

Focusing on obesity through a health equity lens

A collection of innovative approaches and promising practices by European and international health promotion bodies to counteract obesity and improve health equity



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*This is the second edition of the report “Focusing on obesity through a health equity lens”.
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EuroHealthNet is a European Network that consists of regional and national agencies responsible and accountable for health promotion, public health and disease prevention in Europe. The network aims to improve the health of European citizens by striving for a healthier Europe with greater health equity between and within countries. EuroHealthNet supports projects and policy development together with its members and the EU institutions; by exchanging information and by communication in and beyond our network.

Introduction

This report has been compiled by EuroHealthNet with the aim of producing an accessible source of ideas and inspiration for practitioners and policy makers about counteracting obesity and improving health equity. The work is funded under the Equity Channel special project of EuroHealthNet (see page 207) [1], which is part of the International Collaboration on Social Determinants of Health, initiated by the Department of Health for England.

The report:

- describes innovative approaches and promising practices to reduce obesity by health promoting bodies at local, regional, national, European and international level;
- is an identification of work where the initiatives address different socio-economic groups with a specific focus on lower socio-economic communities, and therefore contribute to reducing health inequalities; and
- is an update of the 2006 summary of action collated by EuroHealthNet [2].

Report Content

Lifestyle choices regarding nutrition and physical activity are the most proximal determinants of overweight and obesity. However, while predominantly concerned with nutrition and physical activity initiatives, the remit of the report was to include any possibly relevant interventions that counteract obesity. This information was collected from:

- EuroHealthNet member and partner organisations;
- DETERMINE [3] member and partner organisation;
- statutory bodies at European, national, regional and local levels in Europe; and
- other sources with their clear permission (e.g. academic, private or nongovernmental organisations)

While the report mainly focuses on obesity prevention initiatives targeting different socio-economic groups in Europe, it also describes projects implemented at the international level. As various people involved in obesity prevention projects outside the EU had expressed their interest in the document after its first publication in July 2009, they were invited to make a contribution as well. The international project descriptions can be used to further stimulate debate, to provide new ideas, and to highlight interesting approaches implemented overseas.

A framework document, including specific questions related to counteracting obesity among vulnerable groups and details of the project's methodology, was developed and sent to interested parties in and outside Europe. In total 97 relevant descriptions of innovative approaches were submitted, running in twenty-four different countries in Europe (figure 1) and four countries outside the EU. The practices described are implemented at either International, European, national, regional or local level. Most interventions found are community based approaches that are active at the regional or local level.

The report includes interventions which are 'innovative'. This is a broad concept that can be defined as a new or different approach to addressing an issue [4]. This could for instance include involving new partnerships or finding new ways to target and reach specific groups.

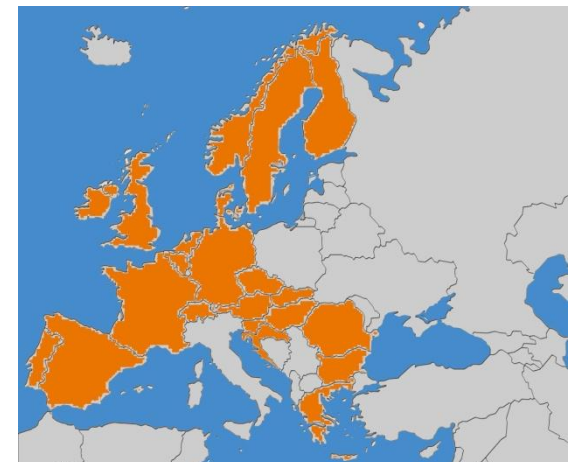


Figure 1 Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, England, Finland, France, Germany, Greece, Hungary, Ireland, the Netherlands, Norway, Portugal, Romania, Scotland, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Wales.

However, it is important to note that the aim of this report was not to categorise the projects, to say whether one intervention is more innovative than another, nor to find new strategies that could be implemented all across Europe. Innovation depends on the context it operates in, it is relative to the country where it is implemented and it will constantly be changing.

The goal of the report was therefore to highlight new, recent approaches that have the potential to work and to be effective, to make local practices visible at the international level, and to provide others with new ideas and inspiration to tackle obesity and improve health equity.

Report Layout

After an introduction to the obesity pandemic, a description of health inequalities and the importance of targeting vulnerable groups, the content of the report is laid out as follows:

- Chapter 2: Examples of programmes running at European level
- Chapter 3: Examples of ongoing interventions at national level
- Chapter 4: Examples of projects that are operating at regional or local level
- Chapter 5: Examples of initiatives implemented at international level
- Chapter 6 & 7: Overview of Responses and Conclusions
- Chapter 8: Index

European Level Regarding the programmes that are being implemented at European level, examples were included which focus on the prevention of obesity or obesity and health inequalities. Chapter two is subdivided into two sections: programmes that target (school) children and their families and programmes that were set up for the general population. Also, the projects described are either ‘running programmes’, ‘policy development programmes’ or ‘research studies’.

National Level In 2006 EuroHealthNet published a document highlighting health promotion measures that had been put in place by EU Member States at national level [2]. These actions include the implementation of national action plans, health policies or national programmes and campaigns. However, this report did not identify whether these actions acknowledged lower socio-economic communities as special risk groups or not, or whether these actions contribute to reducing health inequalities.

The third chapter of this current report therefore reviewed the outcomes and summarizes which actions also address disadvantaged communities when the goal is to counteract obesity. In addition, further information on new developments since 2006 is provided.

Regional and Local Level Many examples of active initiatives at the regional or local levels were found. Based on their focus they were divided over three categories: nutrition, physical activity or a combined approach.

International Level Finally, the report describes several projects running at the international level. Examples of ongoing initiatives in Brazil, Australia and the United States of America are included. Descriptions of projects implemented at the global level are given as well.

All projects included in this report, either running at International, European, national, regional or local level, are described according to the following framework:

- **Aim & objectives;** what are the aim and objectives of the project?
- **Design;** when did the project started and how was it set up? Was there a pilot phase before the project was launched? Is it based on an on-going programme or is it a new initiative?
- **Support;** where does the financial support come from? Which parties i.e. partnerships are involved?
- **Trigger;** what was the exact trigger of the project? Who was it initiated by (e.g. local authorities, government etc)?
- **Targeted Communities;** why is the project able to target the most disadvantaged communities and what are the benefits to the targeted individuals? Also, how does the project prevent that communities with a high(er) socio-economic status will profit as well and thus that the gap regarding health inequity between the two groups will increase? Does this issue get special attention, or does it not play a role?
- **Evaluation;** has the project proven to be effective? Are there any (published) reports? Are disadvantaged groups indeed targeted and are their health conditions concerning obesity improving?
- **Contact Details;** who can be contacted if further information is requested?

Report Limitations

The majority of the information considered has been taken from English language sources. When possible, reports were translated into English from other languages. Nevertheless it was difficult to obtain information from non English speaking countries concerning initiatives being implemented at the local level, which has seldom been translated. Programmes being implemented at national or European level were more likely to be available in English.

This report does not provide an exhaustive review of innovative approaches – nor is this its aim. The role of this report is to identify examples and to stimulate debate and, where relevant, encourage practitioners to adopt innovative approaches.

In addition, as the information supply largely depended on the response rate of parties approached, the report is not complete in its description of national action plans, policies and campaigns being implemented at national level in European countries. It only includes those countries and authorities that were able to provide new information and that were willing to contribute to this report.

Finally, it is important to take into account that some descriptions of innovative approaches in this report are only covered very briefly. Therefore if further reading is requested, please contact the person involved.

1. Obesity and Health Inequalities

The following chapter outlines the prevalence of obesity within and beyond Europe and gives a detailed overview of the situation within the countries included in this report. In addition, the concept of health inequalities is explained: how do they evolve and how can they be counteracted? In the third paragraph health inequalities are discussed in relation to obesity as well as the importance and relevance of addressing the obesity problem among lower socio-economic groups.

1.1 Obesity and Overweight: The current situation & its long-term vision

Obesity is one of the major health challenges worldwide and is rapidly reaching epidemic proportions [5, 6]. The World Health Organisation (WHO) estimates that in 2005, more than 1 billion people worldwide were overweight and more than 300 million were obese. Prevalence is expected to increase further in almost all countries, with 1.5 billion people being overweight in 2015 [7].

The highest prevalence of obesity and overweight are found in the Americas, Europe and Eastern Mediterranean regions. Data published by the WHO and the International Association for the Study of Obesity (IASO) suggest that the number of obese people in Europe has tripled in the last two decades and has resulted in a prevalence of 130 million obese- and 400 million overweight persons living in the WHO European Region today (figure 2) [8]. This means that over 50% of the adult population in the EU is currently overweight or obese, and about 20% of children are overweight. A third of these are obese [8, 9].

A report published by Sassi et al. [10] predicts that the increasing obesity rates in OECD countries will happen at a faster pace in countries where rates of obesity are historically lower (e.g. Korea, France), and are expected within the next 10 years to reach the same proportions of pre-obese population in countries that currently rank near the top, such as England.

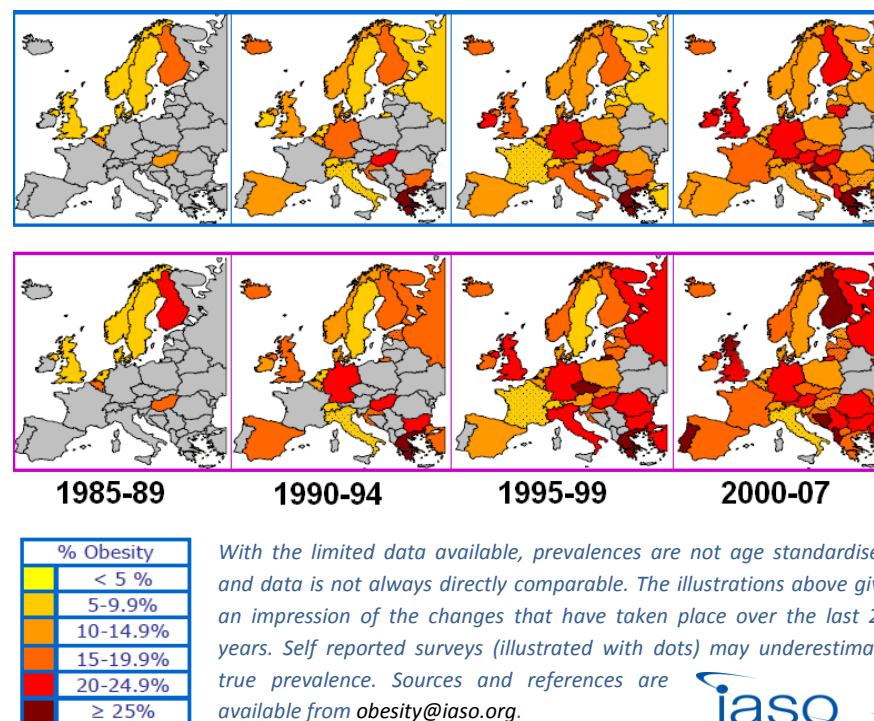


Figure 2, first four illustrations: Obesity prevalence (in per cent) in European males
last four illustrations: Obesity prevalence (in per cent) in European females

Source: © International Association for the Study of Obesity (IASO), London – Feb 2009

Sixty-five percent of the world's population nowadays live in a country where overweight and obesity kills more people than underweight [6]. The condition is regarded as one of the five leading global risks for mortality in the world, as overweight and obesity are responsible for 5% of deaths globally. In addition, 19% of all global deaths are caused by five different diet-related risks combined with low levels of physical activity (table 1).

Risk	World	Low and middle income	High income
Percentage of deaths			
High blood pressure	12.8	12.1	16.8
High blood glucose	5.8	5.6	7.0
Physical inactivity	5.5	5.1	7.7
Overweight and obesity	4.8	4.2	8.4
High cholesterol	4.5	4.3	5.8
Low fruit and vegetable intake	2.9	2.9	2.5
All six risks	19.1	18.1	25.2

Table 1, Percentage of deaths attributable to five diet-related risks and physical inactivity, and to all six risks combined, grouped by WHO region (2004)
Source: © World Health Organization, Global health risks (2009) ISBN 978 9241563871

Obesity is responsible for a large proportion of the total burden of disease, as 65% of the obesity and overweight in the WHO European Region is associated with growing rates of chronic diseases such as heart disease, diabetes and cancers. The condition is thus affecting longevity, and in particular trends in childhood obesity are widely expected to lead to shorter life expectancy for today's children [6,9].

Tackling the causes of obesity is a complex task. The UK Government's Foresight Programme, which together with the Horizon Scanning Centre produces visions of the future of key challenges for society in the UK, published a report on obesity in 2007 [11]. This report identifies over 100 causes of obesity and provides

a map that gives insight into the complexity of and interrelationships between the numerous determinants of the condition. Some of the variables are fairly straight forward and easy to measure, while others are more difficult to quantify. Examples of key determinants that can influence our environment and promote a high energy intake or sedentary behaviour are [12]:

- Psychological and Cultural (e.g. religion, family influences, beliefs);
- Physically active lifestyle (e.g. social environment, access to sport/play areas, urban design);
- Nutritional (cost, taste, marketing, availability and access);
- Physiological (e.g. energy expenditure, genetic factors, pregnancy)
- Knowledge (e.g. nutrition labelling, nutrition and physical activity education through the life course); and
- Socio-economic status (e.g. education, income, social isolation, welfare)

Figure 3 shows the prevalence of obesity and overweight in all countries described in this report. These ranges were determined using the Body Mass Index (BMI), a commonly used measure to classify overweight and obesity. It is defined as the weight in kilograms divided by the square of the height in meters (kg/m^2). BMI classifications apply only to adults, as weight and height measurements of children are constantly changing through normal growth patterns.

The year in brackets following the country name represents the year of data collection. Please note that the age range and years differ between countries and that the prevalence figures are not standardised by age. Due to these dissimilarities and differences in methodology, surveys are therefore not strictly comparable.

Lastly, self reported surveys (indicated with a '*' behind the country name) may underestimate true prevalence; e.g. women tend to under-report their weight and men over-report their height. Biases of up to 30% have been described in the prevalence levels of obesity by using these self reported heights and weights.

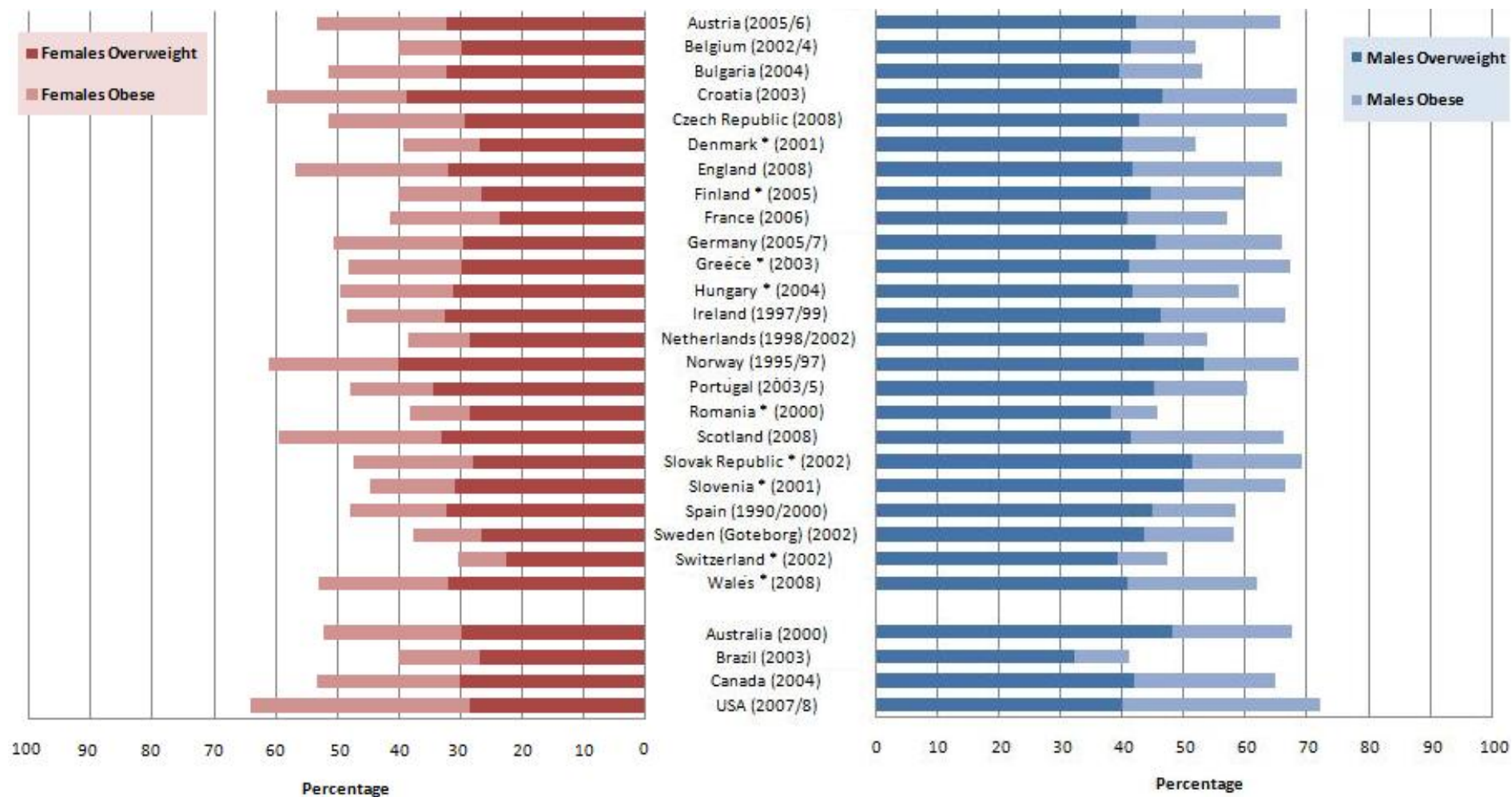


Figure 3: Bars on the left side show female overweight (BMI $\geq 25 - 29.99$) and obesity (BMI ≥ 30), Bars on the right side show male overweight (BMI $\geq 25 - 29.99$) and obesity (BMI ≥ 30).

