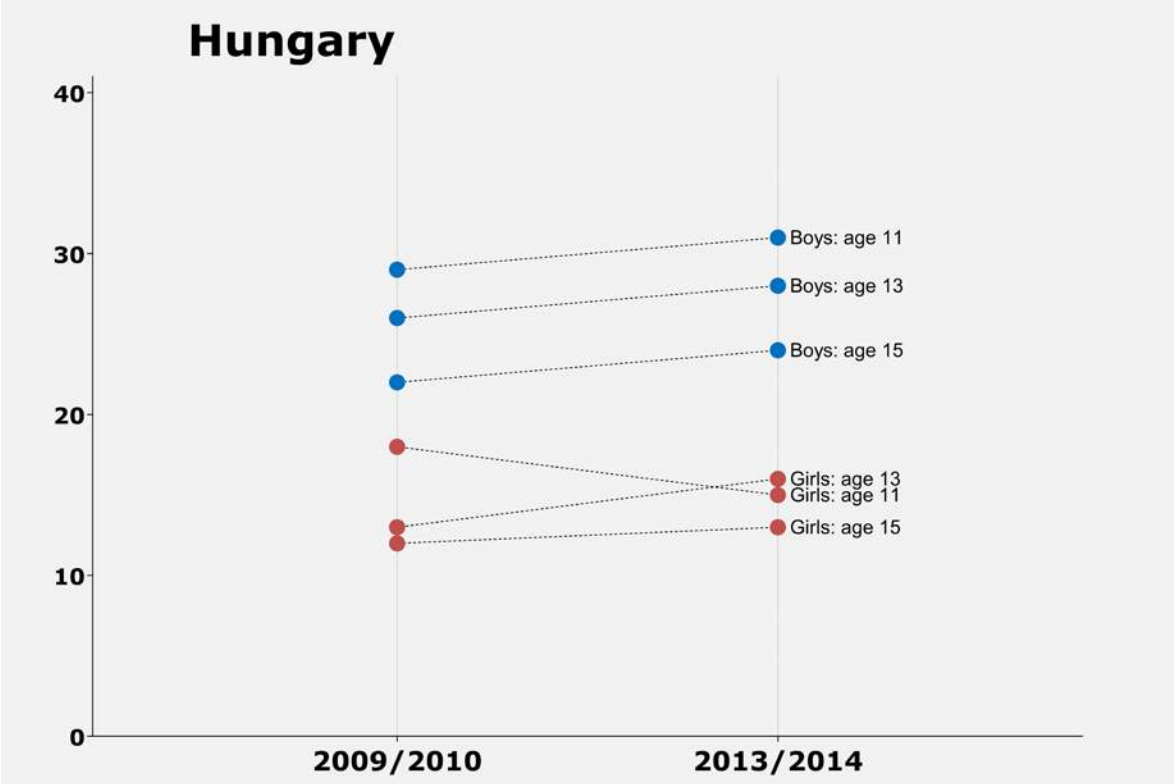
The EU Action Plan on Childhood Obesity 2014-2020 has mainly facilitated the monitoring of the implementation of Hungarian plans and serves as a good framework to ask the government to act. In addition, this document is very supportive in communicating to different stakeholders in the country.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Hungary. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Hungary

1 Children are not included

● yes, already before EU Action plan*
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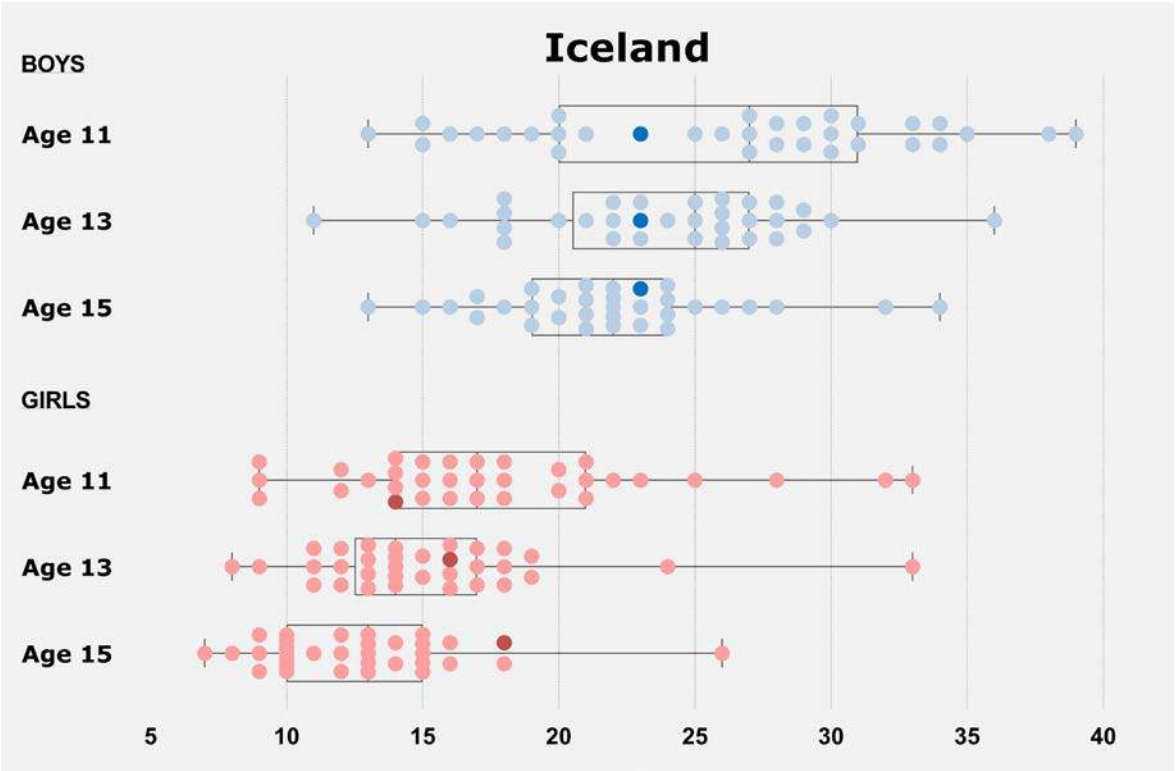
A5.14. Iceland (IS)

Based on the interview conducted with the Icelandic Competent Authorities we learned that Iceland has an action plan on reducing the prevalence of obesity since 2013. However, the Directorate of Health focuses in its work on promoting health and wellbeing across the lifecycle by emphasising a comprehensive approach across sectors and levels (health in all policies). Therefore Iceland actively avoids practices that narrowly focus on weight/obesity and might negatively influence social or emotional health. They rather focus on health promotion and prevention in general by creating a supportive environment that facilitates a healthy lifestyle, health and wellbeing *for all*. In 2016, a ministerial committee accepted a Public health policy and action plan that contributes to a health promoting community -with a special focus on children and adolescents under 18 years of age. This policy, it is about health promotion and prevention in general, e.g. improving the environment, increasing physical activity, improving nutrition, and increasing the number of municipalities in Iceland participating in the “Health promoting community programme” and the “Health promoting schools programme”. “Health Promoting Community” follows the health in all policies approach and is coordinated by The Directorate of Health in close collaboration with relevant stakeholders. The community establishes a steering group that represents different sectors and groups in the community. It supervises the project, establishes where special emphasis is required, based on needs assessment and formulates policies. The Directorate of Health supports the communities in several ways. “Health Promoting School” intends to support schools to fulfil their role in incorporating health and well-being as fundamental pillar of education in all their work. This is one of the six pillars that are stated in the 2011 National curriculum guides for preschools, compulsory and upper secondary schools. With a holistic whole-school approach the Directorate of Health in collaboration with the Ministry of education and Culture, the Ministry of Welfare and other relevant stakeholders, aims to promote healthy habits among children and adolescents through health promoting schools. The projects have four main themes: nutrition, physical activity, mental health and life skills.

As a response to the economic crisis a Steering Committee (the Welfare Watch) was established in 2009 and re-established in 2014. The main role of Welfare Watch is to monitor systematically the social and financial consequences of the economic situation for families and individuals in Iceland and to propose measures to help households and in particular vulnerable groups. It is now a platform with 35 stakeholders represented from all sectors and levels of the society.

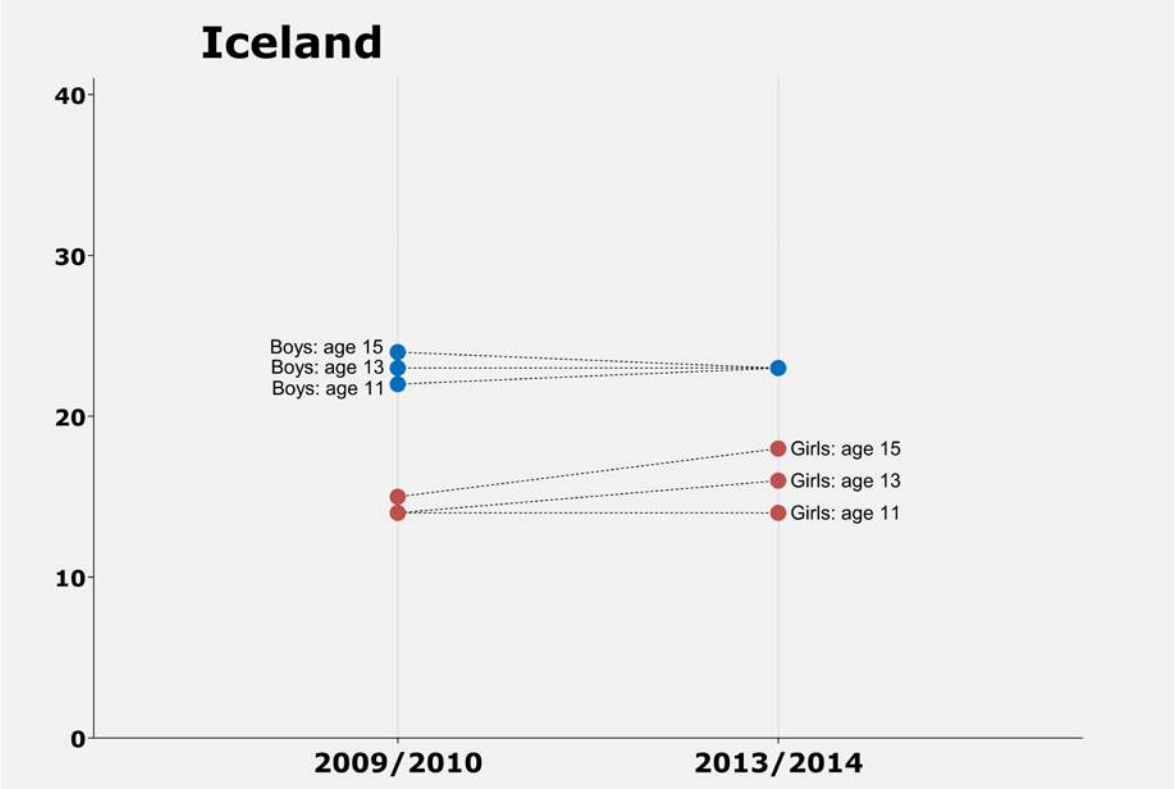
Iceland participates in the EU High Level Group on Nutrition and Physical Activity since 2016. The EU Action Plan on Childhood Obesity 2014-2020 therefore did not specifically facilitate development or implementation of any policies. However, international documents do in general inspire the work in Iceland on health promotion and prevention.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Iceland. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Iceland

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A5.15. Ireland (IE)

Based on the interview conducted with the Irish Competent Authorities we learned that a 10 steps programme: "A Healthy Weight for Ireland: Obesity Policy and Action Plan 2016 – 2025" forms the Irish obesity policy. This plan was aligned with the EU Action Plan on Childhood Obesity 2014-2020. For each of the Ten Steps Forward mentioned in the plan, priority actions to be commenced in the first year are formulated. The ten steps forward are:

1. Embed multi-sectoral actions on obesity prevention with the support of government departments and public sector agencies.
2. Regulate for a healthier environment.
3. Secure appropriate support from the commercial sector to play its part in obesity prevention.
4. Implement a strategic and sustained communications strategy that empowers individuals, communities and service providers to become obesity aware and equipped to change, with a particular focus on families with children in the early years.
5. The Department of Health, through Healthy Ireland, will provide leadership, engage and co-ordinate multi-sectoral action and implement best practice in the governance of the Obesity Policy and Action Plan.
6. Mobilise the health services to better prevent and address overweight and obesity through effective community-based health promotion programmes, training and skills development and through enhanced systems for detection and referrals of overweight and obese patients at primary care level.
7. Develop a service model for specialist care for children and adults.
8. Acknowledge the key role of physical activity in the prevention of overweight and obesity.
9. Allocate resources according to need, in particular to those population groups most in need of support in the prevention and management of obesity, with particular emphasis on families and children during the first 1,000 days of life.
10. Develop a multi-annual research programme that is closely allied to policy actions, invest in surveillance and evaluate progress on an annual basis.

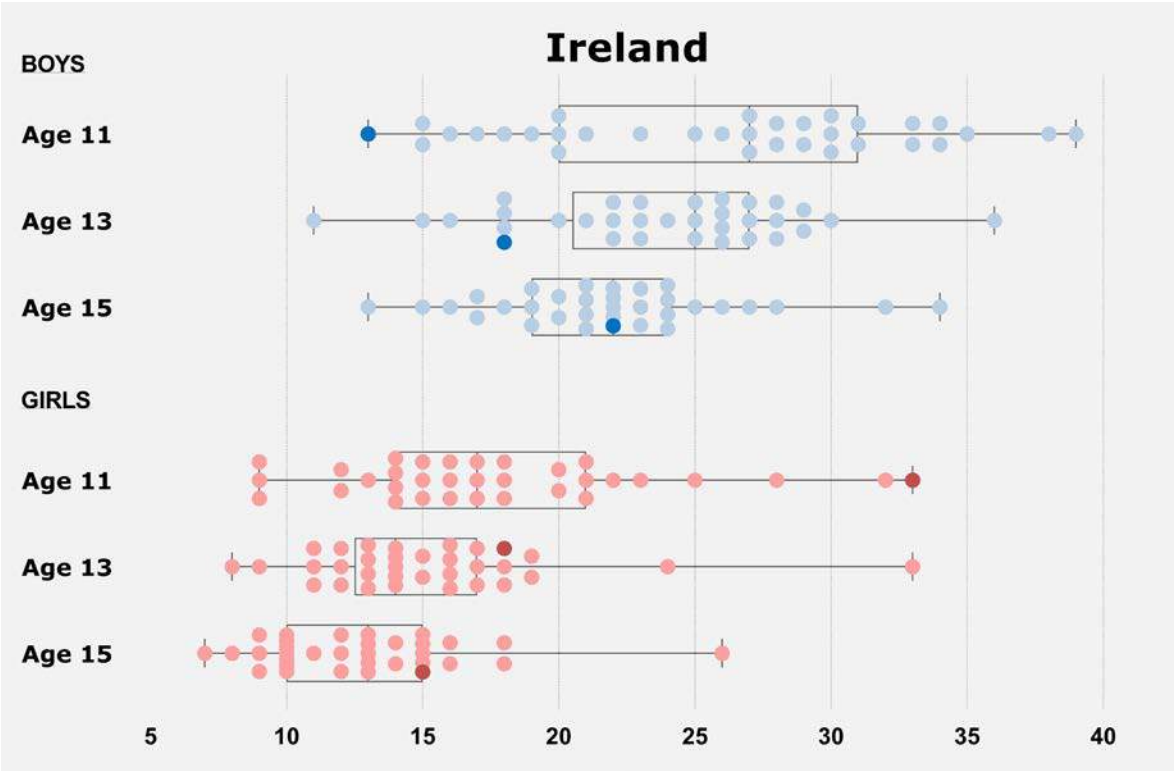
A voluntary Code of Practise on marketing, which is in place since 2017. It is about the promotion, product placement and sponsorship (up to the age of 12) of HFSS foods and drinks for adults and children. For example, in a retail environment with 4 or more check-out desks, 1 check-out desk should be free of HFSS foods. When a company has more than 50-60% of unhealthy products, it cannot sponsor at areas as schools and sport locations.

In 2016, Ireland adopted the plan: "Get Ireland Active! National Physical Activity Plan for Ireland" (2016-2025).

Health inequalities are addressed in several ways in the Irish policies. As part of the Obesity Policy and Action Plan, Ireland has announced a Healthy Ireland Fund of 5 million euros to support community programmes for disadvantaged groups. Local initiatives/projects can apply for funding. Currently, Ireland has several programmes for socially disadvantaged groups. Ireland has since a long time a school food programme for schools that are categorized to be in socially disadvantaged areas.

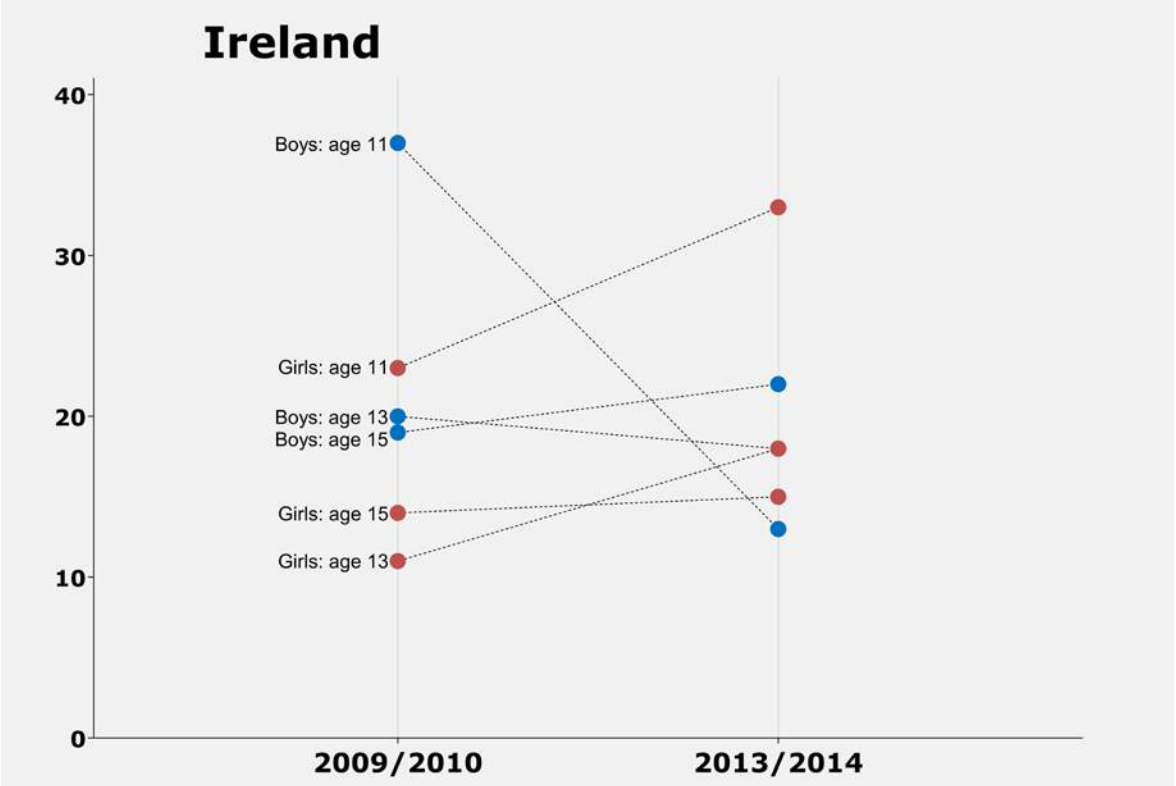
Ireland has a Special Action Group on Obesity, existing of experts in the area of physical activity, clinicians who work in the area of obesity, different agencies working on prevention of obesity and all key stakeholders (except the food industry). The food industry is usually invited once a year to update the Group on its initiatives. This group has published the obesity policy. Ireland is currently looking at establishing an implementation mechanism/group on obesity, led by the Department of Health.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Ireland. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Ireland

AREA 1: Support a healthy start in life
- Guidance before and during pregnancy
- Promote and protect breastfeeding
- Guidance on complementary feeding

AREA 2: Promote healthier environments
- Improving the school environment
- Policies on vending machines
- Policies on energy drinks
- Mandatory nutrition education[1]
- Mandatory physical activity education

AREA 3: Healthy option the easy option
- Food reformulation: salt
- Food reformulation: saturated fat
- Food reformulation: sugar
- Food reformulation: portion sizes
- (Virtually) eliminate trans fat
- Monitoring of food reformulation
- Easy to understand labelling
- Taxation
- Subsidies

AREA 4: Restrict marketing & advertising
- Marketing of (HFSS) foods to children
- Nutrient criteria to reduce marketing

AREA 5: Inform & empower families
- Campaigns on diet & physical activity
- Support community-based interventions
- Screening programmes childhood obesity
- Management services for obese children

AREA 6: Encourage physical activity
- Physical activity promotion for children
- National physical activity guidelines
- Data on weight and height in children

AREA 7: Monitoring & surveillance
- Diet and nutrition surveys
- Monitoring of physical activity
- Participation in COSI

1 In secondary school, not in primary school

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◒ partially, for example in certain settings or certain regions*
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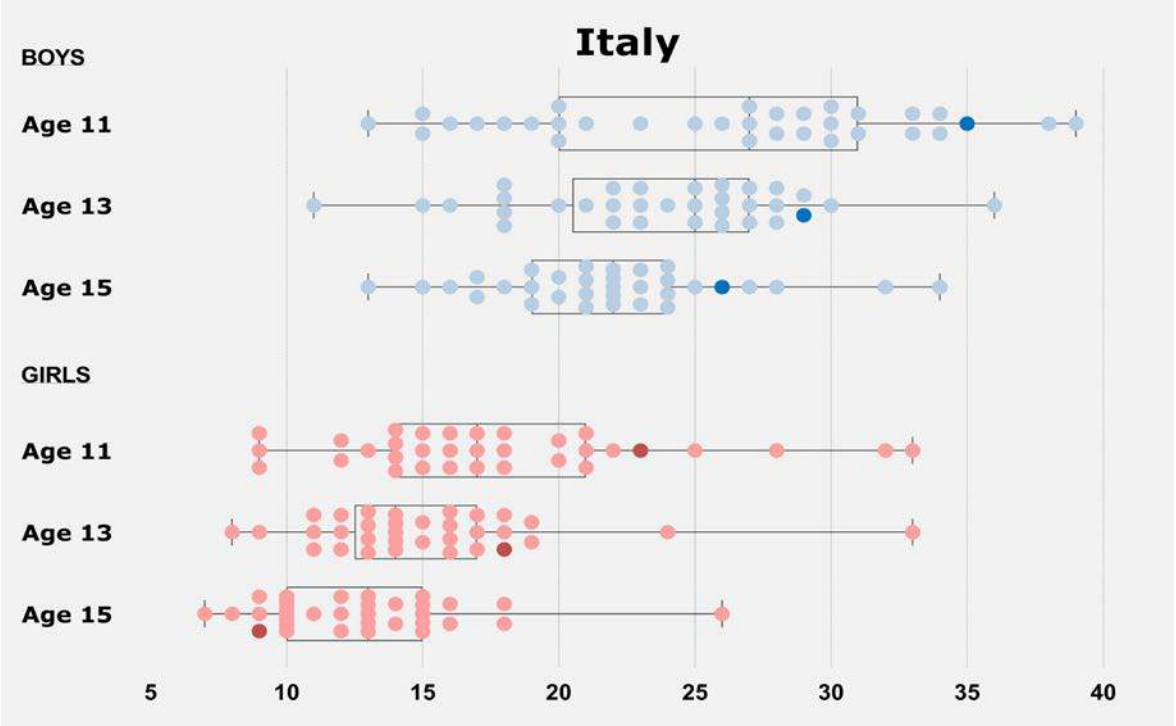
A5.16. Italy (IT)

Based on the interview conducted with the Italian Competent Authorities we learned that the Italian strategy on prevention of non-communicable diseases is based on two main programs that are strongly inter linked: the programme “Gaining health: making healthy choices easier” and the “National Prevention Plan”. “Gaining health” is a Government initiative, adopted in 2007 and led by the Ministry of Health. It follows the health in all policies approach, aiming to promote cross-sector actions, to facilitate healthy behaviours and prevent non-communicable diseases, by acting against main modifiable common risk factors (tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity). The Gaining Health programme has favoured the reduction of salt consumption through voluntary agreements with the food industry and with the main national associations of craft bakers to reformulate a wide range of products available on the market, starting from bread, but also frozen ready-to-eat first courses, soups and frozen vegetable purée. During the EXPO 2015, the Ministry of Health, has signed a memorandum of understanding with certain sectors of the food industry. This document identifies the reformulation efforts carried out so far, and highlights possible opportunities and priorities for future actions. The last “National Prevention Plan” runs from 2014 to 2018 and addresses many topics including actions on overweight and childhood obesity and physical activity. In particular, the consumption of fruit and vegetables and increased physical activity is promoted, as well as the reduction of salt intake. The “National Prevention Plan” invests in the well-being of young people, with a cross-determinants and “life cycle” approach and involves different settings (schools, workplaces, communities, health services). In the last years, the Ministry of Health has implemented a strong alliance with the educational sector to promote several activities, with specific focus on obesity/overweight prevention, healthy eating and physical activity promotion. In collaboration with the educational sector, Local Health Services have activated projects for children/adolescents in schools, whose main deliverables were multimedia educational materials that provide information and tools for healthy lifestyles in a pleasant and stimulating way. Within the “Gaining Health” programme, several regions developed interventions though a "Network of Health Promoting Schools", which have implemented a skills-based approach to health education in order to create or maintain healthy lifestyles. The Ministry of Health also issued "National Guidelines on nutritional quality of canteen menus at school" to improve the quality of school menus and use the lunch time at school to promote healthy eating habits. The Ministry of Health has also been actively working with many sport organizations, such as the Italian Olympic Committee, Sports clubs, and Foundations, in the promotion of active lifestyles, both for schoolchildren, young people and people living in a disadvantaged socioeconomic situation. The “National Prevention Plan” is part of the ethical programme of Italy. It promotes health and equity in health throughout the course of life. All the actions, projects, protocols developed to implement strategies have a specific aim on the inclusion of vulnerable groups.

