Draft final report for stakeholder review

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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EXECUTIVE SUMMARY

Introduction

The Childhood Obesity Study aims to provide the European Commission and the EU Member States with an overview of the efforts during the first-half period of the EU Action Plan on Childhood Obesity 2014-2020 (hereafter named Action Plan) 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. This overview is meant to support the European Commission with the mid-term (2014-2017) evaluation of the Action Plan. The Action Plan consists of eight areas of 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

Information basis for this report

For each area of action several indicators have been included for measuring country actions, which are in line with goals of the Action Plan. They included the 18 indicators that were identified by the Member States, the European Commission and the WHO Regional Office for Europe (WHO/Europe) in 2015. Additional indicators were included, both to cover Area 5 of the Action Plan as well as to cover additional policies (e.g. on breastfeeding, school food, and vending machines) and initiatives (e.g. on monitoring of food product improvement and labelling).

Information on these indicators was obtained through a variety of sources. Telephone interviews with representatives of 29 countries (held between mid-December 2016 and February 2017) were used as primary source of information on the availability of national policies and other initiatives that are initiated, coordinated or supported by national authorities for the first seven areas of action. The representatives were members of the High Level Group on Nutrition and Physical Activity or other competent authorities they appointed. Interview forms were filled out on paper for four countries (DE, ME, PT, RS). Additional sources of information are: some first results from the second Global Nutrition Policy Review Survey (GNPRS2 data collected in 2016) that were kindly provided by WHO/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, summarized in the "APCO-database" 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/Europe who kindly provided the latest available information on the Childhood Obesity Surveillance Initiative (COSI).

The data were analysed and the results provide insight into the level of the quantitative indicators in each country, and into the fulfilment of an action mentioned in the Action Plan at the level of all participating countries, the 28 EU Member States and all individual countries. Fulfilment of an action can imply:

a) (partial) fulfilment of an action, dating back from before the introduction of the action plan
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
e) unknown

The project does not involve the evaluation of the effectiveness of an action.

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 were 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. For relevant projects related to the operational objectives of the Action Plan, information was extracted on the objectives, the participating and coordinating countries, the start and end date and the amount of funding received. Projects were mapped to the areas for action and the operational objectives of the Action Plan. Furthermore we consulted the websites of the World Health Organisation (WHO), WHO/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.

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 and used to identify strengths and weaknesses and to provide recommendations for the second-half-period of the Action Plan.

Prevalence of overweight and obesity

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 schoolyear 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 ranges 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) showed that also among adolescents the prevalence ranges 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.

A recent publication from the NCD Risk Factor Collaboration showed that the increasing trend in children's and adolescents' age-standardized mean body mass index since the 1970's 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. Projections from the World Obesity Federation envision an increase in the prevalence of overweight and obesity among 2-19.9 year olds between 2010 and 2025 for most countries. Systematically collected data to determine trends in the prevalence since the adoption of the Action Plan are not yet available. Data from the most recent 2015/2016 schoolyear of COSI and of a next round of the HBCS survey (2017/2018) will provide more insight. It should be noted, however, that lifestyle changes take time, and that the effects of all actions undertaken, especially those initiated after the adoption of the Action Plan, may not be clearly visible yet.

Activity in the first seven areas for action of the Action Plan
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.

The majority of countries have policies, strategies or actions relating to Area 1 of the Action Plan (support a healthy start in life). In almost all countries, guidance on nutrition and physical activity is provided to women (before), 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. The percentage of hospitals and maternities that have ever been designated baby-friendly ranges from 0.07 to 100%. 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 52.4%. The percentage was not related to the duration of maternity leave. 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 is to be evaluated. In the majority of countries (88%) guidelines on complementary feeding are available and/or young mothers are advised on this issue through child healthcare.

Promote healthier environments, especially in schools (Area 2 of the Action Plan), is one of the areas for action that is best addressed. 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 67% of the countries. In another 18% of the countries tap water is safe, so free drinking water is considered to be available in schools also. In all except a few cases the school food policies include policies on vending machines and energy drinks. Only in a few countries policies on vending machines also apply to settings other than the school environment (6%). In more countries (21%) policies on energy drinks are not restricted to the school setting. All but three EU Member States participated in the EU School Fruit and Vegetable Scheme. In the 2015/2016 schoolyear, the percentage of schools that received school fruit ranged from 21% (secondary schools in Austria) to 97% (in 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 schoolyear. In all countries physical education is included in the school curriculum, whereas nutrition education is also included in all but one of the participating countries. In the majority of countries, the minimum number of hours to be devoted to physical education is specified. Nutrition education is, however, less specifically defined in the curriculum. It is not always mandatory 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) is the area for action that experiences the most growth across Europe. The growth is especially seen for food reformulation/food product improvement. It is 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 (15%), saturated fatty acids (6%) and/or calories/portion sizes (6%). Other countries are planning to do so (18%, 33%, 24% and 24% respectively). Countries that entered the EU after 1995 (EU13) are clearly catching up on EU15 Member States. Easy to understand labelling, such as front-of-pack labelling, is used in 10 countries (30%) to help consumers make healthier food choices (in one it will end in 2017), while it is planned in another two. Also taxation of nutritionally unbalance products is becoming more common, but is not widely used (existing in eight countries). Another three countries (9%) have plans for a levy on sugar-containing beverages. A subsidy on 'healthier' options – other than provision of school meals, the EU Fruit, Vegetable and Milk Scheme - is not implemented, except by Hungary. They consider the lowered VAT rates for some specific food products, such as fresh milk and poultry meat, as a subsidy. Tax rates on

vegetables may also be lowered in the future. VAT rates on fruit and vegetables are now 27%, which is the highest in the countries studied. In the other countries VAT rates on fruit and vegetables range from 0% (in IE, MT and UK) to 25% (in DK).

Area 4 concerns the 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 79% of the countries (n=26) have initiatives or plans in this area and about half of the countries uses nutrient criteria to reduce marketing of HFSS foods to children. Restrictions are usually based on (voluntary) codes issued by the private sector. Competent Authorities of several countries mentioned that their countries will take further position on this topic after the conclusions of the discussion on the EU's Audio Visual Media Services Directive are known.

Food-based dietary guidelines are used to inform consumers about a healthy diet (Area 5: inform and empower families). They are available in 31 of the participating countries and one is working on them (RS). At least 13 of the countries have separate guidelines for children. Twenty-two counties (67%) currently have national campaigns running to inform and educate the population on healthy diet and the importance of physical activity and one (3%) is planning a campaign Somewhat 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 obesity takes place or is planned in 20 countries (61%) and is quite often seen as one of the tasks of child healthcare 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, by the general practitioner, other healthcare providers or through specific programmes.

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 84% of the countries) and available data on weight and height of children (in 91% of the countries). In about half of the countries there are national or subnational schemes to promote active travel to school or there are plans for such schemes. In 30 countries (except for CY, ME and RS) physical activity levels among adolescents are assessed through the HBSC study. In general, the percentage of boys and girls reaching the WHO's physical activity recommendation was higher among 11-year old than among 15-year olds, and boys more often reach WHO's physical activity recommendation 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.

The seventh area for action addresses monitoring and evaluation. National representative nutrition surveys are available in 76% of the countries. However, it is not always clear whether or not children are included in the nutrition surveys. Seventy-three 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. Monitoring of self-reported physical activity is covered by HBSC and in several countries by other projects. All but three countries (CY, ME. RS) participate in HBSC. Monitoring of self-reported height and weight among adolescents is also covered by the HBSC surveys. In the most recent round of COSI 25 countries participated, while at least two countries have other surveys to monitor the prevalence of overweight and obesity among children. Participation in COSI is the indicator that experienced the largest growth since 2014; nine countries (27%) participated for the first time in the last round.

Engagement of the European Commission in EU-wide initiatives
In the Action Plan, the Member States ask the European Commission to be responsible for three key priorities, i.e. 1) to continue providing support and coordination and to further facilitate exchange of information and guidance on best practice, 2) to promote better utilisation of the existing instruments at its disposal, namely the EU Health Programme and the Horizon 2020 growth strategy, and 3) to strengthen its aim to integrate the issue of health in other EU policy areas. The European Commission has several instruments to fulfil the tasks described above. These include the coordination of working groups, special events, etc., 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 is composed of EU and EFTA government representatives dealing with the topics of nutrition and physical activity and 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. 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 them, 138 were funded through the Erasmus+ Programme. The projects mapped to all areas for action of the Action Plan, except to Area 4. However, the Joint Research Centre recently started a study into the exposure of children to marketing. Relatively few projects mapped to Area 3. Many projects, especially from the Erasmus+ Programme mapped to areas 2 and 6. Until now, area 5 is 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.

The objective of **CHRODIS** 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 Joint Action on Nutrition and Physical Activity "**JANPA**" is a joint action that 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, the joint action 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, like researchers, teachers, and sports organisations. Organisations from Italy, Spain and Poland are involved in >60 EU-funded projects, and this is 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 in 2016 presented its final report, describing a comprehensive, integrated package of recommendations to address childhood obesity. WHO/Europe has set up action networks consisting of groups of Member States in order to supports activities at country and international level for implementation of the WHO European Food and Nutrition Action Plan 2015-2020. Furthermore, WHO/Europe is the host, as well as a member, of the European network for the promotion of health-enhancing physical activity, coordinates the WHO European Healthy Cities Network, and provides technical support in implementing COSI. Besides these activities WHO/Europe sets out various surveys, such as Global Nutrition Policy Review survey (GNPR2 survey). The data from these surveys are 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. OECD published their most

recent obesity update in 2017, which focussed on communication policies designed to empower people to make healthier choices. OECD announced a new series of reviews of public health, covering o.a. the topics obesity and unhealthy diets.

Strengths and weaknesses

Activities in Area 2 (promote healthier environments, especially in schools and pre-schools) are most often considered to be among the 'most successful'. These include activities such as setting standards for foods provided in schools, provision of free healthy meals and promoting active breaks. The most 'least successful' activities are reported for Area 3 (make the healthy option the easier option), and refer to activities on food product improvement, labelling and taxation. For Area 1 (support a healthy start in life), Area 2 (promote healthier environments), Area 5 (inform and empower families) and 7 (monitor and evaluate), the number of times respondents mentioned an activity to be 'most successful' was higher than the number of times respondents mentioned an activity to be 'least successful'. In Area 3 and Area 4 (restrict marketing and advertising to children) it was the other way around. In these areas for action, the number of times respondents mentioned an activity to be 'least successful' exceeded the number of times respondents mentioned an activity to be 'most successful'. Political commitment as well as stakeholder involvement and collaboration were mentioned as factors that contributed to the 'most successful' and 'least successful' activities for more than one area for action. These can therefore be considered highly important.

In the interviews that were conducted with the competent authorities of the countries included in this study, 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 done 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 evaluation of each areas for action itself and as a comprehensive approach, to identify which areas are more/less effective or are needed as companion. 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 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, 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 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 be active on a national level.

Main preliminary conclusions and recommendations

From the results of the Childhood Obesity Study the following preliminary main conclusions can be drawn. They will be adapted in the light of the comments to be received from the High Level Group on Nutrition and Physical Activity, the EU Platform for Action on Diet, Physical Activity and Health, WHO/Europe, WOF and the OECD, who will be included in the stakeholder review for this report.

Systematically collected data to determine trends in the prevalence of childhood obesity since the adoption of the Action Plan are not yet available.
A clear picture on the prevalence of overweight and obesity among young children cannot be provided, because published data in children under 5 years of age are scarce and the available data are difficult to compare. More comparable data on the prevalence of overweight and obesity in primary schoolchildren (6-9 years) and adolescents across countries are available from COSI and HBSC, respectively. The prevalence of overweight (including obesity) among primary schoolchildren and adolescents is high, but differs considerably between countries. Systematically collected data to determine trends in the prevalence since the adoption of the Action Plan are not available yet. Data from the most recent 2015/2016 schoolyear of COSI and a next round of the HBCS survey (2017/2018) will provide more insight. WHO/Europe and countries are encouraged to continue their activities with respect to the monitoring of childhood overweight and obesity, such as COSI and HBSC. Countries not yet participating in COSI are encouraged to join the initiative. In many countries height and weight are measured as part of child healthcare. These data could provide more insight in the prevalence among the youngest age groups. The possibility to use these data for monitoring activities could be investigated. It should be noted, however, that lifestyle changes take time, and that the effects of all actions undertaken, especially those initiated after the adoption of the Action Plan, may not be clearly visible yet.

Promote healthier environments, especially in schools and pre-schools (Area 2 of the Action Plan), is one of the areas for action that is best addressed.
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. Most activity is seen in Area 2. Firstly, this is illustrated by the high percentage of countries 1) that have policies to improve the school environment, 2) where physical and nutrition education is included in the school curriculum and 3) that participate in the EU School Fruit, Vegetable and Milk Scheme. Secondly, activities in this area, such as setting standards for foods provided in schools, provision of free healthy meals and promoting active breaks, are often considered to be among the 'most successful' activities in countries. Thirdly, many of the EU-funded projects address operational objectives in this area for action.

Encourage physical activity (Area 6) also seems to be well covered.
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 81-94% of the countries). Also the largest budget from EU programmes is allocated to projects that map to this area for action, especially from the Erasmus+ programme.

Area 3 (make the healthy option the easy option) is the area for action that experiences the most growth across Europe.
Several countries recently started initiatives on food product improvement, while others are planning to do so. Also taxation of nutritionally unbalanced products is becoming more common.

The European Commission helps to create and sustain international and national focus on the topic of childhood obesity.
It is considered useful that the European Commission picked up the discussion on childhood obesity, and keeps the topic on the political agenda. 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). Furthermore, the Action Plan and activities of the European Commission support Member States and regions/communities with their priorities, by setting a uniform framework with European standards and reference recommendations.

Voluntary cooperation of countries and the products that are the result of it can be of value for all.
Voluntary cooperation of countries and the products (recommendations, opinions, interventions, support) that are the result of it can be of value for all, but possibly in particular to (smaller) countries with limited resources or more dependency on import of food produced in other Member States. In several areas of action, there are countries that 'successfully' implemented policies or activities and countries that were less 'successful'. Sharing of information, experiences and good practices is important for voluntary cooperation or collaborative action. This is facilitated amongst others by the instalment of the High Level Group on Nutrition and Physical Activity, JANPA and the activities of the European Commission in the field of food product improvement and public procurement. Diversity between countries, also in terms of contextual factors that play a role in whether or not countries have policies/strategies, provides an important basis for more in-depth comparison between countries. Also projects that encourage the engagement of stakeholders, such as schools and sports organisations in the Member States, for example through the Erasmus+ programme, facilitate cooperation between countries.

The Action Plan could be more focussed on cross-border activities.
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. Nevertheless, common priorities could be stated as well as simultaneous actions in the EU and in Member States, for example in Area 3 (make the healthy option the easier option) and Area 4 (restrict marketing and advertising to children). Activities in Area 3 and Area 4 are more often among the reported 'least successful' than among the reported 'most successful' activities. The 'least successful' activities include food reformulation/food product improvement, taxation and easy to understand labelling. These areas for action require active involvement and collaboration from industry and concern the EU internal market. Many food companies do not work in a single country, but across Europe and beyond. European support to achieve agreements with industry and to define standards at the European level is deemed necessary. In this respect the dialogue with stakeholders in the context of the EU Platform for on Diet, Physical Activity and Health can be mentioned as a positive action from the European Commission. Competent Authorities of several countries mentioned that their countries will take further position on the topic of marketing and advertising to children after the conclusions of the discussion on the Audio Visual Media Services Directive are known. The definition of nutrition criteria to restrict marketing to children at a European level needs continued attention.

The scope of Area 2 (promote healthier environments) should be broadened to other settings than the school setting.
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. This is illustrated by the observation that only in relatively few countries policies on vending machines and policies on energy drinks also apply to settings other than the school environment. Furthermore, creating a healthy environment in communities through urban planning is important, for example to encourage free-time physical activity. While the educational sector is involved in several activities and in EU-funded projects urban planning seems to be somewhat underrepresented. The European Commission and the countries are encouraged to further collaborate with WHO/Europe in the Healthy Cities Network, in order to increase involvement of urban planning and therewith strengthen the Health in All Policies approach. This would increase efforts that contribute to operational objective 6.2 of the Action Plan "supportive role of urban design and planning in order to reduce afterschool sedentary behaviour".

A more comprehensive approach to the prevention of childhood obesity?
The Action Plan covers most, if not all, areas for action that are relevant to halting the rise in childhood obesity. However, suggested actions in each area for action are presented separately and not as a comprehensive approach. Individual countries as well as the countries in collaboration could focus more on integrated approaches instead of actions in separate areas of action. In this light, it would be useful to identify which areas for action are more/less effective in terms of preventing childhood obesity, and increasing healthy dietary choices and physical activity. Community based prevention programmes according to the EPODE-methodology are an example of a comprehensive integrated approach at the local level. Implementation of this kind of programmes should be encouraged and supported.

Objective evaluation of the effectiveness of policies, activities and interventions as the basis of further evaluation of the outcomes of the Action Plan.
While some countries appear to be on the forefront, at least in terms of having certain policies or strategies in place, it does not necessarily mean that these plans are designed to maximise health impact, are already fully and effectively implemented or successful in terms of halting the rise in childhood obesity. Objective assessment of the effectiveness of policies, activities and interventions would need data on the degree of implementation and effectiveness of different policies and activities. Gathering such data was outside the scope of the Childhood Obesity Project. The evaluation of policies is mentioned as one of the 'least successful' activities by several Competent Authorities or experts. By asking for the 'most successful' and 'least successful' activities, the Childhood Obesity Project tried to contribute to this issue, but this cannot be seen as an objective approach. In the framework of this exercise the term 'success' was not specifically defined and has been referred to by authorities 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). Therefore, to better appreciate the effectiveness of various policies and activities, countries are encouraged to objectively evaluate their activities.

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, also in view of the potential renewal of the plan beyond its expiry after 2020.

RÉSUMÉ

A version of the executive summary in French will be included in the final report.

ZUSAMMENFASSUNG

A version of the executive summary in German will be included in the final report.

ABSTRACT

A 200-250 word abstract will be included in the final report.

ABSTRAIT

A 200-250 word abstract in French will be included in the final report.

ABSTRAKT

A 200-250 word abstract in German will be included in the final report.

CONTENTS

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 a overweight or obese remains worryingly high. A recent publication 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 (1).

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 (2). 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. The high level of overweight and obesity in children and young people in Europe, and worldwide, is therefore an area of particular concern. See Box 1.1 for more background information on childhood obesity.

Box 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 (2). 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 (3, 4).

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 (5-7). However, these behaviours are made possible and are sometimes even stimulated within the socio-cultural and physical environment in which people live (8). Children's behaviour depends much on their immediate physical and social environment (9). 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 healthcare settings). Several reviews generally 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 (10, 11). Similarly, the World Health Organisation (WHO) argues for the implementation of population-based approaches to childhood obesity prevention (12). 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 (13). The purpose of this White Paper was to set out an integrated EU approach 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 are 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.

Following the informal meeting of EU Health Ministers in Dublin in March 2013, organised by the Irish EU Presidency, 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 (14). 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.

Tabel 1.1. Areas of Action in the EU Action Plan on Childhood Obesity (14)

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 could help them to identify nutritious, affordable and convenient food options • encourage food product improvement (reformulation) • 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 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 objectives and actions are still relevant to its objectives
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. 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 the 2014 and 2020 and again in 2020, via the 2014 Council Conclusions on Nutrition and Physical Activity[1].

The Childhood Obesity Study

The Childhood Obesity Study, conducted by the EPHORT consortium, aims to provide the European Commission and thereby the EU Member States with an overview of the efforts 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. The present study also offers information on the prevalence of childhood obesity in the aforementioned countries. 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.

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.

This study 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

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

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 has 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 5. Conclusions and recommendations of the Childhood Obesity Study are described in Chapter 6.

2 METHODOLOGY

2.1 Countries included in the study

The following 33 countries are included in this study, with the following country codes according to the ISO 3166-1 Alpha-2 country codes, except for Greece and the United Kingdom2.

EU Member States: Austria (AT), Belgium (BE), Bulgaria (BG), Croatia (HR), Cyprus (CY), Czech Republic (CZ), Denmark (DK), Estonia (EE), Finland (FI), France (FR), Germany (DE), Greece (EL), Hungary (HU), Ireland (IE), Italy (IT), Latvia (LV), Lithuania (LT), Luxembourg (LU), Malta (MT), the Netherlands (NL), Poland (PL), Portugal (PT), Romania (RO), Slovakia (SK), Slovenia (SI), Spain (ES), Sweden (SE), United Kingdom (UK)

Candidate countries: Montenegro (ME), Serbia (RS)

Other European countries: Iceland (IS, EEA = European Economic Area), Norway (NO, EEA), Switzerland (CH, EFTA=European Free Trade Association).

2.2 Data collection for Task 1 and 2

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 European 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 World Health Organisation Regional Office in Europe (WHO-Europe) and the World Obesity Federation (WOF).
- In addition, an excel-file containing information that has been collected in 2014 and 2015 by Directorate General for Health and Food Safety (DG SANTE) was kindly provided to the research team ("APCO-database").
- 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 kindly provided to the research team. The GNPR2 was conducted in 2016 and the first data were kindly 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 (CA) in the remainder of this document - were asked to provide information on the eight areas of action in the Action Plan, based on their

[2] This nomenclature follows the recommendations of the interinstitutional style guide of the publication office of the European Union (http://publications.europa.eu/code/en/en-000100.htm).
[3] http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/country-work

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 the "APCO database" were 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 database.

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 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

The indicators for measuring country actions, which are in line with goals of the Action Plan, included the 18 indicators that were identified by the Member States, European Commission and WHO Europe in 2015. Additionally, according to the tender specifications the study should also include information on other topics including: the VAT rate on fruit and vegetables; policies on energy drinks; policies on vending machines; policies on school (and kindergartens and crèches) meals , drinking water and physical activity in schools; initiatives on food reformulation; initiatives on food labelling; policies on breastfeeding; and an assessment of the overall awareness and political relevance of the topic among health authorities, political decision-makers and general population. Indicators to cover these topics and to cover Area 5 of the Action Plan ('inform and empower families') 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 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 by:

- Describing the available prevalence data among children below the age of 5 years. As few comparable data were available, data have 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 projections on the prevalence of overweight and obesity in 2025 made by the World Obesity Federation (15).

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 were 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/Europe, interview, experts and the "APCO database" 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.

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, NGO's or commercial parties.

Blue: unknown.

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 countries that were part of the EU in 1995 or before (EU15: AT, BE, DK, FI, FR, DE, EL, IE, IT, LU, NL, PT, ES, SE, UK) and the countries that became part of the EU after 1995 (EU13: BG, HR, CY, CA, EE, HU, LV, LT, MT, PL, RO, SK, SI).
- 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 (16). On this ladder the least intrusive and most non-committal measures are placed at the bottom, and the most intrusive and most invasive 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 (17).

2.5 Data collection, handling and reporting: Task 3

This task provides 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. Next to this, the outcomes of these were mapped against the operational objectives of the Action Plan as listed under paragraph 3 of the Action Plan (see Annex 3).

Data collection

A non-exhaustive list of documents and relevant project-databases was provided by the European Commission. This list was extended by desk research. In March 2017, the following programmes and databases have been searched for possible relevant 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 (http://cordis.europa.eu/projects/home_en.html).
  - FP7: Health
  - FP7: KBBE (Food, Agriculture and Biotechnology)
  - FP7: IDEAS-ERC

  - FP7: SME (Research for the benefit of SMEs)
  - FP7: ICT (Information and Communication Technologies)
  - H2020: Excellent Science - European Research Council (ERC)
  - H2020: Industrial Leadership - Leadership in enabling and industrial technologies - Information and Communication Technologies (ICT)
  - 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)

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.

Two projects (IMPALA.net and PASTA, funded by the Erasmus+ Programme and H2020, 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.

Furthermore, websites of (international) organisations were consulted to get insight into their engagement. The following international organisations have been included:

- World Health Organisation (WHO) (http://www.who.int/en/)

- WHO - Regional Office for Europe (WHO/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/)

Data handling Task 3

We excluded projects that ended before the endorsement of the Action Plan; projects from the Health Programme database that started before 2010 since only the starting date of projects is provided in this database; basic science projects that study the aetiology of (childhood) obesity and applications for the EU School Fruit, Fruit and Vegetables Scheme and the EU School Milk Scheme. The following information was extracted per project (if available): title, start and end date, participating countries and country coordinating, amount of funding received, summary.

Titles and summaries of projects were screened to judge their relevance with respect to the topic of the prevention of childhood obesity. Projects were included if their aims correspond to the operational objectives of the Action Plan (Annex 3). 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. This resulted in a total number of 160 projects that were further mapped to 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 counties at the European level will be limited. Therefore, projects funded by the Erasmus+ Programme (n=137) were mapped to the areas of action when partners were based in four or more countries and mapped to 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 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 areas of the action with more research activity and those with less research activity.

To provide insight in the efforts of the Commission in the different areas of action, the total budget of the EU funded projects as well as the budget according to each area for action of the Action Plan has been 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 is needed into factors that facilitate or hamper successful development (and implementation) of policies and other initiatives. Information on the 'most successful' and 'least successful' activities in the countries included in the Childhood Obesity Study was gathered with a short questionnaire (see Annex 4). 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 or not.

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.

After the deadline of (mid-September 2017), the answers from all received questionnaires were collated. Answers on similar topics were grouped. Subsequently the number of respondents reporting a certain activity as most (or least) successful was counted. The factors that contributed to the successful development or implementation were summarized, as well as factors that hampered development or implementation. Based on this an overview is given in chapter 5. The answers to the other questions were also grouped and described more qualitatively.

3 GENERAL ASSESSMENT OF THE STATE OF PLAY OF ACTIVITIES IN THE EU ADDRESSING CHILDHOOD OBESITY

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 Chapter 3.3.

3.1 Prevalence of childhood overweight and obesity in the EU

Prevalence of overweight and obesity among children <5 years of age
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.

For 16 countries some data are available (AT, BE, BG, CY, CZ, FI, FR, EL, IE, IT, LT, NL, PL, PT, ES, UK). The prevalence of overweight (including obesity) ranged from around 5% for 2 or 3 year old children in Belgium, Czech Republic and Finland to 20-30% in Finland (5 year olds), Greece, Ireland and Portugal (4 and 5 year olds), Spain (2-4 year olds), Scotland (2-6 year olds) and Wales (3-year-olds). In most countries the prevalence of overweight was higher in girls than in boys, with the exception of Spain and Scotland.

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 (18). 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 were included, where available. While WHO criteria (19) were used for countries participating in COSI, some of the other countries used different criteria for overweight and obesity, mainly the cut-off points of the International Obesity Task Force (IOTF) (AT, CY, NL) (20, 21). The latter mostly result in lower prevalence figures (22). In 2009/2010, the prevalence of overweight (including obesity) ranged from 10.3% in 7-year-old boys in Denmark to 57% in 9-year-old boys in Greece (see Figure 3.1). The highest prevalences (40% or higher) were found in Greece, Spain and Italy. In several countries the prevalence exceeded 30% in some age groups (SI, FI, MT, CY, IE). In most of the other countries the prevalence of overweight was between 20% and 30%. In a pooled analysis of cross-sectional studies between 2006 and 2015 in Romania (23), 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.

Data for 2012/2013 are available from COSI and presented in Figure 3.2. The prevalence of overweight (including obesity) was higher in the 2012/2013 survey than in the 1009/2010 survey for several age and sex subgroups.

- 6-year old boys in Slovenia (2009/2010: 23.5%; 2012/2013: 24.9%)
- 7-year old boys in Lithuania (2009/2010: 24.4%; 2012/2013: 26.5%)
- 7-year old boys in Portugal (2009/2010: 31.5%; 2012/2013: 32.7%)
- 8-year old boys in Spain (2009/2010: 45.3%; 2012/2013: 47.5%)
- 7- and 9-year old girls in Belgium (2009/2010: 24.1% respectively 26.6%; 2012/2013: 25.4% and 28.7%, respectively)
- 7-year old girls in Slovenia (2009/2010: 24.8%; 2012/2013: 25.5%).

In all other countries the prevalence was similar or somewhat lower in 2012/2013 compared to 2009/2010. It should be noted, however, that no formal statistical testing has been done, so we cannot exclude the possibility that any of these 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. These data have been submitted to WHO/Europe but are not yet available for research.

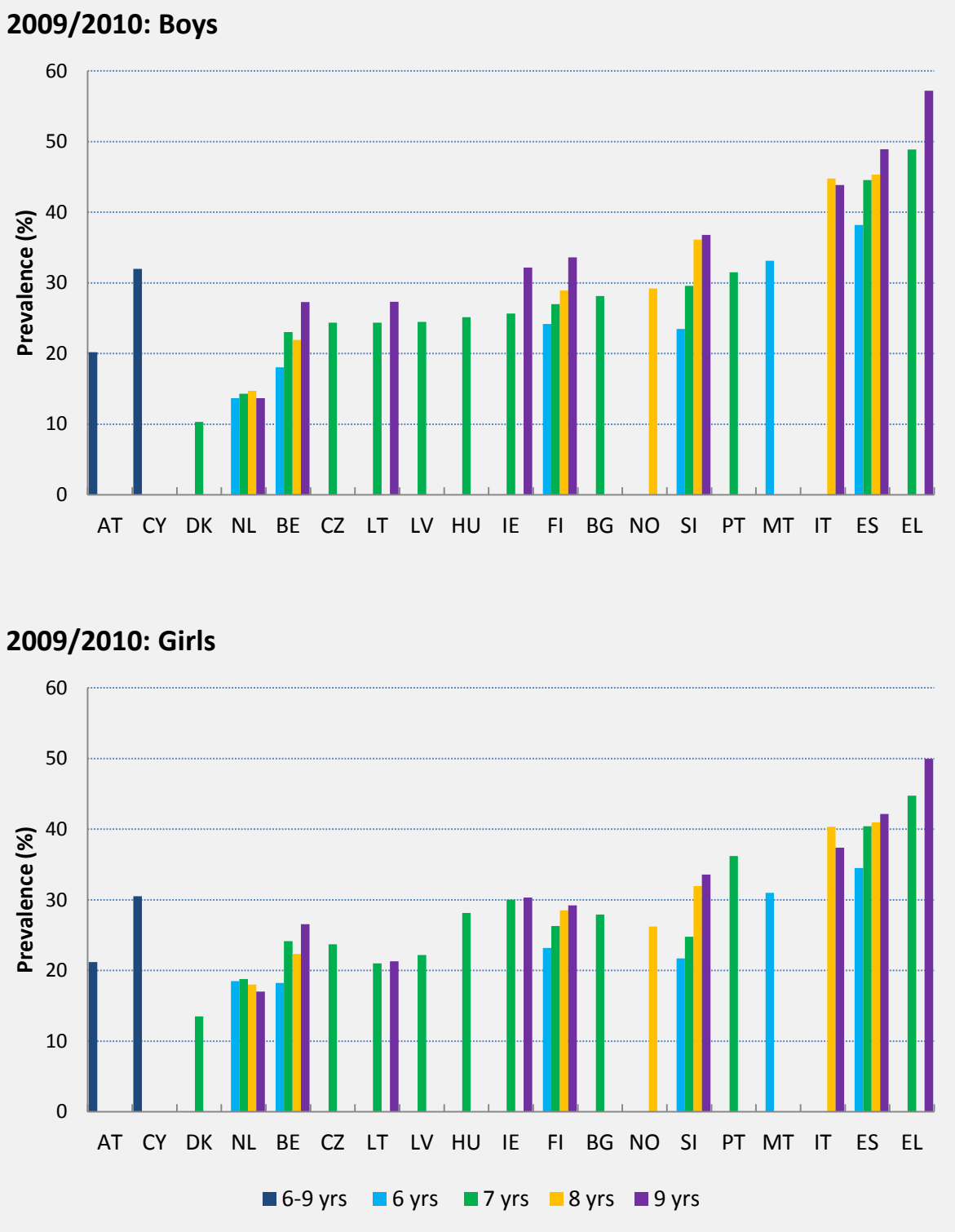


Figure 3.1. *Prevalence of overweight (including obesity) in 2009/2010 according to WHO criteria (19) among 6-9 year old boys (upper panel) and girls (lower panel).*
Source: COSI (2007/2008 data for BG), except for AT (24), CY (25), DK and FI (APCO database, source unknown), NL (26).

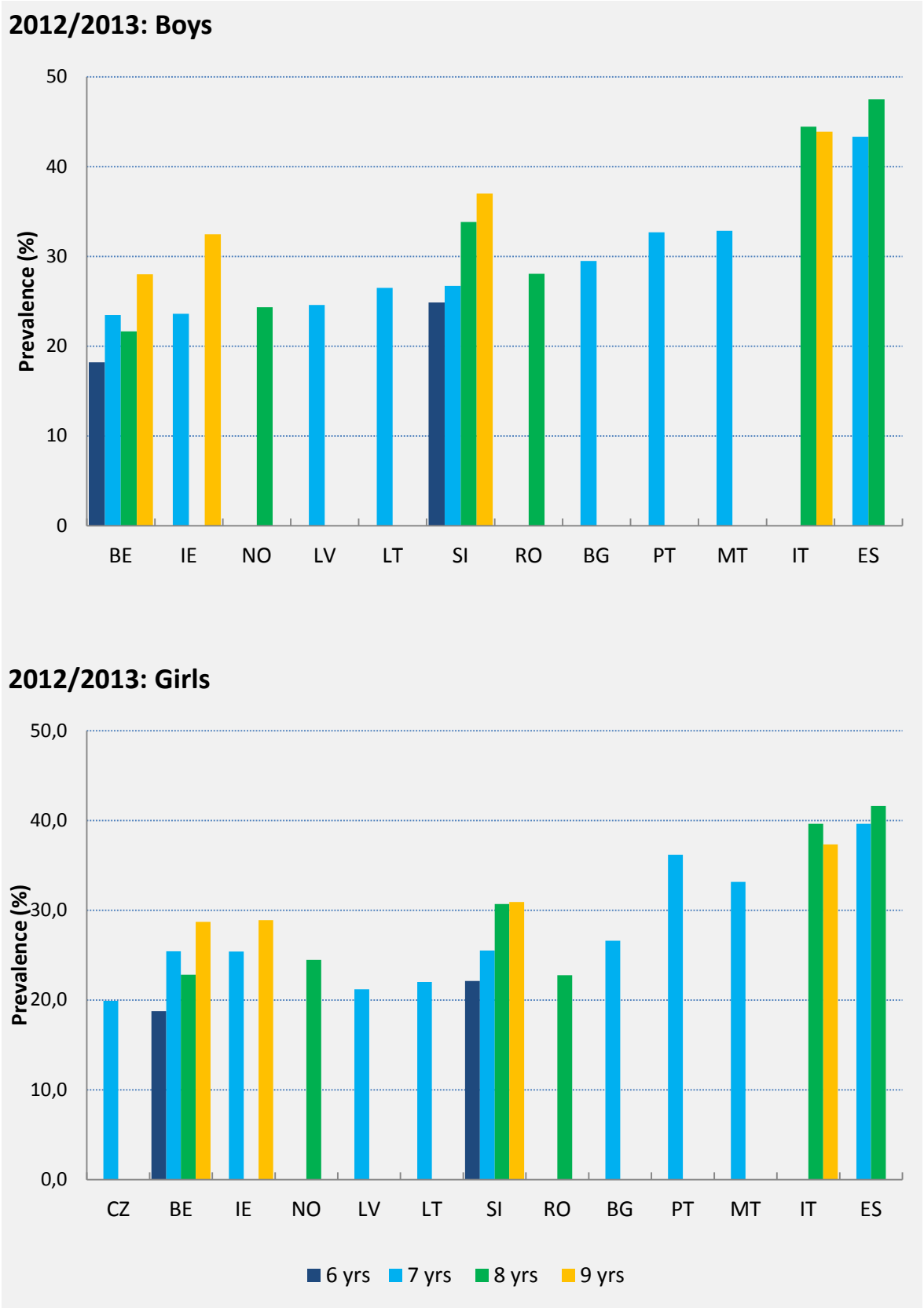


Figure 3.2. *Prevalence of overweight (including obesity) in 2012/2013 according to WHO criteria (19) among 6-9 year old boys (upper panel) and girls (lower panel). Source: COSI.*

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 (27, 28). Data are based on self-reported height and weight. It should be noted that these were missing in some countries for > 30% of the sample (for BE-WAL (Wallonia), IE, LT, UK in both surveys and for MT and RO in 2013/2014). Furthermore, 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 aging in girls (29). Therefore, firm conclusions about trends cannot be drawn from these data.

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). In almost all countries the prevalence was higher in boys than in girls. 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%. Prevalences were higher for boys than for girls with the exception of 13-year olds in Denmark and Ireland (same prevalence in boys and girls).

In the HBSC surveys socioeconomic position at the individual level was measured by the family affluence scale (FAS), 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 (27). 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 (28).

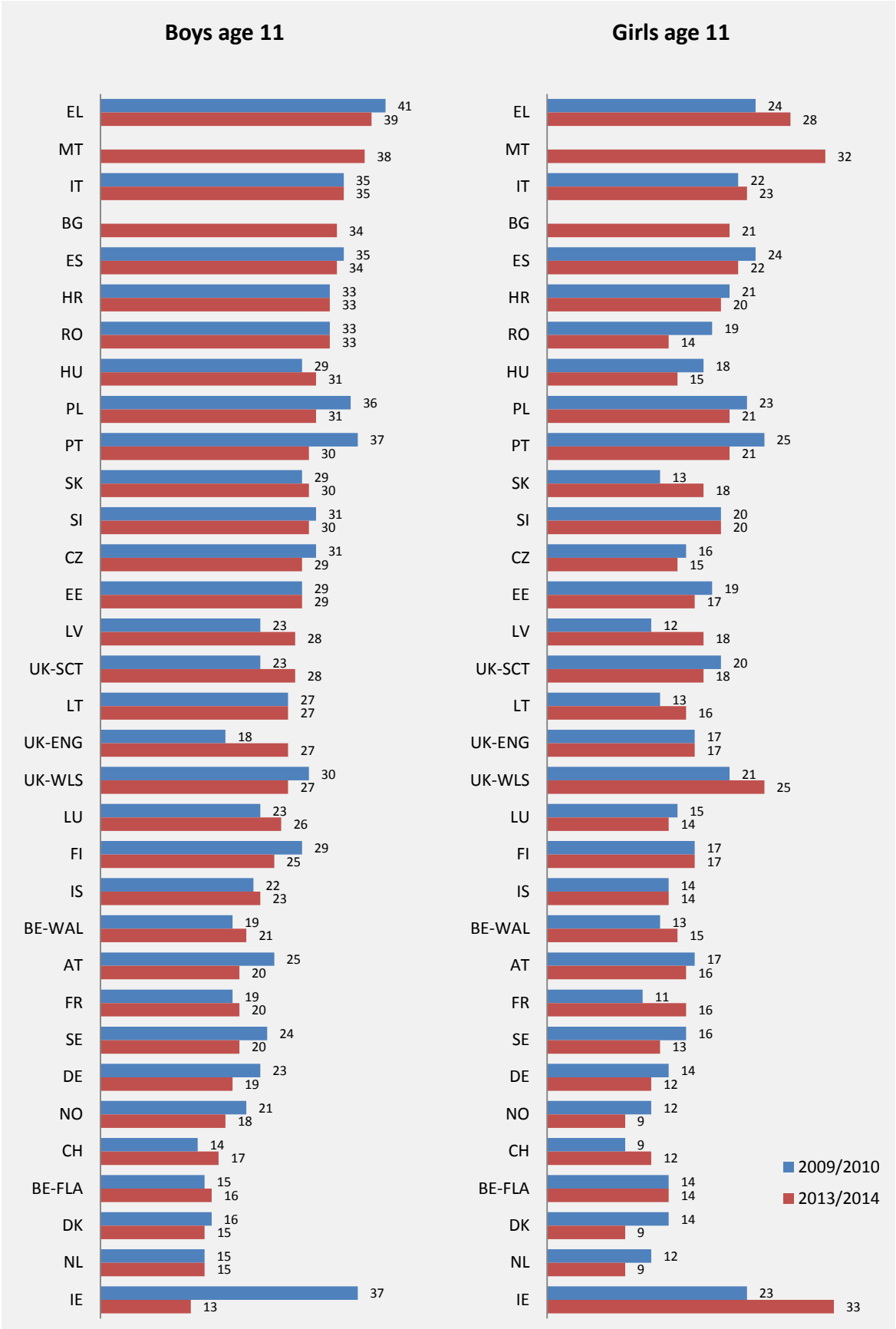


***Figure 3.3**. Prevalence of overweight including obesity in 11-year old boys and girls, according to WHO child growth curve standards (19). Source: HBSC (27, 28).*

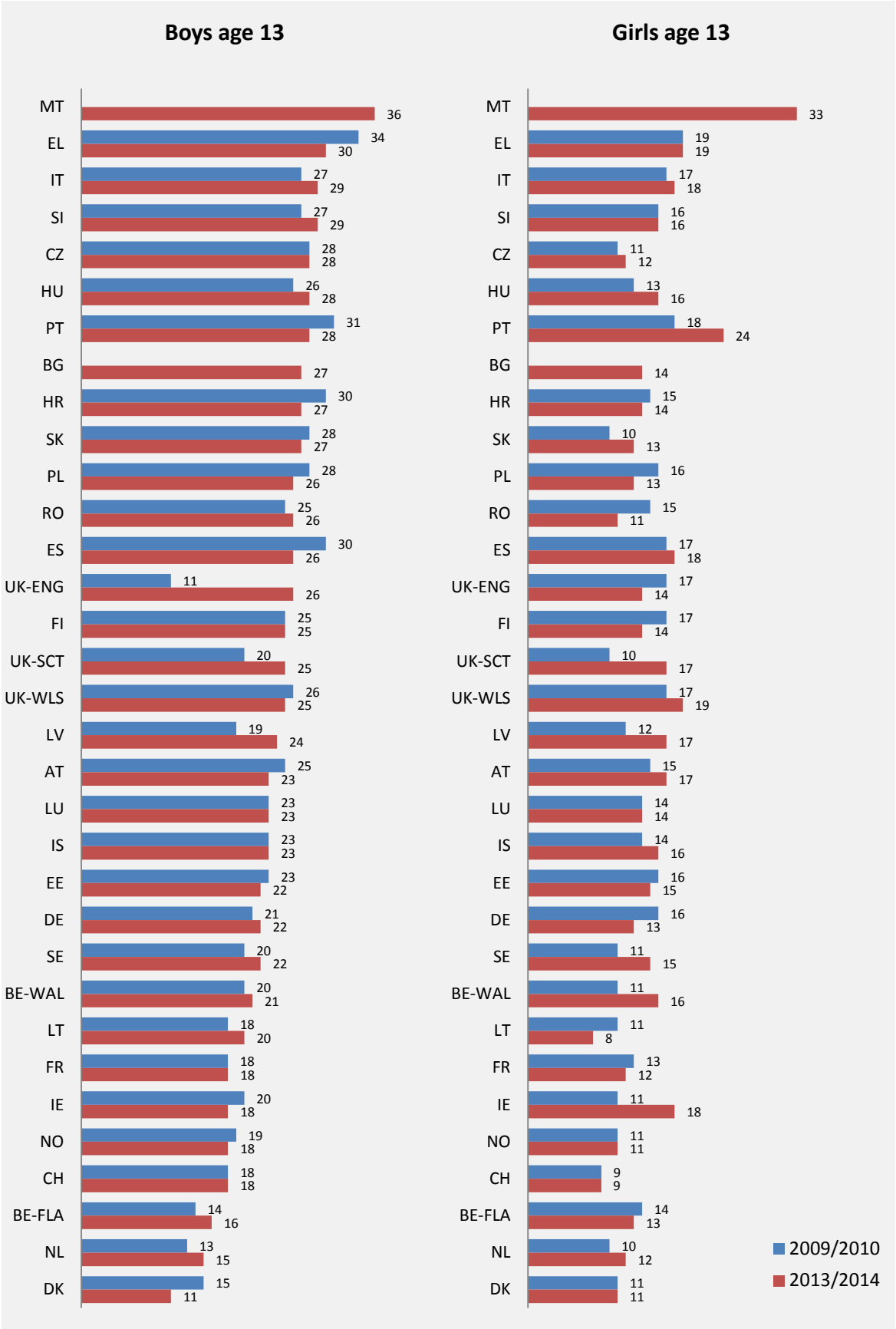


***Figure 3.4**. Prevalence of overweight including obesity in 13-year old boys and girls, according to WHO child growth curve standards (19). Source: HBSC (27, 28).*

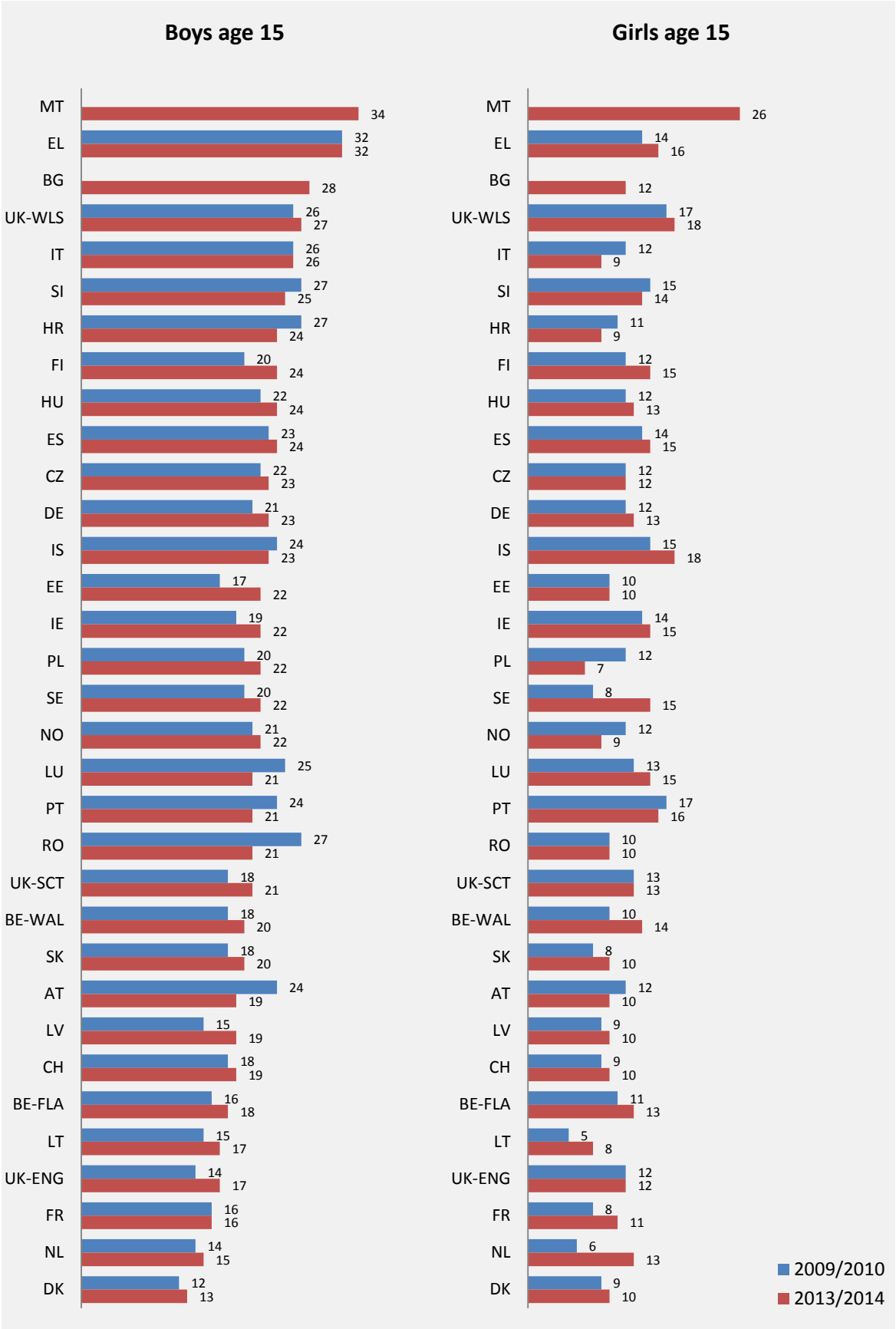


***Figure 3.5**. Prevalence of overweight including obesity in 15-year old boys and girls, according to WHO child growth curve standards (19). Source: HBSC (27, 28).*

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. 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.

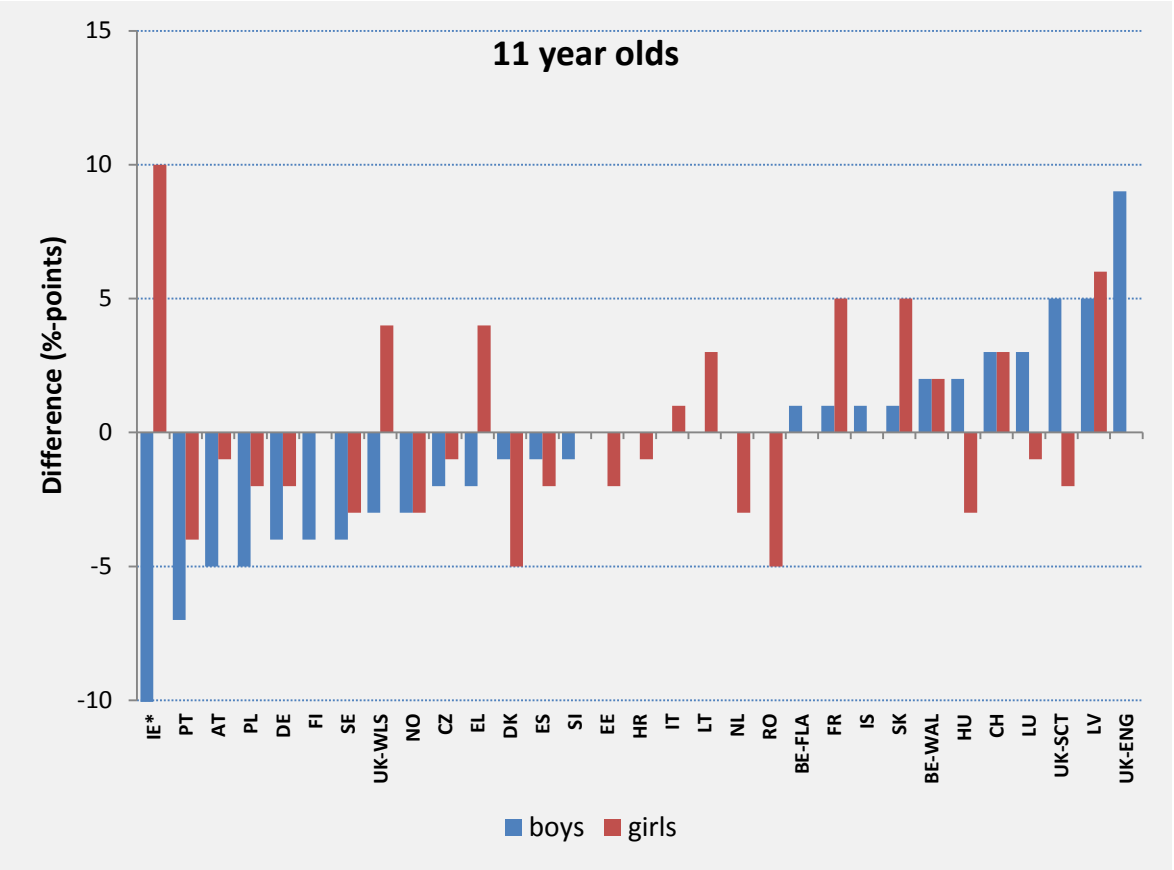


Figure 3.4. *Difference in the prevalence of overweight including obesity between 2013/2014 and 2009/2010 among 11-year old boys and girls, according to WHO child growth curve standards (19). IE* Difference is -24%. Source: HBSC (27, 28).*

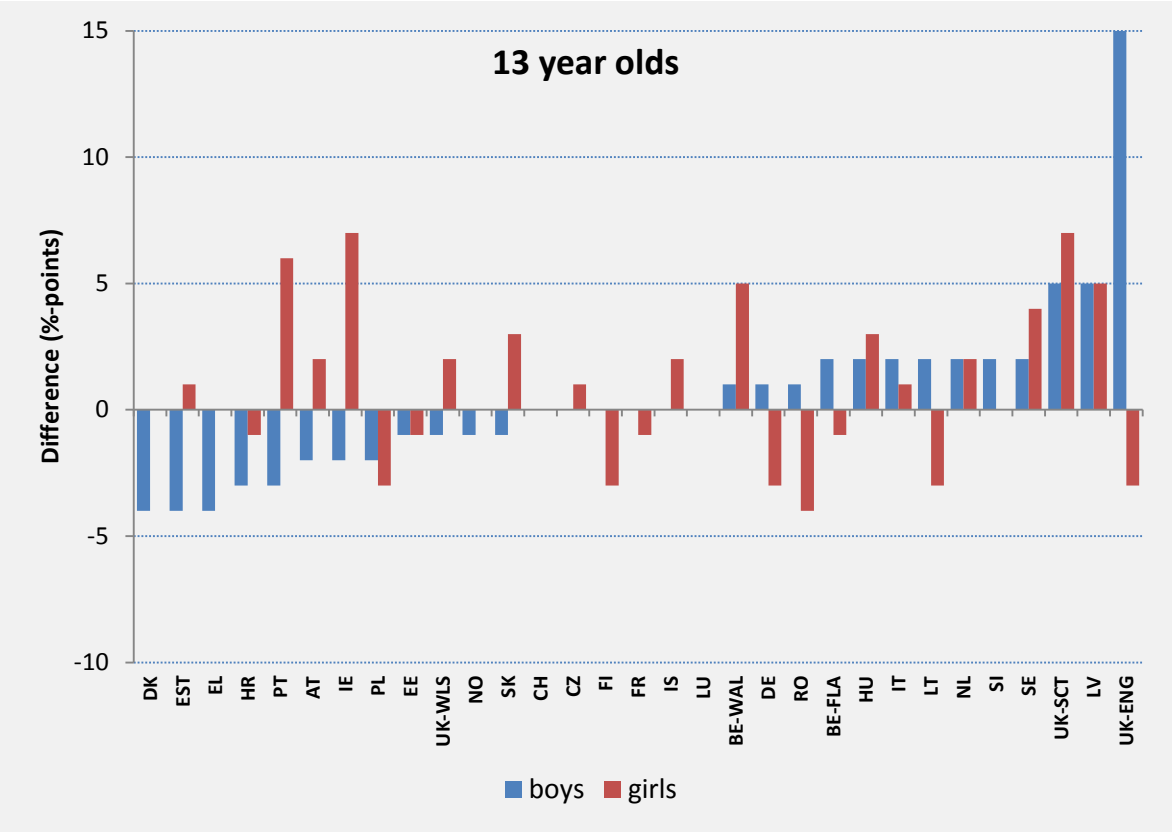


Figure 3.7. *Difference in the prevalence of overweight including obesity between 2013/2014 and 2009/2010 among 13-year old boys and girls, according to WHO child growth curve standards (19). Source: HBSC (27, 28).*

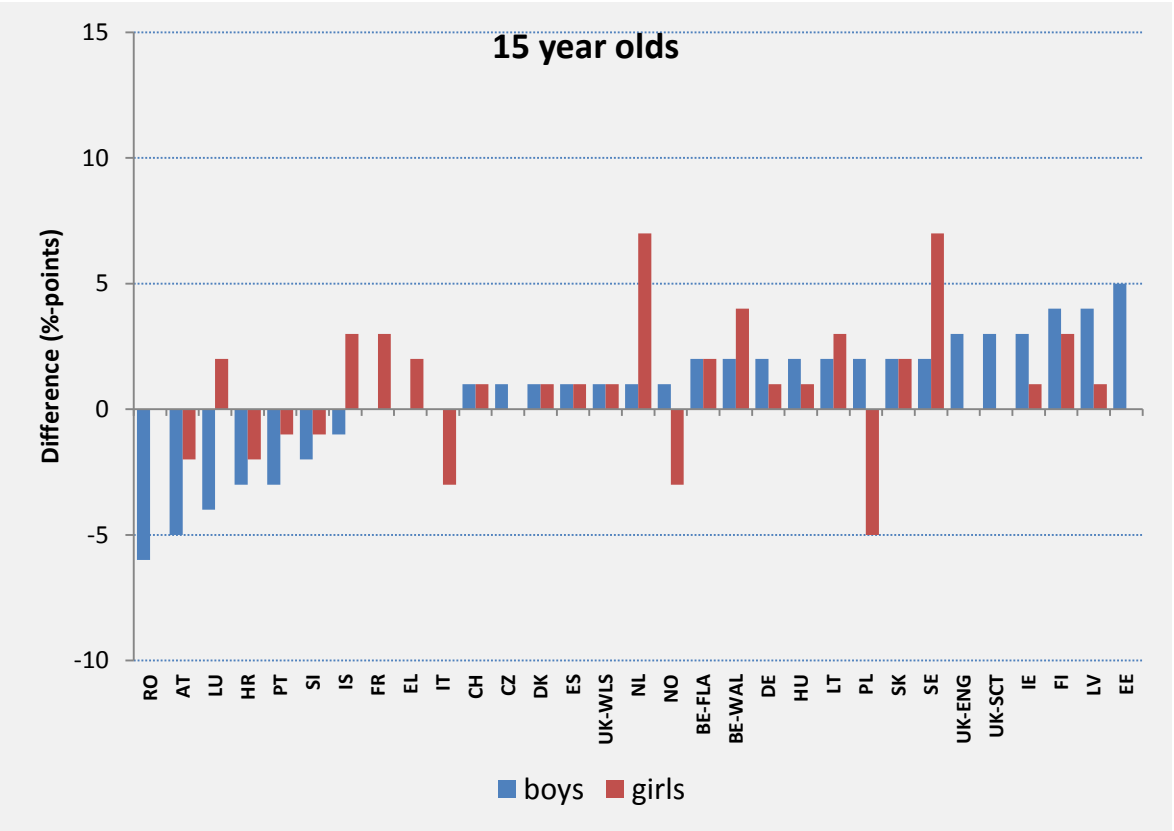


Figure 3.8. *Difference in the prevalence of overweight including obesity between 2013/2014 and 2009/2010 among 13-year old boys and girls, according to WHO child growth curve standards (19). Source: HBSC (27, 28).*

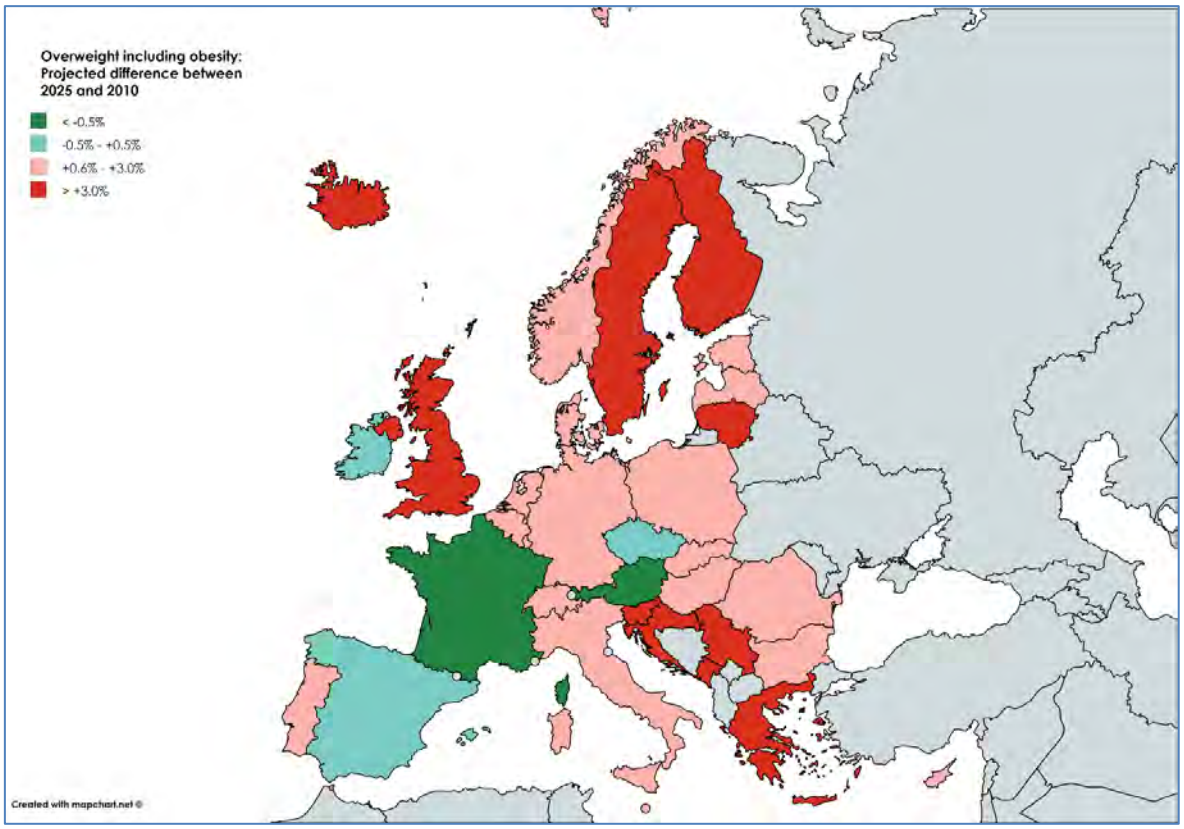
Projections on overweight and obesity prevalence for 2025

The World Obesity Federation has made projections on the prevalence of overweight and obesity among school-aged children and adolescents (2-19.9 years) in 2025 (15). 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.

