A GUIDE FOR PROGRAMME PLANNERS AND DECISION MAKERS ON CREATING HEALTHIER ENVIRONMENTS IN KINDERGARTENS AND SCHOOLS
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Budapest, 2017
Eating and activity habits are developed in early ages

What we eat affects our health. Childhood and adolescence is a critical period to intervene as eating habits, lifestyle and behaviour patterns are developed that may persist throughout adulthood. Many factors influence one’s ability to eat a healthy, balanced diet: access, price, marketing, nutritional quality of the food offer, skills and knowledge all come into play.

Kindergartens and schools are in the front line to form children’s behaviour

They are ideal settings as they reach most children for a number of years at a critical age.
when habits are still being formed. They are the places where children spend most of their time in contact with qualified personnel to teach and guide. Besides, teachers and other school personnel are often role models for students, and majority of parents have a trust in schools. Also, what is learnt here may have multiple effects by being taken home to influence behaviours in the family. As kindergartens and schools are in a key position to form behaviour, also on a longer term, a health promoting environment has to be created2.

The EU Action Plan recommends the followings to create healthy environments:

1. **FACILITATE PHYSICAL ACTIVITY**

2. **PROVIDE EASY ACCESS TO THE HEALTHY OPTIONS AND ELIMINATE UNHEALTHY FOODS**

3. **RESTRICT MARKETING**

4. **IMPROVE EDUCATION ON NUTRITION AND HEALTHY LIFESTYLE**

5. **CARE FOR OVERWEIGHT CHILDREN**

6. **MONITOR AND SCREEN FOR OVERWEIGHT CHILDREN**

School-wide messages delivered through the curriculum, school programmes, school environment and physical facilities must be coherent and consistent as well as mutually reinforcing. The impact of actions has to be maximized by combining environmental elements with educational elements and with the involvement of parents / caregivers.

What can be done in pre-schools and schools?

The following six chapters present the relevant recommendations of the ‘EU Action Plan on Childhood Obesity 2014-2020’ (AP) on the above mentioned areas of actions enriched by ideas, examples and case studies collected in accordance with rigorous criteria from 16 JANPA countries. Listed activities are detailed in the JANPA Toolbox (www.janpa-toolbox.eu) which is a web-based hub aiming to help programme planners, after a decision process, to design and implement effective interventions. It contains the most important outputs of WP6. The main feature of the Toolbox is the good practice database, where interventions can be sorted by countries, settings, intervention focus, intervention type, and budget categories. To understand the context in which these interventions were implemented, each country context is described by a country profile document with up-to-date information on the prevalence of overweight and obesity, structure of the education system, nutrition environment and physical activity in kindergartens and schools. Besides, programme planners can analyze their existing or planned interventions with the self-assessment tool (see also Annex 1), consisting of four checklists with good practice criteria identified and agreed by WP6 experts.

The main purpose of this Guide is to support those who would like to intervene by sharing ideas and lessons drawn from rigorously selected good practices. However, readers have to note that institutional, legal and cultural context of each country are different, as presented also in the JANPA Toolbox and in JANPA Compendium of Good Practices, and adaptations are necessary in order to take into account these differences.
**Recommendations from the EU Action Plan**

Create extensive and well-maintained walking and biking infrastructures for promoting active commuting to and from school ● Work with parents to encourage active commuting ● Provide infrastructures for active breaks according to students’ age (e.g. playgrounds, schoolyards) ● Integrate physical activities into the curriculum ● Use the interior space and equipments for kindergarten and schools to offer different possibilities to be active ● Increase the quality of sequential, age and developmentally appropriate physical education for all kindergarten and school children, taught by certified physical activity teachers ● Ensure an adequate presence of free/low cost sports facilities to promote activities during and after school ● Give children the possibility to participate in school, city and neighbourhood planning in order to create secure and attractive spaces to move ● Increase the awareness of and participation in the European Week of Sport

**Success story from JANPA: ITALY**

A local program in Abruzzo Region aimed to increase children’s active playtime during school breaks. Playgrounds have been marked for outdoor play guided by colourful shapes painted on the surface. Shapes were either geometrical, symbols (e.g. letters, numbers), images (e.g. animals, maps and road signs) or hand- and footprints (of humans or animals) on which or around children could walk, run or jump. At the beginning, there were instructional games strictly defined by rules, but after a few weeks, students could freely change the rules and invent new ones.
Ideas from JANPA

Introduce mandatory daily physical education (PE) lessons (Hungary) ● Make the environment attractive for children to encourage physical activity (Italy, Germany) ● Increase road safety and risk acceptance by parents to allow children walk and cycle to school alone (Germany) ● Build collaborations between schools and nearby sport clubs (interviewee) ● Allocate funding through municipalities to schools for organizing additional sport classes beyond mandatory PE lessons (Latvia) ● Train peer leaders to be able to conduct active breaks (Malta) ● Invite teachers and caregivers to participate in the organized activities together with children (Slovenia)

“Encouraging people to act in ways that their environment makes difficult is not very effective. Allowing cars to dominate (sub)urban spaces, and then tell people they should walk and cycle is not really fair.”

IDEFICS

Case study from JANPA: Multi-level tournaments in Romania

The National Schools Sport Olympiad (ONSS) is a sport competition taking place each year in the Romanian schools. The program is coordinated by the Ministry of Education and it is implemented at school level by the Physical Education teachers. The program involves children from 1st grade (age 7 years) to 12th (age 18-19 years). The competition develops in multiple consecutive rounds, from school level to local level, regional and the final tournaments at national level. There are separate competitions for boys and girls and for each school cycle (primary, secondary and high-school). Children are engaged in several sports such as athletics (different field events), badminton, football, rugby-tag, cycling, swimming, roller-skating, tennis, archery, handball, oina (Romanian traditional sport), table tennis, basketball, volleyball, chess etc. The competition calendar is established by the Ministry of Education at the beginning of each school year. According to the ONSS rules, each school has to organize competitions in at least 5 individual sports and 3 team sports. The ONSS engages children from all around the country in sport competitions within the school environment, being the only national program promoting physical activity in the children and youth population.
How much physical activity do children need? WHO recommends that people in this age group accumulate at least 60 minutes of moderate-to-vigorous intensity physical activity every day, and even more physical activity is likely to have additional health benefits\(^3\). Moreover, children should limit extended periods of sedentary behavior, such as sitting in front of any kind of screen.