With the aim to promote stronger collaboration between areas other than the health sector, in October 2017, the Minister of Health has constituted the National Platform for Gaining Health. This platform consists of representatives of different ministries and other stakeholders. The National Centre for Disease Prevention and Control (CCM), a structure of the Ministry of Health, promotes the creation of synergies between different regional initiatives, through the identification and dissemination of best practices. At the local level, Local Health Units (LHUs) are responsible for protecting and promoting public health and achieving the health objectives and targets established by national and regional planning.

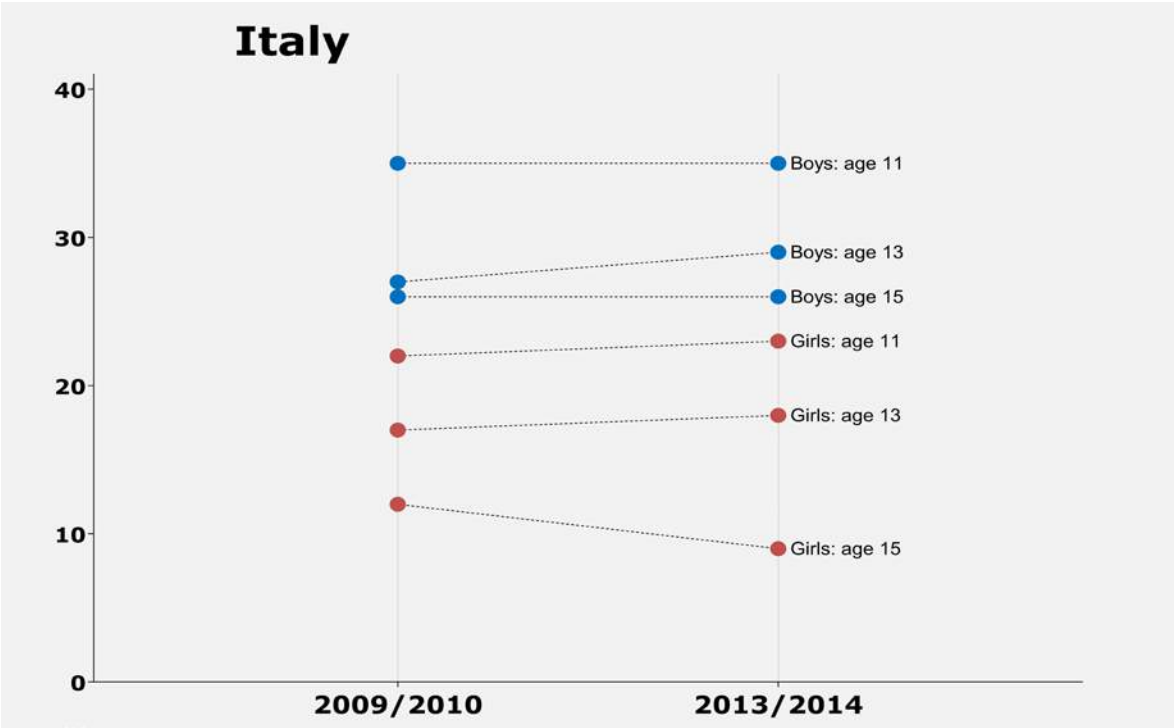
The strategies on the prevention of overweight and obesity started in Italy already in 2005, when the first National Prevention Plan was adopted. The EU Action Plan on Childhood Obesity 2014-2020 has contributed to increasing the priority of this topic in Italy. It provided a framework of actions that have been important for the implementation of strategies on healthy diet and physical activity.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)[35]



The dark dots represent the prevalence in Italy. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014[28]



[35] Italy oversampled the HBSC study in order to have regional representativeness. For the international HBSC survey a subsample of the national survey has been utilized. In the larger national sample the prevalences are (sometimes considerably) lower, especially among 11-year old boys. In all the groups the prevalence was lower in the 2014 survey than in the 2010 survey (77, 78).

Overview of policies / activities according to the various areas of action of the EU Action Plan in Italy

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.17. Latvia (LV)

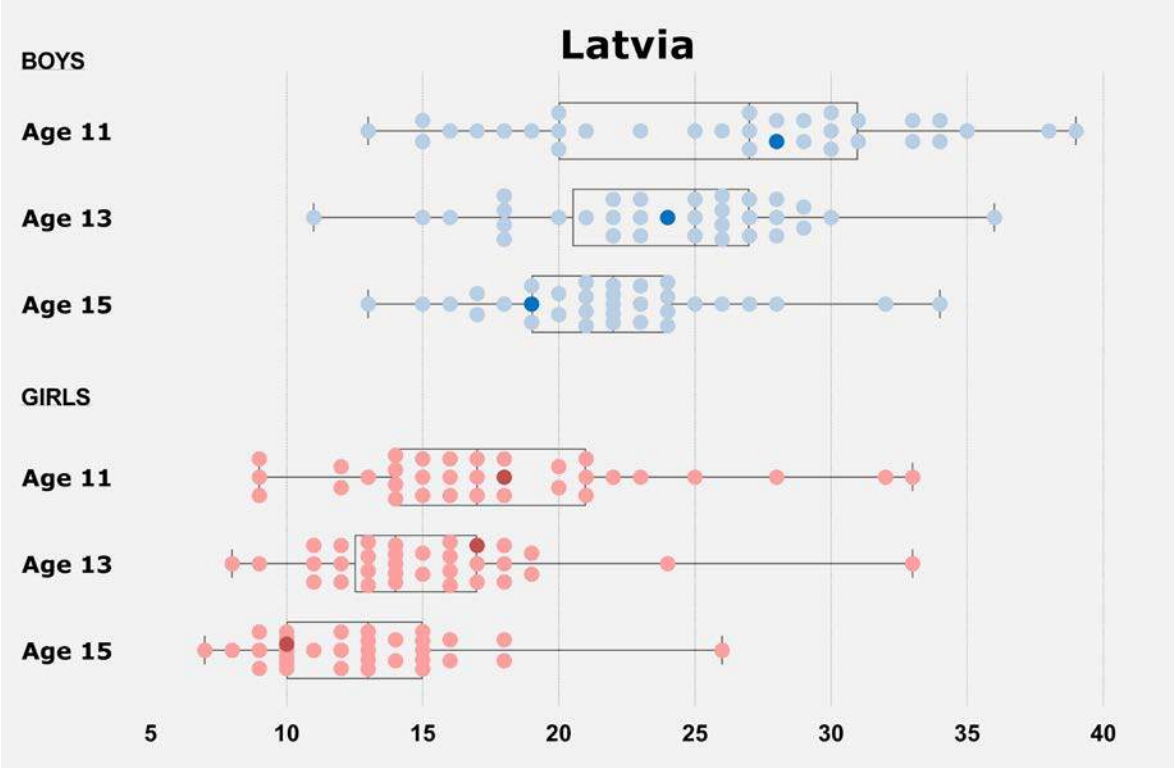
Based on the interview conducted with the Latvian Competent Authorities we learned that the topics of (childhood) obesity, nutrition, physical activity and non-communicable diseases are covered by the "Public Health Strategy 2014-2020". This is the main public health policy planning document in Latvia and takes a multi-sectorial approach. It sets up the overarching objective of the public health policy, i.e. to increase the number of healthy life years of inhabitants of Latvia and to prevent premature death, preserving, improving and restoring health. Two of six main directions for action in this policy are related to childhood obesity: reduction of the spread of non-communicable disease risk factors and health improvement of pregnant women and children.

In Latvia non-communicable diseases are the main cause of death. These diseases are influenced by lifestyle, such as unhealthy nutrition and insufficient physical activity. Investment in health during early childhood will create positive results in the context of healthy adulthood and active ageing. Therefore a life-course approach is very important and health promotion for all, including children is priority in Latvia. In line with the "Public Health Strategy for 2014-2020" extensive programmes to address health inequalities will be implemented in the coming 6 years, targeting poor people, unemployed, children and other vulnerable groups. These programmes will be on healthy nutrition, sufficient physical activity etc. In November 2017 new national energy and nutritional norms, including those for pregnant women and children, were adopted. These revised recommendations will be integrated in the normative regulation on nutritional norms for children in educational institutions (schools and kindergartens) as well as patients of medical treatment institutions and clients of social care and social rehabilitation institutions.

Several multi-sectoral councils that are involved in the implementation of the Public Health Strategy are installed in Latvia. The Nutrition Council and the Maternal and Child Health Advisory Council are coordinating and advisory councils chaired by the Ministry of Health. The Food Industry Council is chaired by the Ministry of Agriculture and the Latvian National Sports Council and the Youth Sports Council are chaired by the Ministry of Science and Education.

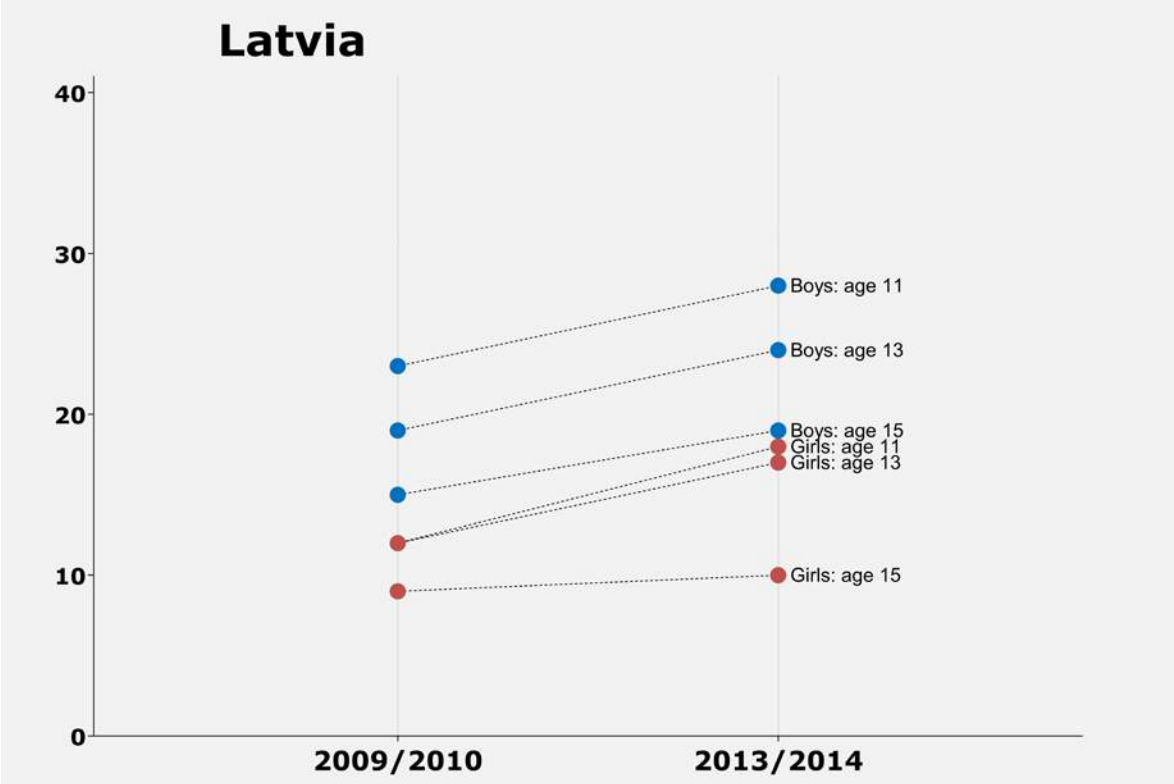
The EU Action Plan on Childhood Obesity 2014-2020 facilitated the development of the Latvian "Public Health Strategy for 2014-2020" and other policy documents. In general, Latvian policy planning documents are being developed based on EU policy documents.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Latvia. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Latvia

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.18. Lithuania (LT)

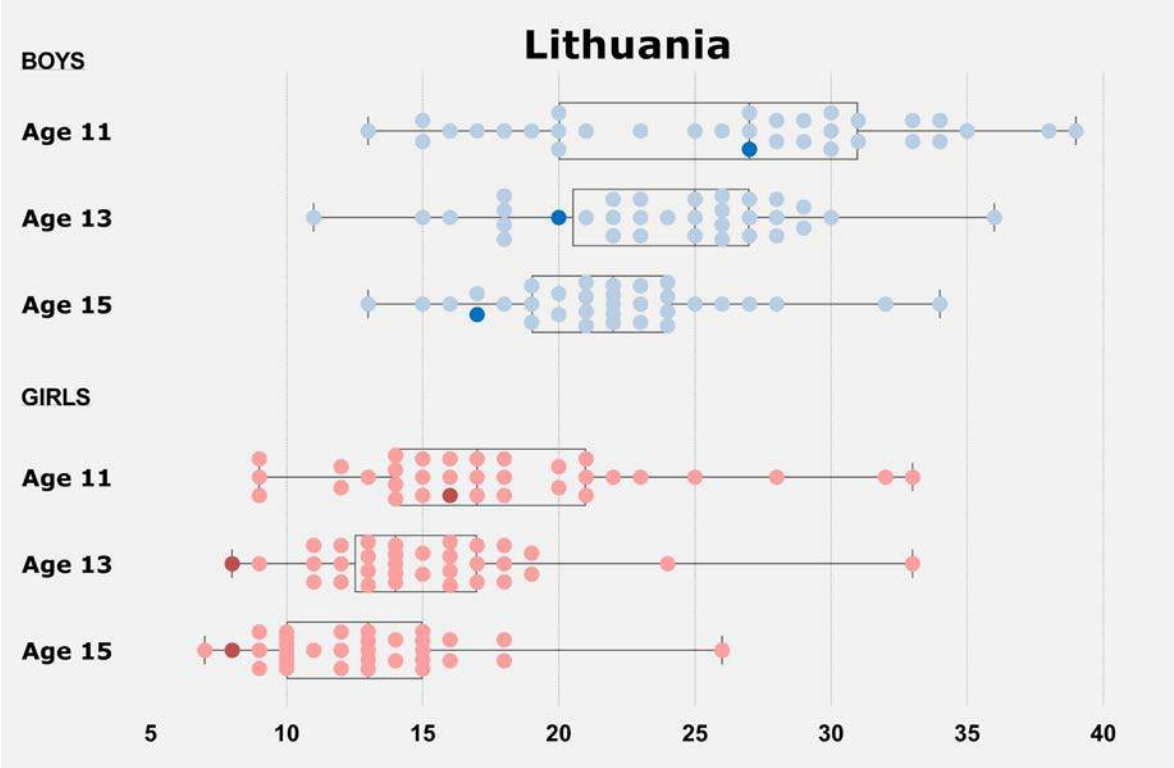
Based on the interview conducted with the Lithuanian Competent Authorities we learned that the topic of (childhood) obesity is covered in the general Health Policy of Lithuania (National Health Strategy 2014-2025, State Public Health Development Programme 2016-2023, etc.). This policy also has a chapter on nutrition, therefore the State Food and Nutrition Strategy State Action Plan for 2003–2010 is no longer ongoing. The Ministry of Health is the responsible coordinator. At the Parliament level there is a Health Affairs Committee and a Committee for Youth Affairs. Additionally, there is a National Committee on Physical Activity and Sports. Lithuania has a National Sport Development Strategy for 2011—2020, which serves as a national policy strategy on physical activity, specifically addressing 'Sports for All' promotion. This is supplemented by the Interinstitutional Action Plan for the Implementation of the 2011—2020 National Sports Development Strategy. Together, these plans aim to create conditions for greater inclusion in sports and physical activity in Lithuania. Three main themes make up the strategy: increasing general public awareness of the benefits of physical activity; promoting healthy lifestyles through physical activity, physical education (PE) and sports; and creating the right conditions for citizens to engage in sports and exercise. More specifically, this includes initiatives to encourage young people to participate in voluntary sports activities; recommendations that establish and implement minimum standards for local sports and health infrastructure; and environmental restructuring to encourage children, adolescents and elderly people to participate in healthy lifestyles and sports. Also Action Plans for non-communicable diseases, i.e. for cancer, for coronary heart disease and for diabetes include strategies that are relevant for the prevention of obesity, as obesity is interrelated with these diseases.

Every year additional actions and/or policies are initiated to improve the general Health Policy of Lithuania. The government of Lithuania asked to improve the already implemented health education at schools. Furthermore, the policies on nutrition at schools will be improved. Now Lithuania is planning to set additional maximum levels for certain nutrients (sugar, salt) at schools

Childhood obesity is not considered a very important topic in Lithuania as Lithuanian children are relatively slim. However, the prevalence of obesity is slightly increasing so Lithuania tries to tackle it as early as possible, primarily through education and nutrition in schools. Priority areas are school nutrition (school meals and education), provision of free milk and fruit at school, promotion of physical activity and limitation of trans fat in foods. There are no specific legal acts or policies to address children's health inequalities. Lithuania is a small country and there are little inequalities, so there is no need for specific action.

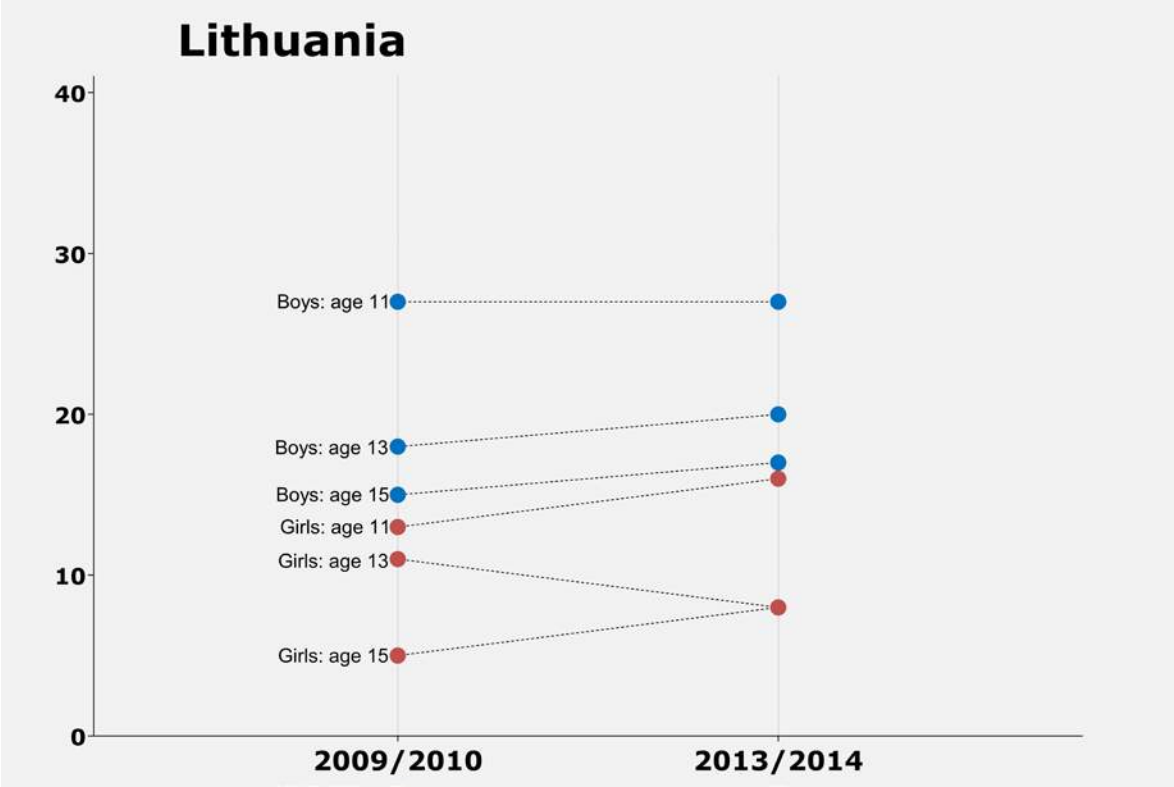
The EU Action Plan on Childhood Obesity 2014-2020 strengthens Lithuanian activities, because when they draft national plans they can refer to the Action Plan

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Lithuania. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Lithuania

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
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A5.19. Luxembourg (LU)

Based on the interview conducted with the Luxembourg Competent Authorities we learned that since 2006, Luxembourg has a national inter-ministerial strategy for healthy nutrition and physical activity, with an action plan to improve the situation nationwide, especially in children and adolescents. In 2011, the part on physical activity was extended. The main aims of the strategy for healthy nutrition and physical activity are to have a coherent and collaborative approach, to improve local competencies and actions, and to improve exchange and collaboration at all levels. The strategy is therefore carried out with a tight network with partners, communities, municipalities, schools, etc. The Ministry of Health coordinates the strategy, with involvement of the Ministry of Sport, Ministry of Education and the Ministry of Family. The prevention of non-communicable diseases is additionally addressed by other programs like the national cancer plan and the national tobacco plan. For Luxembourg priority topics are:

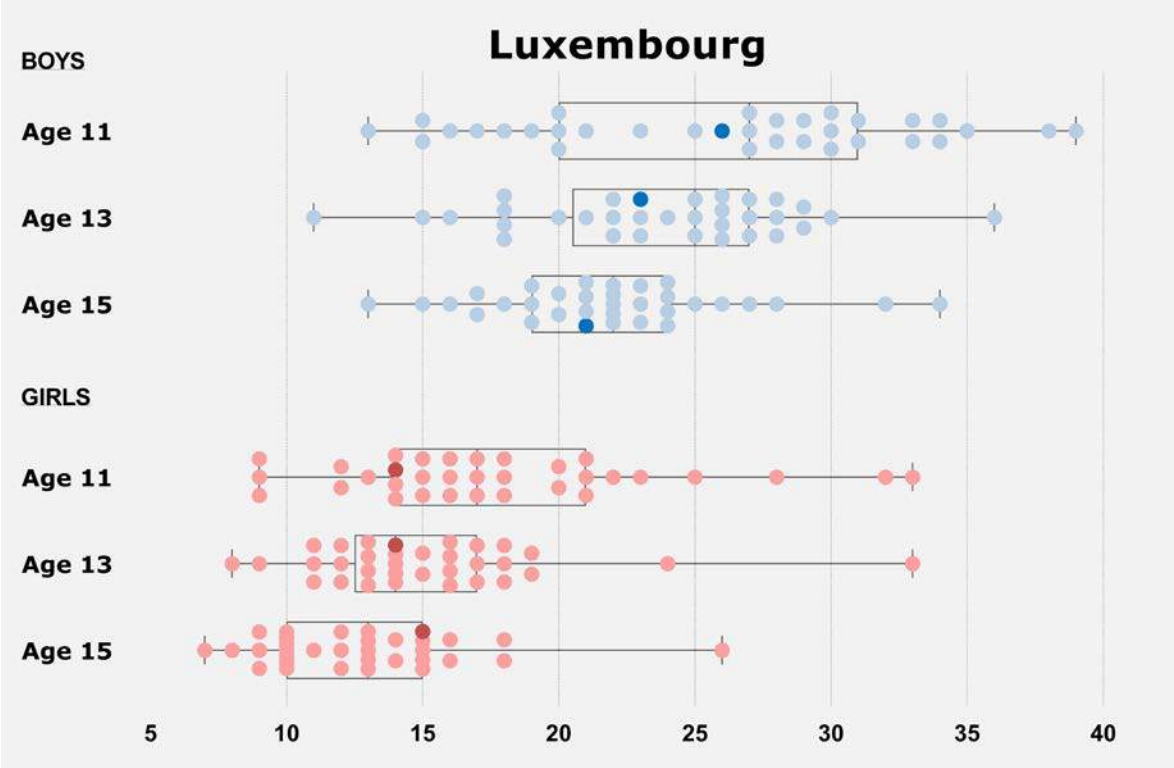
- Wellbeing and the health of children and adolescents at physical, psychological, and social economic level
- Physical activity and healthy nutrition in children
- To prevent and reduce overweight and obesity in the general population
- Healthy and balanced nutrition for the whole population
- To improve the competences and opportunities to make good choices
- Equal access for all

The National strategy on healthy nutrition and physical activity is a continuum of ongoing actions and actions in preparation. In the beginning of 2017 new national nutrition quality guidelines for children's canteens have been issued. This guideline has been developed in collaboration with day care centres. Besides nutritional aspects, it includes psychological and physiological aspects of eating. With respect to physical activity, Luxembourg invests a lot in teachers, educators, and sports trainers. Many actions are addressed in schools and places were all children, independently from their socio economic or cultural background, are reached. However, it is still considered a problem in Luxembourg that underprivileged children and especially their parents are difficult to reach. This will be a priority in the next plan on healthy nutrition and physical activity that Luxembourg is currently working on and will be finished mid-2018.