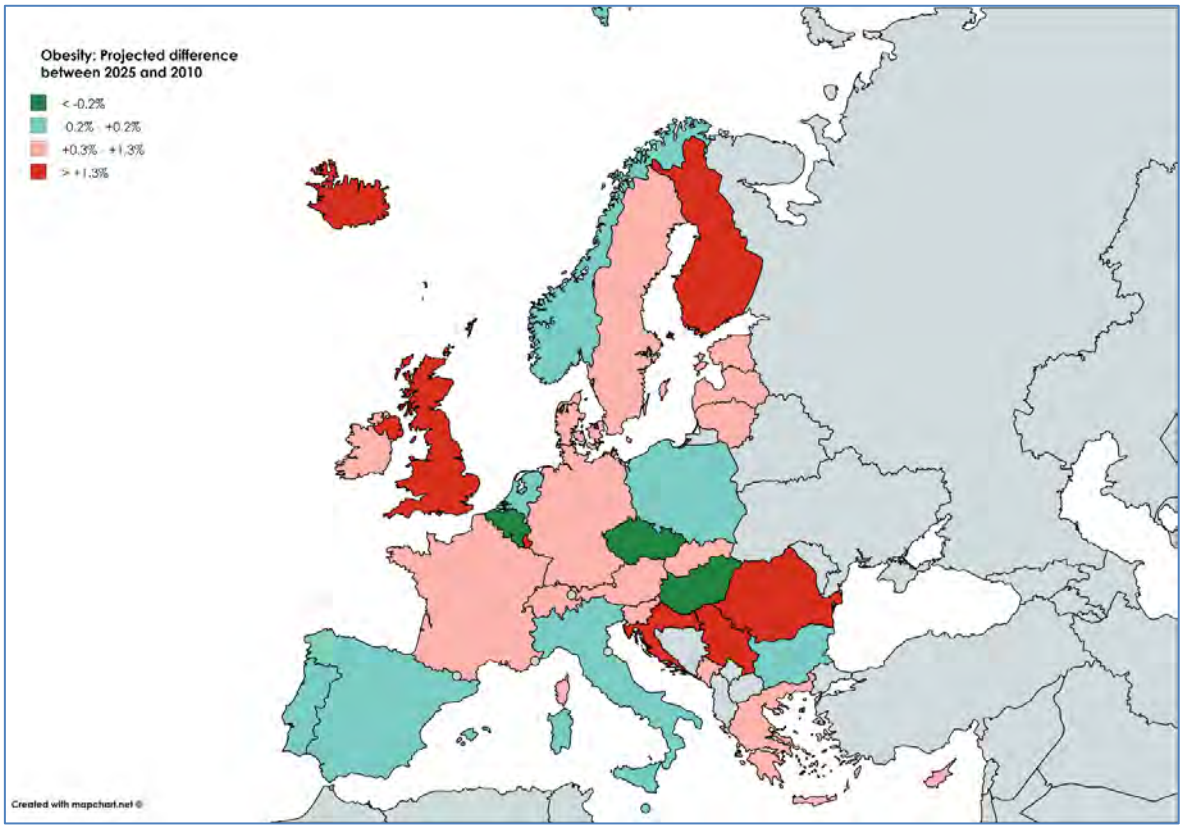
Lobstein et al. (15) used estimates of overweight and obesity from the Global Burden of Disease (GBD) programme for 2000 and 2013 to make estimates for 2010 (to match the WHO baseline year). Subsequently, these estimates were projected forward to 2025 on the basis that no effective intervention was implemented to significantly change the trend (linear projection). Overweight and obesity were defined according to the IOTF criteria. The projections only give an indication of the expected change in the prevalence of overweight and obesity between 2010 and 2025 and are not to be interpreted as truly expected prevalences in 2025.

Map 3.1 presents the predicted changes in the prevalence of overweight including obesity in 2010-2025 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 showed 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 prevalence of obesity (without overweight) was also expected to be 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.



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 (15). 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 20 year old children e (15). Based on IOTF criteria under the assumption that that no effective intervention is implemented to significantly change the trend.*

3.2 Overall assessment of the state-of-play of activities in the EU

This overall assessment is mainly based on the information provided in the interviews with High Level Group Members or other representatives of the countries appointed by them. 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 included in the Action Plan 2014-2020. 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.

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 Nutrition education included in school curricula
2.5 Physical activity included in school curricula

Area 3: Make the healthy option the easy option
3.1 Policies or initiatives on food product improvement (a.k.a. reformulation) 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 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*

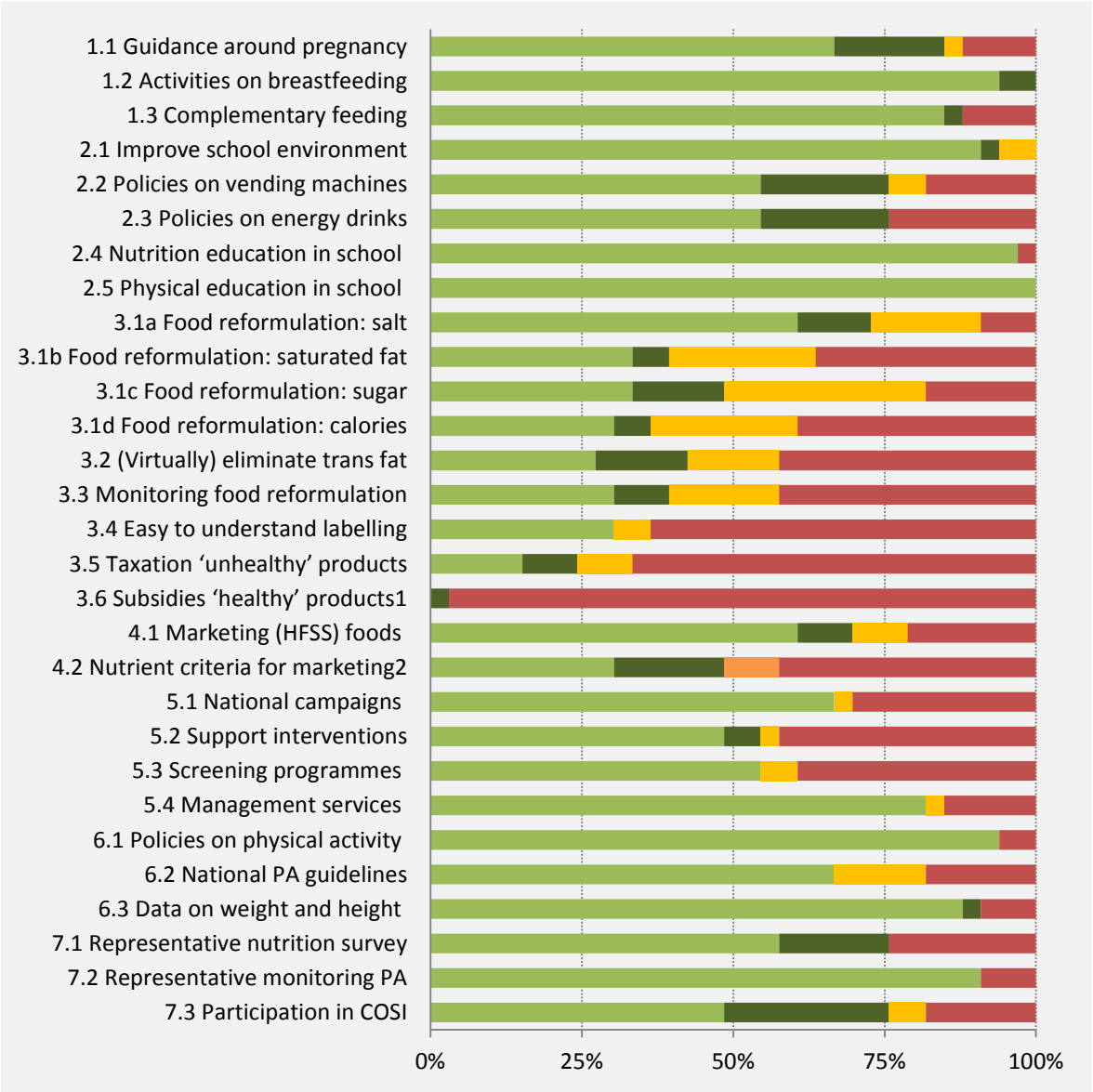
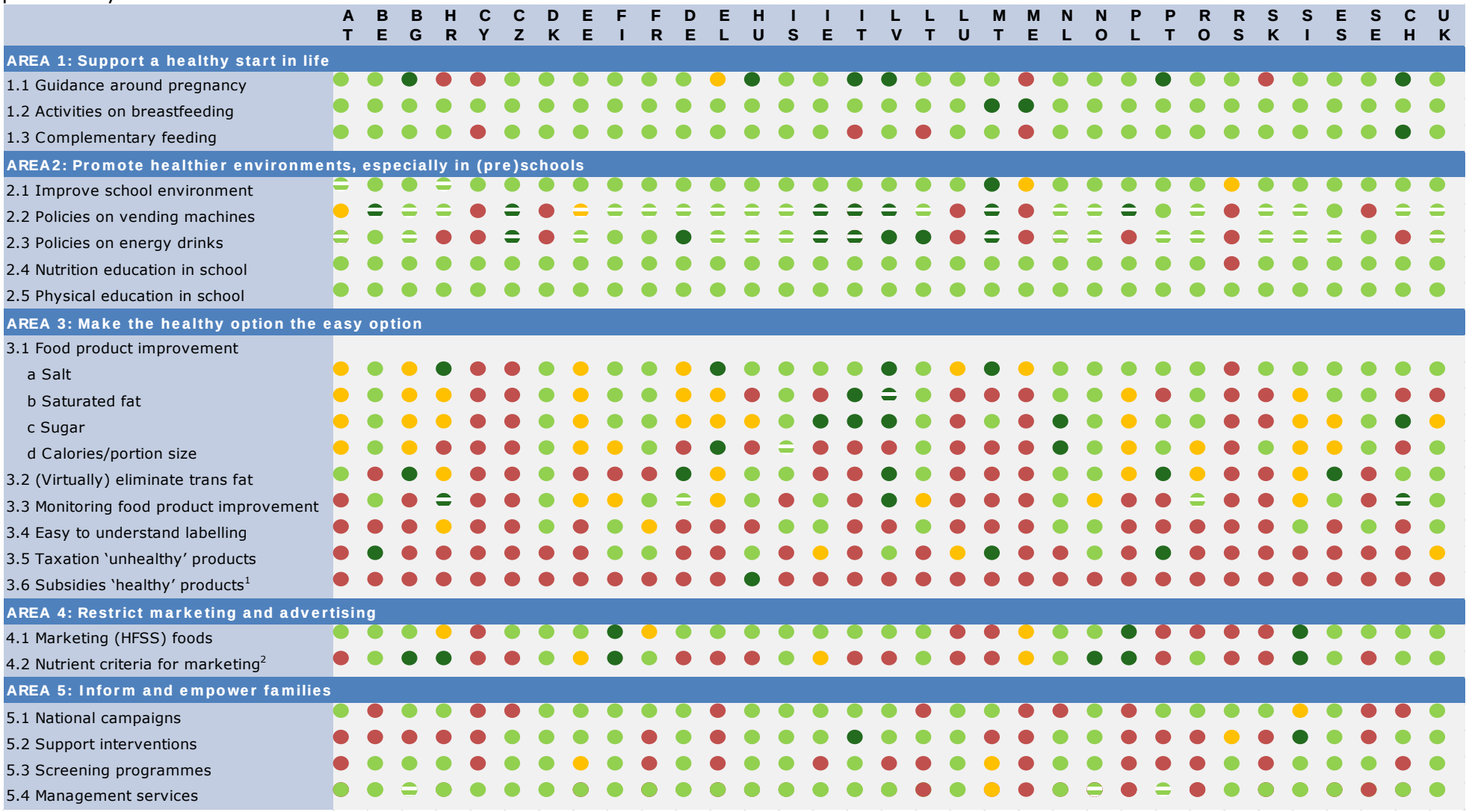


Figure 3.9. *Summary of implementation of the EU Action Plan expressed as percentage of all countries having activities in the mentioned areas.*

[1] other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme
[2] other than included in school policies
yes, already before EU Action plan*
yes, since EU Action plan*
no action is initiated or supported by national authorities (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 (partially) undertaken, but does not contain an evaluation of effectiveness from our part.

Table 3.1. Overview of policies/strategies according to the areas of action included in the Action Plan on Childhood Obesity 2014-2020 per country.



[1] Other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme
[2] Other than included in school policies

Table 3.1 continued. Overview of policies/strategies according to the areas of action included in the Action Plan on Childhood Obesity 2014-2020 per country.

	AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IS	IE	IT	LV	LT	LU	MT	ME	NL	NO	PL	PT	RO	RS	SK	SI	ES	SE	CH	UK
AREA 6: Encourage physical activity																																	
6.1 Policies on physical activity	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
6.2 National PA guidelines	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	◒	●	●	●
6.3 Data on weight and height	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
AREA 7: Monitoring and surveillance																																	
7.1 Representative nutrition survey	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
7.2 Representative monitoring PA	◒	◒	◒	◒	●	◒	◒	◒	●	◒	●	◒	◒	◒	●	◒	◒	●	◒	◒	●	●	●	◒	●	◒	●	◒	◒	●	●	◒	●
7.3 Participation in COSI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

● yes, already before EU Action plan*
● yes, since EU Action plan*
◒ ◓ partially, for example in certain settings or certain regions*,
● no action is initiated or supported by national authorities (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 (partially) undertaken, but does not contain an evaluation of effectiveness from our part.

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 (before), 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 (88%) 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 a few countries policies also apply to settings other than the school environment. In all countries physical education is included in the school curriculum. In the majority of countries, a minimum number of hours is specified. Although nutrition education is also included in school curricula in all but one of the participating countries, it is not always mandatory and is often part of 'biology', 'home economics' or other lessons without specification of the number of hours to be provided.
- Food product improvement, also known as reformulation, is an area that experiences growth across Europe (Area 3). Several countries recently started reformulation initiatives, while others are planning to do so. Easy to understand labelling, such as front-of-pack labelling, is used in 10 countries (30%) to make the healthy option the easy choice (in one it will end in 2017), while planned in another two. Also taxation of 'unhealthy' products is not widely used (in eight countries, 24%), but another three countries (9%) have plans for a levy (additional legal charge) on sugar-containing beverages and in two countries a levy may be foreseen. 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. In 2017, Hungary decreased taxation on some products, for example fresh milk and eggs. There are plans to decrease taxes on fish and vegetables as well.
- 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 70% of the countries (n=23) have initiatives in this area, and 3 countries have plans for the near future. They are usually based on (voluntary) codes issued by the private sector. National authorities may or may not to some extent have been involved in these voluntary codes. Therefore, it is possible that some countries during the interview mentioned not to have any policies and others mentioned they do, while voluntary codes of conduct are in place. Nineteen countries use nutrient criteria to reduce marketing of foods to children or have plans for such criteria.
- Twenty-two counties (67%) 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%) 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 obesity takes place or is planned in 20 countries (61%) and is quite often seen as one of the tasks of child healthcare 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), the presence of or planning of national guidelines (in 81% of the countries) and available data on weight and height of children (in 91% of the countries).
- National representative nutrition surveys are available in 76% of the countries. However, it is not always clear whether or not children are included in these

surveys. All but three countries participate in the Health Behaviour in School-aged Children (HBSC) surveys and 25 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 physical activity is at least covered through the HBSC-study and thus concerns adolescents.

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 obesity. No clear pattern was apparent (see Annex 5, table A5A). 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 product improvement (Annex 5, table A5B).

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

This chapter presents further description and several maps of the indicators included in the Childhood Obesity Study (see Annex 2) according to the areas for action of the Action Plan. No indicators for Area 8: "Increase research" are included, as the operational objectives in the Action Plan are mainly for the European Commission. Furthermore, participation in EU-wide projects is covered in the next chapter.

4.1 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

Twenty-eight countries 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. Six countries (BG, HU, IT, LV, PT, CH) have implemented (new) guidance since 2014. The percentage of Member States that implemented (new) guidance or do not yet provide guidance is larger in the newer EU Member States than in the original EU Member States (EU15). In Greece, new national nutritional guidelines are expected to be adopted this year. They will include recommendations for pregnant women, based on the scientific evidence and with a special focus on the Mediterranean diet.

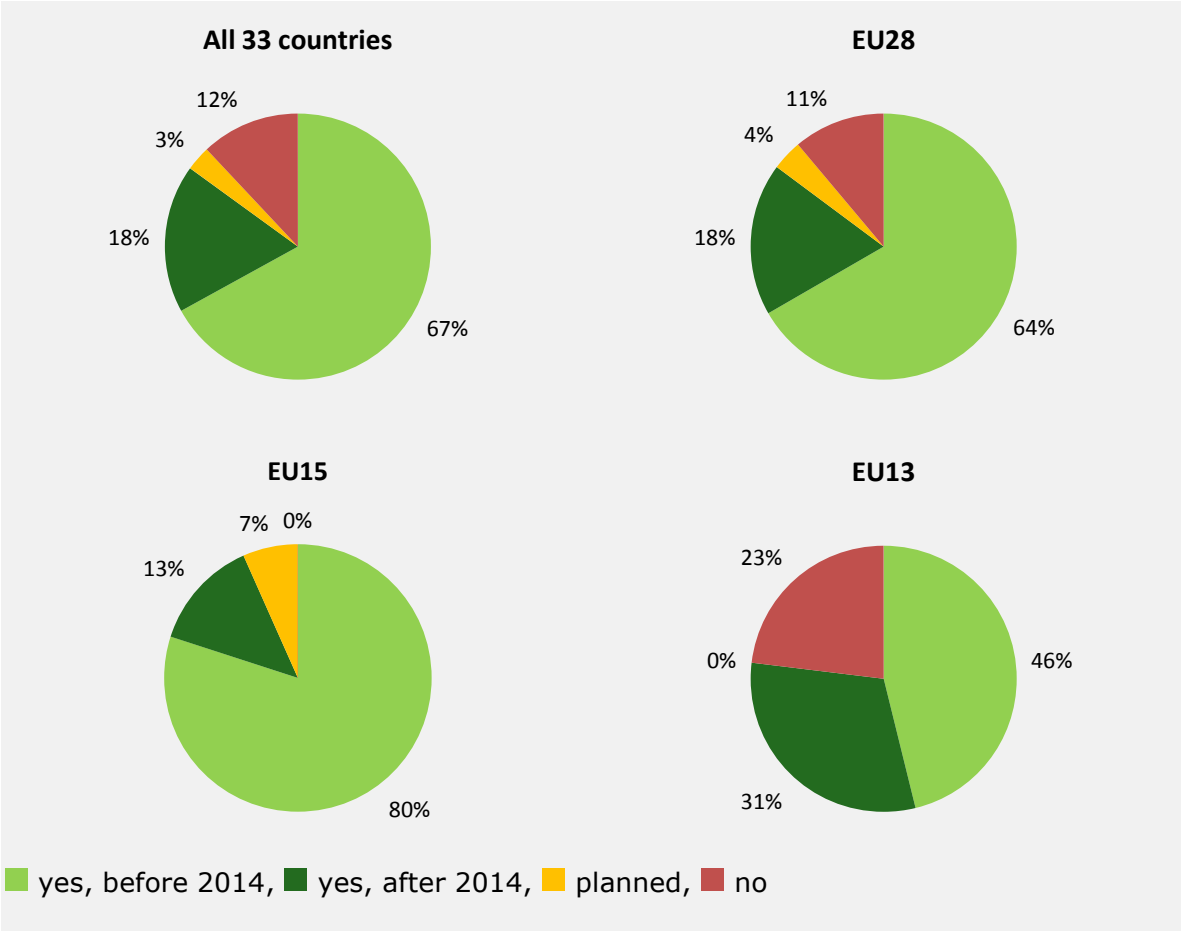
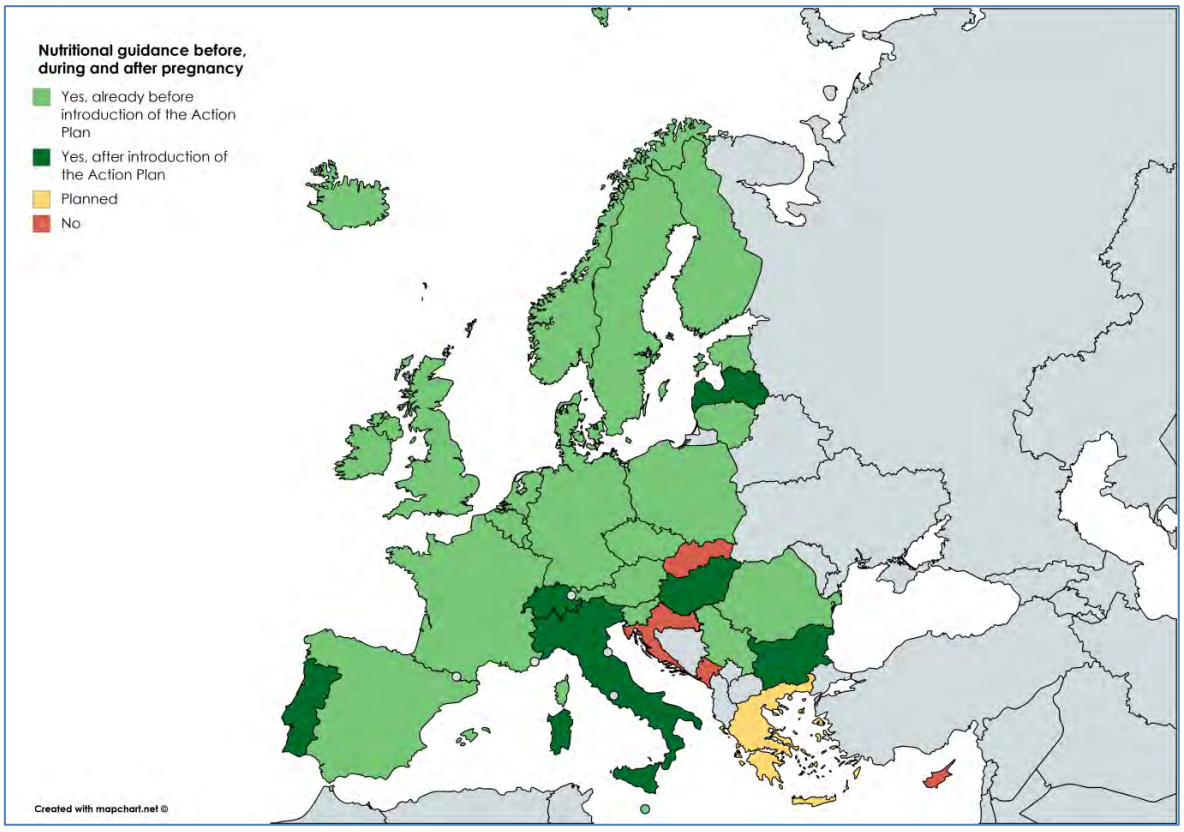


***Figure 4.1**. Provision of nutritional guidance before, during and after pregnancy. EU13: Member States that joined the EU after 1995.*



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

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 (30). 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, 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 in 2017 (EE, FI, IE, ES). According to the GNPR2 survey of WHO (no data are available for six countries), breastfeeding promotion 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.

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 (31), 27 of the 33 countries States (82%) currently have implemented the initiative, one since 2015 (CY) (Figure 4.2). Four have implemented it previously (DK, EE, LV, RO) and two never implemented it (IS, MT). In Malta, the ten steps are, however, integrated into national quality standards.

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 52.4% in Croatia (figure 4.4). National representative data on exclusive breastfeeding were obtained from WHO's Global Health Observatory data repository[4] and WHO's country profiles on nutrition, physical activity and obesity[5] for 31 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), data were obtained from DG SANTE (through the APCO database). These data were provided by national representatives. Data were collected with different methods and over different time periods. All surveys originate before introduction of the Action Plan (ranging from 2003-2014). 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 infants aged 0–5.9 months who are fed exclusively on breast milk. Alternative definitions were used in Bulgaria (at 4-5 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.

[4] http://apps.who.int/gho/data/view.main.NUT1730?lang=en. Global Health observatory data repository
[5] http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/country-work

The duration of maternity leave might also influence the percentage of children that are exclusively breastfed until the age of six months. However, the percentage of children exclusively breastfed was not associated with the duration of maternity leave (figure 4.5). Data on the duration of maternity leave were obtained from the experts or the European Parliamentary Research Service (32) (for BE, DE, FR, LV, LU, PT, SI). No data are available for Switzerland. The number of weeks for maternal leave ranges from 10 in Portugal to 156 in Estonia and Slovakia.

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.

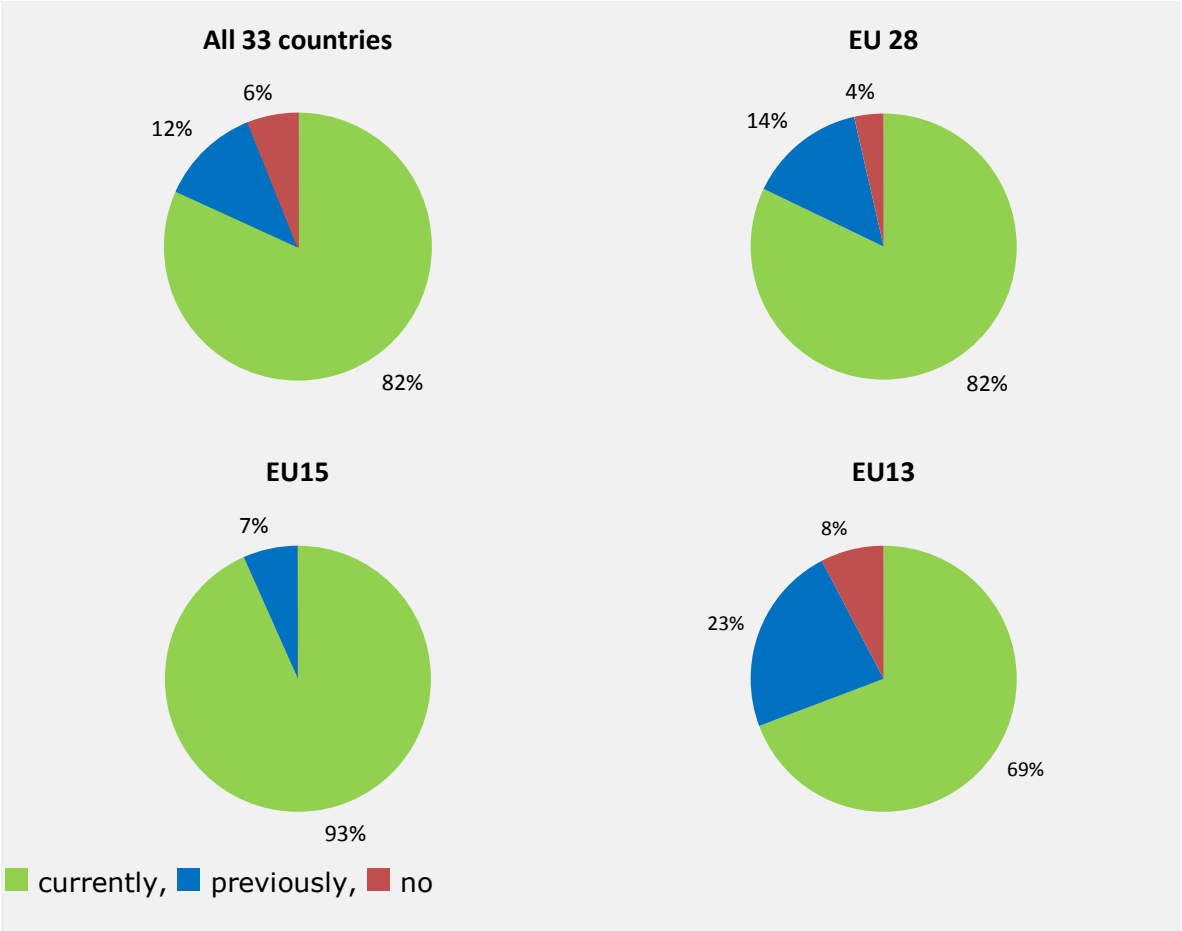


***Figure 4.2**. Implementation of the Baby-Friendly Hospital Initiative. Situation in 2016 (31). EU13: Member States that joined the EU after 1995.*

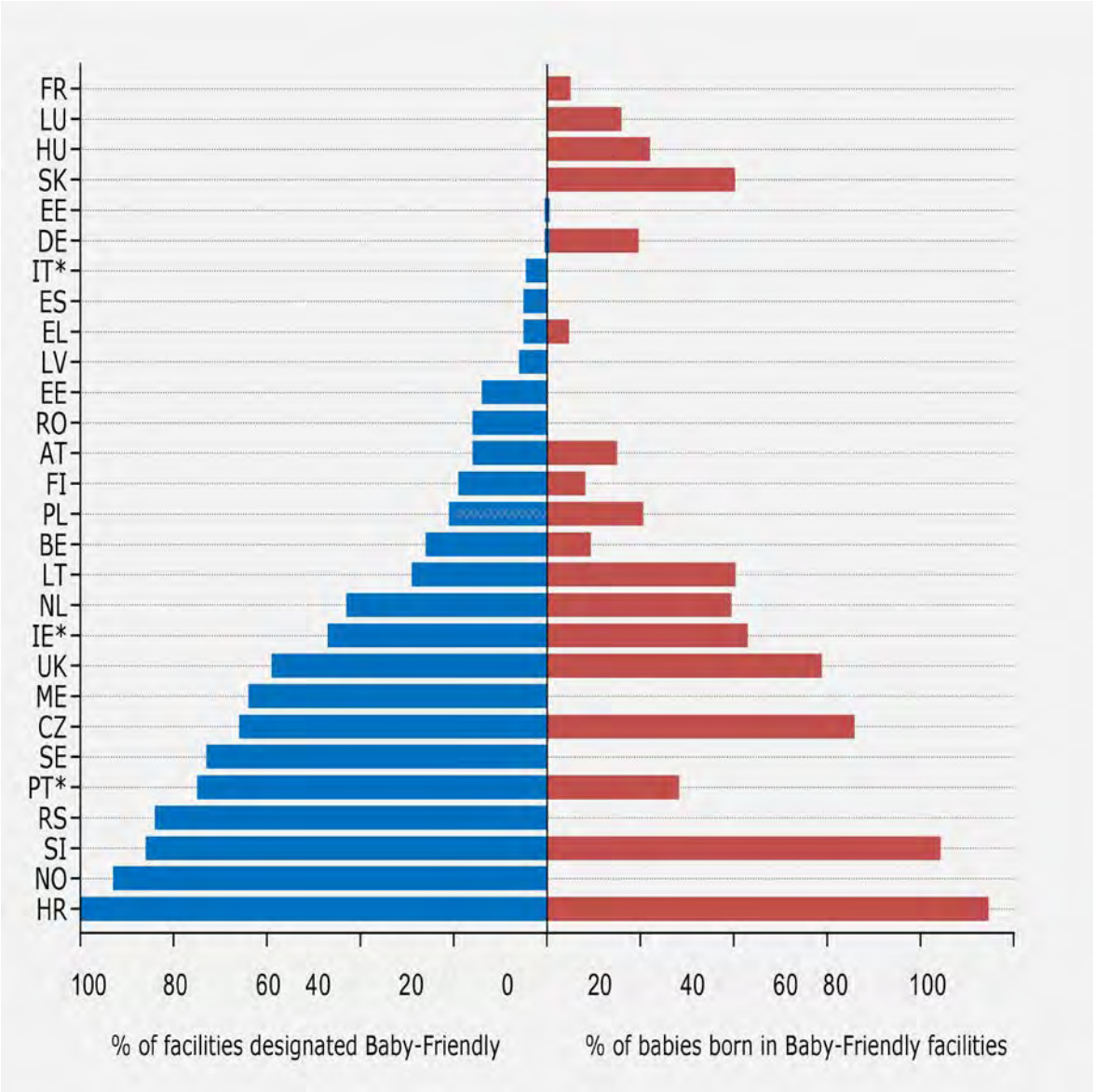


***Figure 4.3**. Percentage hospitals and maternities designated as baby friendly according to the Baby Friendly Hospital Initiative (left) and the percentage of babies born in such hospitals and maternities. Situation in 2016 (31). * Data on % of hospitals and maternities designated obtained from experts.*

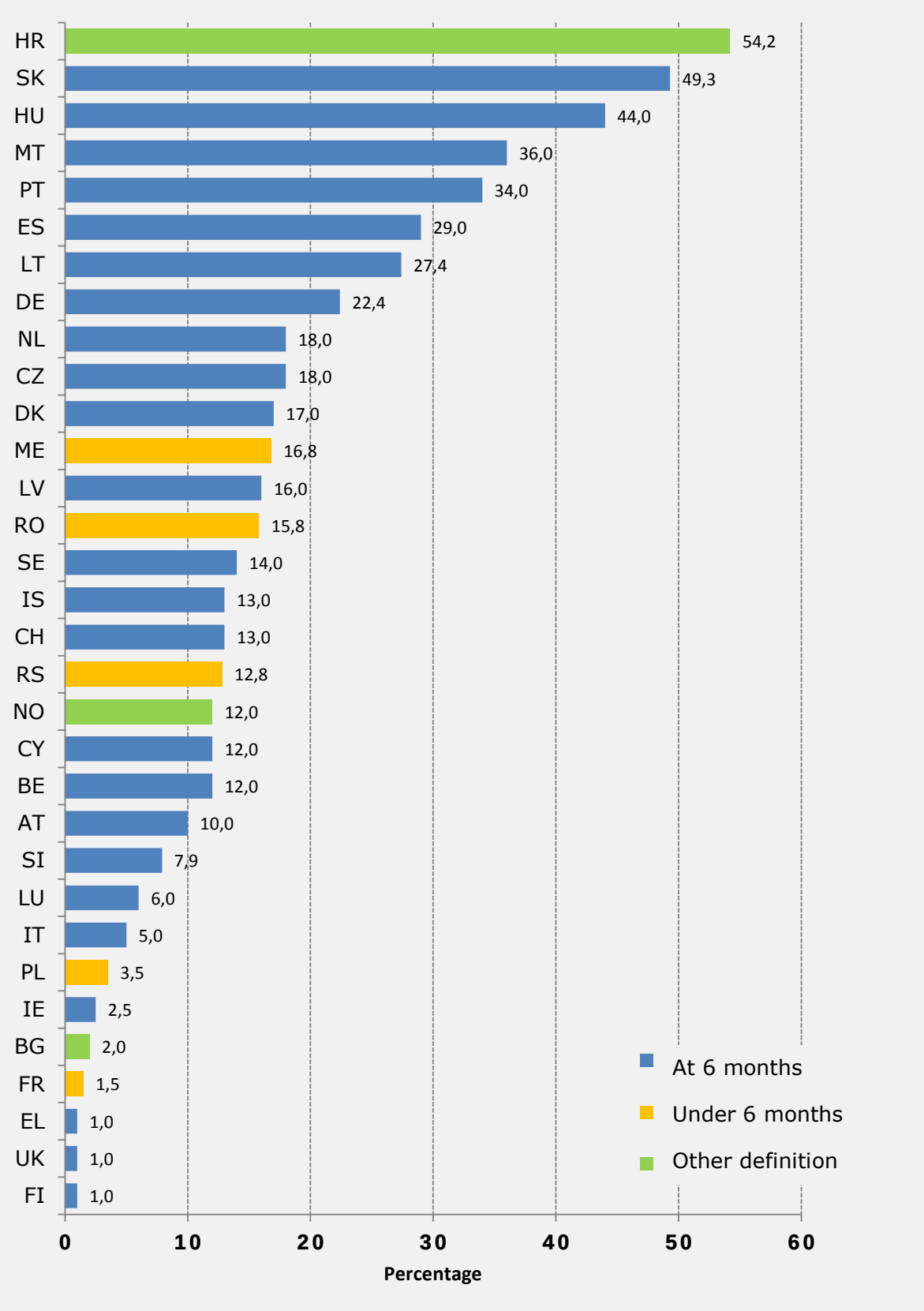


***Figure 4.4**. Percentage of children exclusively breastfed in 28 EU Member states, plus Montenegro, Norway, Iceland, Serbia, and Switzerland.*

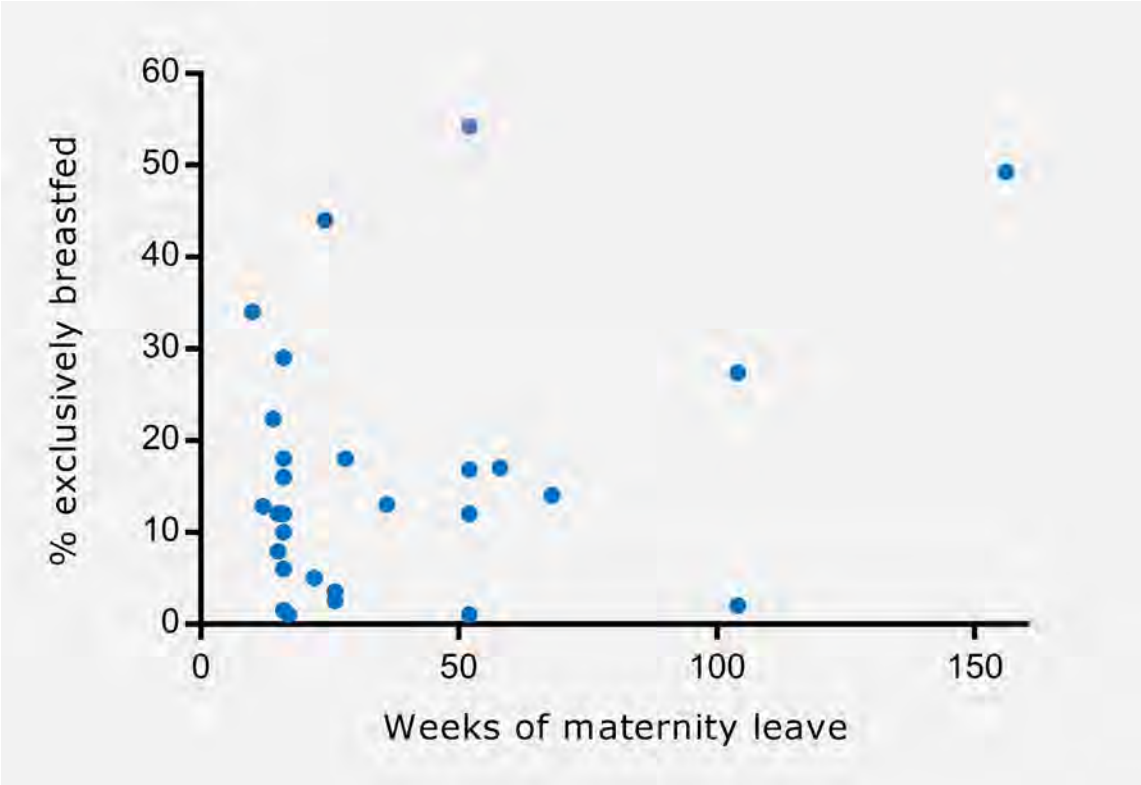


***Figure 4.5**. Relation between the duration of maternity leave and the percentage of children exclusively breastfed for 6 months.*

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 (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 counties 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 somewhat higher in EU15 than in the other EU Member States.

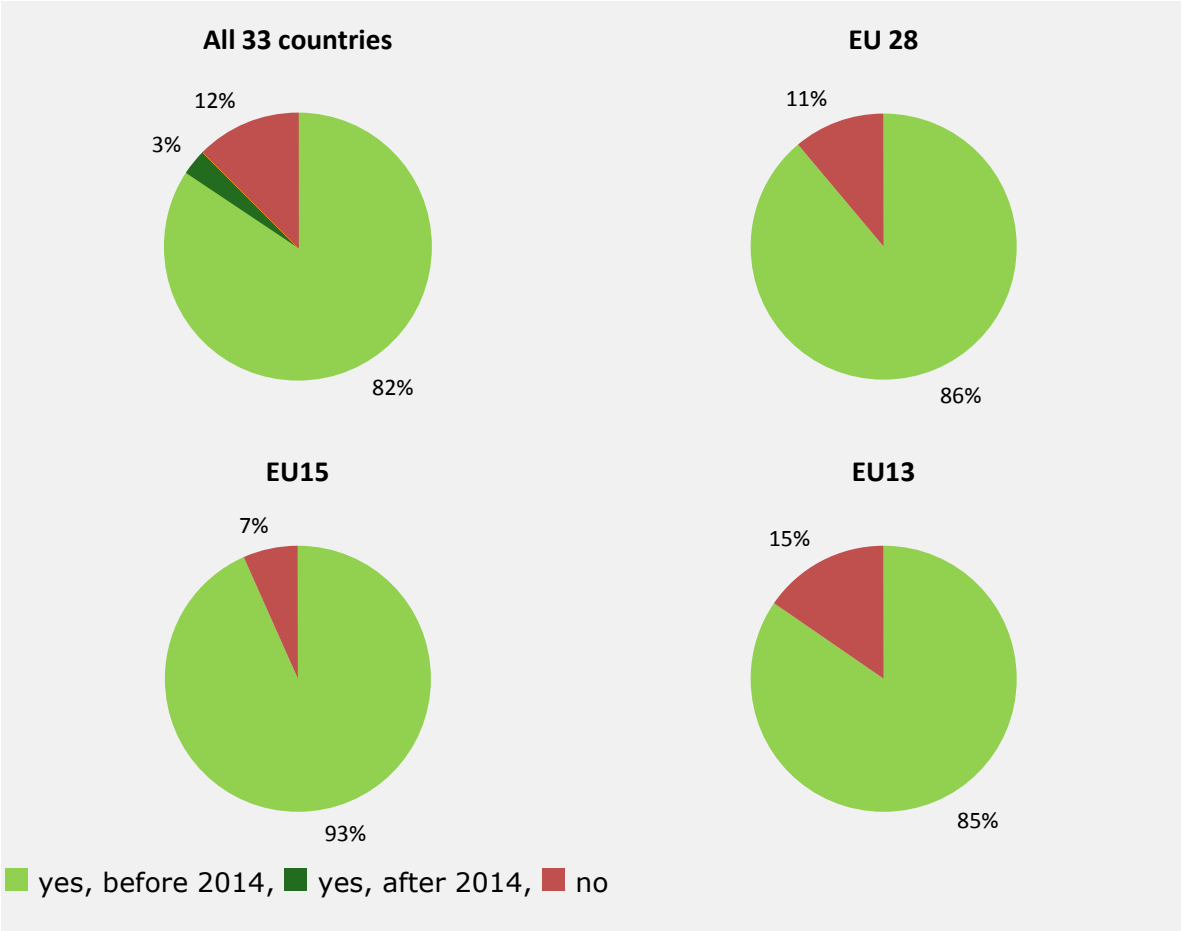
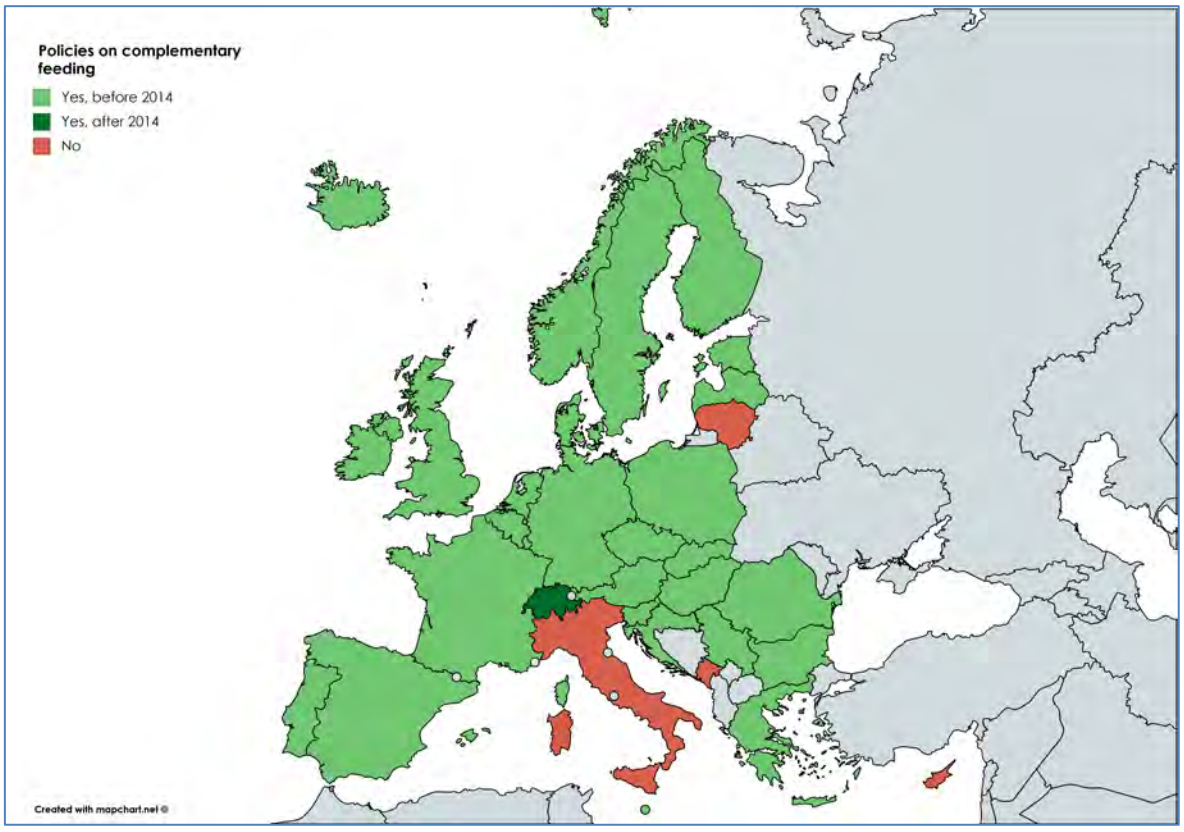


***Figure 4.6**. Guidance on complementary feeding. EU13: Member States that joined the EU after 1995.*



***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

Based on a study from 2102 (33), in the Action Plan it was recognized that young people in the EU consume substantial amounts of sugar-sweetened beverages. Data of HBSC from 2013/2014 show that there are large differences in the percentage of adolescents that daily consume sugar-sweetened beverages between countries (28). The percentage ranged from 3% to 37% among 11 year-olds, from 4% to 41% among 13 year-olds and from 5% to 34.5% among 15 year-olds (Figure 4.7). In general, a smaller percentage of girls daily consumed sugar-sweetened beverages (1% to 30% among 11 year-olds, %1 to 34% among 13 year-olds and 1% to 30% among 15 year-olds). In Belgium, Switzerland, Hungary and Bulgaria, more than 20% 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% to39% in boys and from 17% to 20% in girls). None of the experts provided more recent information.

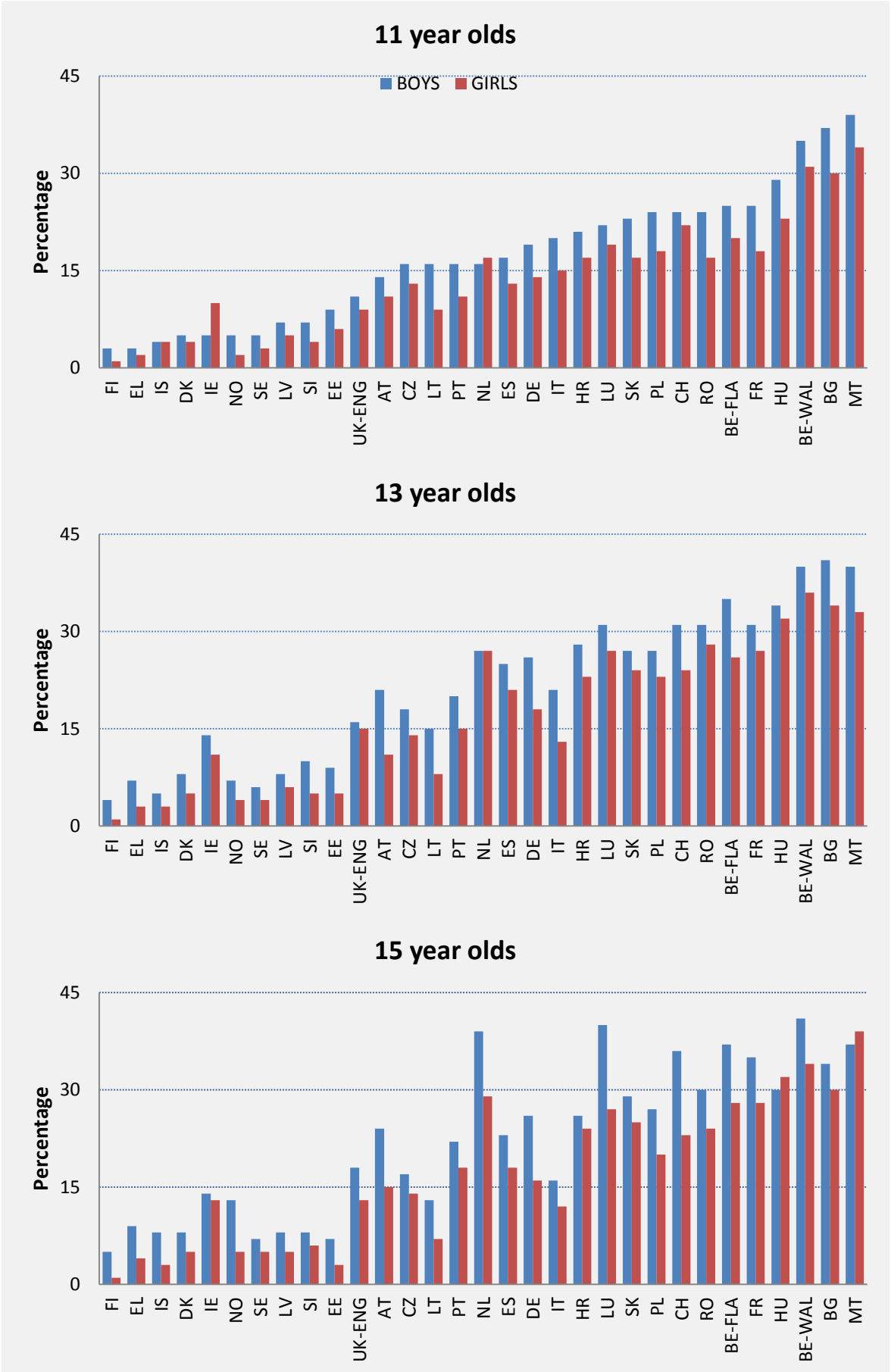
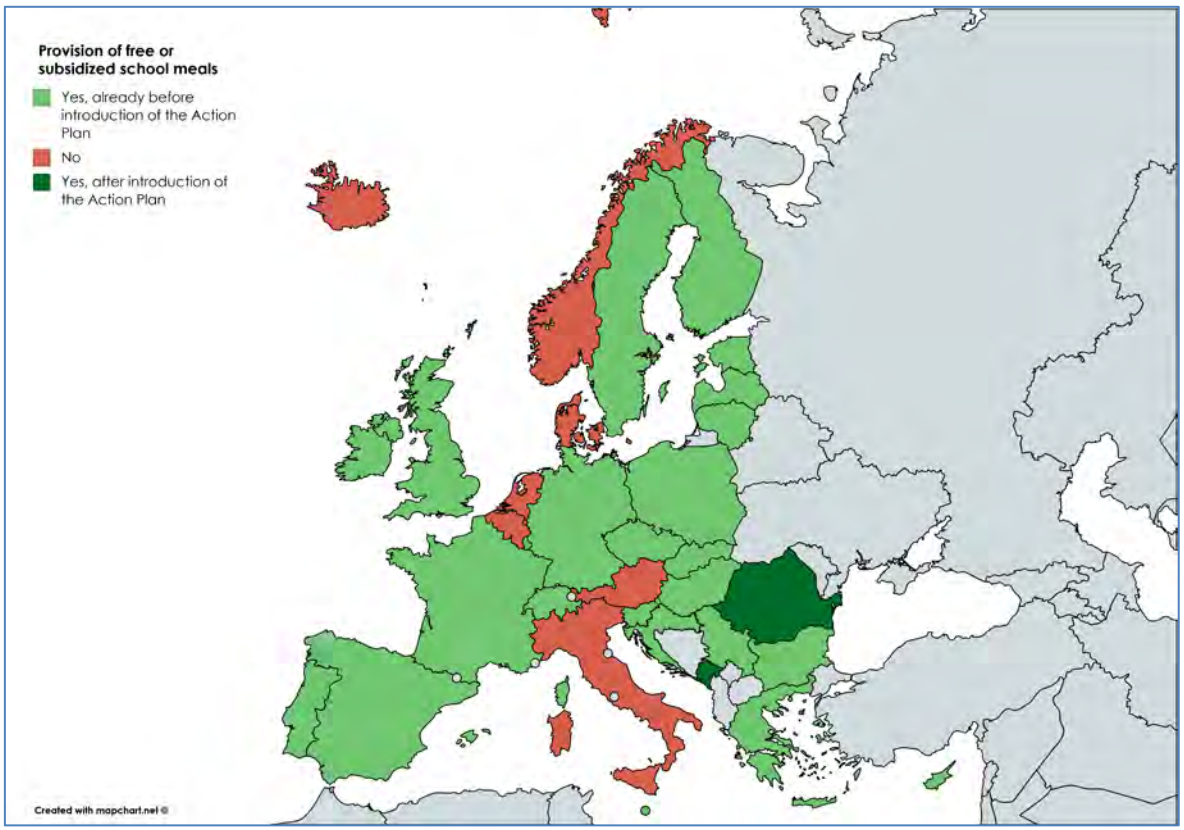


Figure 4.7. *Percentage of children daily consuming sugar sweetened beverages. Source: HBSC 2013/2014 (28). No data are available for Cyprus, Montenegro and Serbia.*

Policies on improving the children's school environment

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 itself. Map 4.3 shows whether or not schools provide free or subsidized meals. Schools are therefore an essential environment to consider when tackling overweight and obesity in children and young people. All competent authorities interviewed mentioned to have policies to improve the school environment in their country or that they are being prepared. These include at least mandatory or voluntary standards that are specified for school meals and other foods provided or sold at schools. More detailed information can be found in the school food policy country sheets of the Joint Research Centre of the European Commission (JRC)[6].