Source: International Association for the Study of Obesity (IASO)

1.2 Health inequalities and the Social Determinants of Health

Even though there has been an improvement in overall health in Europe over the past few decades, European countries are faced with substantial disparities in health within their populations. These health inequalities can be found worldwide and can be described as *'systematic differences in morbidity and mortality rates between people of higher and lower socio-economic status, as indicated by e.g. level of education, occupational class or income level'* [13]. As the health of those from upper classes is improving at a faster rate, the gap between high and low socio-economic communities is growing and has increased the urgency of this public health challenge [4].

Figure 4 shows a simplified diagram explaining which factors mediate between low socio-economic status (SES) and risk of ill-health.

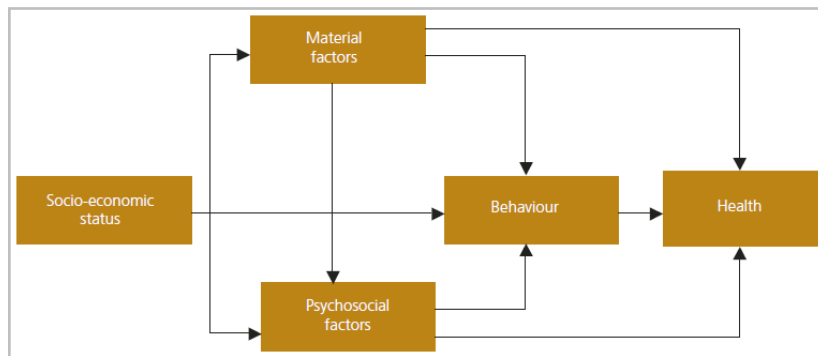


Figure 4: Explanatory diagram of factors mediating between SES and ill health.

Source: JP Mackenbach – *Health Inequalities: Europe in Profile* (2006)

Health inequalities are not exclusively determined by bio-medical factors or lifestyle choices. Research has shown that health inequalities reflect structural inequalities in the distribution of wealth and resources within and between

societies. Health inequalities are thus also a consequence of the social conditions that people operate in, known as the social determinants of health [4]. A model which describes this in more detail can be found in a report published by the WHO Commission on the Social Determinants of Health (*A Conceptual Framework for Action on the Social Determinants of Health* - 2007) [14]. Lastly, it is not simply the poorest that experience less than optimal health; there is a social gradient of risk across society. There is a systematic correlation between social status and level of health.

Both Mackenbach and the WHO pathways model show the complexity of health inequalities due to multi-layered factors that influence the health of individuals. Consequently, it illustrates the many difficulties one has to face when aiming to improve health equity.

1.3 Health inequalities in relation to obesity

A review of studies published by Sobal and Stunkard in 1989 [15] concluded that obesity in developing countries would essentially be a disease of the higher socio-economic classes. It would be a disease of the elite. Nowadays this view has changed as this positive association between wealth and obesity is only found among adults and children in low-income countries. The trend flattens out in middle-income countries and transforms to a negative association in high-income countries, where the obesity risk is thus higher among lower socio-economic groups (SEGs) [16]. In addition, evidence suggests that the difference between socio-economic groups is widening, i.e. the gradient is becoming steeper [12].

A study by Robertson, Lobstein and Knai [12] showed that there is a consistent and profound social gradient in the prevalence of obesity in countries in Western Europe. Some 20-25% of the obesity found in men, and some 40-50% of the obesity found in women can be attributed to differences in socio-economic status.

Several studies have found that the food eaten by people in lower SEGs are higher in energy and lower in micronutrients compared with higher SEGs. Also, members of low SEGs eat less fruit vegetables and children drink more soft drinks than those from higher classes [17-20]. Physical activity levels among adults and children, especially girls, from lower SEGs are lower in general as well [12, 18, 21-22].

There are various reasons why a relation between socio-economic status and obesity is relevant. Many variables have been described that seem to have an effect on obesity prevalence and the processes leading to obesity between and within different groups in society. Some key examples are:

Income

Income inequality has been associated with numerous ill-health and negative psychosocial effects. A book published in 2009 by Richard Wilkinson and Kate Pickett [23] shows the link between income inequalities and obesity prevalence; the levels of obesity tend to be lower in countries where income differences are smaller. The differences between countries are smaller for overweight children than for obese adults, but the same pattern is observed internationally for children. Thus, more children are overweight in more unequal countries (figure 5). Besides obesity prevalence, other studies have shown that income inequality is also related to average calorie intake, BMI among women, diabetes mortality, and weight gain at the waist (in American men) [24-27].

Also, as a result of low income, material disadvantage can affect obesity prevalence since it influences the ability to purchase nutritious food or to live in a neighbourhood with markets that sell affordable healthy products and offer facilities to exercise. For example, people with higher incomes can obtain social and material resources (e.g. gym subscription) that maintain physical activity even in adverse weather conditions [22].

In addition to this, material hardship could also increase obesity risk as it is a source of chronic stress. This might in turn limit people's ability to change weight related behaviours - even when informed and motivated [28, 29].

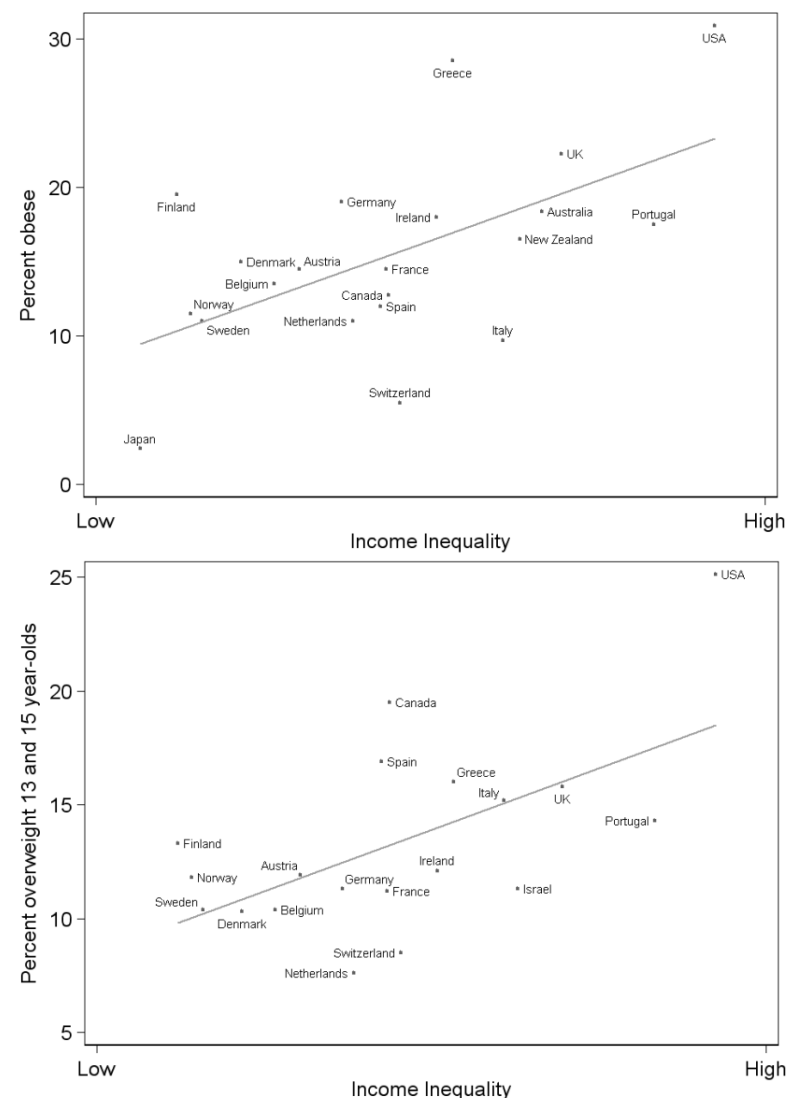


Figure 5: **Upper figure:** Percent obese adults (vertical axis) in countries by level of income inequality. **Lower figure:** Percent overweight 13-15 year olds (vertical axis) in countries by level of income inequality

Source: Richard Wilkinson and Kate Pickett, *The Spirit Level* (2009) 10

Gender

In many countries in the world, particularly in the OECD area, gender seems to have an effect on obesity prevalence as women in lower socio-economic groups (SEGs) tend to show higher obesity rates compared to men [9,10]. This might be due to different lifestyle choices (e.g. smoking, alcohol abuse) or environmental pressures (e.g. discrimination in employment; family gate-keeper; and lower self-esteem associated with a failure to meet societal norms and models) [10, 12].

In addition, women belonging to disadvantaged socio-economic groups are more likely to give birth to under- and over-weight babies (both are risk factors for later obesity) and are less likely follow recommended breastfeeding and infant feeding practices (also linked to obesity risk) [12]. Their children will in turn have fewer chances of moving up the social ladder, perpetuating the link between obesity and socio-economic disadvantage [10, 12].

Education

Other studies suggest that disparities by education among women (in OECD countries) have an effect on overweight and obesity rates, as more educated and higher socio-economic status women display substantially lower overweight and obesity rates [10, 30]. However, mixed patterns are observed among men. This finding is supported by the WHO MONICA project [31], which for ten years monitored ten million men and women living in 21 countries (14 in the European region). It found that higher educational levels were linked to lower BMIs in about half of the population groups with respect to men, and in almost all of the groups with respect to women [12].

Ethnicity

Wardle et al. [32] showed that, even after controlling for differences in socio-economic conditions, women in certain ethnic minority groups are substantially more likely to be obese than other women. However, not all minority groups display higher rates of overweight and obesity.

Living Environment

Unequal distributions and availability of resources in rich and poor areas that can promote opportunities for physical activity (e.g., green areas, recreational trails, and sidewalks) are likely to influence people's behaviour. Also the possibility to live in a neighbourhood with safe, pleasant places to exercise has an effect [33-35]. In addition, researchers have found that there are differences in the density of food stores within urban settings. Privileged areas often have a higher number of large food stores, which sell more fresh products and good quality food compared to small shops [36, 37].

Also between different types of living environments, disparities exist. For example, studies have shown that rural residents are less likely than people in urban areas to be physically active, and within rural populations, people with lower income are less active than people with higher income [38, 39].

Social Support

Studies have reported an association between social support (family and friends, healthcare providers, community organisations) and healthy behaviour, as socially isolated people are less likely to eat enough fruit and vegetable or to meet physical activity guidelines than people with large social networks. As social support and integration are more prevalent in higher SEGs, this is again confirming the link between obesity and socio-economic disadvantage [8, 40- 41].

In conclusion, around the world obesity and overweight are reaching epidemic proportions and especially affect disadvantaged communities. Explanations limited to lifestyle causes such as diet and exercise are inadequate as there are many more complex underlying factors (e.g. genetic, physiological, psychological, social, economic, educational etc.). Better understanding of the complexity of causation is therefore needed and interventions that address the prevention and treatment of obesity and overweight at multiple levels across the gradient are of great importance. By sharing evidence, success factors of strategies can be identified that can contribute to a reduction of the social gradient in obesity.

2. Projects at European Level

Several projects are implemented at European level aiming to counteract the obesity pandemic and to improve health equity. This chapter is subdivided into two sections; (1) Programmes that target (school) children and their families, and (2) Projects that were set up for the general European population. Furthermore, these two sections are divided into several paragraphs. 'Running programmes' gives an overview of ongoing projects at European level. 'Policy development' describes approaches that effectively evaluated or developed policy projects throughout Europe. Finally, a third paragraph consists of examples of research studies – projects with scientific objectives. The aim of these studies is to gain insight into, or increase our understanding of people's health, health behaviours and their social context.

The chapter is laid out as follows:

2.1 (School) Children in Europe	13
2.1.1 Running programmes	
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■ School Milk Scheme	
■ EPODE	
■ In Form Project	
2.1.2 Policy development	
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2.2.2 Policy development	
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■ EURO-PREVOB	
■ Teenage Project	
■ European Public Health & Agriculture Consortium	
2.2.3 Research studies	
■ HELENA Study	
■ IMAGE Project	

2.1 (School) Children in Europe

2.1.1 Running Programmes

School Fruit Scheme

<http://ec.europa.eu/agriculture/markets/fruitveg/sfs/>

The School Fruit Scheme is a European Union-wide programme aiming to encourage good eating habits in young people. Besides providing Fruit & Vegetables (F&V) to be consumed, the scheme requires participating Member States to set up, accompanying measures including educational initiatives (such as farm visits, gardening sessions, etc.) in order to ensure the effectiveness of the program by raising the awareness of the target group to the importance of a healthy diet.

The scheme began at the beginning of the 2009/2010 school year and 23 Member States opted to participate. Participation in the scheme is voluntary and the EU co finances 50% of the cost, 75% in convergence regions. In total, European funds worth €90 million per year will pay for the purchase and distribution of fresh and processed F&V to schools, plus some related costs for logistics, monitoring, evaluation and communication. The Community aid cannot be used to replace existing national financing, but should encourage additional activities in the existing programmes or create completely new initiatives. Member States have to draw up a national strategy in conjunction with public health and education authorities and also involve the industry and interest groups, tailored to national preferences. An evaluation report to the European Parliament and the Council accompanied, if necessary, by appropriate amending proposals, will be prepared by the Commission in 2012.

Background On 15 June 2007, in the context of the reform of the Common Market Organisation (CMO) for Fruit and Vegetables, the Council launched a

Declaration stating that "...In light of the dramatic increase in obesity amongst school children, which has been highlighted in the recently published Commission White Paper 'A Strategy for Europe on Nutrition, Overweight and Obesity related health issues', the Council invited the Commission to come forward with a proposal for a school fruit scheme (SFS) as soon as possible based on an Impact assessment (IA) of the benefits, practicability and administrative costs involved".

Aim & Objectives: The aim is to reverse children's stagnated consumption of F&V, as an effort to tackle child obesity and serious diseases) linked to unhealthy diet and obesity, by ensuring a policy and funding framework for Member State initiatives. Finally, the SFS plays an important role in contributing to social cohesion by ensuring equal opportunities to schoolchildren concerning the consumption of F&V.



Figure 6: School Fruit Scheme

Source: http://ec.europa.eu/agriculture/markets/fruitveg/sfs/documents/index_en.htm

Support: The Commission is putting on the table €90 million per year for the provision of fruit and vegetables in schools [42]. Governments would have the choice of whether to participate or not. The programmes would be co-financed, either on a 50/50 basis, or 75/25 in the so-called 'convergence regions', where GDP/capita is lower, as well as outermost regions. Member States can if they wish require a compulsory parental contribution. This money could not be used to replace existing national financing, but would encourage additional activities, be it linked to existing programmes or creating completely new initiatives. And Member States could of course add extra money if they wanted to. National

authorities would have to draw up a strategy in conjunction with public health and education authorities, also involving the industry and interest groups, tailored of course to national preferences.

Trigger: An estimated 22 million children in the EU are overweight and 5.1 million of these are obese [43]. In other words, almost every third child in Europe is concerned and this number is rising by more than 400.000 every year, leading to a range of health, physiological and social problems with a high cost to society. Although the World Health Organisation recommends a daily net intake of 400 grams of F&V per person, the majority of Europeans fail to meet this target and the downward trend is particularly evident among the young and disadvantaged social groups.

Targeted Communities: Studies show that healthy eating habits are formed in childhood, high F&V consumers remain so when adults, as opposed to low consumers whom in general tend to keep an unchanged lifestyle also consequently affecting their own children. Furthermore, the direct link between low household income, other social factors and insufficient expenditure on F&V has been established by several studies in Europe.

Evaluation: Experience proved that School Fruit Schemes are an effective tool to increase the consumption of F&V; in particular, if together with the distribution of the products the Scheme foresees the so called accompanying measures aiming to reinforce the efficiency of the program and its sustainability through a better understanding of the benefits of a healthy diet and thus raising the awareness. Encouragement will also be given to the exchange of know-how and best practices between stakeholders, scientific experts and national authorities who run successful similar schemes.

Contact Details: For more information, please contact:



European Commission, DG for Agriculture & Rural Development
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+32 2 295 0442 – 298 1380 – 295 7554
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School Milk Scheme

<http://drinkitup.europa.eu>

Aim & Objectives: The European School Milk Programme encourages children to consume dairy products and maintain a balanced diet. It plays an educational role by supporting the development of good eating and nutritional habits that will last a lifetime.

Design: The School Milk Programme was introduced to pupils in the European Community in the 80's in order to promote healthy life style and nutrition patterns.

In the 2006-2007 school year, the School Milk Programme distributed the equivalent of 305,000 tonnes of milk to schools in 22 Member States. All participating institutions displayed a poster in their entrance hall showing that they receive subsidies through the European School Milk Programme.



In 2008, the School Milk Programme was reviewed by the European Commission, and during this process requests and suggestions from the Member States, the European Parliament and the Council of the European Union were taken into account.

On 11 July 2008 it was decided to expend the Programme in order to increase the range of products covered by the subsidy.

Figure 7: School Milk Scheme

Source: http://ec.europa.eu/agriculture/markets/milk/schoolmilk/index_en.htm

Products now available since the 2008-2009 school year are the following (divided over 5 categories):

Category 1

- Heat-treated milk, including lactose-free milk drinks;
- Heat-treated milk with chocolate, fruit juice or flavour, containing at least 90% by weight of the milk indicated in point 1 and containing a maximum of 7% added sugar and/or honey;
- Fermented milk products with or without fruit juice, flavoured or non-flavoured, containing at least 90% by weight of the milk indicated in point 1 and containing a maximum of 7% added sugar and/or honey.

Category 2

- Flavoured and non-flavoured fermented milk products with fruit, containing at least 75 % by weight of the milk indicated in Category I point 1 and containing maximum 7 % of added sugar and/or honey.