There are specific working groups on several topics relevant to the strategy, for example to elaborate guidelines for day care centres, infrastructures, i.e. places where children are staying, reformulation, and physical activity.

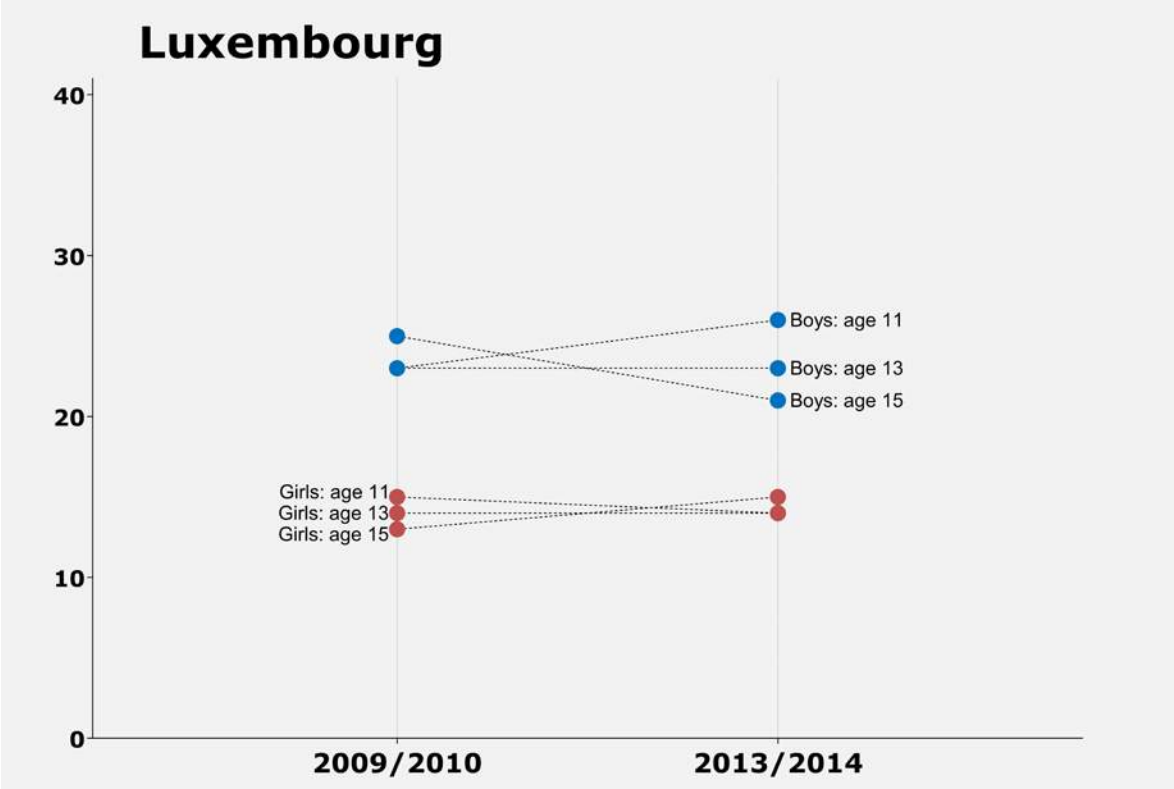
The EU Action Plan on Childhood Obesity 2014-2020 indirectly facilitated policy development in Luxembourg. Topics of the European action plan will be included in the next plan on healthy nutrition and physical activity.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Luxembourg. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Luxembourg

- **AREA 1: Support a healthy start in life**
  - Guidance before and during pregnancy
  - Promote and protect breastfeeding
  - Guidance on complementary feeding
- **AREA 2: Promote healthier environments**
  - Improving the school environment
  - Policies on vending machines
  - Policies on energy drinks
  - Mandatory nutrition education
  - Mandatory physical activity education
- **AREA 3: Healthy option the easy option**
  - Food reformulation: salt
  - Food reformulation: saturated fat
  - Food reformulation: sugar[1]
  - Food reformulation: calories
  - (Virtually) eliminate trans fat
  - Monitoring of food reformulation
  - Easy to understand labelling
  - Taxation
  - Subsidies
- **AREA 4: Restrict marketing & advertising**
  - Marketing of (HFSS) foods to children
  - Nutrient criteria to reduce marketing
- **AREA 5: Inform & empower families**
  - Campaigns on diet & physical activity
  - Support community-based interventions
  - Screening programmes childhood obesity
  - Management services for obese children
- **AREA 6: Encourage physical activity**
  - Physical activity promotion for children
  - National physical activity guidelines
  - Data on weight and height in children
- **AREA 7: Monitoring & surveillance**
  - Diet and nutrition surveys
  - Monitoring of physical activity
  - Participation in COSI

[1] There will be in next action plans, but no preparatory work is being done yet

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.20. Malta (MT)

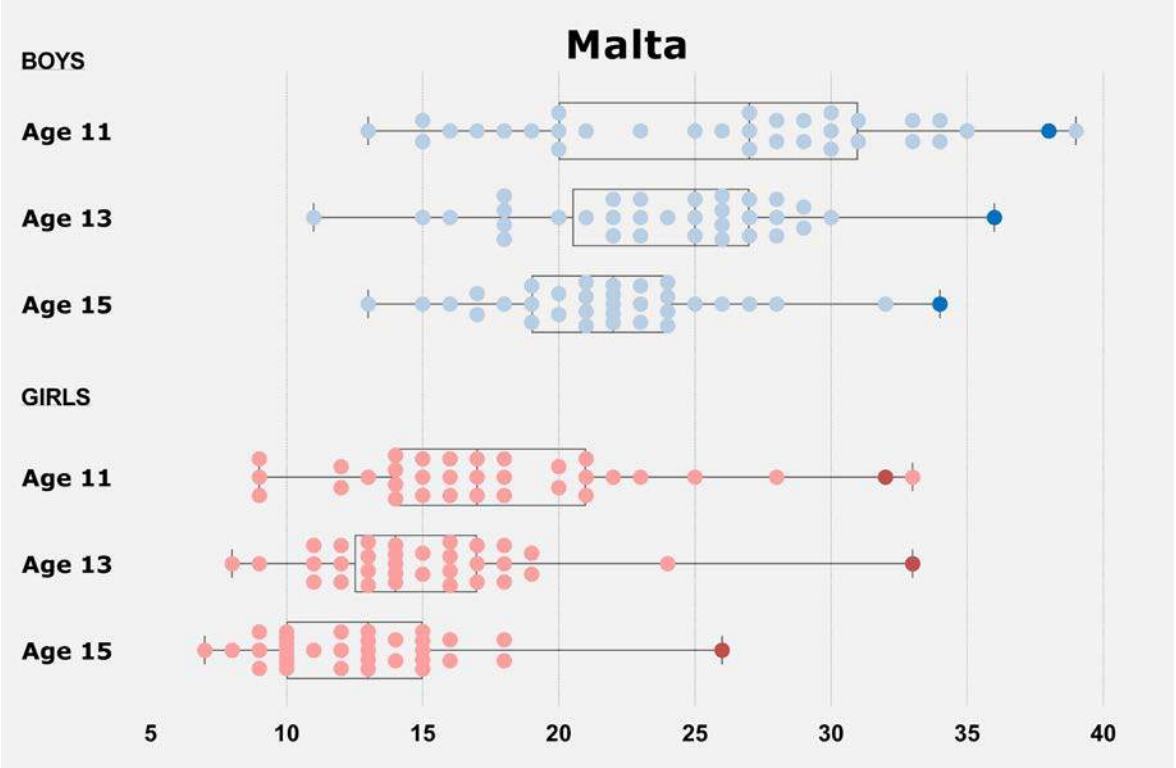
Based on the interview conducted with the Maltese member of the High Level Group on Physical Activity and Nutrition we learned that in Malta, policies on the prevention of childhood obesity are incorporated in several health policies. In 2010 a strategy on non-communicable diseases, including obesity was launched. 'A Healthy Weight for Life: A National Strategy for Malta 2012-2020' was issued in 2012 by the Superintendence of Public Health Ministry for Health, the Elderly and Community Care. The Maltese authorities develop strategies and policies through a whole-of-government and whole-of-society approach. They take a life-course approach to obesity prevention and they focus a lot of the policies and actions to children. The Food and Nutrition Policy and Action Plan for Malta 2015 – 2020 was launched in 2014. This action plan focusses on the wider aspects of food and nutrition. Furthermore, Malta adopted the "Whole school approach to a healthy lifestyle: Healthy Eating and Physical Activity Policy", which includes policies and strategies on healthy eating and physical activity in February 2015. Most recently, a National Policy for Sport in Malta & Gozo 2017-2027 has been launched, while a HEPA strategy is being drafted.

In January 2016 an advisory council has been set up that works inter-sectoral on obesity and non-communicable diseases. This council advises the Minister of health on strategies and possible new legislation. Beginning 2017 there are several plans. First, there is a plan to strengthen the focus on the life course approach and focus on promising initiatives to strengthen them. Second, there are plans to have legislation on foods that are allowed to be sold in schools and those that are not, including regulation of sponsorships in schools. Currently, there is a policy in place on this topic. Third, evaluation of the availability of potable water in schools in ongoing with the aim of having measures in place to have a supply of freely available drinking water to all schools. Fourth, in 2016 a project was piloted focussing on increasing skills of children, starting already very young, so they learn about healthy foods. This will be taken up by all schools. In the 2018/2019 school year, Malta will be enhancing actions on health topics in kindergartens, as part of the Joint Action Chrodis Plus.

As there is still a rising trend in obesity in Malta, it is necessary to stop (and curb) this trend. Therefore, the Maltese strategy takes a life course approach, starting very young, and also focussing on young mothers to be, so children get a healthy start in life. Increasing skills is an important aspect of the strategies. Statistics in Malta clearly show that they follow the world-wide observation that people with lower socioeconomic status have higher obesity rates. Addressing lower socioeconomic groups is a key priority when tackling the whole problem of obesity. Therefore, September 2016, a specific unit on health inequalities has been set up and a number of initiatives are ongoing that specifically address people with lower socioeconomic status. These initiatives have a family approach and focus on skills development, for example by group talks.

The EU Action Plan on Childhood Obesity 2014-2020 is guiding the implementation group so they can focus on those strategies that are most successful.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represents the prevalence in Malta. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014

No HBSC data for 2009/2010 are available for Malta.

Overview of policies / activities according to the various areas of action of the EU Action Plan in Malta

AREA 1: Support a healthy start in life
- Guidance before and during pregnancy
- Promote and protect breastfeeding
- Guidance on complementary feeding

AREA 2: Promote healthier environments
- Improving the school environment
- Policies on vending machines
- Policies on energy drinks
- Mandatory nutrition education
- Mandatory physical activity education

AREA 3: Healthy option the easy option
- Food reformulation: salt
- Food reformulation: saturated fat
- Food reformulation: sugar
- Food reformulation: portion sizes
- (Virtually) eliminate trans fat[1]
- Monitoring of food reformulation
- Easy to understand labelling
- Taxation
- Subsidies

AREA 4: Restrict marketing & advertising
- Marketing of (HFSS) foods to children
- Nutrient criteria to reduce marketing

AREA 5: Inform & empower families
- Campaigns on diet & physical activity
- Support community-based interventions
- Screening programmes childhood obesity
- Management services for obese children

AREA 6: Encourage physical activity
- Physical activity promotion for children
- National physical activity guidelines
- Data on weight and height in children

AREA 7: Monitoring & surveillance
- Diet and nutrition surveys
- Monitoring of physical activity
- Participation in COSI

1 Voluntary agreement with or from industry

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.21. Montenegro (ME)

Based on the information provided[36] by the Competent Authority of Montenegro we learned that Montenegro adopted a Strategy for non-communicable diseases in 2008 and a new action plan on nutrition (for 2017/2018) in January 2017. Since there are no national guidelines yet, the Ministry of Health have put the development of two guidelines in its top of priorities for the next period:

- Preparation of national guidelines for nutrition in preschool institutions and primary schools.
- Development of Guidelines for reducing advertisement to children of food that is rich in calories, saturated fat, trans fats, sugars and salt.

According to the action plan on nutrition, in 2017 a national survey of nutritional habits of infants and young children will be prepared. The results will serve as starting point for a National Action plan on childhood obesity. Furthermore, it is expected that the results of 4th COSI round in Montenegro will increase awareness among decision makers, like the Ministry of Health, the Ministry of Education and other relevant stakeholders.

The Institute of Public Health of Montenegro through its work in the field of counselling for nutrition, specific projects for childhood obesity and their work on health education, is the main institute working on the prevention of childhood obesity.

The EU Action Plan on Childhood Obesity 2014-2020 is considered to be the main document that a national strategy for ending childhood obesity will lean on.

Prevalence of overweight including obesity (%) (HBSC)

For Montenegro, no data on the prevalence of overweight including obesity is available from HBSC.

[36] The representative for Montenegro filled out the answers on the interview on paper. Therefore answers well less extensive than for other countries. This may have affected interpretation.

Overview of policies / activities according to the various areas of action of the EU Action Plan in Montenegro

- **AREA 1: Support a healthy start in life**
- Guidance before and during pregnancy
- Promote and protect breastfeeding
- Guidance on complementary feeding
- **AREA 2: Promote healthier environments**
- Improving the school environment
- Policies on vending machines
- Policies on energy drinks
- Mandatory nutrition education
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- Food reformulation: salt
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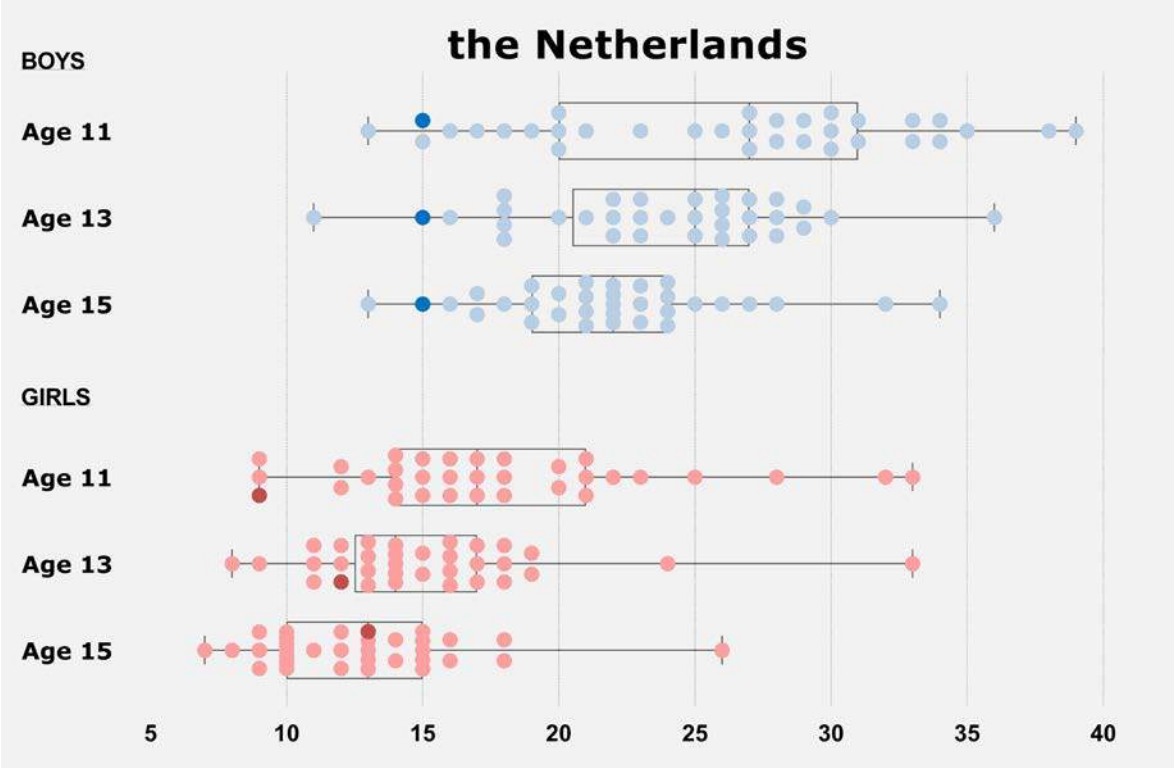
A5.22. The Netherlands (NL)

Based on the interview conducted with the Dutch Competent Authorities we learned that the Netherlands do not have national plans for the prevention of childhood obesity with specific aims and targets. Since before 1980, the Netherlands has the target to change the increasing prevalence of overweight and obesity among children into a decreasing trend. The policy and strategy on childhood obesity is stable and existing programmes are already going on for some years. Nutrition, physical activity and other relevant priority topics, such as sleep are addressed with an integral approach at the local level. An integral approach at the local level is important as it seems the most effective approach to solve the complex problem of (childhood) obesity. The approach includes several national community based interventions implemented at the local level at a voluntary basis. In these interventions, several areas, such as nutrition (e.g. healthy schools and healthy school canteens), physical activity, child/day care are integrated. These programmes are financed by the Ministry of Health, Welfare and Sport and where relevant other ministries (e.g. Healthy School programme is co-financed by the ministry of Education, Culture and Science). JOGG is the Dutch acronym for Jongeren Op Gezond Gewicht (Young People at Healthy Weight) and is part of the international EPODE-network. It is a programme that aims to create an environment that reinforces healthy lifestyle choices of children and teenagers. Most of the municipalities participating in JOGG (around 30% of all municipalities in August 2017) are municipalities with health inequalities. “Gezond in” is a special programme for municipalities to reduce health inequalities. Furthermore, there are more smaller or local programmes addressing health inequalities.

Dutch Government finances several institutes that address or coordinate activities, relevant for the prevention of childhood obesity. The Health Council of the Netherlands is an independent scientific advisory body for government and parliament. Among other things, they develop nutrition guideline (updated version issued November 2015) and norms for physical activity and sedentary behaviour. The Netherlands Nutrition Centre develops practical guidelines on nutrition (based on the formal guidelines) and provides consumers with scientifically sound, independent information on healthy, safe and sustainable food choices. The Netherlands Youth Institute is the Dutch national institute for compiling, verifying and disseminating knowledge on children and youth matters.

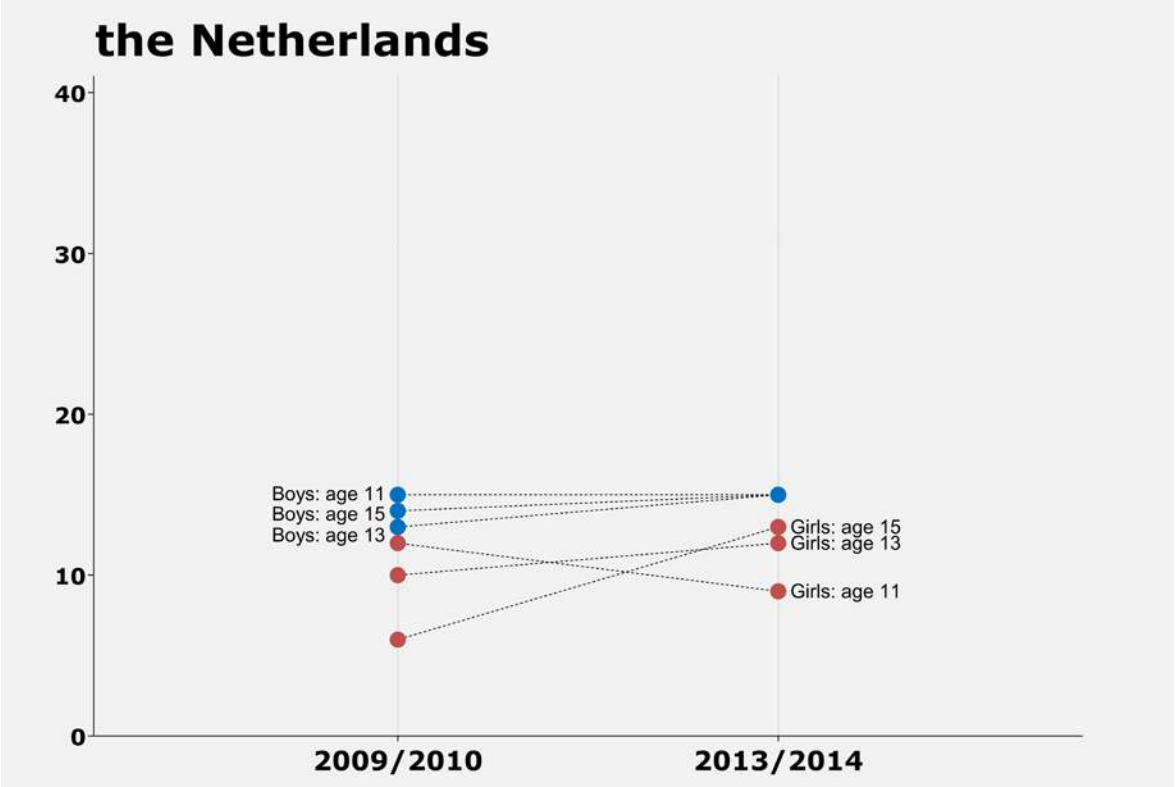
The Netherlands did not support the EU Action Plan on Childhood Obesity 2014-2020. Although it fully agrees with the need for action on childhood obesity and the implementation areas, it considers most of the actions lacking cross-border elements and having a dominant national character, thus falling under national responsibility. Therefore the Netherlands regards the Action Plan as not being sufficiently in line with subsidiarity requirements in order to legitimize an Action Plan coordinated by the European Commission.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in the Netherlands. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in the Netherlands

1 Voluntary agreement with or from industry

2 Healthy choices logo will disappear in 2018

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.23. Norway (NO)

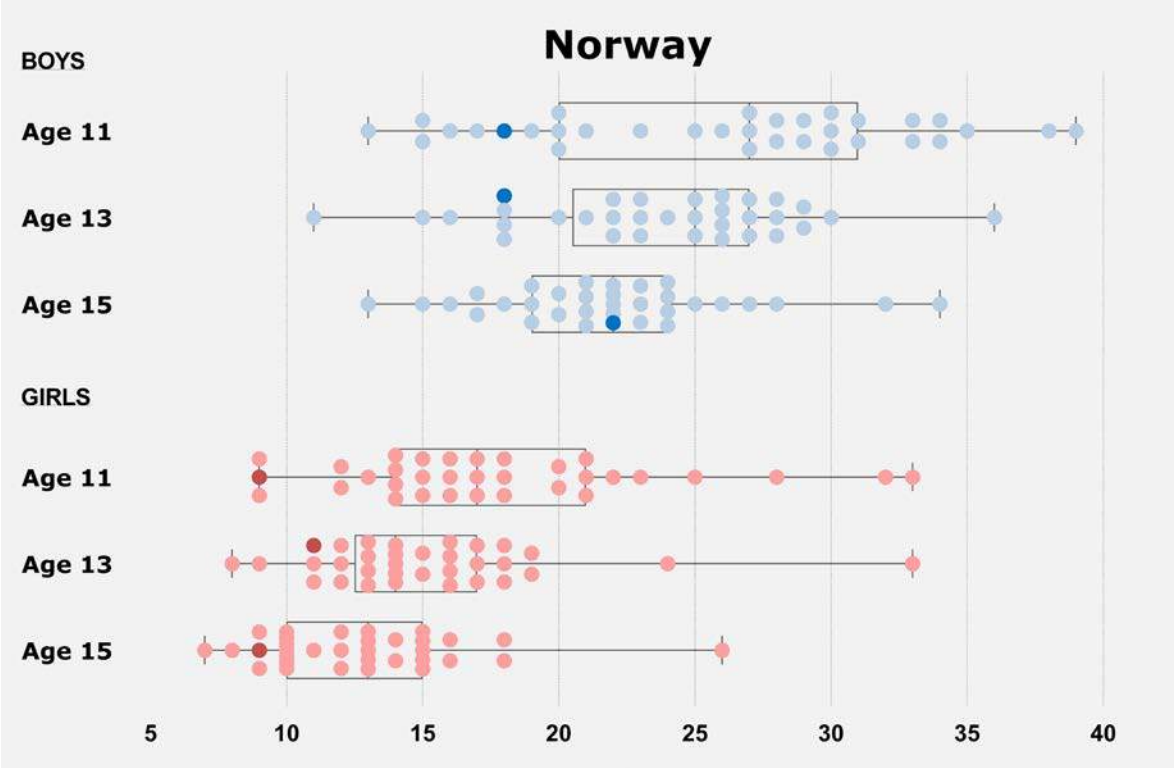
From the interview with the Norwegian Competent Authorities we learned that Norway has a national strategy on non-communicable diseases that runs from 2013 to 2017. One of the goals of this strategy is to stop the increase in the prevalence of obesity. The national strategy consists of two parts. The first part concerns health promoting strategies on nutrition, physical activity, tobacco and alcohol. The second part focuses on the health care system. Topics are early intervention and (secondary) prevention and the use of lifestyle in treatment and rehabilitation of patients with non-communicable diseases. Defined goals have been set for example on strengthening the quality assurance of food, meals and nutrition in the health service. In addition goals targeting the general public include amongst others, an increased proportion of the population that knows and follows the national dietary guidelines, and increased proportion of breastfed infants, maintain the high level of awareness of the Keyhole label, reduce the salt consumption, and help children and young people establish healthy eating habits. The Norwegian Ministry of Health and Care Services has proposed the possibility for a new strategy on non-communicable diseases in 2018.