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

In 22 of the 33 countries (67%) there are policies or guidelines on supplying easily accessible, free fresh drinking water at schools, usually as part of school food policies. This is the case in 20 of the 28 EU Member States (72%). Representatives or experts of several countries reported that the quality of drinking water is secured, so students have access to free drinking tap water in school. So 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 4.8 and Map 4.4). The percentage is somewhat lower in the Member States that entered the EU after 1995 (EU13). 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 area for action. 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.

[6] https://ec.europa.eu/jrc/en/publication/school-food-policy-country-factsheets

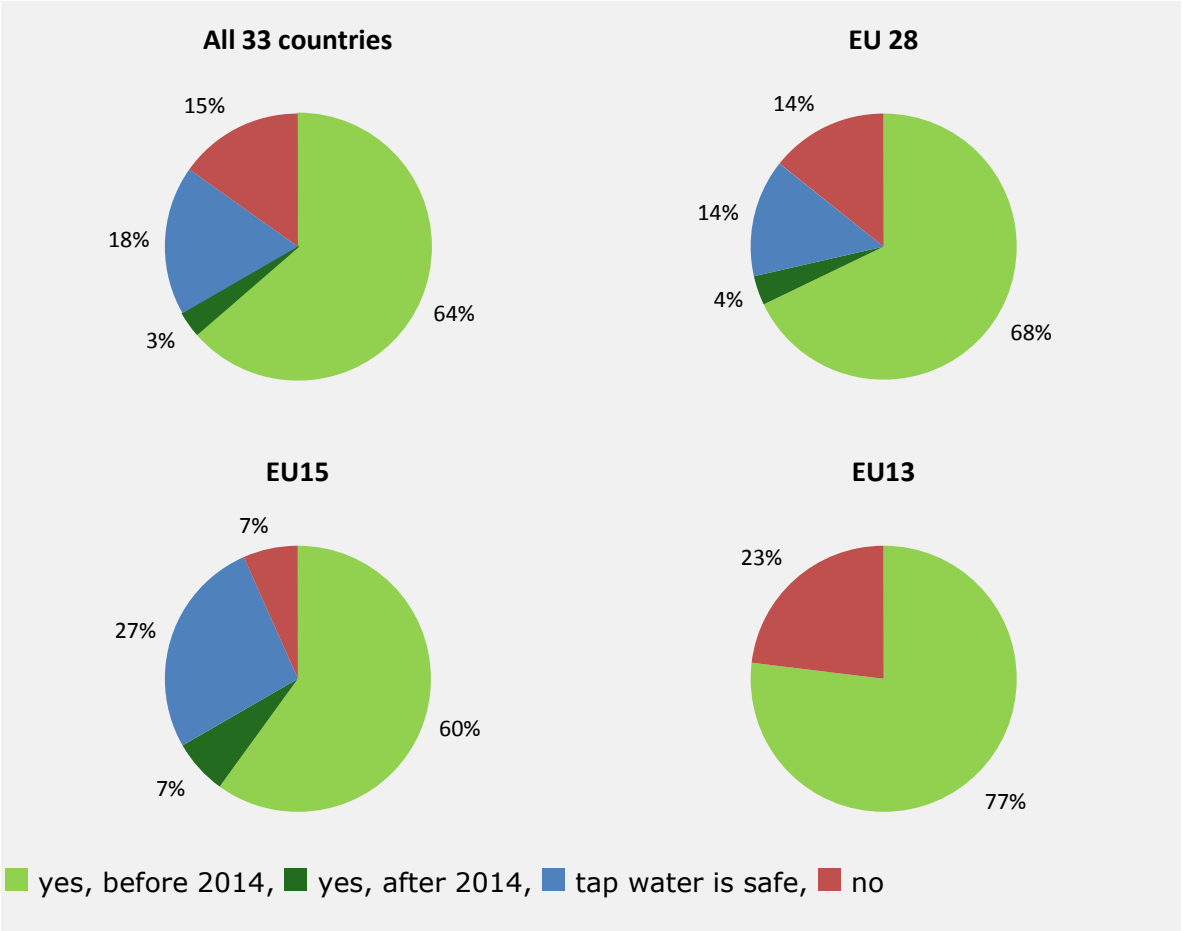
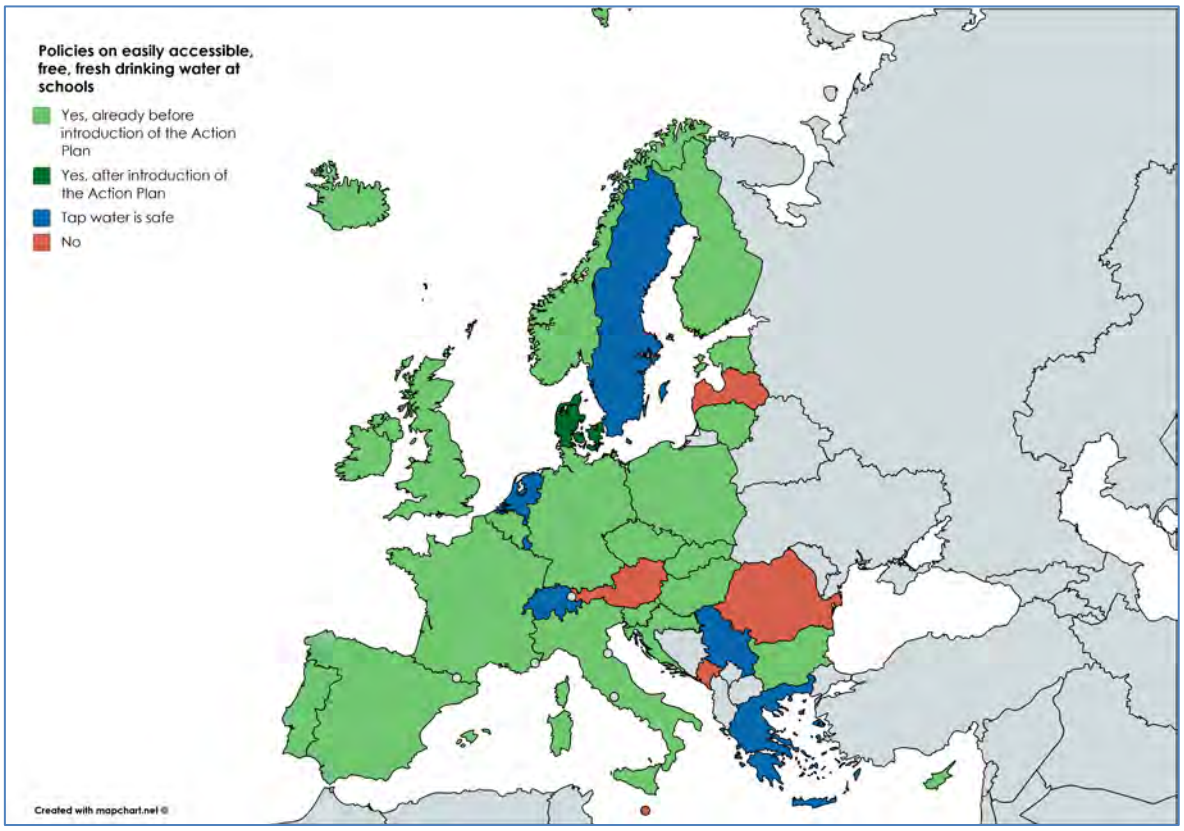


Figure 4.8. *Policies or guidelines on supplying easily accessible, free fresh drinking water at schools. EU13: Member States that joined the EU after 1995.*



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

Policies, strategies etc. on vending machines

The standards for school meals and other foods provided at schools often include regulations for vending machines, which can be banned in total from the school premises or can contain only certain products. In Portugal and Spain policies also apply to or initiatives are ongoing on vending machines outside of schools. In Portugal some products are not allowed in vending machines at the National Service of Health, while in Spain there are initiatives from different stakeholders to facilitate a healthier supply in vending machines at other places than schools, like hospitals and the workplace. Five countries mentioned not to have policies on vending machines (CY, DK, LU, ME, RS and SE). This often has a reason. In Cyprus and Serbia most schools do not have vending machines. In Denmark 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. In Sweden the school's headmaster decides on the strategies with respect to vending machines, while in Luxembourg they focus more on developing competences to make healthy choices. In the majority of countries with school food policies, energy drinks also fall under these policies.

Policies, strategies etc. on energy drinks for children

In several counties 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. The Parliament of Latvia approved a "Law on the handling of energy drinks". This law prohibits the sale of energy drinks to people under the age of 18 and came into force on June 2016. Due to taxation policies, in France available all energy drinks are below a certain level of caffeine. Furthermore, the free refill system is not allowed in all restaurant settings for beverages with added sugars or with sweeteners. 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 the Swedish Retail Trade, which is the majority, follow this agreement. 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. 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 Parent's Association has issued guidelines at the community and city level saying that energy drinks are forbidden, but this is not official policy. In Iceland some shops have decided on a voluntary basis to set an age limit for the sale of energy drinks.

Participation in the EU School Fruit and Vegetable Scheme

The EU-wide School Fruit and Vegetable Scheme provides school children with fruit and vegetables. The aim is to encourage good eating habits in young people. Additionally, the scheme requires participating EU Member States to set up strategies including educational and awareness-raising initiatives. Schoolyear 2016/2017 is the last year of implementation of this scheme. Finland, Sweden and the UK did not participate. However, data from WHO's GNPRS2 survey showed that Finland and Norway do have a school fruit and vegetable scheme. 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.

The percentage of schools that received school fruit in the 2013/2014 school year ranged from 9.8% (FR) to 98,6% (MT). In many countries the percentage of schools that received school fruit was higher in the 2015/2016 schoolyear. The increase was largest (>15 percent points) in Slovakia, Bulgaria, Austria (primary schools), and Luxemburg). A large decrease was observed in Romania only (see Figure 4.9).

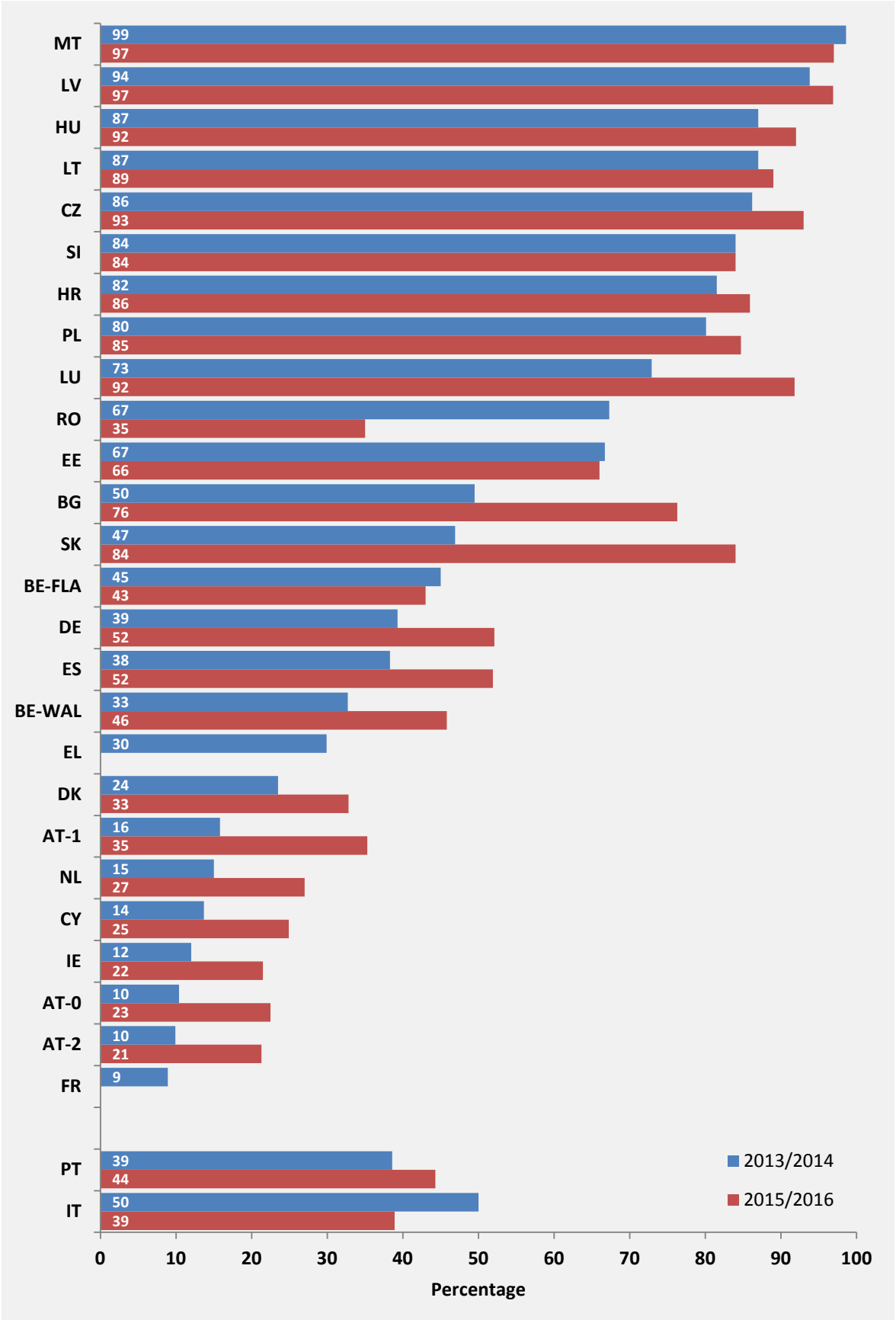


Figure 4.9. *Percentage of schools participating in the EU School Fruit and Vegetable Scheme in schoolyear 2013/2014 and 2015/2016. For PT and IT, the percentage of children reached by the Scheme is presented.AT-0: Austrian kindergartens, AT-1: primary schools, AT-2: secondary schools. Source: https://ec.europa.eu/agriculture/sfs/eu-countries_nl.*

Nutrition education included in school curricula
All but one country (RS) have nutrition education included in the school curricula. In 10 countries nutrition education is voluntary (AT, BE, BG, DK, DE, EL, LT, NL, RO, UK). In the other countries it is mandatory. However, the exact amount of nutrition education to be provided to school children is usually not known as it is often included in broader topics, such as home economics or biology.

Physical activity education included 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: "National curriculum in England: physical education programmes of study". In England as part of 'Childhood Obesity: a plan for action' 30-60 minutes of physical activity at schools is, however, recommended. There are school inspections and it is marked when schools do not provide 30 minutes of physical activity a day. Schools can get a prize is they do well on this issue. Only in the Netherlands the minimum number of hours to be dedicated to physical education is to be determined by the schools themselves. There, 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. In Spain, minimum requirements are set by the autonomous regions.

4.3 AREA 3: Make the healthy option the easy option

4.3.1 Food product improvement

Food product improvement, also known as food reformulation, 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 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 their council conclusions on food product improvement of 17-06-2016, 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".

Initiatives on food product improvement for salt are most common. They are in preparation or planned in six countries (AT, BG, DE, EE, LU, ME), while 24 countries already have initiatives ongoing (see Figure 4.10 and Map 4.5). All EU15 Member States have initiatives on food product improvement for salt or have them planned. The other EU Member States are catching up; in 23% of them initiatives have been implemented since 2014.

Food product improvement with respect to sugar gets a lot of recent attention, with initiatives in preparation or planned in 11 countries and already ongoing in another 16 countries (see Figure 4.10 and Map 4.6). Also for food product improvement with respect to sugar, the other EU Member States are catching up on the EU15 Member States, although for sugar the majority of the initiatives are in a preparatory phase.

Initiatives for food product improvement for saturated fat and calories (including portion sizes) are ongoing or planned in fewer countries (see Figure 4.10, Map 4.7 and Map 4.8). Initiatives for the reduction of saturated fat are in preparation or planned in eight countries, while 13 countries have them already. For food product improvement with respect to calories/portion size, this applies to eight and 12 countries,

respectively. Food product improvement initiatives are in general voluntary agreements with industry.

Several countries mentioned that they use a logo (front-of-pack labelling) as strategy for food product improvement (DK, FI, IS, LT, SE). 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. In addition to this indirect strategy, Denmark has a partnership with different stakeholders on salt since two years, while Finland is working on new plans for specific measures on food product improvement. The competent authority of Hungary mentioned that the public health product tax also facilitates food product improvement, as the industry improves products, so that they do not have to pay tax. This seems to be successful for sugar and salt.

Thirteen countries reported to monitor the level of food product improvement in their country (BE, HR, DK, FI, FR, DE (for trans fats), HU, LV (only in schools), NL, RO (sugar in children's products), ES, CH and UK). Another five countries are planning for a monitoring system (EE, FI, EL, LT and NO).

Information on policies to (virtually) eliminate trans fatty acids have been obtained from WHO/Europe (data from the GNPR2 survey and are complemented with information from the interviews where information was missing. Such policies are implemented or planned in 19 countries (see Figure 4.11 and Map 4.9).

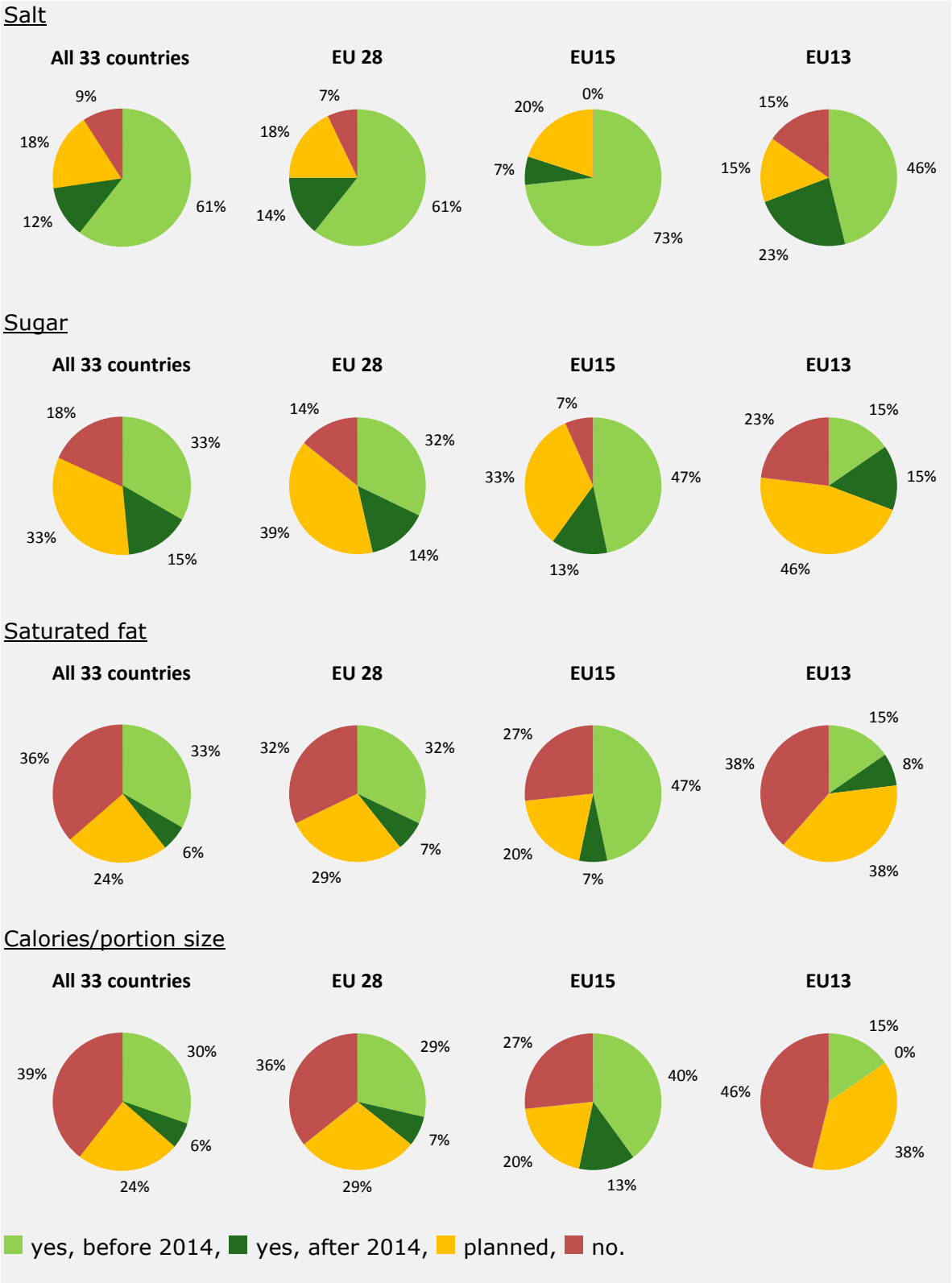
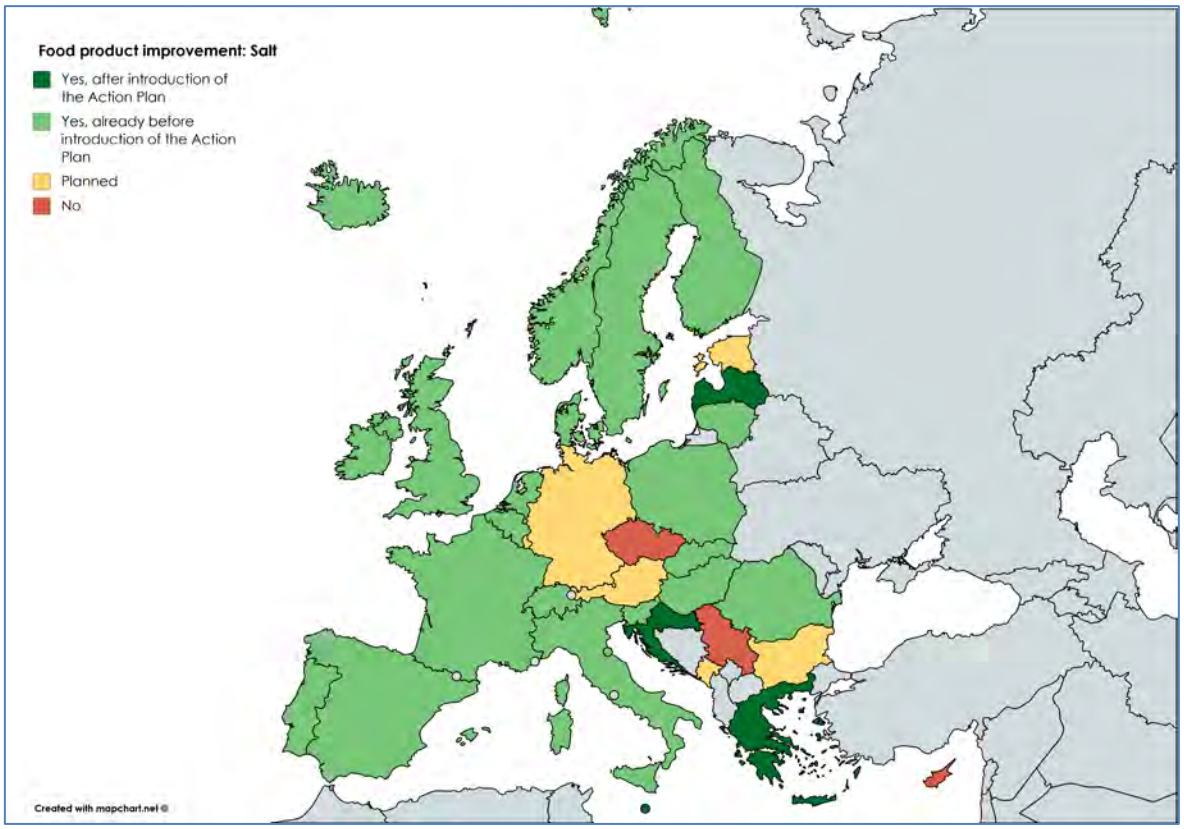
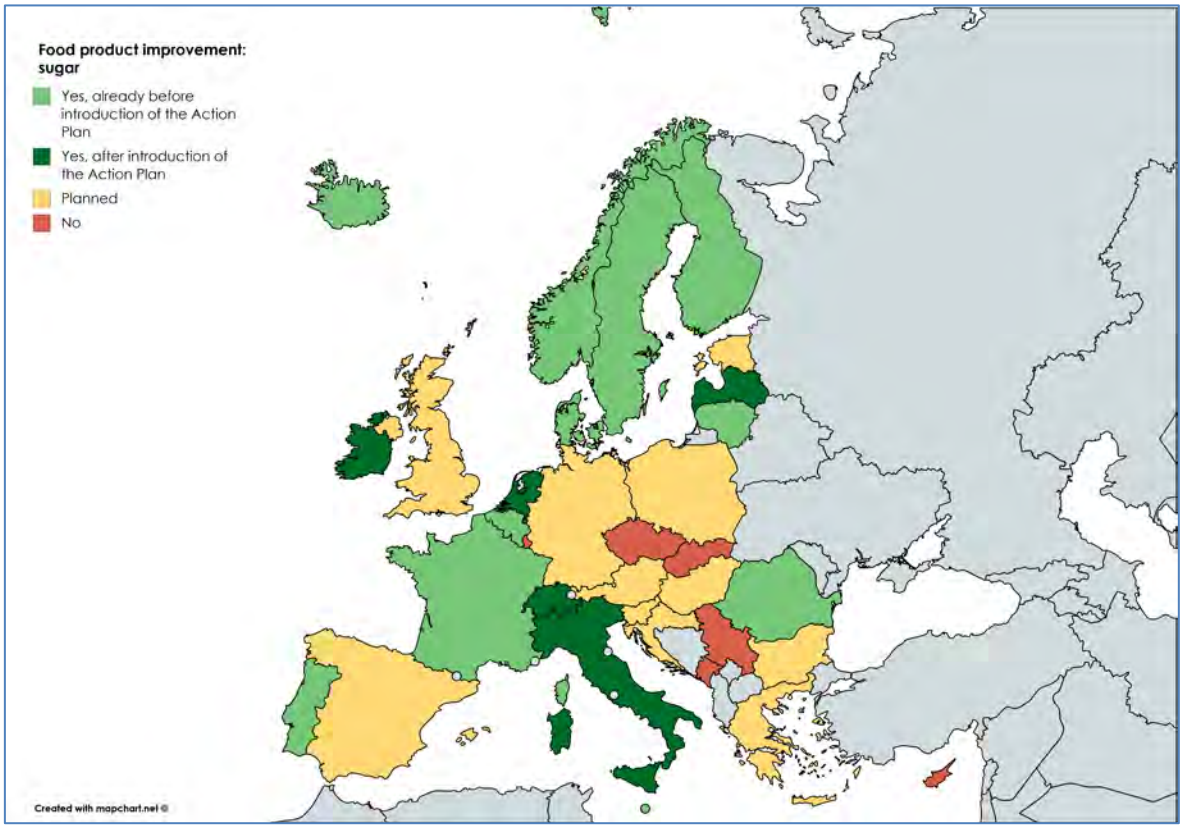


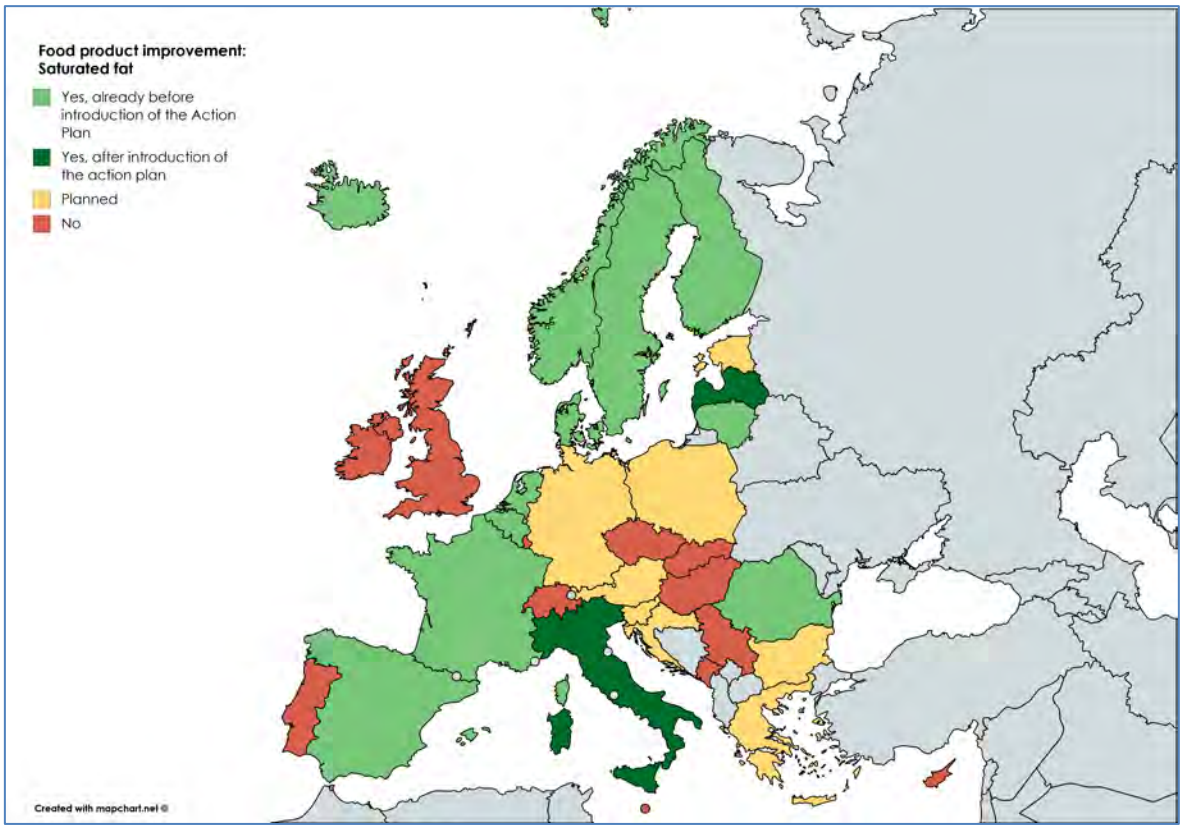
Figure 4.10. *Activities on food product improvement. EU13: Member States that joined the EU after 1995.*



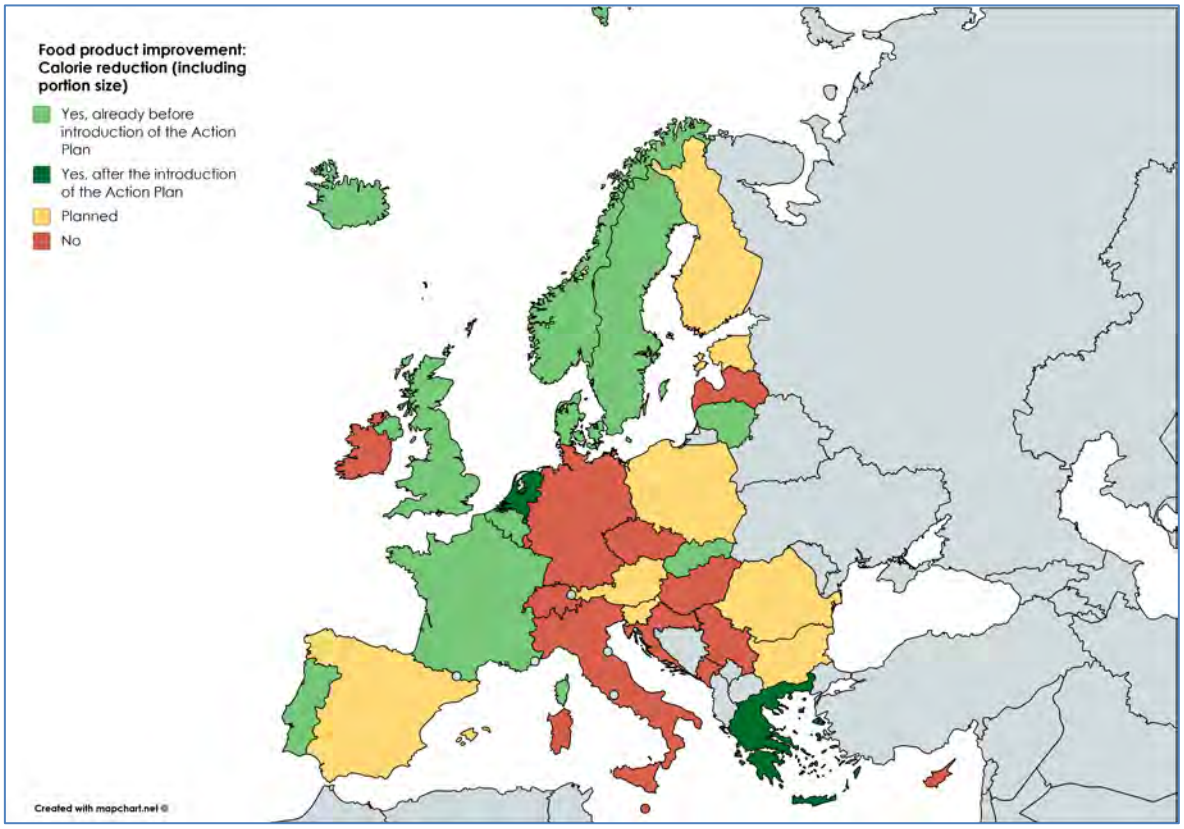
Map 4.5. *Food product improvement initiatives for salt in 28 EU Member states, Montenegro, Norway, Iceland, Serbia, and Switzerland.*



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



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



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

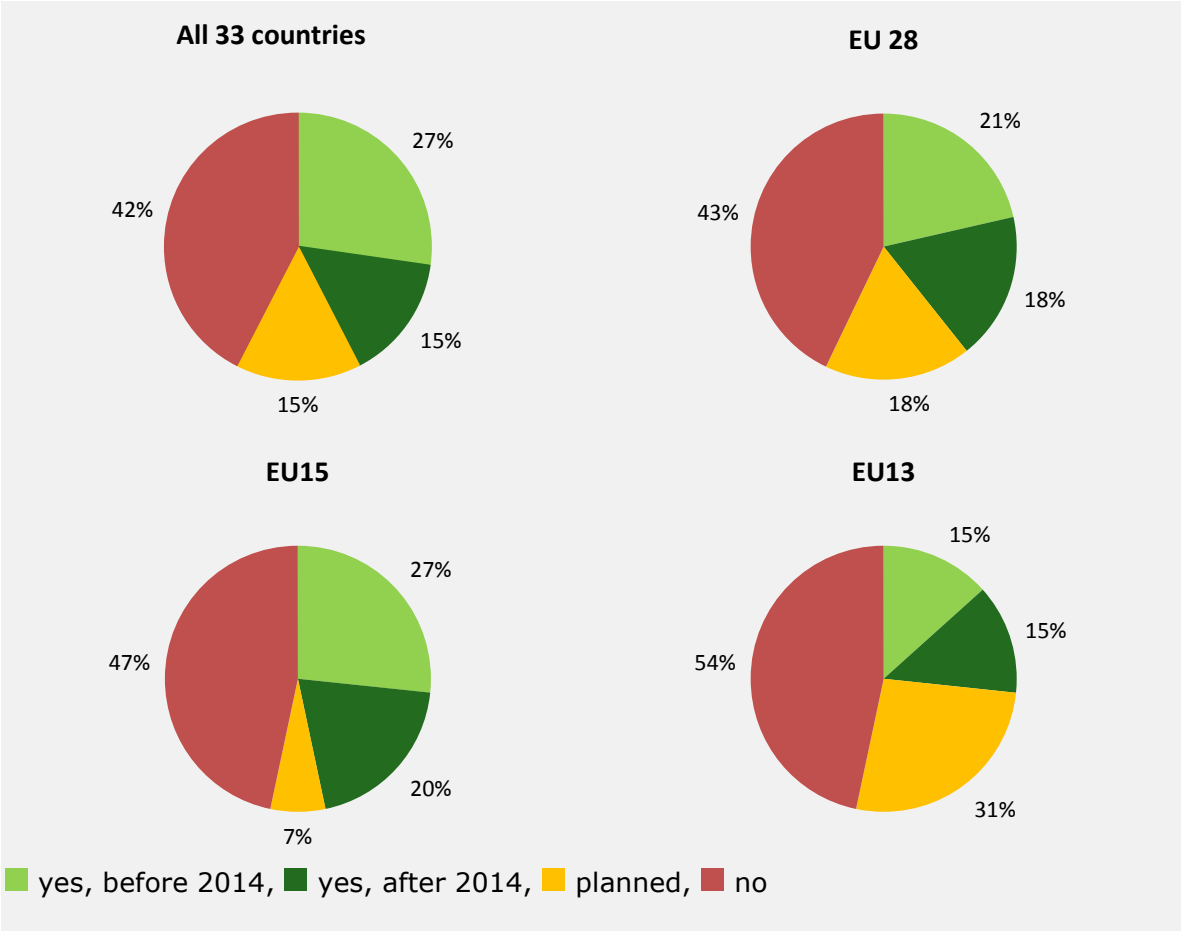
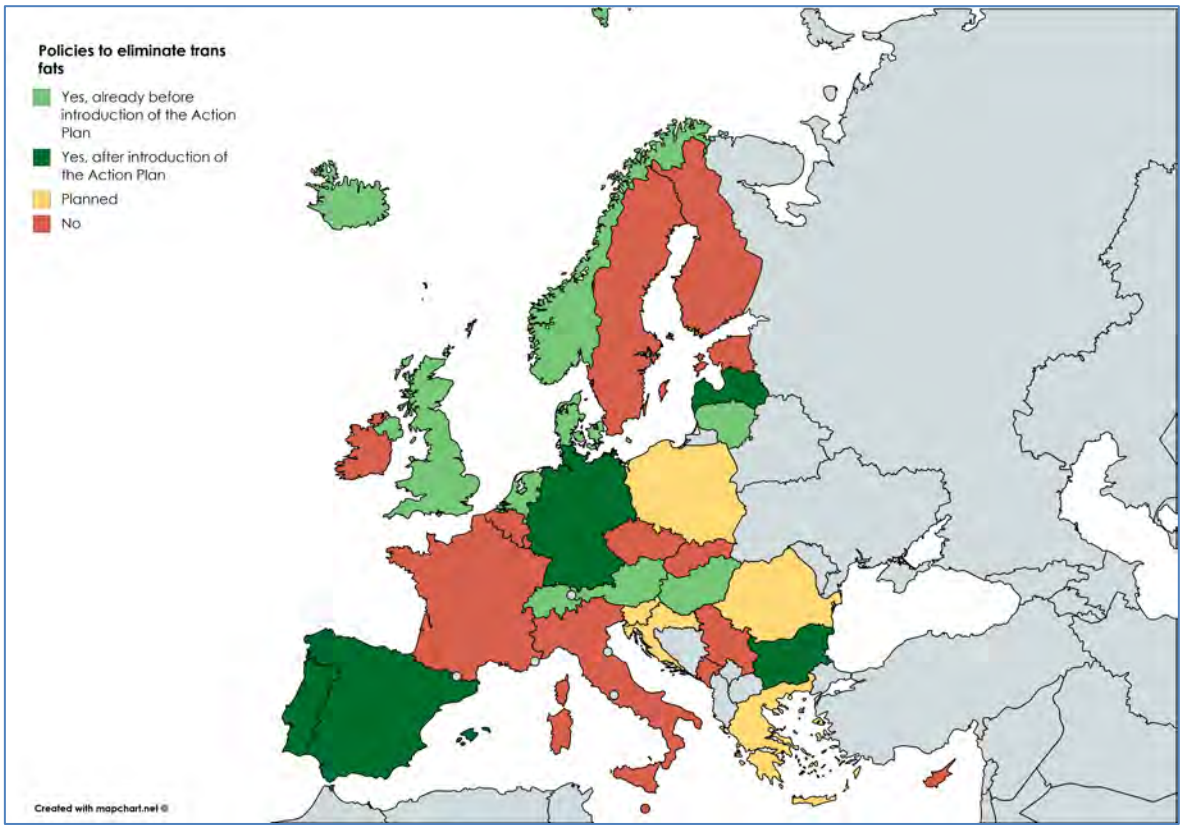


Figure 4.11. *Policies to (virtually) eliminate trans fatty acids. EU13: Member States that joined the EU after 1995.*



Map 4.9. *Policies to (virtually) eliminate trans fatty acids in 28 EU Member states, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

4.3.2 Easy to understand labelling

Easy to understand labelling, such as front-of pack logo's, is used in ten countries to help consumers make healthier food choices (DK, FI, IS, IE, LT, NL, NO, SI, SE, UK). These logos do not communicate precise nutrient content levels, but flag products that qualify against a priori, defined criteria across certain nutrients and energy. In 2017 the Netherlands will stop with the logo, while France and Croatia are planning the introduction.

4.3.3 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 (34). Such strategies are based on the economic theory that an increase in price will result in a decrease in quantity sold and vice versa and thereby leads to healthier consumption patterns. Evidence suggests that taxation of sugar-sweetened beverages and subsidies on fruit and vegetables appear to be the most effective pricing strategies (35). Eight countries have introduced a levy on sugar and/or sweetened beverages (BE, FI, FR, HU, LV, MT, NO, PT). Another three countries are planning to do so (IE, LU, UK, see figure 4.12). In Estonia a law proposing an excess tax on sugar-sweetened beverages was adopted by the Government and Parliament, but not implemented. Denmark had a tax on soft drinks in place for 80 years and introduced a wide-ranging tax on saturated fat in 2011. The taxes were abandoned because of unintended consequences, such as cross-border shopping, job losses and negative profit impacts for producers (36). Since 2011, Finland had a levy on sweets, sugar-sweetened beverages and ice-cream. For economic reasons, as per 1 January 2017, only sugar-sweetened beverages are taxed.

Hungary considers the lowered VAT rates for some specific food products (fresh milk, poultry meat and eggs) as subsidy and is planning to reduce tax rates for fish and vegetables as well.

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 ranges from 2.5% (CH) to 27% (HU). In the Netherlands the new government has plans to raise the VAT-rate from the current 6% to 9%.

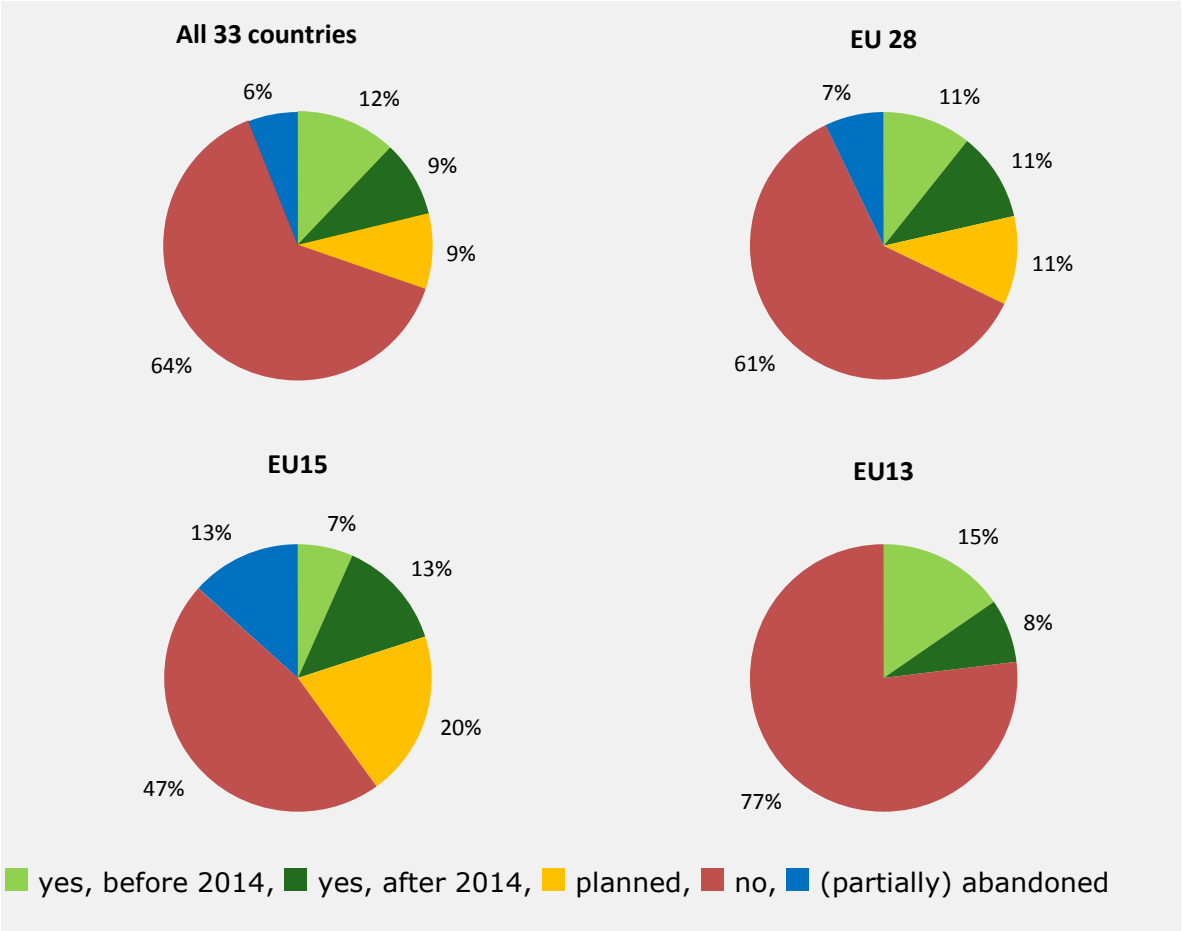


Figure 4.12. *Taxation policies. EU13: Member States that joined the EU after 1995.*

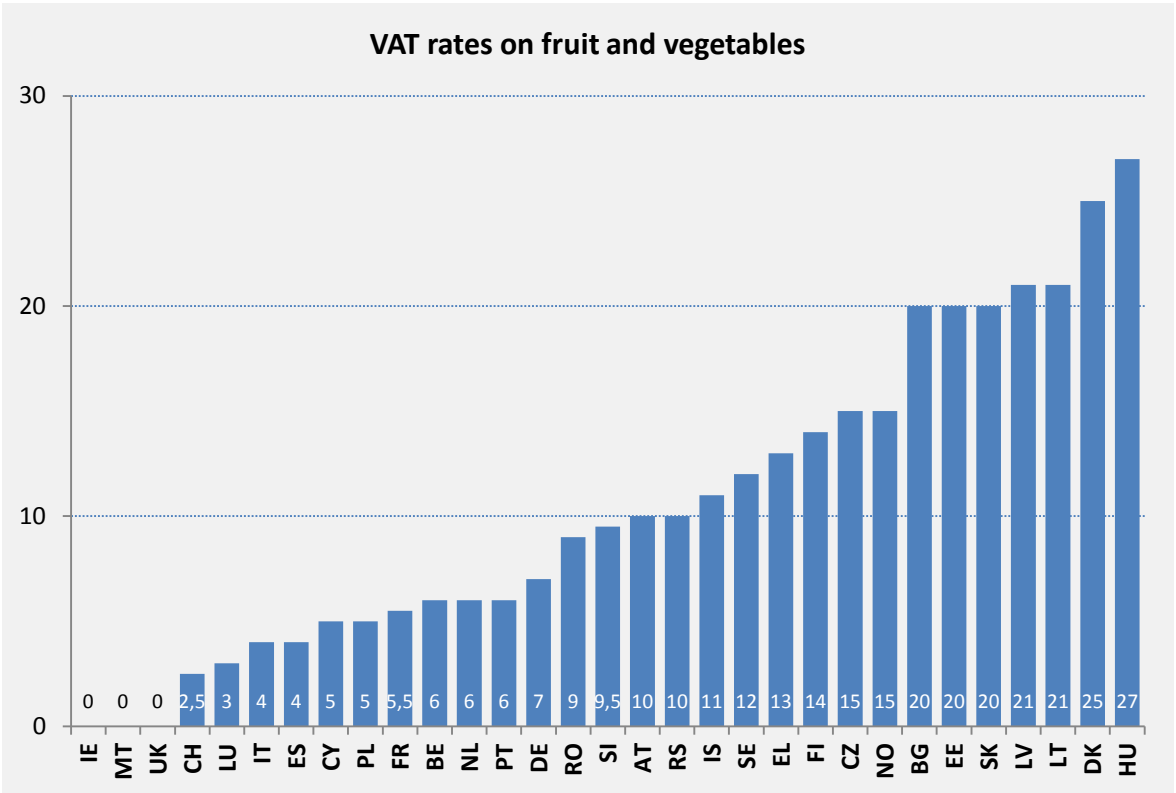


Figure 4.13. *VAT rates on fruit and vegetables. No data for HR and ME.*

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 (37). In Europe, the Audio-Visual 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. According to the interviews, in 24 of the 33 countries in this study initiatives are undertaken or planned to reduce marketing of HFSS foods to children (see Figure 4.14 and Map 4.10).

The majority of the countries rely on general advertising regulations and on self-regulatory mechanisms. A new legislative proposal amending the directive has been adopted by the European Commission on 25 May 2016. The directive is currently open for review. Several countries mentioned that they will take position on this topic or that probably new self-regulatory codes will be implemented after the conclusions of the discussion on the EU's Audio Visual Media Services Directive are known (MT, HR, FI, SE).

Another objective with respect to marketing to children mentioned in the Action Plan (14) 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, 16 countries use nutrient profiles or criteria to reduce marketing to children (Figure 4.15 and Map 4.11). For six of them this was after the introduction of the Action Plan. Slovenia has adopted the criteria set by WHO. Three countries are currently working on this topic (EE, IE, ME). The percentage of counties with nutrient criteria to reduce marketing to children is comparable, between EU15 Member States and the newer Member States. The newer Member States have caught up since 2014.