Category 3

- Fresh and processed cheeses, containing maximum 10 % of non-lactic ingredients

Category 4

- Grana Padano cheese and Parmigiano Reggiano cheese.

Category 5

- Cheeses, containing maximum 10 % of non-lactic ingredients, and not falling under categories 3 and 4.

Furthermore, since the Programme has been reviewed, Member States have the possibility to choose the products they wish to distribute and they can apply stricter standards than those set out in the Community list. The new regulation also ensures that secondary schools have the same access to the scheme as nursery schools, other pre-school establishments and primary schools. Secondary schools were in the past often not participating in the School Milk Scheme as it was not obligatory for the Member States to include them.

In October 2008, the European Commission launched an EU-wide campaign to promote the relaunched School Milk Programme. Under the slogan “Milk – Drink

it up”, the information campaign aimed to raise awareness of the benefits of milk consumption and the availability of EU funds to schools.

Support: Through the European School Milk Programme, the European Union provided subsidies to schools and other educational establishments so that they could provide their students with selected milk and milk products. Subsidies that were provided, per food category, are:

- Category 1 - EUR 18.15/100 kg
- Category 2 - EUR 16.34/100 kg
- Category 3 – EUR 54.45/100 kg
- Category 4 – EUR 163.14/100 kg
- Category 5 – EUR 138.85/100 kg

In the 2006-2007 school year, the European Union provided more than €50 million in subsidies.

Targeted Communities: Schoolchildren in EU Member States. The following authorities were able to apply for aid:

- An educational establishment;
- An education authority in respect of the products distributed to the pupils within its area;
- The supplier of the products, if the Member State so provides;
- An organisation acting on behalf of one or more educational establishments or education authorities and specifically established for that purpose, if the Member State so provides.

Evaluation: The School Milk Programme has not been evaluated again after its review process in 2008.

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EPODE

<http://www.epode-european-network.com>;
<http://www.epode.fr>; <http://thaoweb.com>; <http://www.viasano.be>

EPODE (*Together Let's Prevent Childhood Obesity - Ensemble Prévenons l'Obésité Des Enfants*) is a methodology designed to involve all relevant local stakeholders in an integrated and concrete prevention program aimed at facilitating the adoption of healthier lifestyles in the everyday life. The programmes developed on the basis of the EPODE framework are long term, aimed at changing the environment and thereby the unhealthy behaviours.

The first EPODE programme started in France in 2003 - Initiated by mayors who first developed the pilot program. EPODE now extends to nearly 1.8 million inhabitants in 167 French cities, 31 cities in Spain (THAO Salud Infantil Programa) and 8 cities in Belgium (VIASANO Program). Success to date is measured by a large field mobilization in the pilot cities and by the encouraging evolution of the BMI of children in France within the pilot cities. EPODE is about to be implemented in Greece, Québec (Canada) and in Australia. The national coordination team recruits motivated cities.

The methodology enables the creation of new educational schemes mobilizing local stakeholders (health professionals, teachers, parents, catering services, local producers...) within their daily activities, to empower families and individuals in a sustainable way. These actions are coordinated by a local project manager, nominated by the mayor (or other local leader) and delivered under the lead, at the national level, of a social marketing team and the expertise of an independent scientific committee.

It also requires a cross-cutting engagement within a municipality, which is not so easy to settle. High degree of motivation and commitment are key words for the programme's success.

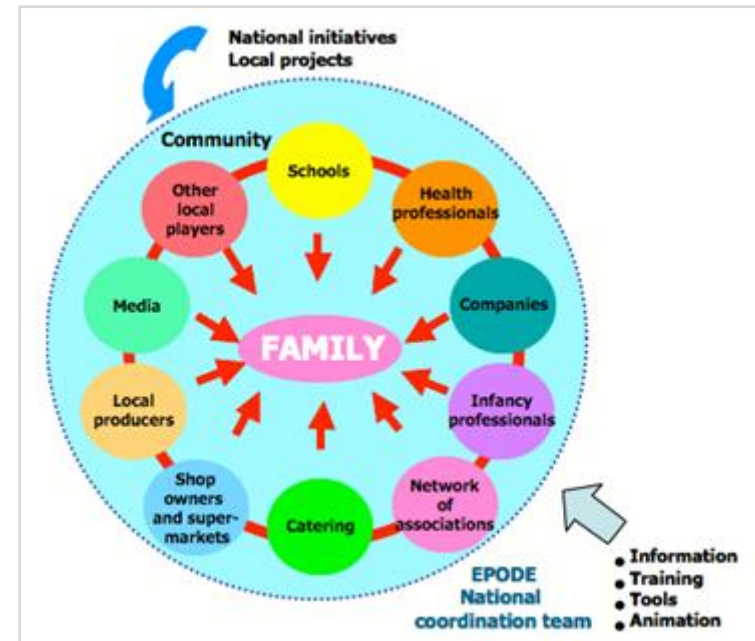


Figure 8: Parties involved for the implementation of the EPODE programme

Source: Protéines ©

The themes developed for the past 4 years in France were all linked to the objectives of the National Nutrition Program the French government is developing: Fruits and vegetables, starchy products and pulses, drinking water and less sugary drinks, cooking easily a balanced meal with little money, portion sizes and meals structures, enjoying eating properly treats. In parallel, 4 themes have focused on being more physical active, such as approaches based on 'just playing with a friend' or in school yards or reducing time spent in front of screens. Structural goals are also pursued such as the creation of secured

playgrounds in lower income neighbourhoods, adapting school meals and environment, offering a non-competitive sport practice for all the families, etc.

Based on EPODE (France)/ THAO (Spain)/ VIASANO (Belgium) pilot experiences, the EPODE European Network (EEN) is a European project with the support of the European Commission (DG SANCO) and the collaboration of 4 European universities and private partners, in order to facilitate the deployment of the EPODE methodology in other European countries. It exchanges and shares information of project practices.

Aim & Objectives: The objective is to foster healthier lifestyles and contribute to the reduction of childhood overweight and obesity through a methodology that establishes prevention at the heart of the city networks. The 4 pillars of EPODE are: strong political will, a sound scientific background, a social marketing approach and multi stakeholder approach.

Support: Three kinds of private partnerships are possible within the programme:

- At national level: big companies (including food producers) contribute significantly to the funding of the activities of the national coordination team;
- At a local level: two types
 1. “all-the-year” partners are the ones who contribute to the development of the programme; and
 2. “occasional” partners are the ones who contribute to occasional local actions (e.g. “week of the bread” event in a city)

The cost is evaluated as 2 to 4 EUROS per year per inhabitant altogether in a mature phase. One Euro per year per inhabitant is funded by the commercial sector and finances mainly activities of the national coordination team, e.g. its productions and coordination expenses. The rest of the funding is provided by the cities, which budget is bearing the cost of the fulltime project manager plus

all local expenses: publishing materials, subsidies to NGOs taking part to some actions, yearly events, etc.

Trigger: The EPODE Programme was developed in France in 2003 by mayors and is inspired by the experience developed in previous community and school-based interventions. It is based on key considerations: preventing a child from becoming obese by acting on the behaviour of the whole family, changing its environment and social norms.

Targeted Communities: Children (and their families) living in Europe; Lower socio-economic groups are not specifically targeted.

Evaluation: Sociological evaluations focusing on the perception of EPODE in families and local stakeholders indicate particularly that the program is seen as a common positive action for the community and a concrete aid that helps parents to guide and support their educational role towards their children. Since its launch in 2004, more than 1,000 actions per year have been implemented thanks to a large field mobilization in the French pilot cities by the local stakeholders.

As part of the project assessment, all EPODE communities measure and weigh children annually. The first assessment for the 10 communities (2005) is the one that will serve as a reference to assess the procedure at its conclusion, shows an average rate of prevalence of overweight and obesity of 20.6% for all the towns, with rates varying from town to town between 10% and 25%. As in the other studies, a clear correlation is observed between the socio-economic level of the population and the obesity rate. The least affluent neighbourhoods and towns are most at risk.

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InForm Project

<http://inform.sanicaademia.eu>

The idea behind the In Form project (full title: *"In Form - Campaign against obesity in children and adolescents"*) is to have a European campaign against obesity in children and adolescents taking into account that besides creating awareness a preventive and therapeutic approach has to recognize the addictive aspect of overeating as well as its co-morbidity with ADHD. Ways of interdisciplinary cooperation have to be found to create synergies in the treatment and prevention.

The project is based on a local project that has been started in Villach, Austria, in 2007, including an awareness campaign, diagnosis and treatment of children as well as an interdisciplinary trainer course and has been received very well.

Aim & Objectives: The general objective of the InForm project is to develop integrated overweight/obesity prevention and treatment strategies for children and adolescents.

More concretely, a European, interdisciplinary manual on prevention and treatment of childhood obesity, including standards and guidelines is being developed, a European, interdisciplinary training course for health professionals, accredited with the respective, competent national authorities in each partner country, to become certified "obesity trainers" is being implemented. Furthermore creating awareness via a social marketing campaign at local levels in all participating countries, targeting children and adolescents, their families and immediate environment as well as the establishment of a network of competence centres, which, beyond the project time, will implement the manual and the training course, including the spread to other European countries, are part of the project.

Support: The In Form project receives funding from the European Union in the framework of the public health programme.

Trigger: Over the last decades obesity has become a great problem in Europe and prevention and treatment of obese children and adolescents not only benefit the affected individuals but also the health care systems in the member states. Many local projects exist, but there is still need to figure out how to put local success stories in a European perspective. The interdisciplinary and international approach of the In Form project tries to come up with one possible way to prevent and reduce obesity on a level that can be easily implemented in all member states.

Targeted Communities: The target groups of the In Form project are manifold. While the trainer course and the standards are targeted at professionals (e.g. physicians, psychologists, pediatric nurses, psychotherapists, nutrition scientists/counsellors, sports therapists/counsellors/scientists, social workers) and institutions working with (obese) children and adolescents, the social marketing campaign targets children and adolescents, their families and immediate environment.

Evaluation: The Project has not yet been evaluated, currently ongoing.

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2.1.2 Policy Development

Schools for Health in Europe (SHE) network

<http://www.schoolsforhealth.eu>

The Schools for Health in Europe network (SHE network) is the European platform for school health promotion. The network is coordinated by NIGZ, as a WHO Collaborating Centre for School Health Promotion.

The SHE network has a longstanding history and was formerly known as the European Network for Health Promoting Schools (ENHPS). Since 1992 it operates in 43 countries in the European region. It has demonstrated progress in establishing school health promotion as part of the core work of schools in several member countries. SHE makes progress in increasing the cooperation between the health sector and the education sector and focuses on making school health promotion a more integral part of policy development in both sectors in Europe.

The SHE approach for school health promotion in Europe is based on the following five core values and five pillars. SHE acknowledges the UN Convention on the Rights of the Child.

The five SHE core values are:

1. **Equity** Health promoting schools ensure equal access for all to the full range of educational and health opportunities. In this way they have the potential to reduce inequalities in health.
2. **Sustainability** Health promoting schools acknowledge that health, education and development are closely linked. Schools act as centres of academic learning and support to develop a responsible and positive view on pupil's future role in society.

Health promoting schools develop best when efforts and achievements are implemented in a systematic way for a prolonged period, for at least 5-7 years. Outcomes (both in health and educational) mostly occur in the medium or long term.

3. **Inclusion** Health promoting schools celebrate diversity and ensure that schools are communities of learning, where all feel trusted and respected. Good relationships among pupils, between pupils and school staff and between school, parents and the school community are important.
4. **Empowerment and action competence** Health promoting schools enable children, young people and all members of the school community to be actively involved in setting health-related aims and in taking actions at school and community level, to reach these aims
5. **Democracy** Health promoting schools are based on democratic values and practice the use of rights and responsibilities

The five SHE pillars that underpin the health promoting school approach are:

1. **Whole school approach to health** There is a coherence between the school's policies and practices in the following areas which is acknowledged and understood by the whole school community:
 - ♦ a participatory and action-oriented health education;
 - ♦ taking into account student's own concept of health;
 - ♦ healthy school policies;
 - ♦ the physical and social environment of the school;
 - ♦ life competencies;
 - ♦ links with home and the community;
 - ♦ health services
2. **Participation** A sense of ownership is fostered by student, staff and parent through participation and meaningful engagement, which is a prerequisite for the effectiveness of health promoting activities in schools.
3. **School quality** Health promoting schools create better teaching and learning processes. Healthy students learn better, healthy teachers and

non-teaching staff work better and have a higher job satisfaction. The school's main task is maximizing school outcomes. Health promoting schools support schools in achieving their educational and social goals.

4. **Evidence** Schools for health in Europe are informed by existing and emerging research and evidence focused on effective approaches and practice in school health promotion, both on health topics (e.g. mental health, eating, substance use), and on the whole-school approach.
5. **Schools and communities** Health promoting schools are part of the surrounding community. They endorse active collaboration between the school and the community and are active agents in strengthening social capital and health literacy.

Its methods of working are:

- to act as the platform for professionals active in the area of school health promotion;
- to stimulate professional exchange on theoretical, conceptual and methodological development in the area of school health promotion, including research and good practice;
- to facilitate exchange of learning and practice between individual schools and students in different member countries as appropriate;
- to stimulate the development and extension of partnerships between the health sector, the education sector, the youth care sector and other appropriate sectors at the European and national level

Aim & Objectives: The main aim of the Schools for Health in Europe network is to act as the European platform for school health promotion by supporting organisations and professionals to further develop and implement school health promotion.

Support: The network receives support from the Council of Europe, the European Commission and WHO Regional Office for Europe.



Figure 9: School for Health in Europe (SHE) Network

Source: <http://schoolsforhealth.eu>

Trigger: In Europe it is generally accepted that every child has a right to education, health and security. This is also formally recognised in global documents such as the Convention on the Rights of the Child (United Nations, 1989). Clearly the central role of schools is learning and teaching. Schools also have great potential to promote the health and development of children, young people, families and all of the school community including the staff.

Targeted Communities: The network has focused on positively influencing the health and health behaviour of school age children (aged 4-18 years) and school staff in Europe by developing and implementing quality-based and evidence-based health promotion programmes for the school setting.

Evaluation: Experience over the last 15 years has shown that a systematic process of partnership-working, advocacy, planning, developing and implementation of the programme and providing technical support, are key components for success.

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Shape Up

<http://www.shapeupeurope.net>

The 3-year European framework project Shape Up (2006-2008) proposes a new approach to promote a healthy and balanced growing up. After 2008 Shape Up project has independently continued by the cities.

Shape Up involves the school and community, including families, from the start, jointly with the child. To promote healthy habits requires new ideas to convey a broader vision of the benefits of a balanced diet and regular physical activity, focusing on a positive and critical view of food and body movement:

- **Child participation.** Shape Up is not merely about involving children in pre-defined school-based or community-based activities, but also having them decide about the type of activities they want to implement. Participation is also about letting them decide for themselves the types of games, sports and other activities that most appeal to them.
- **School-community collaboration.** Shape Up involves the school and community, including families, from the start, jointly with the child. It provides an opportunity for them all to think and talk about their lifestyles and living conditions and what they can do together to improve them.
- **Research.** Shape Up is based on in-depth research, and forms a basis for further investigation. Research linked to the project helped to determine what works within specific contexts, and what is learnt from this experience will inform future health promotion activities.
- **No stigma.** Shape Up focuses on a positive and critical view of food and body movement.
- **Capacity building.** Shape Up co-funded the recruitment of two dedicated staff members in each city, who were responsible for training local community partners and monitoring the project at a city level over its

three-year duration. Five European competence centres joined forces to bring new expertise to the cities.

- **City involvement.** A Shape Up promoting group was convened with the support of the city council to assist children, families and schools with the development of initiatives.
- **More resources.** Shape Up provides guidelines, materials and finance for specific health-promoting actions both in and out of school.
- **Measuring success.** The Shape Up process, together with its results and achievements, was evaluated in order to demonstrate the validity of its innovative approach.
- **European collaboration.** 20 cities all over Europe took part in Shape Up, creating the opportunities for new exchanges, twinning, and the discovery of new cultural environments.
- **Spreading the message.** Shape Up results were communicated to all interested cities.

Shape Up was a direct response to the commitment for action required by the EU Platform on Diet, Physical Activity and Health. Moreover it strengthened links with the European Network of Health Promoting Schools which acts as a collaborating partner.

A team of researchers from the Research Programme for Environmental and Health Education at the Danish University of Education was responsible for designing and researching the methodological framework for Shape Up. The framework was based on evidence in democratic health education and health promoting schools research. The following research findings provided the basis for the Shape Up methodological approach:

- Ownership and empowerment are key elements of effective health promotion programmes;
- In order to adopt healthy lifestyles and to acquire competence to bring about health-promoting changes, children and young people need to be

guided to develop action-oriented knowledge about health, eating and body movement;

- Action-oriented knowledge is multidisciplinary and multidimensional;
- Action-oriented knowledge can only be gained through participation in taking concrete health-promoting actions individually or collectively, and through participation which is guided by competent adults and adequate organizations structures in school and community;
- Effective participatory school-work involves collaboration between school and local community and cross-cultural exchange.

The main characteristics of the Shape Up methodological framework are:

- It is a framework, rather than a static step-by-step method. The aim is to suggest new ideas and participatory ways to work with the issues of food, physical exercise and health. Our wish is to inspire teachers, Shape Up facilitators, coordinators and the other Shape Up staff to explore, test and modify these ideas in their specific contexts, cultures and environments.
- The methodological framework itself is developed in participatory ways. In designing the framework we have taken as a starting point the ideas and opinions about health, food and physical activity of children and young people from different countries. Furthermore, we have asked teachers, local stakeholders and the national coordinators of the European Network of Health Promoting Schools to give us feedback on the initial methodological guidelines and their inputs are integrated in the final design.