The Norwegian authorities consider it important to have a healthy lifestyle from the beginning of life, as it influences children's health and their behaviours later in life. Therefore education and providing information on healthy nutrition and physical activity during pregnancy and childhood are priorities. For a long time Norway has been working on the promotion of breastfeeding, which is recognized to be important in the prevention of overweight. In addition, 'consultation clinics' (i.e. health centres where the mother and children go during pregnancy and a few years after children are born) provide much information to (future) parents on nutrition and physical activity. Every child is going to these 'consultation clinics' and a great proportion of 1-5 year old children is going to kindergartens and (pre-)schools (91% in 2016). By focussing on these settings Norway reaches all children, which is considered to be important for reducing health inequalities.

The Norwegian government launched a national action plan on nutrition in March 2017, which will be in place until 2020/2021. It has a special focus on children and will include different actions on the promotion of healthy nutrition in (pre)schools, such as implementation of nutrition guidelines and revising the nutrition guidelines in kindergartens. Furthermore, the Norwegian government has developed a national action plan on outdoor recreation, which is a follow up of a white paper published on this topic in 2016. Physical activity promotion for children will probably part of it and at the moment a political majority wants at least 1 hour of physical activity every day for students in the 1st to 10th grade.

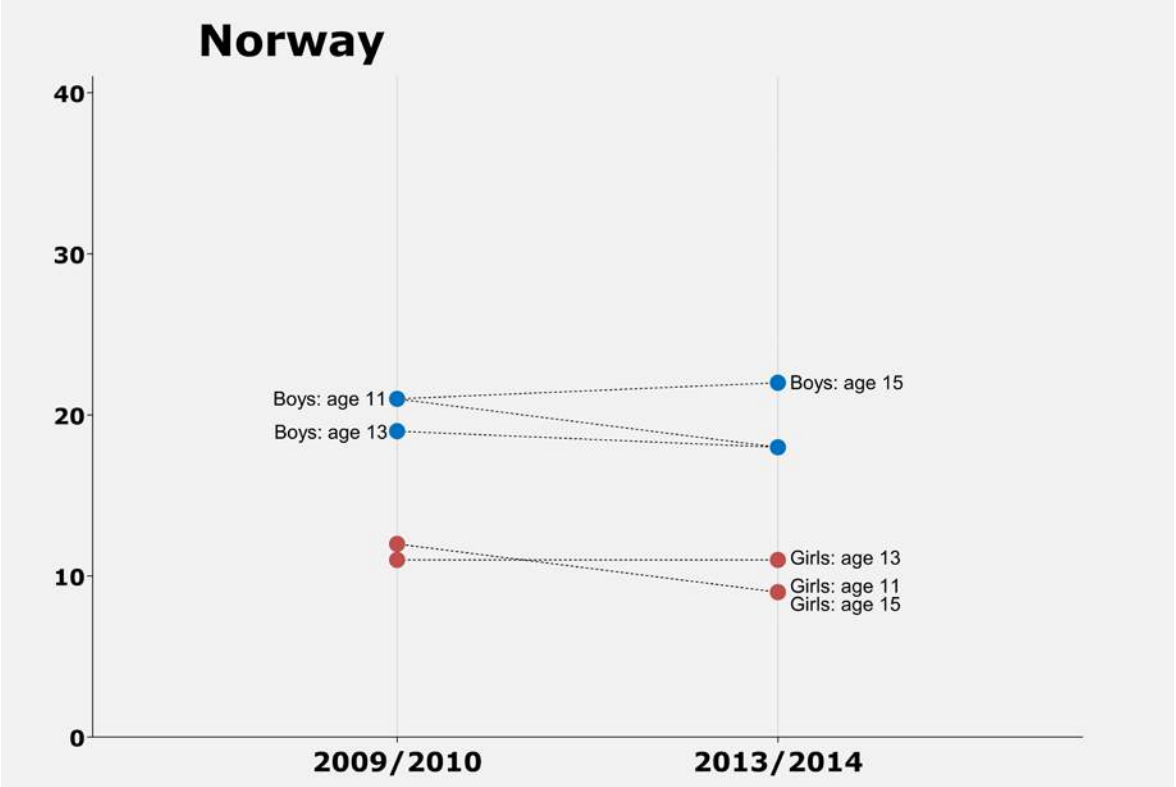
The Norwegian National Centre for Food, Health and Physical activity, established in 2013, helps kindergartens, schools, public health centre services, Universities and University Colleges to implement and execute national health (and education) policy. It has a nationwide function and is responsible for development and dissemination of knowledge, experienced based support and guidance material. Furthermore it shows how nutrition and physical activity can be naturally integrated across disciplines and it contributes to networks and cooperation across disciplines and education.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Norway. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Norway

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
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A5.24. Poland (PL)

Based on the interview conducted with the Polish Competent Authorities we learned that Poland does not have a national action plan on childhood obesity. Physical activity promotion, nutrition and nutritional status are integrated in two governmental priority documents, i.e. the 'Act on Public Health' from September 11, 2015 and the 'regulation of the Council of Ministers from August 4, 2016 on the National Health Programme for the period 2016-2020'. The National Health Programme describes the following operating tasks on the improvement of nutrition and physical activity.

1) promotion of proper nutrition and physical activity especially in schools and preschool institutions,
2) improvement of the availability of advice on nutrition and dietetic given to pregnant women and parents of children from 0-5 by health professionals,
3) programmes aimed at the reduction of body mass among people with overweight and obesity and
4) epidemiologic studies on the prevalence of overweight and obesity in Poland as well as financial support for such projects.

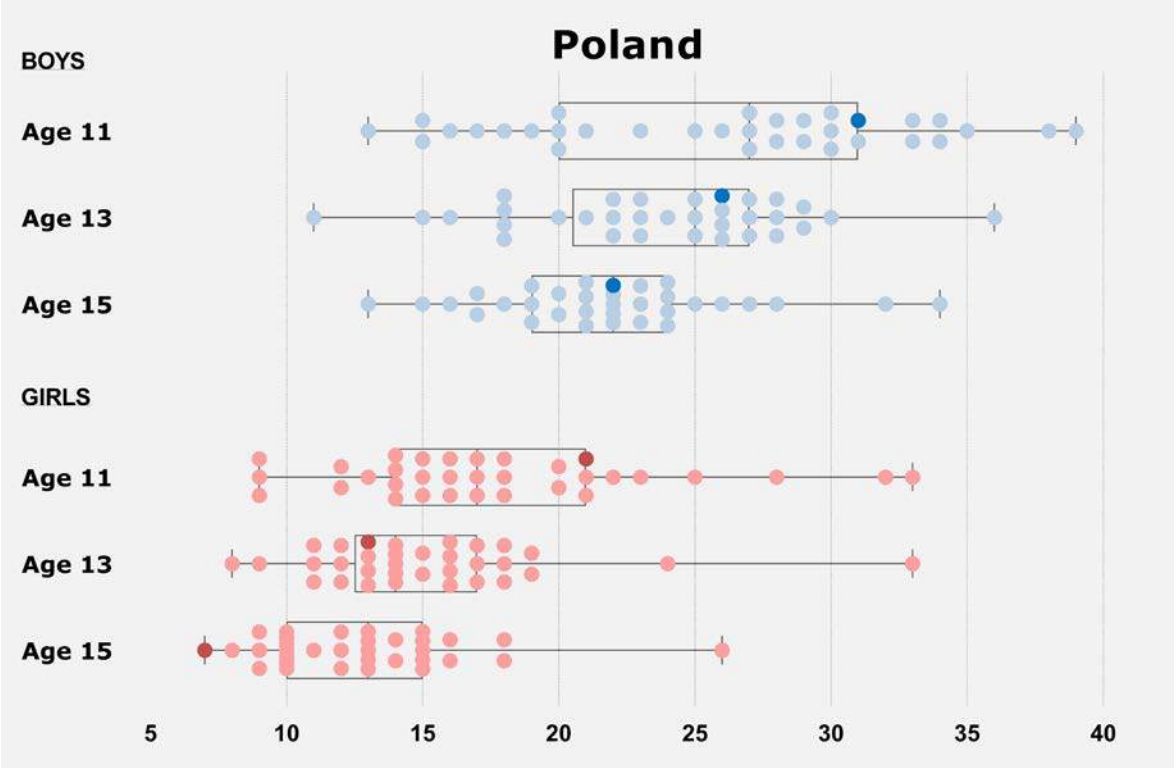
These tasks are directed at the general population, but there are smaller tasks for children as well. Health inequalities are not directly addressed but the National Health Programme supports smaller and more deprived areas in the country with its plans. Related to the first task is the "Regulation of the Minister of Health on groups of foods intended for sale to children and adolescents in units of the education system" of 26 July 2016. This regulation introduced nutritional standards for schools and includes a positive list of groups of products that can be sold in school shops and vending machines in schools. In addition, foods used in school canteens must meet the relevant requirements for a given age group, resulting from current nutrition standards for the Polish population.

The Ministry of Health is responsible for realisation of the National Health Programme, and several institutions are designated to realise particular tasks, among them the Institute on Food and Nutrition. In collaboration with the Ministry of Health, this institute carried out the project "School/Pre-school friendly to nutrition and physical activity" under the SwissPolish Cooperation Program (KIK / 34) that ran from 2011 to 2016. It was a certification programme for the activities of schools and kindergartens to improve nutrition and increase physical activity among children. Institutions that successfully implemented the program in accordance with the developed criteria received the certificate. This 2-year program covered 1,600 branches from various educational levels (pre-, primary, middle and high schools) throughout Poland. Schools participating in the certification project achieved beneficial changes in the nutritional behaviour of children and adolescents. Currently, the project is not continued. There is, however, still a need for a unified nationwide program with proven effectiveness to improve the eating habits and physical activity of pupils in all schools. Planned and systematic activities in schools should motivate the entire school environment (directors, teachers, students and their parents) to undertake joint activities in the area of proper nutrition and increasing physical activity.

The National Centre for Nutritional Education (NCEŻ), established in 2017, provides education to parents and teachers. Through a web portal, everyone interested in improving their health and quality of life has access to the latest research results and a number of educational articles and video materials. Several specially created applications for mobile phones and tablets can also be found in the portal, including "Healthy Nutrition Assistant", "Healthy Mama", and "Zdrowice" a game about health for children and adolescents". These applications help to implement the principles of a healthy lifestyle based on proper nutrition and physical activity.

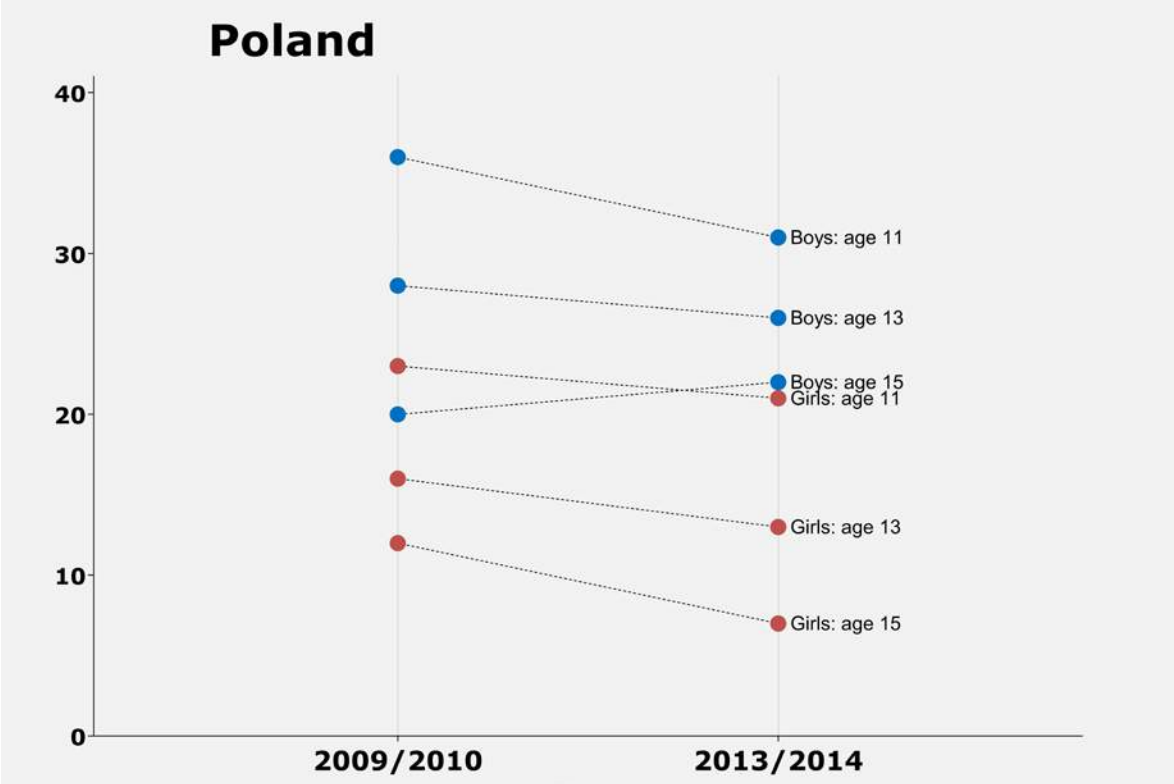
Probably, the EU Action Plan on Childhood Obesity 2014-2020 did not directly stimulate development or implementation of policies yet. For the Polish government the actions/policies are implemented in the National Health Programme and in the Act on Public Health.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Poland. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Poland

1 Voluntary agreement with/from industry

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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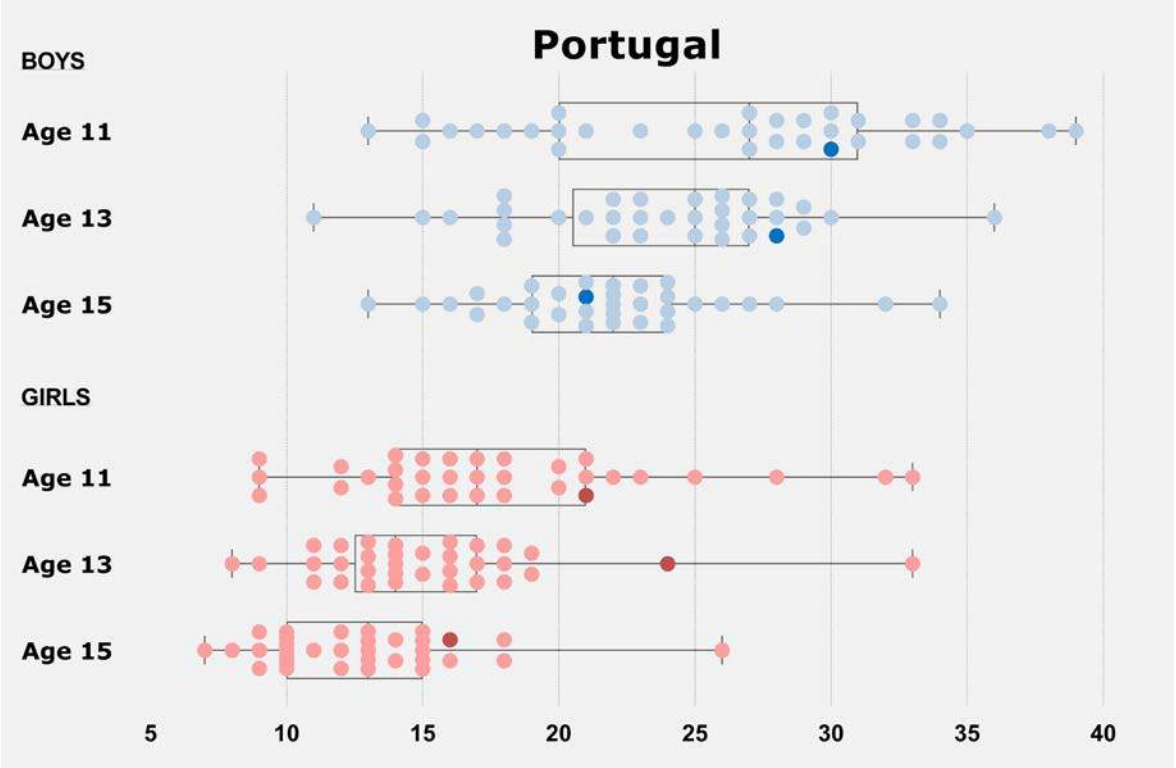
A5.25. Portugal (PT)

Based on the information provided[37] by the Portuguese Competent Authority we learned that Portugal has action plans on physical activity promotion (2016), nutrition (2012) and prevention of non-communicable diseases (2016). Because no high quality data on (childhood) obesity were available before monitoring is considered as one of the priority topics. Promoting Healthy Food in Schools is another, because schools settings are considered an important area for education and intervention. Through public schools regulations also health inequalities can be addressed. Another way to address health inequalities in Portugal is to support deprived families through healthy food baskets in collaboration with the Ministry of Social Security. Taxation on sugar-containing beverages has been implemented in 2017. Also new laws on marketing of foods to children were expected.

The EU Action Plan on Childhood Obesity2014-2020 supports the work of the National Program for the Promotion of Healthy Eating both in rational and implementation ideas from other countries.

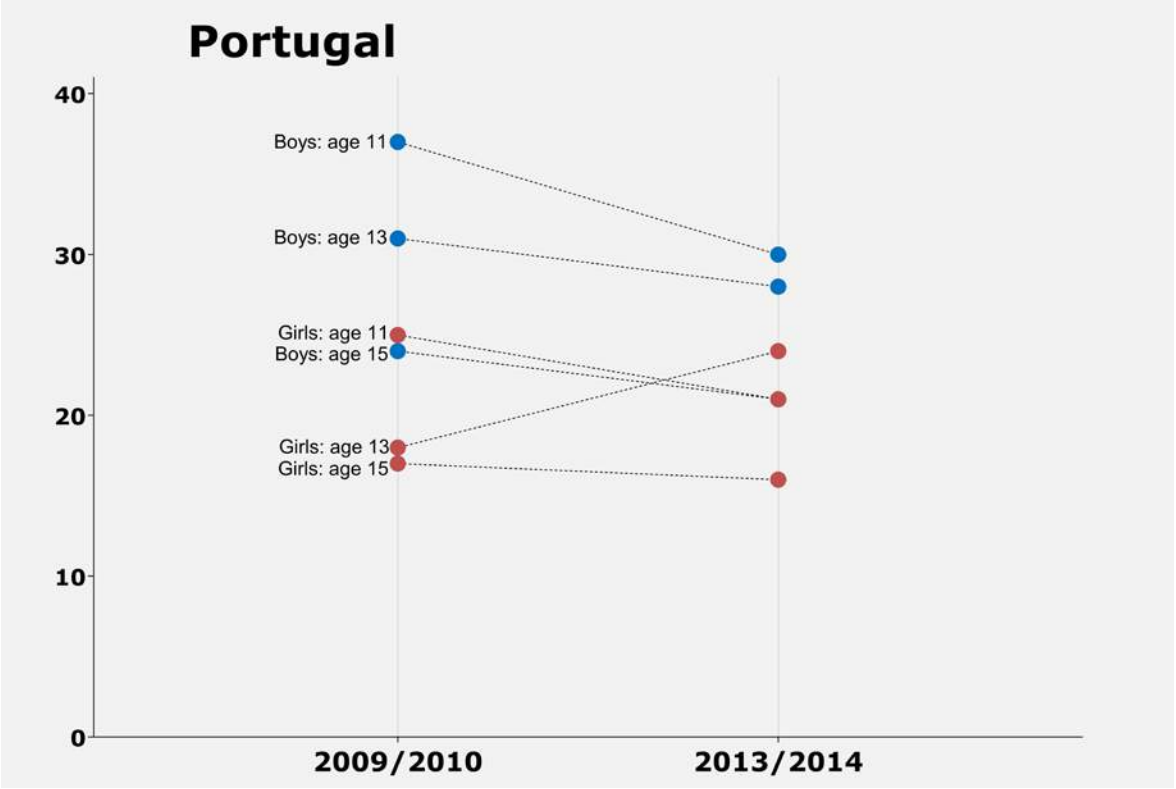
[37] The representative for Portugal filled out the answers on the interview on paper. Therefore answers well less extensive than for other countries. This may have affected interpretation.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Portugal. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Portugal

1 Voluntary agreement with or from industry

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
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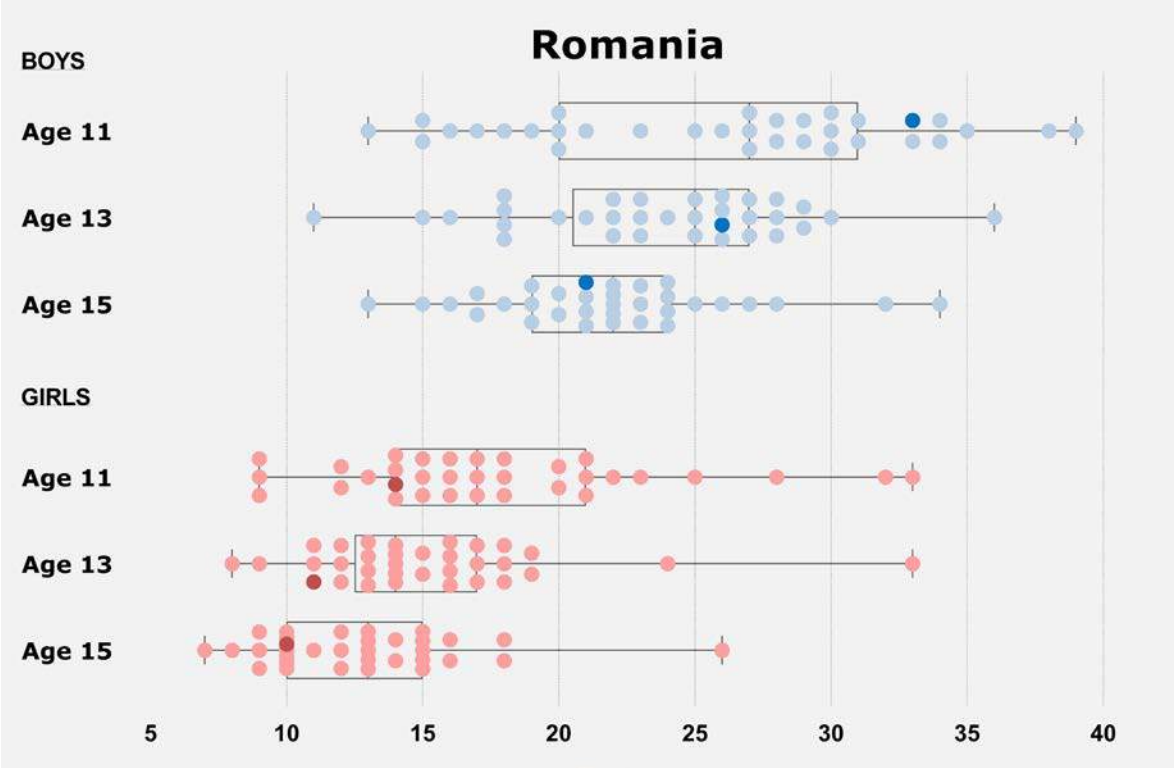
A5.26. Romania (RO)

Based on the interview conducted with the Romanian Competent Authorities we learned that since a long time Romania has an action plan on the prevention of non-communicable diseases that includes specific actions for children below the age of 18 years. Overweight prevention is integrated in this plan. Prevention of childhood obesity in primary health care has priority in Romania. Every child in Romania has a general practitioner as supervisor. They see the child most regular, and will refer the child if necessary. Therefore, prevention in primary care is important. One of the preventive actions for example is that general practitioners measure body mass index and ask some questions on food habits. Based on the results they can advise children and adults how to change their diet and how to lower their weight. The money and time for this is, however, very limited so it is done only in more severe cases of overweight. Additionally, Romania has planned policies to control advertising of unhealthy food for children less than 12 years of age in the media. In 2017, a pilot program started offering free hot meals at schools. If children eat well they probably don't have a need for unhealthy food after school. This pilot program will mostly target poor areas, because there it is more important. It is expected that in poor areas, the program will be more effective because those children see the food as a reason to come to school. The program free food in school is coordinated by a working group, consisting of doctors and people from the Ministry of Education, and Ministry of Health and Ministry of Agriculture.

The Institution of Care for Mother and Child, which is targeting small children until 4, is considered to be a centre of excellence in the field of obesity prevention.