Programmes and policies from JANPA (for more details visit www.janpa-toolbox.eu)

- Germany – Eat better. Move more. Health-promoting Regions (Besser essen. Mehr bewegen. Kinderleicht-Regionen)
- Germany – IDEFICS
- Germany – Kindergartens focusing on physical activity and nutrition (Anerkannter Bewegungskindergarten mit dem Pluspunkt Ernährung)
- Hungary – Regulation on daily physical education in schools
- Italy – PA promotion in primary school children. Intervention study centered on playground marking
- Latvia – Sports for all students
- Malta – OPEN – Schools on the move
- Romania – National Schools Sport Olympiad (ONSS)
- Slovakia – National Health Promotion Programme (NPPZ)
- Slovenia – Eat healthy, exercise constantly
- Spain – MOVI Program
- Spain – Holistic Health Program (SI!)
ACTION AREA 2 – PROVIDE EASY ACCESS TO THE HEALTHY OPTIONS AND ELIMINATE UNHEALTHY FOODS

Recommendations from the EU Action Plan

Provide quality standards (e.g. a products catalogue) for the foods and meals to be sold or provided in kindergartens and schools ● Meals and foods must comply with national nutrient recommendations and guidelines on portion sizes ● Promote the intake of water ● Limit the intake of sweetened beverages ● Ban vending machines in schools where meals are offered ● Ban vending machines with soft drinks in schools where no meals are proposed ● Ensure free supply of fresh drinking water in schools through e.g. installation of water fountains ● Promote tap water ● Distribute freely healthy foods including fruit and vegetables focusing on disadvantaged areas ● Develop a sign posting scheme promoting the healthy options in school premises including vending machines, canteens or at school lunch ● Implement the EU School Fruit Scheme, School Milk Scheme and New School Scheme

Ideas from JANPA

Do not allow flavoured milk in schools (Luxembourg) ● Ensure that healthy nutrition is the most important aspect to consider in public procure-

Success story from JANPA: BULGARIA

The country has taken a comprehensive approach to promote healthy diets through kindergartens and schools. Starting in 2009, a series of regulations were introduced, including the mandatory standards for meals in schools (2009), in kindergartens (2011) and in crèches (2013). For each legislative document a Recipe Book with specific guidelines was developed and approved by Ministry of Health (MoH) for helping the implementation of the legislations. The MoH with 28 Regional Health Inspectorates (RHI) is responsible for the monitoring and control of the implementation. National Centre of Public Health and Analyses provides methodological guidelines and materials for RHI and training courses for the staff of RHI. The 28 RHI ensure training of employees (i.e. headmasters, medical staff, kitchen staff, etc.) from kindergartens and schools and promote healthy nutrition through different educational campaigns and interventions for children. The strong collaboration between MoH, National Centre of Public Health and 28 RHI ensures that messages are coherent. The main barrier is the current public procurement legislation which orders that the offer with the lowest price has to be chosen.
ment of food (Bulgaria) ● Introduce a legislation on public catering to regulate the quality of school meals by law (Bulgaria, Latvia, Hungary) ● Impose a statutory restriction on the availability of HFSS (high fat, salt and sugar) foods and drinks in vending machines, school canteens and school shops with government-led, transparent monitoring of compliance (Greece, Hungary, Latvia) ● Mandatory ban of vending machines to avoid unhealthy snacking at school (France)

Programmes and policies from JANPA (for more details visit www.janpa-toolbox.eu)

• France – Intervention improving the food supply (excluding school meals) with educational support in middle and high schools
• France – Improve the composition or stop systematic morning snack offer in kindergartens
• France – PRALIMAP
• Germany – Eat better. Move more. Health-promoting Regions (Besser essen. Mehr bewegen. Kinderleicht-Regionen)
• Germany – IDEFICS
• Greece – School canteen policy
• Hungary – Public Catering Act
• Hungary – HAPPY Programme and HAPPY Week
• Latvia – Regulations to restrict unhealthy foods in kindergartens and schools
• Romania – Milk and croissant (‘Laptele si cornul’)
• Slovakia – School Programme (SP) (School Milk and School Fruit Scheme)

Case study from JANPA: The school canteen policy in Greece

Ministry of Health (2004) has established a law (updated in 2015) determining in detail the products permitted to be sold in public and private school canteens, including the way to be prepared and/or stored. The school canteen policy provides only healthy options to children by ensuring that certain food and beverages are not sold in school premises, therefore making the healthy choice the easy choice. According to the law, school premises with dining halls offering school lunch to students (by some specific private schools in Greece) should follow a weekly menu based on the Mediterranean diet pyramid (Ministry of Health, 1999). Portion sizes of foods and drinks sold in canteens and/or dining halls, are mandatory based on Greek dietary guidelines. Apart from food-based standards, energy- and nutrient-based standards regarding fat, sodium and sugars content of foods and drinks are also included. Implementation is regularly evaluated by Regional Public Health Services.

For detailed guidance see the EC Joint Research Centre Technical Report on Public Procurement of Food (2017)
ACTION AREA 3 – RESTRICT MARKETING AND ADVERTISING TO CHILDREN

Recommendations from the EU Action Plan

Ensure that schools and childcare facilities are free from marketing of less healthy food and drink options, and during any sporting and cultural activities that are held on these premises ● Do not allow any sponsorship by food and drink companies in schools ● Ensure that kindergartens and schools and other places for children are protected environments and free from marketing of less healthy foods and drinks

“Industry self-regulation of food advertising to children is failing across Europe.”

StanMark Project, International Association for the Study of Obesity, 2012

Case study from JANPA: Legislation on marketing to children in child welfare and education premises in Hungary

Hungary prohibits all advertising directed at children under 18 years in child welfare and child protection institutions, kindergartens, elementary schools and their dormitories based on Section 8 of Act XLVIII on Basic Requirements and Certain Restrictions of Commercial Advertising Activities (2008). Advertisements promoting a “healthy lifestyle” are exempt from the ban. The term “healthy lifestyle” is not defined by Section 8, and school boards determine on a case-by-case basis if an advertisement complies with this exception, in addition to adhering to national regulatory mechanisms and EU regulations on health claims. Health promotion and prevention activities in schools may only involve external organizations and consultants who are recommended by the National Institute for Health Development according to Section 128(7) of the Ministerial Decree 20/2012 (VIII. 31.) on the Operation of Public Education Institutions and the Use of Names of Public Education Institutions. The same decree specifies that the products which are subject to the Public Health Product Tax (i.e. products that carry proven health risks when consumed, ready-to-eat foods including soft drinks, energy drinks, pre-packaged sugar-sweetened products) cannot be sold on school premises and on events organized for children.
What is “less healthy”? The Nutrient Profile Model of the World Health Organization Regional Office for Europe is a tool to classify food and drink products that contain excess sugar, salt, and fat. It has been specifically designed for the purpose of restricting the marketing of foods to children. The nutrients and criteria were defined by a series of consultations with Member States.

Ideas from JANPA

Although ‘Commercial marketing of foods’ was perceived as the major barrier for childhood obesity prevention in the WP6 web-based survey completed by 187 respondents from 12 countries (see Annex 2), none of the selected Good Practices addressed this aspect. This finding should have implications for the future work in childhood obesity prevention.

Common types of marketing in kindergartens and schools*

PRODUCT AND BRAND ADVERTISING: typical advertisement can be branded vending machines or displays at school canteens

SPONSORSHIP: due to increased pressure on school budgets, sponsorships are often seen as an alternative way to gather resources to diversify school activities. Industry often sponsors sports events, school programmes or educational materials e.g. notebooks and pens

PROMOTION: typical promotion in educational premises can be done through free samples or vouchers targeting either students or the parents

*Adapted from WHO WPR. Be smart, drink water (2016)
**Recommendations from the EU Action Plan**

Educate children about nutrition and healthy lifestyle ● Introduce awareness raising activities e.g. school gardens or food preparing kitchens ● Introduce nutritional training to all school staff ● Integrate nutrition education aspects into the curriculum ● Introduce practical cooking classes ● Order mandatory nutritional education to school kitchen staff (license to prepare school food) ● Create a healthy school environment that promotes healthy eating and sufficient physical activity

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**“Education materials should suit a variety of literacy levels and offer a variety of teaching methods.”**

*Expert from Ireland*

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**Example from JANPA: Age-appropriate messages**

Photographic atlas from Target snack (Italy) - foods are compared to everyday objects with standard volume (e.g. tennis ball, deck of cards) to give children and teachers the skills for serving the proper portion for snack.
“What is helpful in schools, in general, is the implementation in regular lessons. When it is not something additional, what needs to be remembered, but when it can be adapted to the regular procedure of a lesson.”