The methodological guidelines include theoretical explanations, children and young people's ideas and case stories from practice, organised in the following topics:

- The innovative participatory model – IVAC (Investigation; Vision; Action, Change) and actions to address the root causes of obesity;
- The concepts of health, food and physical activity;

- Participation of children and young people in health matters that concern them;
- School-community collaboration;
- International collaboration;
- Self evaluation and learning from experience.

The methodological guideline publication was supplemented with a lot of activity examples and other practical resources within the “Pedagogical Material” section of this portal, which was updated regularly as the project goes along.

Shape Up was based on a European networking strategy to convince as many European schools as possible to share this common framework and join the Shape Up community. A European Shape Up portal sustained all aspects of the strategy. European co-financing is crucial to encourage such an intensive use of ICT - especially in the less-equipped member states - and favour virtual twinning between schools to exchange experiences and practices and find mutual inspiration to develop their own health promotion strategies.

Aim & Objectives: The fundamental premise of Shape Up was that promoting good habits to a healthier life among the youth requires new messages to convey a broader vision of sound nutrition and regular physical exercise.

Shape Up aims to:

- Bring together the principles of health education, prevention and promotion in an integrated programme,
- Promote health and wellbeing;
- Tackle social and environmental health determinants;
- Involve schools and local communities in constructive dialogue and action planning concerning health education and promotion;
- Enhance children's and young people's competences to carry out health promoting actions and bring about positive changes;
- Undertake health-promoting actions at the local level, initiated through schools by children and youth, in collaboration with local stakeholders;

- Empower a European network of schools and local actors in all the member states.

Support: The Danish University of Education and P.A.U. Education are responsible for the coordination of the project.

Competence centres: The Danish University of Education: Research and Methods, P.A.U. Education (Barcelona, Spain): Coordination, Community building, Dissemination and Portal, ABCittà (Milan, Italy): Training, Schulen ans Netz (Bonn, Germany): ICT at school and Portal, The University of Hull (Hull, United Kingdom): Evaluation

Supporting partners: European Commission - Directorate General for Health and Consumer Affairs (DG SANCO), Kraft Cares (Kraft Foods)

Trigger: It was submitted to the Public Health 2005 call for proposals launched by the European Commission Directorate General for Health and Consumer Affairs.

Evaluation: Shape Up has proven to be effective in initiating and bringing about health-promoting changes in the following determinants related to healthy eating and physical activity [44]:

School level

- School health policies
- School environment, facilities and food offer (more opportunities for healthy eating and physical activity)
- Educational strategies and contents in health education and physical education classes

Community level

- Physical environment, facilities and food offer in the community surrounding the schools (more opportunities for healthy eating and physical activity)

Partnerships

- Sustainable partnerships between schools, municipalities, city councils and other local stakeholders in the area of prevention and health promotion
- Focused cooperation with parents and extended families to encourage and sustain healthier choices

Individual level

- Children's and young people's sense of ownership, motivation and empowerment in terms of dealing with the issues of healthy eating and physical activity in their own lives and in their surroundings
- Parental awareness and motivation related to dealing with the issues of healthy eating and physical activity in their family lives and in their surroundings

Pupils' individual behaviour and habits concerning healthy eating and physical activity: Even though this was not the focus of Shape Up, the local coordinators and facilitators indicated that the work on Shape Up positively influenced pupils' health-related behaviour. The Shape Up approach, characterised by the mechanisms of pupil participation, IVAC-pedagogical design, and school community collaboration, has the potential to be effective in involving pupils in and enabling them to address obesogenic environments on a school and local community level.

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HEPS

<http://www.hepseurope.eu>

The HEPS Project started on 1st May 2008. Across EU member states there are many initiatives on reducing the prevalence of overweight among school-aged children with a practical focus towards developing activities, programmes and teaching methods. However, currently no EU member state has an effective national school policy in operation. HEPS aims to bridge this gap by being a policy development project on a national level across Europe. HEPS will help to implement these programmes in a sustainable way at school level. Unique for HEPS is that it will evaluate its impact on national policy in the EU member states.

To achieve its aim, the HEPS School kit will be developed in the three year time period. The HEPS School kit will help member states develop national policy to promote healthy eating and physical activity in schools based on the health promoting school approach. The HEPS School kit consists of the following six components:

- HEPS guidelines: a set of principles on promoting healthy eating and physical activity in schools, meant for organisations working on the national level in Europe;
- HEPS advocacy guide: a tool assisting those advocating for the development of national school policy towards promoting healthy eating and physical activity;
- HEPS inventory tool: an inventory tool including quality assessment of school programmes on healthy eating and physical activity;
- HEPS tool for schools: a guide for school policy development on healthy eating and physical activity;
- HEPS training resource: a programme that will be used to train trainers in promoting healthy eating and physical activity in schools;

- HEPS monitoring tool: used to monitor how effectively the HEPS School kit is being implemented in each member state.

Aim & Objectives: The general objectives of the HEPS Project are:

1. to develop, implement and evaluate an effective national policy and sustainable practices on healthy eating and physical activity in schools in all EU member states
2. to support the development and implementation of comprehensive, sustainable and evidence-based school programmes in the member states to combat and prevent overweight ¹ among school-aged children in the most efficient way by developing and implementing guiding principles and tools to promote healthy eating and physical activity in schools

Support: The HEPS Project is a three year project which started on 1st May 2008 and will end on 30 April 2011. It is co-funded by the European Commission, DG SANCO and by ZON Mw (the Netherlands organisation for health research and development).

The NIGZ is coordinating the HEPS Project in collaboration with: Université Libre de Bruxelles (Belgium), Welsh Assembly Government (Wales), Danish School of Education, Aarhus University (Denmark) Institute for Child Health (Greece), University Maastricht (the Netherlands), NHS Health Scotland, Warsaw University (Poland), University of Bergen (Norway), Leuphana University Lüneburg (Germany), National University of Ireland, Galway (Ireland), Ludwig Boltzmann Gesellschaft (Austria) State Environmental Health Centre, Ministry of Health (Lithuania).

Trigger: In Europe close to one in four school children are overweight, with numbers rapidly increasing. An integrated approach is required to stop this

¹ Preventing overweight in this context means: promoting healthy eating and physical activity, including mental health aspects

trend. HEPS introduces the health promoting school approach as a new way of developing school health policy.

Moreover, the HEPS Project is connected with the Schools for Health in Europe (SHE) network. SHE-coordinators will be able to give their input during the HEPS Project and profit from the outcomes. At the same time they are the key figures who will implement the HEPS School kit in their own country.

Targeted Communities: In Europe it is generally accepted that every child has a right to education, health and security. Schools can contribute to improve children's health by promoting healthy eating and physical activity and by encouraging their participation and training their skills. A strategy built on the health promoting school approach helps school communities to:

- manage health and social issues;
- enhance student learning;
- improve school effectiveness

One of the core values for health promoting schools is equity: that all children and young people have equal access to health and to develop health literacy. This is one of the founding principles - that is built into the HEPS School kit. Furthermore, in the health promoting school approach the school plays a central role. The health programmes and activities are carefully chosen to meet the specific needs of the school, which is important to reach the target group in an effective way.

Evaluation: In the 3rd year the impact of the HEPS School kit on national and regional policy development on promoting healthy eating and physical activity in schools will be assessed.

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2.1.3 Research Studies

Pro Children Project

<http://www.prochildren.org>

The Pro Children Project was designed to provide information on actual consumption levels of vegetables and fruits in European schoolchildren and their parents, to understand the determinants of consumption patterns among the children, and to develop and test effective strategies to promote adequate consumption levels of fruits and vegetables among schoolchildren. The project consists of two phases. In the first phase, relevant information for the planned development and implementation of fruit- and vegetable-promoting interventions is gathered. In the second phase, the planned interventions are developed, implemented and evaluated in group-randomized field studies. The first phase is conducted in 9 participating countries, i.e. in Austria, Belgium, Denmark, Iceland, the Netherlands, Norway, Portugal, Spain and Sweden, while the second phase is restricted to 3 countries, i.e. Spain, the Netherlands and Norway, as efficacy will have to be established prior to broader dissemination.

Aim & Objectives: The specific research objectives are:

Assessing fruit and vegetable consumption and correlates of consumption levels

- To develop valid and reliable instruments for assessing fruit and vegetable consumption among schoolchildren and parents
- To develop valid and reliable instruments for identifying factors influencing consumption patterns among schoolchildren
- To determine the consumption levels of fruits and vegetables among schoolchildren and their parents in participating countries and in various subgroups (such as gender, socio-economic groups and cultural background)

- To determine factors influencing the consumption of fruits and vegetables among schoolchildren in participating countries and in various subgroups (such as gender, socio-economic groups and cultural background)
- To determine cross-national differences in fruit and vegetable consumption among children and their parents, as well as determinants of fruit and vegetable consumption among children
- To determine the local, regional and national policies and organizational structures (including school meals) related to fruit and vegetable consumption

Design, implementation and evaluation (process, impact and efficacy) of the intervention programme

- To design culturally relevant, but theoretically similar intervention programmes to be implemented in 3 participating countries
- To determine facilitating and inhibiting factors for implementing the planned interventions
- To determine how the various intervention components are perceived by the target groups (i.e. children and parents), as well as by other relevant actors (including teachers, school health personnel, local fruit and vegetable producers and distributors)
- To determine to what extent the various intervention components are being implemented as planned
- To determine whether the intervention produce the expected increase in fruit and vegetable consumption
- To determine whether the intervention is equally effective in producing change across countries and within countries (in different demographic groups such as gender and socio-economic groups)
- To determine whether changes in the identified theoretical factors account for the observed changes in fruit and vegetable consumption
- To determine the cost-effectiveness of such an intervention programme.

Support: The Pro Children project started April 1, 2002 for duration of 48 months, financed by the European Commission Research Directorate General (Contract no. QLK1-CT-2001-00547)

Ten research organisations from nine European countries were involved: (1) University of Oslo, Norway, (2) Unidad de Nutricion Comunitaria, Spain, (3) Landspítali University Hospital, Iceland, (4) University of Copenhagen, Denmark, (5) Universidade do Porto, Portugal, (6) University of Vienna, Austria, (7) Royal Veterinary and Agricultural University, Denmark, (8) Erasmus Medical Centre Rotterdam, Netherlands, (9) Karolinska Institutet, Sweden, and (10) Ghent University, Belgium

Trigger: The project was initiated by Knut-Inge Klepp in collaboration with Johannes Brug. Similar project were available in the USA but not yet in Europe. Moreover, up to date data on consumption levels of fruit and vegetables among schoolchildren was not available. In order to develop an evidence based intervention, there was the need to investigate consumption levels and its determinants.

Targeted Communities: The intervention developed within the whole project was implemented at primary schools, and was not specifically developed to target children from low SES families. In the Netherlands, however, the intervention was implemented at schools in Rotterdam, one of the major cities and with a high proportion of non-Western immigrant children (about 50%). The school was chosen as the location of intervention because all children can be reached, also those who are normally hard to reach, such as children from low SES families.

Evaluation: The project has already been evaluated and has been published [45]. The programme has proven to be effective, at least at the shorter term, after one year into the intervention (see publication). After two years the intervention was only effective in Norway, where the intervention seems to be best implemented. The intervention was most intensive during the first year, when children were

not only provided with free fruit and vegetables but also were involved in class activities such as taste testing and homework assignments. During the first year parents were also involved by means of parent meetings, newsletters and homework assignments.

Additional analyses showed children's appreciation and parental involvement were important mediators of the intervention [46].

No subgroup analyses have been conducted to see whether children from low SES families improved more or less compared to children from high SES families. Furthermore, no health conditions were measures and it could therefore not be examined whether the intervention improved the health condition of the children.

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Health Behaviour in School-aged Children (HBSC)

<http://www.hbsc.org>

Health Behaviour in School-aged Children (HBSC) is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into, and increase our understanding of young people's health and well-being, health behaviours and their social context.

It is important that young people's health is considered in its broadest sense, encompassing physical, social and emotional wellbeing. Health should be viewed as a resource for everyday living, and not just the absence of disease.

Therefore, research into children's health needs to consider the positive aspects of health, as well as risk factors for future ill health and disease. Family, school and peer settings and relationships need to be explored, as does the socio-economic environment in which young people grow up, if we are to understand fully the patterns of health and health behaviour found in the adolescent population.

Aim & Objectives: As well as aiming to increase understanding of young people's health, the findings from the HBSC surveys are used to inform and influence health promotion and health education policy and practice at national and international levels.

Its objectives are:

- to initiate and sustain national and international research on health behaviour, health and well being and their social contexts in school-aged children
- to contribute to theoretical, conceptual, and methodological development in the said area of research
- to contribute to the knowledge base in the said research area

- to monitor and to compare health and health behaviour and social contexts of school-aged children in member countries through the collection of relevant data
- to disseminate findings to the relevant audiences including researchers, health and education policy makers, health promotion practitioners, teachers, parents and young people
- to develop partnerships with relevant external agencies in relation to adolescent health to support the development of health promotion with school-aged children
- to promote and support the establishment of national expertise on health behaviour and on the social context of health in school-aged children
- to establish and strengthen a multi-disciplinary international network of experts in this field
- to provide an international source of expertise and intelligence on adolescent health for public health and health education

There are now 43 participating countries and regions. At present, membership of HBSC is restricted to countries and states within the WHO European region. Each country/region is represented by a Principal Investigator (PI) and national research team.

The first cross-national survey was conducted in 1983/84, the second in 1985/86 and since then data collection has been carried out every four years using a common research protocol. The most recent survey, the seventh in the series, was conducted in 2005/06.

HBSC is a school-based survey with data collected through self-completion questionnaires administered in the classroom. Fieldwork for each cross-national survey is carried out over a period of around seven to eight months, from October to May of the following year. This reflects the sampling strategy used in each country in order to achieve the mean ages of 11.5, 13.5 and 15.5.

The HBSC survey instrument is a standard questionnaire developed by the international research network and used by all participating countries. The HBSC Research Network comprises member country Principal Investigators and their research teams. There are approximately 300 individual researchers in the network from a range of disciplines.

Each survey questionnaire contains a core set of questions looking at the following:

- *Social and developmental contexts*: demographics and maturation, social background (family structure, socio-economic status), family and peer relationships, school environment
- *Health behaviours*: physical activity, eating and dieting, smoking, alcohol use, cannabis use, sexual behaviour, violence and bullying, injuries
- *Health and well-being*: symptoms, life satisfaction, self-reported health, Body Mass Index, body image

Many countries also include additional items in their national questionnaire that are of particular interest on a national level.

The data collected in each country is sent to the HBSC Data Bank at the University of Bergen, Norway. It is then cleaned and compiled into an international data file by the Norwegian Social Science Data Services (NSD) under the guidance of the study's Data Bank Manager. When all national data has been received and accepted according to the Protocol, the files are merged and the combined data file is made available to the Principal Investigators of each participating country.

The international data file is available for use by member country teams for a period of three years, after which time the data is available for external use by agreement with the International Coordinator and the Principal Investigators.

The international standard questionnaire enables the collection of common data across all participating countries and thus enables the quantification of patterns

of key health behaviours, health indicators and contextual variables. These data allow cross-national comparisons to be made and, with successive surveys, trend data is gathered and may be examined at both the national and cross-national level.

Data analysis is carried out by members of the research network working individually and in topic focus groups.

The study encompasses school systems, embraces many cultures and languages (within and between countries). Every effort is made to standardise the methods employed across countries in order to achieve the best possible comparable data that a cross-national survey will allow.

Support: Each member country needs to secure national funding to carry out the surveys and to contribute to the management and development of the international study. NHS Health Scotland provides funding for the study's international coordination. The International Coordinating Centre (ICC) is based within the Child and Adolescent Health Research Unit (CAHRU), University of Edinburgh.

Collaboration with the study's primary partner, the World Health Organization Regional Office for Europe creates opportunities for, and facilitates, the wide dissemination and utilisation of HBSC research findings. The main outputs of this collaboration are the publication of international reports by the Copenhagen Office and the WHO/HBSC Forum series in collaboration with the European Office for Investment for Health & Development in Venice. The goal of the WHO/HBSC Forum series is to bring policy-makers, practitioners and researchers together to compare and learn from experiences in addressing the socio-economic determinants of adolescent health.

Trigger: HBSC was initiated in 1982 by researchers from three countries and shortly afterwards the project was adopted by the World Health Organization as a WHO collaborative study.

Targeted Communities: The target population of the HBSC study is school children, aged between 11 and 15 years old. These age groups represent the onset of adolescence, the challenge of physical and emotional changes, and the middle years when important life and career decisions are beginning to be made.

The survey is carried out on a nationally representative sample in each participating country. The sample consists of a minimum of 1500 from school years 7 (11 year olds), 9 (13 year olds) and 11 (15 year olds) providing a sample size of approximately 4500 from each participating country.

Evaluation: HBSC provides intelligence for the development and evaluation of public health policy and practice at national, sub-national and international levels through the WHO/HBSC forum series. Forum processes convene researchers, policy-makers and practitioners from across Europe to analyse data, review policies and interventions, and identify lessons learned to improve the health of adolescents through actions that address the social contexts that influence their health. Each Forum process consists of case studies produced by interdisciplinary teams in countries and regions, cross-country evidence reviews, a European consultation, an outcomes statement within a final publication, and a Web-based knowledge platform. In addition to emphasizing the translation of research into action, the Forum series focuses on increasing knowledge in order to scale up inter-sectoral policies and interventions; reduce health inequities; and involve young people in the design, implementation and evaluation of policies and interventions.

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ENERGY Project

<http://www.emgo.nl>

The full title of the project is: the **EuropeaN Energy balance Research** to prevent excessive weight **Gain among Youth: Theory and evidence-based development and validation of an intervention scheme to promote healthy nutrition and physical activity.** The ENERGY Project started on the 1st of February 2009.

The ENERGY Project will carry out multidisciplinary analysis of impact and utility of financial and non-financial incentive schemes on extrinsic and intrinsic factors determining healthy behaviour in children and adolescents. ENERGY will further examine the influence of existing schemes on different populations, settings, and purposes and a new intervention scheme will be developed according to theory and evidence-based methods and validated for improved capacity to encourage and sustain the adoption of healthy behaviours.