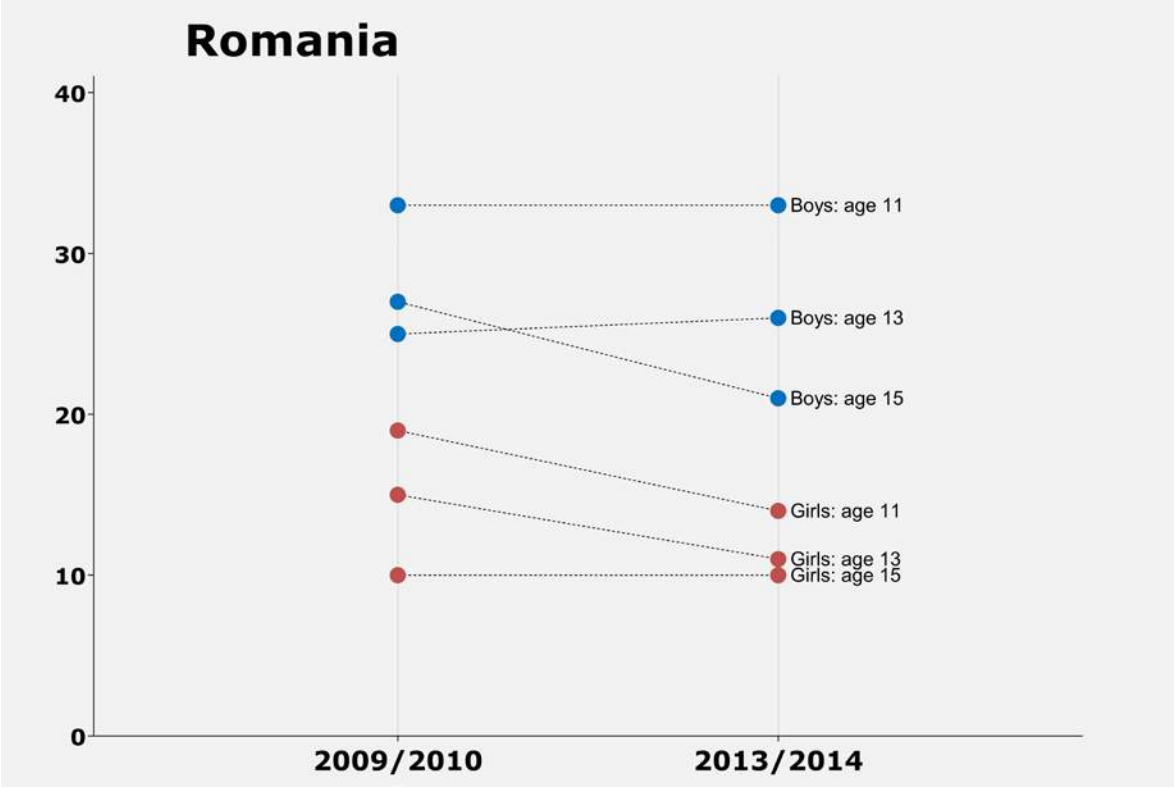
The EU Action Plan on Childhood Obesity 2014-2020 offers Romania a theoretical basis for making national policies. Furthermore, Romania received direct financial aid because of the plan, in the form of subsidies for programmes (e.g. apple in school programme, as part of the EU school fruit and vegetable programme).

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Romenia. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Romania

yes, already before EU Action plan*
partially, for example in certain settings or certain regions*
yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
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A5.27. Serbia (RS)

Based on the information provided[38] by the Serbian Competent Authority we learned that in 2009 the "Strategy on Prevention and Control of Chronic Non-communicable Diseases" was issued. It defines specific objectives and activities aimed at the prevention of obesity and reduction of its incidence in children. Coordination mechanisms for nutrition or physical activity have not been established in Serbia.

Prevalence of overweight including obesity (%) (HBSC)

For Serbia, no data on the prevalence of overweight including obesity is available from HBSC.

[38] The representative for Serbia filled out the answers on the interview on paper. Therefore answers well less extensive than for other countries. This may have affected interpretation.

Overview of policies / activities according to the various areas of action of the EU Action Plan in Serbia

- **AREA 1: Support a healthy start in life**
  - Guidance before and during pregnancy
  - Promote and protect breastfeeding
  - Guidance on complementary feeding
- **AREA 2: Promote healthier environments**
  - Improving the school environment
  - Policies on vending machines
  - Policies on energy drinks
  - Mandatory nutrition education
  - Mandatory physical activity education
- **AREA 3: Healthy option the easy option**
  - Food reformulation: salt
  - Food reformulation: saturated fat
  - Food reformulation: sugar
  - Food reformulation: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food reformulation
  - Easy to understand labelling
  - Taxation
  - Subsidies
- **AREA 4: Restrict marketing & advertising**
  - Marketing of (HFSS) foods to children
  - Nutrient criteria to reduce marketing
- **AREA 5: Inform & empower families**
  - Campaigns on diet & physical activity
  - Support community-based interventions
  - Screening programmes childhood obesity
  - Management services for obese children
- **AREA 6: Encourage physical activity**
  - Physical activity promotion for children
  - National physical activity guidelines
  - Data on weight and height in children
- **AREA 7: Monitoring & surveillance**
  - Diet and nutrition surveys
  - Monitoring of physical activity
  - Participation in COSI

● yes, already before EU Action plan*
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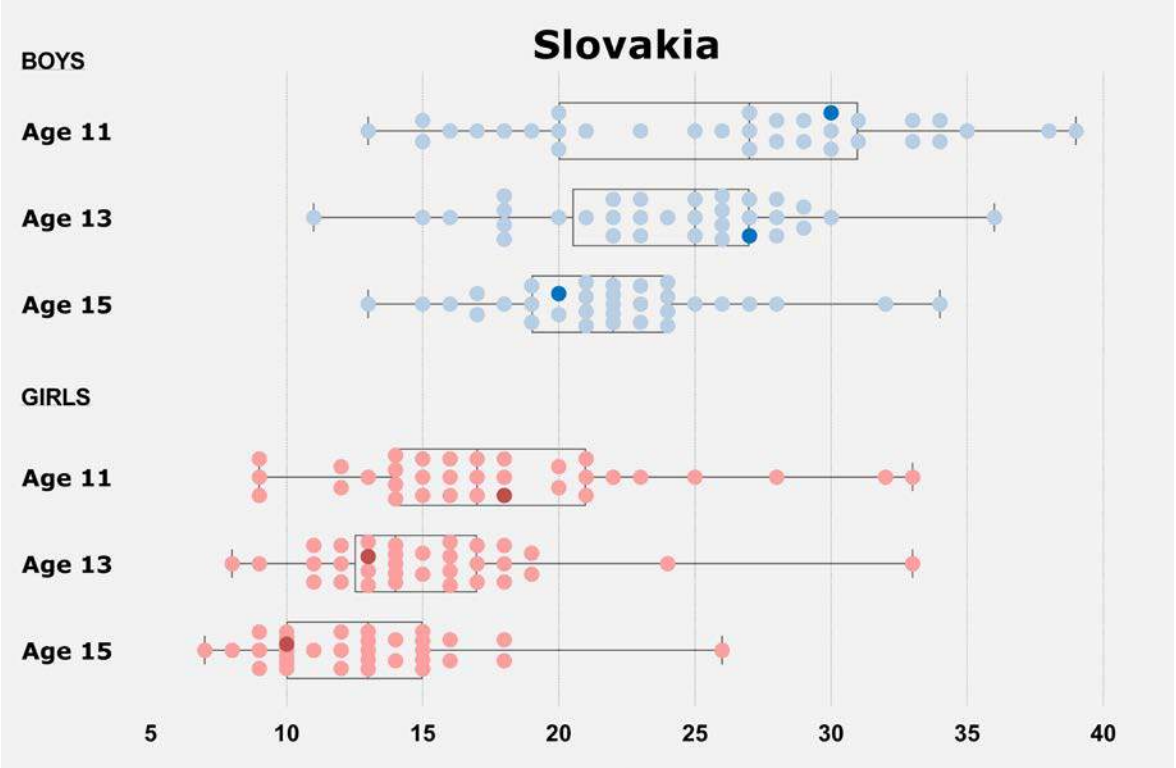
A5.28. Slovakia (SK)

Based on the interview conducted with the Slovakian Competent Authorities we learned that Slovakia has a National Action Plan for Obesity Prevention, running from 2015 to 2025. There is a part on children, describing several activities for children, which cover most areas of action of the EU Action Plan on Childhood Obesity 2014-2020. Furthermore, the National Health Promotion programme and Strategic framework of care for health for the years 2014 – 2030 was adopted in 2013. This programme addresses non-communicable diseases as priority topics. Slovakia is in the process of developing a national action plan for physical activity promotion (2017-2020) and a national action plan for food and nutrition (2017-2025) is in the process of being adopted by Slovakian Government. There is intersectoral cooperation between the Ministry of Health, Ministry of Education, and the Ministry of Social Efforts, to improve the effects of the action plans. The public Health authority of the Slovak Republic has a working group/advisory board that coordinates and makes new proposals on obesity prevention. It also monitors the activities of the action plan on obesity prevention. The working group cooperates with research institutes and universities, but there is room for improvement to make the working group more effective. The Ministry of Education plans to improve personal capacities of this working group.

From a medical point of view, nutrition and physical inactivity are the main risk factors for non-communicable diseases. Therefore, nutrition and physical activity are included in the National Programme on Obesity Prevention as priority topics for the health sector (Ministry of health and health authorities). From the point of view of the education sector, education itself is one of the main determinants of health. Therefore, for the Ministry of Education priority topics include general education for teachers, parents and children about healthy lifestyles and about nutrition. The focus is on informal education, provided during leisure time activities after school in. There is already attention for adding this topic in formal education in the future. Health inequalities are not addressed directly in the action plans or policies. A health promotion programme for vulnerable groups existed in 2009, but has now ended.

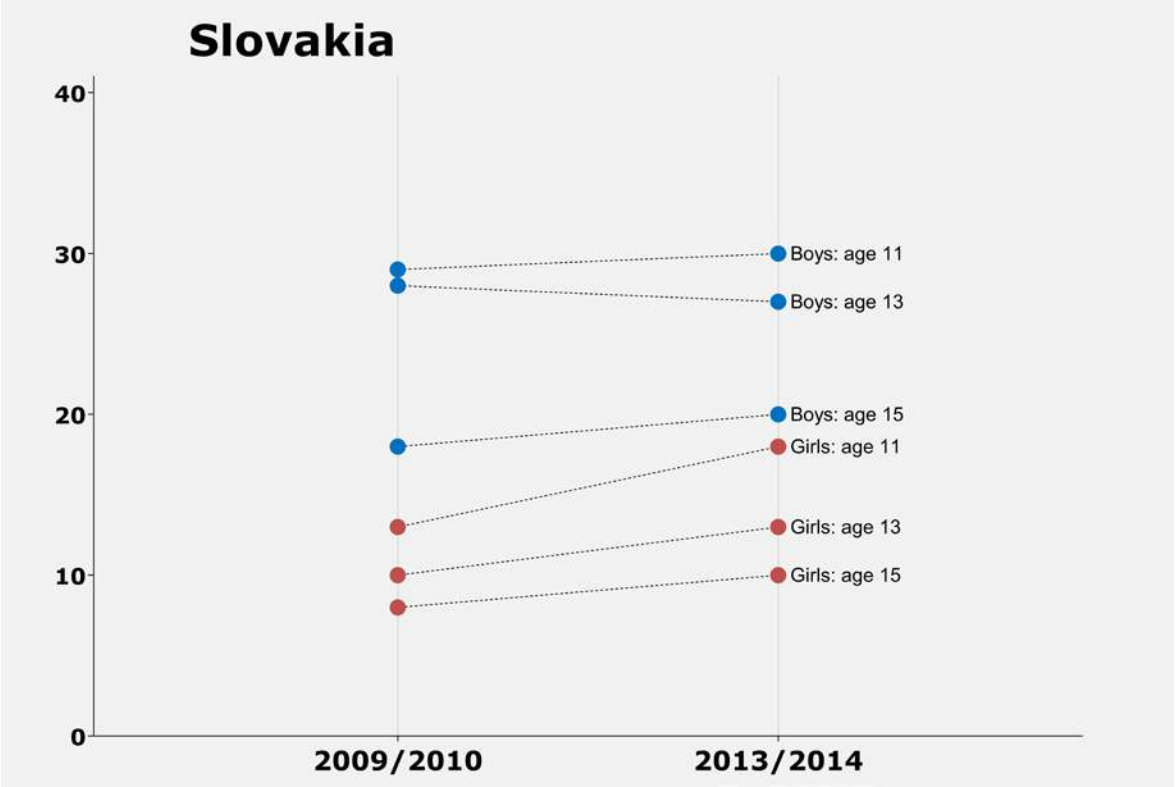
The question how the EU Action Plan on Childhood Obesity 2014-2020 facilitates development or implementation of any of the policies is difficult to answer. It might have some influence, but nobody measures when and how it facilities development or implementation.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Slovakia. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Slovakia

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
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A5.29. Slovenia (SI)

Based on the interview conducted with the Slovenian Competent Authorities we learned that following a government resolution, the "National Programme for Nutrition and Health Enhancing Physical Activity (HEPA) 2015—2025" has been adopted in Slovenia in 2015. The programme aims to address the nutrition and physical activity habits of the Slovenian population from the early years of life to old age, by promoting daily physical activity addressing supportive environments for healthy nutrition and physical activity. The programme defines ten areas of action:

1. Nutrition, in line with guidelines
2. Improvement of the food offer
3. Healthy choices for socially disadvantaged and vulnerable groups
4. Local sustainable food supply and food safety
5. Food labelling and marketing
6. Encouraging health enhancing physical activity in different life periods
7. Creating environments that support physical activity
8. Increase the role of primary health care and hospitals in prevention and health promotion to prevent chronic diseases and obesity
9. Education and research on nutrition and physical activity
10. Provide information and raise awareness about nutrition and physical activity within the general population and subgroups in the population

All actions in Slovenia take health inequalities into account and there are specific actions targeting lower socio economic and vulnerable groups. Area 3 of the programme is about how to provide socially deprived/vulnerable people with healthy foods. For the implementation of specific measures Action plans for 2-3 year periods are prepared, along with monitoring and evaluation. For 2016-2018, Slovenia has adopted one comprehensive implementation action plan on nutrition and physical activity, coordinated by the Ministry of Health. Childhood obesity prevention and promotion of health is part of this implementation action plan.

Slovenia had a comprehensive evaluation of the previous nutrition policy and less extensively for the physical activity policy. Amongst others, the lessons learned from this evaluation were used to set priorities topics and settings. The health system is one of the priority settings. The main priority topics for 2017 and 2018 are:

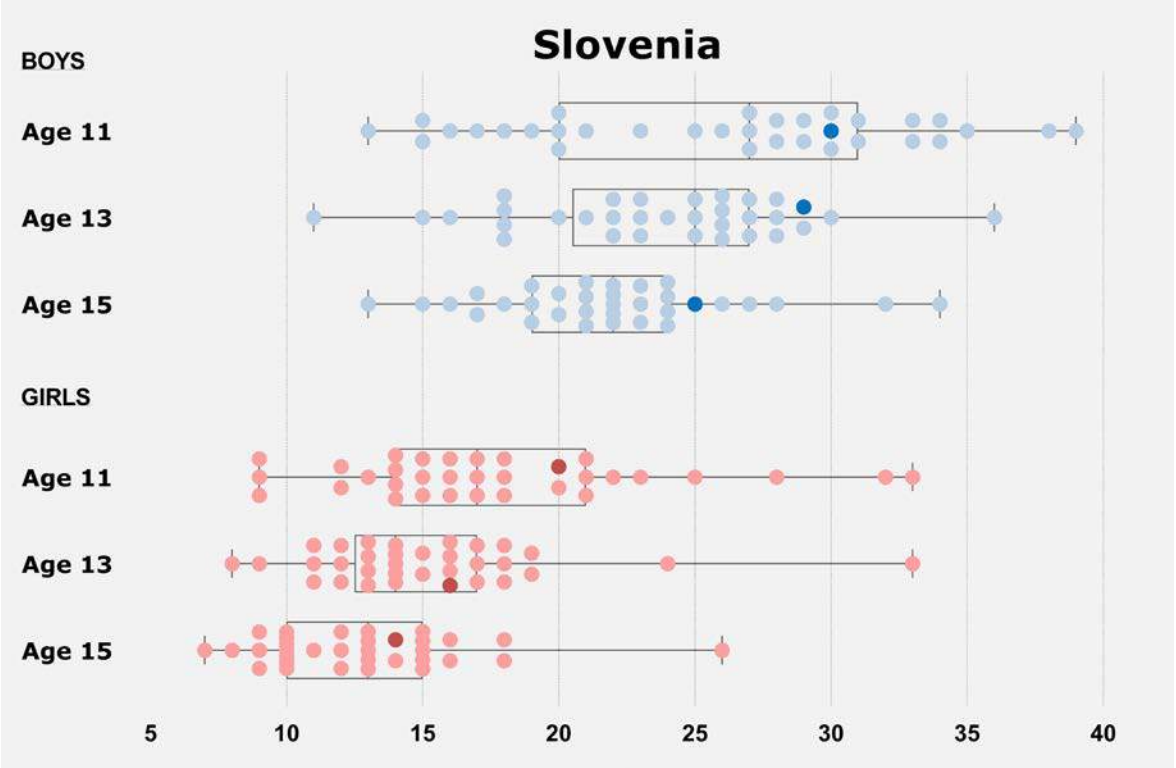
- Nutrition in early childhood, e.g. breastfeeding and complementary feeding.
- Marketing of food to children.
- Physical activity in the school system.
- Implementation of improved and new programmes for the prevention and management of childhood obesity.

In the near future, a more comprehensive approach to food reformulation is planned. A draft report "Healthy choice is the easy choice" (2017-2025) will hopefully be adopted within a few months. It will include legislation on trans fatty acids. Several industries, like dairy and bakery, will probably agree soon on reformulation. Furthermore, Slovenia is planning to update policies for food procurement.

The National Programme is led by the Ministry of Health that is also the main coordinating authority for the implementation action plan 2016-2018. A number of defined inter-sectoral working groups develop the action plans and work on the implementation. Next to this, task groups will be composed and active on specific topics when there is a need for it. Next to ministries (e.g. Ministry of Finance, Ministry of Education, Ministry of Public Administration, Ministry of Social Affairs and Family) also other organisations are involved in the task groups, such as NGOs, consumer organisations, academics, industries and paediatrics clinics.

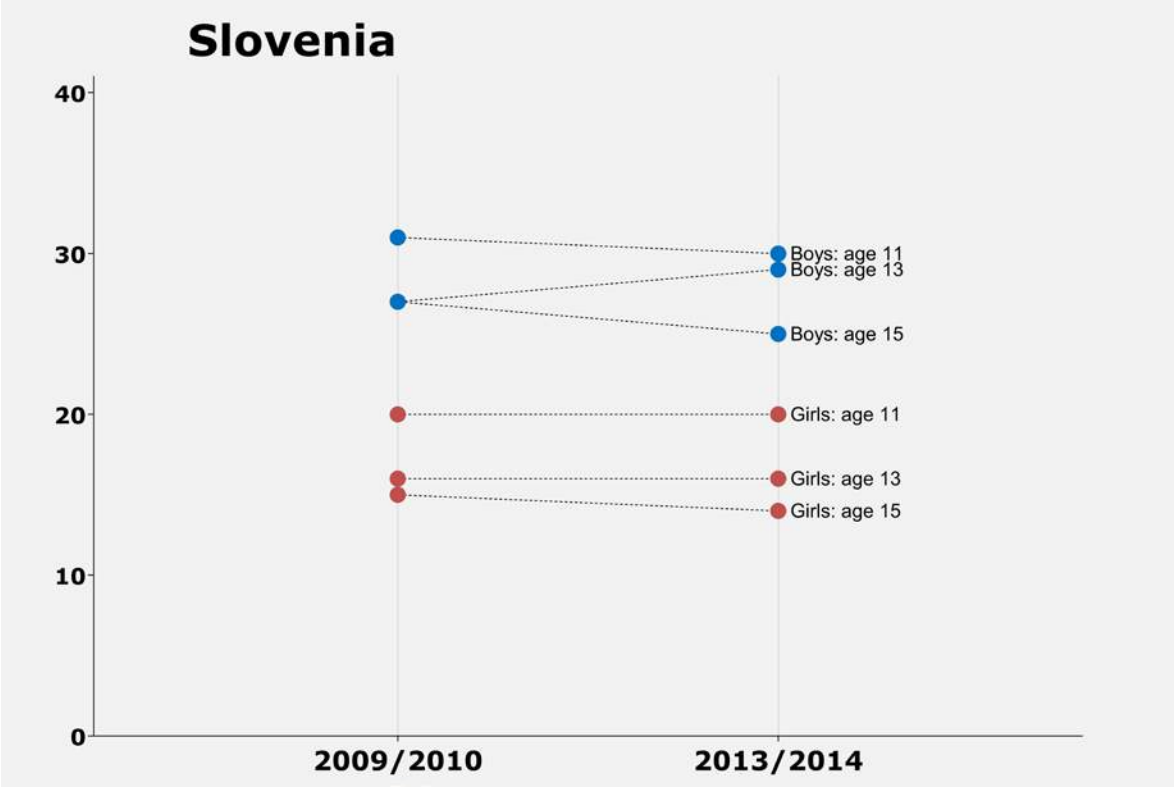
The EU Action Plan on Childhood Obesity 2014-2020 provides support and is definitely encouraging. Slovenia participated actively in the preparation of the action plan, so it is 'hand-in-hand' work together with the input of other countries.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Slovenia. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Slovenia

[1] Has been improved after 2014

yes, already before EU Action plan*
partially, for example in certain settings or certain regions*
yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
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A5.30. Spain (ES)

Based on the interview conducted with the Spanish Competent Authorities we learned that there is no national action plan on childhood obesity in Spain. However, since 2005 the NAOS Strategy (Nutrition, Physical activity, and Prevention of Obesity Strategy) of the Spanish Agency for Consumer Affairs, Food Safety and Nutrition (AECOSAN) focuses on several approaches to promote a healthy diet and improve physical activity in order to prevent obesity. It was launched by the Ministry of Health, Social Services and Equality and further strengthened in 2011 by the Spanish Law 17/2011 on Food Safety and Nutrition. The NAOS strategy takes a holistic and comprehensive approach from different settings (school, family and community, enterprise, health and working environment) coordinating and empowering synergy between different public and private stakeholders.

Prevalence of overweight among 6-9 year old children in Spain is high, although it decreased significantly since 2011 from 26.2% to 23.2%. The prevalence of obesity remained stable, so the prevalence of overweight including obesity has been reduced since 2011 (from 44.5% to 41.3%). These data reinforce the necessity to continue encouraging policies to achieve a further decrease in overweight and obesity and to monitor further trends with information collection. Education and making the choice for healthier options easier are important ways to improve diet and physical activity. Therefore, there are several priority topics in Spain:

- Information and education
- Special promotion in the school environment (Law 17/2011 article 40)
- Reformulation and make easy healthier options
- Involvement in providing information to families
- Promote and empower interventions, initiatives and programmes close to the citizens (in the community, health centre, social environments)
- Co-regulation of food and beverages advertising directed to minors (PAOS code)
- Monitoring of childhood obesity through COSI

Socioeconomic differences and health inequalities are always taken into account when developing strategies. In the framework of The Observatory for Nutrition and Obesity, epidemiological data on nutrition and obesity are collected and analysed by gender and socioeconomic factors. The results are used to improve strategies and prioritize most vulnerable groups. The information is transmitted to regional authorities and to others stakeholders.

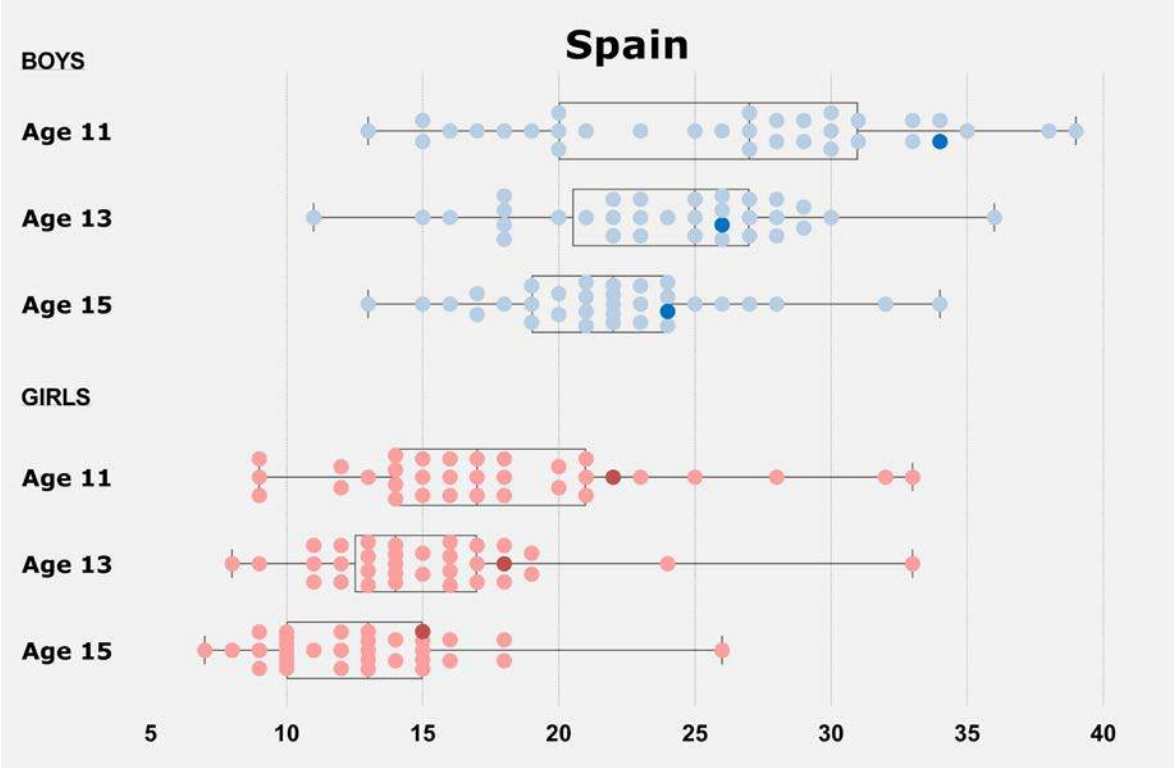
At the end of 2017 the NAOS Strategy launched a campaign to promote healthy eating and habits in the first 1000 days of life. Another campaign to raise citizens' awareness of the sugar content of food will be launched in 2018. NAOS Strategy works together with regional authorities (Health and Education authorities), medical professionals in primary health care and other sectors to look for effective actions, interventions and good practices that can be implemented for the prevention of childhood obesity.