Expert from Germany

Programmes and policies from JANPA (for more details visit www.janpa-toolbox.eu)

- France – PRALIMAP
- Germany – IDEFICS
- Germany – KLASSE2000
- Germany – Kindergartens focusing on physical activity and nutrition (Anerkannter bewegungskindergarten mit dem pluspunkt ernährung)
- Greece – E.Y.Z.H.N – National action for children’s health
- Greece – The Hellenic national action plan for the assessment, prevention and treatment of childhood obesity
- Ireland – Eatright
- Ireland – Little Bites
- Ireland – Healthy Lunchboxes
- Italy – School Fruit Scheme: Teachers’ Training
- Italy – School Fruit Scheme: Accompanying Measures “Fruit Olympic Games” and “School in the Field”

Case study from JANPA: Complex nutrition education programme in Poland

This programme aims at supporting the proper development of children and adolescents through healthy nutrition, promoting physical activity, improving the quality of food served at child care and educational facilities and raising awareness of parents about the importance of healthy diet in children. During the programme, nutrition education has been provided for children and parents (nearly 8,000 persons have attended the nutrition workshops carried out by employees of the State Sanitary Inspection and nourishment specialists) and also for kitchen staff in nurseries, kindergartens and schools. In order to implement the programme, a manual was developed for the trainers. The implementation of this complex educational programme involving children, parents and the most important people responsible for nourishment in educational facilities, resulted in an improvement in the quality of meals served in these facilities.
• Italy – OKKIO ALLE 3 A (Nutrition, attitudes to healthy behaviours and physical activity)
• Italy – “Peer educator mothers” promoting health
• Italy – Target snack
• Luxembourg – Healthy and balanced nutrition for and with children
• Poland – Nutrition for health ("Zywienie na wagę zdrowia")
• Slovakia – National Health Promotion Programme (NPPZ)
• Slovenia – Eat healthy, exercise constantly
• Slovenia – Together for better health of children and adults (‘Skupaj za boljše zdravje otrok in odraslih’)
• Spain – Holistic Health Programme (‘SI!’)
ACTION AREA 5 – OVERWEIGHT MANAGEMENT, CARE FOR OVERWEIGHT CHILDREN AND PREVENT THEM MAKING THE TRANSITION TO OBESITY

Recommendations from the EU Action Plan

Adopt and apply evidence based guidelines on overweight and obesity screening and management for children including families ● Ensure opportunistic screening and early intervention at general practitioners (GPs), pediatricians, other health professionals or school nurses ● Promote healthy eating and physical activity regardless of body size and appearance ● Avoid stigmatization

How can weight stigma be reduced in schools? Children who are overweight are often targets of stigma and may be especially vulnerable to the consequences. Negative attitudes towards obese youth develop in children as young as three years old. Peers are common performers of weight-related bullying and teasing and derogatory names, and school is a frequent venue where stigma occurs. Some strategies to reduce weight stigma within school setting are:

- increase education and awareness among teachers and other school staff of the serious adverse consequences of weight stigma,
- implement a zero-tolerance bullying policy which includes weight-based bullying,
- educate children about the complex causes of obesity and ensure that students have an understanding that causes come mainly from external factors and that individuals cannot, with the pressure of the environment, ensure a healthy behavior.

Ideas from JANPA

To set up realistic targets for the families, assess the lifestyle as well as readiness to change of the child and parents in parallel (Estonia) ● Use social media for feedback and peer support (Estonia, France) ● Notify overweight and obese students both orally and in writing together with their parents and GPs (France) ● Combine school-based screening with school-based care (France) ● Initiate cooperation with insurance companies to cover the costs of preventive measures (Slovakia)

Example from a JANPA country: IRELAND

The Irish Government is pilot-testing a school programme to measure weight and height of children periodically and to give feedback to overweight children and their parents with leaflets and online resources to promote healthy lifestyle practices. Obese children are invited to a supervised lifestyle programme (personal communication).

7 http://www.euro.who.int/__data/assets/pdf_file/0017/351026/WeightBias.pdf
8 www.obesity.org
PRALIMAP trial

Case study from JANPA: A school-based care management for adolescents with low socio-economic status in France

PRALIMAP-INES aimed to design an intervention to tackle social inequalities in overweight and obese adolescents aged 13-18 years involving more than 10,000 adolescents in 35 secondary schools. To identify the best option, standard care was assessed vs. a strengthen care management. In the standard care, five 2-hour sessions were scheduled around themes of healthy eating and physical activity led by a multi-disciplinary team belonged to a specialized health network. Sessions were set up in each school with upstream planning to account for the specificities of schools. School nurse was invited to contribute to the sessions. For the strengthened care management proposed to less advanced adolescents, the following activities were offered additionally: 1) phone call to parents explaining the initiative; 2) multi-disciplinary team meetings involving PRALIMAP-INES professionals, school medical doctors and nurses, dieticians, psychologists, physical activity practitioners, specialized obesity professionals and if available, the adolescent's GP; 3) motivational interviews; 4) sporting good and school sport coupon (up to 40 Euro); 5) local physical activity guide leaflet; 6) food workshops (2 times 1.5 hours supervised by dietician); 7) peer health promotion and peer facilitators; 8) social media activities.

“School nurses’ responsibilities are vital but underutilized in delivering school-based obesity prevention.”

Programmes and policies from JANPA (for more details visit www.janpa-toolbox.eu)

- Estonia – Personalized approach in child obesity management
- France – PRALIMAP-INES
- France – PRALIMAP
**Recommendations from the EU Action Plan**

Increase childhood screening and surveillance, in particular by identifying overweight and obese children ● Define indicators for school nutrition ● Establish annual monitoring of objectively measured physical fitness and physical activity of students as a part of sports curricula ● Improve monitoring and reporting of initiatives

**Ideas from JANPA**

Aim to *measure* weight and height instead of self-reporting as it can lead to numerous overweight children being missed (France) ● Computer-assisted questionnaire completion is easier than the paper version (France) ● Assist data collection procedure with trained staff if the questionnaire is targeting children (France) ● Add waist circumference measurements and medical examination to BMI measurements to avoid misclassification (France) ● Provide annual feedback about the results to parents (Greece) ● Regularly assess the quality of school meals preferable by using laboratory measurements (Hungary, Poland)

**How is obesity in children measured?**

Assessing obesity in children is different and more complex than in adults, because children grow and develop at different paces at different ages. To assess a child’s weight category, his/her body mass index (BMI) is compared with different ‘BMI-for-age' charts (i.e. using WHO, IOTF, CDC or national growth charts).