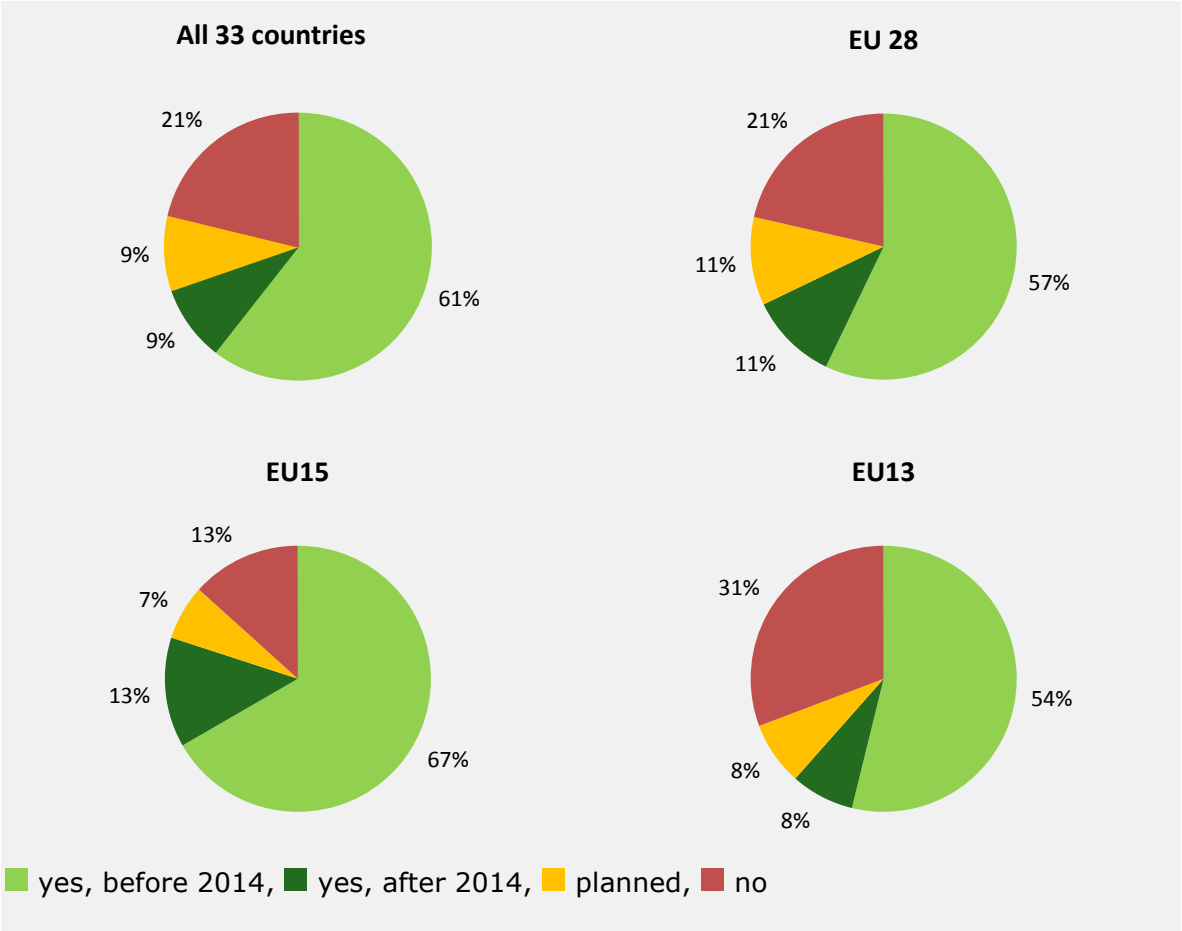
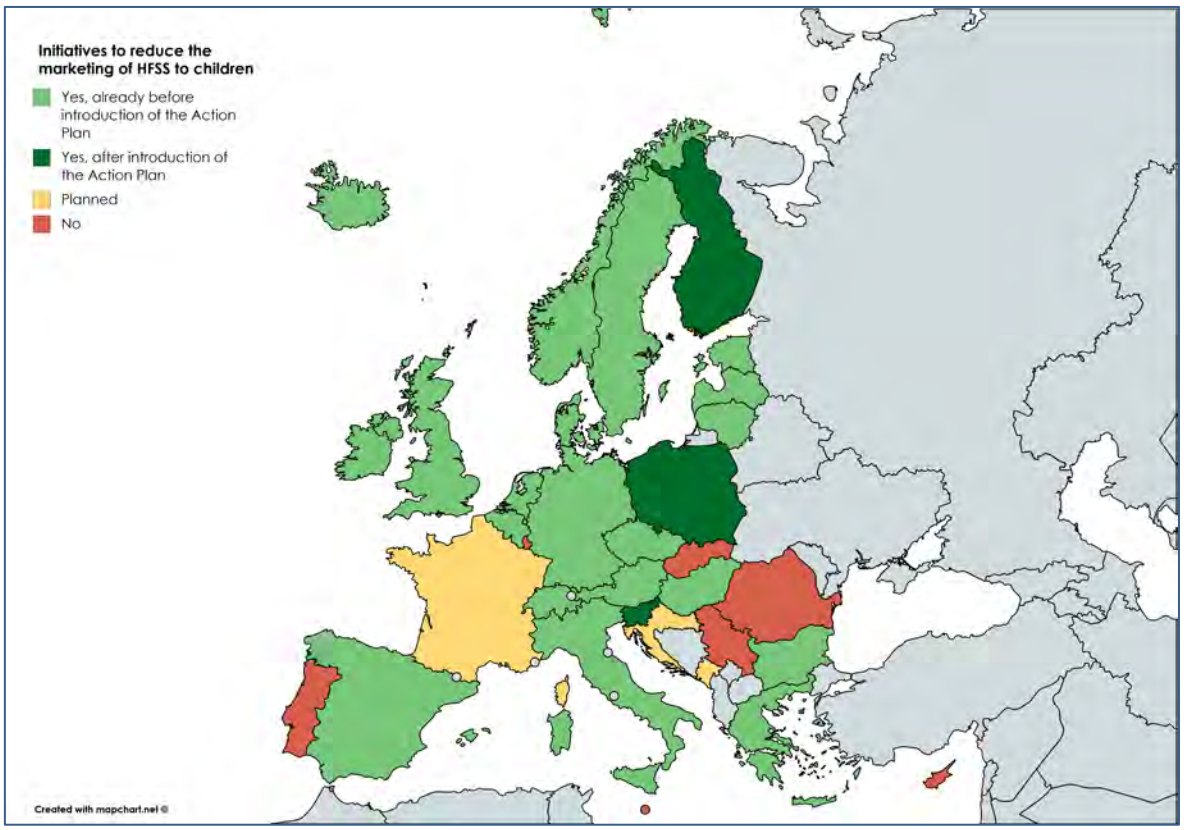


Figure 4.14. *Initiatives to reduce marketing and advertising to children. EU13: Member States that joined the EU after 1995.*



Map 4.10. *Countries taking initiatives to reduce the marketing of HFSS foods and beverages in 28 EU Member states, Montenegro, Norway, Iceland, Serbia, and Switzerland.*

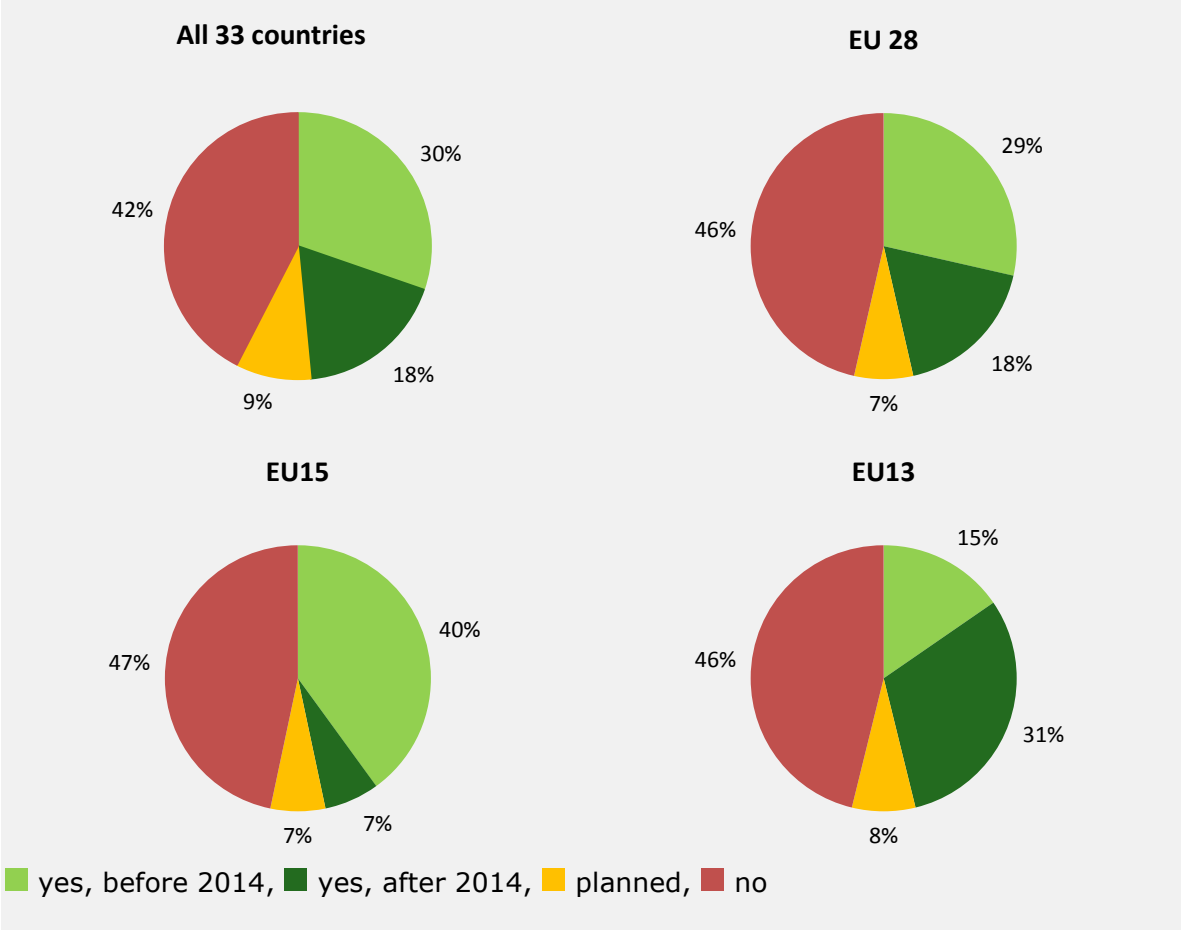
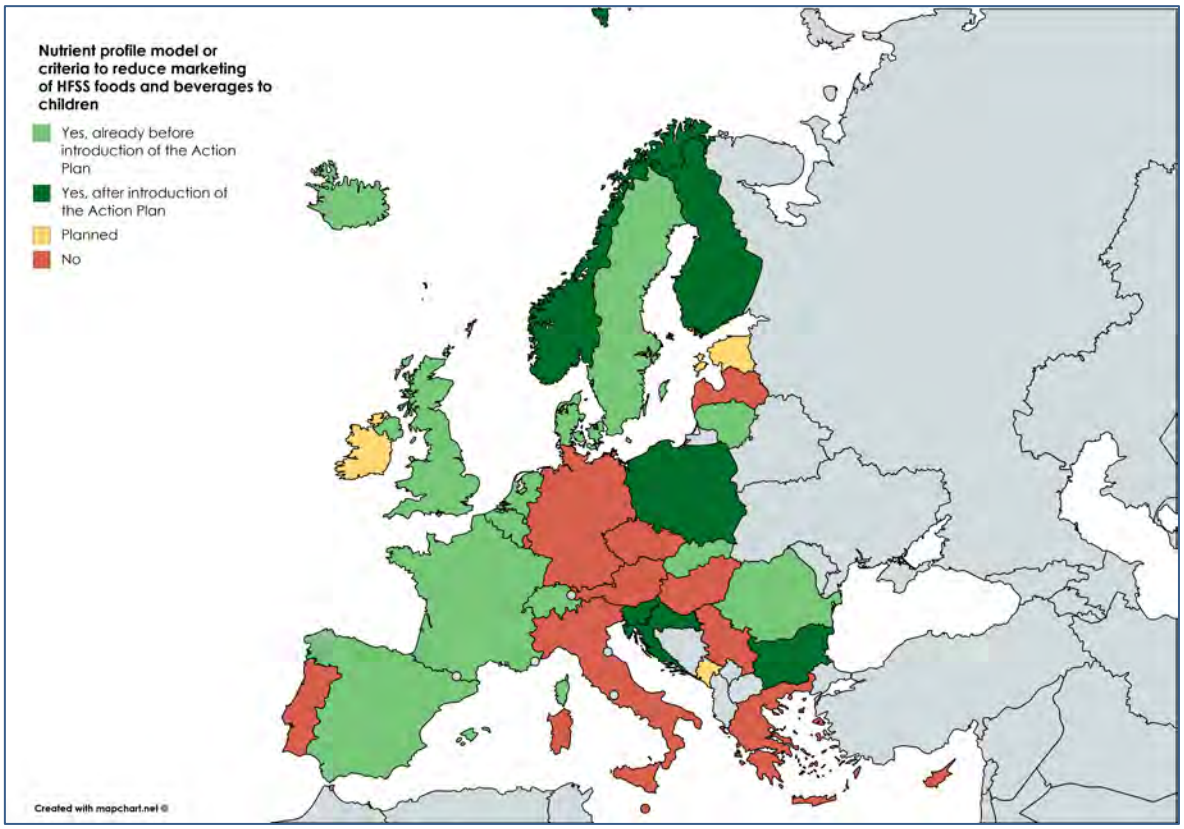


Figure 4.15. *Nutrient profiles to reduce marketing for HFSS foods and beverages to children. EU13: Member States that joined the EU after 1995.*



Map 4.11. *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 have food-based dietary guidelines (Figure 4.16 and Map 4.12) and Serbia is planning for them. Nine countries published updated guidelines after the introduction of the Action Plan (FI, IE, IS, MT, NL, NO, SI, SE, UK). At least 13 of them have specific recommendations for children (AT, BE, HR, CY, EE, FR, LV, NO, PL, PT, ES, SE, CH). The guidelines of four countries (BG, EL, HU, MT) are aimed at the adult population only.

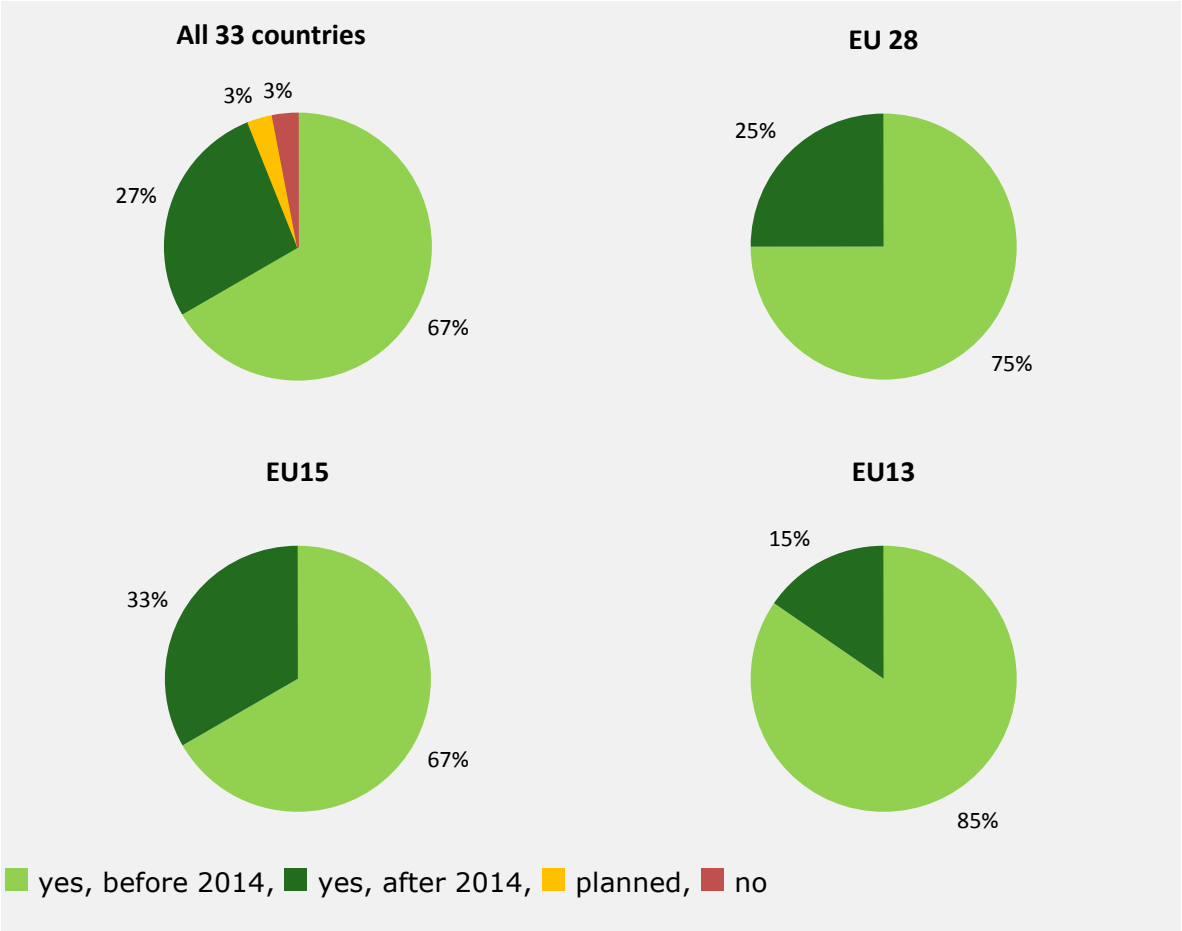
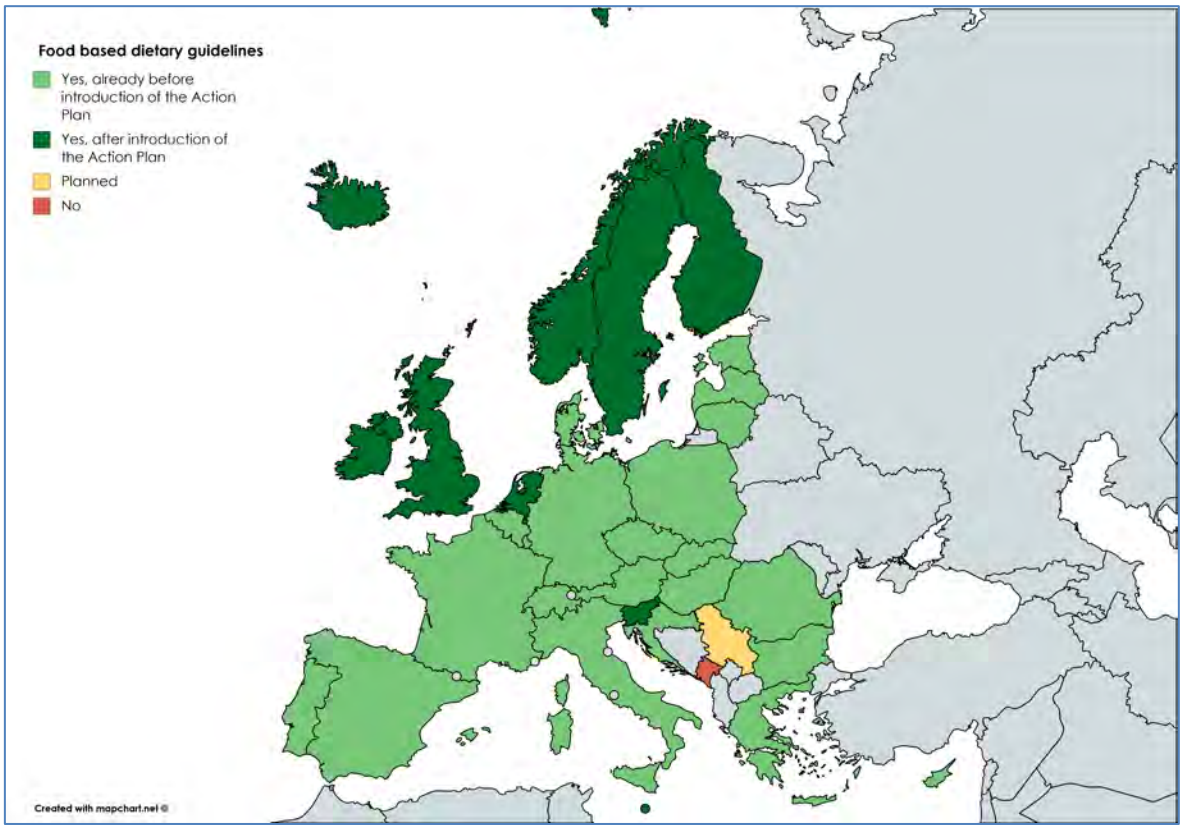


Figure 4.16. *Availability of food based dietary guidelines. EU13: Member States that joined the EU after 1995.*



Map 4.12. *Availability of food based dietary guidelines in 28 EU Member States plus Montenegro, Iceland, Norway, Serbia and Switzerland.*

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, 22 have some form of campaign running and one is planning campaigns (SI) (see Figure 4.17). Ten countries (BE, CY, CZ, EL, LT, ME. NL, PL, SE, CH) reported currently not having national campaigns running. However, some of had national campaigns in the past (BE, CY, CZ, NL, SE). There is no clear geographical pattern to be seen.

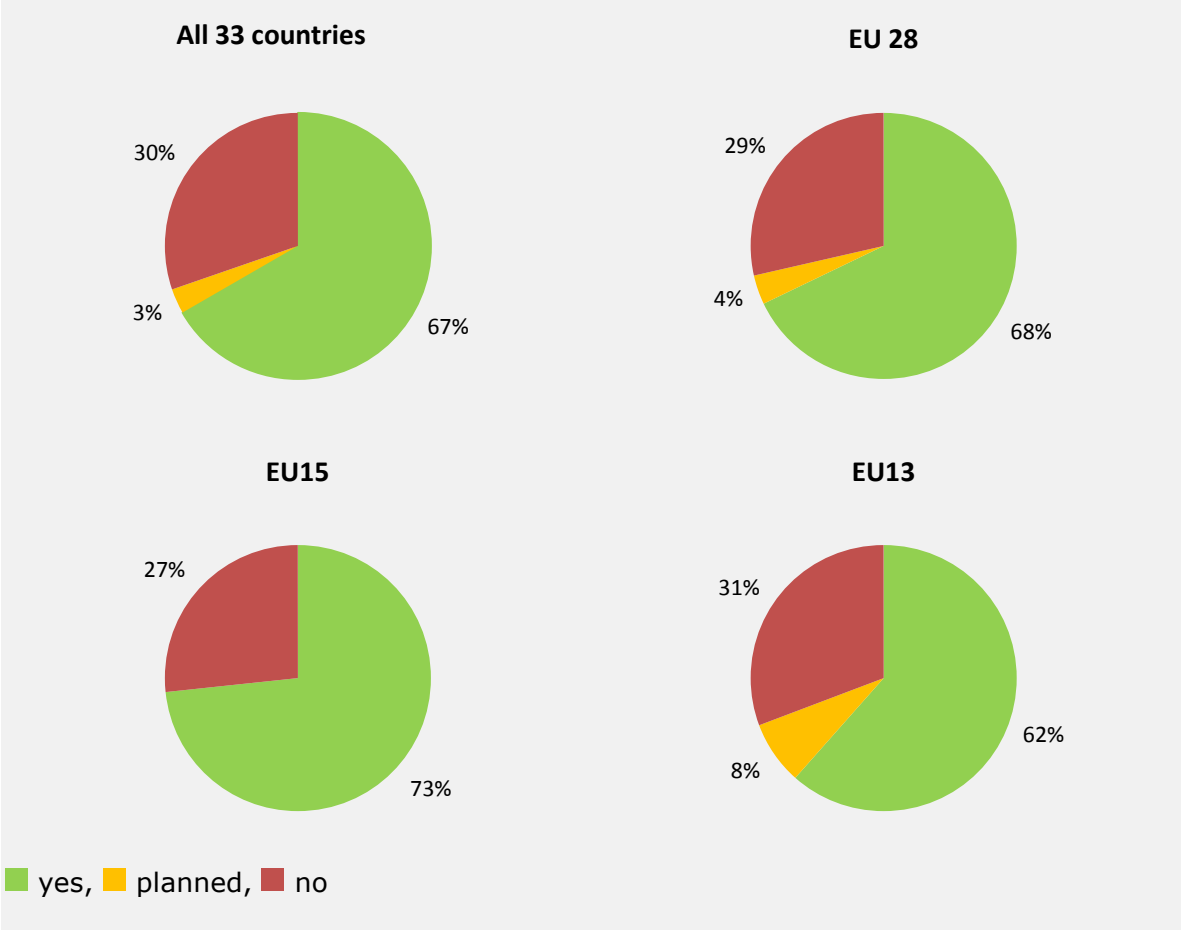


Figure 4.17. *National campaigns. EU13: Member States that joined the EU after 1995.*

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 so as 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. EPODE's community approach can prevent childhood obesity. It changes the micro and macro environment, behaviours and social norms step by step using social marketing, scientific evaluation, ensuring political support and the involvement of all sectors, particularly the public and private spheres.

The EPODE International Network was launched in 2008, as a European network, 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 all stakeholders within the community. Furthermore, the programme 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. This initiative should encompass either both nutritional and physical activity aspects of healthy living. Support from families as well as from local politicians is essential. As members of the Epode International Network these programmes will be supported in order to reach an EPODE-like status.

In 10 countries (AT, BE, HR, FR, EL, HU, IT, NL, PL, RO) such 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 4.13).

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 4.14).

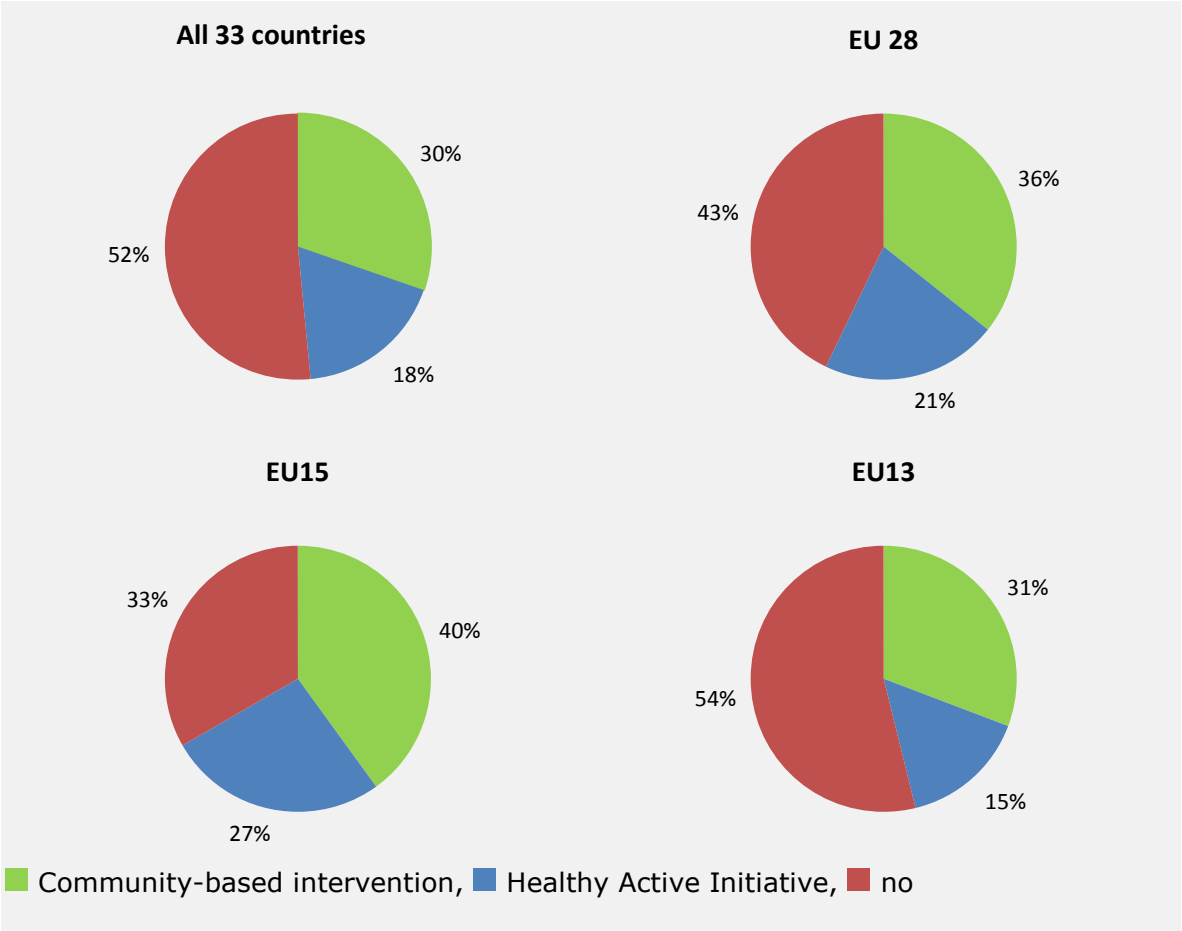
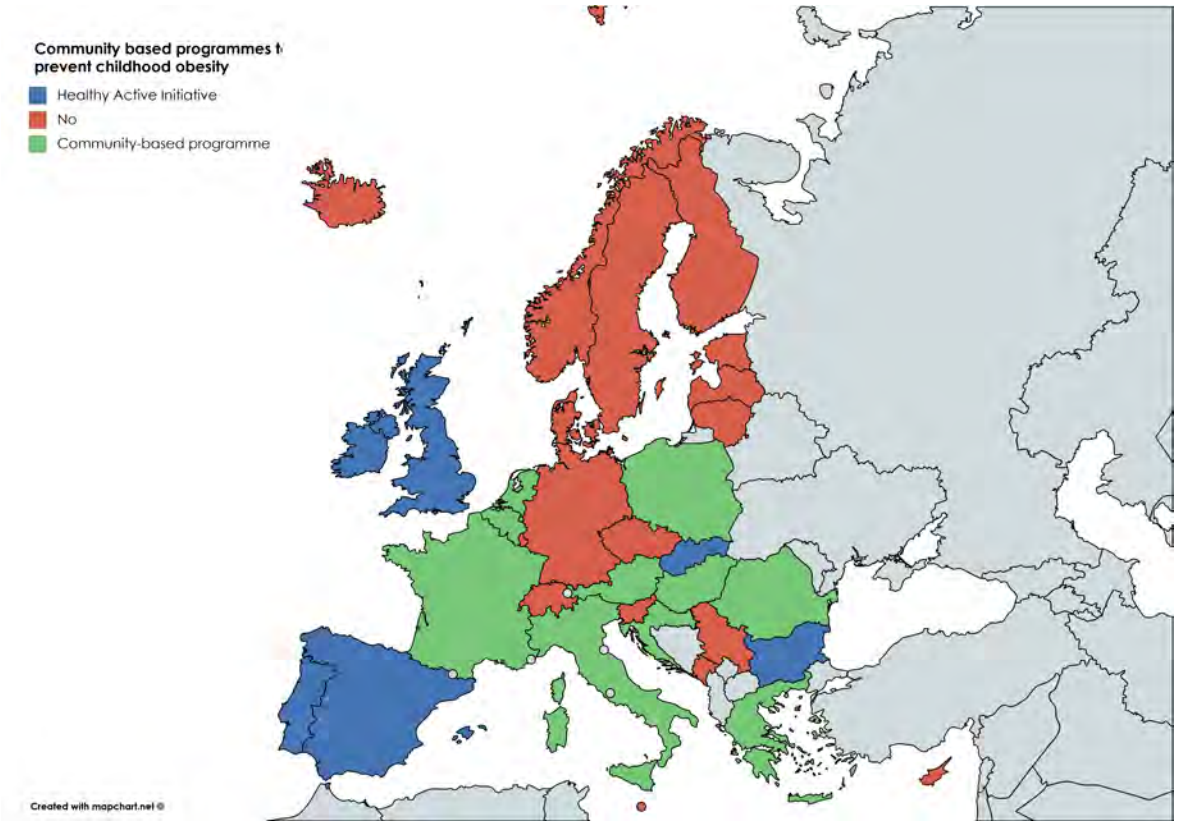


Figure 4.18. *Community-based programmes according to the EPODE-methodology. EU13: Member States that joined the EU after 1995.*



Map 4.13. *Community-based interventions according to the EPODE-methodology in 28 EU Member states Montenegro, Norway, Iceland, Serbia, and Switzerland.*

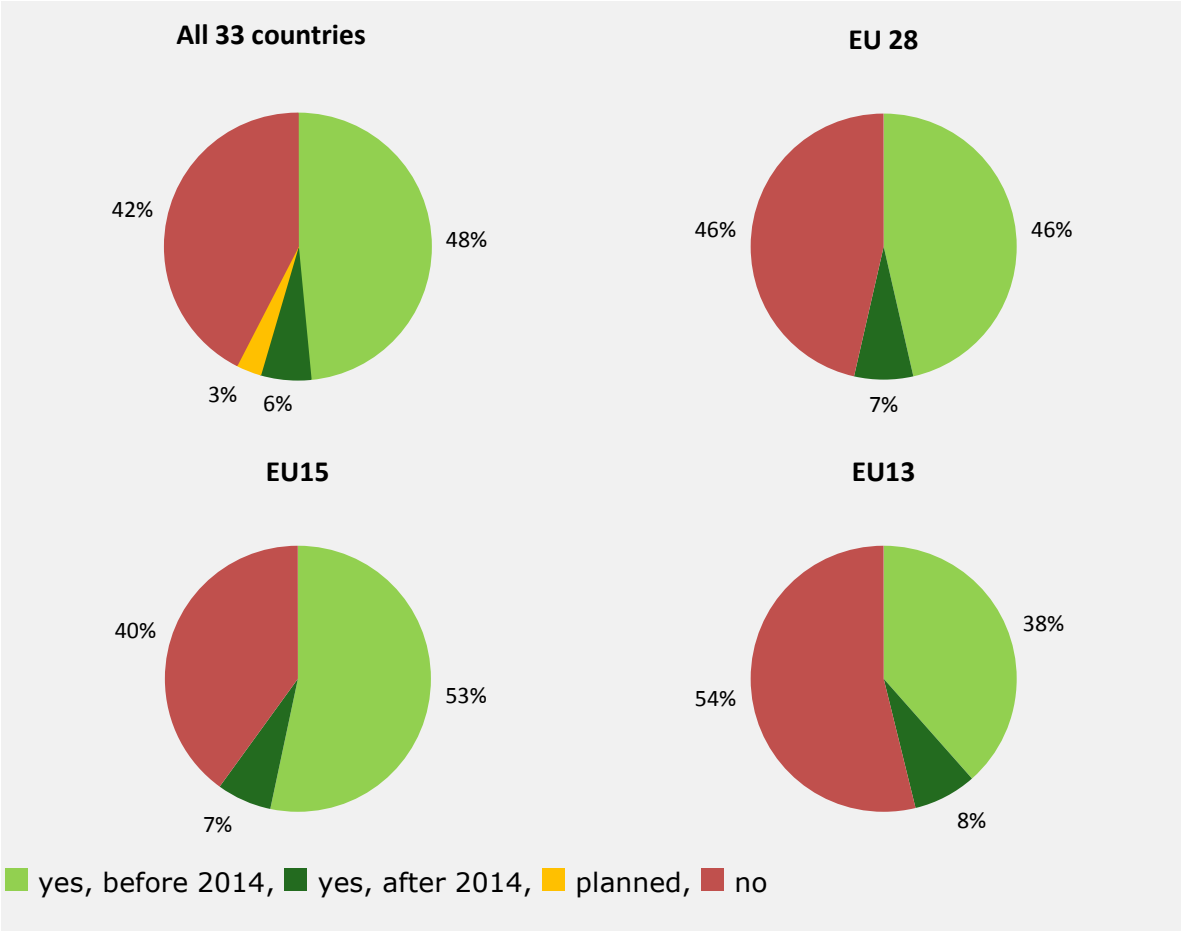
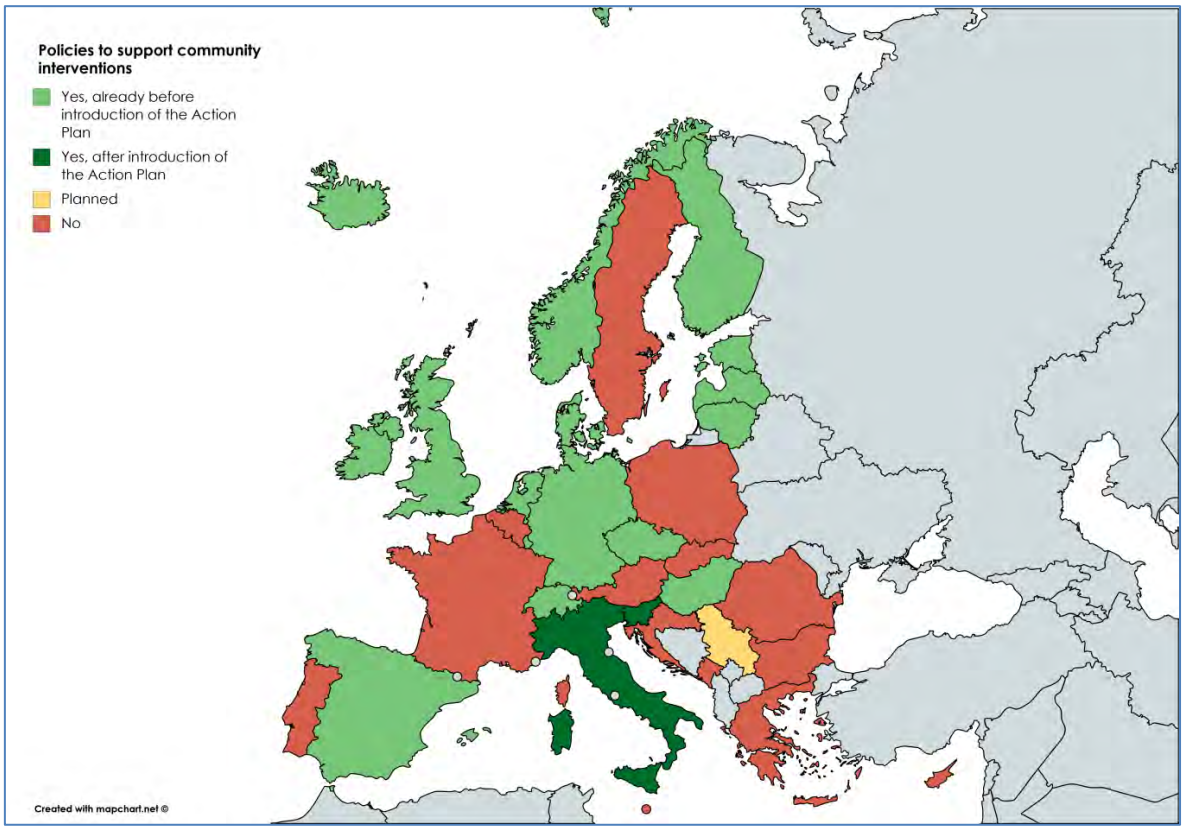


Figure 4.19. *Supporting community based interventions. EU13: Member States that joined the EU after 1995.*



Map 4.14. *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 obesity is in place in 18 countries (BE, BG, HR, CZ, DK, FI, DE, HU, IS, IT, LU, NL, NO, RS, SI, ES, SE, UK) often implemented in systems of school healthcare, child healthcare or primary care. 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 is 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 (Figure 4.20 and Map 4.15).

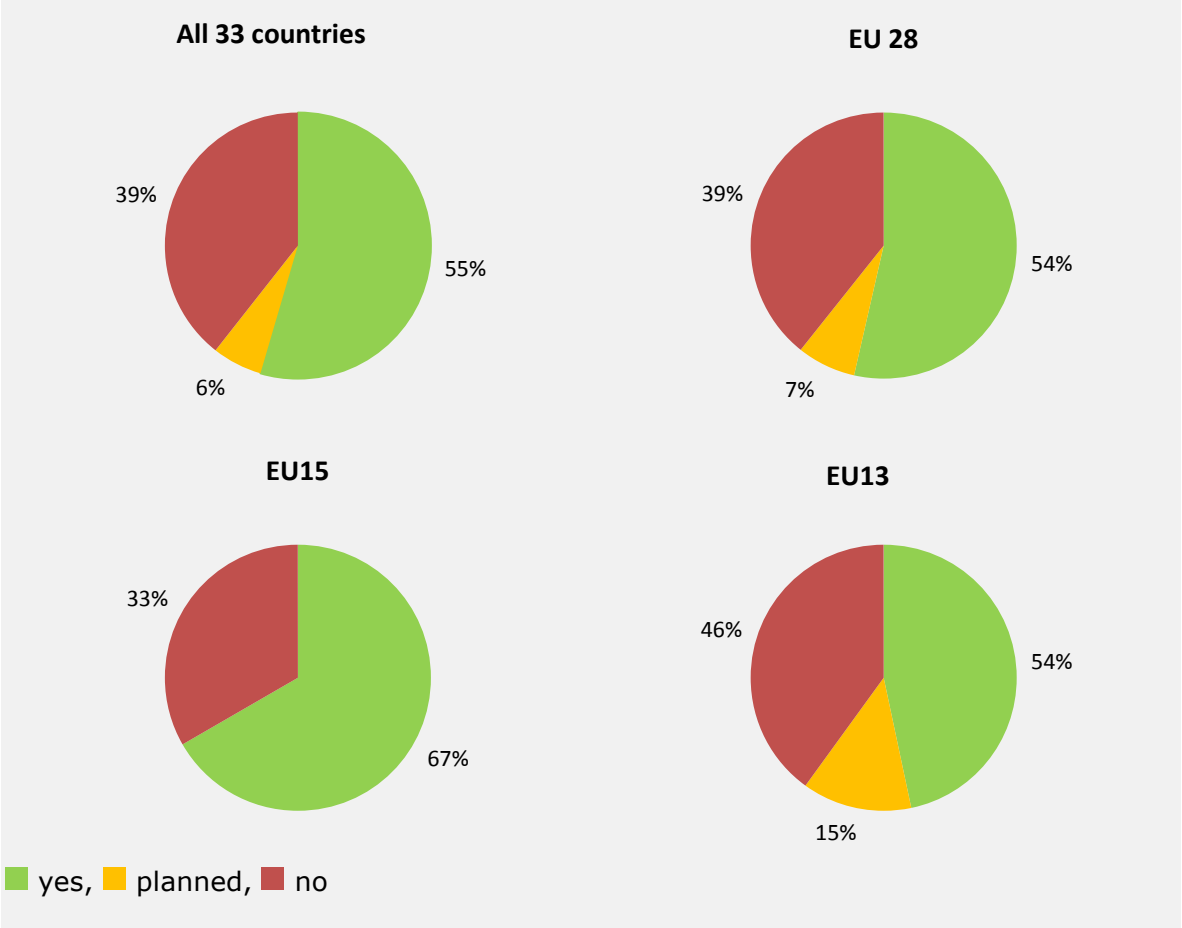
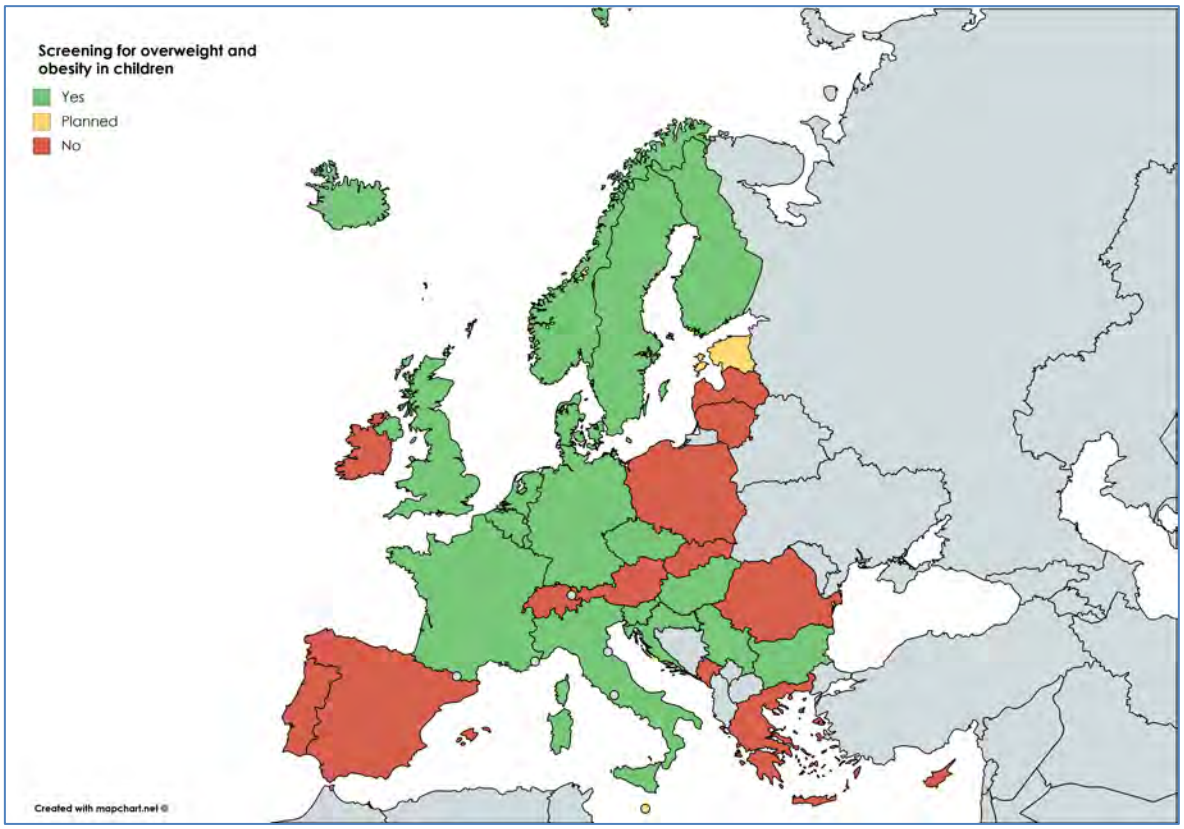


Figure 4.20. *Screening for overweight and obesity in children. EU13: Member States that joined the EU after 1995.*



Map 4.15. *Screening for overweight and obesity in children in 28 EU Member states Montenegro, Norway, Iceland, Serbia, and Switzerland.*

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 healthcare 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 there are management services for adults, but not yet for children. In 2015 Malta organised training for health professionals to guide children with obesity, mainly by motivational interviewing of them and their families. Together with WHO and EASO they are now working together to expand this to train the trainer courses. 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).

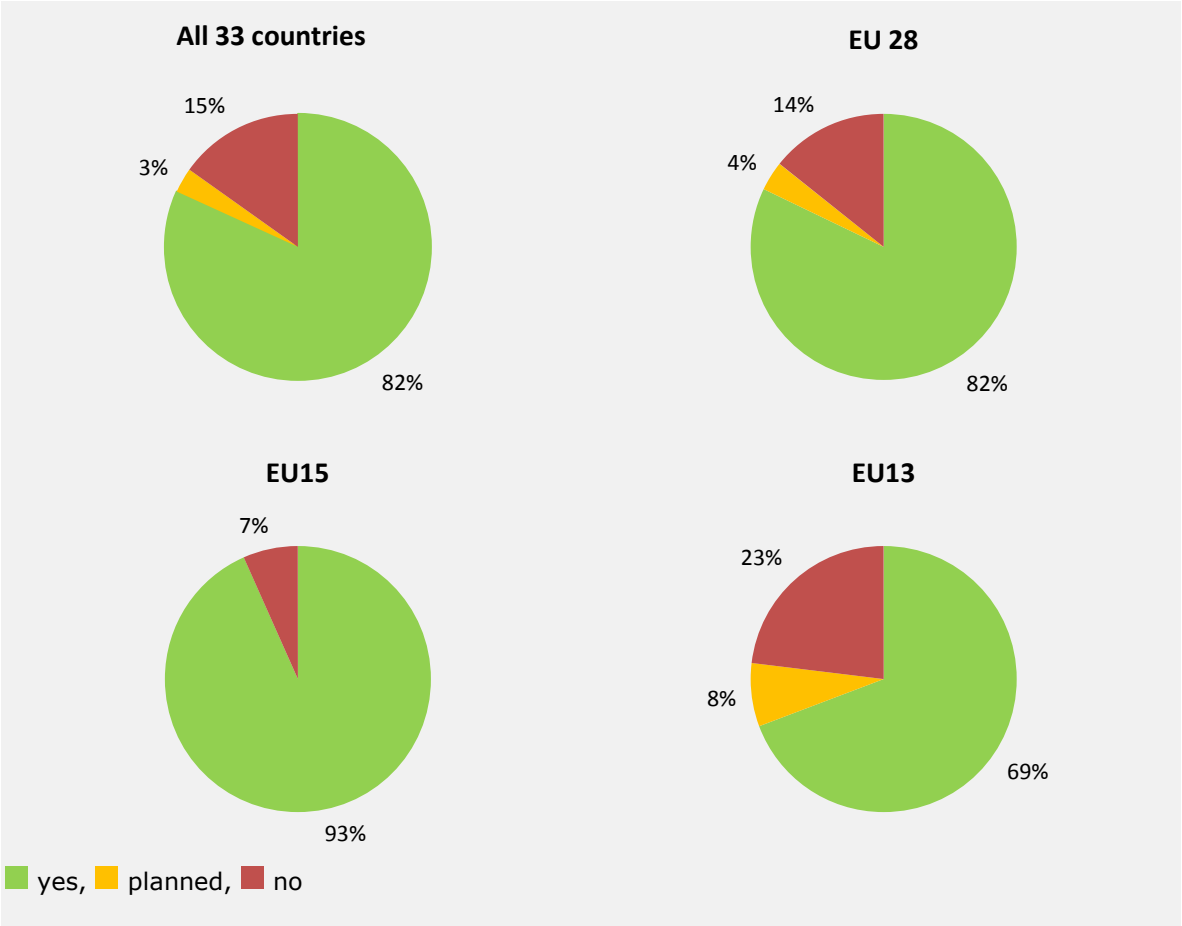


Figure 4.21. *Management services, such as interventions or weight loss programmes, for overweight and obese children. EU13: Member States that joined the EU after 1995.*

4.6 AREA 6: Encourage physical activity

Physical activity plays a vital role in maintaining health. 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 of the WHO European Region[7] 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. Only six countries indicated that they do not have guidelines on physical activity (CZ, ME, PL, RO, RS, SK), but for some of them their aims are in accordance with WHO's Global Recommendations on Physical Activity for Health (CZ, LT, PL, SK). Five countries reported to be working on national recommendations on physical activity for children (CY, HR, EL, LT, SI). Two countries mentioned that they are working on an update of their current recommendations (EE, NL).

In 30 countries (except for CY, ME and RS) physical activity levels among adolescents are assessed through the HBSC surveys. In general, at the age of 11, 13 and 15 years, boys more often reach the WHO's physical activity recommendation than girls (Figure 4.22 (2009/2010) and Figure 4.23 (2013/2014)). The percentage of boys reaching the WHO's physical activity recommendation 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 old than among 15-year olds. Generally, 13-year old body and girls have intermediate values.

For 28 of the 30 countries participating in the HBSC surveys, (except BG and MT) data were available from 2009/2010 as well as from 2013/2014. Four-year differences in the percentage boys and girls reaching 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.

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, a total of 15 countries implemented such schemes (see Figure 4.25 and Map 4.16). At least in the Netherlands these are mostly small-scale local initiatives. For three countries schemes for active travel to school are foreseen (BG, LV, SI).

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

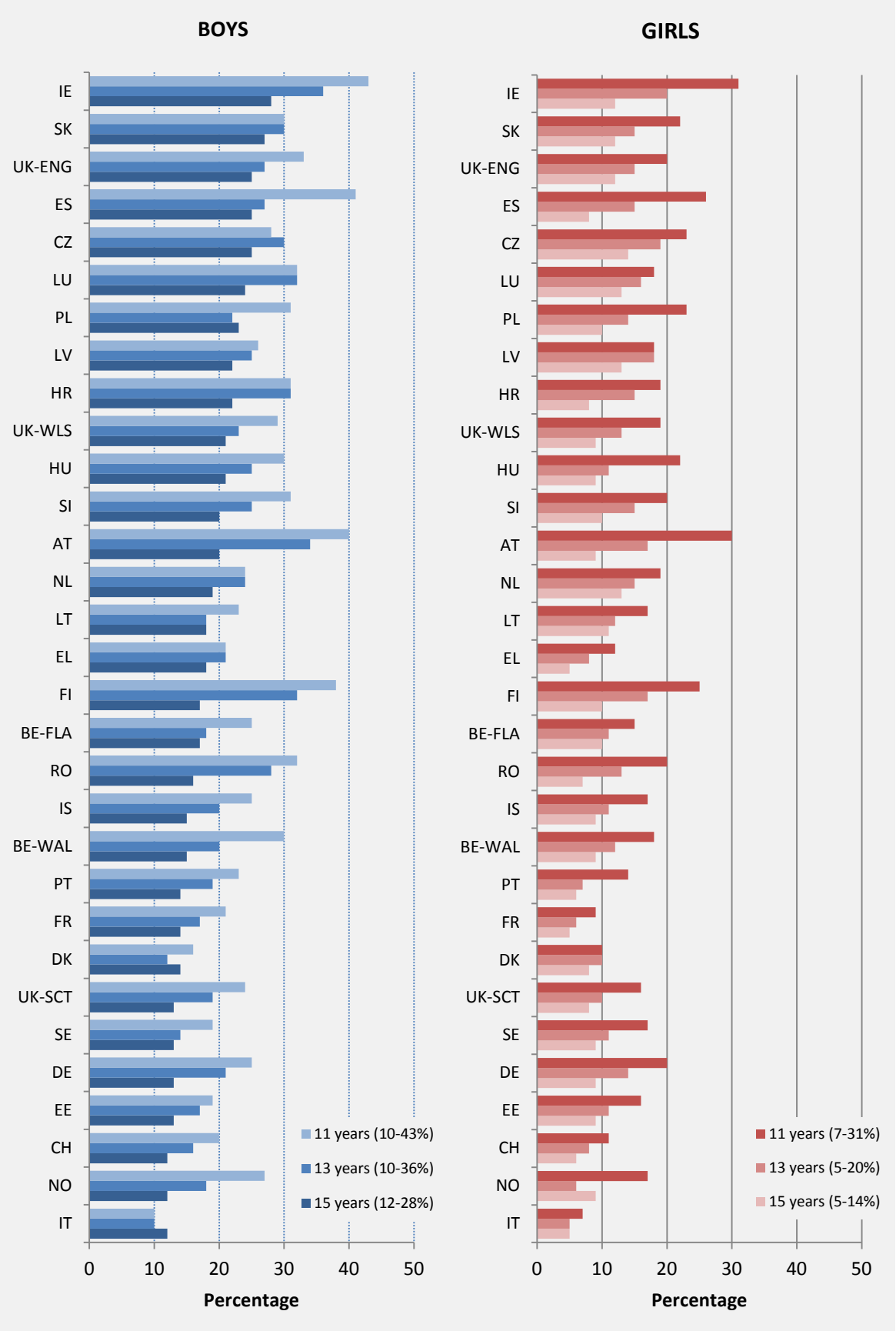


Figure 4.22. *Percentage boys (left panel) and girls (right panel) aged 11, 13 and 15 years reaching WHO's physical activity recommendations in* ***2009/2010*** *by county (HBSC).*

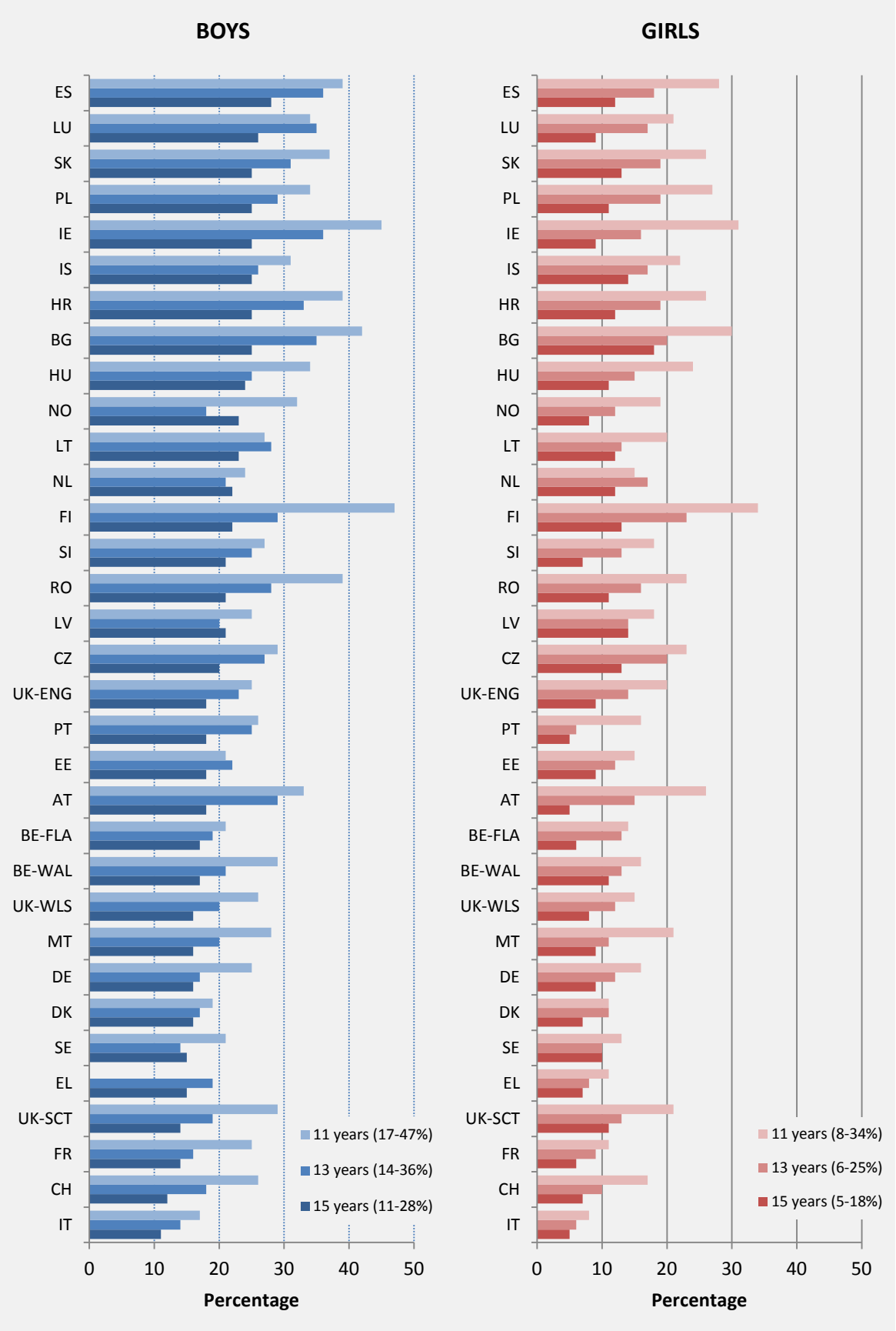


Figure 4.23. *Percentage boys (blue) and girls (pink) aged 11, 13 and 15 years reaching WHO's physical activity recommendations in* ***2013/2014*** *by country (HBSC).*

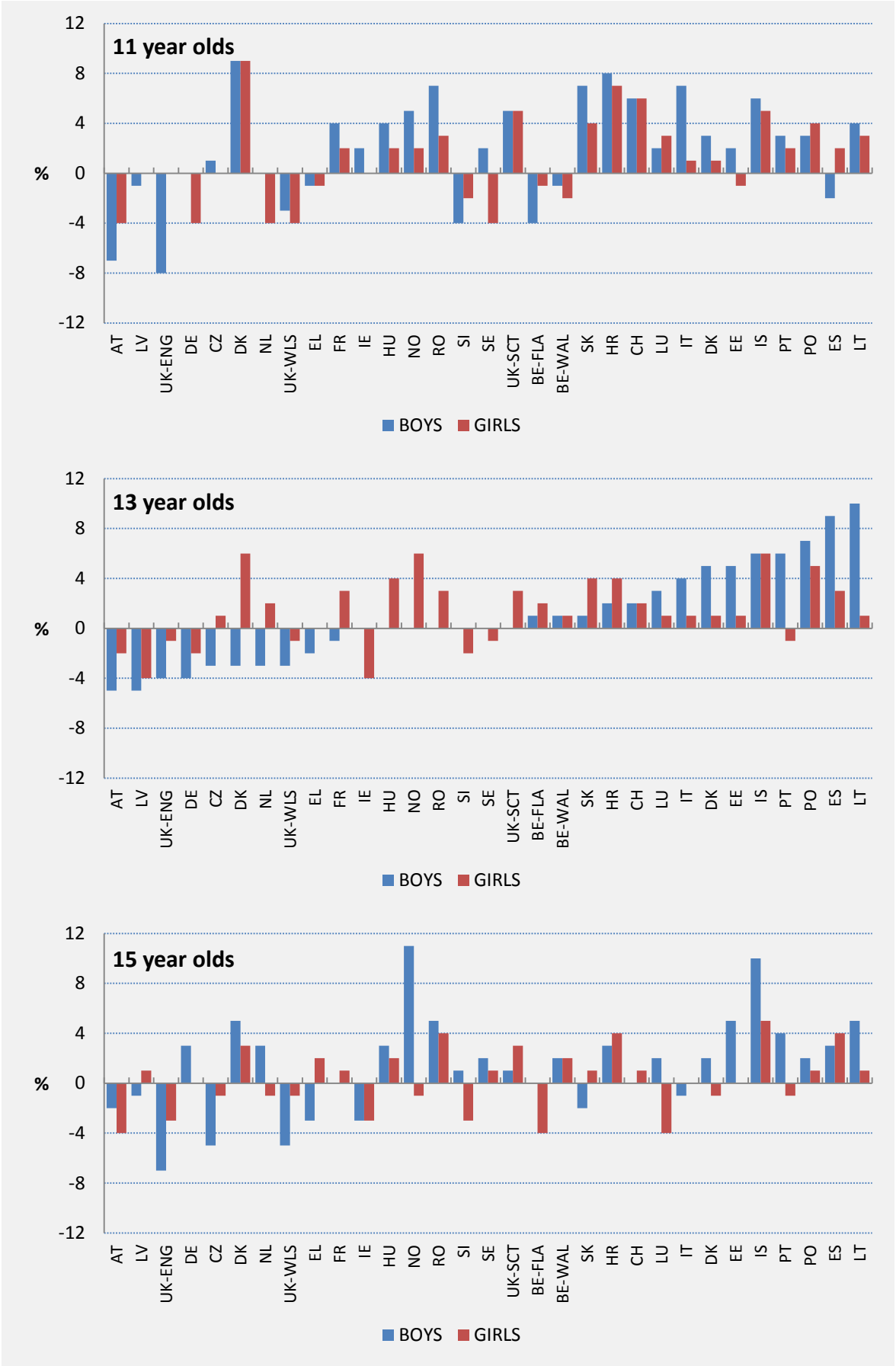


Figure 4.24. *Four-year differences in the percentage boys and girls aged 11, 13 and 15 reaching WHO's physical activity recommendations in 2013/2014 as compared to 2009/2010 by country (HBSC).*

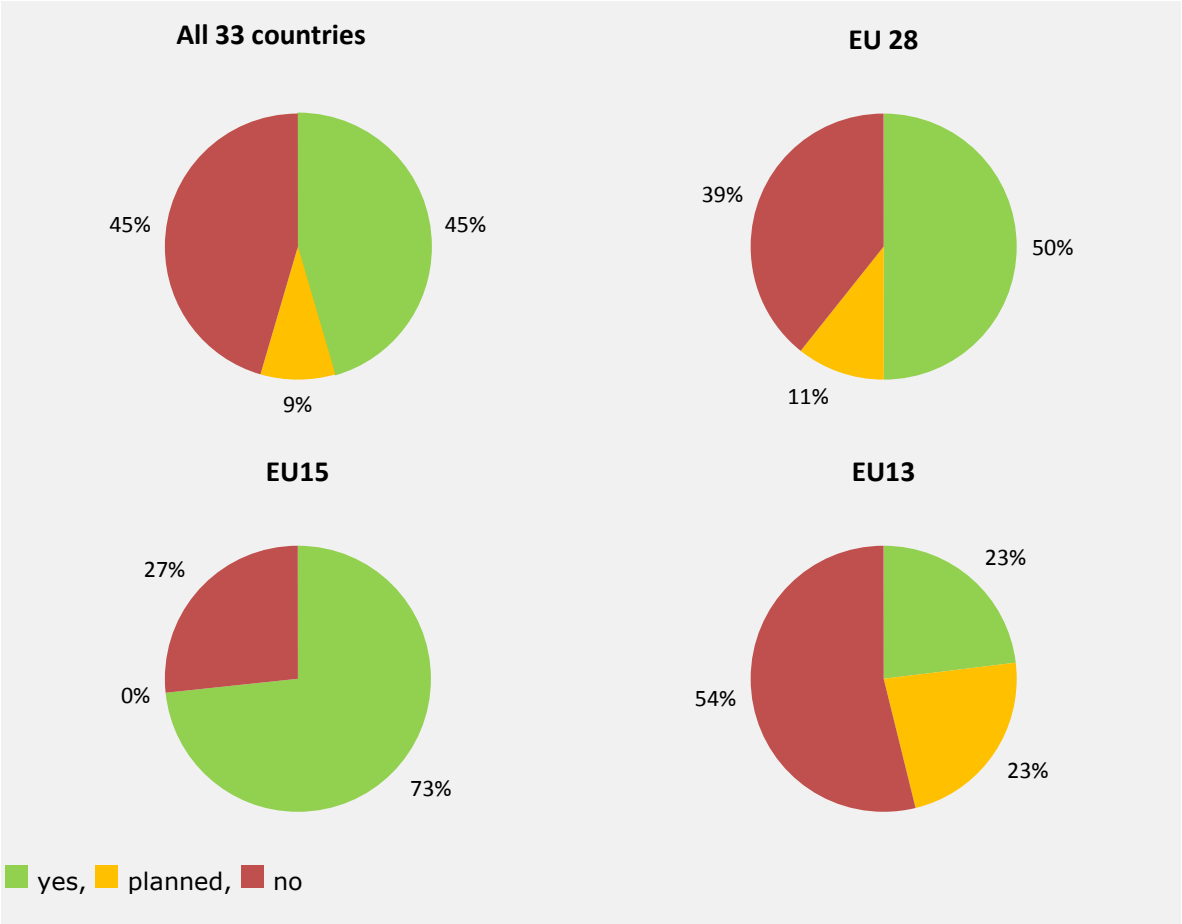
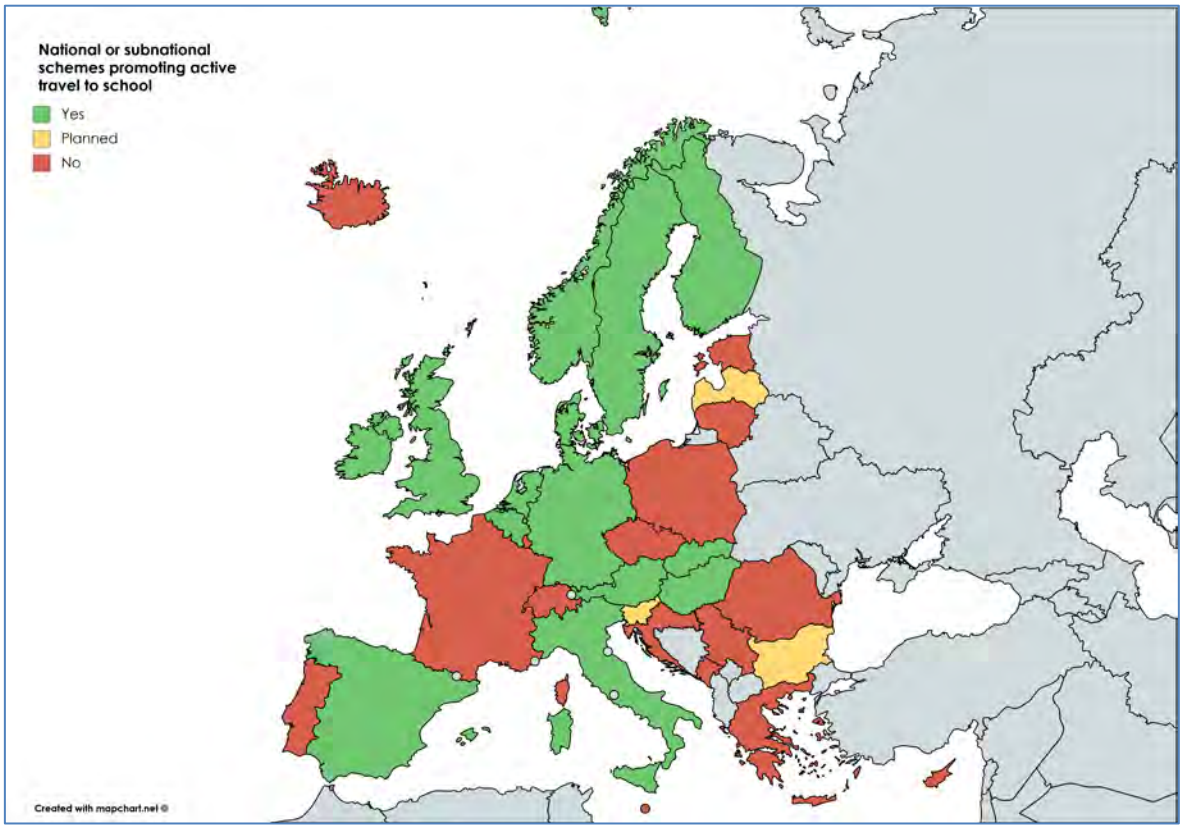


Figure 4.25. *National or subnational schemes to promote active travel to school. EU13: Member States that joined the EU after 1995.*



Map 4.16. *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 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) 25 countries participated (see Figure 4.26 and Map 4.17), 11 more than in the round before (2012/2013). The nine countries indicated in dark green participated for the first time in the 2015/2016 round. All countries that entered the EU after 1995 currently participate in COSI. Finland and the Netherlands are exploring the possibility to join COSI. 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 2014-2017 the next examination survey is conducted. The Health Survey for England (UK) 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 (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children. Experts of the other countries (no data for FR, LU and CH) reported that there are data on weight and height in children. According to the 'APCO database' of DG SANTE France has data, but Luxembourg and Switzerland not. 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.