Aim & Objectives: The overall aim of the ENERGY Study is the development of a new theory- and evidence-based multi component intervention scheme ready to be implemented across Europe promoting the adoption or continuation of health behaviours that contribute to a healthy energy balance. We expect to develop an intervention scheme that is both school-based and family involved, and aimed at the age group of 10-12 year olds, in the transition between childhood and adolescence.

Support: The project is funded by the European Commission (FP7-HEALTH-2007-B).

Parties involved are (1) the VU University Medical Center – VUmc Netherlands, (2) the University of Ghent – Ugent Belgium, (3) the University of Oslo – UiO Norway, (4) the University of Agder - UiA Norway, (5) the University of Teesside - Tees UK, (6) the Federal Research Centre for Nutrition and Food - BfEL Germany, (7) the University of Copenhagen - KU Denmark, (8) the University of Zaragoza –

UniZar Spain, (9) the Harokopio University of Athens -HUA Greece, (10) the International Taskforce on Obesity – IASO- IOTF UK, (11) the Slovenian Heart Foundation –SHF Slovenia, (12) the University of Pecs – PTE Hungary, the (13) World Health Organisation Europe – WHO/ EURO Denmark and (14) the Deakin University - Deakin Australia.

Trigger: The project was initiated by the parties mentioned above.

Targeted Communities: ENERGY targets:

- 10-12-year olds;
- Schools; and
- Family environments.

The multi component school-based intervention will be tailored to subjects from different socio-economic backgrounds building upon systematic inventories of existing scientific evidence. The moderating effects of socio-economic status are specifically examined and adapt the intervention accordingly our findings.

Evaluation: Not yet applicable.

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2.2 Overall European population

2.2.1 Running Programmes

Most Deprived People (MDP) Scheme

<http://ec.europa.eu/agriculture/markets/freefood/>

Aim & Objectives: The MDP's goal is to reduce food insecurity and so help guarantee the right to food in the EU. Aid is typically provided to a wide range of people living in poverty, including families in difficulties, elderly people with insufficient means, people who are homeless, or disabled, children at risk, low paid people, migrant workers and asylum seekers [47].

Design: The scheme to distribute free food to the most deprived persons in the Community was launched as an emergency measure in the exceptionally cold winter of 1986/87, when surplus stocks of agricultural produce were given to Member State charities for distribution to people in need.

Over the years, the MDP scheme has been responsible for ensuring that products based on beef, olive oil, butter, milk powder, rice, cereals and sugar have been distributed to people in need in the European Union. Before the reform of the CAP [48], stocks of these products were usually plentiful and stored in warehouses around Europe at the taxpayer's expense.



Figure 10: Most Deprived People Scheme

Source: <http://ec.europa.eu/agriculture/markets/freefood>

As a result of the reform process that the CAP has undergone since the early 1990s, large surplus stocks are now non-existent. The phasing-down of systematic intervention on the markets, together with a growth in demand for staple food products, means that only small quantities are now available for the MDP scheme.

To ensure that the scheme could continue, it was amended in 1995 to allow the surplus stocks to be complemented by a financial contribution, when this was necessary. The Commission decided to make finance available for approved charities to buy food on the open market on a permanent basis.

Introducing co-financing will help to improve planning and management of funds and allow Member States to take greater responsibility for the programme. To further enhance efficiency and to ensure continuity, a three-year distribution plan was established and products are thus no longer limited to those for which the intervention applies. For example, fruit and vegetables and cooking oil are, for the first time, covered by the programme.

The choice of food is made by national authorities on the basis of nutritional criteria and distributed in cooperation with civil society partners. Food is sourced either from intervention stocks, if available, or from the market with priority given to the use of intervention stocks where these are available. Distribution must be free of charge or at a price no greater than justified by the costs incurred by the designated organisation in distributing the food.

Member States that want to take part in the programme select suitable organisations - usually charities or local social services - to carry out the food distribution. They then identify their needs for a three-year programming period and make their request to the Commission, which allocates the budget. This is done on an annual basis, to enable adjustments to be made if the situation changes in the course of the programming period [47].

Support: The overall budget for the programme increased from just under € 100 million in 1988 to over € 300 million in 2008. In September 2008, the European Commission proposed to further improve the food distribution programme by

increasing the budget by two thirds to around € 500 million from 2009 and extending the range of products which can be provided [47].

From the 2010/12 plan, the scheme would be co-financed (75 percent from the EU budget, and 85 percent in cohesion areas). From the 2013/15 plan, co-financing would be split 50/50, with the EU budget providing 75 percent in cohesion regions.

The Commission believes an increase in the budget to be necessary because rising food prices are adversely affecting the food security of needy people and increasing the cost of providing food aid [47].

Trigger: Although the EU has, on average, among the highest living standards in the world, some people are unable to adequately feed themselves. An estimated 43 million people in the EU are at risk of food poverty, meaning that they cannot afford a meal with meat, chicken or fish every second day [47].

Targeted Communities: Member States are free to choose whether or not to participate in the programme. Aid is typically provided to a wide range of people living in poverty, including families in difficulties, elderly people with insufficient means, the homeless, the disabled, children at risk, the working poor, migrant workers and asylum seekers. In 2006, more than 13 million EU citizens benefited from this aid scheme.

Some 19 Member States currently participate in the programme: Belgium, Bulgaria, Czech Republic, Estonia, Greece, Spain, France, Ireland, Italy, Latvia, Lithuania, Luxembourg, Hungary, Malta, Poland, Portugal, Romania, Slovenia and Finland [47].

Evaluation: As intervention stocks are likely to remain low for the foreseeable future, the Commission launched an Impact Assessment of the Most Deprived programme in 2008 to examine options for the scheme's future. The aim of the Impact Assessment process was, first, to identify the problem that is being addressed and the policy objectives, and then to identify options for achieving

those objectives and analyse their likely economic, environmental and social impact. It describes the advantages and disadvantages of each option and examines possible synergies and trade-offs [47].

Following the Commission's Guidelines, the Impact Assessment was conducted by an Inter-service Steering Group made up of representatives from the relevant Commission services and was chaired by the Directorate-General for Agriculture and Rural Development. The advice, views and contributions of concerned charities, government services and NGOs, as well as the general public, were sought in the course of the assessment process [47].

A proposal for the future of the scheme was put forward on 17 September 2008 [49]. It was concluded that: *"The EU Programme of Food Aid to the Most Deprived does not set out to resolve all food poverty in the Member States. It aims to enhance and/or trigger Member State action, and to help support charities and civil society in developing their own initiatives to ensure the right of all EU citizens to food."*

Options 2 (Intervention stocks complemented by market purchases) and 3 (Market purchases only) both meet the objectives assigned to a renewed MDP. As well as administrative simplification and improved governance, the Programme could introduce innovations as concerns food waste and insertion into the broader social context."

2.2.2 Policy Development

HOPE Project

<http://www.hopeproject.eu>

The central objective of the HOPE project – **H**ealth promotion through **O**besity **P**revention across **E**urope - is to support and advance the development of policies effective for the prevention of overweight, obesity and their negative consequences on health and health inequalities. This is achieved by providing estimates of the potential impact of interventions directed at key determinants of obesity in the European Union.

Based on a 'network of network', the HOPE project will gather all available evidence to provide an overview of preventive intervention and policy measures, encompassing the life course stages and focusing on the lower socio-economic groups. The enormous variation across Europe in nutrition, physical activity, obesity and environmental determinants will form the basis to assess potential effects of a variety of measures.

During the project, the following *proximal determinants* will be studied:

- Nutrition and physical activity lifestyle factors, with a specific emphasis on more specific obesogenic or obeso-preventive behaviours such as:
- Intake of high fat, sugar-rich and other energy-dense foods
- Intake of fruit and vegetables and other fibre-rich foods
- Intake of sugar-sweetened drinks
- Meal patterns, i.e. breakfast habits, meal frequency and frequency of snack food consumption
- Transport physical activities
- Leisure time physical activities
- Sport activities
- Sedentary behaviours, i.e. TV viewing

And the following *distal determinants* will be studied:

- Socio-economic factors: educational level, employment status, wealth and household income
- Macro-environmental factors, with a specific focus on the policy and informational environmental
- Factors at the European, Member State and/or regional level
- Micro-environmental factors, with a specific focus on physical, social-cultural, and political environmental factors at the family, school and workplace level.

This Project was set up for several reasons. Firstly, few studies have focused on the distal obesogenic physical, social-cultural, financial and political environmental factors that drive obesogenic behaviours. Furthermore, no co-ordination action has integrated knowledge and translated this into recommendations for policies and interventions at key age groups, i.e., early childhood, adolescence and early adulthood. There is limited exchange between EU Member States on strategies and methodologies. As a result, learning effects have been modest, and an EU-wide comprehensive inventory of preventive interventions aimed at broad implementation is lacking. Furthermore, ongoing interventions have not been evaluated extensively, and their impact on the lower socio-economic groups has not been established or published internationally. Although some reviews on the effectiveness of educational campaigns and policy measures for nutrition and physical activity have been carried out, these are outdated or restricted to certain groups. Finally, no attempts have been made to assess the potential impact of effective interventions to tackle environmental determinants on the European population through the development of scenarios.

Aim & Objectives: The HOPE project aims to support and advance the development and implementation of systematic, evidence-based European, national and regional policies effective for the prevention of obesity and its negative consequences on health and health inequalities.

The project specifically aims:

1. To integrate scientific knowledge from ongoing scientific efforts on nutrition, physical activity, overweight and obesity, and health inequalities, and to translate it into policy recommendations for obesity prevention across Europe.
2. To improve understanding of obesity and lifestyle factors by estimating the prevalence and trends of overweight and obesity, physical activity and nutrition patterns among infants, adolescents and adults.
3. To assess the impact of macro-policy and micro-level environmental factors at the family, school and work place on obesity and on preventive nutrition and physical activity behaviours across Member States.
4. To improve understanding of obesity-related health inequalities by assessing socio-economic differences in physical activity, nutrition, overweight and obesity and their determinants across Member States.
5. To assess the potential to tackle these determinants by conducting systematic reviews and inventories of evidence-based interventions and policies across Europe, with an emphasis on the school and workplace settings, and on the lower socio-economic groups.
6. To estimate the future burden and impact of obesity on future trends in morbidity, mortality and health inequalities, through the development of scenarios of the impact of implementing plausible effective policies and interventions among children, adolescents and adults across the European Union.

Support: The HOPE project consortium consists of a multidisciplinary team of specialists in the fields of obesity, epidemiology, nutrition, physical activity, public health and health promotion from 14 countries. The project is financial supported by the European Union and coordinated by the Department of Public Health of the Erasmus University Medical Centre assisted by the International Obesity task Force and the International Association of the Study of Obesity.

Trigger: The number of overweight children is estimated to be 22 million in 2006, increasing by over one million per year. This includes over 5 million children who are obese, a figure which is rising annually by over 300,000.

Targeted Communities: The overall target community is the European population, but based on a 'network of networks', the HOPE project will gather all available evidence to provide an overview of preventive intervention and policy measures, and focusing on the lower socio-economic groups.

Sub target communities are: early childhood, adolescents (10-18 years), young adults and lower socio-economic groups:

Evaluation: The project is not yet evaluated.

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EURO-PREVOB

<http://www.europrevob.eu>

EURO-PREVOB is a European Coordination Action project linking science and policy-making to tackle obesity and inequalities in obesity in Europe. The project promotes collaboration across existing networks, to address the social and economic determinants of obesity, including developments that recognise the specificities of sub-regional groupings of countries. EURO-PREVOB started in April 2007 and is set to run until March 2010.

Aim & Objectives: The project aims to (1) improve the understanding of the broad determinants of, and inequalities in, obesity, (2) identify policy initiatives that can impact positively on the determinants of obesity, (3) develop and pilot tools to assist policy analysis, and (4) draw upon the project outputs to propose recommendations contributing to efforts at preventing obesity in Europe. The programme of work integrates complementary activities, such as reviews of the literature and current policies, development and piloting of a portfolio of instruments to assist policy analysis, dissemination of information through consultations and collaboration across networks.

Support: EURO-PREVOB is funded by the European Commission's 6th Framework Programme and involves 14 participants from 10 European countries (Bosnia and Herzegovina, the Czech Republic, Denmark, France, Italy, Latvia, Slovenia, Switzerland, Turkey, and the United Kingdom) and from a variety of key disciplines, including nutrition, physical activity research, public health, epidemiology, economics, and health policy.

Trigger: EURO-PREVOB was developed in response to a call from the European Commission. The project specifically responds to the fact that current scientific knowledge remains inadequately integrated into health protection policies, so that action on nutrition and physical activity fails to tackle obesity and especially

inequalities in obesity in Europe. This coordination action project integrates, at a European level, resources and expertise within and beyond the area of public health nutrition and physical activity.

Targeted Communities: Addressing socio-economic inequalities in obesity, and specifically creating the opportunities for making healthy food choices and for physical activity, are central to the aims of EURO-PREVOB. A key premise of the project is that individuals (and their intrinsic risk of obesity) are influenced by the environments in which they live. Thus one element of EURO-PREVOB is to examine socio-economic differentials in the environmental determinants of obesity, specifically by piloting a Policy Analysis Tool in five sub-regions of Europe.

The Policy Analysis Tool has two main components: (1) The Policy Checklist: a questionnaire on the status of national policy on four thematic areas (food environment, built environment, maternal and young child health services, and schools) with explicit questions on whether socio-economic inequalities are addressed in each policy area; and (2) the Community Questionnaire: a rapid assessment of environmental indicators at the community level divided into two thematic sections (food environment and built environment), designed to be used in areas representing a spectrum of socio-economic levels.

The Policy Analysis Tool was piloted in five countries from different sub-regions of Europe (in brackets are the cities where the Community Questionnaire was tested): (1) Czech Republic for Central and Eastern Europe (Brno); (2) Latvia for the Nordic-Baltic Region (Riga); (3) Turkey for Southern Europe (Ankara); (4) Bosnia and Herzegovina for South Eastern Europe (Sarajevo); and (5) France for Western Europe (Marseille).

The Tool was found to be relevant, comprehensive and useful for collecting information on national policies and their links to obesity and social inequalities within the European context. Results from the pilot tests also showed that it has the capacity to compare policy response to obesity and to its determinants

among countries, illustrate actions taken to address obesity at the policy level, and provide information on the relative ease with which policy information was accessed.

The EURO-PREVOB Consortium is currently developing a set of recommendations for obesity prevention in Europe based on the project's findings, taking into account socio-economic inequalities in obesity.

Evaluation: Evaluation mechanisms have been developed and included into all parts of EURO-PREVOB. Monitoring is integrated within the project by way of an Advisory Board that comprises a group of experts in obesity and related fields. The Advisory Board is mandated to ensure that the project proceeds in a satisfactory manner and in a way that responds to the needs of policy-makers and stakeholder groups.

Evaluation was an intrinsic part of the development and testing of the Policy Analysis Tool described above. The first version of the tool was reviewed by a group of experts and stakeholders. The revised tool was then piloted in five countries. Process evaluation questionnaires were developed to assess the applicability and usefulness of the tool during the pilot tests, and to document its actual implementation. Results from the pilot tests, including process evaluation, and other project outputs will be published as reports made available on the project website and as peer-reviewed articles.

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TEENAGE Project

<http://www.teenageproject.eu>

The scope of the project TEENAGE is the prevention of socio-economic inequalities in health behaviour in adolescents in Europe by collecting and disseminating evidence throughout Europe. The project aims to identify and evaluate the effectiveness of comprehensive policy approaches to address health inequalities. In addition the project wants to identify, evaluate and disseminate good practice on including a social determinants focus in strategies that address determinants of socio-economic inequalities such as nutrition and physical activity, tobacco, drugs, and alcohol.

The TEENAGE consortium brings together expertise in the field of health inequalities and of health promotion. It consists of a variety of experts in the fields of socio-economic inequalities in health, public health, epidemiology, nutrition, physical activity, tobacco, drugs and alcohol from five different European countries: the Netherlands, Belgium, Norway, United Kingdom and Italy and several collaborating institutes from other countries.

Many 'modern' health promotion interventions are currently conducted, including use of the Internet, and changes in the environment. Knowledge of the effectiveness and the transferability throughout Europe of such interventions can contribute to the prevention of socio-economic inequalities in health behaviour by formulating policy recommendations.

The major innovations of TEENAGE are:

- The project brings together expertise in the field of health inequalities and of health promotion;
- The project focuses on the prevention of socio-economic inequalities in health behaviours instead of the reduction in inequalities;

- The project will assess whether interventions are effective in host countries and if interventions can be transferred to other countries;
- The project will develop and apply an instrument on the basis of which the applicability of interventions can be assessed. This instrument enables to extend the formulation of policy to countries without ongoing interventions in different European regions;
- The project will apply state-of the-art statistical techniques to re-analyse interventions, even if this was not done so in original analyses. It will therefore generate important new evidence of the evaluation of public health interventions and interventions to prevent socio-economic inequalities in health, directly relevant for policy makers; and
- The project develops training materials for the prevention of socio-economic inequalities in health, which are currently unavailable.

The work to be done within the TEENAGE project is divided into 9 so-called work packages (WP) and will be conducted under the leading roll of Erasmus MC, University Rotterdam (the Netherlands).

1. **WP1: Coordination TEENAGE project;** the aim of this work package is to support the overall running of the project through the co-ordination of activities of all work packages and the construction of a management information system. This work package will comprise the co-ordination task to promote and ensure integrated and timely progress of the project and reporting to the EU. It will carry out the administrative tasks and will be responsible for the financial and organizational management of the project.
2. **WP2: Dissemination results TEENAGE;** the main objective will be to disseminate all output/deliverables of the project. This will be mainly done in a form that can help policy makers at the European, national and local level to obtain the information needed to formulate policies.
3. **WP3: Evaluation TEENAGE project;** this WP aims to evaluate the project, both in terms of process outcomes as well as project outcomes.
4. **WP4: The prevention of SES inequalities in physical inactivity in adolescence;** the aim of this work package is to develop evidence of effectiveness of

interventions and policies to prevent physical inactivity in European adolescents (11-18 years).