**Programmes and policies from JANPA** *(for more details visit www.janpa-toolbox.eu)*

- France – PRALIMAP
- Greece – E.Y.Z.H.N – National action for children’s health
- Poland – Nutrition for health (“Zywienie na wagę zdrowia”)

**Example from a JANPA country: SLOVENIA**

SLOfit, running since 1982, is a national school-based surveillance system assessing the physical and motor development of children. All schools in the country are included from primary schools to universities. Measurements (3 anthropometric and 8 fitness tests) follow a standardized protocol and carried out in every April by PE teachers. In 2016, My SLOfit web application was developed. Individual reports are accessible for children, parents and school physicians.
Case study from JANPA: The school health system in Hungary

In Hungary, each school has an assigned school health team that consists of a medical doctor and a specialized school nurse. This system is unique to Hungary, as community and school nurses provide healthcare and health education for children and their parents from the beginning of pregnancy through the end of school age. The foundation of the service dates to the early 20th century (1915). The ministerial decree 26/1997 (IX.3.) defines the roles and responsibilities of the school nurses, which includes school-based screenings carried out by a standard protocol from the first grade to 11th grade biannually. As a result, weight and height measurements are available from these ages and by law the school nurses have reporting requirements from the so-called index classes (grades 5, 9 and 11). The big advantage of this system is the wealth of data that has been accumulated and available since almost a century ago. The weaknesses of the system are the measuring equipment which varies from school to school and the not too strictly standardized weight and height measurements, which add some uncertainty to data quality. Other shortcoming of the system is the aggregated data reporting (i.e. data are reported at school level). Overall with some quality assurance steps and changes in the reporting requirements this screening system would provide excellent opportunity for screening and early intervention in Hungary.

Case study from JANPA: Surveillance system in Greece

Greece participates in the WHO European Childhood Obesity Surveillance Initiative (COSI) since 2009. The program is under the auspices of the Ministry of Health and implemented by Alexander Technological Educational Institute (ATEITH), Institute of Thessaloniki and the Hellenic Association for the study of Obesity (HMSO). A nationally representative sample has been measured and studied on the basis of the common WHO protocol and approach, followed by all participating members, during the different rounds of COSI. COSI increases childhood screening and surveillance in Greece, by identifying overweight children and monitoring school nutrition environment. Members of the local coordination team are experienced scientists, among which very well-trained dietitians who perform anthropometric measurements on the basis of the common protocol and show good collaboration with the schools in their region. School personnel gives information about school premises, school nutrition environment, availability of indoor gyms, physical education lessons curriculum, organization of sport activities outside the school hours and others. Therefore, COSI data can be used as a source to develop a national nutrition policy for childhood obesity.
RECOMMENDATIONS ON THE IMPLEMENTATION OF POLICY OPTIONS FOR ADDRESSING CHILDHOOD OBESITY IN KINDERGARTENS AND SCHOOLS

The following guiding principles for how to create healthy environment in kindergartens and schools are based on the knowledge and experience gathered during the work in JANPA WP6, particularly during the web-based survey and semi-structured interviews with decision makers in the partner countries.

A) USE AN INTEGRATED APPROACH

The EU Action Plan is calling Member States to work on integrated approaches with a specific focus on kindergarten and school settings. In line with this request, in WP6 the work was focused on collecting and analysing integrated approaches. The term integrated approach has a wide range of meanings. In WP6 we focused on four dimensions and defined integrated approaches as approaches which are fulfilling one of the following criteria: 1) Multi-component intervention: the approach is addressing multiple aspects of childhood obesity; 2) Inclusive approach: the approach is involving all stakeholders of a particular setting; 3) Intersectoral approach: the approach is including actors from different sectors; or 4) Multi-level intervention: the approach is a multi-level measure (e.g. intervene in parallel at individual and environmental level). However, at the end, multi-level actions received much less attention than the other three aspects.

In accordance with the EU Action Plan, the various stakeholders reached by JANPA WP6 emphasized the importance of integrated approaches. Based on the analysis of the web-based survey conducted by JANPA WP6, the potentials of integrated approaches were perceived high, especially in fighting against social inequalities as they “offer access to physical activity and healthy food in school / kindergarten environment, even if parents can’t afford it at home”. Qualitative interviews carried out by JANPA WP6 reveal that for example, in Hungary, “in recent years the public health approach has gained ground in face of the government and integrated approaches have become more dominant” (government structure Ministry of Human Capacities is an example in this regard). “The Public Catering Act, integrated measures for promoting physical activity and compulsory kindergarten from the

WE WOULD LIKE TO THANK FOR THE INTERVIEWEES FOR THEIR VALUABLE INPUTS

- Poland: respondents from the Ministry of Health and the Ministry of Sport and Tourism
- Hungary: respondents from the Ministry of Human Capacities
- Greece: respondents from the Ministry of Education, the Ministry of Health and Nutrition and the Ministry of Sports and Physical Activity
- Germany: respondents from two different Federal Ministries and a State Ministry
- Romania: respondents from the National Institute of Public Health, the National Institute for Sport Research, the Ministry of Education and the Romanian Nutrition, Diabetes and Metabolic Diseases Federation
- EU-Level: respondents from a European Teacher Organization, a European Parents Association and a European Alliance for Childhood
The determinants of obesity are complex and varied. It is important to recognize that no single intervention is likely to prevent childhood obesity\(^9\). To realize the greatest impact, actions need to be undertaken in multiple settings in parallel, incorporate a variety of approaches and involve a wide range of stakeholders. For instance, in the frame of the ‘Bulgarian National Programme for the Prevention of NCDs’ several different approaches (e.g. awareness raising campaigns, education, training workshops, discussion forums, legislation) in different areas (e.g. reformulation, marketing, public catering) targeting different actors (e.g. food manufacturers, food retailers, general public, children, school staff) were carried out in parallel.

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**Success story from JANPA: SPAIN**

Program SI! is a comprehensive kindergarten-based intervention targeting children aged 3-5 years using their own environment (school, teachers, and families) as an integrated system for intervention. It entails four lifestyle-related components: diet, physical activity, knowledge of the human body and management of emotions. The program is based on three domains of behavior change: 1) Knowledge, 2) Attitudes, and 3) Habits, and has four targets: children, parents, teachers, and the school environment. The intervention was embedded in the curriculum and delivered by kindergarten teachers. In each school, a teacher volunteered as the intervention coordinator and received regional, government-certified training in the SI! Program contents and strategies (an expert-led 30-h course). All preschool teachers had access to an online repository of the intervention resources and they also interacted via the intervention website to share and discuss activities. Over the academic year, teachers delivered the intervention through classroom materials for a minimum of 20 h for the diet, physical activity, and human body components and a minimum of 10 h for the emotion management component. Additionally, the intervention included activities for the family over the weekends, as well as strategies involving the whole school environment, such as an annual health fair.

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\(^9\) [http://www.who.int/dietphysicalactivity/childhood/WHO_new_childhoodobesity_PREVENTION_27nov_HR_PRINT_OK.pdf](http://www.who.int/dietphysicalactivity/childhood/WHO_new_childhoodobesity_PREVENTION_27nov_HR_PRINT_OK.pdf)
2) Inclusive approach

All JANPA interviewees considered that communication and collaboration between all actors in the society brings benefits in the effort for childhood obesity prevention. Therefore, a wide range of stakeholders should be involved in any proposal from the beginning and throughout the process (“more cooperation between local authorities, schools, GPs, meal providers and sport clubs is needed”; “teachers are the very core when the aim is changing knowledge and behaviours of children, and children are the best way to reach the family. Furthermore, all the public institutions of the area, not just the education

“Things work better, when it’s not going top-down, when people are involved and have an ownership.”