Since 2008, the NAOS Strategy is working jointly with the Regional authorities of Health of the Autonomous Communities through a technical working group, in the areas of responsibility of each Administration. The working group also liaises with national and regional authorities of Agriculture and Education when issues concerning them are addressed. The group develops joint initiatives for which consensus or shared criteria are needed to facilitate better, more uniform implementation or development in Spain. This concerns initiatives on issues addressed in Law 17/2011 on Food Safety and Nutrition, on programmes to promote healthy diets, nutrition and physical activity for the prevention of obesity or on European lines of action, etc. After discussions in the technical working groups, technical conclusions are transferred to others commissions, integrated by General Directors, who take the final decision.

Physical activity promotion is managed by several institutions, i.e. the Ministry of Health, Social Services and Equality (including AECOSAN and another Directorate), the High Council for Sports (CSD), and the corresponding regional authorities (Health, Education and Sports). CSD is the focal point for the HEPA working group (WHO), established in 2015. The working group brings together representatives from various ministries and autonomous communities, and is primarily tasked with aligning the activities of the different government actors, gathering information and analysing data for all issues relating to HEPA.

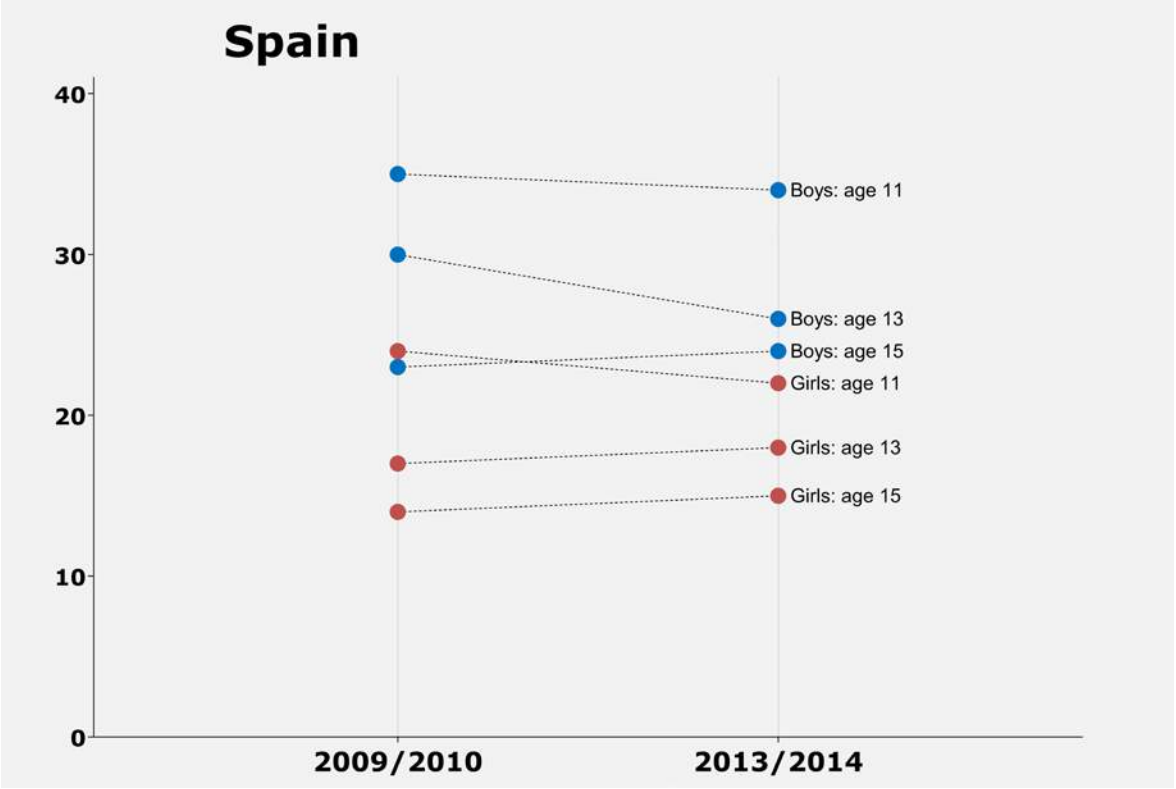
For Spain, the EU Action Plan on Childhood Obesity 2014-2020 is a very useful framework to help implement or strengthen national policies. It also facilitates the adoption of measures if there is an European perspective. Referring to an EU plan facilitates discussions with various stakeholders (e.g. industry). Furthermore, information and best practices can be shared with other countries in a constructive and positive way. An example of such European support and public-private collaboration is the “Collaboration plan for the improvement of food and beverages and other measures (2017-2020).

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Spain. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Spain

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
● no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
● in preparation or planned; adoption may still be contingent on policy process.

* indicates that an action is undertaken, but does not contain an evaluation of effectiveness from our part.

A5.31. Sweden (SE)

Based on the interview conducted with the Swedish Competent Authorities we learned that overweight prevention is addressed through different acts and guidelines. Sweden has an established chain of responsibility, with an overlap between maternal and child health care and school health services. A new Education Act came into force July 1, 2011. As a result of this the school health service, the special student welfare and special education efforts were combined into a comprehensive student health system, Elevhälsan. Student health shall be provided to pupils in pre-, primary, and secondary school. Students are offered health visits that include general health, growth, development and learning. It is mandatory for schools to measurements 4 to 5 times from the age of 6 to 18 years. Also, schools have to provide free lunch to every child in (9-years of) compulsory school, and it has to be 'nutritious' (since 2011). Nutritious lunches for all children are also an important equity issue. The Swedish National Agency for Education is responsible for implementing the Swedish Education Act.

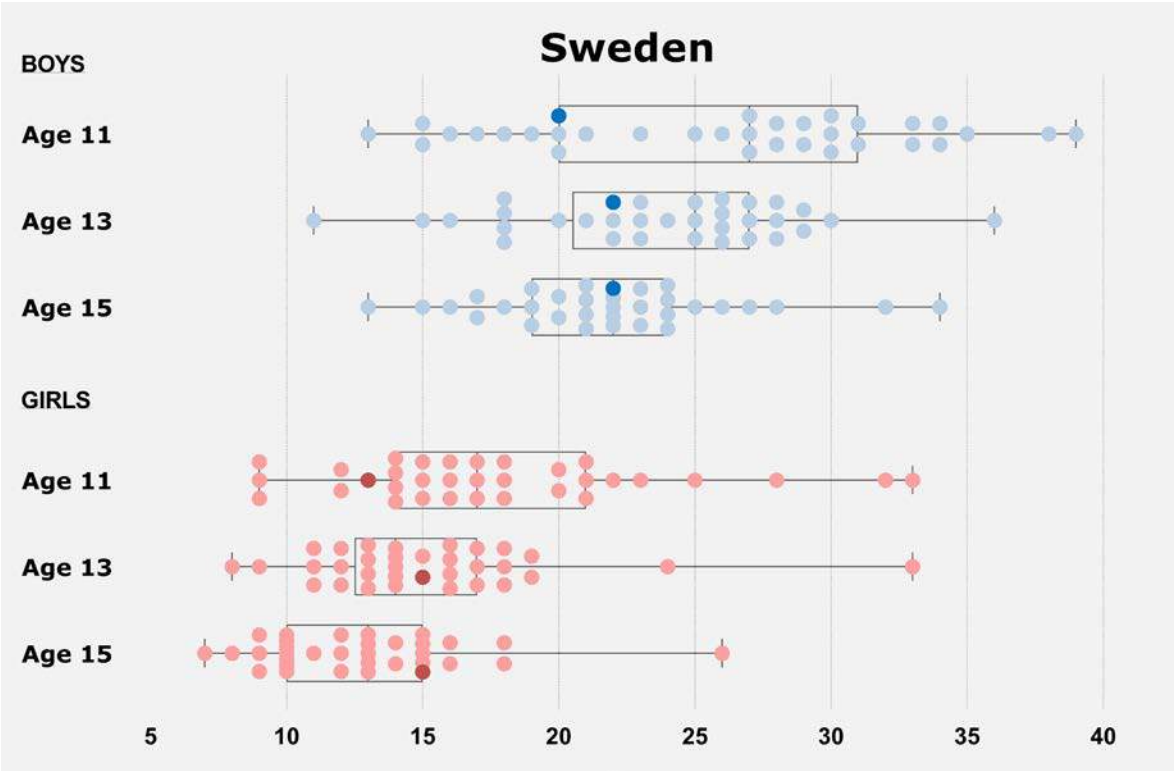
The Public Health Bill of 2002 covers the work of public health in Sweden. The government has an overarching aim, and there are 11 objective domains. Objective 9 concerns promoting physical activity, with a focus on health-promoting living environments, and objective concerns 10 eating habits. The National Board of Health and Welfare has issued national guidelines for health professionals on the steps and actions to take when providing advice in the area of physical activity in order to promote health and reduce risk of disease. These guidelines are being updated (expected in 2018) and will include a younger population. Other policy documents with implications for physical activity include an outdoor recreation policy dealing with public access to natural spaces; “Vision for Sweden 2025” from the National Board of Housing, Building and Planning, addressing issues relating to urban planning, car-free zones and walkability; the Planning and Building Act (2010) that has voluntary guidelines about how outdoor and indoor areas should look like and transport policies affecting opportunities for physical activity and active transport, including children’s travel to school.

Areas where people are at daily basis, like schools, health care and green places, are important health promoting areas. Here you can reach people to prevent or overweight and obesity. Therefore, priorities of the Swedish authorities are early detection, schools, urban planning and sports. Since 2016, the Commission for Equity in Health is to submit proposals that can help to reduce health inequalities in society. In May 2017, the Commission presented their final work on the actions that should be taken at national, regional and local level in order to close the gaps between different groups. These will be general actions but obesity is one area that will be included.

The Public Health Agency of Sweden is the national focal point for the work of health-enhancing physical activity (HEPA) and the work on non-communicable diseases in the WHO European Region. Through this role they coordinate the work between primary national authorities but also national actors.

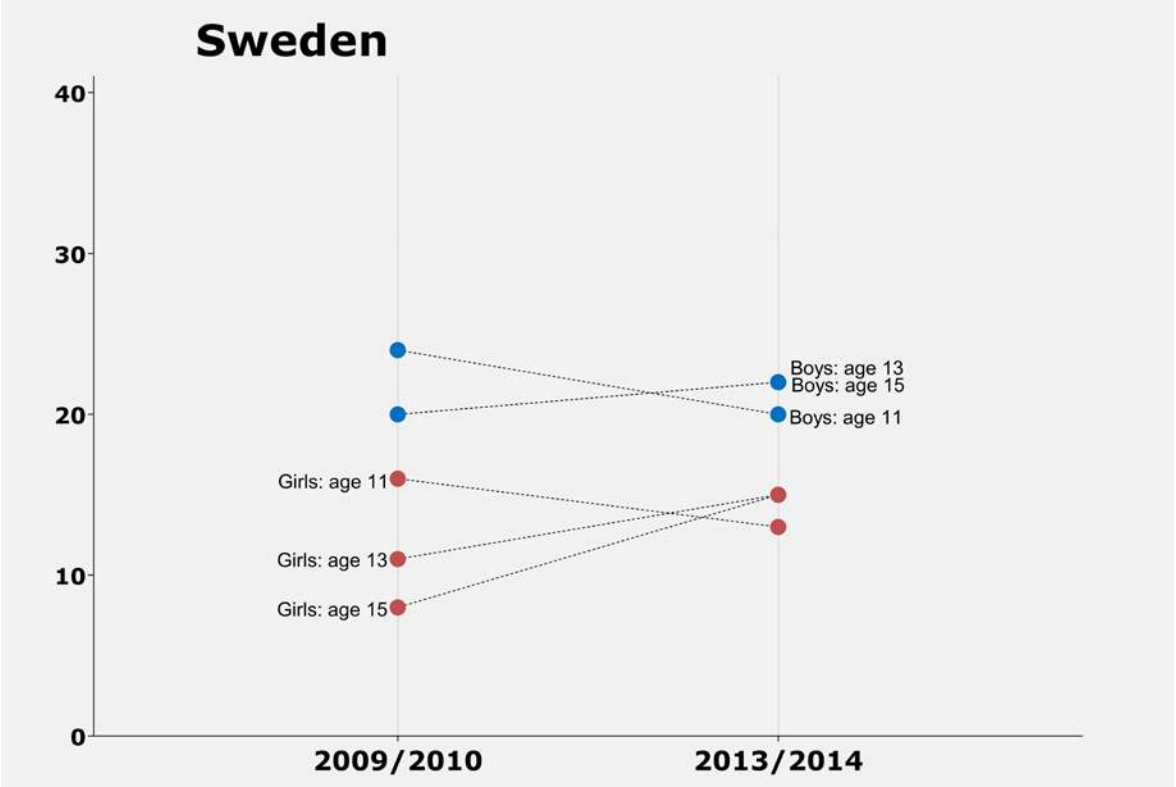
International policy documents, like the EU Action Plan on Childhood Obesity 2014-2020, provide inspiration for national and regional work.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Sweden. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Sweden

- **AREA 1: Support a healthy start in life**
  - Guidance before and during pregnancy
  - Promote and protect breastfeeding
  - Guidance on complementary feeding
- **AREA 2: Promote healthier environments**
  - Improving the school environment
  - Policies on vending machines1
  - Policies on energy drinks
  - Mandatory nutrition education
  - Mandatory physical activity education
- **AREA 3: Healthy option the easy option**
  - Food reformulation: salt[2]
  - Food reformulation: saturated fat[2]
  - Food reformulation: sugar[2]
  - Food reformulation: portion sizes[2]
  - (Virtually) eliminate trans fat[2]
  - Monitoring of food reformulation
  - Easy to understand labelling
  - Taxation
  - Subsidies
- **AREA 4: Restrict marketing & advertising**
  - Marketing of (HFSS) foods to children
  - Nutrient criteria to reduce marketing
- **AREA 5: Inform & empower families**
  - Campaigns on diet & physical activity
  - Support community-based interventions
  - Screening programmes childhood obesity
  - Management services for obese children
- **AREA 6: Encourage physical activity**
  - Physical activity promotion for children
  - National physical activity guidelines
- **AREA 7: Monitoring & surveillance**
  - Data on weight and height in children
  - Diet and nutrition surveys
  - Monitoring of physical activity
  - Participation in COSI

1 No need as it is culturally determined that the few vending machines do not contain unhealthy products

2 Indirectly trough Keyhole logo

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
● no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
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A5.32. Switzerland (CH)

Based on the interview conducted with the Swiss Competent Authorities we learned that Switzerland has adopted a strategy and an Action Plan on non-communicable diseases in 2016. It includes several actions targeted to children in the area of prevention and health promotion, health care and health in businesses. School is an important setting. Implementation started in January 2017. An action plan on nutrition was to be released at the end of 2017. This action plan addresses the general population and several target groups, i.e. mothers, pregnant women, children and elderly. Improvements of the "Swiss Nutrition Policy 2013–2016", reviewed summer 2017, are important input for the action plan. Guidelines on nutrition for infants and toddlers have been published in summer 2017.

An important objective of the strategy on non-communicable diseases 2017 – 2024 and the Swiss nutrition policy 2017-2024 is the improvement of the preventive aspects in the medical setting. Supporting a healthy start in life is another very important area for action for the Swiss national authorities. More specifically, important topics are:

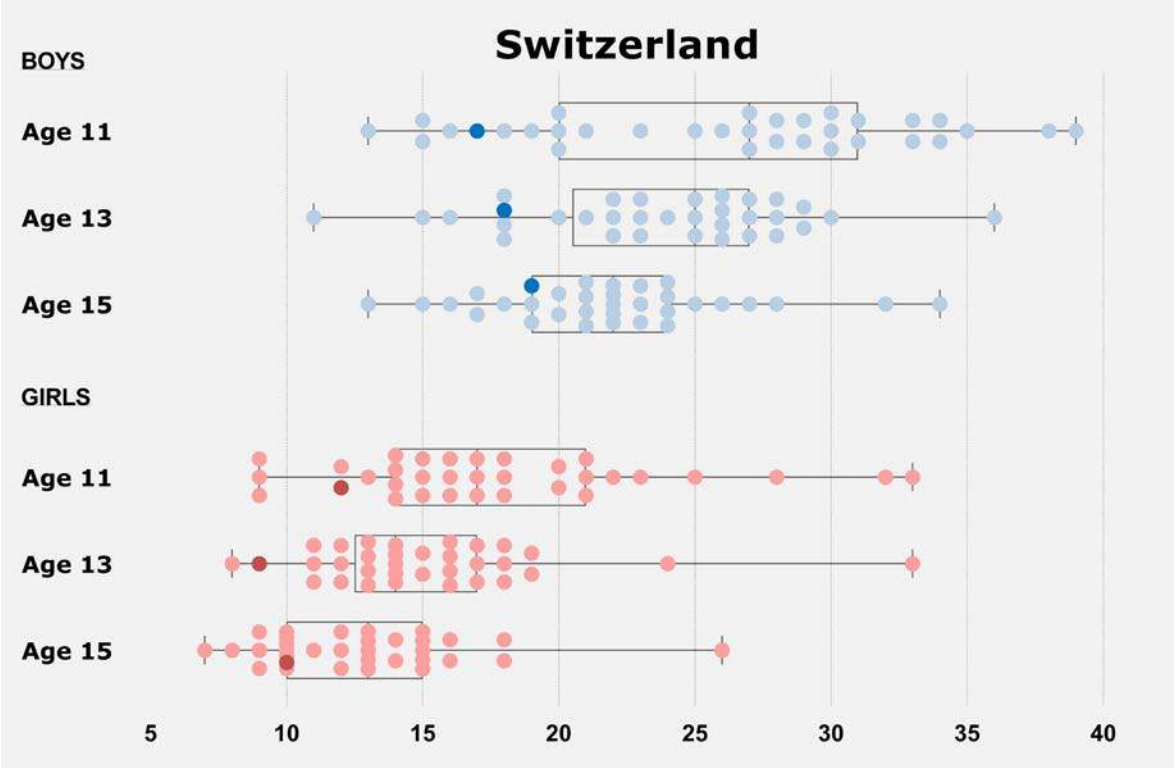
- guidance before, during and immediately after pregnancy
- to support breastfeeding, and guidance on the introduction of complementary feeding;
- voluntary school food policy to improve child nutrition, learn healthy habits, reduce/prevent obesity and non-communicable diseases, tackle healthy inequalities and support local and seasonal fruits and vegetables (since 2012, developed by the Federal Food Safety and Veterinary Office FSVO)
- make the healthy option the easier option
- physical activity guidelines for infants, toddlers and children
- improvement of the therapy for overweight and obese children

These are the priority areas because of the notion that the first 1000 days since conception are important for health. Furthermore, Switzerland puts a lot of effort in working together with several partners, such as health professionals, industry and the Cantons. The latter are important partners in the promotion of health as Switzerland is federally organised. Switzerland wants to strengthen their professional association for obesity in children and adolescents.

Health inequalities are addressed by promoting a healthier environment in schools and pre-schools, by educating parents and by education children already from a young age onwards. Implementation in this field largely lies at the Cantons, but national authorities can facilitate by the development of guidelines, stimulation of the development of healthier foods, restrictions on marketing and planning of safer journeys to schools. The Federal Commission on Nutrition provides the Swiss Government with scientific information, e.g. for the development of such (nutrition) guidelines, and make recommendations to the Federal Food Safety and Veterinary Office (FSVO) and health ministers. Furthermore, there are several platforms on the prevention of non-communicable disease, e.g. on nutrition, physical activity and a task force on public health that covers the topics of nutrition and physical activity promotion. These groups provide the possibility to exchange information, to develop an evidence base and to see which projects work well.

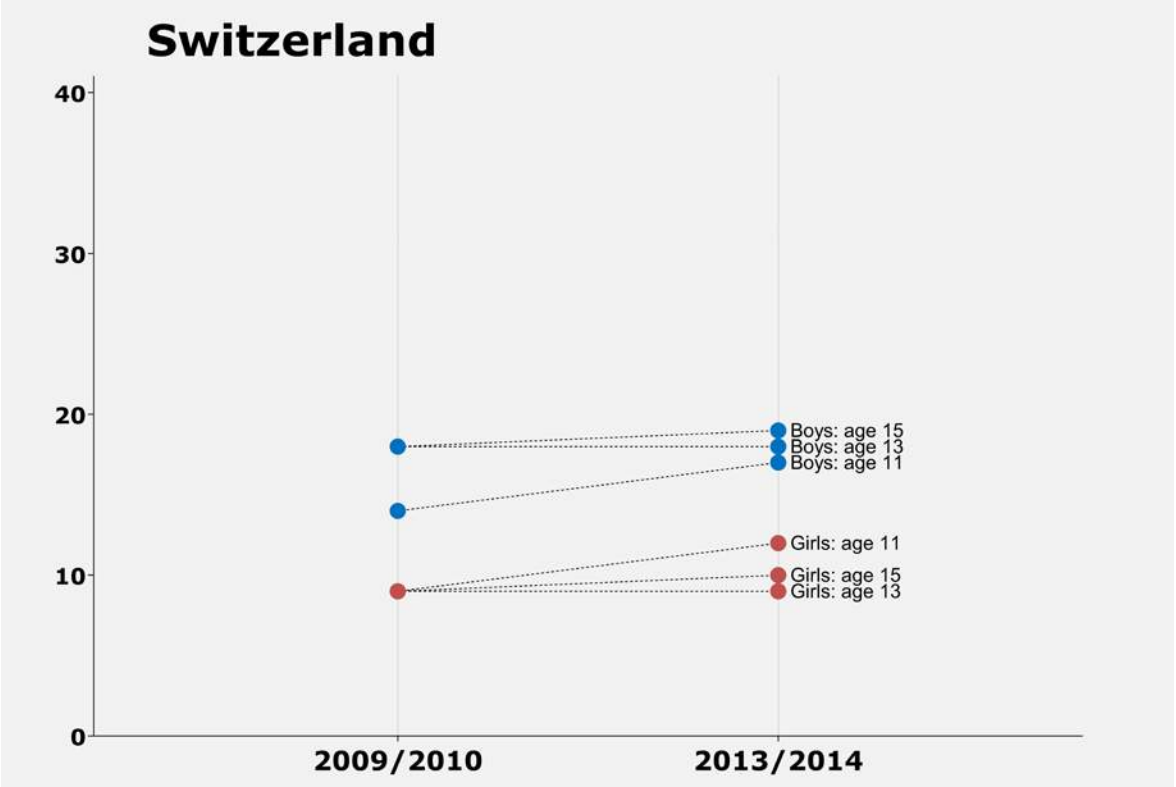
Switzerland cannot officially validate the EU Action Plan on Childhood Obesity 2014-2020, but they do support the Action Plan. The EU action plan was an important basis and facilitated the development of the aforementioned strategies on nutrition and non-communicable diseases.