Representative diet and nutrition surveys
Figure 4.27 and Map 4.18 show whether countries have representative diet and nutrition surveys that are carried out routinely. The information is bass on WHO's GNPR2 survey and information from the consulted experts (for BG, DE, HU, IT, MT, PT, RO, SE. UK) and the APCO database (HR, LU, SI) when no data from GNPR2 were available. Twenty-five countries have representative surveys. However, it is not certain that children are included in all of these surveys. The Competent Authorities of Finland and Switzerland, for example, mentioned that children are not included in their surveys. This may apply to some other countries.

According to the GNPR2 survey and the APCO database (for BG, DE, HU, LU, MT, PT, RO, SI) national food composition tables or databases are not available in nine of the 33 countries (27%; HR, LV, LU, MT, ME, RO, SK, SI, ES). Malta uses US food composition data and Slovenia has data for meat and meat products only. It should be noted, however, that only France (Oqali) and Belgium (Nubel) have food composition databases at the brand level. Oqali is more extensive.

Monitoring of physical activity in children
Physical activity levels are being assessed through the HBSC study among adolescents, except in all but three countries (CY, ME, RS). In addition, experts of ten countries reported to also have other surveillance systems that includes measures of physical activity among children (FI, DE, IE, LT, NL, NO, PT, ES, SE, UK).

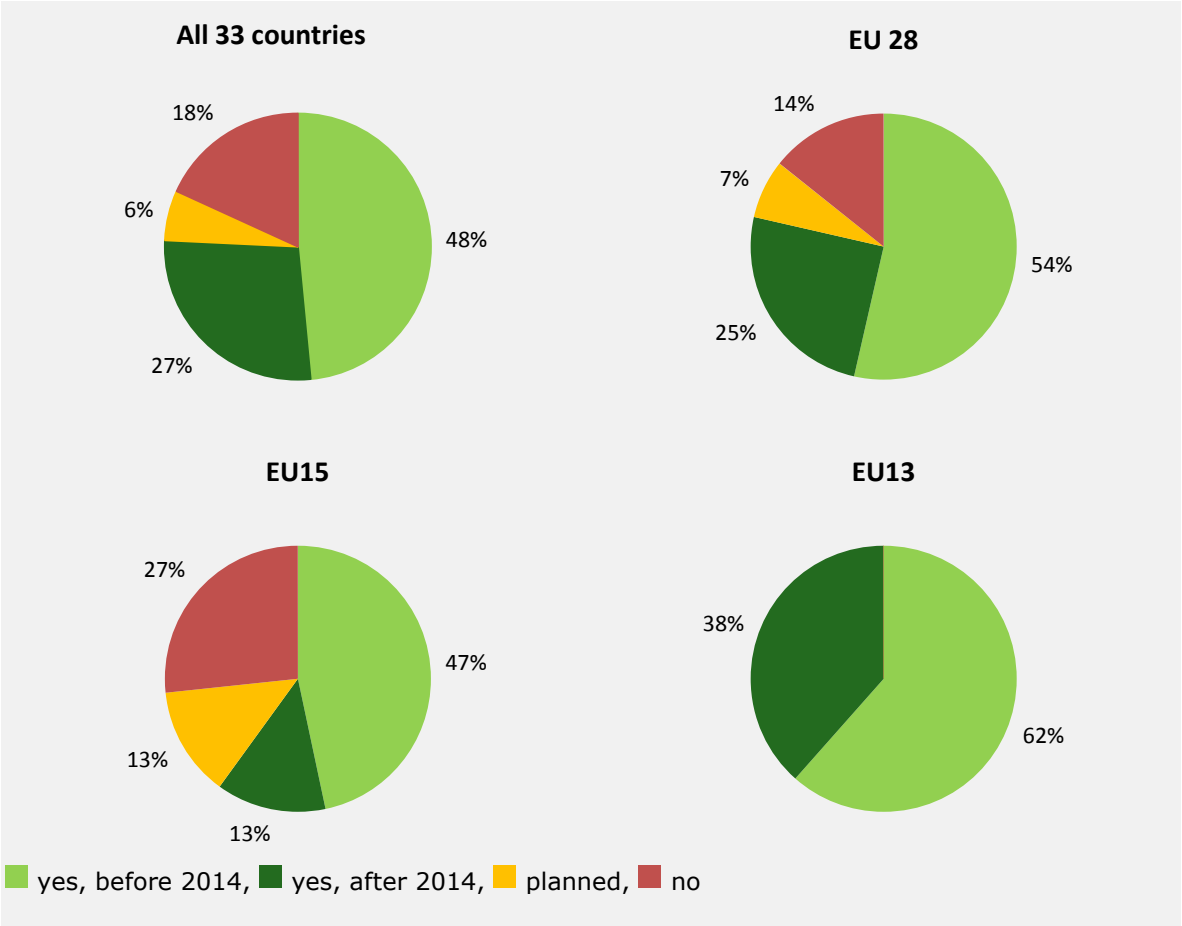
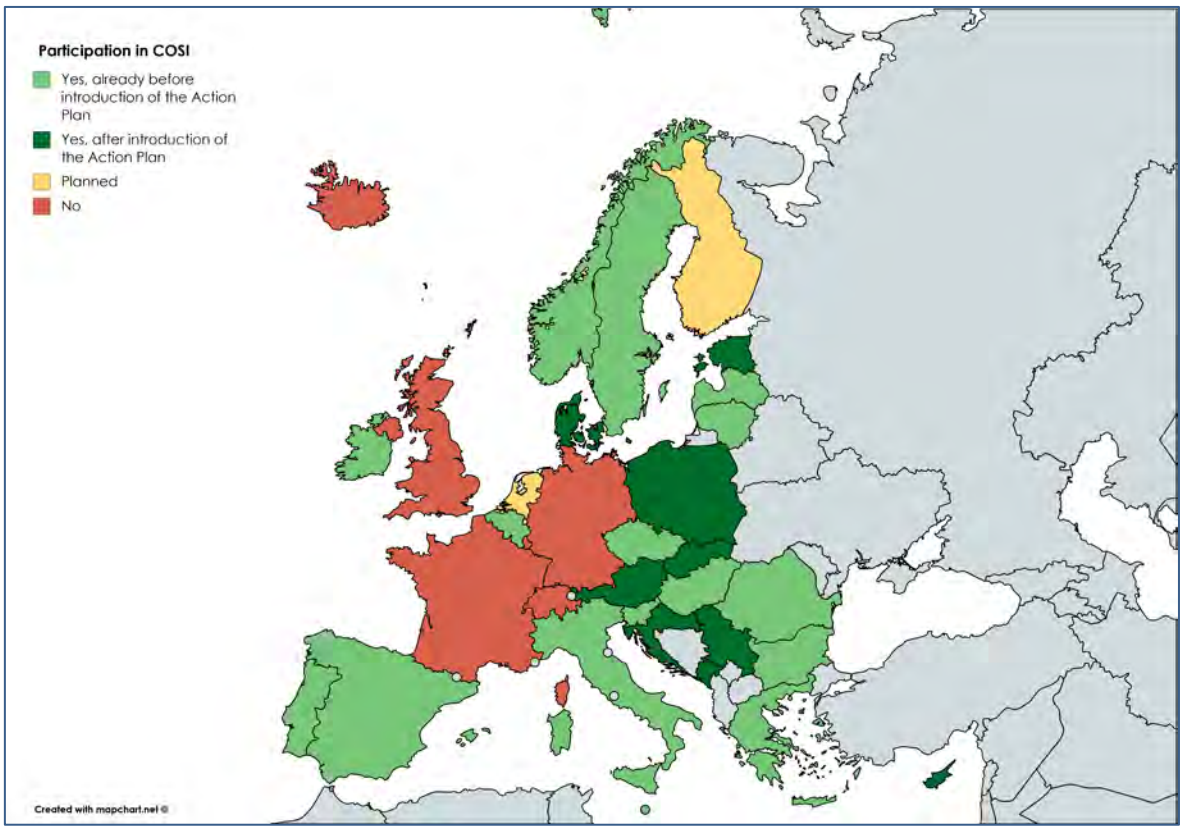


Figure 4.26. *Participation in the Childhood Obesity Surveillance Initiative. EU13: Member States that joined the EU after 1995.*



Map 4.17. *Participation in the Childhood Obesity Surveillance Initiative in 28 EU Member States Montenegro, Iceland, Norway, Serbia and Switzerland.*

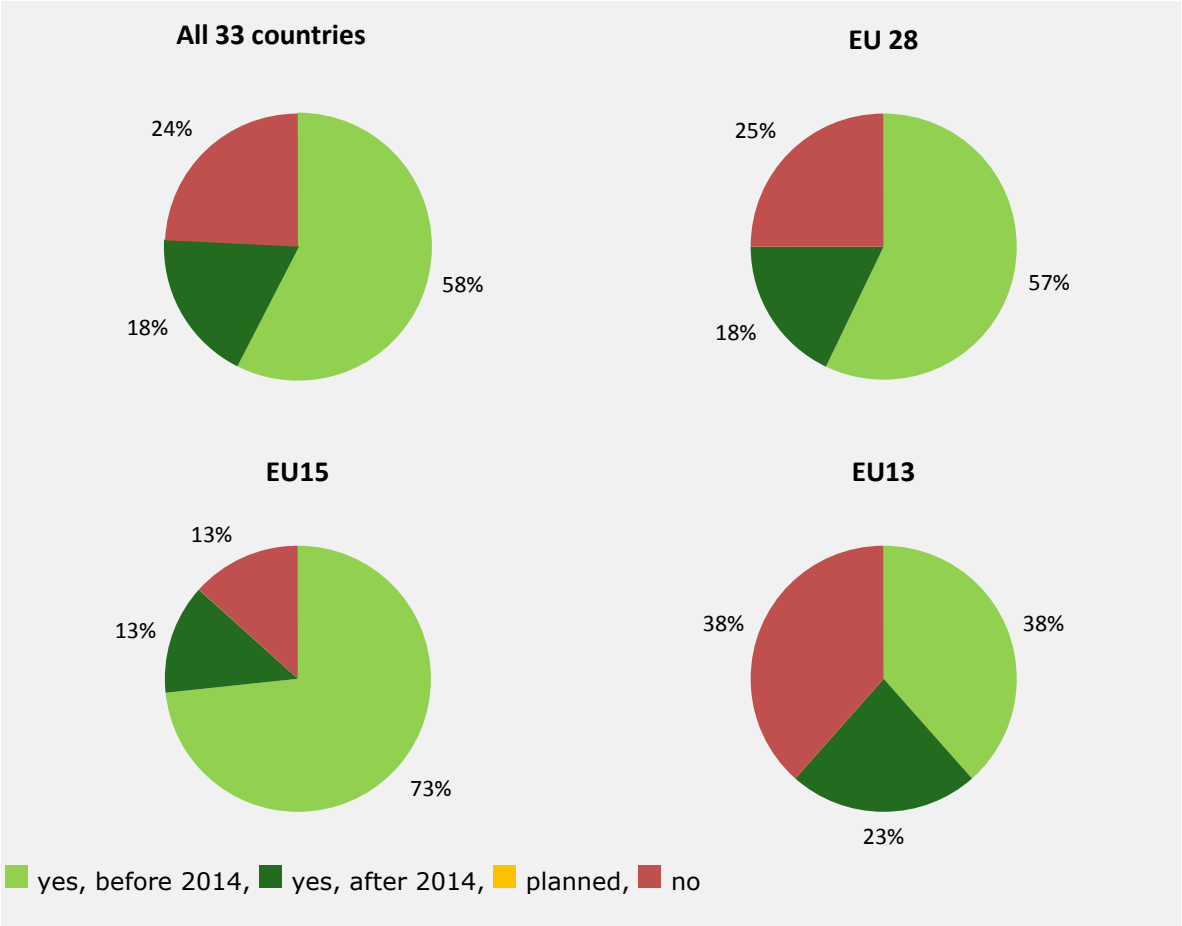
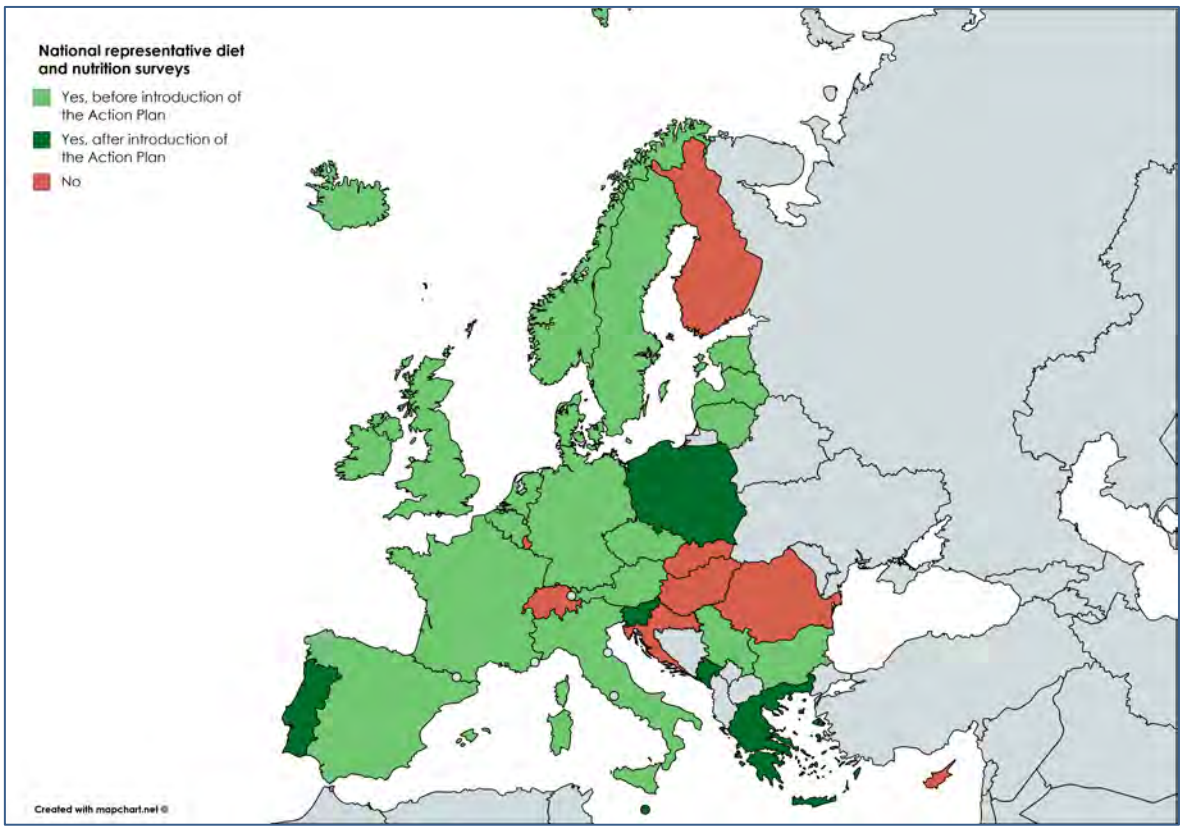


Figure 4.27. *Representative diet and nutrition surveys. EU13: Member States that joined the EU after 1995.*



Map 4.18. *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' (16). On this ladder the least intrusive and most non-committal measures are placed at the bottom, and the most intrusive and most invasive 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 but not always the most effective measures (17).

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 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 of 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, than 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 2.2 Ban on vending machines in schools (and other public places) 2.3 Legislation that prohibits sale of energy drinks to children or in schools 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 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 3.1-3.5 (Voluntary) agreements on food product improvement that affect a whole product group 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 fresh milk, poultry meat and eggs 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 period of time 1.2 Create breastfeeding spaces at public places 2.1 Participation in EU School Fruit and Vegetable Scheme 2.1 Provision of free drinking water in schools 3.1-3.5 (Voluntary) agreements on food product improvement for certain products or with certain producers 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 PA before, during and after pregnancy 1.1 Counselling/support on nutrition and/or PA before, during and after pregnancy 1.1 Mandatory counselling on nutrition and/or PA 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 (16).*

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

This chapter provides 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 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 information to Member States in the form of reports (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** is a group of European Union government representatives dealing with the topics of nutrition and physical activity from all 28 EU Member States plus Iceland, Norway, and Switzerland. The High Level Group 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 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 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 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.

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[8]. 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 from 23 to 30 September. The event has millions of participants. Besides sport activities accessible to the public, some centralised events, have been organised, e.g. by the European Commission. These consisted of conferences and seminars to raise further awareness about the Week. Furthermore, the Commission translates key documents (one-page information sheet, key messages for the Focus Themes, template for press releases) and develops guidance materials to ensure that the same messages are passed Europe-wide during the EWoS. Under the Health Programme (see below) funding for the EWoS has been provided to several countries. 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)[9], 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 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.

[8] http://www.who.int/nmh/ncd-tools/definition-targets/en/
[9] http://www.un.org/sustainabledevelopment/sustainable-development-goals/

5.1.2 Providing information

The Joint Research Centre (JRC) is the science and knowledge service of the European Commission, supporting EU policies with independent research for the entire policy cycle. 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. Within this science area one of the two major areas of focus is school-aged children. Bi-monthly they publish the newsletter "Nutrition Research Highlights".

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, have produced an overview and content analysis of national school food policies in the EU28 plus Norway and Switzerland (38). Other examples of their work in this area are the report on school food and nutrition in Europe (39) and school food policy country factsheets (40). In 2016, the JRC published Lunch at School recipe book (41) and a set of toolkits on promoting water as well as fruit and vegetables in schools (42, 43), 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.

In response to the request of the European Parliament and the Council as part of Regulation (EC) No1169/11 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', JRC published the report "Trans fatty acids in Europe: where do we stand?" in 2014 (44).

JRC also published a report comparing the nutrient profile model recently developed by WHO/Europe with the voluntary industry-devised EU Pledge, both intended to restrict food and drink advertising to children (45). 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, they started a study on the exposure of children to marketing.

The Joint Research Centre, together with the Maltese EU Presidency team and DG SANTE published a technical report on public procurement of food for health in the school setting in 2017 (46).

One of the studies of JRC that is relevant in the context of childhood obesity is 'Peer Active'. 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.

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 possible future initiatives. This paragraph will take a closer look at the Pilot projects and EU-funded projects in the field of nutrition and physical activity. The activities of the projects are also mapped to 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.

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

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.
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.
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.
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.
6.1. Strengthened 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
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. Sharing of good ideas and practices regarding the monitoring of policy initiatives
7.3. Monitoring in order to strengthen obesity prevention.
8.2. Ensure quality and conformity of research projects to existing EU policy objectives and approaches.

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.

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	APCO 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

APCO: EU Action Plan on Childhood Obesity 2014-2020

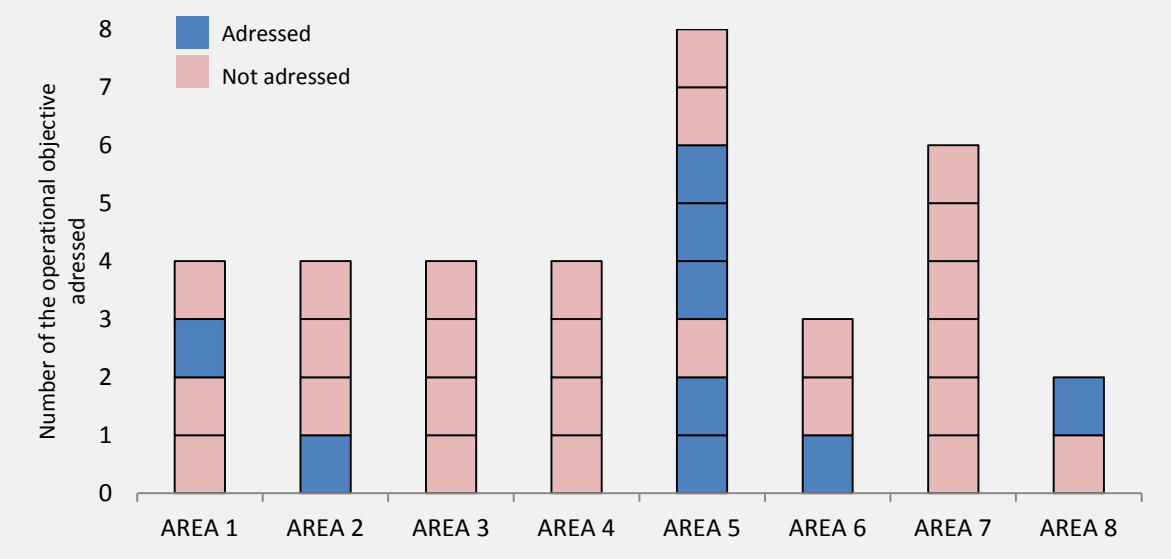


Figure 5.1. *Mapping of the five Pilot projects to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 8 for a description of the operational objectives.*

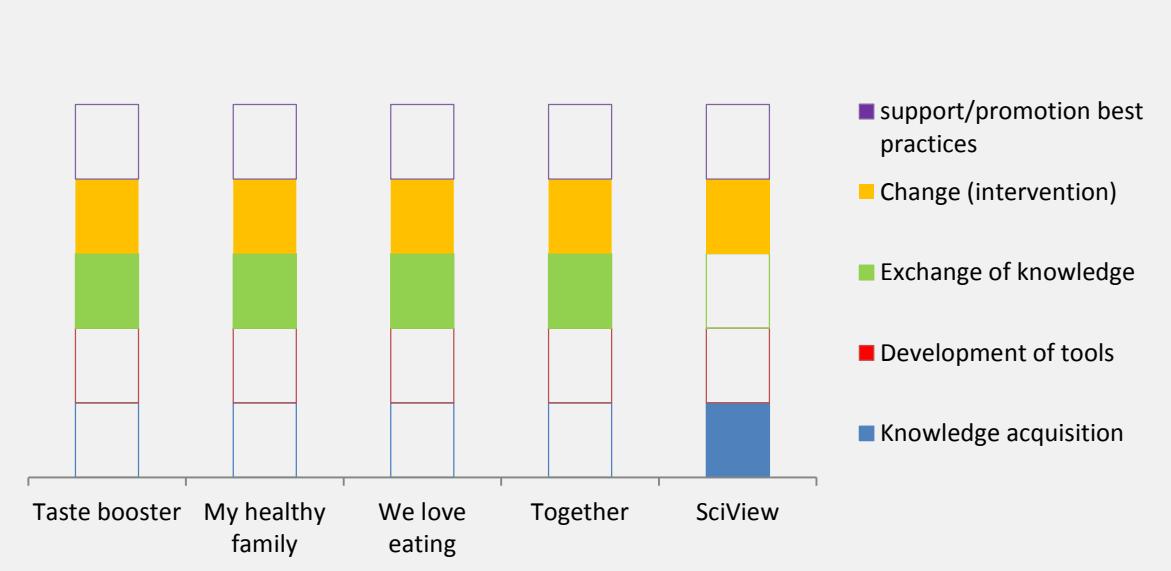


Figure 5.2. *Way in which the five Pilot projects contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

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 feel 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 population 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 not always healthy traditions.

"**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 its 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 mums and mums 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 intend 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[10,11,12,13].

"**SciView**" is a preparatory action that will review 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 are being 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 healthcare 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 nongovernmental organisations (NGO's) 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.

[10]https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2015_tastebooster_howtoguide_en.pdf
[11]https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2015_myhealthyfamily_replicationguide_english.pdf
[12]https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/2016_weloveeating_replicationguide_english.pdf
[13]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, sharing 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. 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	APCO 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			
CBO_FY2013, CBO_FY2014, SHE network, SHE network (2015-2017) (Framework partnership agreement)	2013-2017	NL*	2.1-2.3
SOEEF_FY2014, SOEEFHealth, SOEEF2016	2014-2016	IE*	6.1
OBTAINS-E	2014-2017	WOF (UK*)	1.4

APCO: EU Action Plan on Childhood Obesity 2014-2020

"**CHRODIS**" is the Joint Action addressing chronic diseases and promoting healthy ageing across the life cycle. 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 practiced on (the prevention of) childhood obesity, and on promotion of healthy nutrition and physical activity. 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. 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. 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/Europe and the Joint Research Centre were involved in JANPA. Through the, identification, selection and sharing of best data and practices, the joint action 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. All deliverables and scientific publications that resulted from JANPA can be found at http://www.janpa.eu/outcomes/outcomes.asp.

Box 5.2. Summary of main results and recommendations from JANPA

A position paper[14] and a brochure[15] describe the main conclusions and recommendations resulting from the Joint Action on Nutrition and Physical Activity (JANPA).

JANPA has published an evidence paper[16] 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 healthcare 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[17]. 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.

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

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

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

[17] 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 small and medium enterprises (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) 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. 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. They 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 OBesity Training and INformation Services for Europe (**OBTAINS-E**) of the World Obesity Federation 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.
- 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.

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).

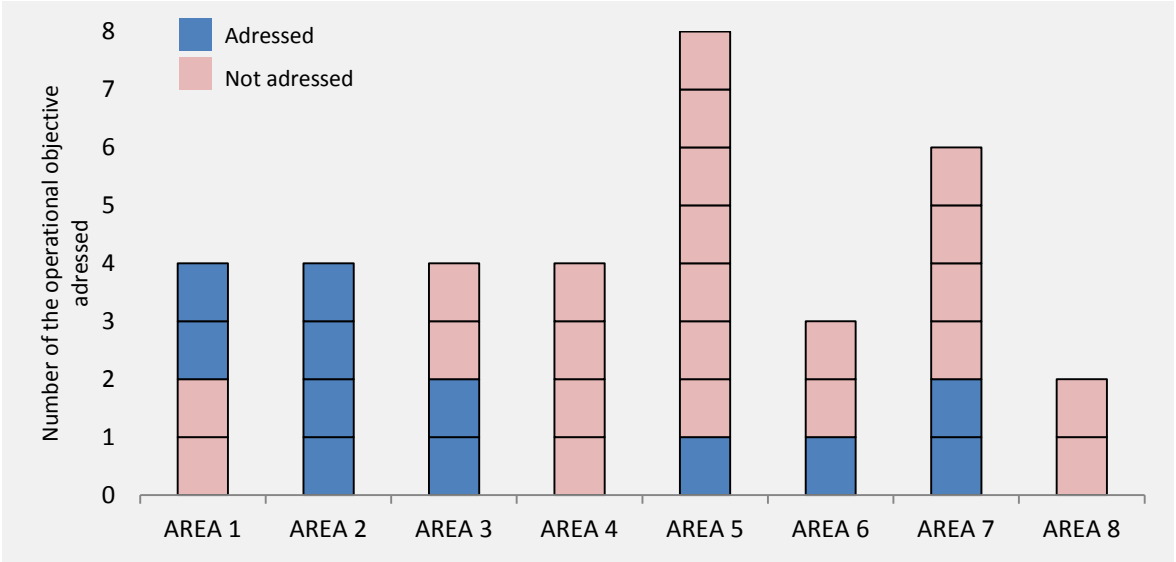


Figure 5.3. *Mapping of the 12 joint actions, projects and operational grants of the EU Health Programme to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 8 for a description of the operational objectives.*

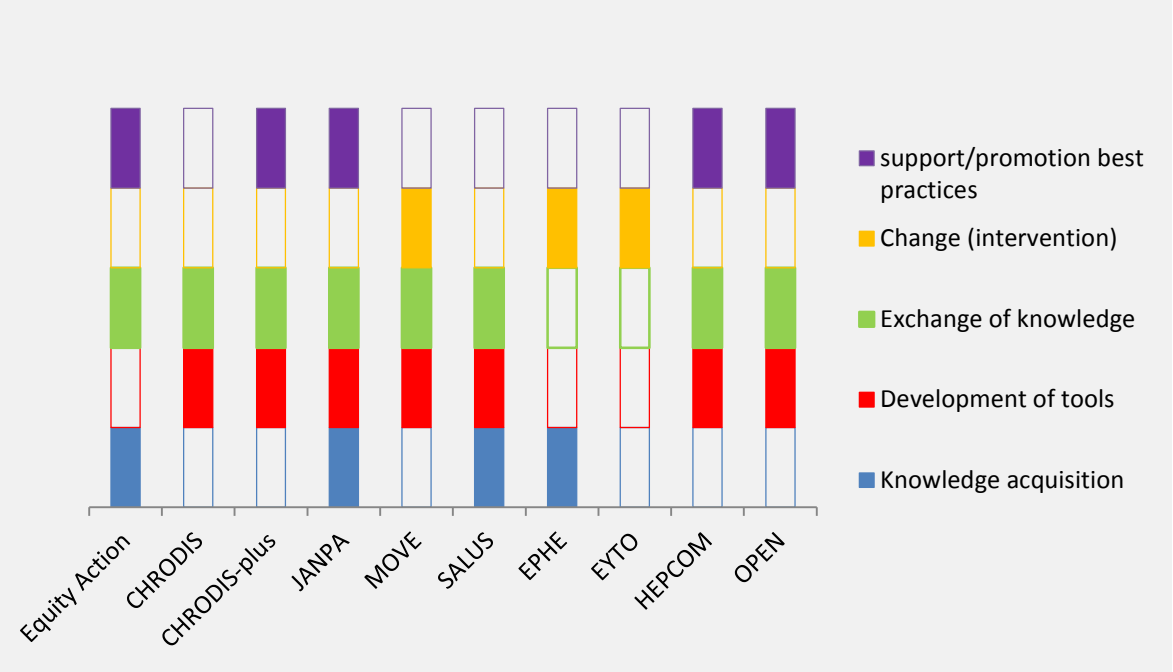


Figure 5.4. *Way in which the 12 Joint Actions, projects and operational grants funded under the EU Health programme contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

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 started or were still running after 2013. 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.

"**HabEat**: Determining factors and critical periods in food habit formation and breaking in early childhood: a multidisciplinary approach" investigated the formation of eating habits in children aged 6 months to 6 years through epidemiological as well as experimental studies. They have 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.

In the "**ToyBox**" project (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) a kindergarten-based, family-involved intervention was developed to promote healthy food and fun and active play in kindergarten settings throughout Europe. The intervention was implemented in 6

European Countries in the schoolyear 2012/2013 and the CHRODIS-project (see above) 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. 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 will develop 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 and in the first phase involved approximately 400 adolescents from three European countries. On their website they provide information and e-courses for teens, parents and teachers (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 will provide 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 the beginning of 2018 on the website of the project (www.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. School and age-matched obese children and adolescents will be the sources for community data. Comprehensive models of the obesity prevalence dependence matrix will be created, allowing, for the first time the data-driven effectiveness predictions about specific policies on a community and the 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. 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	APCO 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

APCO: EU Action Plan on Childhood Obesity 2014-2020

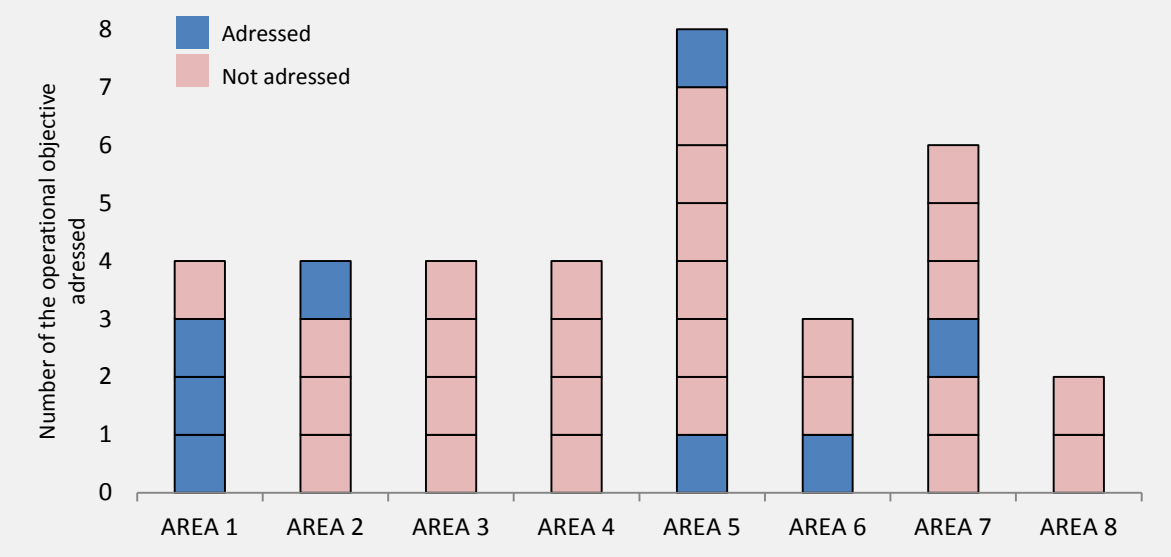


Figure 5.5. *Mapping of the six projects funded by FP7 and H2020 to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 8 for a description of the operational objectives.*

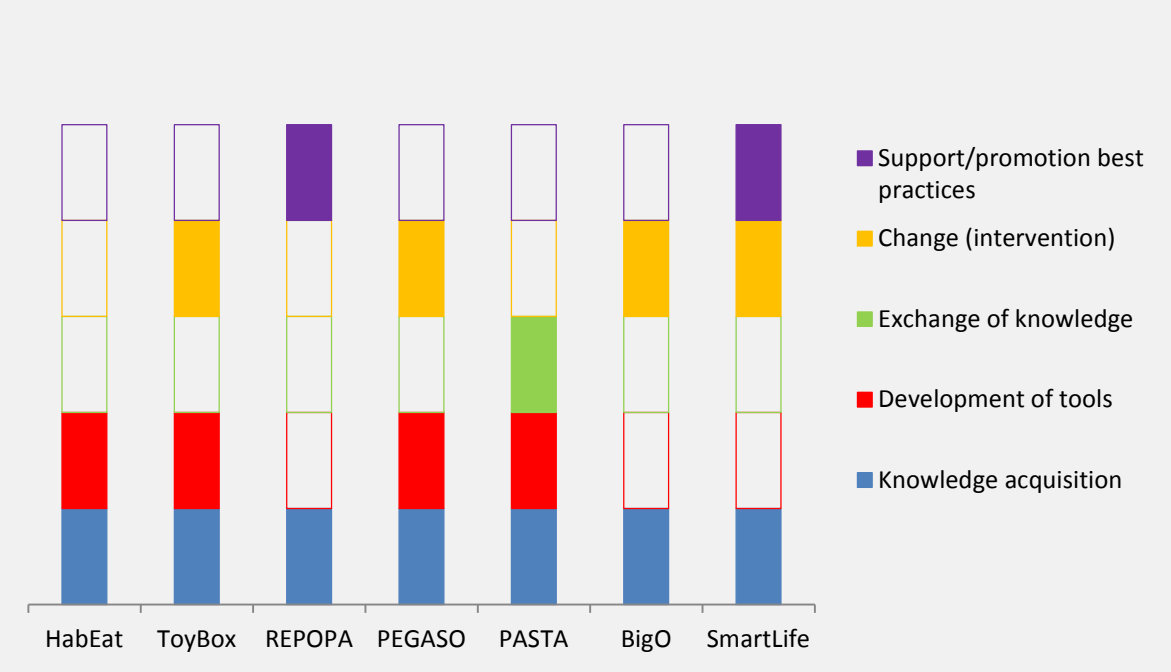


Figure 5.6. *Way in which the seven projects funded under FP7 and H2020 contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

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 to 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 to 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. trough 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).

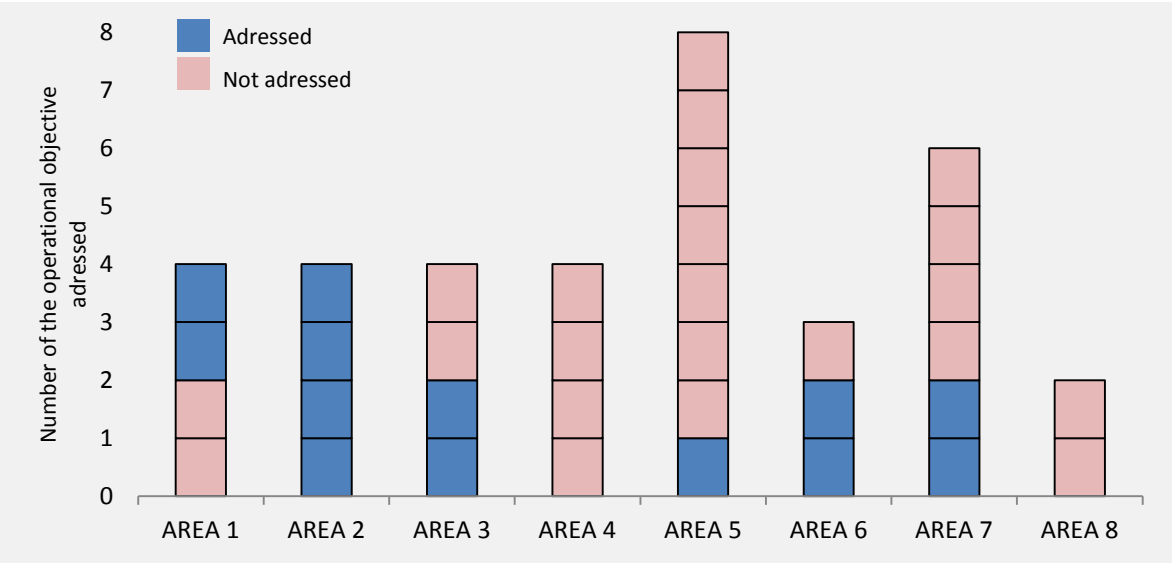


Figure 5.7. *Mapping of 96 of the 138 projects funded the Erasmus+ programme to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 8 for a description of the operational objectives.*

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 (SRAs) 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. 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:

- 1. 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.
- 2. 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.
- 3. 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 33 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. 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. The main objective of ENPADASI is 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. 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.

- The aim of 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 network meeting was organised for the 28 research groups that were selected to elaborate a joint network proposal to start the discussion on the potential structure of the network and the joint proposal. The final funding decision is expected by the end of 2017.

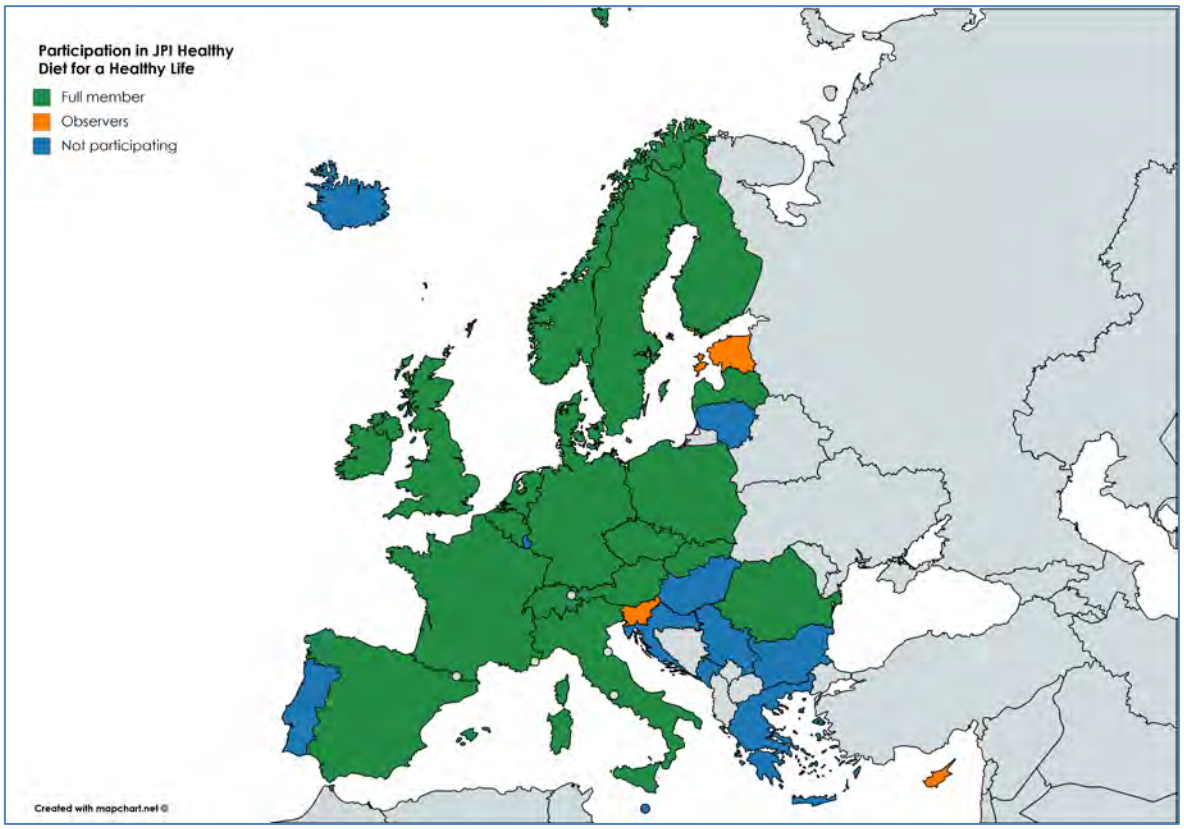
- By establishing working groups on diet related diseases the JPI HDHL aims to support transnational cooperation and communication between individual researchers, research groups and research organisations in order to merge knowledge, data and research results. Three topics are to be addressed in the 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	APCO 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

APCO: EU Action Plan on Childhood Obesity 2014-2020



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

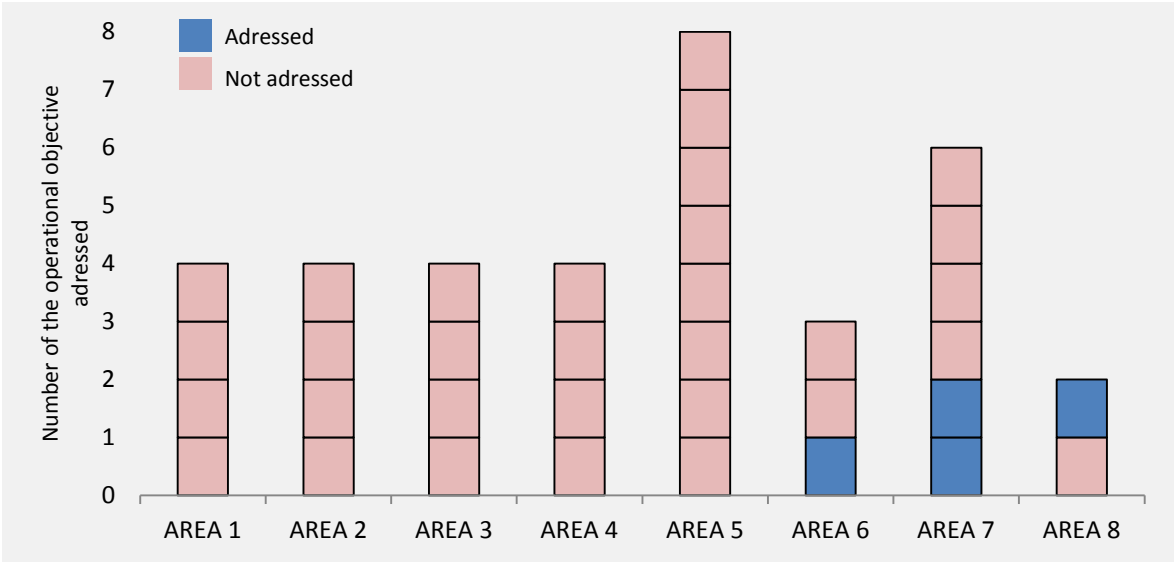


Figure 5.8. *Mapping of JPI-HDHL to the 35 operational objectives of the EU Action Plan on Childhood Obesity 2014-2020. See Box 8 for a description of the operational objectives.*

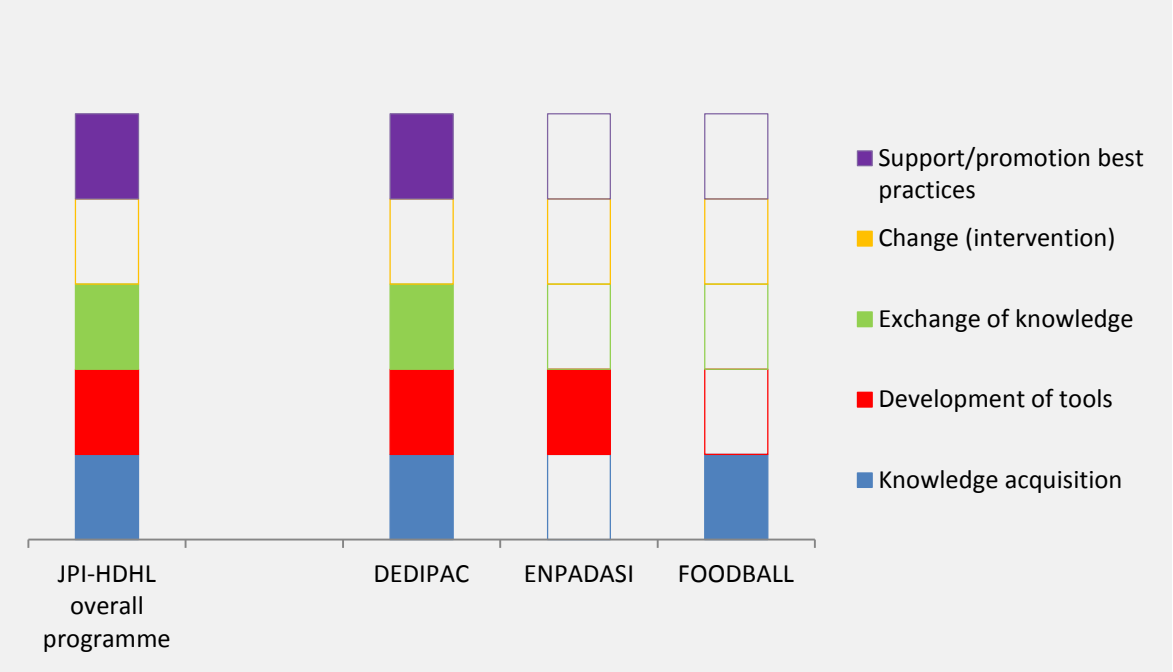


Figure 5.9. *Way in which JPI-HDHL and the projects that resulted from it contribute to the operational objectives of the EU Action Plan on Childhood Obesity 2014-2020.*

5.2.1 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[18]. 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.