Expert at EU level

Case study from JANPA: Eat better. Move more. Health-promoting Regions in Germany

The aim of this intervention in Germany was to test in local networks, by which measures and which collaborations the development of obesity in children can be permanently prevented. From a broad coalition of stakeholders, it is expected that resources are bundled up, individual strengths of the single partners are introduced and innovative developments are allowed by synergies. 24 model projects were selected and evaluated, all of them were local unions of the most different stakeholders. To give an impression of a possible approach, one of the 24 model projects is presented more detailed. The model project took place in a district of Nuremberg where 45% of the population had a migration background, the unemployment rate was around 17% and the prevalence of childhood obesity was above average. A network of social facilities, associations, schools and local authorities developed a health promotion programme including all relevant settings: family, child care, school and leisure time. A regional known association, with experience in project management and network coordination, started and coordinated the network and the activities. Besides offering activities in the district (e.g. dance and swim courses, circus gymnastics, cooking classes for parents), the network was also involved in political decision-making processes. Results of this cooperation were events like a “car-free day”, sport lessons at school offered by a local sports club in cooperation with students and a healthy breakfast at elementary school organized by adolescents. Recommendations for other interventions based on their experience are that all stakeholders in the network should have clearly recognizable benefit of their collaboration and should have a common strategy. As regular meetings, continuous exchange of information is a benefit for networks, as is having fixed contact persons. With the most important cooperation partner of this model project, the elementary school, there was a high fluctuation of the teachers, also the school management changed. The organisation of advanced trainings was thereby complicated.
ones, have to be involved, to improve the efficacy of the messages (e.g. health and agriculture council members).” This approach could include a) asking children and parents about their opinion during planning open public spaces such as parks or playgrounds as the Italian program did for playground marking, b) allowing students to provide input on new options in canteen selection by conducting taste tests as often can be seen as an accompanying measure of School Fruit Scheme, or c) asking for volunteers (e.g. students or parents) to help design artwork promoting fruits and vegetables that can be painted on the cafeteria walls. Other example is a French programme that aimed to improve the quality of food supply in schools and designed activities to involve and sensitize adolescents, parents, teachers and school head masters during the whole work. Engagement helped participants to increase ownership towards the project. In another German project, as a first step, focus group interviews were conducted to learn about the target groups’ needs and barriers to a healthy lifestyle which increased the understanding about the drivers and obstacles towards healthier behaviours. Continuous communication and bi-directional feedback (i.e. from the project team to the participants and from the participants to the team) are very important during the implementation phase (“the most important factor is constant co-operation with the children and the parents and regular positive feedback to the participants”). Informing participating schools about the programme and implementing necessary trainings for the school staff at the beginning of the school year are also very important (“to be effectively integrated in the school programs, every new education proposal should be inserted in the school programs, which are made at the beginning of the academic year and even before. Nothing has to be left without scheduling and programming”). Another message extracted from the JANPA qualitative interviews is making sure that children, parents and the school staffs know about the changes in the environment or in the food supply and about the rationale for the change. Messages have to be coherent and consistent.

3) Intersectoral collaboration

Overweight is determined by numerous social, economic, environmental, political, cultural and commercial factors. Therefore, collaboration and coordinated work with different sectors are required (“a national program with collaboration of all Ministries is recommended” “the complexity of the problem (of childhood obesity) causes a split up of responsibilities between sectors (health, nutrition, education) and levels (federal, state); this can be seen as a barrier but also as an advantage as resources and competences from

“Work together with decision makers from early stages for identifying national priorities in each country and try to translate them into policies and programs.”

Expert from Romania
different sectors can be used for childhood obesity prevention”). Ideally, countries should establish a formal mechanism for intersectoral cooperation to facilitate joint planning and budgeting, even if it is difficult to find shared objectives because of differences in drivers (“There is a resistance from food producers and Ministry of Agriculture in some cases”). A JANPA WP6 interviewee highlighted “the importance of institutionalizing efforts and of having clear responsibilities in cross-sector collaborations”, others recommend strengthening governance via “a national program with collaboration of all Ministries”. A cross-sectoral working group, with strong governance, can ensure coherence and consistent communication to the general public. At the same time, “Network takes time and needs someone who really cares.”

Expert from Germany

Case study from JANPA: Structured network of pediatricians and teachers in Italy

“Since 1998 our team has developed and tested some educational tools about healthy snacks which won, in 2001, the prize “Snacks and Health” established by the Italian Association of Dietetics. However, these programs, for several years, haven’t shown any impact on large scale since only small communities have been involved. At that time in our territory a population-based strategy was impossible to set due to the lack of a structured network of cooperation between local pediatricians and schools. This network has been progressively arranged since 2003 and reinforced since 2008, thanks to the implementation of “Okkio alla salute”, a national surveillance system promoted by the Italian Department of Public Health and by the Italian Department of Public Instruction. To reach our primary target group (i.e. primary school children), we selected as intermediate target the local pediatricians and primary school teachers because they are both in the best position to ensure the effective reach of messages targeted to children in primary schools (either directly or through the parents’ mediation). The fact that the guides used by the pediatricians and the tools for the teachers contained the same messages about snacks was another facilitator for the project. In this way, children and families received the same information from schools and health workers. So there was a synergy and a mutual reinforcement of the messages. Since 2008, we have trained about half of the pediatricians working in our territory (their participation in the project was voluntary) and all the primary school teachers randomly recruited by the survey “Okkio alla salute”. So, thanks to 4 rounds of the surveillance, we have reached, since 2008, more than half of the primary schools (77 out of 150) in our territory. Since the school attendance is mandatory between the age of 6-11 years, and the trained pediatricians and teachers had a wide geographical distribution, this choice promoted not only the wide spreading of messages but also the reduction of inequalities.”
time, effective intersectoral collaboration and governance are the result of a learning process: “intersectoral work and cooperation requires motivation and skills that can be developed.” Ministries of Health should play the leading role and each sector should have clear roles and responsibilities in cross-sector collaborations. During the interviews the importance of legislation was also acknowledged “the presence of good legislation is the key for ensuring healthy nutrition for the children”, and that the topic of childhood obesity prevention should constantly being present on the political agenda for supporting ongoing efforts in this field.

“At the beginning it might need more resources to involve all actors. But for the implementation it is better because everyone feels involved and supports the activities.”

Expert at EU level
B) ENSURE SUSTAINABILITY

Sustainability starts with the beginning of program planning and as such, should not be conceived as a final phase of development\textsuperscript{10}. Although there are factors that affect sustainability but cannot be influenced such as the financial or political climate, several models have been developed to identify factors that are modifiable and pathways that are important to consider at program's inception. The aspect of sustainability was given special attention throughout the JANPA project. This attitude is reflected in setting up the good practice criteria that defined the framework for the entire work package. Applicability to the context (i.e. govern-

“Ongoing promotion is needed to keep initiatives live.”

Expert from Ireland

“To maintain the achievements and motivation of staff, reinforcement actions need to be implemented.”