5. **WP5: The prevention of SES inequalities in poor diet in adolescence;** the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent poor diet in European adolescents (11-18 years).
6. **WP6: prevention of SES inequalities in smoking uptake in adolescence;** the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent smoking in European adolescents (11-18 years).
7. **WP7: The prevention of SES inequalities in alcohol use in adolescents in Europe;** the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent alcohol consumption in European adolescents (11-18 years).
8. **WP8: Assessing the transferability of evidence from "source" countries to other countries;** work package 8 will assess the transferability of results of interventions from 'source' countries (the countries in which the intervention was evaluated) to 5 other countries. Those 5 other countries, the 'target' countries will represent different regions in the EU (North, West, South, and East).
9. **WP9: Integrating evidence of effectiveness and knowledge of transferability into policy recommendations;** work package 9 aims to synthesize the evidence obtained in the specific Work packages 4-7 and the knowledge on the transferability obtained in WP 8 and to translate this into policy recommendations.

Aim & Objectives: The general aim of TEENAGE is to generate and disseminate evidence on the effective approaches for prevention of socio-economic inequalities in health behaviour among adolescents. The evidence will be relevant to the European level as well as national and local levels.

Strategic objectives include:

- Development of evidence on the effectiveness of interventions to prevent physical inactivity, poor diet, smoking, and alcohol consumption in adolescents in lower socio-economic groups across Europe.
- Assessment of the transferability of effective interventions in lower socio-economic groups from 'source' countries to other countries throughout Europe.
- Development of policy recommendations for the prevention of socio-economic inequalities in these health behaviours in adolescents in lower socio-economic groups in Europe.
- Dissemination of the results and development of a European clearing-house on the prevention of the inequalities in unhealthy behaviour in adolescents in Europe.

Support: The project is subsidized by the Public Health programme from the European Commission.

Trigger: Previous and ongoing projects show persistent socio-economic inequalities in health in European countries. Smoking, physical inactivity, poor diet and alcohol consumption contribute at least 30-50% to socio-economic inequalities in health. These behaviours mainly develop in adolescence. A crucial entry point for policies to reduce inequalities in health is the prevention of unhealthy behaviour in adolescents in lower socio-economic groups.

Targeted Communities: Because behaviours developed in adolescence are largely maintained in adulthood, preventing unhealthy behaviour in adolescents in lower socio-economic groups is a crucial strategy for the prevention of socio-economic inequalities in health in adulthood. In addition, current health promotion efforts do not specifically focus on adolescents with the highest probability of unhealthy behaviour in adulthood - those in lower SEGs.

Evaluation: The project is not yet evaluated.

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European Public Health & Agriculture Consortium

<http://www.healthyagriculture.eu>

Aim & Objectives: The European Agriculture and Health Consortium's main goal is to advocate for health promoting Common Agriculture Policy. More specifically, the consortium aims to find synergies between agriculture and health policies that promote diets that benefit chronic disease prevention, ensure global food security and are climate friendly. This requires moving towards:

- Less energy dense, more nutrient dense food, meaning an increased consumption of fruit and vegetables, (whole) grains and plant based diets;
- Decreased consumption of high fat dairy and meats, red meat and confectionary products high in fat and sugar.

Design: Members of the Consortium are EuroHealthNet, European Heart Network, European Public Health Alliance, Heart of Mersey, North West Health Brussels Office and the National Heart Forum.

Food and agriculture policy (CAP) should be based on equity, the universal right to safe, affordable, nutritious food, and good governance and transparency in the food supply chain. It should be aimed at reducing inequalities in diet and chronic disease, producing enough food to feed a growing world population and a "greener" agriculture policy that reduces green house gas emissions from food production

Key points are:

- Healthy eating patterns should be promoted, moving towards plant based diets and addresses overconsumption of meat, energy-dense, highly processed foods, and saturated fats, while respecting the cultural dietary habits and traditions of Europe's diverse population;

- Food and nutrition security for Europe and the rest of the world as a universal human right;
- Public goods provided through rural stewardship, environment and public health;
- Resources are devoted to teach children the skills and knowledge required to produce, prepare, and enjoy healthy, nutritious food;
- Fair and equitable conditions for farmers and land workers in Central, Eastern Europe and developing countries and promoting fair and equitable access to land;
- Transparency ensured across the food chain so that citizens know how their food is produced, where it comes from, what it contains and what it is included in the final price;
- Concentration of power in the food system is addressed and its influence on what is produced and consumed, and brings EU food and agriculture policy closer to European citizens.

Trigger: Chronic Non-Communicable diseases (NCDs) pose one of the greatest threats to public health and economic growth at local, national and global levels. Diet is one of the major modifiable risk factors for Chronic Non-Communicable Diseases (NCDs). Societal and cultural trends have indicated that Member States are moving towards converging diets characterized by energy dense, highly processed, nutrient poor foods. This combined with lower levels of physical inactivity play an important role in increasing rates of Chronic Non-communicable diseases and thus, diminishing people's health status and overall wellbeing. The vision for the post 2013 Common Agriculture provides an opportunity to improve the well being of European citizens

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2.2.3 Research Studies

HELENA Study

<http://www.helenastudy.com>

The HELENA project (**H**ealthy **L**ifestyle in **E**urope by **N**utrition in **A**dolescents) includes cross-sectional, crossover and pilot community intervention multi-centre studies, as an integrated approach. The project started May 1st, 2005 and for the cross-sectional study, there was a pilot study in April-May 2006. The project will provide information about the nutritional status of the European adolescents:

1. dietary intake, nutrition knowledge and eating attitudes;
2. food choices and preferences
3. body composition;
4. plasma lipids and metabolic profile;
5. vitamin status;
6. immune function related to nutritional status;
7. physical activity and fitness; and
8. genotype (to analyse gene-nutrient and gene-environment interactions)

Both scientific and technological objectives should result in reliable and comparable data of a representative sample of European adolescents, concerning: foods and nutrients intake, food choices and preferences, obesity prevalence, dislipidemia, insulin resistance, vitamin and minerals status, immunological markers for subclinical malnutrition, physical activity and fitness patterns, and variations of the nucleotide sequence in selected genes. This will contribute to understand why health-related messages are not being as effective as expected in the adolescent population. A realistic intervention strategy was proposed in order to achieve the goals of understanding and effectively enhancing nutritional and lifestyle habits of adolescents in Europe.

Aim & Objectives: The main objective of the project is to obtain reliable and comparable data of a representative sample of European adolescents. This will contribute to understand why health-related messages are not being as effective as expected in the adolescent population. The requirements for health promoting foods were also identified, and three sensory acceptable products for adolescents were developed.



Figure 11: HELENA Study

Source: Luis Moreno, HELENA Study

Support: The project is supported by the EU 6th Framework programme. Partners involved are: (1) Universidad de Zaragoza (Spain), (2) Consejo Superior de Investigaciones Científicas (Spain), (3) Université de Lille 2 (France), (4) Research Institute of Child Nutrition Dortmund (Germany), (5) Pécsi Tudományegyetem

(University of Pécs) (Hungary), (6) University of Crete School of Medicine (Greece), (7) Rheinische Friedrich Wilhelms Universität (Germany), (8) University of Granada (Spain), (9) Istituto Nazionale di Ricerca per Gli Alimenti e la Nutrizione (Italy), (10) University of Napoli "Federico II" Dept of Food Science (Italy), (11) Ghent University (Belgium), (12) University of Vienna (Austria), (13) Harokopio University (Greece), (14) Institut Pasteur de Lille (France), (15) Karolinska Institutet (Sweden), (16) Asociación de Investigación de la Industria Agroalimentaria (Spain), (17) Campden & Chorleywood Food Research Association (United Kingdom), (18) SIK - Institutet för livsmedel och bioteknik (Sweden), (19) Meurice Recherche & Développement asbl (Belgium), (20) Campden & Chorleywood Food Development Institute (Hungary), (21) Productos Aditivos SA (Spain), (22) Carnicas Serrano SL (Spain), (23) Cederroth International AB (Sweden), (24) Cerealia R&D AB (Sweden), (25) EUFIC (Belgium), (26) Universidad Politécnica de Madrid (Spain).



Figure 12: HELENA Study

Source: Luis Moreno, HELENA Study

Trigger: A school-based lifestyle education intervention was performed in 6 European cities: Ghent (Belgium), Vienna (Austria), Stockholm (Sweden), Dortmund (Germany), Athens (Greece), and Heraklion (Greece), without any specific reason.

Targeted Communities: The HELENA intervention was a feasibility study, in order to try applying it in further intervention studies in Europe. Health inequalities were not taken into account for the feasibility study, but it will be considered in further studies.

Evaluation: There are no published reports describing the intervention outcome. Two papers will be submitted soon.

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IMAGE Project

<http://www.image-project.eu>

The IMAGE project, development and Implementation of a European Guideline and Training Standards for Diabetes Prevention, started in June 2007 and will be finished in May 2010. Building a consortium of expertise, over 40 partner institutions from 22 countries are involved, working in seven work packages (WP) to address the project's objectives (figure 13).

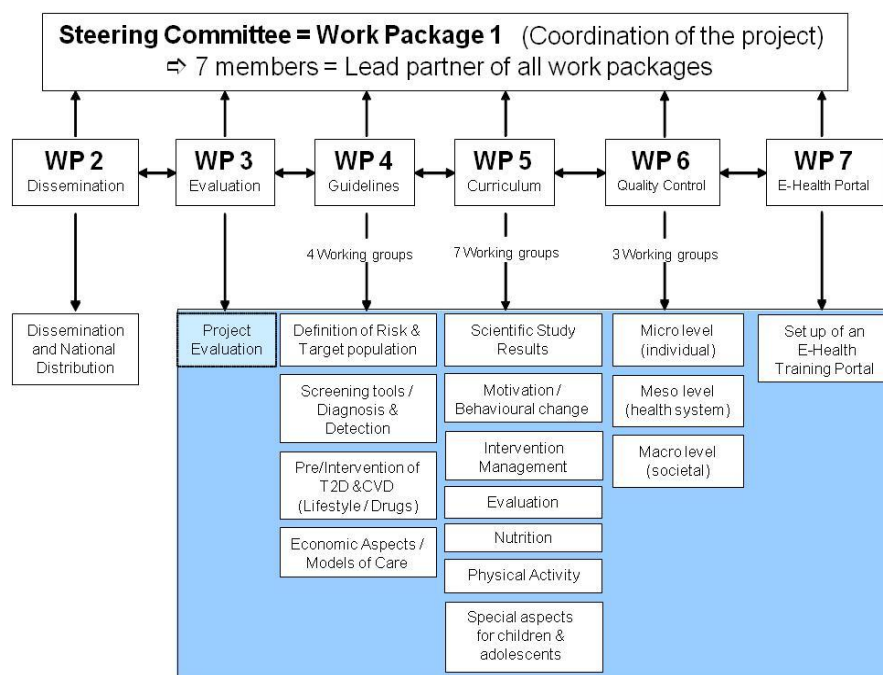


Figure 13: IMAGE Project Structure

Source: Prof. Schwarz, IMAGE Project

The IMAGE project follows up on ideas of the EU public health research project DE-PLAN "Diabetes in Europe - Prevention using Lifestyle, Physical Activity and Nutritional intervention".

Aim & Objectives: Effective primary prevention is the key to reduce the epidemic in type 2 diabetes. The IMAGE project is addressing this through the development of four specific objectives:

1. Development of European practice-oriented guidelines for the primary prevention of type 2 diabetes to improve information and knowledge about public health strategies and to prevent type 2 diabetes and its co-morbidities.
2. Development of a European curriculum for the training of prevention managers to enhance the ability of healthcare professionals to respond swiftly to the drastic increase of type 2 diabetes and its burden to society.
3. Development of European standards quality control in order to monitor and report these systematically both in the member states and at the EU level using comparative data.
4. Development of a European e-health training portal for prevention managers to improve availability of evidence-based health information for health care professionals.

Support: The IMAGE project (No 2006309) is receiving funding from the European Union in the framework of the Public Health Programme (2003-2008). The networking process and the implementation of the IMAGE project results is supported by unrestricted grants from Bayer Health Care, Lilly, Merck, MSD Diabetes, The German Diabetes Foundation and the Herbert-Quandt Foundation.

At the official project start, 27 associate partners from 13 EU member states plus collaborating partners from Serbia, Ukraine and Israel were involved in the project. There are now 40 partner organisations from 16 EU- and 6 non-EU member states involved in the project (figure 14).

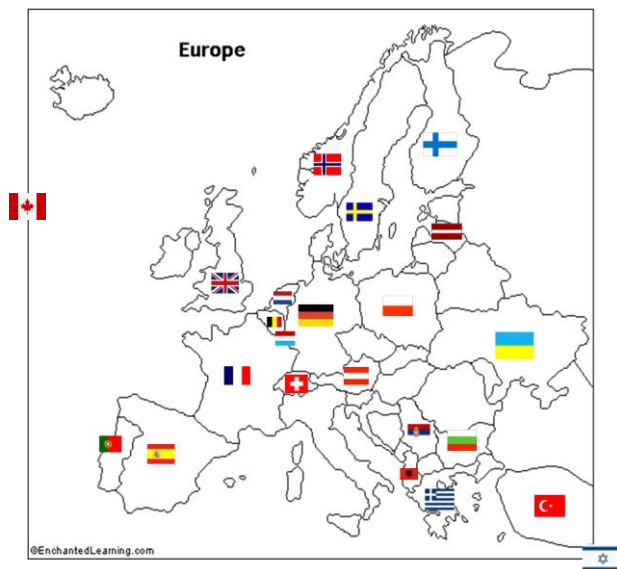


Figure 14: Represented countries IMAGE Project

Source: Prof. Schwarz, IMAGE Project

Trigger: The IMAGE project was built upon ideas and experiences of Prof. Schwarz. Prevention management concepts are being developed which can be implemented into clinical practice. These concepts were discussed on the EU Conference on Prevention of Type 2 Diabetes, where the Austrian EU Presidency highlighted the prevention of type 2 diabetes and its complications as the main health topics during the presidency in 2006. Experts covering all related areas exchanged views and discussed seminal strategies for the implementation of diabetes prevention and management. The results of the discussions are compiled in the “Vienna Declaration” which comprises the main findings and recommendations in tackling the burden of diabetes at EU.

Targeted Communities: The IMAGE project targets healthcare professionals and institutions, health insurance companies, politicians at national, federal and regional level, international and national organisations (WHO, Diabetes Associations, professional organisations, sport clubs), and diabetes support groups / patient organisations in Europe. Considering the multifaceted target audience, the dissemination strategy is divided into two major components: expert information via scientific publications and general information via mass media.

As minority and disadvantaged groups, e.g. immigrants and low-income earners, are especially vulnerable, the IMAGE project group is giving special attention to this target group in the practice-oriented guidelines. The practice-oriented guidelines explain how to deal with challenges of working with special consideration groups, .e.g. ethnic minorities/immigrants and low-income earners. As disadvantaged communities have a higher risk of developing type 2 diabetes and as the IMAGE project predominantly addresses high risk groups through primary prevention, the project is helping to combat the worrying gap regarding health inequity.

Evaluation: The IMAGE project results will be presented at the World Congress on Diabetes Prevention and Its Complications in Dresden, Germany, in April 2010. Several publications have described the logistics, the growth and first results of the project [50-52]. The final report describing final results will be delivered to the European Union in May 2010.

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3. Projects at National Level

This chapter describes what health promotion actions have currently been put in place by countries in Europe that contributed to this report at a national level. The information was collected from the following sources:

- A report published by EuroHealthNet in 2006 (*The contribution of Health Promotion to address obesity in the European Union*) [2]. This document reported on general health promotion measures but did not study whether or not lower socio-economic groups were included as special risk groups. Results were therefore reviewed for relevant data.
- A report published by the World Health Organisation (WHO) in 2007 (*Nutrition, physical activity and the prevention of obesity. Policy developments in the WHO European Region*) [53]. This document contains information on national policy developments and examples of implemented and ongoing programmes at the national and local levels in 48 countries of the WHO European Region. Again, the data described was studied for examples that specifically target disadvantaged communities.
- EuroHealthNet members were asked to send in information on relevant developments since 2006.

The obesity prevention measures within countries are subdivided over three paragraphs:

- **National Strategy:** This section includes descriptions of national action plans, implemented health policies that are relevant to this report, and other national legislative strategies (e.g. also the start of a obesity council)
- **National Support:** This paragraph describes national support organisations such as funds or coordination groups that provide support, guidance and coordination to smaller initiatives. Many of the local projects described in the next chapter will refer to these national support structures.

- **National Programmes:** At last, programmes and campaigns that run at national level and aim to counteract obesity specifically among disadvantaged groups, or define such communities as a special risk group, are described.

This chapter does not aim to provide a full picture of all running health promotion measures within countries, but it is a starting point describing the situation of obesity in relation to health equity at national level. Please note that only those countries are described which contributed to this report. If further information regarding other European countries is requested, please consult the reports published by EuroHealthNet [2] and WHO [53].

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Austria

National Strategy: In Austria, there is no overall National Obesity Strategy. However, the **Austrian Strategy for Sustainable Development** adopted in 2002 (Ministry of Agriculture) can be considered as impacting on obesity [54]. In this report, the importance of targeting different socio-economic groups is being recognised.

National Support: The Austrian organisation **Fund for a Healthy Austria** (Fonds Gesundes Österreich – FGÖ) is a health promoting organisation, founded in 1998, and receives subsidies of the ‘Gesundheit Österreich GmbH’ (Health Austria Ltd). The Fund’s major task is to support practical and research projects, structural development, continuous education, networking and information campaigns in the field of health promotion.