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

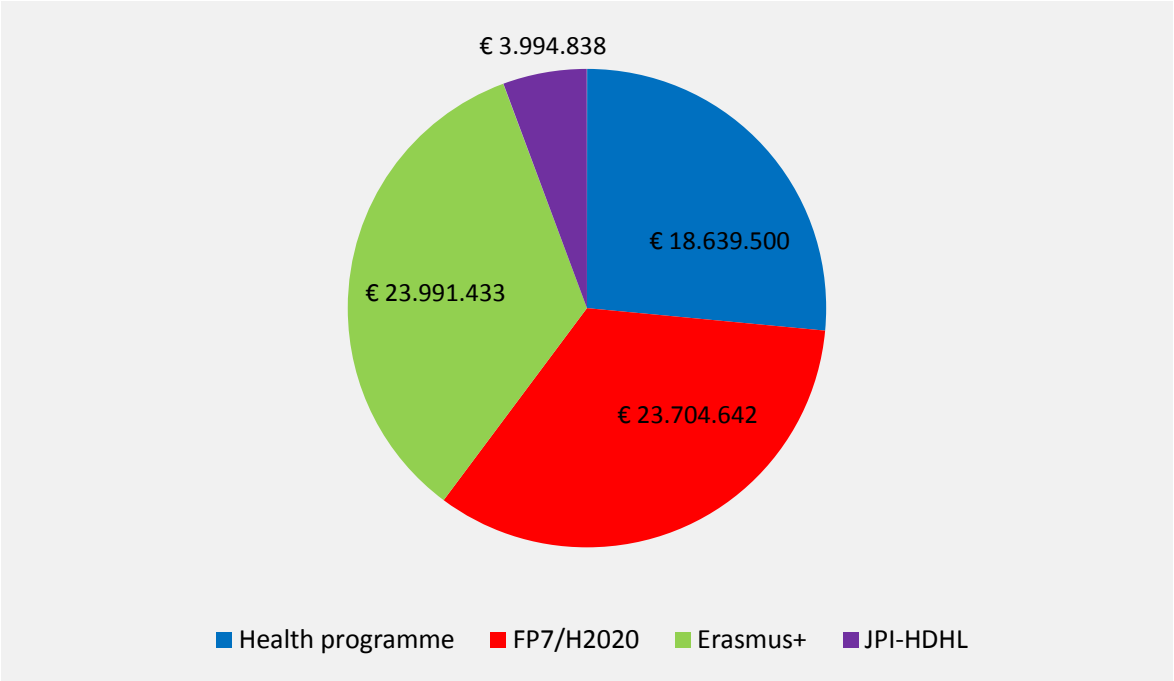


Figure 5.10. *EU-funding of projects relevant to childhood obesity according to the funding programme.*

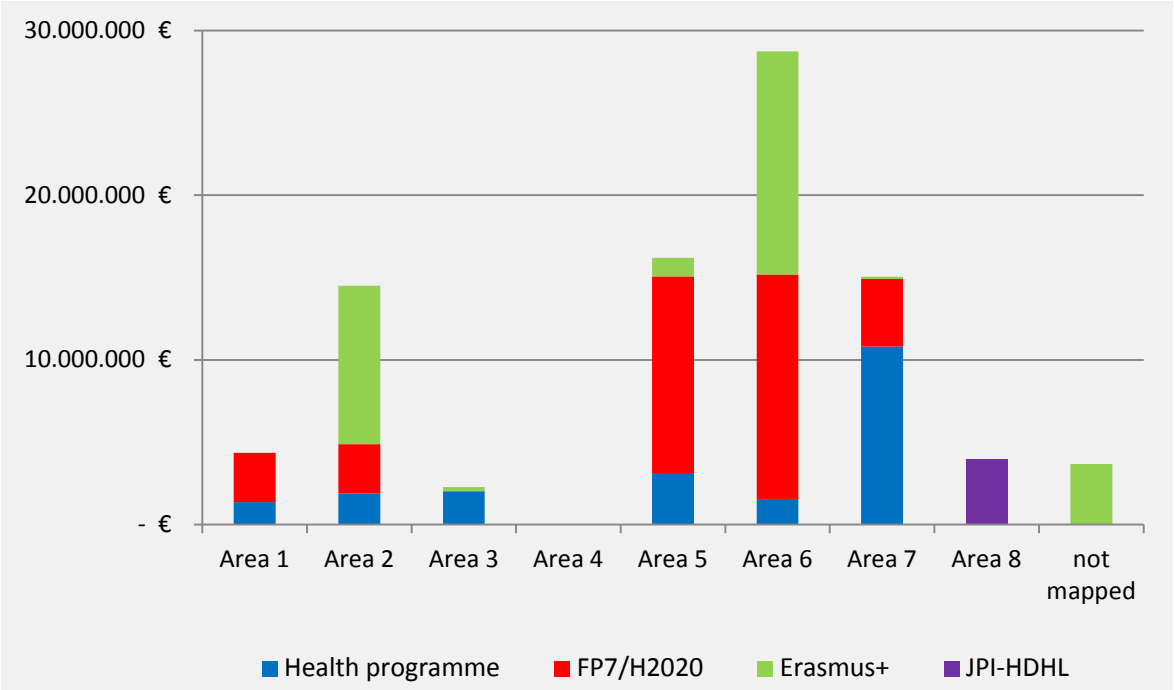


Figure 5.11. *Allocation of funding by EU programmes to areas of action of the EU Action Plan on Childhood Obesity 2014-2020.*

5.2.1 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 countries that joined in 2004, 2007 and 2013. The EEA Grants are jointly financed by Iceland, Liechtenstein and Norway. They are also available in Greece and Portugal. 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, families with low income with children between 5-10 years old.

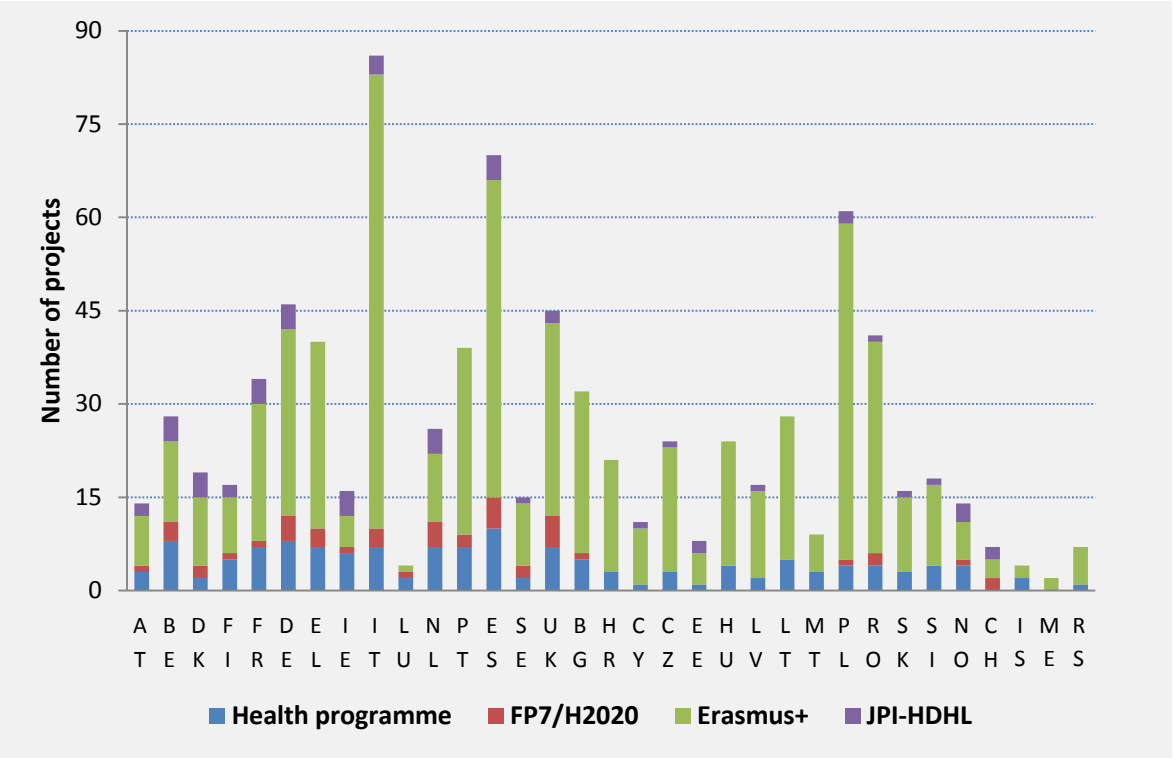


Figure 5.12. *Participation of EU Member States, Norway, Switzerland, Iceland, Montenegro and Serbia in projects funded by EU programmes.*

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.

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 they presented their final report, describing a comprehensive, integrated package of recommendations to address childhood obesity (47). 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 (48)
- Global recommendations on physical activity for health 5 - 17 years old (49)
- An overview of the types of childhood obesity prevention interventions that can be undertaken at national, sub-national and local levels (50).
- A set of tools for Member States to determine and identify priority areas for action (51).
- Guidelines to support primary healthcare workers identify and manage children who are overweight or obese (52).
- Guidelines on the protection, promotion and support of breastfeeding in facilities providing maternity and newborn services (53).

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.

The WHO Regional Office for Europe (WHO/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 WHO/Europe programmes contribute to reversing the obesity epidemic in Europe, including those focusing on physical activity and diet. WHO/Europe supports activities at country and international level to implement the WHO European Food and Nutrition Action Plan 2015-2020 (54). 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/Europe's public health journal, Public Health Panorama, dedicated its issue of December 2017 to obesity and unhealthy diets in the European Region (55). 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/Europe also published a report on Incentives and disincentives for reducing sugar in manufactured foods (56).

WHO/Europe is the host, as well as a 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/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 (57), the European Charter on Counteracting Obesity (58), the Global action plan for the prevention and control of NCDs 2013-2020 (59) and on corresponding documents from the European Commission.

WHO/Europe also coordinates other activities that are relevant to the prevention of childhood obesity. One of them is 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/Europe published a report on transforming public spaces to promote physical activity (60).

WHO/Europe 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. Furthermore WHO/Europe adopted HBSC as a collaborative study in 1983.

Besides these activities WHO/Europe sets out various surveys, such as the Global Nutrition Policy Review survey (GNPR2 survey). The data from these surveys are made available, for example through the Nutrition Obesity Physical Activity (NOPA) database. This database consists of data of WHO/Europe member states to monitor developments on nutrition, diet, physical activity and obesity. 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.

European Association for the Study of Obesity (EASO)
The European Association for the Study of Obesity (EASO) EASO is a federation of professional membership associations from 32 European countries. Organisations from all countries included in this study except for LU, CY, EE, LV, LT, MT are members. The mission of EASO is to decrease the burden of unhealthy weight. It is the voice of the European obesity community, representing scientists, health care practitioners, physicians, public health experts and patients. EASO is in official relations with WHO/Europe and a founding member of the EU Platform 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 (61) 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.

World Obesity Federation (WOF)
World Obesity Federation represents professional members of the scientific, medical and research communities from over 50 regional and national obesity associations. Associations from three countries are member of the EASO, but not of the WOF (ES, SE, ME), while Malta is member of WOF but not of EASO. 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/).

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

The mission of the Organisation for Economic Co-operation and Development (OECD) 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.

The most recent obesity update was published in 2017 (62). 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. In 2015 results of a study on the economics of public health and health promotion was published (63). The study was primarily focused on interventions addressing behavioural risk factors, such as diet and physical activity. In 2013, OECD published a working paper on the role of fiscal policies in health promotion (64).

6 STRENGTHS AND WEAKNESSES

This chapter describes the results of the questionnaire on strengths and weaknesses. Seventy percent (n=23) of the Competent Authorities returned the questionnaire on strengths and weaknesses. 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, the policies that are considered 'most successful' are described (Chapter 6.1), followed by the policies that are considered 'least successful' (Chapter 6.2). It should be noted however, that 'successful' has been referred to by authorities 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). In Chapter 6.3 an overall picture of the strengths and weaknesses is provided. The remainder of this chapter focusses on the Action Plan and the actions of the European Commission that, according to the respondents, are most appreciated and the actions they could intensify.

6.1 Frequency of 'most successful' policies

The policies/activities that are mentioned by the largest number of respondents to be 'most successful' 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 (see figure 6.1). These are followed by activities in Area 5: inform and empower families and in Area 7: monitor and evaluate.

Taken together, activities to restrict marketing and advertising to children (Area 4) were mentioned least often among the 'successful policies', while none of the reported 'successful' activities lie in Area 6: encourage physical activity. Below, for each area for action the success factors are listed. More details on the policies/activities and their achievements is provided in box 3-8.

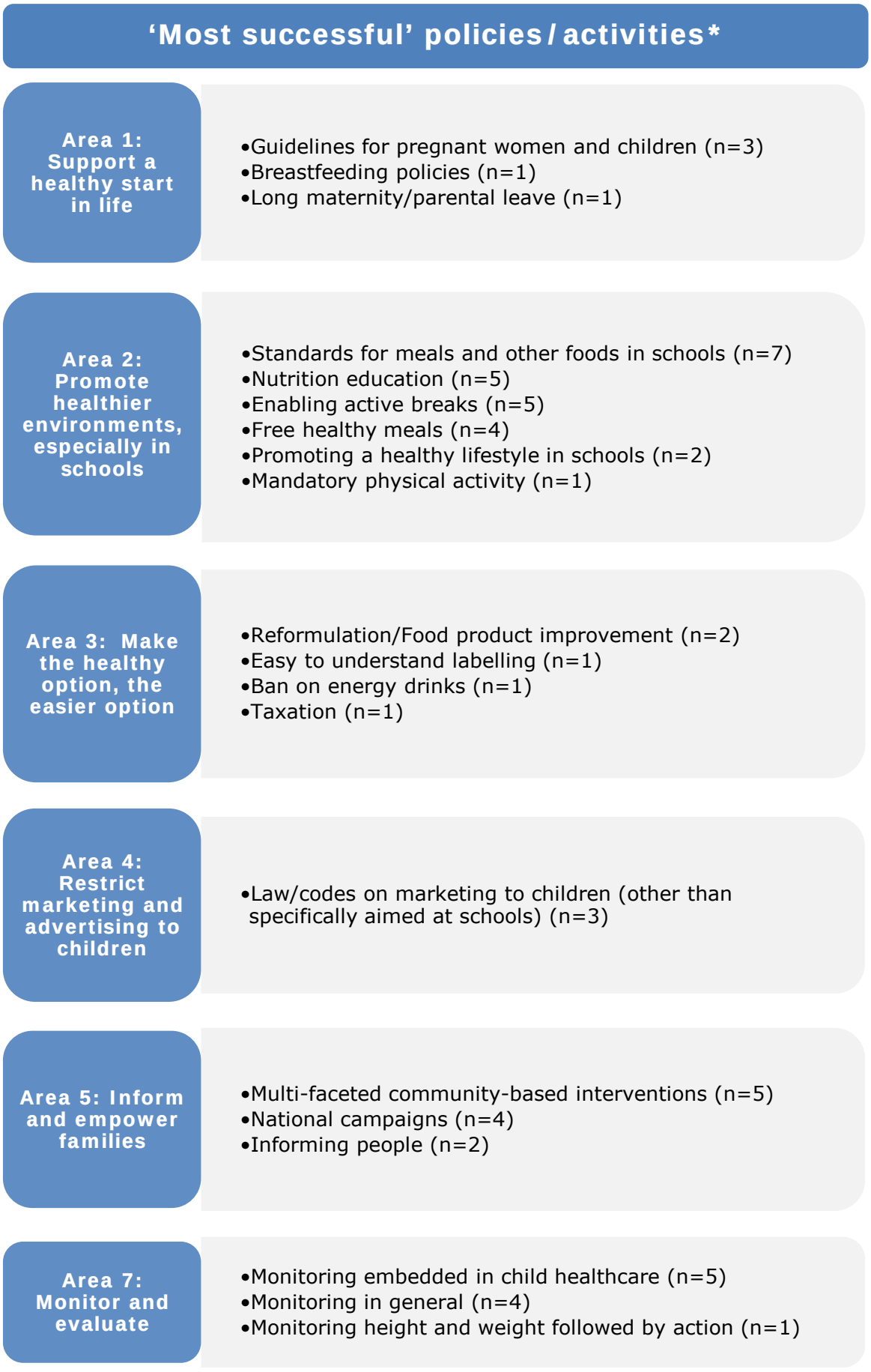


Figure 6.1. *'Most successful' policies/activities *as mentioned and interpreted by competent authorities and consulted experts*

Area for action 1: Support a healthy start in life

Representatives of five countries reported activities in area for action 1 among their 'most successful' actions for the prevention of childhood obesity (see box 6.1). The following success factors are mentioned as reasons for that:

- Implementation is easy when regulated (in part) by legislation
- Guidelines are developed in cooperation with many experts, resulting in wide acceptance
- Information is:
  - adjusted to the specific needs of the target groups
  - understandable
  - consistent across different age-groups
  - available in more languages

Box 6.1. 'Most successful' policies Area 1: support a healthy start in life

Promotion of breastfeeding

Promotion of breastfeeding by legislative actions and education/support for mothers increased the prevalence of children that are breastfed in Greece has been increased. Furthermore, the population and health professionals are more aware of the importance of breastfeeding. These policies were easy to implement, as they contain parts that are regulated by legislation (EL).

Maternity leave

A long maternity leave of 2 years, paid with a very high percent 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 (RO).

Guidelines on (early) nutrition

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 kindergarten 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 (NO).

Dietary guidelines for healthy nutrition of targeted groups like pregnant women, infants, toddlers, children 3-7-year-old, school children 7-19-year-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 (BG).

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 the 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 the 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 (CH).

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

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. Furthermore, providing healthier food and more possibilities for physical activity, endorses nutritional and physical activity education. Box 6.2 shortly describes the activities in different countries that were reported to be among the 'most successful'. According to the respondents, the following factors contributed to the successful implementation of the activities:

- Implementation is easy when regulated (in part) by legislation
- Implementation is comparatively straightforward and less costly compared to other initiatives
- High political commitment
- Provision of governmental budget
- High extended dialogue with stakeholders
- Firm cooperation between local and national players
- Collaborative agreement that is widely accepted by school and health authorities
- Supervision by national and regional authorities
- Annual evaluation of activities that mobilized the institutions to ensure a solid implementation of pro-health activities
- Being part of comprehensive health promotion programme
- Free access to activities
- Use of coherent messages and knowledge
- Testing of materials in advance
- Parents and children participating in the same health education/empowerment activities
- Gentle, educative and positive approach towards healthy lifestyles
- Personal advice on healthy eating patterns and behaviours that fit into lifestyle

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

Free provision of healthy meals

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 kindergarten and at schools ensure adequate nutrition during the preschool/school days for the most of the child population and increase 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 – building a manner to eat regularly balanced meals. It also enables long-lasting and concrete food education during the school years. The served meals and snacks are not only meals served but function as food education included in the curriculum as in primary schools and in kindergartens. 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 (FI).

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 (HU).

Providing free healthy meals in schools resulted not only in children receiving at least one healthy meal a day, but also to 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 (anonymous).

Box 6.2 continued

Guidelines/standards for foods offered in schools

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 (BG).

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 (EL).

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 the supply of energy-dense and nutrient-poor foods to schools. Furthermore, it educates youth to healthy nutrition (LT).

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. Based on the results of monitoring activities of some stakeholders, mandatory introduction of standards could be postponed (HU).

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 (SK).

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 centers” 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 (ES).

The national programme “Healthy Living” has 5 components including “health and education”, “health and physical activity” and “health and nutrition”. 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 (HR).

Box 6.2 continued

Promotion of healthy lifestyle at schools

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 strengthening 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 (LU).

The national program "Gaining Health" aimed to promote healthier environments, especially in schools, and strategies for food reformulation. 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 (IT).

Nutrition education in school curricula

Nutrition education in school curricula. 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.) (BE-WAL).

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 (FI).

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 and the correct messages and knowledge about healthy nutrition and physical activity). This facilitates the credibility of the messages (LU).

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 ion 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 also evaluated. There was an improvement in selected dietary behaviours and selected physical activity indicators, increased knowledge of children and adolescents about the role of nutrition and physical activity for health. An additional achievement was the decline of 1% of excess body weight (overweight and obesity) among students from primary and lower secondary schools participating in the project. The 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 reported to the Ministry of Health by the Institute of Food and Health. A decision has not been made yet (PL).

Nutrition education in school curricula contributed to an increase in nutritional knowledge among school children. Key stakeholders within the Ministry of Education recognize the problem of obesity in children, and work hand in hand with the Ministry for Health to address it by emphasising the need to provide nutritional knowledge and skills to schoolchildren (anonymous).

Box 6.2 continued

Enabling healthy breaks or after school sports

As part of the national programme "Healthy Living", additional education on physical activity and equipment (polygons) to schools that have no gym or sports hall has been provided, Children can be active in the hall or the classroom. The national programme is a comprehensive health promotion programme (HR).

In the 'Open School Programme' municipalities arranged for schools to remain open in the afternoons for extra-curricular activities including archery, tae kwon do, 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/ athletic 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 (CY).

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 in various localities 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 (MT).

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 1st and 2nd years and 3 to 5.5 hours weekly in 3rd and 4th years of public primary education. These include many activities other than physical activities. No statistical data are available to allow assessment of the impact of the national priority programs for the prevention of childhood obesity. 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) (PT).

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 hygienic conditions 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 (SK).

Mandatory daily physical activity lessons

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 (HU).

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

In five countries activities in area for action 3 were among the activities that were considered 'most successful' (see Box 6.3). It was noted that change in nutritional habits takes time and sustained multi-stakeholder efforts therefore have greater possibilities for changing behaviour and affecting childhood obesity rates. Food product improvement is an example of such an effort. The following success factors have been mentioned:

- Development in partnership with relevant stakeholders
- Political agenda setting (importance of cooperation with industry and retailers)
- Inclusion of both information/communication and structural components
- Related effects: logo and taxation results in increased willingness to improve food products.

Box 6.3. 'Most successful' policies Area 3: make the healthy option, the easier option

Food product improvement

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

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 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 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 (CH).

Easy to understand labelling

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 3.000 Keyhole labelled heathier products in supermarkets etc. The Keyhole has furthermore lead to the reformulation of products in a healthier direction. The wholegrain logo is available on 800 products and has a played a major role in increasing wholegrain consumption by more than 70% (DK).

Bans

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 (LT).

Taxation

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 (HU).

Area for action 4: Restrict marketing and advertising to children

Only three countries considered the restriction of marketing and advertising to children to be among their 'most successful' activities (see Box 6.4). Success factors mentioned were:

- Collaborative agreement
- Adherence of many companies

How this was achieved was not reported.

Box 6.4. 'Most successful' policies Area 4: restrict marketing and advertising to children

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. 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 (BE).

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 (LT).

The PAOS CODE for co-regulation of the advertising of food and drink products to minors, obesity prevention and health was launched in 2005 and modified in 2012 and 2013. A new up-to-date version is being prepared. The PAOS Code established a set of ethical rules to assist adhering companies in developing, creating and disseminating advertising messages for food and drink products that target minors. The implementation of the PAOS CODE has caused an objective improvement in the quality and pressure of advertisements for food and drinks that target minors. It is based on collaborative agreement and many companies adhere, which implies that 80% of marketing directed to minors is affected (ES).

Area for action 5: Inform and empower families

Five multi-faceted community-based interventions are 'successfully' implemented in four countries, while representatives of other countries reported 'successful' campaigns (see Box 6.5). When developing and implementing these activities engagement with different actors and stakeholders, such as local service providers, potential local supporters and non-governmental organisations, is considered to be important, so that when starting, the public would encounter an informed and supportive local environment. The following factors were mentions as success factors:

- Engagement of all actors and stakeholders of the municipality
- Development of a network of commercial sector organisations to ensure that many of the biggest companies pledged to support the programme
- Involvement of different settings (schools, workplaces, communities, health services)
- Support for health promotion policies by central and regional institutions
- Sufficient capacity to engage different sectors according to a whole-society approach
- Structural way of working/developing activities
- Implementation for a longer period of time
- Inclusion of process and outcome evaluation
- Use of a life course approach
- Addressing vulnerable groups
- Information provided is:
  - Evidence-based and reliable
  - Practical, for example includes daily meal plans (e.g. in order to develop confidence and skills)
  - Translated into real situations to which target audiences can relate
  - User-friendly
  - Written in memorable language

Box 6.5. 'Most successful' policies Area 5: inform and empower families

Multi-faceted community based interventions

Some municipalities and cities, both in the Flemish and French part, engaged in the ViaSano program based on the original French initiative EPODE of Fleurbaix-Laventie. This initiative (financed by private partners) aims to reduce the 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 (BE).

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. In 14 of them a decrease in BMI has been observed and school canteens and sport canteens became healthier (NL).

The National Prevention Plan 2014-2018, implemented at the regional level, develops 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 (IT).

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 (anonymous).

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 (NL).

Informing people

In the frame of Polish National Health Programme, one successful activity worth to mention, is the development and financing of The National Centre of Nutritional Education (www.ncez.pl). This centre is powered by the Institute of Food and Nutrition and began its activity on 19th January 2017. Success within the 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 on the web. Over 56% are new users which means wider educational dimension with expert content about nutrition and physical activity. 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 (PL).

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, healthcare 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 (anonymous).

Box 6.5 (Continued)

Campaigns

National campaigns to promote healthy diet and physical activity together with policies to support community-based interventions (see below) 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" (IT).

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

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 (anonymous).

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. Several countries considered their achievements in the field of monitoring among the 'most successful'. Furthermore, evaluation of height and weight in the child healthcare system, followed by appropriate action if needed, is considered one of the 'most successful' approaches towards the prevention of obesity in several countries (see Box 6.6). The following factors contribute to their success:

- Surveillance is relatively easy to implement
- Surveillance is not politically controversial
- Good working relationship between the Ministries of Health and Education
- High coverage in the population
- Universal and free access for all children up to the age of 18, both in primary health care and in hospital health care
- Includes all children regardless of socioeconomic status
- Uniform systematic practice for identification of children at risk at a national level
- Long experience with the system
- Staff has high professional skills
- Empowerment of the whole family
- Counselling is based on the family needs
- Personal and individualised feedback
- Direct involvement of both children and their parents

Box 6.6. Most successful policies Area 7: monitor and evaluate

Monitoring and follow-up in child healthcare

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 healthcare 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 the resourceful 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 (FI).

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, 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 (PT).

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 (BE).

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 (DK).

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 (RO).

Monitoring of height and weight followed by action when needed

In the 'Healthy Children Program', carried out by the Research and Education Institute of Child Health between 1995 and 2002, each academic 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 (CY).

Box 6.6 (continued).

Monitoring (general)

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 (PL).

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 (MT).

The Childhood Obesity Surveillance Initiative (COSI) has been conducted for the first time, supported by WHO/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 (RS).

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 (ES).

6.2 'Least successful' policies / activities

Respondents were asked to report the two 'least successful' activities 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 the respondent mentioned the same activities, so these were combined into one response. Other respondents mentioned other activities. They are described but do not count in the number of 'least successful' activities mentioned for each area for action.

It was not always easy for the respondents to the questionnaire on strengths and weaknesses to identify the 'least successful' policies/activities 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.

One of the two points raised by the respondent of Luxembourg pertained not to a specific activity that falls under one of the areas for action of the Action Plan, but to their whole national action plan "Gesond Iesen Mei Bewegen" (GIMB). There is a lack of funds and human resources to develop tools to increase visibility of the program and activities in ways other than through the internet. Also examples of good practice are lacking.

Area 3: Make the healthy option the easier option seems to be the 'least successful' area (see Figure 6.2). Activities within this area, i.e. food product improvement, easy to understand labelling and taxation policies were most often mentioned. This area is followed up by Area 2: promote healthier environments, especially in schools and pre-schools. In this area, activities on nutrition and physical activity education and EU Fruit and Vegetable Scheme are mentioned the most. Laws or codes on the restriction of marketing and advertising to children are also mentioned by several respondents (Area 5), as well as campaigns on nutrition and/or physical activity (Area 5).

Relatively few of the 'least successful' activities lie within Area 1 and Area 7. Remarkably, none of the activities that are reported to be among the 'least successful' lie in Area 6: encourage physical activity. Below, for each area for action, more details are presented.

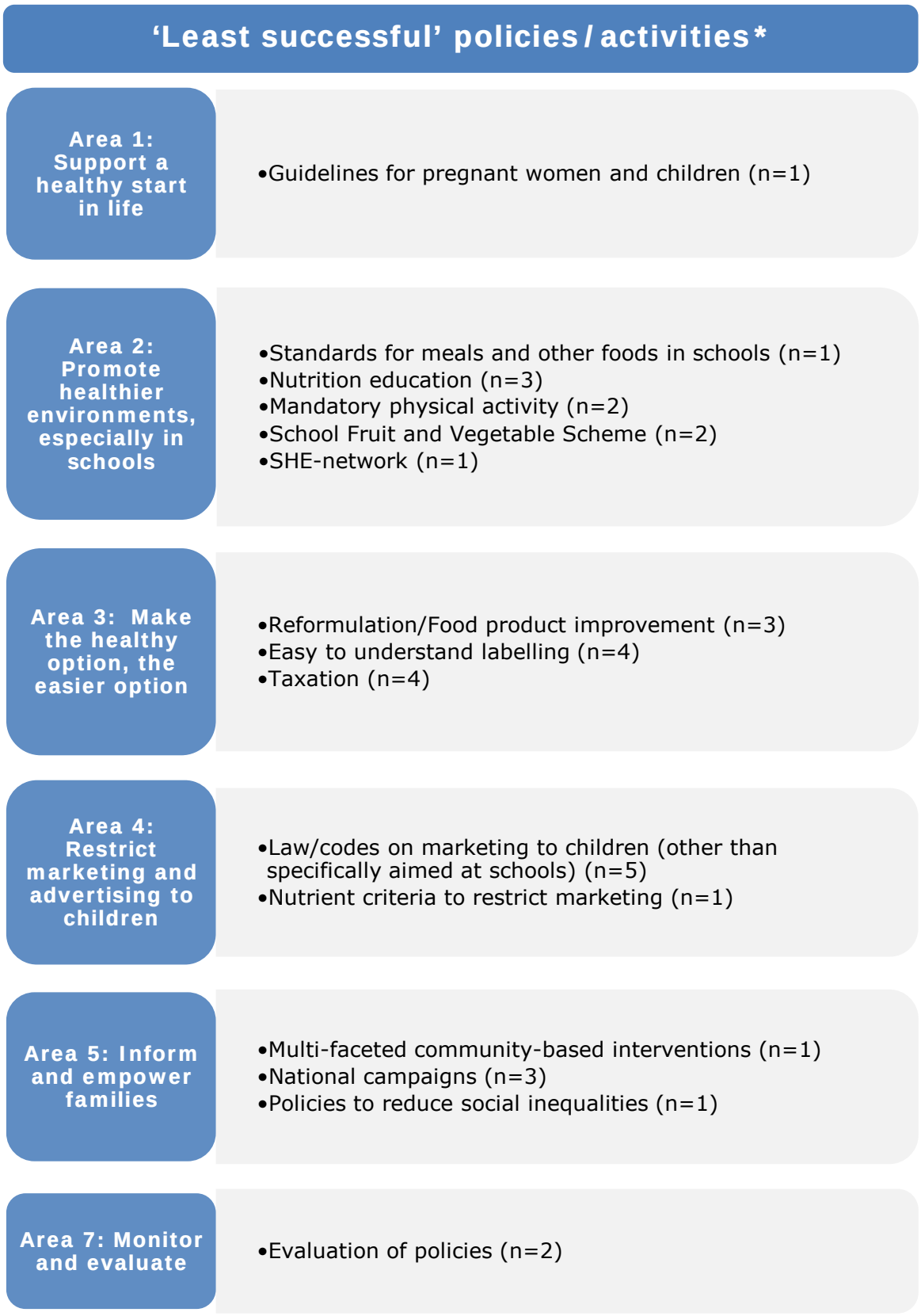


Figure 6.1. *'Least successful' policies/activities *as mentioned and interpreted by competent authorities and consulted experts*

Area for action 1: Support a healthy start in life
In Slovakia experts from regional public health authorities carry out their educational activities before, during and after pregnancy in framework of so called maternity centres. A broader involvement of clinical professionals (gynaecologists, neonatologists) is needed, but it is difficult to cooperate with them. The majority of them are private workers and are not willing to cooperate on international projects without financial reimbursement (SK).

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 *(activity tried or would like to develop but unsuccessful yet)*.

In summary, as hampering factors are mentioned:
- Insufficient involvement of clinical professionals
- Insufficient education on the prevention and treatment of childhood obesity

Area for action 2: Promote healthier environments, especially at schools and pre-schools
Education on a healthy lifestyle, including nutrition, was reported to be among the 'least successful' activities in three countries (LT, RO, PL). In Lithuania, the Children Health Education Programme has been integrated into a variety of other subjects. This caused weakness and fragmentation of the knowledge provided. In Romania it is due to the fact that curricula are already filled with other topics and because of lack of funding, specialised teachers and interest of school. A better collaboration between the Ministry of Health and the Ministry of Education is needed to make it more successful. The 'successful' activity on nutrition education in kindergartens and schools in Poland (task 2 of project KIK/34, see chapter 6.1) was nationwide but involved only 1600 kindergartens and schools. Financial constraints prevented expansion of activities to a wider group of children and young people. Further implementation of the activities in educational institutions and the certification of kindergartens and schools implementing effective and systematic health-related activities, is worth continuing. A proposal for such a certification programme has submitted to the Ministry of Health.

Respondents of two countries (NO, anonymous) reported that the School Fruit and Vegetable Scheme is or was 'least successful'. In Norway the scheme 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 School Fruit and Vegetable Scheme is also lacking interest among schools in Cyprus, partly because of its unrecognizability within schools *(activity tried or would like to develop but unsuccessful yet)*. Especially school representatives and members of local communities need to be motivated better.

Respondents of two countries mentioned that the amount of time allocated to physical education in schools should be increased. In Ireland there are initiatives to increase physical activity in schools, such as Active Flag, 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. The Norwegian government has a clear ambition to increase the level of physical activity in schools *(activity tried or would like to develop but unsuccessful yet)*. To reach the target of one hour daily physical activity in school, education authorities and school owners and leaders need more knowledge to be convinced of the benefit of daily physical activity for the learning environment. Good examples and methods on how physical activity can be included in the education 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.

Related to this is one of the 'least successful' activities in another country, i.e. the Schools for Healthy Education (SHE–) Network. The number of schools participating in the network is less than the initial number and the network is not being developed further to a larger number of schools in the country (anonymous).

In Slovakia 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. They would like to prepare and submit another new Order of the Ministry of Health to the Government which would deal with healthy assortment in school buffets and would like to intensify the cooperation with the Ministry of Education, Science, Research and Sport in the area of education of workers of boarding facilities at schools.

From the above it can be concluded that hampering factors for successful implementation are:

- Insufficient collaboration with other stakeholders
- Suboptimal collaboration between the Ministry of Health and the Ministry of Education
- Costs for parents
- Lack of funding
- Full curricula at schools
- Fragmentation of knowledge provided in health education
- Lack of expertise of professionals in the educational sector on the importance of physical activity

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

Respondents from several countries considered easy to understand labelling, such as front of pack labelling as being one of the 'least successful' activities (BE-WAL, CH, IE, anonymous). One of the reasons is that it is difficult to place a food in a certain category with respect to nutritional value. Besides other things, this makes it difficult to develop a label that is understandable and usable by all. Consensus with other stakeholders, such as consumer organisations is then not achieved. Furthermore, there was industry resistance to the introduction of food labelling. This relates partly to concerns about the costs labelling may infer. Calorie posting on menus is at present a voluntary activity in Ireland. Implementation varies so it is difficult to determine the effect. Norway would like to implement mandatory labelling of added sugar *(activity tried or would like to develop but unsuccessful yet)*. This would allow more accurate application of the three different taxes on sugar. When the EU Food Information Regulation was under debate, Norway proposed that the regulation should include labelling requirements for added sugar. They did not get support for this.

Implementation of taxation was among the 'least successful' activities in four countries (BG, DK, and 2 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. Since then there has been growing resistance to this measure, starting from industry, that used powerful lobbying, spreading to the public and members of the executive power, such as ministers of finance and agriculture. Also in another country there was political and public resistance to introducing taxation and a strong industry lobby. The Danish taxation on saturated fat did not work as intended whereas in another country one of the taxation measures has recently been abandoned. For successful implementation firm governmental commitment is needed 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. 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.

Activities on food product improvement were also among the 'least successful' activities (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, many Member States and stakeholders have committed to increase the efforts in this area. Luxembourg wishes to contribute to these efforts. Food reformulation will be 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 food product improvement is a voluntary process from the food industry, which seems to be facilitated by regulatory measures on other topics, but not very actively pursued by industry. An independent organisation is not involved in monitoring of the activities of the food industry, making the activities less transparent. Also Lithuania would have liked to further develop their activities on food product improvement, but encountered a lack of interest from the food industry *(activity tried or would like to develop but unsuccessful yet)*. Broader commitment is needed with national and international stakeholders of the food chain. EU regulation or European support to achieve agreements with industry at the European level could facilitate this process.

From the information provided by the respondents it can be concluded that hampering factors for successful development or implementation of activities in Area 3 are:

- Lack of EU regulation
- Lack of political commitment
- Resistance from industry
- Public resistance
- Lack of proof of effectiveness
- Insufficiently or wrong informed public
- Lack of consensus on the best way of labelling

Area for action 4: Restrict marketing and advertising to children

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 (HSSF foods and beverages) as 'least successful' activities (BG, RO, CH, 2 anonymous). In some countries the existing code of conduct is not followed or supported by all companies. Also mentioned is that the nutrient profile used by the EU Pledge is not enough restrictive. Furthermore, the marketing and advertising industry discovers and uses new ways medium to reach children and move from visible channels to hidden ones. This leaves room for exposure of children to all kinds of advertisement for HSSF foods and beverages. Several of the respondents mentioned that national measures do not work for multinational products. Common policies and measures, such as nutrient profiles, are needed across Member States. Some suggest that a voluntary approach can be successful if the nutrient profile model is clearly defined, e.g. by governments, and when independent monitoring is done. Others like to see more obligatory measures. Two other countries would have liked (updated) policies on the restriction of marketing (HU, anonymous) *(activity tried or would like to develop but unsuccessful yet)*. Lack of political will and priority to other preventive measures/policies were the reasons for not having (yet) done so.

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 'least successful' activities. Such criteria will facilitate the policies on restricting marketing and advertising of HSSF foods and beverages. Development of such criteria demands cooperation between many public and private sectors. The respondent from Lithuania would also like to set criteria for all foods addressed to children, e.g. by claims, titles or drawings *(activity tried or would like to develop but unsuccessful yet)*. A need for

clear and sound (mandatory) EU regulation is felt, as a country has no possibility to set labelling criteria on its own.

From the information provided by the respondents it can be concluded that hampering factors for successful development or implementation of activities in Area 4 are:

- Resistance from industry
- Lack of common nutrition criteria
- Lack of EU regulation
- Lack of political commitment

Area for action 5: inform and empower families

For the respondents of three countries (BE-WAL, DK, EL) national campaigns to promote healthy diet and physical activity are among the 'least successful' activities. 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 not result in long term behavioural change. For Greece national campaigns are least successful because they are demanding in terms of financial support.

The 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 (HEPCOM – The Learning Platform for Preventing Childhood Obesity in Europe) is also mentioned as 'least successful' activity. Problems of funding play a role herein (anonymous).

Among the 'least successful' policies 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. Socio-economic differences in the prevalence of overweight and obesity are large.

Another respondent would have liked to develop management services for overweight or obese children, but the costs for such an initiative are high (anonymous, *activity tried or would like to develop but unsuccessful yet)*.

From the information provided by the respondents it can be concluded that hampering factors for successful development or implementation of activities in Area 5 are:

- Division of responsibilities
- Lack of stakeholder support and involvement
- Lack of funding

Area for action 7: Monitor and evaluate

Two respondents mentioned that most often evaluation of policies or activities pertaining (at least partly) to childhood obesity is not carried out. Therefore, assessment of the outcome and achievements is lacking (AT, CY). Nevertheless, uni-dimensional approaches involving one setting (e.g. school) without involvement of others, such as the home environment and municipalities, appear to have limited impact in the fight against obesity. Malta mentioned that an increase in workforce is needed to monitor the current activities in the areas of action (under *activity tried or would like to develop but unsuccessful)*.

Cyprus mentioned that schools, parents and teachers request for the return of the 'Healthy Children Program' (*activity tried or would like to develop but unsuccessful).* Due to the high costs this is currently unfeasible.

From the information provided by the respondents it can be concluded that hampering factors for successful development or implementation of activities in Area 5 are:

- Lack of funding
- Lack of capacity.

6.3 General overview of strengths and weaknesses

Figure 6.3 provides an overview of the activities that are considered to be 'most successful' and 'least successful' described in Chapter 6.1 and 6.2. The graphs display the number of times the activities were mentioned by the respondents. In the following areas for action the number of times respondents mentioned an activity to be 'most successful' exceeded the number of times respondents mentioned an activity to be 'least successful':

- Area 1: Support a healthy start in life
- Area 2: Promote healthier environments, especially in schools and pre-schools
- Area 5: Area 5: inform and empower families
- Area 7: Monitor and evaluate.

In Area 3: Make the healthy option the easier option and Area 4: restrict marketing and advertising to children it was the other way around. In these areas for action, the number of times respondents mentioned an activity to be 'least successful' exceeded the number of times respondents mentioned an activity to be 'most successful'.

The large number of most successful and the considerable number of least successful activities 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. Except for nutrition and physical activity education, mostly other activities were considered to be most successful than least successful. This is also observed for Area 7. In the other areas of action, some countries seemed to be more successful in the implementation of the same activity than other countries. This can be seen for food product improvement, easy to understand labelling, taxation policies (all Area 3), codes on marketing and advertising to children (Area 4) and national campaigns (Area 5).

To get more insight into the factors that contribute to successful development and/or implementation of activities and factors that hamper this we grouped the factors into more general factors, i.e. comparable factors mentioned for more than one area for action (see Figure 6.4), and factors that are more specific for a certain country or area for action (Figure 6.5). Political commitment and stakeholder involvement and collaboration are among the general factors that were mentioned both for the most successful and least successful activities. These can therefore be considered highly important. For the area-specific factors different factors were mentioned.

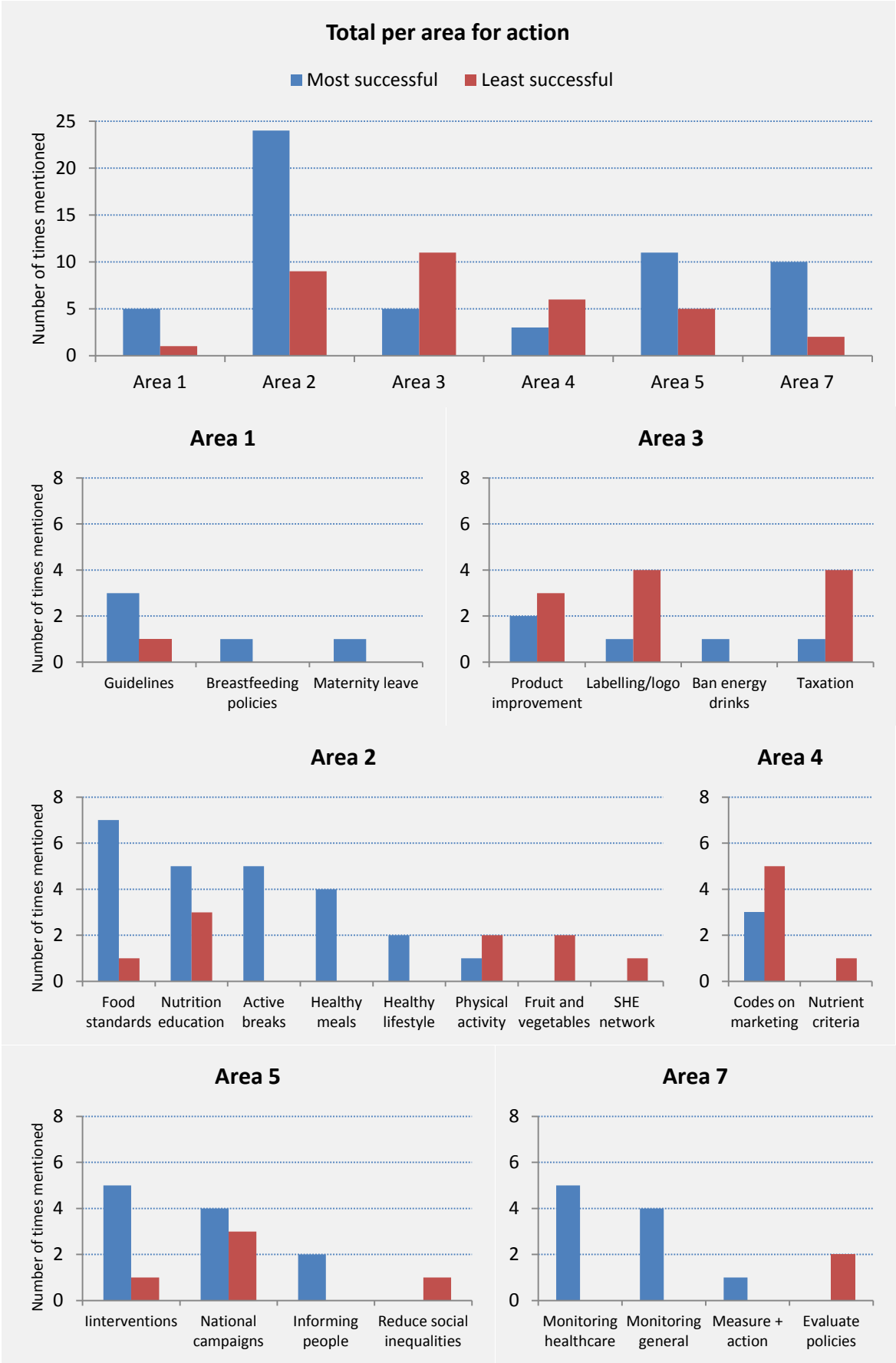


Figure 6.3. *Activities mentioned as 'most successful' and 'least successful' per area for action of the EU Action Plan on Childhood Obesity 2014-2020.*

General succes factors	General hampering factors
Political commitment	Lack of political commitment
Support of central and regional institutions	Insufficient stakeholders involvement and collaboration
Good working relationship between Ministries of Health and Education	Lack of funding
Wide stakeholder involvement and collaboration	Lack of EU regulation
Easy implementation (e.g. when regulated by legislation)	Lack of expertise of professionals (education, clinicians)
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	
Including all children regardless of socioeconomic status	
Direct involvement of both children and their parents	
Uniform systematic practice or structured way of working	
Life course approach	

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

Area-specific succes factors	Area-specific hampering factors
Area 2 Implementation is comparatively straightforward Implementation is comparatively less costly Provision of governmental budget Being part of comprehensive health promotion programme Testing of materials in advance Gentle, educative and positive approach	**Area 2** Suboptimal collaboration between Ministries of Health and Education Costs for parents Full curricula at schools Fragmentation of knowledge provided in health education
Area 3 Inclusion of both communication and structural components Related effects (logo and taxation results in increased willingness to improve food products)	**Area 3** Public resistance Insufficiently or wrong informed public Lack of proof of effectiveness Lack of consensus on the best way of labelling
	Area 4 Lack of common nutrition criteria
Area 5 Implementation for longer period Process and outcome evaluation Addressing vulnerable groups	**Area 5** Division of responsibilities

Figure 6.5. *Factors that contributed to 'most successful' activities (success factors) and factors that contributed to 'least successful' activities (hampering factors) that were mentioned for only one area for action.*

6.4 Role of the EU Action Plan on Childhood Obesity 2014-2020

In the interviews that were conducted with the competent authorities of the countries included in this study, many interviewees reported that 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 that are mentioned in 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. Two other (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 provided awareness, inspiration, example and guidance, or facilitated policy-making, implementation of initiatives or discussions with health and other stakeholders (including with industry).

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 international aspects. 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. Funding could be linked to this area for action. 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 emphasize 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.

6.5 Positive actions and welcome support from the European Commission

Positive actions
When asking for the most useful actions of the European Commission with respect to the implementation of the Action Plan, the following became apparent (see Figure 6.6 for a graphical representation of topics mentioned). Several respondents (AT, DK, HU) find it very useful that the European Commission started the discussion on childhood obesity, and keeps the topic on the political agenda. The European Commission can thus help create and sustain international and national focus on this important topic and related topics (nutrition).

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).

Furthermore, European initiatives are seen as support and reinforcement of national policies, which is the most beneficial support for Members States. For example, support for COSI and surveillance actions (ES, NO, anonymous).

Figure 6.6. *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.*

Joint 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 (HR). The activities (recommendations, opinions, interventions, support) that are the result of collaboration between its members are seen as valuable.

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 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 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.

Support that would be welcome

Several types of support from the European Commission would be welcome in order to improve the implementation of the Action Plan. The results are summarized in Figure 6.7.

Figure 6.7. *Wordcloud illustrating the support respondents would like to see from the European Commission. The larger the word, the more often it was mentioned.*

One country (SK) would appreciate all kinds of steps and activities from the side of the European Commission in the area of childhood obesity prevention. Other things mentioned were:

- Support for national actions of countries, regions and communities in their efforts (BE, EL, RS). For Serbia more specifically the following actions were mentioned:
  - Official recognition of working groups in this area by the European Commission.
  - Supporting for a current project for national Dietary and Physical Activity Guideline development
  - Establishment of EU supported 'Children Obesity Centre' (COU) in Serbia
  - Co-funding of COU for implementation actions of EU action plan AREA 3
- Roadmaps (NO, FI), which may support such national actions
- Ensure that there is political high level commitment to consider childhood obesity as problem that calls for urgent action, for example by lobbying or putting it regularly in the programme of the EU Presidency (BG, FI, DK).
- (Updated) legislation or measures on EU level for issues like regulation of marketing and advertisement to children (BG, EL, FI, MT, LT, PT).
- The development of a EU-wide accepted nutrition profiling system which can be used as a basic standard to ensure a high level of consumer protection (for example to restrict food marketing to children), as well as legal certainty and equal conditions of competition for business operators in the EU (DK, HU, LT).
- Exchange of information, i.e. documents, scientific evidence, guidelines, expertise, and best practices, between Member States and could support them in the implementation of national policies and strategies (HR, IT, MT, PL, RO)

- Coordination of policies and actions across the region (anonymous).
- Support for national, regional or local intervention programs involving as many sectors of the community as possible, for example by providing and suggesting good programmes, introduced successfully in other countries, or supporting the allocation of funds (CY, HU, PT).
- General and technical support regarding food product improvement efforts (LU, MT).
- Funding for obesity research and intervention (CY, RO).
- Childhood obesity should be stated as a priority and be continuously included as topic in the health programs (FI).
- Measures on the regulation of front of pack labelling (MT)
- Reporting obligation for countries (scientific-based evaluation of the process and the outcomes) (AT).
- Campaigns at the European level.

It was further mentioned that the directions on how to pursue with the Action Plan should be better sent directly to the Ministry of Health (CY). Only then specific steps could be pursued in order to further implement the Action Plan.

7 CONCLUSIONS AND RECOMMENDATIONS

The Childhood Obesity 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 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. This overview is meant to support the European Commission with the mid-term evaluation of the Action Plan. From the results described in Chapter 3 to 5 the following preliminary conclusions are drawn. They will be adapted in the light of the comments to be received from the High Level Group on Nutrition and Physical Activity, the EU Platform for Action on Diet, Physical Activity and Health, WHO/Europe, WOF and the OECD, who will be included in the stakeholder review for this report.

Systematically collected data to determine trends in the prevalence of childhood obesity since the adoption of the Action Plan are not yet available.
A clear picture on the prevalence of overweight and obesity among young children cannot be provided, because published data in children under 5 years of age are scarce and the available data are difficult to compare. More comparable data on the prevalence of overweight and obesity in primary schoolchildren (6-9 years) and adolescents across countries are available from COSI and HBSC, respectively. The prevalence of overweight (including obesity) among primary schoolchildren and adolescents is high, but differs considerably between countries. Systematically collected data to determine trends in the prevalence since the adoption of the Action Plan are not available yet. Data from the most recent round (2015/2016 schoolyear) of COSI and a next round of the HBCS survey (2017/2018) will provide more insight. WHO/Europe and countries are encouraged to continue their activities with respect to the monitoring of childhood overweight and obesity, such as COSI and HBSC. Countries not yet participating in COSI are encouraged to join the initiative. In many countries height and weight are measured as part of child healthcare. These data could provide more insight in the prevalence among the youngest age groups. The possibility to use these data for monitoring activities could be investigated. It should be noted, however, that lifestyle changes take time, and that the effects of all actions undertaken, especially those initiated after the adoption of the Action Plan, may not be visible yet.

Promote healthier environments, especially in schools (Area 2 of the Action Plan), is one of the areas for action that is best addressed.
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. Most activity is seen in Area 2. Firstly, this is illustrated by the high percentage of countries 1) that have policies to improve the school environment, 2) where physical and nutrition education is included in the school curriculum and 3) that participate in the EU School Fruit and Vegetable Scheme. Secondly, activities in this area, such as setting standards for foods provided in schools, provision of free healthy meals and promoting active breaks, are often considered to be among the 'most successful' activities in countries. Thirdly, many of the EU-funded projects address operational objectives in this area for action.

Encouraging physical activity (Area 6) also seems to be well covered.
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 81-94% of the countries). Also the largest budget from EU programmes is allocated to projects that map to this area for action, especially from the Erasmus+ programme.

Area 3 (making the healthy option the easy option) is the area for action that experiences the most growth across Europe.

Several countries recently started initiatives on food product improvement, while others are planning to do so. Also taxation of nutritionally unbalanced products is becoming more common.

The European Commission helps to create and sustain international and national focus on the topic of childhood obesity.
It is considered useful that the European Commission picked up the discussion on childhood obesity, and keeps the topic on the political agenda. 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). Furthermore, the Action Plan and activities of the European Commission support Member States and regions/communities with their priorities, by setting a uniform framework with European standards and reference recommendations.

Voluntary cooperation of countries and the products that are the result of it can be of value for all
Voluntary cooperation of countries and the products (recommendations, opinions, interventions, support) that are the result of it can be of value for all, but possibly in particular to (smaller) countries with limited resources or more dependency on import of food produced in other Member States. In several areas of action, there are countries that 'successfully' implemented policies or activities and countries that were less ''successful. Sharing of information, experiences and good practices is important for voluntary cooperation or joint action. This is facilitated amongst others by the instalment of the High Level Group on Nutrition and Physical Activity, JANPA and the activities of the European Commission in the field of food product improvement and public procurement. Diversity between countries, also in terms of contextual factors that play a role in whether or not countries have policies/strategies or not, provides an important basis for more in-depth comparison between countries. Also projects that encourage the engagement of stakeholders, such as schools and sports organisations in the Member States, for example through the Erasmus+ programme, facilitate cooperation between countries.

The Action Plan could be more focussed on cross-border activities.
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. Nevertheless, common priorities could be stated as well as simultaneous actions in the EU and in Member States, for example in Area 3 and Area 4 (restriction of marketing to children). Activities in Area 3 and Area 4 are more often among the reported 'least successful' than among the reported 'most successful' activities. The 'least successful' activities include food product improvement, taxation and easy to understand labelling. These areas for action require active involvement and collaboration from industry. Food industry often operates in many European countries and beyond. Therefore, European support to achieve agreements with industry and to define standards at the European level is deemed necessary. In this respect the dialogue with stakeholders can be mentioned as positive action from the European Commission. Competent Authorities of several countries mentioned that their countries will take further position on the topic of marketing and advertising to children after the conclusions of the discussion on the Audio Visual Media Services Directive are known. The definition of nutrition criteria to restrict marketing to children at a European level needs continued attention.

The scope of Area 2 should be broadened to other settings than the school setting.
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. This is illustrated by the observation that only in relatively few countries policies on vending machines and policies on energy drinks also apply to settings other than the school environment. Furthermore, creating a healthy environment in

communities through urban planning is important, for example to encourage free-time physical activity. While the educational sector is involved in several activities and in EU-funded projects, urban planning seems to be somewhat underrepresented, at least in the programmes investigated in the Childhood Obesity Study. The European Commission and the countries are encouraged to further collaborate with WHO/Europe in the Healthy Cities Network, in order to increase involvement of urban planning and therewith strengthen the Health in All Policies approach. This would increase efforts that contribute to operational objective 6.2 of the Action Plan "supportive role of urban design and planning in order to reduce afterschool sedentary behaviour".

A more comprehensive approach to the prevention of childhood obesity?
The Action Plan covers most, if not all, areas for action that are relevant to halting the rise in childhood obesity. However, suggested actions in each area for action are presented separately and not as a comprehensive approach. Individual countries as well as the countries in collaboration could focus more on integrated approaches instead of actions in separate areas of action. In this light, it would be useful to identify which areas for action are more/less effective in terms of preventing childhood obesity, and increasing healthy dietary choices and physical activity. Community based prevention programmes according to the EPODE-methodology are an example of a comprehensive integrated approach at the local level. Implementation of this kind of programmes should be encouraged and supported.

Objective evaluation of the effectiveness of policies, activities and interventions as the basis of further evaluation of the outcomes of the Action Plan.
While some countries appear to be on the forefront, at least in terms of having certain policies or strategies in place, it does not necessarily mean that these plans are designed to maximise health impact, are already fully and effectively implemented or successful in terms of halting the rise in childhood obesity. Objective assessment of the effectiveness of policies, activities and interventions would need data on the degree of implementation and effectiveness of different policies and activities. Gathering such data was outside the scope of the Childhood Obesity Project. By asking for the 'most successful' and 'least successful' activities, the Childhood Obesity Project tried to contribute to this issue. The evaluation of policies is mentioned as one of the 'least successful' activities by several Competent Authorities or experts. However, the used approach cannot be seen as objective. In the framework of this exercise the term 'success' was not specifically defined and has been referred to by authorities 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). Therefore, to better appreciate the effectiveness of various policies and activities, objective evaluation is needed. 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, also in view of the potential renewal of the plan beyond its expiry after 2020.

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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

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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 was 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 was 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 was 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 was 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 was 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 was 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 was 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 was before or after 2014?)*

<u>AREA 3: Make the healthy option the easy option</u>

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

EPHORT childhood obesity study indicators	Source[1]
Overarching surveillance indicator	
% overweight and obesity among children aged <5 years*	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 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 (31)
% of maternity health facilities and services which are certified WHO baby-friendly (or according to other standards of equal or greater strictness)	WHO report (31)
% 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 "APCO database"
Guidance on appropriate 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
Nutrition education in school curricula	Interview
Physical activity education in school curricula	Interview WHO: factsheets on health-enhancing physical activity

EPHORT childhood obesity study indicators	Source[1]
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 APCO database
Policies to (virtually) eliminate trans fats from the food supply chain*	WHO: GNPR2 survey APCO database Interview
System to monitor the level of nutrients in foods (and thus effect of reformulation)	Interview
(National) schemes for easy to understand or interpretative labelling on front of package (e.g. signposting)	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	
Policies and other initiatives that have the objective of reducing 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 foods High in Fat Sugar and Salt (HFSS) to children?*	Expert Interview APCO database
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 (in primary care)	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
National or subnational schemes promoting active travel to school	WHO: European database on nutrition, obesity and physical activity (NOPA) Expert (Some interviews)

EPHORT childhood obesity study indicators	Source[1]
Area 7: Monitor and evaluate	
Participation in COSI?*	WHO/COSI
Routine representative monitoring of overweight and obesity (or weight and height) monitoring that includes the population < 18 years	Expert
Data on weight and height in children	Expert APCO database
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 Page 246-247 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 ACCORDING TO AREA FOR ACTION[19]

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.
   - 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.
   - 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.
   - 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 activities 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 to be physically active as well as early childhood, e.g. in local authorities and sport clubs can offer special play- and movement offers.