Expert from Italy

Case study from JANPA: A school-based sport competition in Romania that is running since 2005

The National Schools Sport Olympiad (ONSS) is a sport competition coordinated by the Ministry of Education, taking place each school year in the Romanian schools. The program was initiated in 2005 and it is still ongoing. The competitions on different sport branches are organized in each school year in the Romanian high-schools with the contribution of the Physical Education teachers. For the most part (the school, local, and regional – sometimes also the national phases of) the competitions are organized within the sport halls and outdoor sport facilities of the school units. The program implementation is based on the stable structure of the Romanian educational system (respectively the top-down, well established communication channels from The Ministry of Education -> County School Inspectorates -> Schools) and by using the available infrastructure and equipment in each education unit. The Physical Education teachers that have good results in the sport competitions within ONSS are being rewarded with a certain number of points, in accordance with the Romanian educational system reward scheme, and can apply for a merit pay. This is an important part of stimulating the program implementers to be engaged in the ONSS organization and team and individual students’ coaching for competitions. The ONSS sustainability is based on its implementation within the national educational system and on its use of the already schools’ available human and material resources.

\textsuperscript{10} \text{www.who.int/evidence/resources/country_reports/RRSPHprograms.pdf}
“Choosing adolescents can ensure long-term effectiveness because the adolescence period corresponds to when the future adult develops responsibility for health-related behaviours and attitudes that affect their future health.”

Expert from France

“To realize sustainable impact, interventions should aim for a decisive shift in the current system.”

Expert from Germany

ance structures, cultural constructs, economic and social situations and geographical settings) is one of the factors that need to be studied when planning an intervention. One of the favourable findings of WP6 was that in almost all cases cultural, political and social context were evaluated and taken into account in the selected good practices. Interventions should ideally be integrated into existing systems in order to improve cost-efficiency, and as a result sustainability. This suggestion was one of the 9 criteria chosen by WP6 experts as ‘core’ to consider a programme as JANPA Good Practice. Concerning the pathways to achieve sustainable changes, a possible mechanism to reach program sustainability is network or coalition formation (“sustainability of our project is guaranteed by the long-lasting cooperation of the organizations implementing the project”). Another option is the diffusion of a certain intervention to a policy. (e.g. integrated into organizational routines or into an existing policy or introduce a new policy). Finally, if an intervention would initiate significant changes in the environment or in the infrastructures it can also have a potential to reach long-lasting effects (“the most important barrier for childhood obesity prevention is population’s mentality - when the population will perceive a need and start pressing the governors to allocate funds things might change. Now the political interest is very low, because nobody “screams”, nobody says: “we need conditions” for health, sport, being active”).

C) INCREASE CAPACITY FOR TRANSFERABILITY AND REPRODUCIBILITY

Transferability refers to the degree to which an initiative can be transferred to other contexts achieving the same effectiveness and outcomes, while reproducibility primarily stands for the repetition at the same place with the same target group. High transferability of an initiative can facilitate geographical spread of a good practice within and between countries. Of course it is not really possible (and usually nobody aims for) to replicate exactly the same intervention in another context with exactly the same success. Contextual and personal factors that play a role when transferring an intervention to another place are resources, skills and capacity to implement the intervention (“training of the staff involved in the imple-

“The concept should remain flexible for implementation and financing in order to be adaptable to the local context.”

Expert from Germany

“Standardization of procedures and tools may ensure the reproducibility of the experience.”

Expert from Italy

“To build trust in a new region and to establish a new measure, a constant contact person is crucial on the ground.”

Expert from Germany

mention of the activities is essential”), the characteristics of the target population including cultural practices and level of literacy or access of the target population to the requisite facilities\(^1\). However, an important element that can increase programmes’ capacity for transferability and reproducibility is the accurate and detailed documentation of the intervention together with the context. This aspect is reflected among the JANPA Good Practice criteria (see Annex 1), but also mentioned by the WP6 interviewees and appeared in most of the collected interventions. This is the reason why the collected interventions are presented together with a detailed description of the country contexts. Nevertheless, there are factors that are usually neither detected nor documented but may have significant impact on the effectiveness of a particular intervention. These are, for instance, the personality and experience of the programme leader or engagement of the staff (“One of the main facilitators for us was the committed and skilled people in the team, meanwhile main barriers were the low motivation of some parents and children for changing unhealthy practices and higher priority of other hobbies of the children which led to dropout”) or motivation of the participants (“motivational interviews may be also a crucial component to include in the children’s initial health evaluations, as it can be used to assess readiness for change”). Obviously, these factors cannot be standardized but a thorough process evaluation can help at least to identify and analyse these elements and to get closer to the understanding of their impact. Finally, “cultural aspects/attitudes should be understood and addressed simultaneously with other measures for realizing a change”.
D) CONSIDER DIMENSIONS AROUND EQUITY

Health inequalities exist among children throughout the European Region, both within and between countries. The socio-economic situation of a family has strong direct and indirect effects on the likelihood of obesity\(^\text{12}\). Therefore, during planning, implementing and evaluating an action, equitable access must be ensured, with particular attention to disadvantaged groups\(^\text{13}\). To approach a hard-to-reach group properly, it is essential to understand its needs and barriers. This was reflected in the design of the Irish initiative ‘Eatright’ that targeted early school leavers. During the needs assessment, low literacy, previous poor engagement with traditional education resources and a shortage of materials tailored to the demand of these young people were identi-

Success story from JANPA: ITALY

The “Peer educator mothers promoting health” program, running since 2013, aims at empowering families with low socio-economic status (SES) to reduce the prevalence of obesity in children. A group of mothers with low SES has been involved in analyzing main determinants of childhood obesity and main barriers in health promotion to children. These mothers transfer their skills to other mothers (peer educator mothers) through empower them about health promotion themes: healthy diet (e.g. fruit and vegetable consumption, reduction of soft drinks, quality snacks, regular breakfast), promotion of physical activity and reduction of sedentary behaviours. The process actively and systematically involves teachers as well as other school staff and staffs of municipalities (i.e. mayor, city councilor).

“For minority groups, we need free-of-charge and low threshold services if possible directly at the place of residence.”

Expert from Germany

\(^\text{12}\) https://www.oecd.org/els/health-systems/46044572.pdf

\(^\text{13}\) Low threshold means a customer-oriented attitude and bringing services close to people. Cooperation with vulnerable groups and taking their opinions and needs into account is essential when developing low threshold services.
Case study from JANPA: Kindergartens focusing on physical activity and nutrition in Germany

This intervention was designed for kindergartens in North Rhine-Westphalia (Germany) with a special focus on kindergartens with a high rate of children who are socially disadvantaged and are migrants. Kindergartens were selected to take part in the intervention based on the percentage of families having low income and the percentage of families with a migration background. The intervention consists of trainings in physical activity and nutrition, which are provided to the kindergarten teachers. For the implementation of an intervention, media and individual counselling are provided as well. Support in the organization of events to inform the parents is offered and a network for all participating institutions is established. The participating kindergartens get a certificate. Additionally, parents with low income can get a reduction or remission of the kindergarten fee.

paid or partially subsidised schemes also operate through the mechanism of overcoming barriers to access for children who have inadequate availability at home14 (“program poses significant reduction of financial burden on parents - not only of majority population but also in marginalized population groups”). In situations with limited resources, consideration may thus be to target and intensify the scheme to meet the needs of those groups most effectively (e.g. by focusing on schools with low socioeconomic areas).