Two out of its six key priorities are Exercise and Nutrition. All recent Work programmes have integrated these two key priorities and FGÖ gives financial support to many projects concerning the promotion of healthy nutrition and/or physical activity. FGÖ has been conducting activities to enhance health awareness in these fields through, on the one hand, public information and education campaigns and, on the other hand, project funding. A list of all projects can be found on the FGÖ website (<http://www.fgoe.org>), and more information about the Fund and the national programmes it is supporting are listed in the EuroHealthNet and WHO reports.

Thus far, more than €25 million has gone into supporting 542 projects (approved/recommended up to now). The FGÖ support only goes to projects involving total funding of more than €10,000.

National Programmes: At national level, there are no campaigns running that aim to counteract obesity specifically among lower socio-economic groups.

Belgium

(Extra information was provided by the Flemish Institute of Health Promotion and Disease Prevention (VIGeZ) - EuroHealthNet member)

National Strategy: The **National Plan for Nutrition and Health 2005 – 2010** (Plan National Nutrition et Santé) was officially launched in March 2005 [55]. The plan emphasizes the need to create an environment that stimulates healthy eating habits and physical activity by improving education on food and nutrition and involving a number of stakeholders. The National plan recommends measures such as:

- Leading actions aimed at encouraging everyone but above youngsters to give more importance to physical exercise and to healthy eating habits,
- Organising targeted actions focused on specific groups such as young children, aged people, pregnant woman, teenagers, etc.
- Encouraging the private sector to engage more in reaching the objectives of the National Plan Nutrition and Health,
- Tackling prevention and undernutrition treatment,
- Evaluating eating habits and Belgian people’s lifestyles, through eating surveys,
- Stimulating scientific research devoted to eating behaviours.

The French Community: In November 2005, a plan to stimulate healthy eating and physical activity for children was approved and launched (**Manger Bouger**). The main goal of the French Community Plan is to reduce factors leading to cardiovascular diseases, but it also aims to half the growing incidence of obesity in young people by encouraging them to eat healthier and be more physically active. The message must be comprehensible for every environment affecting children from 0 to 18 years of age: day care, school, outside school and family.

It is based on various communication tools and has been established in accordance with the National Nutrition and Health Plan.

The Flemish Community: An [action plan on diet and physical activity 2008 – 2015](#) for Flanders was launched in October 2008 [56] and adopted by the Flemish parliament and the Flemish government in 2009. The ambition behind this action plan is to encourage the entire population of Flanders to be more physically active and to have a more balanced diet. Alongside its proactive attitude the action plan also adopts a problem-based approach; it aims to keep the prevalence of obesity under control.

The action plan promotes balanced eating patterns and adequate physical activity in accordance with the recommendations of the Flemish Food and Physical activity Guide named 'The active Food triangle' (figure 15) developed by the Flemish Institute of health Promotion and Disease Preventions (VIGeZ). These recommendations are based on the national nutritional recommendations from the Health Board and the HEPA 2001 recommendations for physical activity. Further input to the Flemish action plan has come from the Nutrition Action Plan 2004.

The Flemish action plan focuses on a set of six strategies, with a consistent focus on educational activities, environmental measures, policy measures and professional development.

- **Strategy 1:** Adequate physical activity and a more balanced diet in the local community.
- **Strategy 2:** Adequate physical activity and a more balanced diet among children and young people from birth to age 18.
- **Strategy 3:** Adequate physical activity and a more balanced diet at school
- **Strategy 4:** Adequate physical activity and a more balanced diet among the working Population
- **Strategy 5:** Improved provision of support to care providers
- **Strategy 6:** To promote adequate physical activity and a more balanced diet via information and communication

The actions included in strategy 1 are clustered within 2 priorities. Priority one aims to 'provide appropriate resources to local policymakers and organisations

working with low-opportunity and/or ethnic cultural minorities, in order to encourage adequate physical activity and balanced diet among social risk groups.' Thus, the Flemish action plan pays special attention to lower socio-economic groups while aiming to counteract obesity.

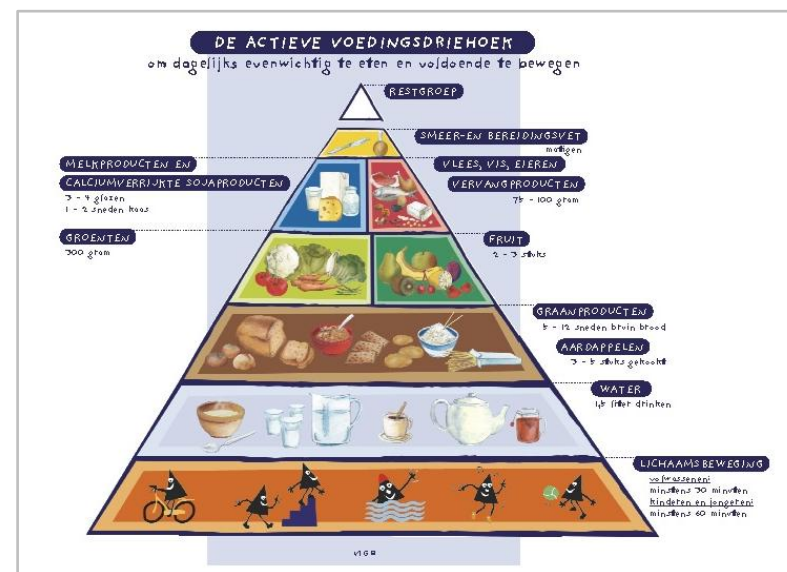


Figure 15: The active food triangle: Recommendations for daily intake of foodstuffs in different categories and daily physical activity, from age 6 onwards. Source: ©VIGeZ (2004)

The further development of strategies and scheduling of any necessary evaluation will take place during the subsequent implementation phase. All players developing or implementing methodologies are being encouraged to guarantee their accessibility to at-risk groups. In addition, the Minister's policy document focuses specific attention on the growing group made up by seniors.


National Support: Several programmes and campaigns are developed by the **Flemish Institute of Health Promotion and Disease Prevention** (VIGeZ). VIGeZ is an expert centre on the subject of health promotion healthy life styles, warranted by the Flemish authorities to provide government, professional intermediaries and local health networks with general support and the coordination of policy implementation, internal quality assurance, and the development of new strategies, programmes and materials.

While operating as the medium to advocate the Flemish government's guidelines with respect to health promotion, VIGeZ seeks to guarantee sufficient expertise, quality, feedback and the dissemination of results.

Furthermore, VIGeZ:

- Organises health promotion training with people living in poverty and with underprivileged foreign groups, for local welfare organisations, players in the healthcare sector and policymakers;
- Develops specific versions of methodologies for healthy nutrition and physical activity for people living in poverty and for foreign groups in those areas where the current methodologies have so far failed to reach enough at-risk groups, such as the tailor-made "shopping exercises" (being able to make healthy shopping decisions) and the "active food triangle for the Moroccan/Turkish communities". These tailor-made versions are modified in consultation with the target group;
- Collaborates with the VVSG (Flemish Association of Cities and Municipalities) to generate support for local policy and for the "OCMWs" (Public Centres for Social Welfare) in all Flemish cities and municipalities in conducting a local policy "Iedereen gezond!" (Good health for everyone!);
- Stimulates the dissemination of good practices across sectors with the interactive website www.gezondeinspiratie.be (see page 50);
- Supports Flemish poverty policy in focusing on opportunities for healthy living by contributing to long-term planning via initiatives like ViA (Flanders in Action) and VAPA (Flemish Poverty Action Plan).

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National Support: The mission of the **King Baudouin Foundation** (Koning Boudewijn Stichting) is to help to improve living conditions for the population. In its 1976 Constitution the Foundation is described as "an independent structure that encourages original ideas and sets up new projects." The Foundation works together with other institutions and foundations in both Belgium and Europe.

The King Baudouin Foundation (<http://www.kbs-frb.be>) supports projects and citizens who are committed to create a better society. It focuses on specific themes and is based in Brussels, but also supports projects far beyond the borders of Belgium and Europe. The activity domains are grouped around Poverty & Social Justice, Health, Democracy in Belgium, Democracy in the Balkans, Heritage, Philanthropy, Migration, Development, Leadership, Local engagement and Partnership or exceptional support for projects. Under the activity domain 'Health', the foundation supports many projects that are targeting the lower socio-economic communities.

Since 1998, cooperation exists on supralocal level (regions from 250.000 – 300.000 inhabitants) for the coordination and support of local initiatives in Flanders. **Logo's** – an abbreviation for **Lokaal Gezondheidsoverleg** – are local health consultative bodies that work together to promote health and to contribute to the realisation of the Flemish Health Objectives. One of these six targets is to improve physical activity and healthy nutrition. Logo's are a network of organisations, whereby not only the health sector is involved but also the local authorities, the OCMW's, and the wealth, social-cultural and educational sectors.

OCMW's (Openbaar Centrum voor Maatschappelijk Welzijn) are Public Centres focusing on a community's health and wellbeing. Every city or town has its own OCMW.

National Programmes: The following two healthy lifestyle programmes are implemented in Flanders.

Healthy Inspiration

"Gezonde Inspiratie" | <http://www.gezondeinspiratie.be>

VIGeZ has developed a website that aims to provide information of initiatives and good practices started by Flemish organisations that target specific at-risk groups, and to share materials and experiences about healthy living initiatives.

Aim & Objectives: This inventory seeks to make a contribution by facilitating the exchange of specific experiences, approaches and materials between different organisations, different regions and different sectors. You can spend more of your energy actually working with people if you don't have to reinvent the wheel.

Design: The project started with the determination that a number of different sectors in Flanders (welfare organisations, local governments, health promoters, target group associations) were already developing good practices and materials, but that these generally were not disseminated across sectors.

Based on the inventory performed by the King Baudouin Foundation of "local practices for healthy nutrition in socially weak groups", a concept was developed for an interactive website for sharing experiences about healthy living initiatives with at-risk groups.

This knowledge base contains information about what healthy lifestyle initiatives for at-risk groups have already been implemented by different organisations in Flanders. In a short presentation, the initiators explain their actual approach,

what bottlenecks they encountered, with what results (if any), how much time it took and with whom they collaborated.

The initiatives included seek to provide suggestions for a healthy lifestyle for people in socially disadvantaged positions. Specific emphasis is placed on initiatives that take cultural diversity into consideration. While the website addresses all themes of the Flemish health targets, healthy nutrition and physical activity occupy a prominent place.

The website www.gezondeinspiratie.be is free and accessible to everyone and may grow into an interactive forum. Anyone who has experience with similar initiatives is encouraged to provide input (this requires registering first). This allows others to gain inspiration and to learn from previous experiences, improves collaboration and minimises the duplication of efforts.

Support: The website was developed by the non-profit organisation VIGeZ vzw in the context of its regular activities, with the support of the Flemish Ministry of Well-being, Public Health and Family. All initiative files were filled in by the local players involved, also acting within their regular subsidised capacities.

Trigger: An overview at the Flemish level brought to light the development of similar methodologies by several different local players. Not enough knowledge was being shared, however, about the initiatives' outcomes and about practical experiences in terms of their implementation.

Targeted Communities: The project seeks to play both a motivational role – more initiators working on tailor-made health promotion initiatives for at-risk groups – and an inspirational one: sharing knowledge and exchanging experiences about suitable approaches. It is available to all organisations and caregivers in neighbourhoods and municipalities throughout Flanders.

Depending on the situation, existing general approaches may be modified, or tailor-made solutions may be developed where necessary in a collaborative atmosphere.



Figure 16: Screenshot website 'Gezonde Inspiratie' Source: <http://www.gezondeinspiratie.be>

Evaluation: If the local organisations involved have evaluation data, these are listed in the files. The use of the website and its impact on local health promotion efforts targeted at at-risk groups will be assessed one year after its launch.

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School in good condition "Fitte School" | <http://www.fitteschool.be>

Since 2004 the classic educational model for healthy nutrition in Flanders (the food triangle) was changed into the 'active food triangle'. From then off a strong combination is made between nutrition and physical activity.

With 'Fit School' the educational model of the active food triangle is translated into school policy. The action is the first in Belgium that combines nutrition and physical activity in one methodology for schools. The action is organised by a joint venture between the National Institute for Health Promotion and Disease Prevention (VIGeZ), Nutrition Information Center (a non-profit organisation to provide scientifically founded and educational information about nutrition) (NICE) and the Flemish Institute for School Sports (SVS).



Figure 17: Screenshot website 'Fitte School'

Source: <http://www.fitteschool.be>

Aim & Objectives: Building on the actualised concept of healthy school (see: www.gezondeschool.be), the project aims to give schools the opportunity to fill in their school policy on nutrition and physical activity with concrete interventions, activities, programmes and projects.

Design: For this aim 'Fitte School' offers schools:

- A global methodology to work on school policy on healthy nutrition and physical activities, with 3 important components:
 1. Education: the construction of a curriculum through the different grades for food- and physical education, linking the educational contents of both themes.
 2. Structural interventions: a concrete offer of activities on school level to take part of a healthy catering (school meals, drinks, snacks) and to work on a stimulating environment for physical activities (play yard, active transport, use of the sport infrastructure,...); a practical offer of school projects to work on healthy food (project week, healthy breakfast, school fruit,...) and actions to organize physical activities in the lessons, between the lessons and after school day (physical breaks, competitions between schools,...).
 3. Agreements: a practical methodology to work on agreements with school teams, pupils and parents on nutrition and physical activity.
- A collection of concrete programmes and activities organised by different national and local organisations from health, education and sports. Now we are working on a package for organising a day at the school where healthy food and movement are crucial (Fit School Day). The point is not to disturb the usual school day, but by taking simple actions schools can learn which actions they can take in their policy. It must be a primary step to motivate the schools to work at the food and movement policy.
- Instruments for schools to explore their needs and to evaluate their school policy.

At the end of the school year the schools can choose to be evaluated (the instrument of evaluation can also be used for self-evaluation) and in a large meeting the good practices get nominated and interaction between schools is organised.

The process consultancy for schools is organised in 2 ways:

1. Formation: a various offer of formation for school policy makers, teachers and local health professionals
2. Process consultancy for schools by the local field workers on school sports and the local health counsels.

Support: The project is an initiative of three organizations:

1. SVS – Stichting Vlaamse Schoolsport (Flemish Institute for School Sports)
2. VIGeZ – Flemish Institute for Health Promotion and Disease Prevention
3. NICE – Nutrition Information Centre

The project was initially financed by VLAM (Flemish Institute for Fisheries and Agro-marketing). From 2006 until 2009 it was also financed by the Flemish Government (department of Education, department of Health, department of Sports and department of Agriculture).

The project won the WHO Counteracting Obesity Award in 2006.

Trigger: With the introduction of the active food triangle SVS thought it would be interesting to link the same two themes and reach out more actions and methodologies to schools. Finding the right partners lead to a qualitative and good project.

Targeted Communities: The project focuses on the schools. Through the schools it is possible to reach the children and youngsters. When schools pay attention to a good health policy, the pupils learn to make the right choices and this for the rest of their life.



Figure 18: Posters used during the 'Fitte School project'. Left side: Poster used at primary schools, Right side: Poster used at secondary schools

Source: <http://www.fitteschool.be>

Evaluation: The evaluation is planned to be carried out in 2010. This will be done by the instrument of VIGeZ: a survey that is conducted every three years and which will assess the impact of the programme on the health of the participants in terms of nutrition, exercise and tobacco.

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Bulgaria

(Extra information was provided by the National Centre of Public Health Protection - EuroHealthNet member)

National Strategy: The **National Food and Nutrition Action Plan** (NFNAP) was launched in December 2004 and adopted by the Council of Ministers in August 2005. Its strategic goal is to improve the health of the Bulgarian population by improving nutrition and the reduction of the risk of food-borne and diet-related chronic diseases [57].

The action plan covers three strategic areas: nutrition, food safety and food security. It aims at a multi-sectoral approach involving the private sector and nongovernmental organizations, and includes activities addressing people of low socio-economic status. Other activities targeting overweight and obesity relate to the development of new standards for the nutritional content, labelling and marketing of foods, incentives to encourage the production and sale of healthier foods, and the training of health professionals.

The action plan describes a significant difference in the availability of food products depending on population income and a lower availability of the majority of foodstuffs in low income households, in households with 6 and more members, those with 3 and more children and households where the head is unemployed is established, comparing to the average availability per capita in the country.

Since 1997, six **national surveys** have been conducted on the diet and nutritional status of the population older than one year, as well as of specific risk groups. Special software was developed to monitor foods consumed and calculate intake of energy and nutrients at individual and population levels. The results of this survey have been used as a basis for the development of the above mentioned National Food and Nutrition Action Plan.

The 2004 National Nutrition Survey revealed that among those aged 19-60 years, 22% of the males and 17% of the females were obese. For women aged 60-75 years, the percentages were even higher: 39% were overweight and 32% were obese. In addition, 25.6% of 13 years old boys living in Bulgaria are overweight and 6.9% are obese.

National Support: Bulgaria is involved in several programmes – most of them being international programmes set up by the WHO. An overview and description can be found in the EuroHealthNet and WHO report [2, 53].

Apart from the campaigns mentioned in these documents, the National Centre of Public Health Protection is currently developing nutrition manuals and recipes collection on healthy nutrition for different age groups (3-6 yrs, 7-19 yrs), and it is developing nutrition standards for foods in school.

National Programmes: At the moment there are no ongoing obesity prevention programmes in Bulgaria that specifically target disadvantaged communities.



Croatia

(Extra information was provided by the Human Nutrition Department of the Croatian Institute of Public health)

National Strategy: At the national level, the Ministry of Health and the Croatian National Institute of Public Health issued in 1999 the **Croatian Food and Nutrition Policy** [58]. This policy document has a multi-sectored approach (agriculture, ecology, education and food industry are all included) and aims to promote (healthy) diet, physical activity and healthy lifestyle. It has a special focus on obesity in children and adolescents as it opts for a 20% reduction by increasing the consumption of healthy foods amongst general population.