[19] As phrased in the EU Action Plan on Childhood Obesity 2014-2020

4. Further improve the effective response of the health care sector.
   - 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 practitioner, 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.
   - 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.
   - 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.
    - 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.
    - 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.
    - 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.
    - 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.
    - 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.
   - 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.
   - 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.
   - Building on existing schemes, develop appropriate nutrition criteria to use in marketing of foods to children. This could be implemented in collaboration with Stakeholders. (Member States / Stakeholders (for implementation))
3. Set recommendations for marketing foods via TV, internet, sport events etc.
   - 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.
   - 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 audio-visual 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.
   - 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.
   - 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. See for inspiration the Commission funded Framework Programme 7 projects FLABEL and CLYMBOL. 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.
   - Improve nutrition labelling through the implementation of EU Regulations and guidelines on labelling and on nutrition and health claims.
     - 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. o-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.
   - 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)
   - Implementation of a pilot project (2014-2015) 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.
6. Support disadvantaged communities to help reduce food poverty. (Commission)
   - Implementation of a pilot project on the promotion of healthy diets targeting children, pregnant women and older people (2014-2016).
   - 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.
   - 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/healthcare centres initiative.
8. Encourage/support families, professionals and day-care centres to integrate physical activity in the children's daily routine.
   - 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)
   - 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.
   - 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).
   - 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.
   - 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
   - Increase the number of Member States being part of the COSI project. (WHO)
2. Sharing of good ideas and practices regarding the monitoring of policy initiatives
   - 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.
   - 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.
   - 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).
   - 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.
   - 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.
   - 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)
   - 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

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[20] 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.

[20] 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. OVERVIEW OF POLICIES/STRATEGIES PER COUNTRY ORDERED BY PREVALENCE OF OVERWEIGHT (INCLUDING OBESITY, TABLE A5A) AND POPULATION SIZE (TABLE A5B)

Table A5A. Overview of policies/strategies per country ordered by the prevalence of overweight (including obesity) among adolescents (HBSC).

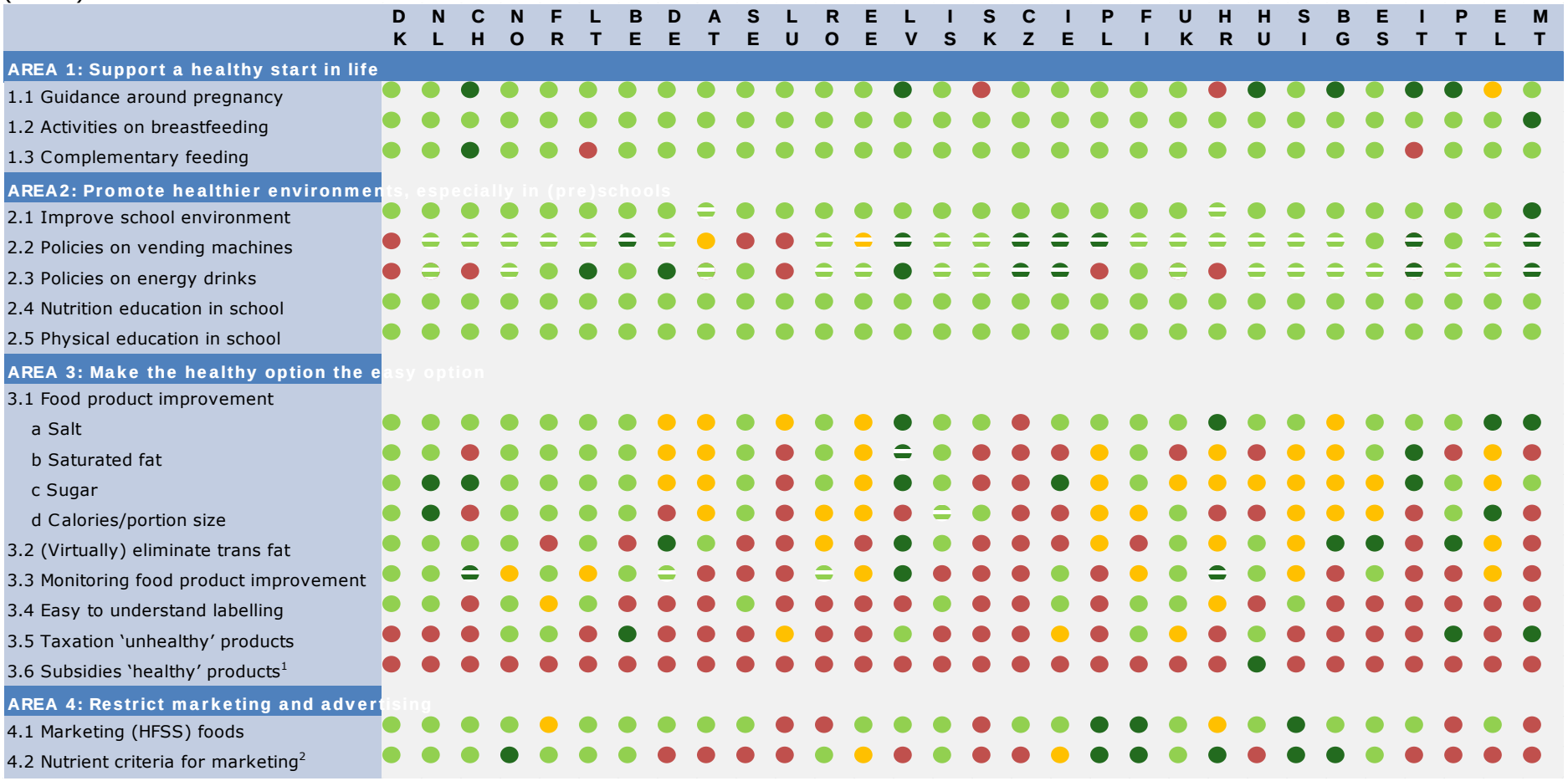
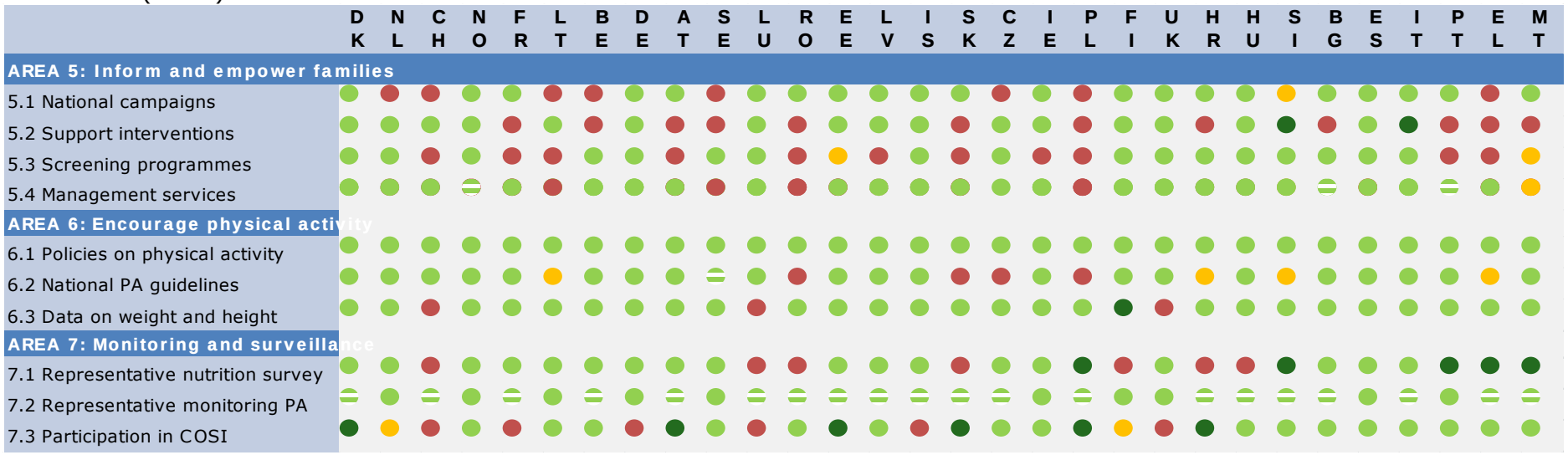


Table A5A (continued). Overview of policies/strategies per country ordered by the prevalence of overweight (including obesity) among adolescents (HBSC).



No data for Cyprus, Montenegro and Serbia.

[1] Other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme

[2] Other than included in school policies

● yes, already before EU Action plan*

● yes, since EU Action plan*

◒ ◓ partially, for example in certain settings or certain regions*,

● no action is initiated or supported by national authorities (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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Table A5A. Overview of policies/strategies per country ordered by the population size per 1-1-2016.

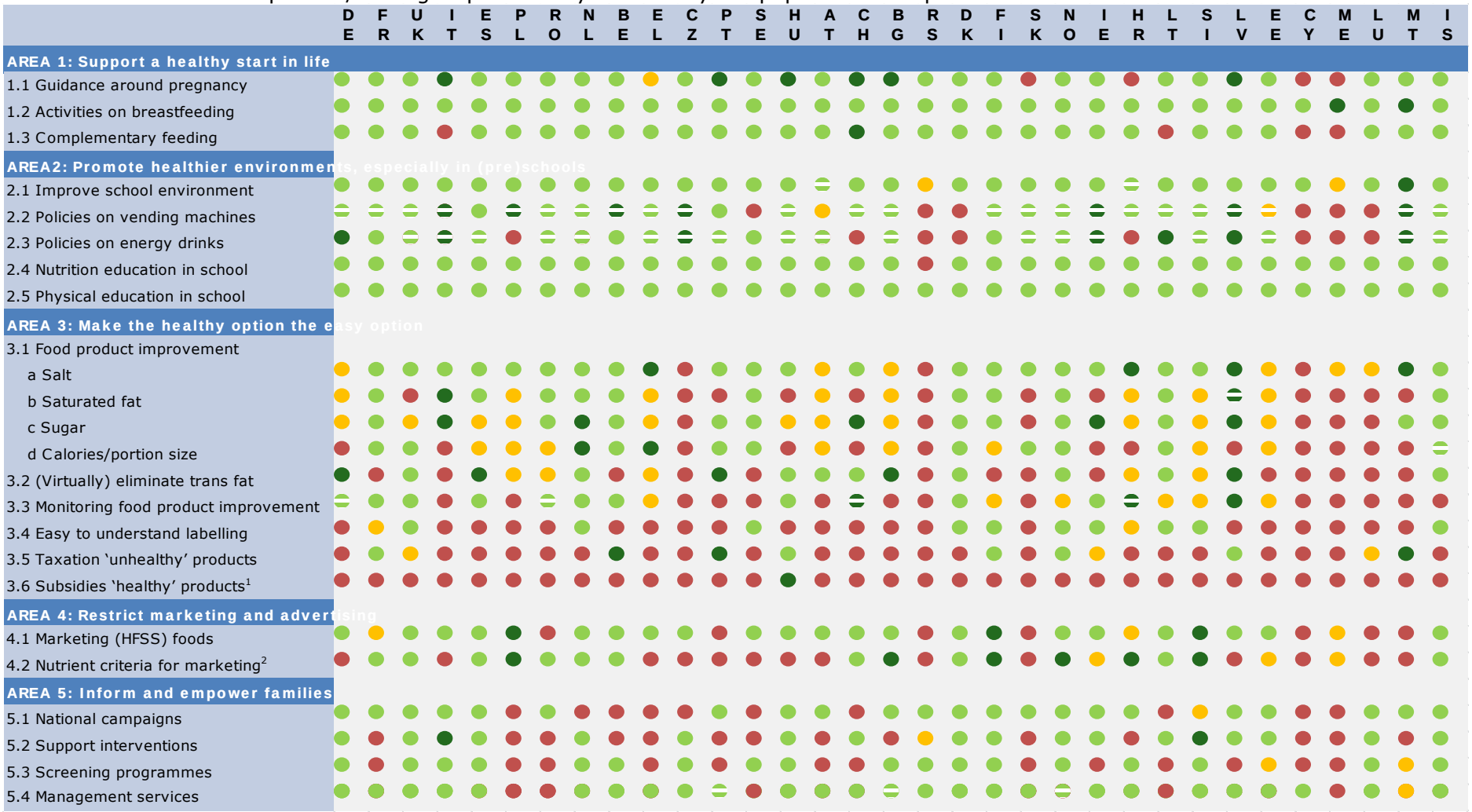

Table A5A (continued). Overview of policies/strategies per country ordered by the population size per 1-1-2016[21].

	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 6: Encourage physical activity																																	
6.1 Policies on physical activity	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
6.2 National PA guidelines	●	●	●	●	●	●	●	●	●	●	●	●	◒	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
6.3 Data on weight and height	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
AREA 7: Monitoring and surveillance																																	
7.1 Representative nutrition survey	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
7.2 Representative monitoring PA	●	◒	●	◒	●	◒	◒	●	◒	◒	◒	●	●	◒	◒	◒	◒	●	◒	●	◒	●	◒	●	●	◒	◒	◒	●	●	◒	◒	◒	◒
7.3 Participation in COSI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

[1] Other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme

[2] Other than included in school policies

● yes, already before EU Action plan*

● yes, since EU Action plan*

◒ ◒ partially, for example in certain settings or certain regions*,

● no action is initiated or supported by national authorities (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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[21] http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00001&plugin=1

ANNEX 6. COUNTRY LEVEL OVERVIEWS ON THE IMPLEMENTATION OF THE EU ACTION PLAN

A6.1. 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).

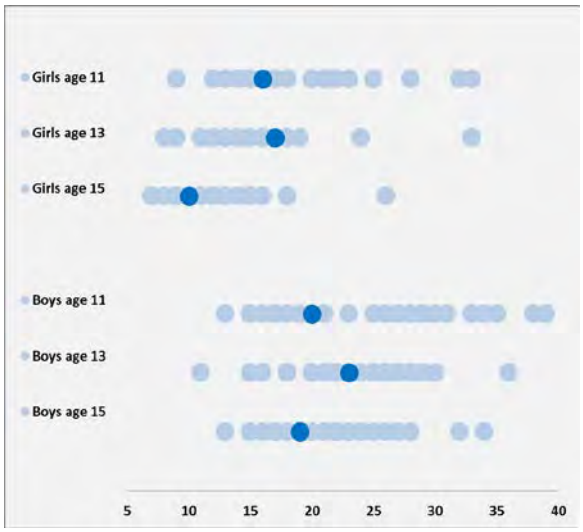
The National Action Plan Physical Activity contains strategies on promotion of physical activity, sports and health for everyone. There are no specific actions for children below 18 years of age. The National Action Plan on Nutrition does include special initiatives for children <18 years. One is a health promotion program for pregnant and lactating woman and children until 3 years ('Healthy eating from the start', 2008- until now). The 'Healthy eating from the start' project already addressed babies and toddlers, but attention should also be paid to older children. Therefore, since the middle of 2017 Austria focusses more on kindergartens and primary schools (children aged 3-10 years). In March 2017 a guideline for healthy kindergarten meals has been adopted. Another project called 'project school cafeteria' (2011- until now) is about providing healthy school snacks 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.

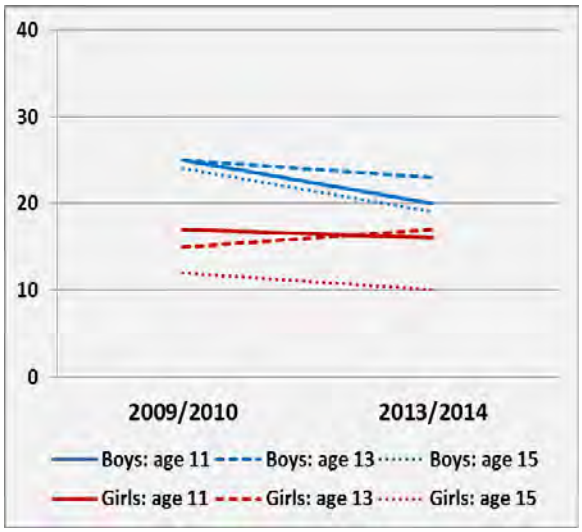
The EU Action Plan on Childhood Obesity 2014-2020 helps Austria with argumentation to get funding for projects from the regions (e.g. School cafeteria project which has no fixed budget). Furthermore it gives directions and ideas about actions that can be implemented and how.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Austria. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
  - Food product improvement: saturated fat
  - Food product improvement: sugar
  - Food product improvement: calories
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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*, partially, for example in certain settings or certain regions*, yes, since EU Action plan*, no**, in preparation or planned***

* Indicates that an action is (partially) undertaken, but does not contain an evaluation of effectiveness from our part. ** Actions may, however, be undertaken on initiative from local authorities, NGO's or private parties. *** Adoption may still be contingent on policy process.

A6.2. 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

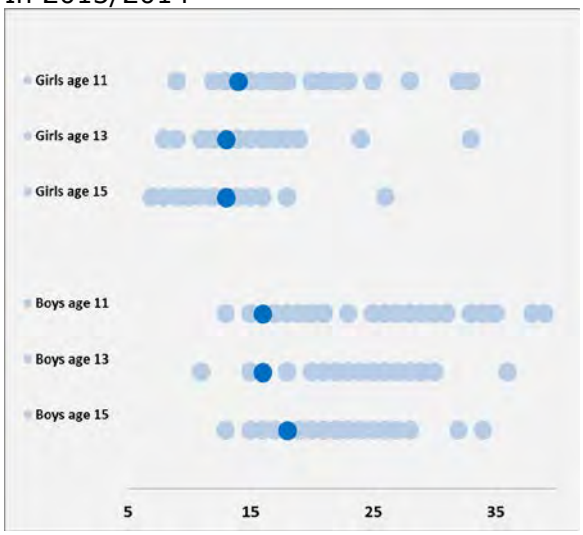
At the federal level, Belgium's priority topics include 1) improving the nutritional value of the food supply, 2) improving health status by a better quality of care, including breastfeeding promotion, 3) maintaining the food consumption survey to gather information on behaviour, body mass index and 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.

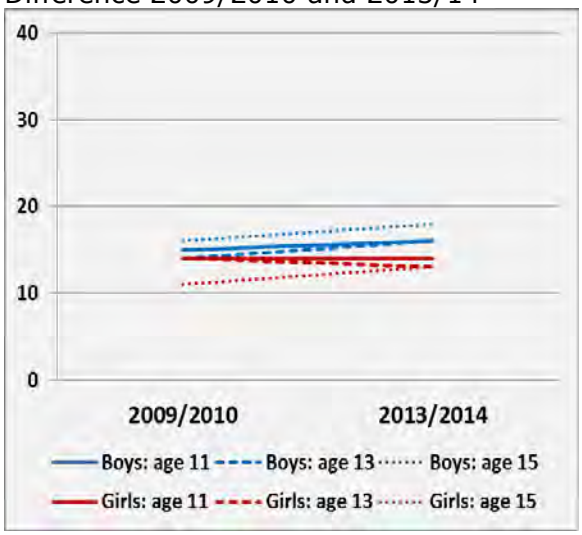
The EU Action Plan on Childhood Obesity 2014-2020 consolidates and justifies the Belgian policies. The actions defined in the Action Plan are for the great majority included at federal or regional level since the publication of the "Federal Health and Nutrition Plan" in 2006.

Prevalence of overweight including obesity (%) in Flanders (BE) (HBSC)

In 2013/2014



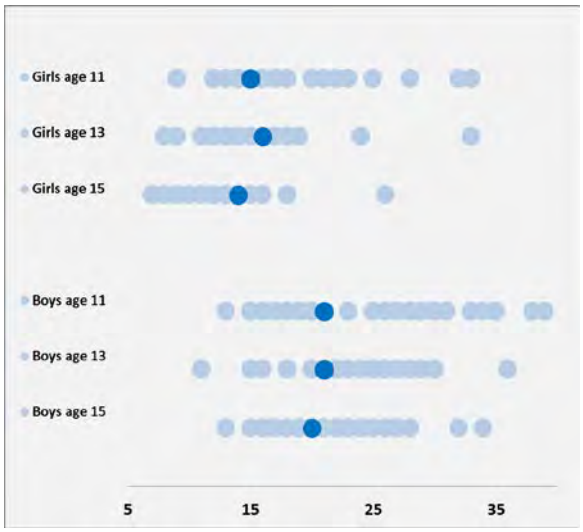
Difference 2009/2010 and 2013/14



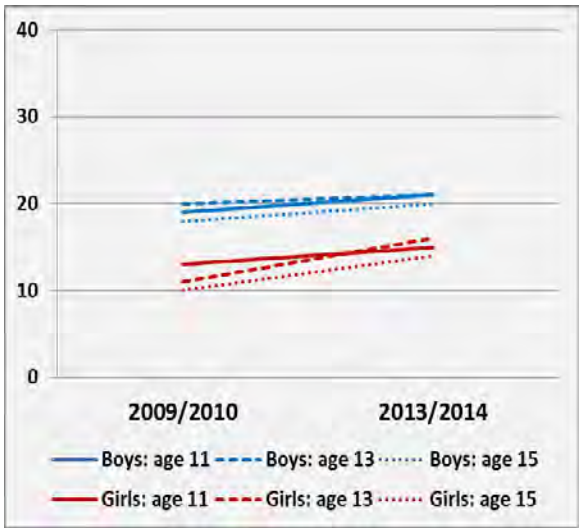
The dark blue dot represents the prevalence in Flanders (BE). The light blue dots represent the prevalence in the other countries.

Prevalence of overweight including obesity (%) in Wallonia (BE) (HBSC)

In 2013/2014

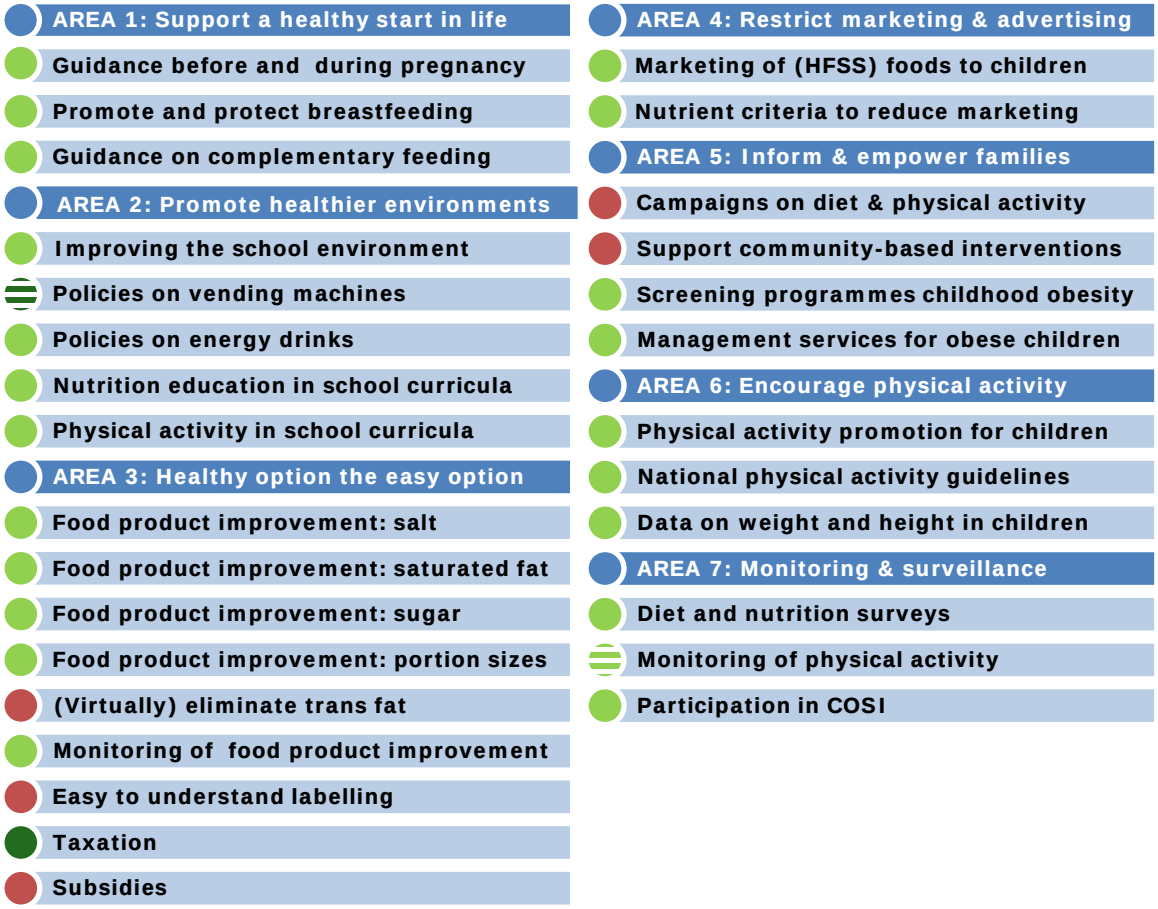


Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Wallonia (BE). The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of 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**, in preparation or planned***

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A6.3. 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).

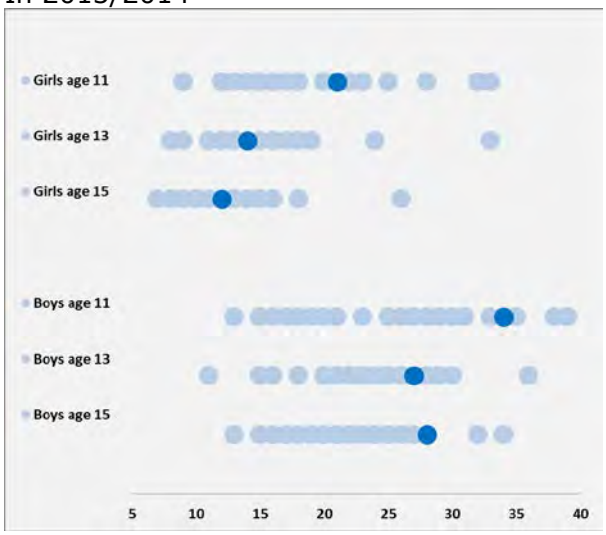
The policies that are relevant to childhood obesity do not really address health inequalities, but there are actions targeting the Roma population, which will include the topic of nutrition in the future. In Bulgaria, the prevalence of childhood obesity is high and the priority is to apply national regulations and to adjust them to European regulations. For example, a document on food procurement for healthy nutrition at school is being 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)

In 2013/2014



The dark blue dot represents the prevalence in Bulgaria. The light blue dots represent the prevalence in the other countries. No HBSC data for 2009/2010 are available in Bulgaria.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
  - Food product improvement: saturated fat
  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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
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  - Diet and nutrition surveys
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  - Participation in COSI

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A6.4. Croatia (HR)

Based on the interview conducted with the Croatian Competent Authority we learned that the Ministry of Health and Social Care 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 by the Government and eight responsible ministries. This programme deals with health promotion and lays out actions for the whole population, from babies to elderly. This programme includes several topics, relevant for the prevention of childhood obesity:

- Education on physical activity, nutrition, mental and sexual health, mainly directed at children
- Health and physical activity directed to the whole population, including children. Activities are meant to be implemented locally, but across all counties of the nation. For example 'Walking towards health' is a programme introducing walking as a cheap way to be physically active.
- Provision of equipment to schools that have no gym or sports hall, so children can be active in the hall or the classroom.
- Introducing easy to understand labelling to enable consumers to make healthier choices.
- Health and environment. In this area they try to mould how families spent their leisure time, raising awareness about healthy nutrition and increasing physical activity.

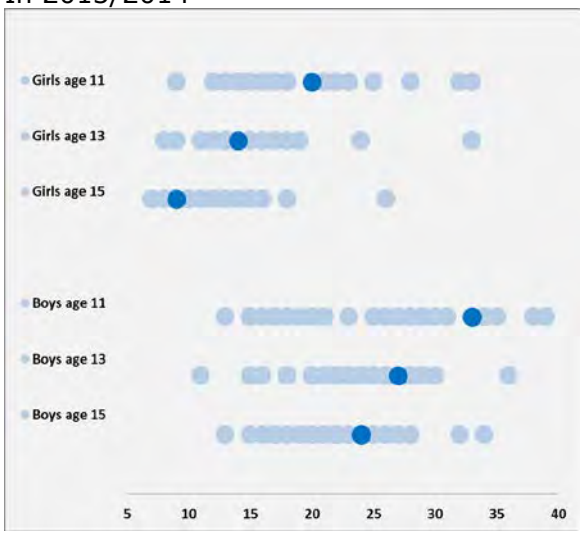
Activities in the National Programme are adapted to all socioeconomic groups. They should not infer any additional costs. This enables Croatians with lower socioeconomic status to participate. For all areas of the National Programme, working groups exist. No formal coordination mechanism exists for childhood 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.

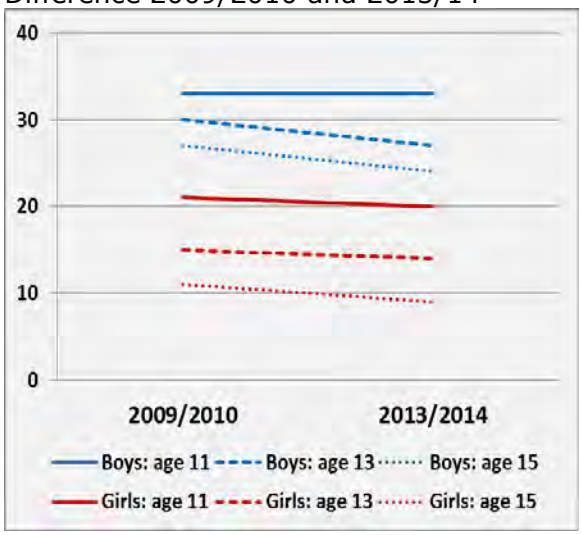
The EU Action Plan on childhood Obesity 2014-2020 is considered to be an important document for Croatia. Since the publication, the Ministry of Health has shown increased awareness. Croatian government sees childhood obesity as an issue, but it is not very high on the agenda yet. The EU Action Plan facilitated participation in the Childhood Obesity 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)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Croatia. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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  - 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*, partially, for example in certain settings or certain regions*, yes, since EU Action plan*, no**, in preparation or planned***

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A6.5. 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:

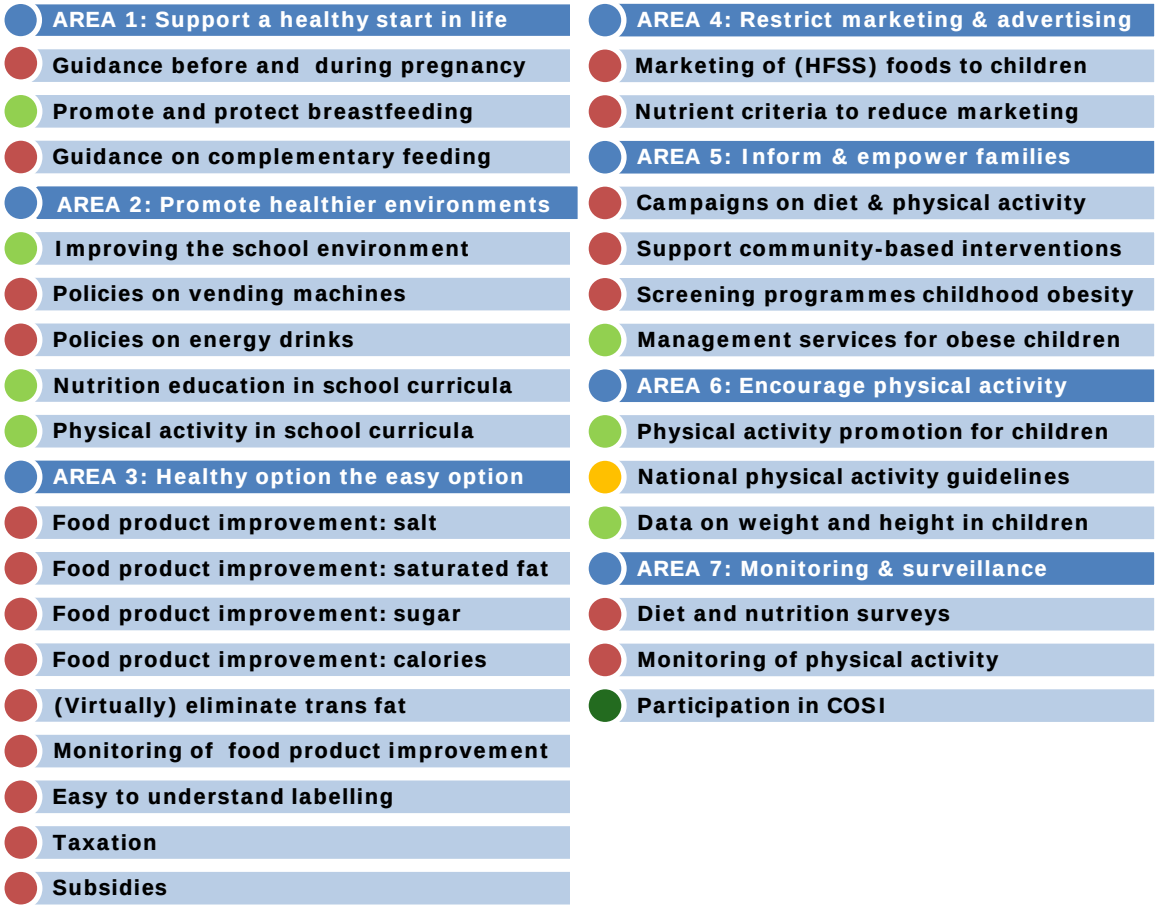
- School canteens and school environment
- Diabetes, which is related to childhood obesity
- Monitoring and surveillance by participation in the most recent round of the Childhood Obesity Surveillance Initiative (COSI). The results from COSI might be used for implementation of further actions.

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 according to the various areas of action of the EU Action Plan



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A6.6. Czech Republic (CZ)

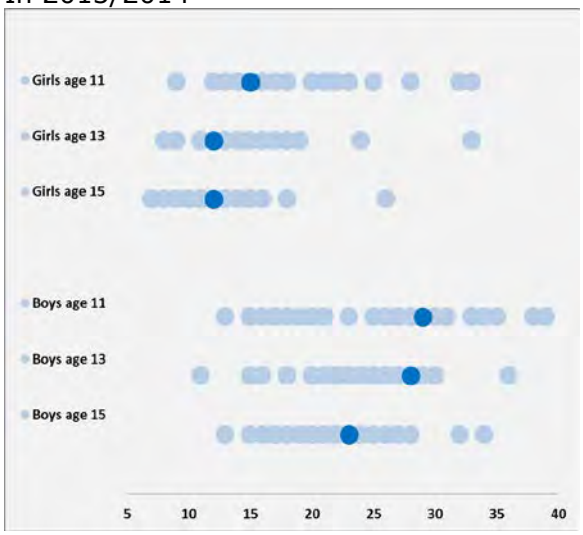
Based on the interview conducted with the Czech Competent Authority we learned that the Czech Republic has a long term strategy on public health and health promotion. This framework has been amended and approved in 2014 by the government. Several action plans fall under this strategy entitled "Health 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)

In 2013/2014



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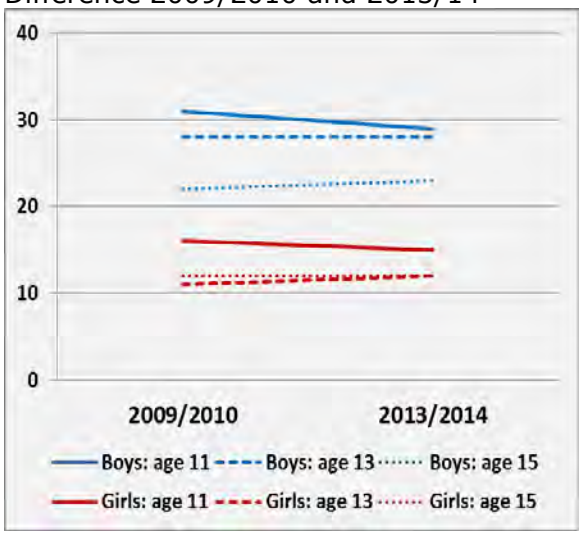

The dark blue dot represents the prevalence in the Czech Republic. The light blue dots represent the prevalence in the other countries.

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A6.7. 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 the 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 physical activity and on food and meals health promotion packages exists (since 2012).

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.

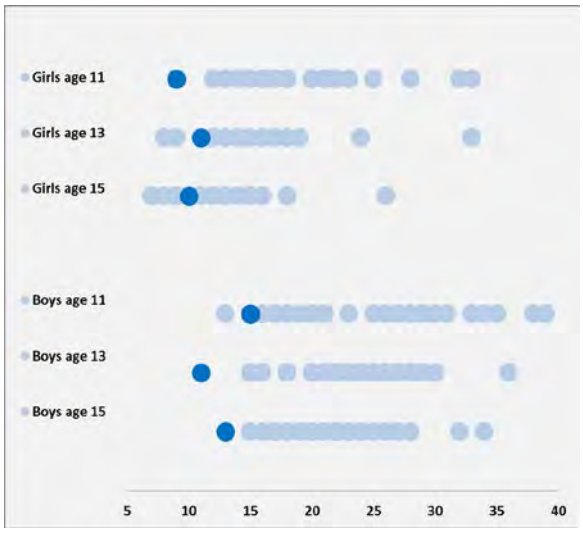
With respect to nutrition, priority topics focus on two groups. These are children and vulnerable groups. For children, nutrition education is considered to be important as well as the availability of healthy foods. The focus on vulnerable groups is meant to address health inequalities.

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 will be produced to get insight into effective interventions. Subsequently, recommendations for the regions will be developed that describes models of interventions that municipalities can implement (planned in 2018). Furthermore, spring 2017 new school recommendations on nutrition will be implemented. These are voluntary guidelines and there will be a labelling system for schools that follow the recommendations. In 2018, new mandatory recommendations on nutrition will be issued for day care, which will to a large extent be the same as for schools. These will be easier to follow than the existing day care recommendations.

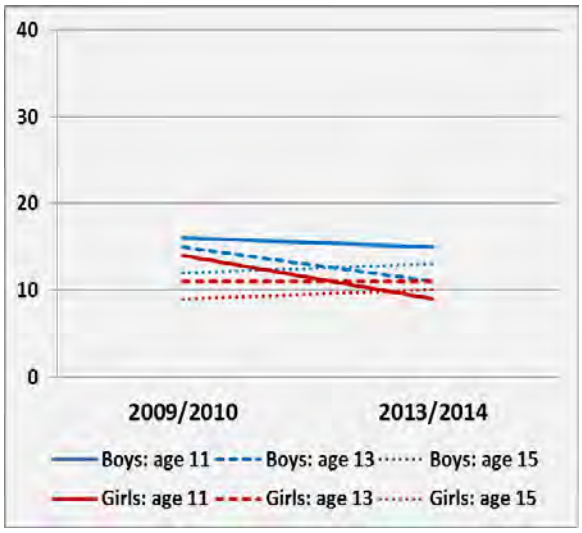
Denmark stands behind the EU Action Plan on Childhood Obesity 2104-2020. Danish' actions and policies are and were already in line with the action plan goals. The action plan did not have direct influence on Danish policy making, but indirectly it provides more focus and awareness for the topic of childhood 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)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Denmark. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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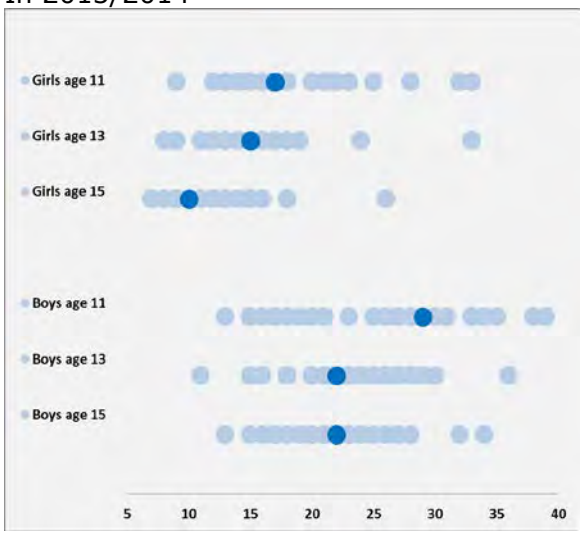
A6.8. Estonia (EE)

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)

In 2013/2014



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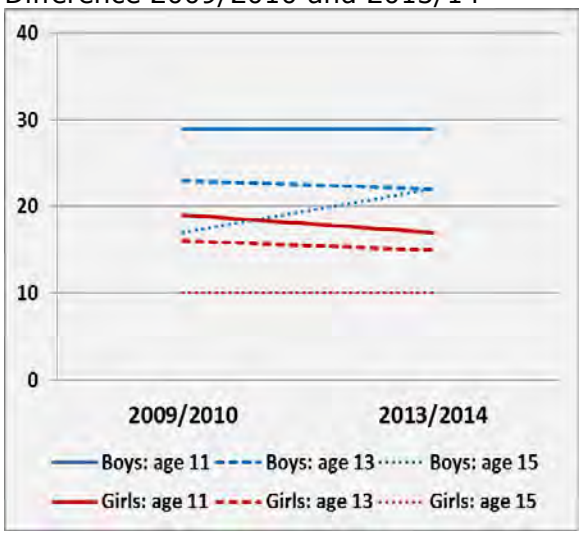

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A6.9. Finland (FI)

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 programme covers also 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" in Finland. Advisory groups and groups of stakeholders have regular meetings. The National Nutrition Council coordinates the implementation measures for food recommendations and collects data on the implementation of guidelines in public catering (like schools).

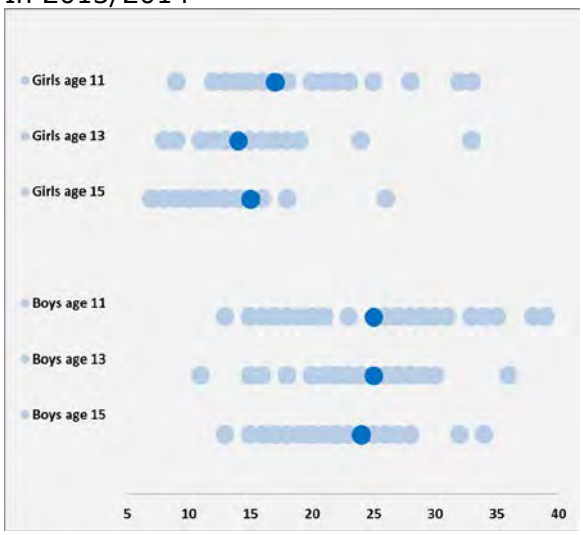
Because the first 1000 days and early childhood are considered to be important for the development of obesity, Finland focusses on early prevention. Therefore, the major topic is lifestyle counselling in families with children, including among others counselling on nutrition, physical activity, and sleep. 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 the beginning of 2018. Furthermore the Ministry is funding governmental key projects on health promotion for 2 years (2017-2018). One of these is "Resourceful 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. The Finnish Heart Association runs the programme to implement the nutrition recommendations in child health care and school heath care.

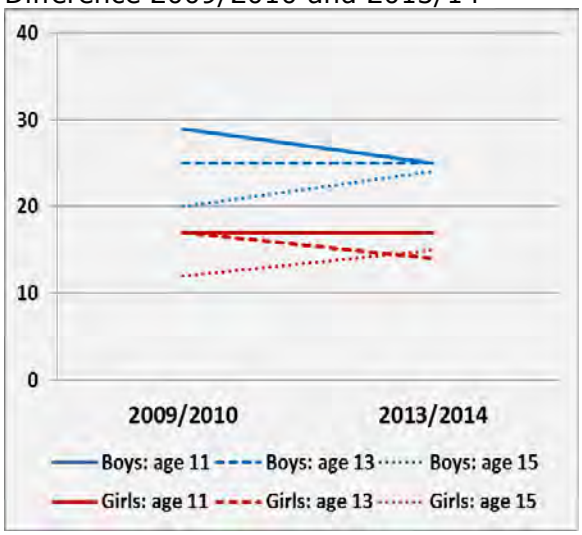
The topic of prevention of childhood obesity has been already on the Finnish agenda for 10-15 years. Nevertheless, the EU Action Plan on Childhood Obesity 2014-2020 stimulates policy makers to go further with their actions on the prevention of childhood obesity. It serves as an important background document 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)

In 2013/2014



Difference 2009/2010 and 2013/14



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- **AREA 7: Monitoring & surveillance**
  - Diet and nutrition surveys[1]
  - Monitoring of physical activity
  - Participation in COSI

[1] Finland has representative nutrition surveys, but not in children.

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A6.10. France (FR)

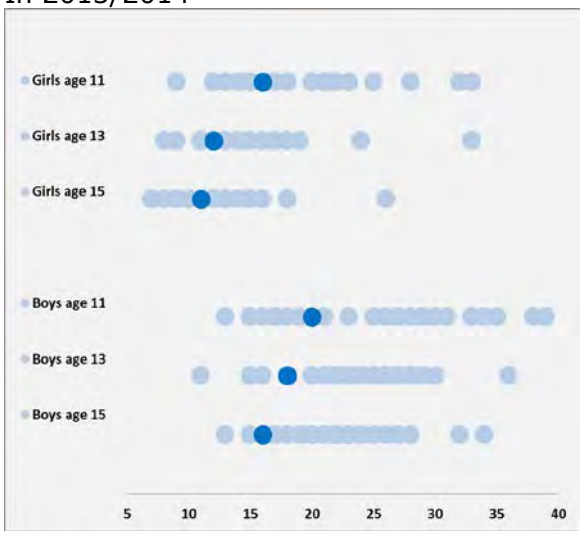
Based on the interview conducted with the French Competent Authorities we learned that there is no separate action plan on childhood obesity in France. Since 2001 France has a "National Nutrition and Health Programme" (PNNS). In December 2012, the Ministry of Health published the 2011-2015 Programme. 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. Expectedly, these new objectives will be defined in 2017. Additionally, in 2017 decisions on front of pack labelling are expected and new national food based dietary guidelines will be issued. These will apply to the general population. Specific guidelines for children are expected in 2018. 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)

In 2013/2014



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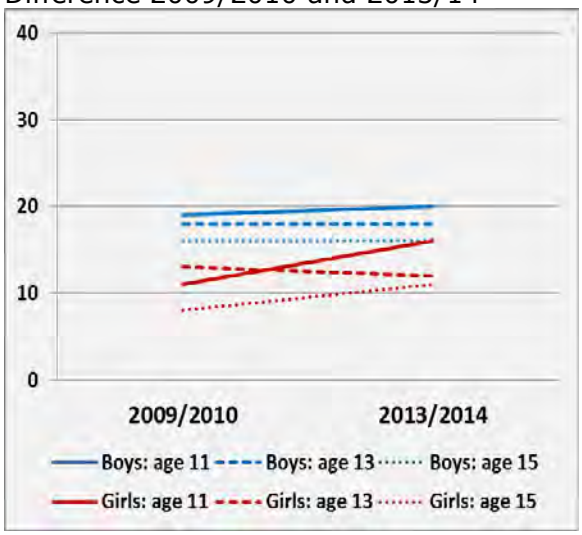

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A6.11. Germany (DE)

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).

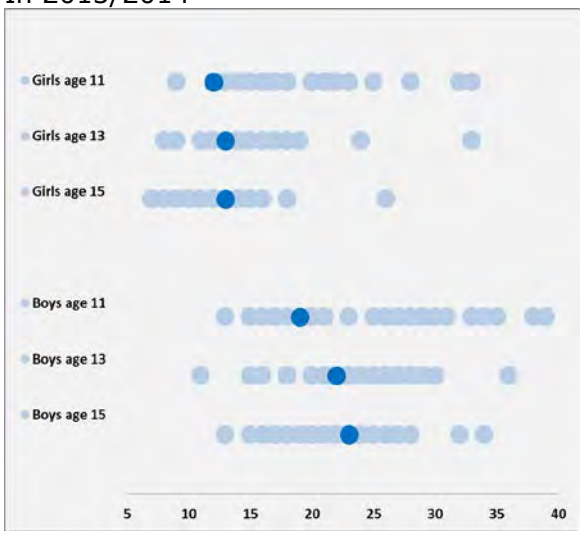
The priority topics are healthy upbringing (the first 1000 days) and a healthy diet and dietary education in childcare facilities and schools, because they seem to represent key aspects according to the current state of scientific knowledge in the field of childhood obesity. Activities focus on health 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. 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 activities will mainly 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.

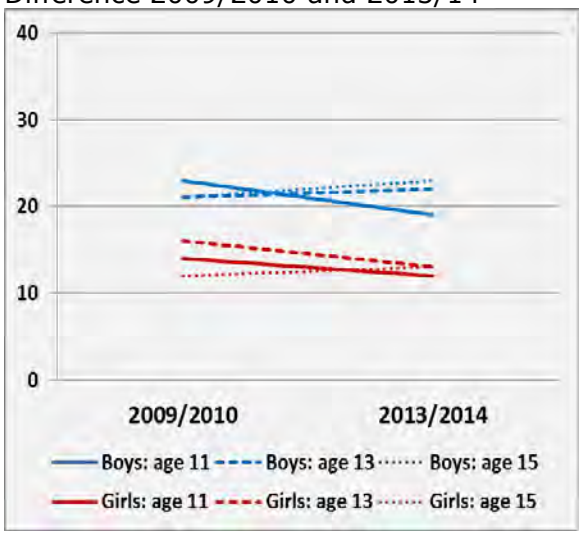
Besides "IN FORM", the Preventive Health Care Act entered into force on 25th July 2015. It strengthens the basis for enhanced co-operation among the social security institutions, the Laender, and the local authorities in the areas of prevention and health promotion for all age-groups and in multiple life settings. With the assistance of this law, early detection 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)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Germany. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
  - Food product improvement: saturated fat
  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement[1]
  - 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] For salt

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A6.12. Greece (EL)

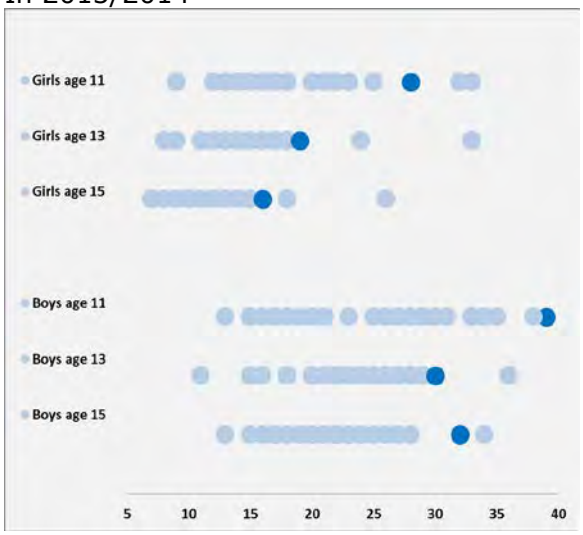
Based on the interview conducted with the Greek Competent Authorities we learned that Greece does not have a national action plan on childhood obesity, physical activity, nutrition or non-communicable diseases. On the internet a national nutrition policy document can be found, but this document has not 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)

In 2013/2014



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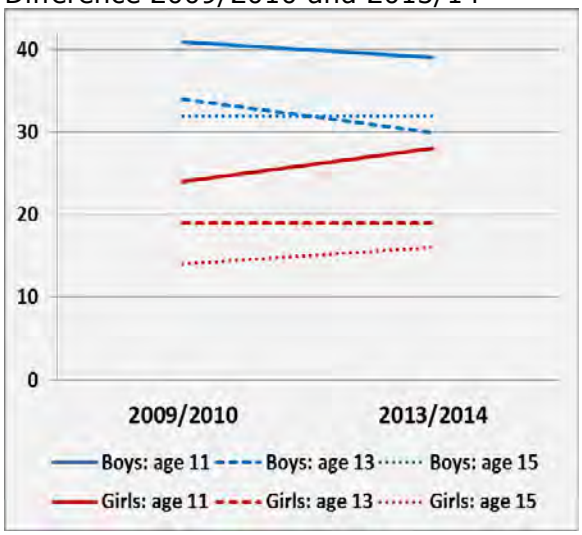

The dark blue dot represents the prevalence in Greece. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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  - Policies on vending machines
  - Policies on energy drinks
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
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  - Easy to understand labelling
  - Taxation
  - Subsidies
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A6.13. 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 mandatory healthy public procurement). 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.

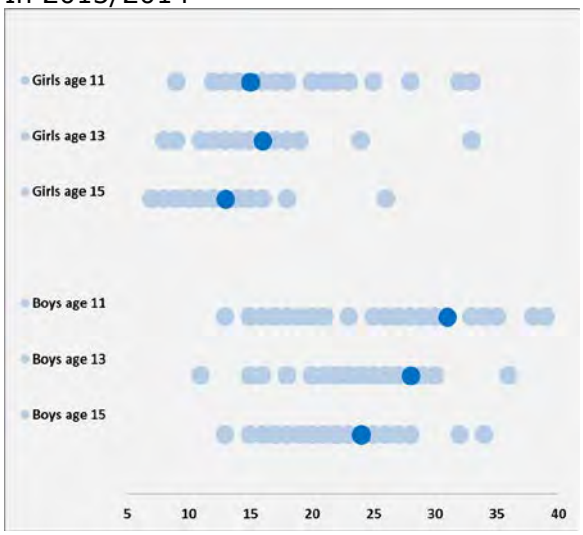
Central coordination for these plans is the Ministry of Human Capacities. Under this ministry, there are two main governmental institutions covering the topic of childhood obesity, nutrition or physical activity promotion, i.e. the National Institute of Nutrition and the National Institute of Health Development. The National Pharmacy and Nutrition Institute serves as a centre of excellence in the area of nutrition. This institute 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 of children with a low social economic status. They financially support healthy catering for these groups of children – with 3 free meals per day.

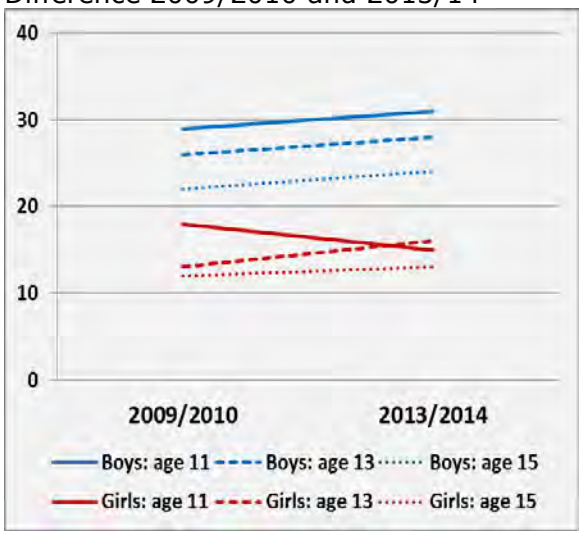
The EU Action Plan on Childhood Obesity 2014-2020 has mainly facilitated the monitoring of the implementation of Hungarian plans and serves as a good framework to ask the government to act. In addition, this document is very supportive in communicating to different stakeholders in the country.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Hungary. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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  - Easy to understand labelling
  - Taxation
  - Subsidies
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  - Participation in COSI

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A6.14. Iceland (IS)

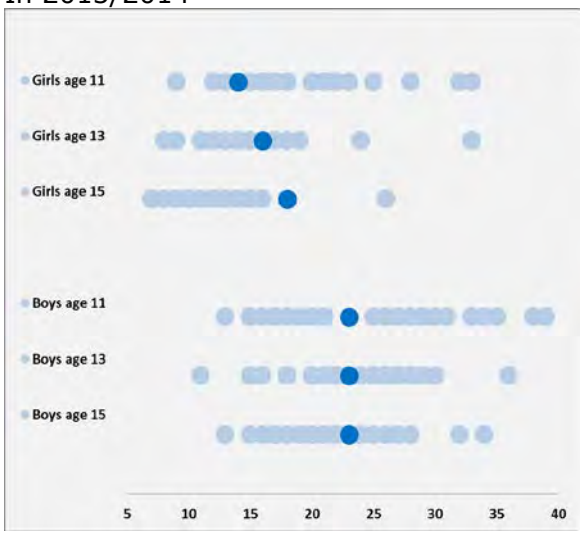
Based on the interview conducted with the Icelandic Competent Authorities we learned that Iceland has an action plan on reducing the prevalence of obesity since 2013. However, the Directorate of Health focuses in its work on promoting health and wellbeing across the lifecycle by emphasising a comprehensive 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 2011National 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.