E) INCLUDE A ROBUST PROCESS AND IMPACT EVALUATION

One of the main findings of WP6 is that although there are plenty of interventions targeting childhood obesity only a minority of them have been rigorously evaluated. This statement is particularly valid for policies. Assessment of the impact of a particular measure should be planned at an early phase, as it will require the collection, assembly and interpretation of baseline data. Evaluation of both the outcome and the process helps to demonstrate effectiveness and offers insights for improvement15. Regarding the evaluation of the process, it is very useful to have focus group interviews with the target group (e.g. the above-mentioned French project that aimed to improve food supply in high schools carried out both individu-

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15 A possible supporting framework can be the RE-AIM approach (Reach, Efficacy, Adoption, Implementation, and Maintenance) that is on the increase to use in assessing the impact of health promotion initiatives.
al and group interviews with adolescents to study their opinion about the changes, their satisfaction and to understand facilitators and barriers of such a project. It would be also important to plan adequate financial and human resources for evaluation in advance.

Besides, thorough risk assessment at the beginning and cost-effectiveness analysis at the end should be part of the work. Given the limited resources in most countries, it is crucial to distinguish between effective policies and interventions and those initiatives that should be questioned as their efficiency is doubtful. In spite of this, less than half of the collected interventions have been evaluated in the year following their completion, and hardly some have been costed. Moreover, understanding the mechanisms and identifying factors that make an intervention or policy to run successfully is essential. Even though a properly planned pilot phase can help to assess the feasibility and understand the context in a small-scale, pilot study was performed in less than half of the selected JANPA WP6 programmes. Without rigorous evaluation, it is not possible to identify those initiatives that deserve to be shared and up-scaled.

“Linking a program to the national surveillance system can help to evaluate the effectiveness of an action without additional financial investment.”

Expert from Italy
Within the frame of national or regional policies, and after a thorough analysis of the legislative landscape and capacities, and adaptation to the context, the following steps should be considered:

**What can national governments do?**

- Establish clear standards based on nutrition guidelines for foods and drinks that can be provided, sold or marketed (with a special attention for certain brands) in kindergartens and schools and at school events
- Enact legislation to
  - increase the number of mandatory hours for physical education
  - restrict less healthy food and beverage marketing to children
  - integrate mandatory hours for nutrition education into the curriculum
  - ban the provision and sale of sugary drinks in school and at school events
  - monitor weight status of students regularly and ensure screening for overweight and obesity
- Evaluate the impact of these measures periodically

**What can municipal governments do?**

- Introduce zoning restrictions of cars close to educational premises to facilitate active commuting
- Ban food and beverage marketing to children at municipal properties, such as kindergartens, schools, public transport, playgrounds and parks
- Run public awareness campaigns and organize public events to improve knowledge and skills among parents and caregivers about healthy lifestyle
- Ensure that health and nutrition aspects are taken into account in food procurement specifications
- Launch tender for
  - creating / improving facilities for physical activity in kindergartens and schools
  - installation of water fountains in kindergartens and schools
- Provide targeted counselling for overweight and obese children and for their parents

**What can schools do?**

- Review contracts with food and beverage companies to ensure the healthfulness of food and drink options sold and/or provided in schools including, when they are not banned, the numbers, content and placement of vending machines
- Introduce active breaks
- Ensure that safe drinking water is accessible at all times in school and at school events
- In the absence of national or municipal regulation, establish own school policies
- Provide nutrition training to teachers and to school kitchen staff
- Open the schools to parents in order to make them aware of the pedagogy and be active in the process
Annex 1

SELF-ASSESSMENT TOOL OF GOOD PRACTICES FOR CHILDHOOD OBESITY PREVENTION PROGRAMS IN KINDERGARTENS AND SCHOOLS

The aim of this self-assessment tool is to support programme planners in designing effective and sustainable interventions in kindergartens and schools for childhood obesity prevention. These checklists help to identify gaps during the planning phase that, if addressed, could improve the intervention. Ideally this self-assessment tool is used before the program is initiated but ongoing programs can be assessed as well.

Start with the Core criteria checklist. Tick the criteria that your program fulfills. If it meets all nine, then the programme is a good practice by JANPA standards! If you are in the planning phase aim to meet the first seven criteria. There are criteria related to the intervention characteristics, implementation and evaluation of the programme. Try to meet as many as possible of these criteria too.

Checklist for Good Practice Core Criteria

<table>
<thead>
<tr>
<th>1. Programme characteristics</th>
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<tbody>
<tr>
<td>Are the objectives of the programme SMART and clear (Specific, Measurable, Achievable, Realistic and Time-bound)? □</td>
</tr>
<tr>
<td>Is the target group clearly defined (including age, gender and socio-economic status)? □</td>
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<tr>
<td>Is the approach you use proven to be successful and effective in practice (has had a positive impact on individuals and/or communities)? □</td>
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<tr>
<th>2. Implementation</th>
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<tbody>
<tr>
<td>Is the target group aimed to be empowered by enhancing their knowledge, skills and competences so that they can make decisions independently? □</td>
</tr>
<tr>
<td>Are the activities using/integrating existing structures? □</td>
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<tr>
<td>Is there a broad support for the intervention amongst the intended target populations? □</td>
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<th>3. Monitoring and evaluation</th>
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<tbody>
<tr>
<td>Are the financial and human resources in place for evaluation? □</td>
</tr>
<tr>
<td>Have the planned activities been performed and have most of the objectives been reached? □</td>
</tr>
<tr>
<td>Is the outcome or impact evaluation showed significant contribution to the target behaviour or its determinants? □</td>
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### Good Practice Criteria Category 1 – Intervention Characteristics

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Is the concept evidence-based?</td>
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<tr>
<td>Were the cultural, political and social contexts (as well as barriers) evaluated and taken into account?</td>
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<tr>
<td>Have needs assessment and/or community analysis of the targeted group been performed?</td>
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<tr>
<td>Does it have clearly defined aim, target audience, targeted behaviour, approach and intervention that is available in a manual or in a protocol?</td>
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<td>Are the concept and/or the methodology innovative?</td>
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<td>Does the programme involve professionals from different sectors (multi-sectorial)?</td>
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<td>Does it involve family (parents participating in programmes for children)?</td>
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<tr>
<td>Does it have a community component?</td>
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<tr>
<td>Does the programme focus on vulnerable groups (efforts are made to facilitate vulnerable group's access to relevant services - &quot;low threshold&quot; approach)?</td>
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<tr>
<td>Is co-creation approach used (end-users are involved in the planning to support a joint sense of ownership)?</td>
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<td>Are ethical, responsibilities, inequalities, gender values respected?</td>
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<tr>
<td>Is the programme transferable (can be easily adopted in another context)?</td>
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<tr>
<td>Is the programme replicable (can be repeated at another time with same conditions)?</td>
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### Good Practice Criteria Category 2 – Implementation