Prevalence of overweight including obesity (%) (HBSC 2013/2014)



The dark dots represent the prevalence in Switserland. The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in Switzerland

1 Children are not included

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
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A5.33. United Kingdom (UK)

Based on the interview conducted with the British Competent Authorities we learned that the Department of Health published on 18 August 2016 “Childhood obesity: a plan for action”. This is the government’s plan to reduce England’s rate of childhood obesity within the next 10 years by encouraging industry to cut the amount of sugar in food and drinks and primary school children to eat more healthily and stay active. The launch of this plan represents the start of a conversation, rather than the final word, although clear goals and firm actions are described. The plans mentioned in there will be developed in more detail in the future. The UK has chosen those policies that would have the most impact and will be most efficient to implement. These include:

- Introducing a soft drinks industry levy
- Taking out 20% of sugar in products
- Supporting innovation to help businesses to make their products healthier
- Developing a new framework by updating the nutrient profile model
- Making healthy options available in the public sector
- Continuing to provide support with the cost of healthy food for those who need it most
- Helping all children to enjoy an hour of physical activity every day
- Improving the co-ordination of quality sport and physical activity programmes for schools
- Creating a new healthy rating scheme for primary schools
- Making school food healthier
- Clearer food labelling
- Supporting early years settings
- Harnessing the best new technology
- Enabling health professionals to support families

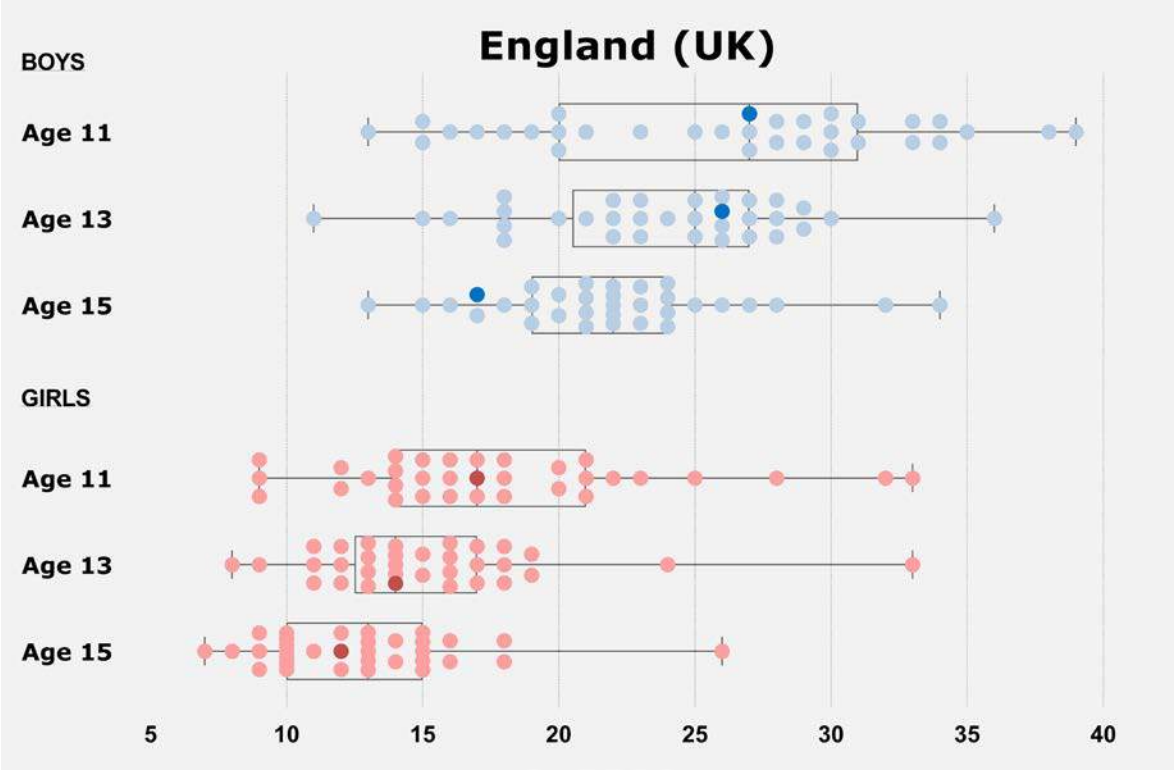
The UK expects that all policies will have some effect on health inequalities, as they will affect lower socioeconomic groups more. As a first major step towards tackling childhood obesity, a soft drinks industry levy will be introduced across the UK. In England, the revenue from the levy will be invested in programmes to reduce obesity and encourage physical activity and balanced diets for school age children.

For the Childhood Obesity Action Plan a cross-governmental steering group has been installed, including representatives from the Department of Health, The Department of Education, and Public Health England, etc. This group cannot issue policy documents but is more a management group that sees that the actions in the Action Plan are being carried out. Furthermore, various working groups address specific technical topics included in the Action Plan.

The National Institute for Health and Care Excellence (NICE) published “National guidance on the prevention of overweight and obesity in adults and children” in England and Wales in 2006 and updated them in 2015. Furthermore, the National Health Services (NHS) are mandated for preventing and treating non-communicable diseases and specific goals are determined. However, how to reach these goals is up to NHS, local authorities and health care providers. NICE issues a lot of guidelines and protocols for GP’s and other health care professionals to support them.

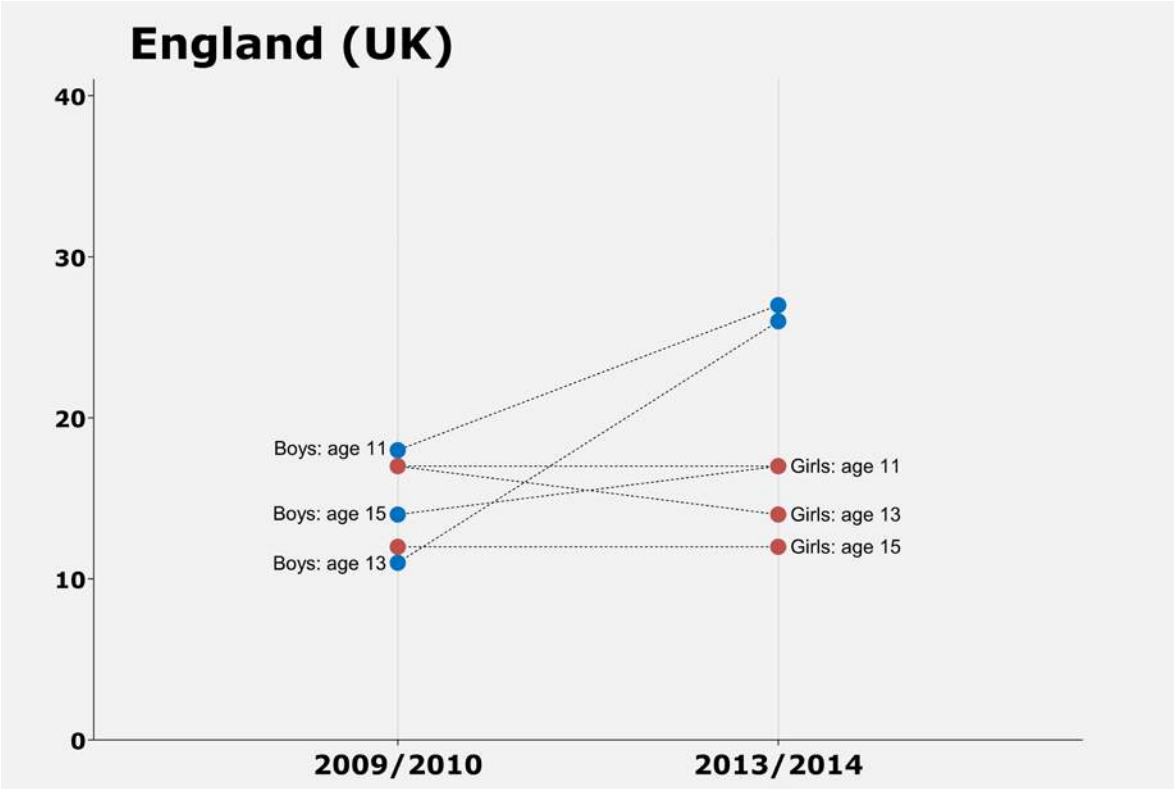
The EU Action Plan on Childhood Obesity 2014-2020 acts as a benchmark and reference for the UK to see whether what they have planned is in line with other countries and to see whether other countries move in the same direction. The EU Action Plan had no direct influence on the development of the National Action Plan.

Prevalence of overweight including obesity (%) in England (UK) (HBSC 2013/2014)

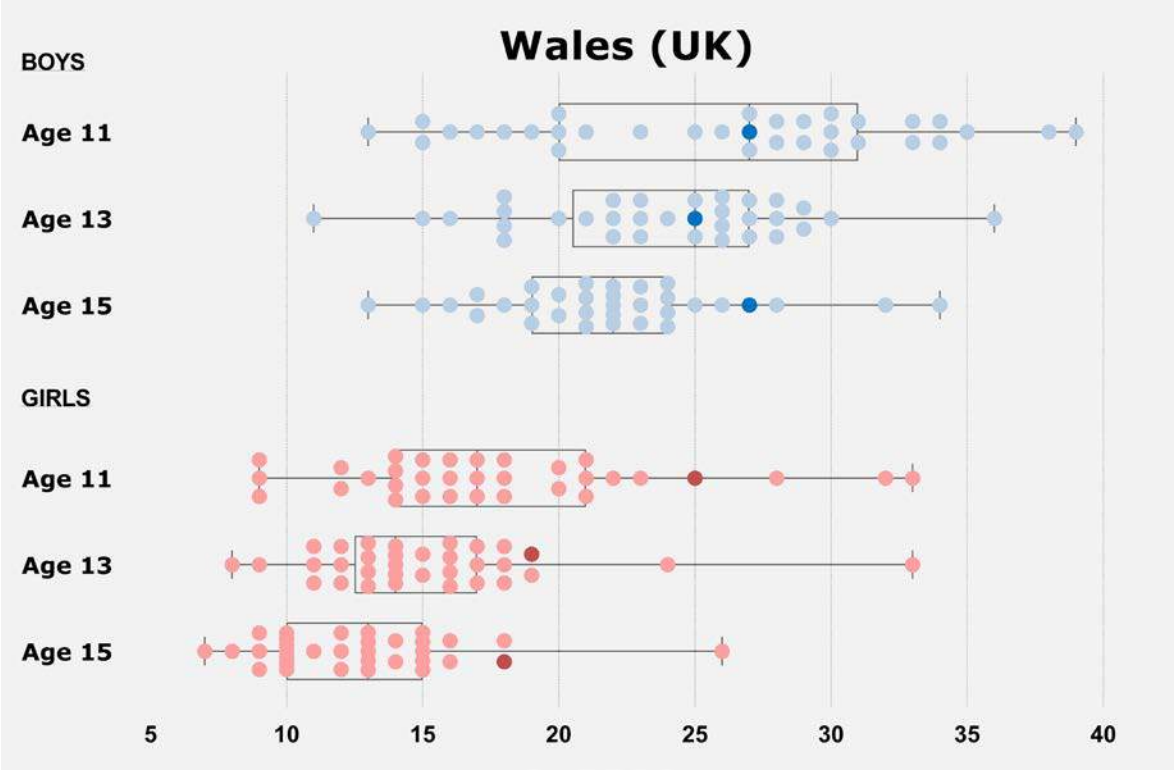


The dark dots represent the prevalence in England (UK). The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014

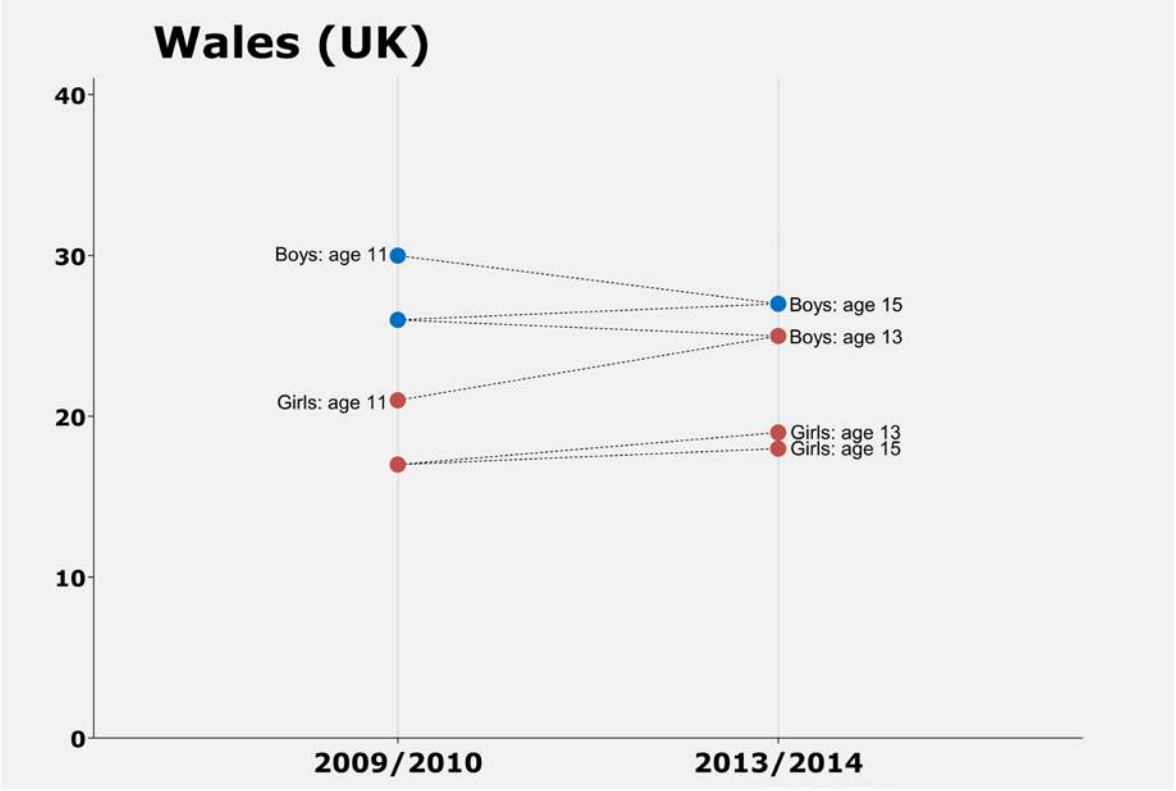


Prevalence of overweight including obesity (%) in Wales (UK) (HBSC 2013/2014)

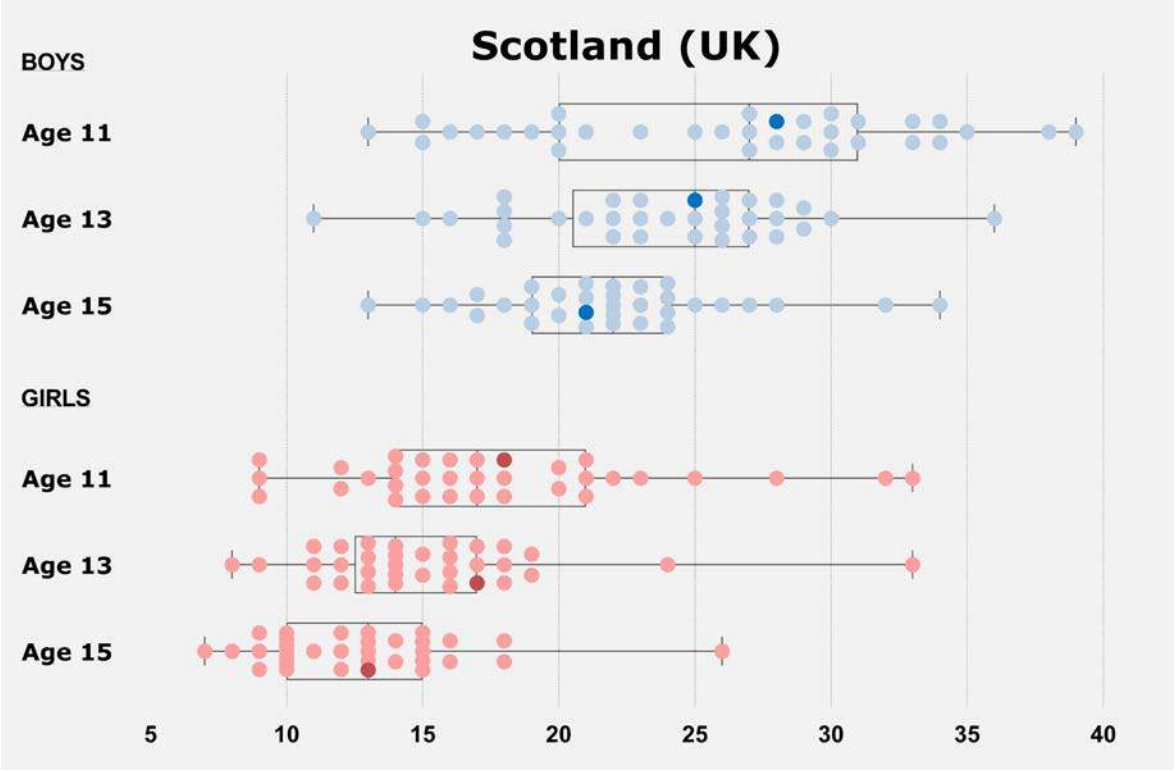


The dark dots represent the prevalence in Wales (UK). The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014

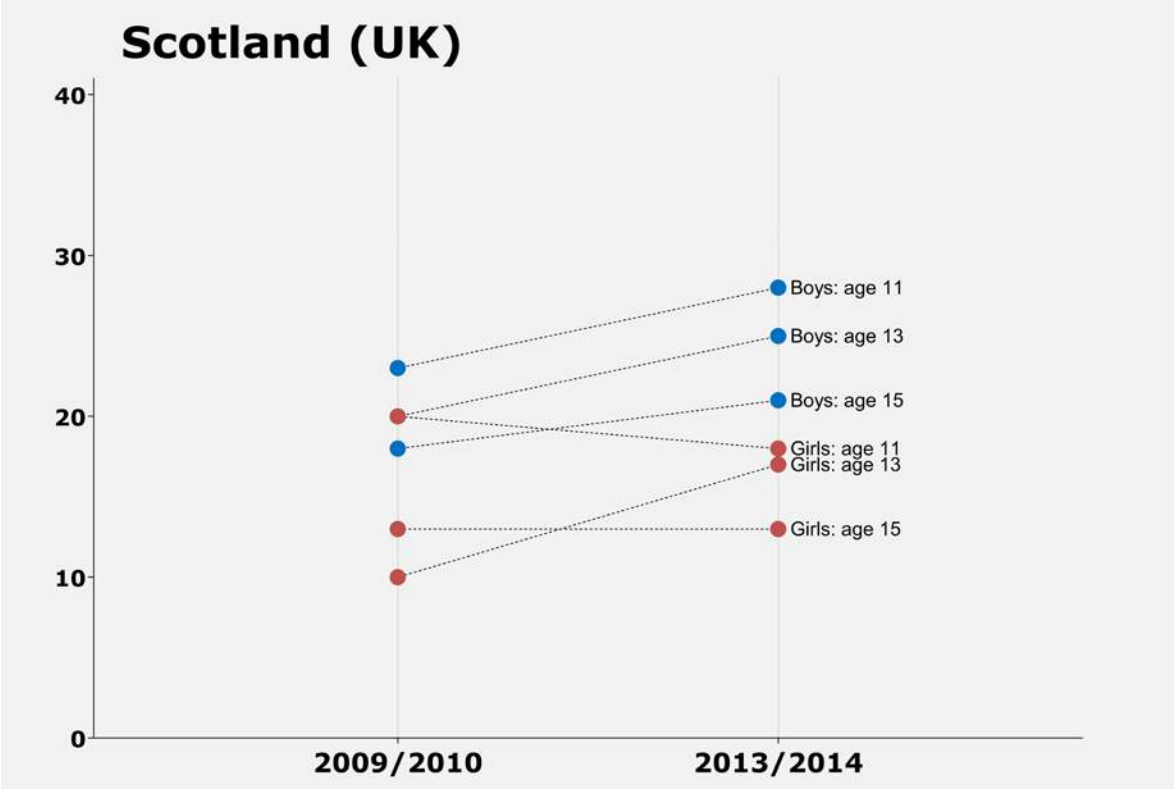


Prevalence of overweight including obesity (%) in Scotland (UK) (HBSC 2013/2014)



The dark dots represent the prevalence in Scotland (UK). The light dots represent the prevalence in the other countries.

Difference in prevalence of overweight including obesity (%) between HBSC 2009/2010 and HBSC 2013/2014



Overview of policies / activities according to the various areas of action of the EU Action Plan in the United Kingdom

1 in Scotland only

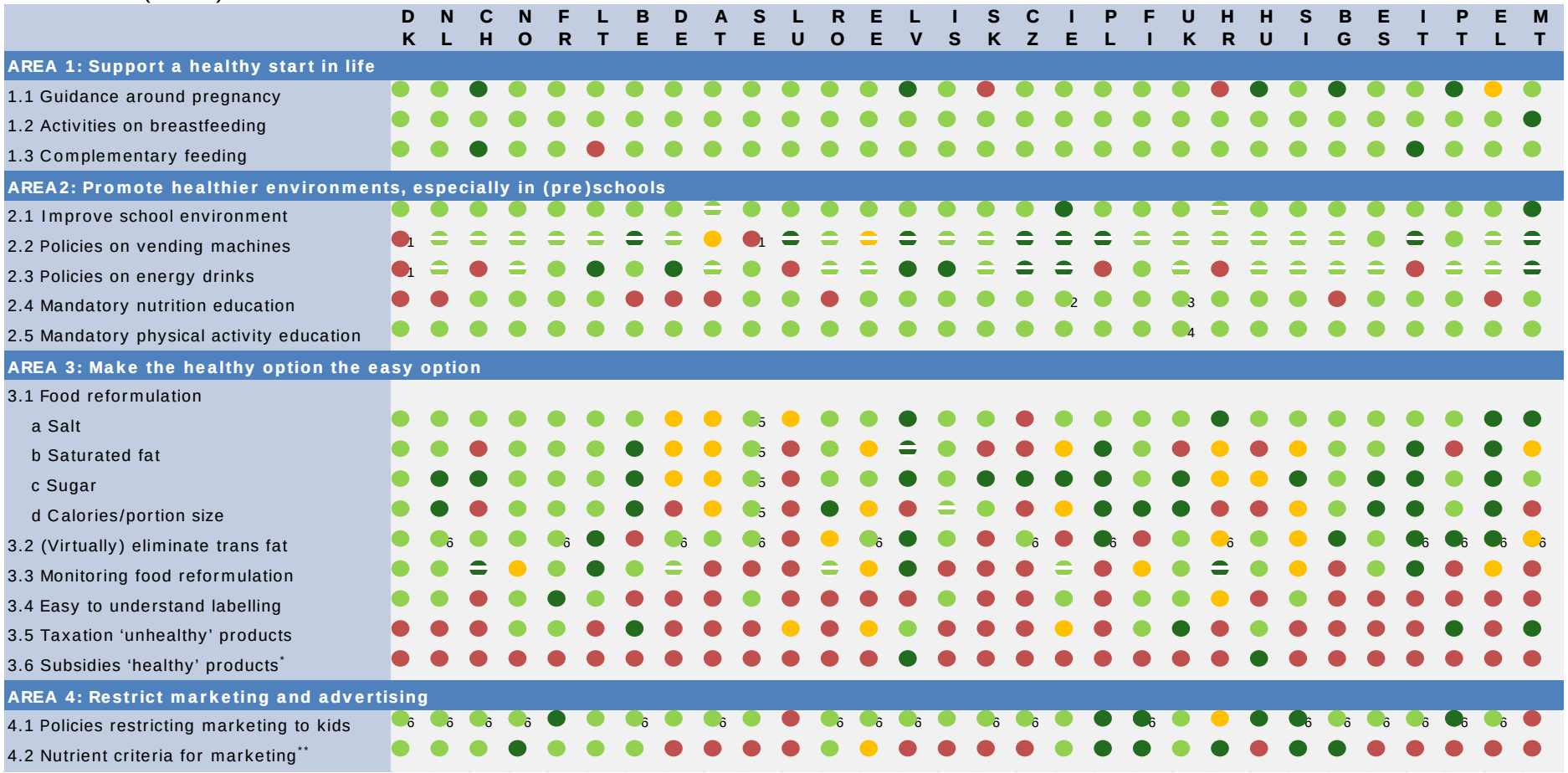
2 not in England

● yes, already before EU Action plan*
◒ partially, for example in certain settings or certain regions*
● yes, since EU Action plan*. This does not necessarily mean that the action is undertaken as a result of the Action Plan
● no** but actions may, however, be undertaken on initiative from local authorities, NGO's or private parties.
● in preparation or planned; adoption may still be contingent on policy process.

* indicates that an action is undertaken, but does not contain an evaluation of effectiveness from our part.

ANNEX 6. OVERVIEW OF POLICIES/STRATEGIES PER COUNTRY ORDERED BY PREVALENCE OF OVERWEIGHT (INCLUDING OBESITY, TABLE A6A) AND POPULATION SIZE (TABLE A6B)

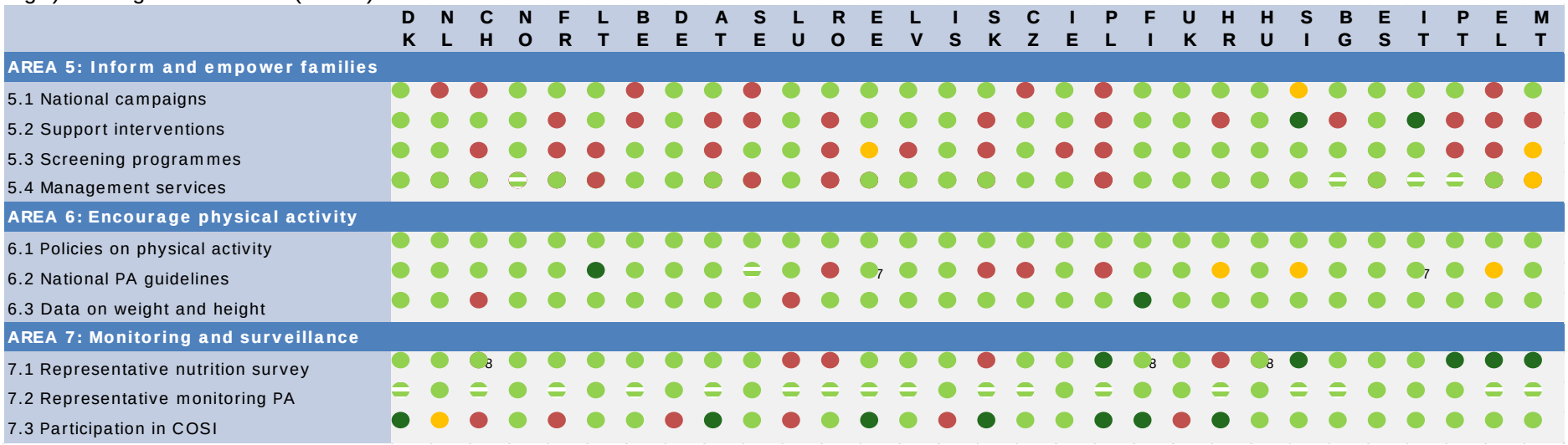
Table A6A. Overview of policies/strategies per country ordered by the prevalence of overweight including obesity (low to high) among adolescents (HBSC).