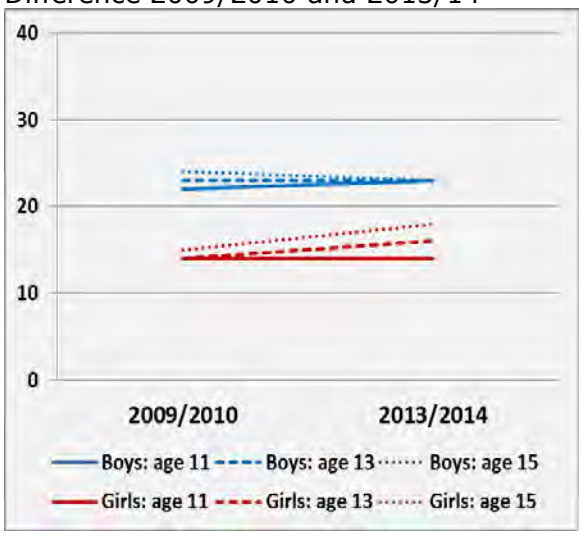
Iceland participates in the EU High Level Group on Nutrition and Physical activity since 2016. The EU Action Plan on Childhood Obesity 2014-2020 therefore did not specifically facilitate development or implementation of any policies. However, international documents do in general inspire the work in Iceland on health promotion and prevention.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



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  - Easy to understand labelling
  - Taxation
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A6.15. 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.

Currently Ireland is finalizing a voluntary Code of Practise on marketing, which will be in place early 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.

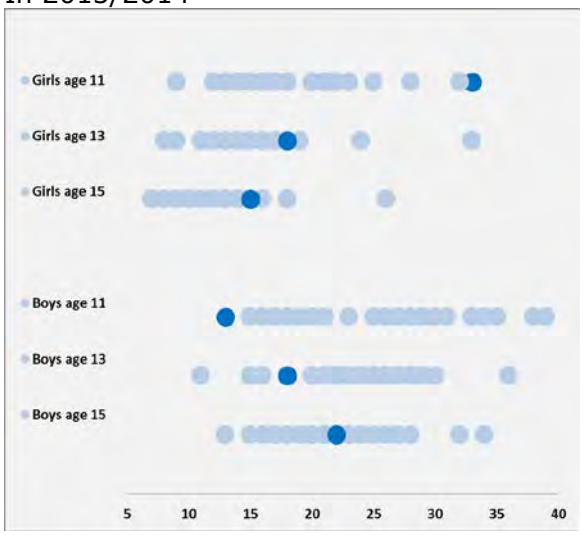
In 2016, Ireland adopted the plan: "Get Ireland Active! National Physical Activity Plan for Ireland" (2016-2025).

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.

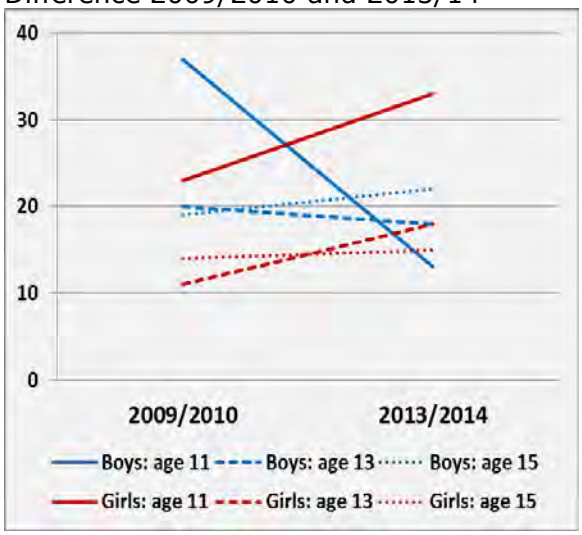
Ireland has a Special Action Group on Obesity, existing of experts in the area of physical activity, clinicians who work in the area of obesity, different agencies working on prevention of obesity and all key stakeholders (except the food industry). The food industry is usually invited once a year to 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)

In 2013/2014



Difference 2009/2010 and 2013/14



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A6.16. Italy (IT)

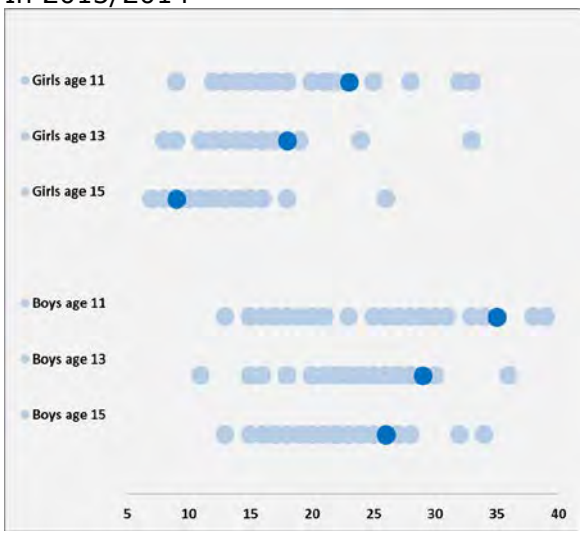
Based on the interview conducted with the Italian Competent Authorities we learned that the Italian strategy on prevention of non-communicable diseases is based on two main programs that are strongly inter linked: the programme "Gaining health: making healthy choices easier" and the "National Prevention 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 new "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 finalized to the promotion of 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. According to 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 an active lifestyles, both for schoolchildren, young people and people living in a disadvantaged socio-economic situation. The "National Prevention Plan" is part of the ethical programme of Italy. The programme involves different stakeholders and partners, and 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.

At the national level, actions on childhood obesity are coordinated by a commission including representatives of different ministries and representatives of other stakeholders. Schools are an important setting to implement actions and thus important collaborators. The National Centre for Disease Prevention and Control (CCM), a structure of the Ministry of Health, promotes 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. The EU Action Plan on Childhood Obesity 2014-2020 provided a framework of actions that have been important for the implementation of strategies on healthy diet and physical activity in Italy. It has increased the priority of this topic in Italy.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



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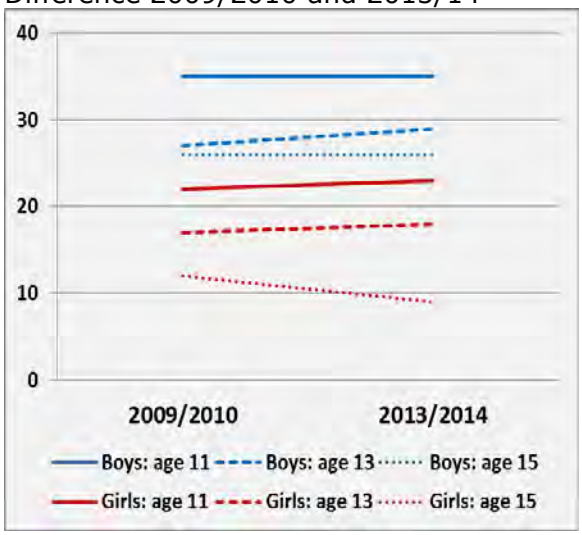

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- Screening programmes childhood obesity
- Management services for obese children

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*, partially, for example in certain settings or certain regions*, yes, since EU Action plan*, no**, in preparation or planned***
* Indicates that an action is (partially) undertaken, but does not contain an evaluation of effectiveness from our part. ** Actions may, however, be undertaken on initiative from local authorities, NGO's or private parties. *** Adoption may still be contingent on policy process.

A6.17. 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.

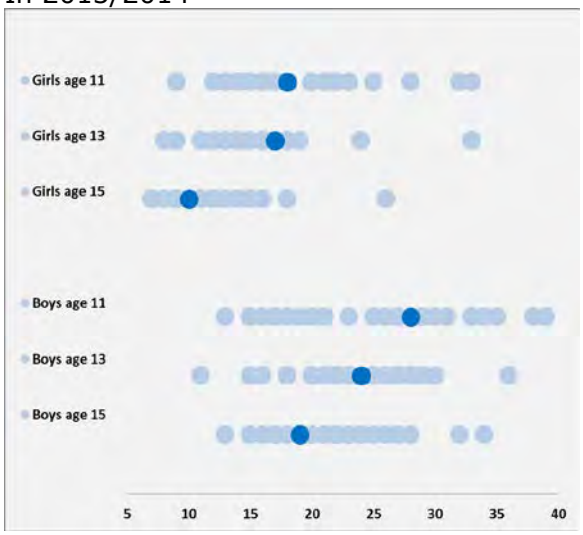
In Latvia non-communicable diseases are the main cause of death. These diseases are influenced by lifestyle, such as unhealthy nutrition and insufficient physical activity. Investment in health during early childhood will create positive results in the context of healthy adulthood and active ageing. 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 2017 the national energy and nutritional norms, including those for pregnant women and children, will be revised. Then the 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.

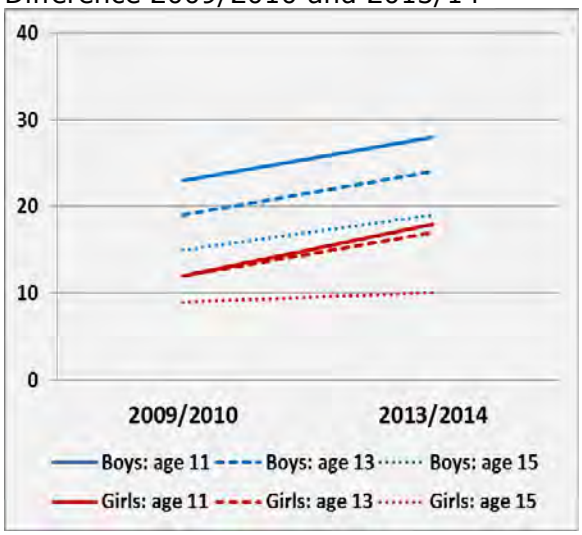
The EU Action Plan on Childhood Obesity 2014-2020 facilitated the development of the Latvian 'Public Health Strategy 2014-2020" and other policy documents. In general, Latvian policy planning documents are being developed based on EU policy documents.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Latvia. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
  - Food product improvement: saturated fat
  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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

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A6.18. 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.

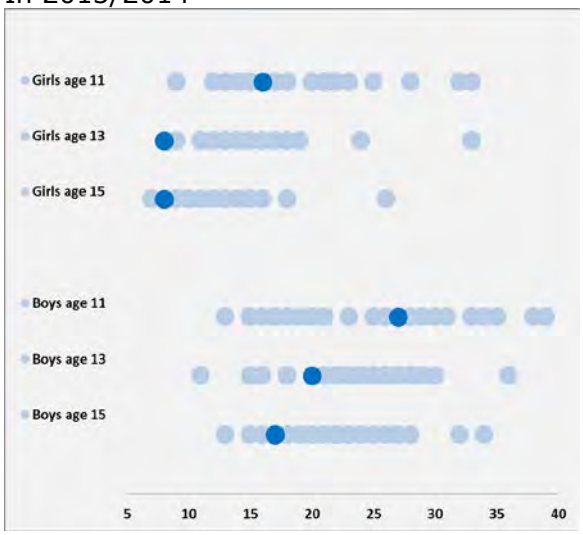
Every year additional actions and/or policies are initiated to improve the general Health Policy of Lithuania. The new government of Lithuania (installed last autumn) asked to improve the already implemented health education at schools. Furthermore, the policies on nutrition at schools will be improved. 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.

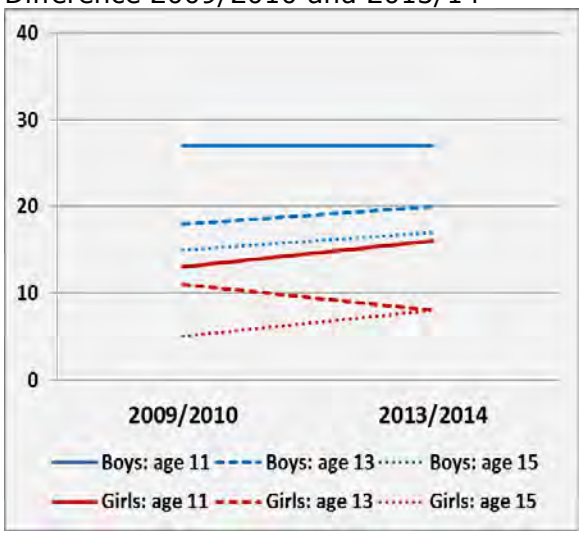
The EU Action Plan on Childhood Obesity 2014-2020 strengthens Lithuanian activities, because when they draft national plans they can refer to the Action Plan

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Lithuania. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
  - Food product improvement: saturated fat
  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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*, partially, for example in certain settings or certain regions*, yes, since EU Action plan*, no**, in preparation or planned***

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A6.19. 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 2010, 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

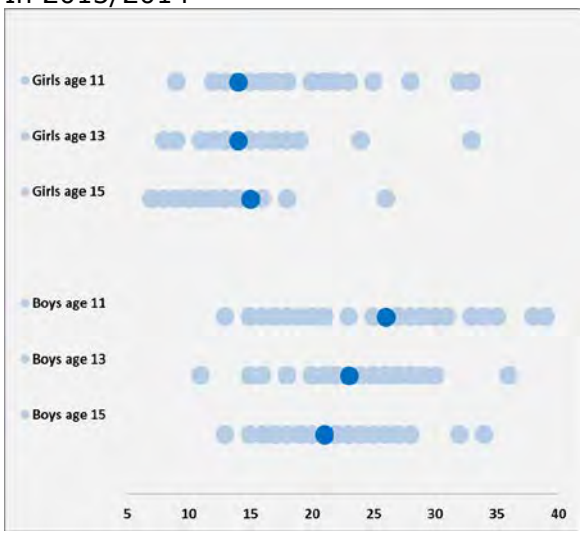
The National strategy on healthy nutrition and physical activity is a continuum of ongoing actions and actions in preparation. In the beginning of 2017, new national nutrition quality guidelines for children's canteens will be issued. This guideline has been developed in collaboration with day care centres. 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-2017.

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.

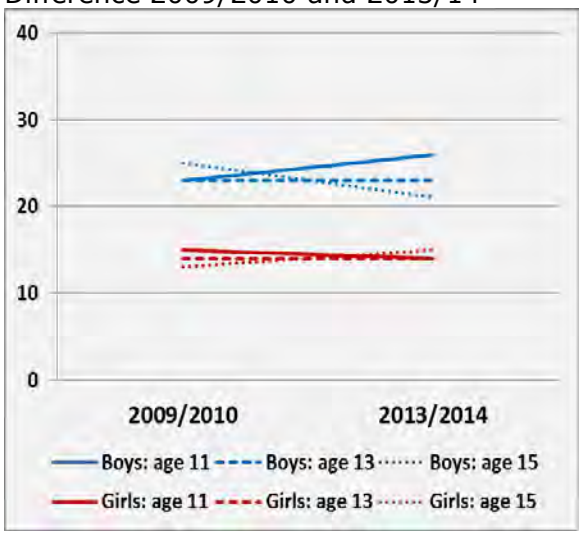
The EU Action Plan on Childhood Obesity 2014-2020 indirectly facilitated policy development in Luxembourg. Topics of the European action plan will be included in the next plan on healthy nutrition and physical activity.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Luxembourg. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

AREA 1: Support a healthy start in life	**AREA 4: Restrict marketing & advertising**
Guidance before and during pregnancy	Marketing of (HFSS) foods to children
Promote and protect breastfeeding	Nutrient criteria to reduce marketing
Guidance on complementary feeding	**AREA 5: Inform & empower families**
AREA 2: Promote healthier environments	Campaigns on diet & physical activity
Improving the school environment	Support community-based interventions
Policies on vending machines	Screening programmes childhood obesity
Policies on energy drinks	Management services for obese children
Nutrition education in school curricula	**AREA 6: Encourage physical activity**
Physical activity in school curricula	Physical activity promotion for children
AREA 3: Healthy option the easy option	National physical activity guidelines
Food product improvement: salt	Data on weight and height in children
Food product improvement: saturated fat	**AREA 7: Monitoring & surveillance**
Food product improvement: sugar[1]	Diet and nutrition surveys
Food product improvement: calories	Monitoring of physical activity
(Virtually) eliminate trans fat	Participation in COSI
Monitoring of food product improvement	
Easy to understand labelling	
Taxation	
Subsidies	

[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*, yes, since EU Action plan*, no**, in preparation or planned***

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A6.20. 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. Malta adopted the 'Whole school approach to a healthy lifestyle', which includes policies and strategies on healthy eating and physical activity in February 2015. Besides this, 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.

A National Policy for Sport in Malta & Gozo 2017-2027 has been drafted and is now open for public consultation that will run until January 31, 2017. There is also the HEPA strategy, which is an internal document to be used by the lifestyle council.

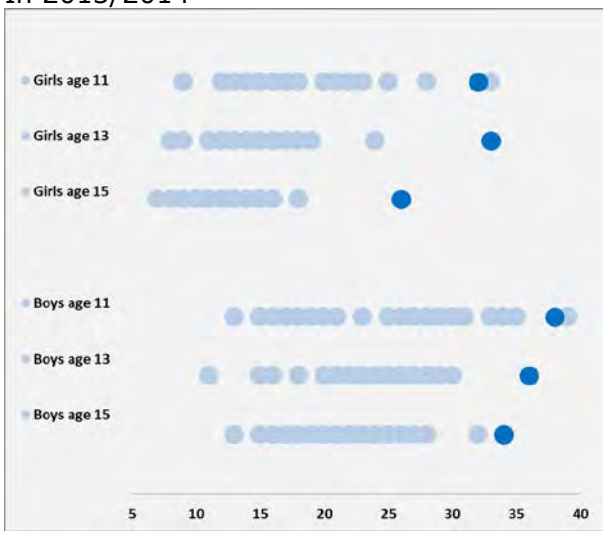
In January 2016 an advisory council has been set up that works inter-sectoral on obesity and non-communicable diseases. This council advises the Minister of health on strategies and possible new legislation. Beginning 2017 there are several plans. First, there is a wish for an even stronger focus on 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. 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 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.

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 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. September 2016, a specific unit on health inequalities has been set up. WHO supports this unit.

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)

In 2013/2014



The dark blue dot represents the prevalence in Malta. The light blue dots represent the prevalence in the other countries. No HBSC data for 2009/2010 are available in Malta.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
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  - Taxation
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- **AREA 4: Restrict marketing & advertising**
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- **AREA 5: Inform & empower families**
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  - 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

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A6.21. Montenegro (ME)

Based on the information provided[22] 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.

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.

[22] 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.

Prevalence of overweight including obesity (%) (HBSC)

For Montenegro, no data on the prevalence of overweight including obesity is available from HBSC.

Overview according to the various areas of action of the EU Action Plan

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A6.22. The Netherlands (NL)

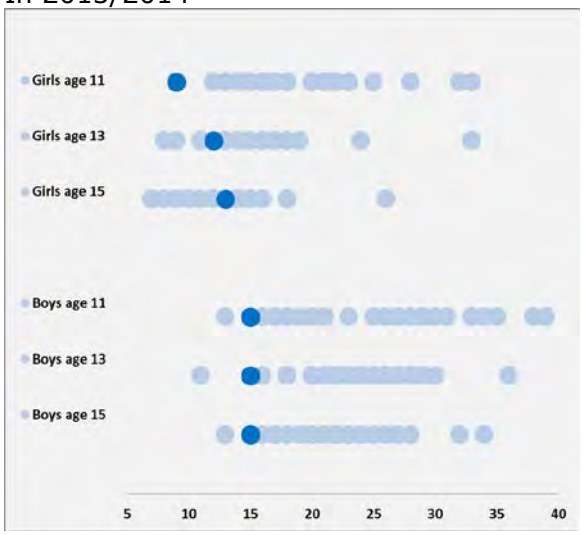
Based on the interview conducted with the Dutch Competent Authorities we learned that the Netherlands do not have national plans for the prevention of childhood obesity with specific aims and targets. Since before 1980, the Netherlands has the target to change the increasing prevalence of overweight 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.

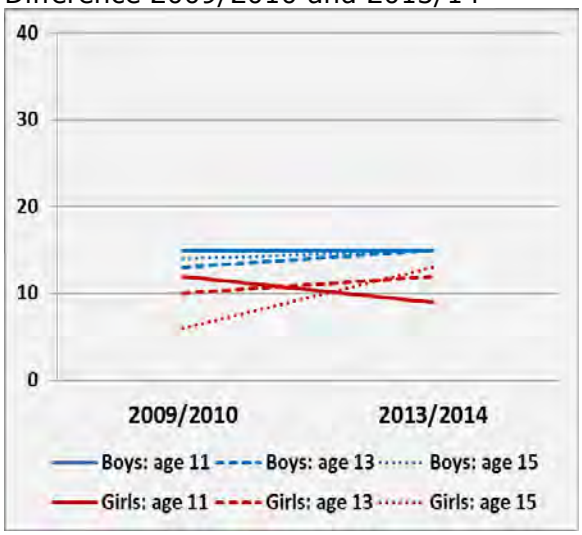
The Netherlands did not support the EU Action Plan on Childhood Obesity 2014-2020. Although it fully agrees with the need for action on childhood obesity and the implementation areas, it considers most of the actions lacking cross-border elements and having a dominant national character, thus falling 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)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in the Netherlands. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
  - Food product improvement: saturated fat
  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - Easy to understand labelling[1]
  - Taxation
  - Subsidies
- **AREA 4: Restrict marketing & advertising**
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  - 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] Healthy choices logo will disappear in 2017

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A6.23. 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 focusses on the healthcare system. Topics are early intervention and (secondary) prevention and the use of lifestyle in treatment and rehabilitation of patients with non-communicable diseases. Goals have been set, as well as ways how to obtain them in society and in healthcare. Goals are, for example, an increase the proportion of the population that knows and follows the national dietary guidelines, maintain the high level of awareness of the KeyHole label, reduce the salt consumption, and help children and young people establish healthy eating habits.

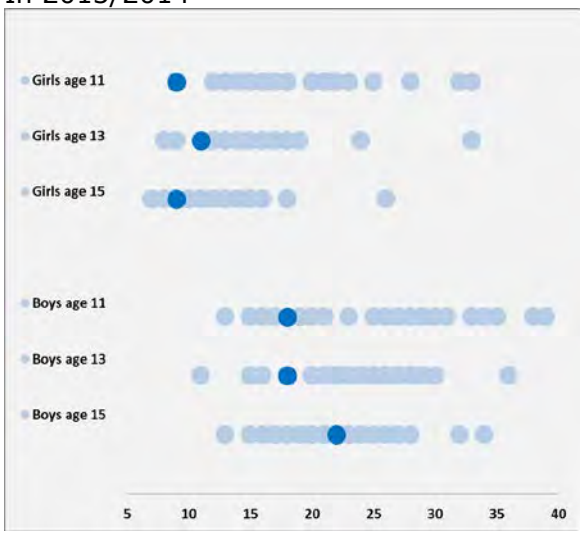
The Norwegian authorities consider it important to have a healthy lifestyle from the beginning of life, as it influences children's health and their behaviours later in life. Therefore education and providing information on healthy nutrition and physical activity during pregnancy and childhood are priorities. For a long time Norway is working on the promotion of breastfeeding. 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' as well as to kindergartens and (pre-)schools. By focussing on these settings Norway reaches all children, which is considered to be important for reducing health inequalities.

The Norwegian government is now developing a national action plan on nutrition, which will be launched in March 2017 and 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.

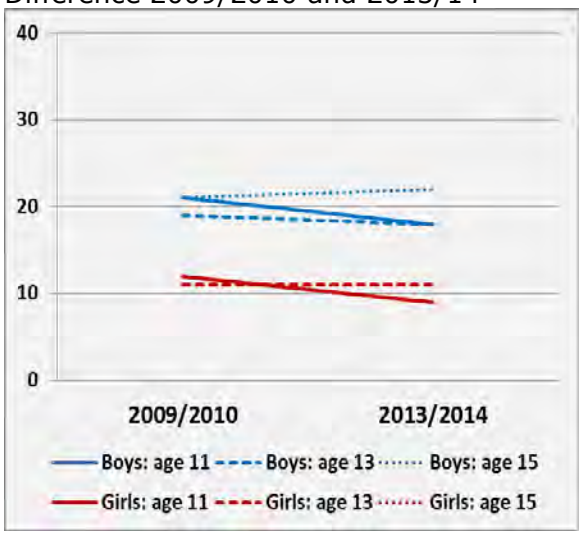
The Norwegian national centre for food, health and physical activity, established in 2013, is responsible for the promotion of healthy nutrition and physical activity in Norway. It has a nationwide function and is responsible for development and dissemination of knowledge, experienced based support and 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)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Norway. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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
- Nutrition education in school curricula
- Physical activity in school curricula

AREA 3: Healthy option the easy option
- Food product improvement: salt
- Food product improvement: saturated fat
- Food product improvement: sugar
- Food product improvement: calories
- (Virtually) eliminate trans fat
- Monitoring of food product improvement
- 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*, partially, for example in certain settings or certain regions*, yes, since EU Action plan*, no**, in preparation or planned***
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A6.24. Poland (PL)

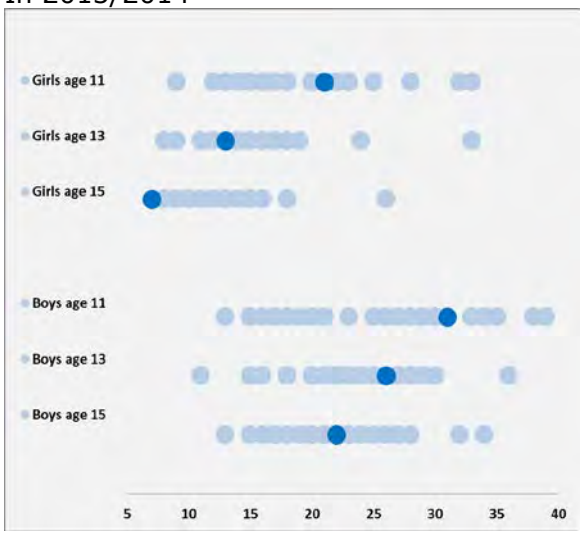
Based on the interview conducted with the Polish Competent Authorities we learned that Poland does not have a national action plan on childhood obesity. Physical activity promotion, nutrition and nutritional status are integrated in two governmental priority documents, i.e. the 'Act on Public Health' 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'. In these documents there are operating tasks on the improvement of nutrition and physical activity. These operating tasks are directed at the global population, but there are smaller tasks for children as well. In the National Health Programme the following tasks are mentioned: 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. Health inequalities are not directly addressed in projects on nutrition of physical activity. However, the National Health Programme supports smaller and more deprived areas in the country with the plans in the programme. 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 National Food and Nutrition Institute.

The National food and nutrition institute recently reported to the Polish Ministry of Health about the project "School friendly to nutrition and physical activity". It is a certification programme about the improvement of nutritional education and physical activity to reduce overweight and obesity and to improve the educational opportunities of children and adolescents. They are waiting for the decision of Polish Ministry of Health on the implementation of the project.

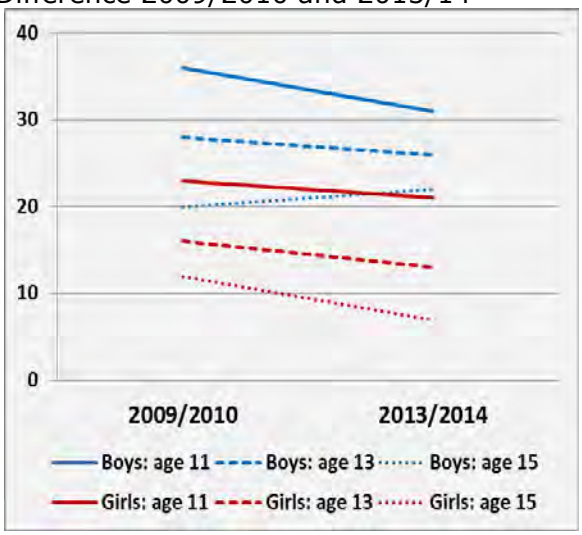
Probably, the EU Action Plan on Childhood Obesity 2014-2020 did not directly stimulate development or implementation of policies yet. For the Polish government the actions/policies are implemented in the national health programme and in the Law on public health.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Poland. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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  - Guidance before and during pregnancy
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A6.25. Portugal (PT)

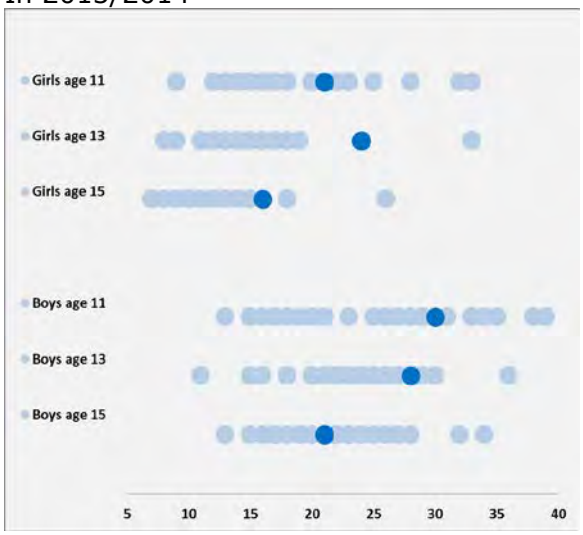
Based on the information provided[23] by the Portuguese Competent Authority we learned that Portugal has action plans on physical activity promotion (2016), nutrition (2012) and prevention of non-communicable diseases (2016). Because no high quality data on (childhood) obesity were available before monitoring 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. New laws on marketing of foods to children are expected in 2017, as well as taxation on sugar-containing beverages.

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.

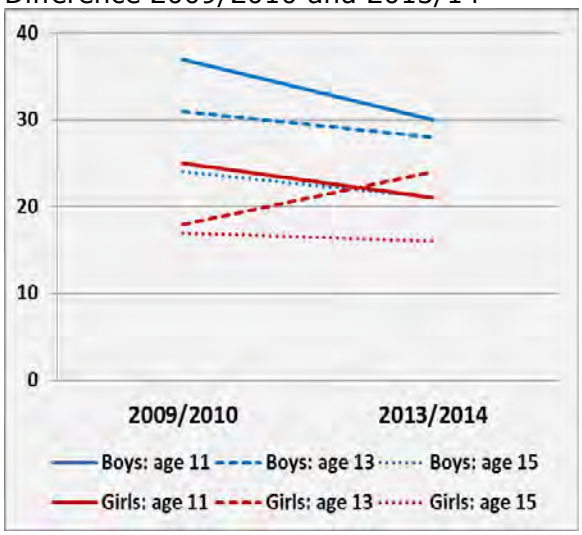
[23] The representative for Portugal filled out the answers on the interview on paper. Therefore answers well less extensive than for other countries. This may have affected interpretation.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Portugal. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

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AREA 7: Monitoring & surveillance
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- Monitoring of physical activity
- Participation in COSI

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A6.26. Romania (RO)

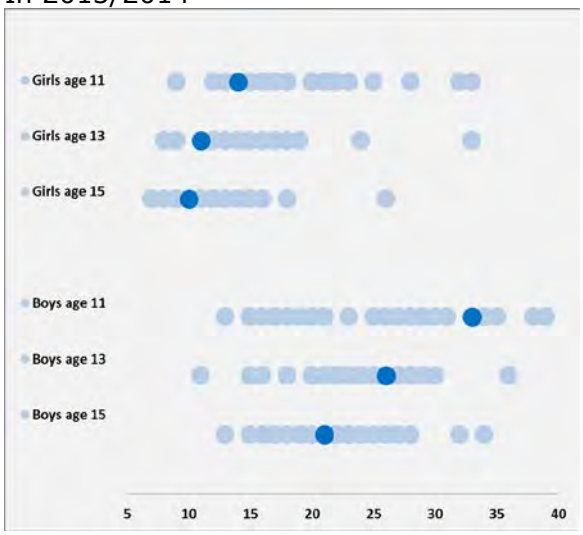
Based on the interview conducted with the Polish Competent Authorities we learned that since a long time Romania has an action plan on the prevention of non-communicable diseases that includes specific actions for children below the age of 18 years in place. Overweight prevention is integrated in this plan. Prevention of childhood obesity in primary healthcare 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 will start on 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.

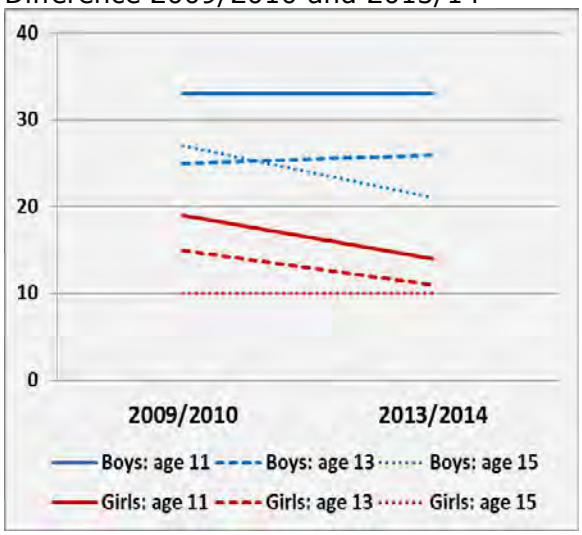
The EU Action Plan on Childhood Obesity 2014-2020 offers Romania a theoretical basis for making national policies. Furthermore, Romania received direct financial aid because of the plan, in the form of subsidies for programmes (e.g. apple in school programme, as part of the EU school fruit and vegetable programme).

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Romenia. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **AREA 1: Support a healthy start in life**
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A6.27. Serbia (RS)

Based on the information provided[24] 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.

[24] 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.

Prevalence of overweight including obesity (%) (HBSC)

For Serbia, no data on the prevalence of overweight including obesity is available from HBSC.

Overview according to the various areas of action of the EU Action Plan

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A6.28. Slovakia (SK)

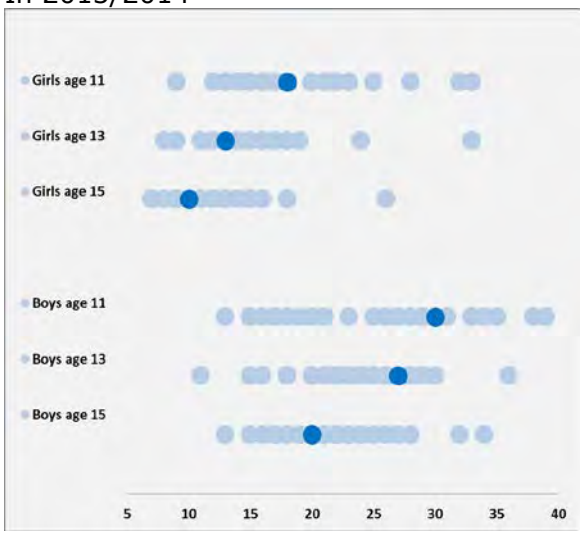
Based on the interview conducted with the Slovakian Competent Authorities we learned that Slovakia has a National Action Plan for Obesity Prevention, running from 2015 to 2025. There is a part on children, describing several activities for children, which cover most areas of action of the EU Action Plan 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 finished now.

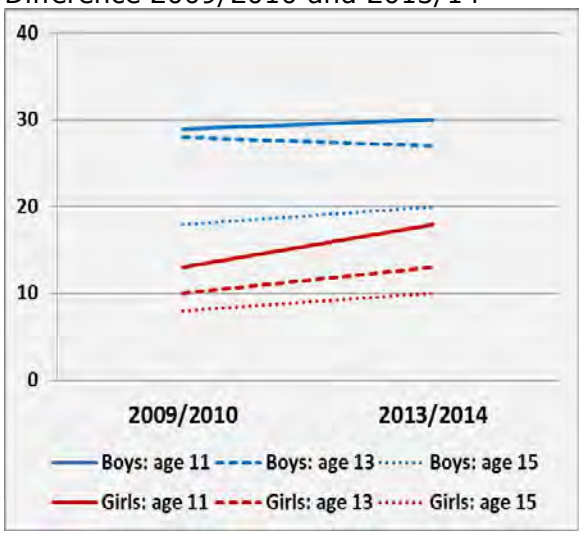
The question how the EU Action Plan on Childhood Obesity 2014-2020 facilitates development or implementation of any of the policies is difficult to answer. It might have some influence, but nobody measures when and how it facilities development or implementation.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Slovakia. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
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  - Policies on energy drinks
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  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
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  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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**
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  - Screening programmes childhood obesity
  - Management services for obese children
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  - Monitoring of physical activity
  - Participation in COSI

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A6.29. 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.

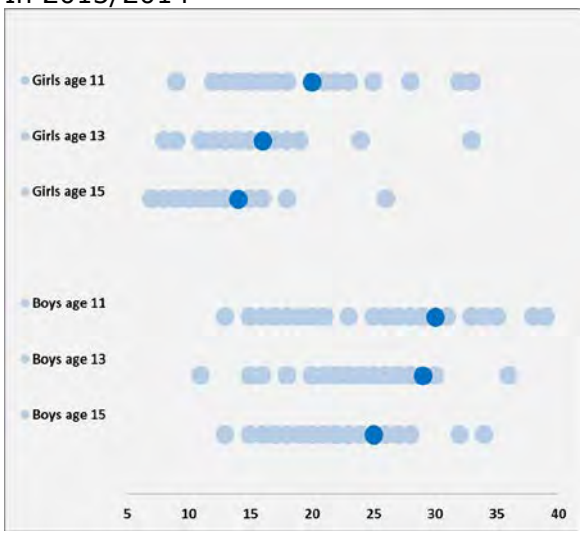
In the near future, a more comprehensive approach for food reformulation is planned. A draft report "Healthy choice is the easy choice" (2017-2025) will hopefully be adopted within a few months. It will include legislation on trans fatty acids. Several industries, like dairy and bakery, will probably 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.

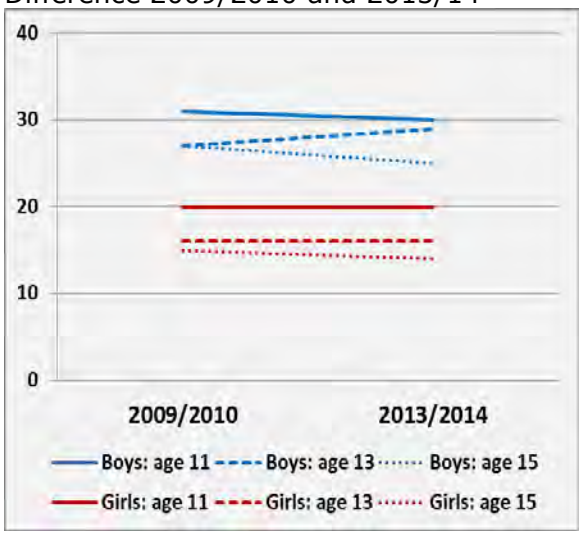
The EU Action Plan on Childhood Obesity 2014-2020 provides support and is definitely encouraging. Slovenia participated actively in the preparation of the action plan, so it is 'hand-in-hand' work together with the input of other countries.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



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Overview according to the various areas of action of the EU Action Plan

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  - Guidance on complementary feeding
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[1] Has been improved after 2014.

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A6.30. 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 obesity 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 41.2%). So, it is confirmed that the temporal obesity trend among 6-9 year old children has switched in Spain. These data reinforce the necessity to continue encouraging policies to achieve further decrease in overweight and obesity and to monitor further trends with further 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 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 the WHO Childhood Obesity Surveillance Initiative (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.

The NAOS Strategy (AECOSAN) is planning to start new campaigns, such as campaigns on sugar and breastfeeding in the next future. Furthermore 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.

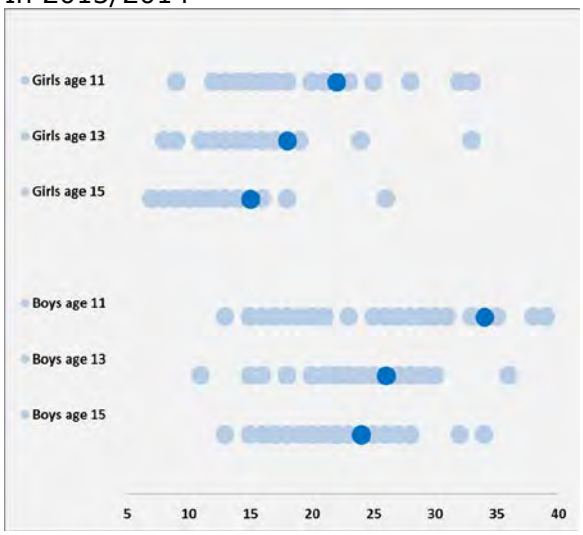
Since 2008, the NAOS Strategy is working jointly with the Regional authorities of Health of the Autonomous Communities through a technical working group, in the areas of responsibility of each Administration. The working group also liaises with national and regional authorities of Agriculture and Education 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.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



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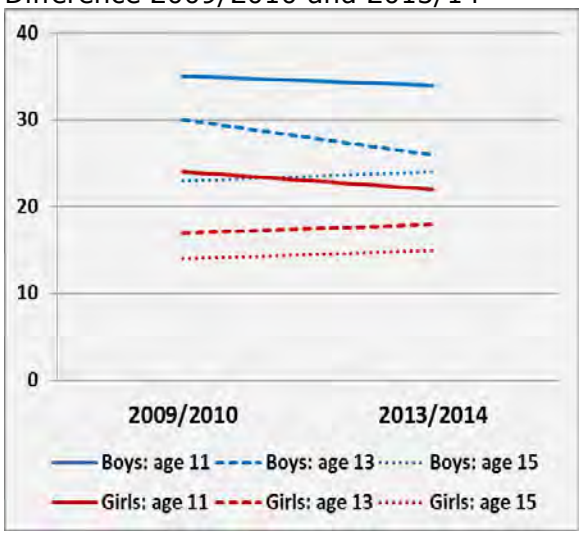

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  - Improving the school environment
  - Policies on vending machines
  - Policies on energy drinks
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
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  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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

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A6.31. 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. The 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.

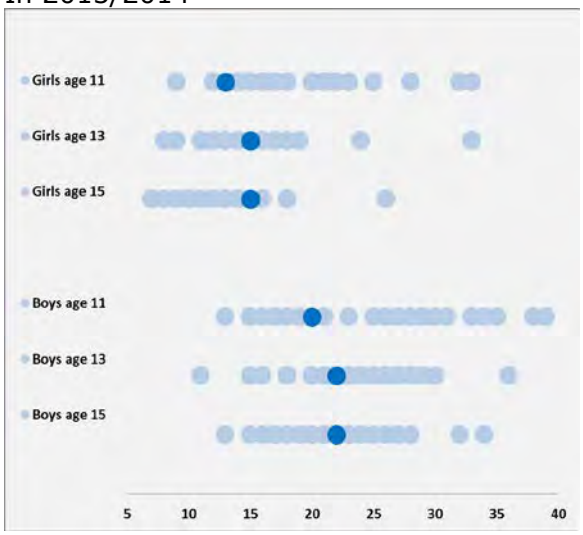
Areas where people are at daily basis, like schools, health care and green places, are important health promoting areas. Here you can reach people to prevent or overweight and obesity. Therefore, priorities of the Swedish authorities are early detection, schools, urban planning and sports. Since 2016, the Commission for Equity in Health is to submit proposals that can help to reduce health inequalities in society. In May 2017, the Commission will present 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.

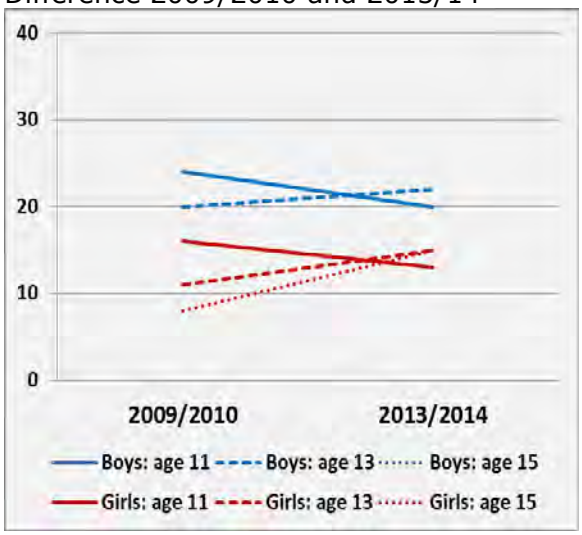
International policy documents, like the EU Action Plan on Childhood Obesity 2014-2020, provide inspiration and scientific evidence for national and regional work.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Sweden. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **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
  - Nutrition education in school curricula
  - Physical activity in school curricula
- **AREA 3: Healthy option the easy option**
  - Food product improvement: salt
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  - Food product improvement: sugar
  - Food product improvement: portion sizes
  - (Virtually) eliminate trans fat
  - Monitoring of food product improvement
  - 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

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A6.32. 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 will start January 2017. An action plan on nutrition will be released at the end of 2017. This action plan will address the general population and several target groups, i.e. mothers, pregnant women, children and elderly. Improvements of the "Swiss Nutrition Policy 2013–2016", which will be reviewed this summer, 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

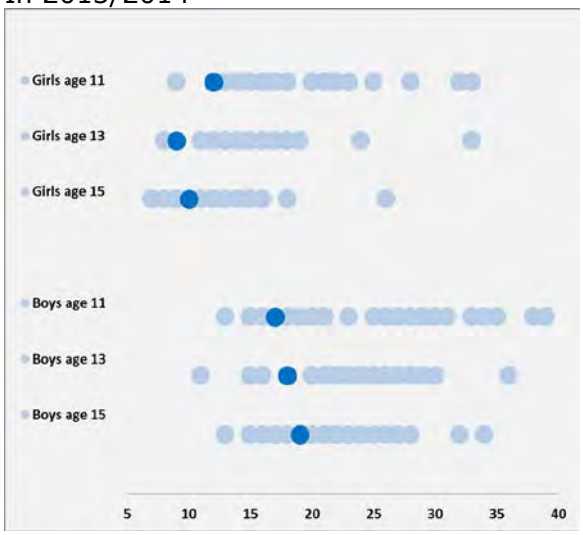
These are the priority areas because of the notion that the first 1000 days since conception are important for health. Furthermore, Switzerland puts a lot of effort in working together with several partners, such as health professionals, industry and the Cantons. The latter are important partners in 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.

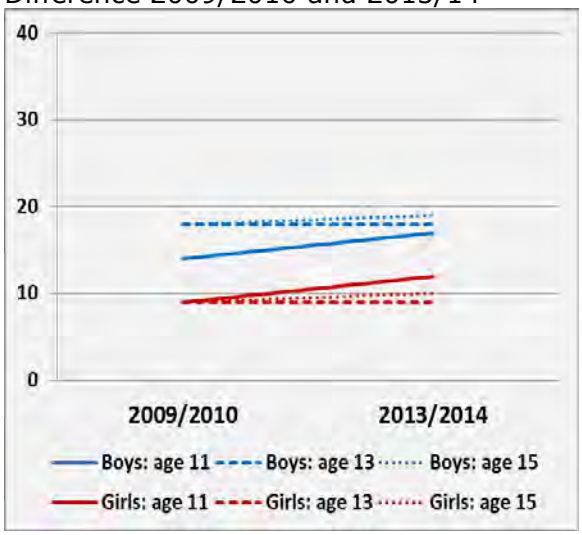
Switzerland cannot officially adopt the EU Action Plan on Childhood Obesity 2014-2020, but they do support the Action Plan. The EU action plan was an important basis and facilitated the development of the aforementioned strategies on nutrition and non-communicable diseases.

Prevalence of overweight including obesity (%) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



The dark blue dot represents the prevalence in Switserland. The light blue dots represent the prevalence in the other countries.

Overview according to the various areas of action of the EU Action Plan

- **AREA 1: Support a healthy start in life**
  - Guidance before and during pregnancy
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- **AREA 2: Promote healthier environments**
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  - Food product improvement: salt
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  - Taxation
  - Subsidies
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  - 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[1]
  - Monitoring of physical activity
  - Participation in COSI

[1] Switserland does have diet and nutrition surveys, but they do not include children.

yes, already before EU Action plan*, partially, for example in certain settings or certain regions*, yes, since EU Action plan*, no**, in preparation or planned***

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A6.33. 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.

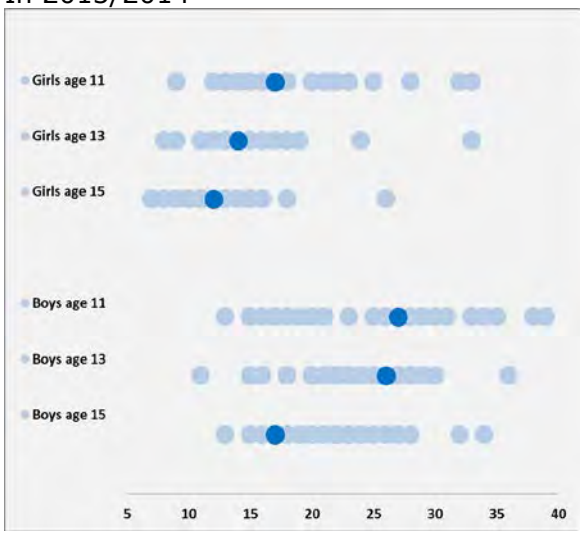
For the Childhood Obesity Action Plan a cross-governmental steering group has been installed, including representatives from the Department of Health, The Department of Education, and Public Health England, etc. This group cannot issue policy documents but is more a management group that sees that the 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.

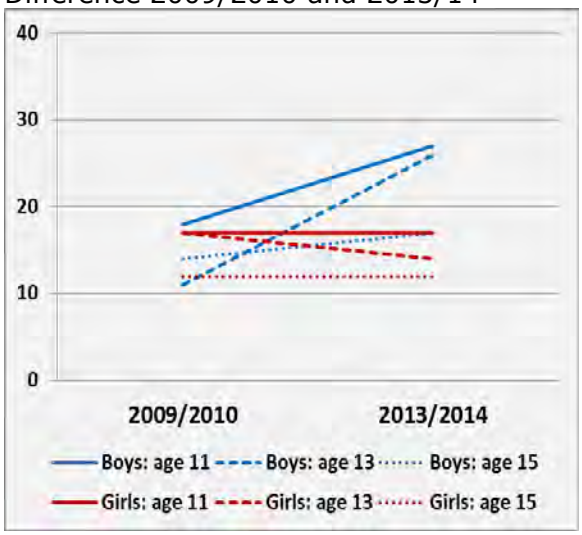
The EU Action Plan on Childhood Obesity 2014-2020 acts as a benchmark and reference for the UK to see whether what they have planned is in line with other countries and to see whether other countries move in the same direction. The EU Action Plan had no direct influence on the development of the National Action Plan.

Prevalence of overweight including obesity (%) in England (UK) (HBSC)

In 2013/2014



Difference 2009/2010 and 2013/14



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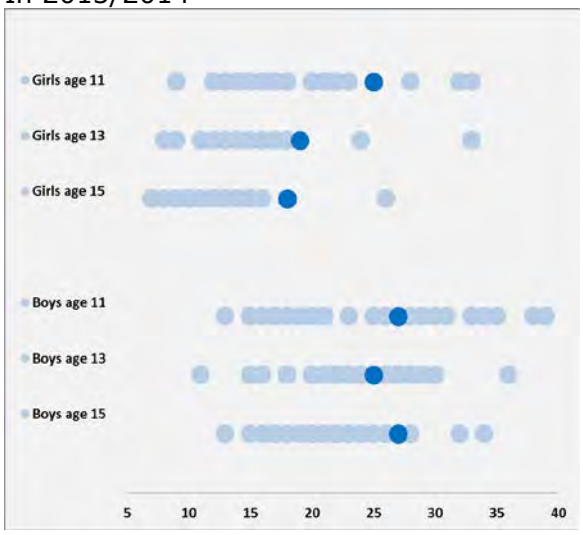
Prevalence of overweight including obesity (%) in Wales (UK) (HBSC)

In 2013/2014



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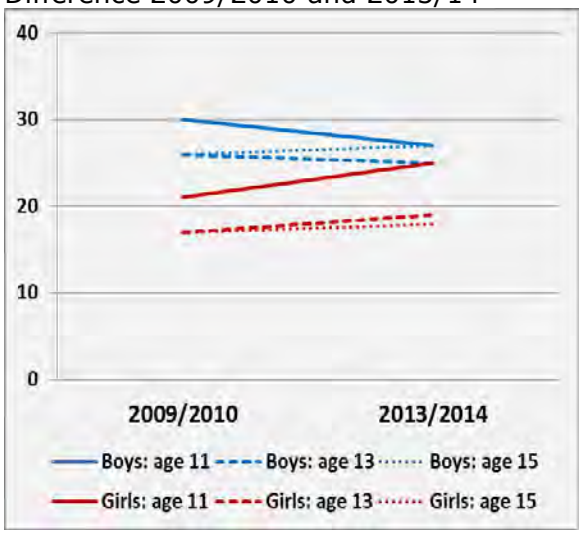

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Prevalence of overweight including obesity (%) in Scotland (UK) (HBSC)

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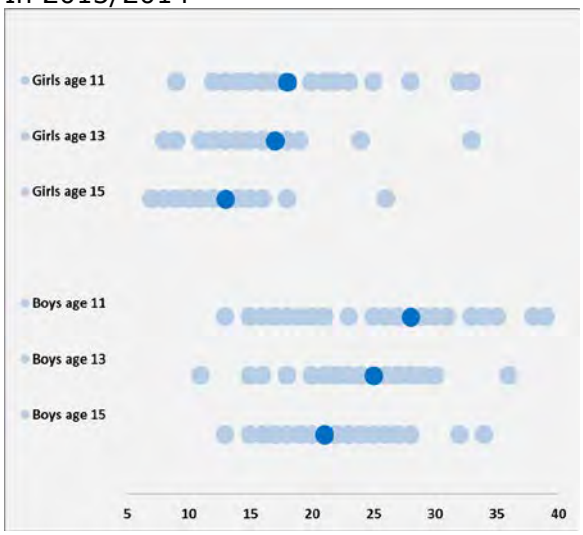

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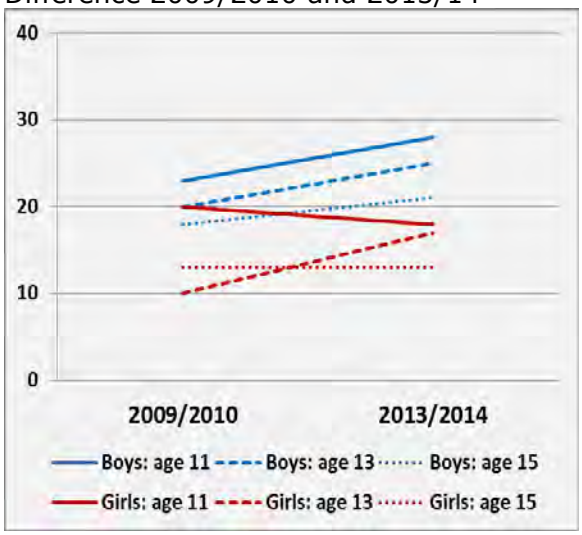

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ANNEX 7: LIST OF EU FUNDED PROJECTS UNDER THE ERASMUS+ PROGRAMME

Title	Start and end date	Participating countries**	APCO 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**	APCO 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
Innovative teaching	2016-2018	LT*, EL, IT, BG, ES	2

Title	Start and end date	Participating countries**	APCO Area for action or operational objectives†
methodology of health friendly nutrition development and practice in (pre-) primary education			
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*)	
Fight the beast don't become obese [b]	2016	IE*, LV, MT	
TRY: TRansition Youth [b]	2016	PL*, IT, ES	

Title	Start and end date	Participating countries**	APCO Area for action or operational objectives†
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
WAVE on WAVE	2017-2018	IT*, SK, FR, HR, PL, ES	6.1
Development and	2017-2019	EL*, IT, ES, BG, UK,	6.1

Title	Start and end date	Participating countries**	APCO Area for action or operational objectives†
evaluation of guide-models mass athletics for sports in students with special needs (obese, disabled persons etc.)		HR	
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*	
WELCOME-Integration of young refugees through sport activity	2017	IT*, HR, CY	
Tennis Table Crossing	2017	HR*, SI, DE	

Title	Start and end date	Participating countries**	APCO Area for action or operational objectives†
Borders			
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 to areas of Action, projects with 5 or more countries involved are mapped to 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/Europe kindly 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

"APCO database" kindly provided by DG SANTE

Websites
FAO: Food based dietary guidelines: http://www.fao.org/nutrition/education/food-dietary-guidelines/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
- http://www.globalblue.com/tax-free-shopping/italy/
- https://www.unizo.be/advies/welke-btw-tarieven-moet-u-toepassen
- http://www.purs.gov.rs/en/Legal-entities/Vat/Thelaw/VALUEADDEDTAXLAW.html
- https://spectator.sme.sk/c/20070826/lower-vat-reduces-prices-on-some-food.html

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

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 (WHO/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/

Persons consulted / interviewed
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Country experts in the field of childhood obesity, nutrition and/or physical activity

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