<table>
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<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>Has pilot study been performed?</td>
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<td>Is high population reach achieved?</td>
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<tr>
<td>Are the relevant stakeholders involved?</td>
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<tr>
<td>Did you engage the intermediaries/multipliers to promote the participation of the target population (e.g. Are community doctors or local school teachers made aware of the existence of a community counselling service)?</td>
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<tr>
<td>Does your programme have high popularity and participants’ satisfaction?</td>
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<td>Is the continuation of the project ensured through follow-up funding and human resources?</td>
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<tr>
<td>Question</td>
<td>Yes/No</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>Do the activities of the programme address environmental factors as well (i.e. factors beyond individual control)?</td>
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<td>Is the programme technically feasible (easy to learn and to implement)?</td>
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<tr>
<td>Are there specific actions taken to address the equity dimensions in implementation?</td>
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<tr>
<td>Are there clear structures for management and decision-making established and maintained?</td>
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<tr>
<td>Is the main programme documentation publicly available (at least a web link)?</td>
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<tr>
<td>Does the programme have explicit guidelines for accepting sponsorships and managing conflict of interest)?</td>
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<tr>
<td>Are the relevant stakeholder groups targeted?</td>
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<td>Are the proper methods used?</td>
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**Good Practice Criteria Category 3 – Evaluation**

<table>
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<tr>
<th>Question</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Are the methods for evaluation properly described?</td>
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<tr>
<td>Is there a regular monitoring of results with valid pre-set indicators (using process, output and outcome indicators)?</td>
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<tr>
<td>Are external and/or internal evaluation carried out?</td>
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<tr>
<td>Is a follow-up performed (at least 6–12 months after the intervention)?</td>
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<tr>
<td>Are cost-effectiveness calculations made?</td>
<td></td>
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<tr>
<td>Are the costs clearly stated (indicated per budget items)?</td>
<td></td>
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<tr>
<td>Are the finances feasible (i.e. cost is not a barrier to repeat and/or to transfer)?</td>
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<tr>
<td>Does the monitoring show acceptable participation rates of the intervention or uptake of the policy?</td>
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<tr>
<td>Are the effects specified as not only statistically significant but also relevant in practice?</td>
<td></td>
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<tr>
<td>Are negative consequences and/or risks evaluated (including stigmatization)?</td>
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<tr>
<td>Is the analysis of requirements for eventual scaling up such as foreseen barriers and facilitators (e.g. resources, organizational commitment, etc.) available?</td>
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Annex 2
BARRIERS, FACILITATORS AND CAPACITIES FOR CHILDHOOD OBESITY PREVENTION: RESULTS OF THE WEB-BASED SURVEY AND SEMI-STRUCTURED INTERVIEWS

1. Summary of the results of the semi-structured interviews

To provide guidance for the EU Member states on policy options and initiatives at different levels for facilitating measures that are more effective the WP6 team has conducted 17 semi-structured interviews with national and local level stakeholders in the fields of nutrition, health, sport, and education sectors in Germany, Greece, Hungary, Poland, Romania and at EU-Level to assess existing capacities for childhood obesity prevention (COP) programs.

Childhood obesity is one of the most important health problems and its prevention entails a multi sectoral approach. The experts interviewed considered family, schools and kindergartens including institutional care and public catering as settings with the highest relevance. Communities, the primary care and the media are also mentioned as well as multi-setting interventions. Municipalities, schools and kindergartens including school authorities, ministries, families and parent associations and sport clubs are often named as important actors. Some experts also mentioned credible professional organization like national Association of Dietitians or universities, teachers, internet and social media, doctors, midwives, as well as cooperation between kindergartens/schools and parents or the food industry and consumer associations as being important. The lack of awareness of the relevance of a healthy nutrition and physical activity, improper nutrition habits at home and partially the higher costs of healthy food, the lack of parental support, the lack of personnel and financial resources in childhood obesity prevention as well as food marketing through mass media for unhealthy food are understood as main barriers for childhood obesity prevention. The situation in schools, namely not appropriate school areas where children can play without the supervision of an adult, lack of school staffs support and lack of support for the school staff, is also mentioned. As facilitators, the respondents named restricted food marketing in schools as well as overall regulations on food advertisement. Moreover, programs for schools and kindergartens (including e.g. healthy meal offers, nutritional education, the promotion of physical activity and physical education) and the collaboration between ministries and other actors (i.e. strong networks), like municipalities, families, sport clubs and persons responsible in kindergartens and schools, were also mentioned as facilitators for COP.

Almost all experts see opportunities to increase efforts for childhood obesity prevention. However, there is a need for a better infrastructure and funding to do so in some countries. Means proposed are diverse, but more collaboration between the different actors including networking and coordination was mentioned most often. Examples of integrated approaches – planned or implemented
– for obesity prevention in kindergartens and schools at national level were reported in all countries. It is controversial, whether integrated approaches are preferable to approaches that deal with either physical activity or nutrition, but all expert think that integrated approaches have the potential to fight social inequality in health, as, for example, they offer access to physical activity and healthy food in school/kindergarten environment, even if parents can’t afford it at home.

2. Summary of the results of the web-survey

In order to collect additional information, a web-survey based on a standardized questionnaire was conducted. As with the semi-standardized interviews, questions of the web-survey explored existing facilitators, barriers and capacities for childhood obesity prevention. In total, 187 respondents from 12 nations completed the survey. Respondents were policymakers and stakeholders who are active in the field of childhood obesity prevention. When asked about facilitators for childhood obesity prevention, respondents named a physical activity friendly built environment, parental support for healthy eating and physical activity, and restricted marketing for unhealthy foods in the school setting as being important. Regarding important barriers for childhood obesity prevention, the commercial marketing of unhealthy food, the lack of public funding and resources, and the lack of parental support were named by respondents (see figures on page 42).

Results of the web-survey regarding existing capacities for childhood obesity prevention were insightful. Respondents reported that their respective organizations had specific goals regarding the prevention of childhood obesity, felt obliged to act in this area, and also saw opportunities to increase efforts. However, respondents reported that very few of their organizations had sufficient human and financial resources to do so (see the figure below).

### Capacities for childhood obesity prevention (% of respondents who agree/strongly agree with the items)

- My organisation has specific goals regarding the prevention of childhood obesity: 59.6%
- My organisation feels obliged to be active for the prevention of childhood obesity: 75.4%
- The human resources of my organisation for the prevention of childhood obesity are enough: 21%
- The financial resources of my organisation for the prevention of childhood obesity are enough: 9.4%
- My organisation sees opportunities to increase efforts in childhood obesity prevention: 64.6%

Results of the web-survey highlight the importance of adequate funding and resources to step-up efforts for childhood obesity prevention. Policymakers and stakeholders report being committed to increase these efforts, however, in order to succeed they will most likely need additional resources.
Web-based survey result
Perceived facilitators for childhood obesity prevention

The ___ is a facilitator for childhood obesity prevention in my country (1=strongly disagree, 5=strongly agree)

- Adequate funding and resources: 3.62
- Government regulation and guidance: 3.42
- Parental support: 3.9
- Motivation/support of school staff: 3.74
- Physical activity friendly environments: 3.94
- Subsidies of healthy foods: 3.35
- Availability of healthy food choices: 3.72
- Restricted marketing in the school setting: 3.75

Web-based survey result
Perceived barriers for childhood obesity prevention

The ___ is a barrier for childhood obesity prevention in my country (1=strongly disagree, 5=strongly agree)

- Lack of public funding and resources: 3.89
- Lack of government regulation and guidance: 3.42
- Lack of parental support: 3.86
- Lack of understanding and acceptance as a public health problem: 3.76
- Undermotivation and lack of support of school staff: 3.62
- Lack of physical activity friendly environments: 3.78
- Lack of healthy food choices: 3.36
- Commercial marketing of foods: 4.01
- High relative price of healthy foods: 3.71
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