* Other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme

** Other than included in school policies

Table A6A (continued). Overview of policies/strategies per country ordered by the prevalence of overweight including obesity (low to high) among adolescents (HBSC).



No data for Cyprus, Montenegro and Serbia.

Light green: (when striped: partial, for example in certain settings or certain regions) fulfilment of an action, dating back from before the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated.

Dark green: (when striped: partial, for example in certain settings or certain regions) fulfilment of an action, since the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated. This does also not necessarily mean that the action is undertaken as a result of the Action Plan.

Orange: actions in preparation. They may still be contingent on the outcomes of policy processes.

Red: no action is initiated or supported by national authorities. This does not mean, however, that no action is undertaken, e.g. by local authorities, non-governmental organisations (NGOs) or commercial parties.

[1] There are few vending machines and it is a cultural phenomenon that foods high in sugar, salt and fat, including energy drinks, are not sold in schools. Therefore, there is no need for specific policies addressing vending machines and/or energy drinks.

[2] In secondary school, not in primary school

[3] In Scotland only

[4] Except in England

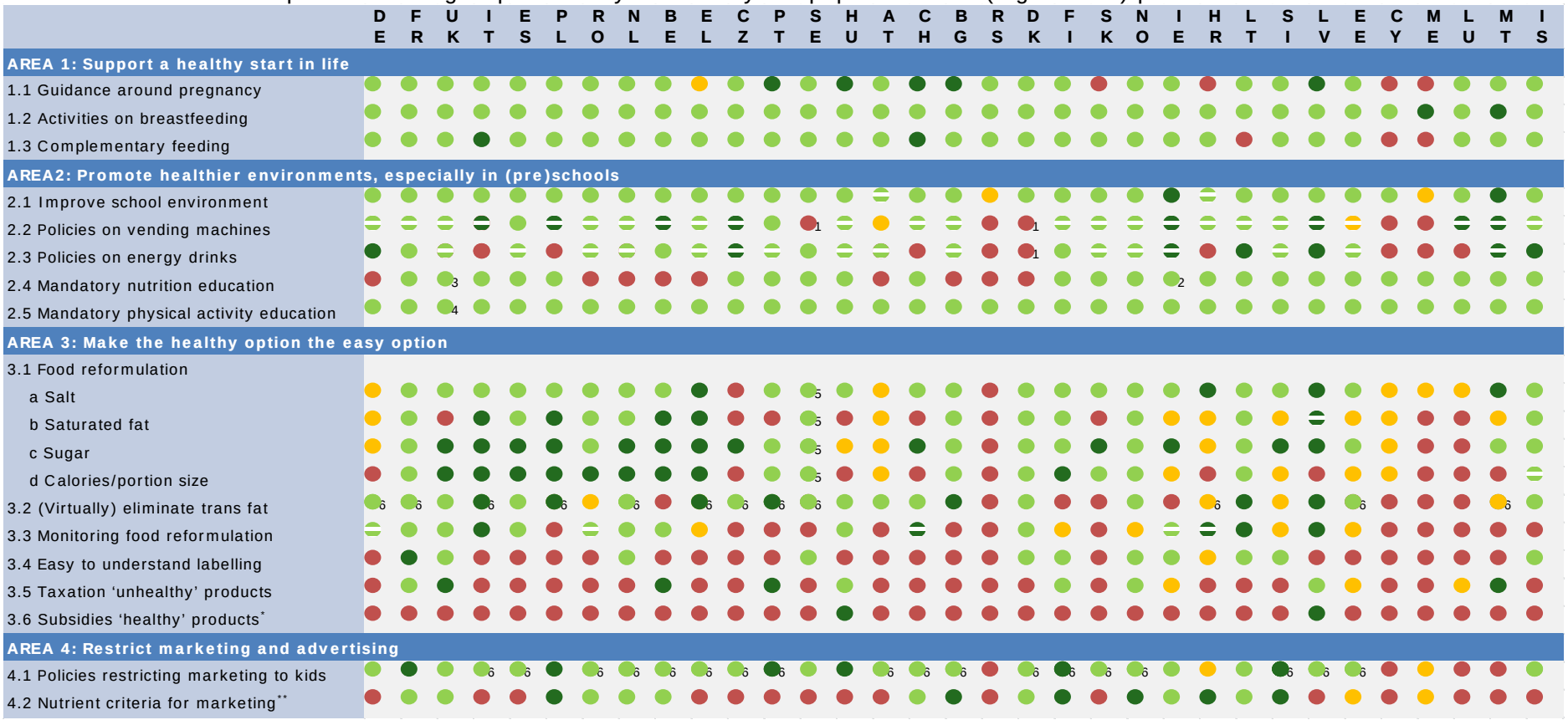
[5] Indirect through Keyhole logo, not seen as explicit policy

[6] Voluntary agreement with/of industry

[7] New guidelines planned

[8] Children are not included

Table A6B. Overview of policies/strategies per country ordered by the population size (high to low) per 1-1-2016[39].



* Other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme

** Other than included in school policies

[39] http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00001&plugin=1

Table A6B (continued). Overview of policies/strategies per country ordered by the population size (high to low) per 1-1-2016.

	DE	FR	UK	IT	ES	PL	RO	NL	BE	EL	CZ	PT	SE	HU	AT	CH	BG	RS	DK	FI	SK	NO	IE	HR	LT	SI	LV	EE	CY	ME	LU	MT	IS
AREA 5: Inform and empower families																																	
5.1 National campaigns	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
5.2 Support interventions	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
5.3 Screening programmes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
5.4 Management services	●	●	●	◒	●	●	●	●	●	●	●	◒	●	●	●	●	◒	●	●	●	●	◒	●	●	●	●	●	●	●	●	●	●	●	●
AREA 6: Encourage physical activity																																	
6.1 Policies on physical activity	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
6.2 National PA guidelines	●	●	●	● [7]	●	●	●	●	●	●	●	●	◒	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	● [7]	●	●	●	●
6.3 Data on weight and height	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
AREA 7: Monitoring and surveillance																																	
7.1 Representative nutrition survey	●	●	●	●	●	●	●	●	●	●	●	●	●	● [8]	●	● [8]	●	●	●	● [8]	●	●	●	●	●	●	●	●	●	●	●	●	●
7.2 Representative monitoring PA	●	◒	●	●	●	◒	◒	●	◒	◒	◒	●	●	●	◒	◒	◒	●	◒	●	◒	●	●	◒	●	◒	◒	◒	●	●	◒	◒	●
7.3 Participation in COSI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

● Light green: (when striped: partial, for example in certain settings or certain regions) fulfilment of an action, dating back from before the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated.
● Dark green: (when striped: partial, for example in certain settings or certain regions) fulfilment of an action, since the introduction of the action plan. Fulfilment means presence of a policy or activity; it does not imply that the effectiveness of an action was evaluated. This does also not necessarily mean that the action is undertaken as a result of the Action Plan.
● Orange: actions in preparation. They may still be contingent on the outcomes of policy processes.
● Red: no action is initiated or supported by national authorities. This does not mean, however, that no action is undertaken, e.g. by local authorities, non-governmental organisations (NGOs) or commercial parties.

[1] There are few vending machines and it is a cultural phenomenon that foods high in sugar, salt and fat, including energy drinks, are not sold in schools. Therefore, there is no need for specific policies addressing vending machines and/or energy drinks.
[2] In secondary school, not in primary school
[3] In Scotland only
[4] Except in England
[5] Indirect through Keyhole logo, not seen as explicit policy
[6] Voluntary agreement with/of industry
[7] New guidelines planned
[8] Children are not included

ANNEX 7. LIST OF EU FUNDED PROJECTS UNDER THE ERASMUS+ PROGRAMME

Title	Start and end date	Participating countries**	Action Plan area for action or operational objectives†
Cooperation for innovation and the exchange of good practices			
Building potential of school in areas of healthy lifestyle and protecting environment the way of balanced students' development	2014-2016	PL*, PT, RO, LV, IT, ES, SK, BG, CY, EL	2.2
RISE and SHINE	2014-2016	IT, HU, LV, ES, EL, NO, (TR*)	6.1
European Child - Healthy body, clever mind [b]	2014-2016	PL*, RO, LV, UK, SI, CY, ES	2.2, 5.1
Sport as a mean to foster healthy behaviours and allowing equal opportunities	2014-2017	IT*, LT, PT, PL, UK, ES	2.2
Comer Bien, Crecer Mejor (Eat Well, Grow Better)	2015-2017	ES*, PT, BG, MK, PL, RO, CZ	2.2
Eat right - Be smart	2015-2017	SE*, PT, DE, RO, IT, LT	2.2
Ready, Steady... Life!	2015-2017	FR*, PL, ES, IT, HU, EL, LV	2.2
Be Healthy, Be Natural, Be Smart	2015-2017	RO*,ES, PT, EL, , PL, IT	2.2
“Mens sana in corpore sano”.	2015-2017	AT*, UK, PL, FR, ES, IT	2.2
Healthy life style for hopeful future	2015-2018	IT*, TR, ES,PL, IS, SE, AT	2.2, 6.1
Healthy? Wealthy. Top tips.	2015-2018	PL*, NO, EL, IT, ES, TR, PT	2.2
Eating For Life	2016-2018	UK*, PL, IT, NO, MT, PT	2.2
Healthy Kids	2016-2018	ES, EL, RO, IT, PT, PL, (TR*)	2.2, 5.1, 5.4
Healthy Body Healthy Mind	2016-2018	UK*, PL, LT, ES, SI, IT	2.2
Sport, health, addiction and relaxation in education	2016-2018	UK*, PL, LT, EL, DE, NO	2.2
Internationale Essentdecker auf Spurensuche	2016-2018	DE*, PL, LT, HU, SI, IT	2.2
Healthy Minds of Europe	2016-2018	UK*, HR, CY, EL, PL, IT	2.2
Enriching Leisure Lifestyle for European Youth	2016-2018	ES*, TR, BG, RO, IT, NL, DE	2.2, 6.1
Healthy living and equal opportunities through sport	2016-2019	PT*, LV, RO, PL, IT, ES, EL	2.2
Learn4Health	2016-2019	DK*, ES, LT, NL, UK, SI	2.2
Move your body and mind - healthy lifestyle for adolescents	2016-2019	BG*, ES, FR, RO, PL, UK, LV	2.2
European Youth Health Champions	2017-2019	UK*, BG, DK, BE, MT, IT	6.1
Healthy Life's Codes	2014-2016	ES, IT, HU, PL, (TR*)	2

Title	Start and end date	Participating countries**	Action Plan area for action or operational objectives†
Organic and healthy food in Europe	2014-2016	BG, RO, PT, IT, (TR*)	2
Let's make it better!	2014-2016	RO*, ES, LT, EL, HR	2
Taste of Life, regional healthy food in schools [b]	2014-2016	NL*, RO, BE, CZ, DE	2
SHAPE	2014-2016	SE*, ES, UK, LT	6
Power up! Get active for your future	2014-2016	DE*, ES, FR, EL, RO	2
Developing educational tools for healthy & creative food regions	2014-2016	UK*, BG, IE, HU	3
It's My Life - It's My Choice	2014-2017	ES*, FR, NL, SE	2
Youth and healthy habits	2014-2017	FR*, HU, DE, EE	2
Organic Cooks in Public Settings	2014-2017	DE*, DK, IT, SK, CZ	2
All for Health and Health for All	2015-2017	ES*, BG, IT, PL, RO	2
Learning through sports	2015-2017	PL, EL, CZ, IT, (TR*)	6
Smart Moves	2015-2017	FI*, NL, UK, ES, PL	2
Activity & Eating: small steps to a healthier you	2015-2017	PL*, FR, HU, IT, PT	2
Live Naturally, Live Healthy	2015-2017	IT*, ES, LT, RO	2
Prevention of school failure related to bad habits and addictions: Good educational practices exchange	2015-2017	ES*, IT, DE, SE, PL	2
Yes for traditional dishes-No more obesity!	2015-2017	ES, HU, PL, LT, CZ, (TR*)	2
Mens fervida in corpore sano	2015-2017	FR*, ES, PL, DE	2
Youth Leaders Across Borders	2015-2017	UK*, PL, DE, SE	6
Creative and innovative training based on digital materials and games	2015-2018	SK, IT, BG, UK, (TR*)	2
Let schools move in a healthy, safe and sustainable way	2015-2018	ES*, PL, HR, FR	6
Enhancing quality in primary physical education	2015-2018	UK*, PL, CZ, RO, EL	2, 6
Spring Celebration	2015-2018	SK*, IT, ES, EE, PT	2
Improvement of Education and Competences in Dietetics	2015-2018	AT*, BE, DE, NL	5
Salud y juventud: un enfoque + TIC!	2016-2017	ES*, PT, IT, HU	6
Sports and health; the best way to enjoy learning about Europe.	2016-2018	ES*, IT, PL, RO	2, 6

Title	Start and end date	Participating countries**	Action Plan area for action or operational objectives†
Innovative teaching methodology of health friendly nutrition development and practice in (pre-) primary education	2016-2018	LT*, EL, IT, BG, ES	2
Health4Life	2016-2018	PL*, PT, EL, LT, IT	2
Many countries one goal	2016-2018	PL*, IT, TR, ES, FR	2, 6
Health, earth, agriculture, recipes, and technology at heart	2016-2018	MT*,BG, IT, PL, SK	2
Self-organised healthy sports	2016-2018	DE*, FI, CY, ES, LT	2,6
Let's play outside	2016-2018	LV, IT, RO, PT, (TR*)	2
Healthyland	2016-2018	PL*, RO, BG, EL, IT	2, 6
European School Run: Integration, Health, Brain	2016-2018	ES*, DE, FR, PL	6
Organic food production in schools for sustainability and healthy future generations	2016-2018	CZ*, RO, AT, SE	2
Health education for life [a,b]	2014-2016	PL*, HU	
Facing future with health and empowerment	2014-2016	FI*, CZ, EL	
Strong body-Healthy Life	2014-2016	BG, RO, PL, (TR*)	
Wie war es damals? Oma, Opa erzählt mal[b]	2014-2016	CZ*, AT, DE	
Towards a healthy and responsible adulthood	2014-2016	ES*, RO, TR	
School in movement: enjoying wealth being in good health!	2014-2017	ES*, LV, TR, IT	
Sport and Inclusion for an Healthy Lifestyle	2015-2016	IT*, DE	
Coordinating large-scale youth sport work events for inclusion	2015-2016	RS*	
Global Obesity	2015-2017	RO, IT, (TR*)	
From ancient to modern: Challenging obstacles at a stroke with sport	2015-2017	EL, (TR*)	
Health promotion in multicultural Europe	2015-2017	FI*, IT	
Ronimisakadeemia annab tiivad	2015-2017	EE*, UK	
Be fit!	2015-2018	CZ*, SK	
Enhancing European cooperation on the basis of the olympic idea	2015-2018	DE*, UK	
Identifying best practice across physical education teacher education programmes	2015-2018	CZ, IE, IT, (TR*)	

Title	Start and end date	Participating countries**	Action Plan area for action or operational objectives†
Fight the beast don't become obese [b]	2016	IE*, LV, MT	
TRY: TRansition Youth [b]	2016	PL*, IT, ES	
Strategic partnerships and activities for promotion of youth sport work during the European Week of Sport	2016	RS*	
Sport Events Make Friends	2016-2017	DE*, SE, IT	
Young European in Sports	2016-2018	FR*, DE, ES	
Keep IT, stay FIT!	2016-2018	PL*, DE, LT	
Healthy eating for better living: Let's move!	2016-2018	FR*, PL, CZ	
Sport unites	2016-2018	CZ*, DE	
Young, active and health	2016-2018	PL*	
Mamy Modę Na Działania	2016-2018	PL*, LT	
European Schools Cooperating	2016-2019	UK*, FR	
Move Your School	2016-2019	BE*, ES, NO	
Sub-programme sport			
EU Be Active	2015	LT*, PL, LV, ES, TR, BG	6.1
Promotion and encouragement of recreational team sport	2015-2016	LV*, LT, PL, EE, CH, CZ	6.1
Sport and Support [b]	2015-2016	IT*, HR, HU, ME, PT, DK, CY, BE, RS, EL, BG, FR, UK	6.1
IMPALA.net[b]	2015-2016	DE*, AT, DK, FI, IT, LT, NL	6.2
Encouraging Girls' Participation in Sports	2015-2017	IT*, CY, CZ, PT, SE, UK	6.1
Sport Empowers Disabled Youth	2015-2017	NL*, LT, UK, SE, FR, PT, FI	6.1
The Sport Physical Education And Coaching in Health (SPEACH) Project	2015-2017	NL*, PT, UK, ES, BE, LT, DK, FR	2.2, 6.1
Multisport Against Physical Sedentary	2016-2017	IT*, NL, PL, PT, EL, DE, HR	6.1
ON THE MOVE	2016-2017	HR*, PT, SI, SK, MT, UK	5.1, 6.1
3SP: Special Sports for Special People	2016-2017	IT*, UK, BE, HR, ES, DE	6.1
Move up to be healthy and happy	2016-2017	PL*, IT, UK, RO, CZ, PT	2.2
Active School Communities	2016-2017	BG*, DE, DK, HU, IT, UK, SI, CH, FR	6.1
European Everyday of Sport	2016-2017	BG*, LT, PL, SK, HU, HR, IT	6.3
Train with Brain	2017	LT*, LV, PL, SI, EL, IT	6.1
Sport "MyWAY", Multisport Coaches for Young Athletes	2017-2018	HR*, IT, EL, RS, CY, DK, BE, PT	6.1
Change Your Mindset-Sport4Everyone	2017-2018	HR*, AT, IT, ME, RS, SI	6.1

Title	Start and end date	Participating countries**	Action Plan area for action or operational objectives†
WAVE on WAVE	2017-2018	IT*, SK, FR, HR, PL, ES	6.1
Development and evaluation of guide-models mass athletics for sports in students with special needs (obese, disabled persons etc.)	2017-2019	EL*, IT, ES, BG, UK, HR	6.1
Keep Youngsters involved	2017-2019	NL*, IE, FI, RO, PT, DE, BE	6.1
Enriched Sport Activities Program	2017-2019	IT*, DE, LT, ES, PT, TR, HR	6.1
“Identifying and Motivating youth who mostly need physical activity	2017-2019	EL*, , DE, IT, ES, UK, CH, FR	2.2, 6.1
Junior Hop	2015-2016	RO*, TR, BG, CZ, EL	6
Health Promotion at Sport Clubs network [b]	2015-2016	IT*, BG, SI, CY, EL	6
Civil Society – a Fair Play Actor of European Union	2016-2017	RO*, BG, SI, IT, UK	6
Share & Shake	2016-2017	IT*, EL, PT, PL, BE	2, 6, 7
Sport for all	2016-2017	BG*, HU, PT, EL, RO	6
Sport for Life	2017	ES*, CZ, NO, PL, IT	6
Efficient recommended MVPA obtainment for school children and teenagers	2017-2018	HR*, SI, HU, IT, CZ	2, 6
Te(a)chIn Sport	2017-2018	BG*, IS, HU, AT, EE	6
Young Ambassadors for Sport and Volunteering	2017-2018	IT*, BG, DK, PL	6
Sport4Citizens	2017-2018	CZ*, HR, RS, HU, SK	6
Do it yourself!	2017-2018	RO*, MT, SK, IT, DK	2, 6
ObLoMoV	2017-2019	IT*, FI, EL, PL, BE	6
GetActive#BeActive	2015-2016	BE*	
Intergenerational Olympics 2015!	2015-2016	PT*	
EURO HOOP for All	2015-2016	IT*	
Action Learning for Children in Schools 2	2016-2017	BE*	
Families Live European Week of Sport	2016-2017	IT*	
Enlargement of European school sport day	2016-2017	HU*	
Sport in nature for all	2016-2017	RO*	
Come Together Youth - EWOS 2016	2016-2017	IT*	
Développement Européen du parachutisme, de l'ascensionnel et du vol en soufflerie en faveur des personnes en situation de handicap moteur	2016-2017	FR*	

Title	Start and end date	Participating countries**	Action Plan area for action or operational objectives†
WELCOME-Integration of young refugees through sport activity	2017	IT*, HR, CY	
Tennis Table Crossing Borders	2017	HR*, SI, DE	
SPIIS - SPort, Inclusion and Interculturality in Society	2017	ES*, IT	
Skating for Kids And Teachers all over Europe	2017-2018	IT*, ES, PT	
Central-European network of sport clubs to increase the popularity of badminton among teachers and students in schools	2017-2018	HU*, HR, SI	
Other sub-programmes			
Recall: Games of the Past – Sports for Today [a, b]	2014	DE*, IE, HU, PL, FR, DK, FI, LU, PT	6.1
Sağlıklı Beslen, Hareketli Ol, Kaliteli Yaşa [b]	2014	IT, (TR*)	
Peer to Peer Education for Health Life Style	2014	BG, RO, IT, (AL*)	
"Healthy You(th) For Healthy Future"	2014	LV, RO, (GE*)	
Keep on moving!	2014	ES, SK, RO, (AM*)	
Healthy Aging Summit for EU	2014-2016	UK, LV, PL, (TR*)	
" Заедно"	2015	BG*, RO, EL	

** Excluding countries that are not included in the Childhood Obesity Study
† Projects with 3 or more countries involved are mapped against areas of Action, projects with 5 or more countries involved are mapped against the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020 (APCO).
* Coordinator is based in this country
a marked as success story in the VALOR+ database
b marked as good practice example in the Valor+ database

DATA SOURCES USED

Published literature: See reference list.

WHO Regional Office for Europe provided data of:

- The Childhood Obesity Surveillance Initiative (COSI)
- The second Global Nutrition Policy Review Survey 2016 (GNPRS2)

Country profiles

WHO: Country profiles on nutrition, physical activity and obesity: http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/country-work

WHO: factsheets on health-enhancing physical activity: http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/country-work

School food policy country factsheets: https://ec.europa.eu/jrc/en/publication/school-food-policy-country-factsheets

Food baskets: http://ec.europa.eu/social/main.jsp?advSearchKey=basket&policyArea=0&policyAreaSub=0&year=0&mode=advancedSubmit&catId=738&langId=en&search=Search

Databases

WHO: Global Health Observatory data repository: http://apps.who.int/gho/data/view.main.NUT1730?lang=en

WHO: European database on nutrition, obesity and physical activity (NOPA): http://www.whonopa.eu/

Health programmes database: https://webgate.ec.europa.eu/chafea_pdb/health/projects/

CORDIS: http://cordis.europa.eu/projects/home_en.html

The Erasmus+ Project Results Platform: http://ec.europa.eu/programmes/erasmus-plus/projects/

The project database for the Creative Europe Programme: http://ec.europa.eu/programmes/creative-europe/projects/

The general project database "EU for results": http://ec.europa.eu/budget/euprojects/search-projects_en

Information collected by DG SANTE for the 2014 and 2015 snapshot on the Action Plan

Websites

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EPODE International Network: http://epodeinternationalnetwork.com/members/programmes

Annual monitoring reports for the EU School Fruit and Vegetable Scheme: https://ec.europa.eu/agriculture/sfs/eu-countries_en

VAT rates on fruits and vegetables:

- AVALARA VATLine: International VAT and GST rates 2017: https://www.vatlive.com/vat-rates/international-vat-and-gst-rates/
- European Commission: VAT rates applied in the Member States of the European Union. Taxud.c1(2017)-en: https://ec.europa.eu/taxation_customs/sites/taxation/files/resources/documents/taxation/vat/how_vat_works/rates/vat_rates_en.pdf

- OECD: Consumption Tax trends 2016:
- http://www.keepeek.com/Digital-Asset-Management/oecd/taxation/consumption-tax-trends-2016_ctt-2016-en#.WgoLaNKoucw
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- https://www.unizo.be/advies/welke-btw-tarieven-moet-u-toepassen
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Pilot projects funded by the European Parliament: https://.ec.europa.eu/health/nutrition_physical_activity/projects/ep_funded_projects_en#fragment4

The EU Sport Programme: https://ec.europa.eu/sport/

Joint Programming Initiative: http://ec.europa.eu/research/era/joint-programming-initiatives_en.html

World Health Organisation (WHO): http://www.who.int/en/

WHO - Regional Office for Europe: http://www.euro.who.int/en/

European Association for the Study of Obesity (EASO): http://easo.org/

World Obesity Federation (WOF): https://www.worldobesity.org/

The Organisation for Economic Co-operation and Development (OECD): http://www.oecd.org/

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