In regard to overweight and obesity, strategies of the policy are to provide a proper education for professionals in the field of nutrition at all levels, to collaborate with the food industry in implementing different programs (e.g. production of healthier foodstuffs, such as decrease in saturated fats), and to take care of the socio-economically disadvantaged and nutritionally vulnerable groups by:

- Providing them with an adequate diet;
- Ensure an adequate nutrition for school children through organized catering and delivery of school lunch programs;
- Improve workers nutrition via organized meal catering at work places;
- Promote the healthy diet and ensure consumer information about the nutritional value of served meals in hotels and restaurants;
- Implement the National breastfeeding strategy;
- Continue monitoring the nutritional status and diets of different population groups and continuous conduct of public health nutrition education and promotion of healthy lifestyles (healthy nutrition, physical activity, non-smoking, etc.).

A draft version of the National **Food and Nutrition Action Plan 2006-2010 (FNAP)** also addresses the problems of socio-economical development, nutrition, food

production, food safety and health care. Areas covered in FNAP are food labeling, marketing of foods, overweight and obesity activities, problems of special groups (pregnant women, school, kindergarten and working population), surveillance of dietary habits and patterns, and nutritional status of general population – especially the vulnerable groups.

FNAP encourages production and sale of healthier foods, plans provision of food to socially handicapped and vulnerable groups, fighting deficits, public health programs for healthy diet and physical activity, collaboration with food industry and training of health professionals.

The **National Action Plan for Overweight Prevention and Treatment (APOPT)** [59] was published in 2008 by the Ministry of Health and Social Welfare in cooperation with the Croatian National Institute of Public Health. It targets the main problems of overweight and obesity through nutrition, physical activity, education and collaboration with food industry. Main goals of this action plan are to promote a healthier lifestyle and health in general and to raise awareness about the importance of achieving and/or maintaining a healthy weight, on both national and local levels, through prevention of obesity, promotion of optimal healthy nutrition and physical activity (promotion of cycling, walking and sport facilities, urban planning for PA-friendly environments, etc.) and reducing marketing pressure on children. Important roles are given to the community and to the public sector through the plans multi-sectored approach.

The **Law for Health Protection and Plan and Program of Health Protection Measures** [60] clearly state the need for nutrition counseling for pregnant women, which is partly implemented at national level, and availability of low cost or free nutrition counseling in primary care level at local level.

The **State Pedagogy Standard for elementary School Education** [61] opts for provision of free or subsidized school meals, the removal of energy-dense nutrient-poor foods and beverages from school vending machines, regulations on marketing of unhealthy foods and non-alcoholic beverages to children, which are

partly implemented at national level, and mandatory inclusion of nutrition education, which is entirely implemented on a national level.

The **National Action Plan for Physical Activity** (draft version) focuses on physical activity, sport, recreation and education. More specifically, it focuses on the role of physical activity in obesity prevention, urban planning for PA-friendly environments, improvement of road safety, promotion of cycling and/or walking, improvement and promotion of sporting and leisure facilities and improvement of physical activity in general. Responsible bodies for this action plan are Ministry of Health and Social Welfare together with Faculty of Physical Education.

Dietary guidelines for children were published by the Croatian National Institute of Public Health and Ministry of Health and Social Welfare. They were written a format which is interesting and easy to understand for children of all ages. The aim of this brochure is to educate children about healthy foods and dietary habits. It is also intended to be used as a teaching aid for school teachers.

Dietary guidelines for adults were published in 2002 by the Croatian National Institute for Public Health. Printed in the form of a brochure, the aim of the document is to educate the adult population of Croatia about healthy nutrition and the impacts of healthy nutrition on preservation of health, especially the importance of healthy nutrition and maintaining of healthy weight.

Guidelines for whole school approach to healthy eating were first published in 2004 by Ministry of Health and Social Welfare together with Croatian National Institute of Public Health. The second edition was published in 2008. These whole school approach guidelines not only focus on healthy eating in schools, but also at home, and put emphasis on the importance of a proper theoretical knowledge about nutrition as well as eating habits.

The whole school approach guidelines focus on collaboration between parents and schools, as well as with school medicine, food suppliers, local community and other participants outside the field of education. Objectives of the guidelines

include improving and implementing the food policy in schools. A special focus is put on the school's role in education about the importance of food and nutrition in everyday life. These guidelines are based on the analysis of the current nutritional status, dietary and life habits, experience and scientific results in the field of nutrition and health of school age children, to insure the optimal development and growth of children and to preserve their health.

National Programmes: The **Nutrition Friendly Schools Initiative (NFSI)** [62] – pilot project was conducted from 2006 to 2008, in 8 schools throughout Croatia. The project had an impact on the school nutrition policy at the national level, and results from the project were included in the FNAP. The Ministry of Health and Social Welfare and the Ministry of Science, Education and Sport both supported the NFSI Project. One of the results of the project (currently in process) is the revision of nutritional standards for kindergartens and elementary schools (collaboration between MHSW, MSES and CNIPH).

There are several support systems regarding prevention of obesity in place at the regional and local level. In some regions, school health centers organize counseling for overweight/obese children, and in the city of Zagreb, the **Association for prevention of obesity** (<http://uppt.hr>) has a free counseling centre for overweight and obese individuals, which was set up in cooperation with the city authorities. The Center's main priority is to help people who are overweight or obese.

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Czech Republic

(Extra information was provided by the Ministry of Health of Czech Republic - MZCR)

National Strategy: In 2004, the Minister of Health established the **National Council for Obesity** as a permanent specialist advisory body to the Ministry of Health. The basic task of the Council is to design and implement the National Action Plan against Obesity. However, to date no action plan focused on the prevention of obesity exists in Czech Republic.

A programme related to obesity is the long-term **Programme for Improving the Health Status of the Population in Czech Republic** (Health for All in the 21st Century) which was adopted in 2002. It consists of 21 objectives to be reached and some of these targets are focused on obesity [2].

Further details regarding national strategies, and national campaigns and projects can be found in the EuroHealthNet document and the report written by WHO [2, 53].

Denmark

(Extra information was provided by the National Board of Health - EuroHealthNet member)

National Strategy: The Danish Public Health Policy of the Government of Denmark: **Healthy throughout Life** (2002-2010) was adopted in 2002 and addressed diet, physical activity and obesity as risk factors [63]. To ensure regular monitoring and documentation of trends in the health status and health behaviour of the population, a catalogue of indicators was developed. Several initiatives were listed with the aim of increasing the commitment of specific actors. One of these was the creation of a National action plan against obesity.

In March 2003 the Danish National Board of Health launched the Danish **National Action Plan against Obesity** [64]. Denmark was the first country in Europe to launch such a specific action plan. It presents 66 recommendations specifying actions to be taken at private, community and public sector level. These recommendations aim to target different groups and areas. However, these classifications are based on groups being overweight or obese already or not. The national action plan thus does not target the lower socio-economic groups in a specific matter, but the recommendations in the action plan are however based on the knowledge about the social inequalities in health.

National Support: Since the launch of the action plan in 2003, the **National Board of Health** has initiated a series of projects covering the period 2005–2008. An overview can be found in the EuroHealthNet document [2]. Also, together with the Ministry of Health, a **cross-ministerial coordination** group was established to ensure collaboration across political areas on central elements of the action plan. Secondly, a financial pool of €10 million was allocated for developing and evaluating prevention strategies in Danish municipalities [53].

National Programmes: The National Board of Health provided EuroHealthNet with the description of five programmes running in Danish municipalities.

The Municipalities plan against Obesity (2005 – 2008)

Denmark is divided into 98 municipalities. The municipalities apply for financial support from the pool in order to finance different sorts of projects focusing on prevention and treatment of obesity among children and adolescents. In total 31 projects have been set up in the period 2005-2008. All projects have duration of 3 years.

The projects focus on general prevention as well as treatment of obesity. Examples of initiatives related to general prevention are: establishment of diet and exercise policies in schools and daycares, education of professionals in subjects related to nutrition and physical activity, establishment of secure paths for biking, etc. Examples of initiatives related to treatment of obesity are: establishment of a model for recruiting the overweight children and adolescents involving the health care nurses, establishment of coordinated interventions within the municipality involving a central person to coordinate, establishment of a treatment clinic focusing on diet, physical activities and psychological aspects, etc.

Aim & Objectives: The programme is supporting municipality based projects with the following overall purposes:

- To implement structured interventions in a number of municipalities for prevention and treatment of obesity in children and adolescence with special focus on socially exposed children and adolescents
- To secure evaluation of the financially supported projects so that they can be used as future models in Denmark

Support: In 2005, the Danish Government established a financial pool of approximately 10 million Euros. In addition to this sum, 1.3 million Euros have been allocated for centrally supported initiatives, including a travel team who provide consultancy services for the municipalities in relation to physical activity and overweight, a cross sectional evaluation, conferences and seminars for the professionals working in the municipalities.

Trigger: The prevalence of obesity among children and adolescents has increased in Denmark within the last decades. There seems to be a social gradient and gradient between ethnic groups in the prevalence, and there is no convincing evidence as how to prevent or treat obesity.

Targeted Communities: The municipalities are responsible for central interventions in relation to children and adolescents in socially exposed families, starting from the first visit of the health care nurse until the child leaves the school. The municipality is thus well qualified to create an organisational framework that ensures a strengthened coordination of the interventions regarding obesity among children and adolescents. The projects in the different municipalities focus on different target groups including ethnical minorities, pregnant women, preschool children etc.

Evaluation: The projects will be evaluated separately by the municipalities. A cross sectional evaluation of all projects will be performed centrally. Results from projects finishing in 2008, will be presented in a report in summer 2009. The cross sectional evaluation of all projects will be published in a report in 2012.

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Weight loss and weight maintenance among obese adults (2007 – 2010)

One part of the project is to develop a course for health professionals to increase their qualifications in working with obese adults. Health professionals are educated to advice in weight loss and maintenance of a weight loss, with main focus on motivating the target groups to change lifestyle. The complete course consists of three seminars of three, two and one day, respectively. In between each module the participants do exercises on an e-platform. All together 9 whole days are acquired for the course, which normally is spread out on a four month period. The counselling, in which the participants are trained, is based on a concept called “small steps”. The counselling motivates the target groups to small changes in lifestyle and changes in diet and exercise habits. Examples of small changes are: walk to work, use fat-free milk over whole milk, increases the fibre in the diet.

All 98 municipalities and five regions in Denmark have the option to apply for financial support to projects aiming to test and establish the new weight loss-concept. For the municipalities and regions to receive money, the Danish National Board of Health demands, that the particular project include participation of health professionals in the course of the national weight loss-concept and that the qualifications received on the course are implemented in the project.

There will be two application-rounds for the municipalities and regions to apply for financial support to test and anchor the weight loss-concept. The first application deadline was in July 2008, at which thirty projects were financed. The second application-round is expected to be in May 2009. Furthermore, it will be possible for municipalities and regions to apply the National Board of Health for financial support to offer the course to employees, which is not involved in a

project financed by the pool, but work with obese adults through other initiatives.

Another part of the initiative is to create a healthier environment on work places with a high percentage of employees with obesity. This includes qualifying certain employees to become “key persons” at the work place. The key person then has the responsibility to keep informed about local initiatives and share the information with the rest of the employees. Thereby, a better contact is created between the qualified people working with obesity in the municipality and the particular workplace. Furthermore, the work place can apply for money to establish general initiatives to improve the environment for people, who are motivated to lose weight. This includes for instance introducing fresh fruit in the canteen and offering cheap gym-lessons.

The work places can apply the National Board of Health for a supply to establish the project, when the municipality, where upon the work place are located, is establishing the weight loss-concept.

Aim & Objectives: The objectives of the financial pool are:

- To establish initiatives which support adults with obesity in increasing their empowerment for losing weight and maintaining weight loss. These qualifications should be increased by increasing the qualifications among health professionals in their work with obese adults, through a new national weight loss-concept
- To secure evaluation of the financially supported projects and the national weight loss-concept, so that it can be used as a future model for a national weight loss-concept in Denmark

Support: In 2007, the Danish Government established a financial pool of approximately 7.7 million Euros to decrease the inequality in health among socially exposed groups, in particular on the area of weight loss and weight maintenance among obese adults.

Trigger: Obesity increases the risk of type 2-diabetes, cardio-vascular disease, hypertension and certain kinds of cancer. 10 – 13 % of the Danish population is obese and the number is increasing.

Targeted Communities: The main target groups to receive weight loss and weight maintenance counselling are:

- Ethnical minorities
- Unemployed
- Non-educated employees
- Pregnant women and mothers of newborn babies

Evaluation: The projects will be evaluated separately by the municipalities. 0.4 Million Euros is furthermore earmarked to a cross sectional evaluation of all projects, which will be performed centrally, by an extern evaluator. The cross sectional evaluation of all projects is expected to be published in a report in 2013.

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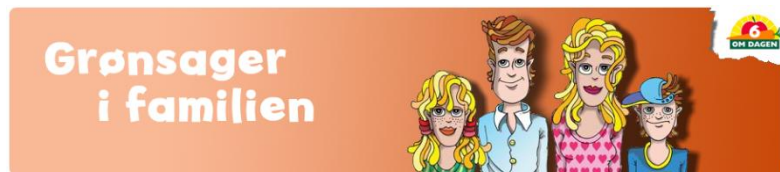


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6 a day

“6 om dagen” | <http://www.6omdagen.dk>

6 a day started in 1999 as a public-private partnership with representatives from government agencies, non-governmental health organizations and the fruit and vegetable industry. 6 a day provide the general public with the dietary advice “Eat fruit and vegetables – 6 a day”. The message is based on solid scientific evidence that confirms that an increase in the fruit and vegetable intake to 600 g a day for adults and 400 g a day for children aged 4-10 years, does have an effect on the prevalence of cancer and cardiovascular disease. It also contributes to increasing the dietary fibre and to lowering the energy content.



Aim & Objectives: The 6 a day campaign's overall aim is to increase consumption of fruits and vegetables in the Danish population, ideally 6 a day, representing 600 grams fruit and vegetables a day and 400 grams for children. Data from 2003-2006 show that:

- Children (4-10 years) on average had a daily intake of 353 grams of fruit and vegetables and that 33 percent of the children met the recommended intake of 400 grams a day;
- Adults (11-75 years) on average had a daily intake of 398 grams of fruit and vegetables and that 16 percent of the adults met the recommended intake of 600 grams a day.

Also, the aim of the project is to increase awareness about the importance of a sufficient intake of fruit and vegetables and in the long run make the per capita intake of fruit and vegetables meet the official recommendations.

This is implemented through activities and campaigns to increase the Danes' dietary intake of fruit and vegetables. The programme informs schools and companies about the fruit and vegetable scheme, and produces campaigns to promote the intake of fruit and vegetables. Among other things focus has been on school fruits, fruit parties for kids and fruit at work.

The overall objectives can be defined as:

- Reduce the number of Danish people between the age 11-75 years that has an intake of less than 300 grams of fruit and vegetables a day from 36 percent in 2003/04 to 25 percent by the end of 2011.
- Reduce the number of children between 4-10 years that has an intake of less than 300 grams from 39 percent in 2003/04 to 25 percent by the end of 2011.

Support: The partners are: (1) Danish Veterinary and Food Administration, (2) the Danish National Board of Health, (3) The Danish Cancer Society, (4) The Danish Heart Foundation, (5) Danish Fruit, Vegetable and Potato Board, (6) Danish Meat Association, (7) Danish Horticulture, (8) The Danish Consumers Co-operative Society. 6 a day is a member of the International Fruit and vegetable Alliance (IFAVA).

Trigger: The 6 a day recommendations and the campaign that should increase the intake of fruit and vegetables among the Danish population rest on Danish scientific recommendations published by the National Food Institute in 1998 and updated in 2002 and 2007. These studies showed an intake below the recommended.

Targeted Communities: For children the fruit parties for kids, which provide ideas for how fruit and vegetables can be a natural part of children's parties, have been a focus point. Furthermore, in 2007 there was a special initiative to promote the school fruit scheme, and to provide all children with the opportunity to eat fruit during the school day by implementing a nationwide pilot

of a school fruit and vegetable program called “Frugtkvarter”, meaning Fruit break. The Ministry for Food, Agriculture and Fisheries appropriated 8 million DKK for a free introduction period.

During the period 2008-2011 focus will be on families with small children, men and adolescents, with the families with small children being the primary focus throughout the entire campaign period. Also, focus will be on behavioural changes among those families with the lowest intake of fruit and vegetables.

Evaluation: Knowledge of the message 6 a day is evaluated regularly. Studies on diet by the Directorate of Food under Ministry of Food, Agriculture and Fisheries and the 6 a day studies of the Danes’ consumption of fruit and vegetables reveal that the intake of fruit and vegetables is increasing. This data is supported by figures from Statistics Denmark.

At the same time, studies reveal that knowledge of the 6 a day programs is increasing among the general public.

Regarding the populations general knowledge of the campaign it is the overall objective that by August 2011, 70 percent of the population should be able to recognize the campaign without any help and 90 percent of the population should be able recognize the campaign if assisted.

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Diet in a nutshell – a taste for life

“Alt om kost – smag for livet” | <http://www.altomkost.dk>

In 2002, the project Alt om Kost – smag for livet (Diet in a nutshell - a taste for life) was launched by the Danish Veterinary and Food Administration under the Ministry of Food, Agriculture and Fisheries. In partnership with other administrations, research institutions, and interest organisations, projects under Diet in a nutshell have been launched to promote health and reliable nutrition information for children, adults and the elderly.

Diet in a nutshell has its own website under the Danish Veterinary and Food Administration which provides information and inspiration for healthy food and physical activity with a point of departure in the official Danish dietary advice illustrated within the nutritional compass representing the 8 nutritional principles (<http://www.altomkost.dk>).

Diet in a nutshell offers a “flying squad” (travel team) that travels nationwide to lecture about health. This service is provided free of charge. Members of the flying squad travel to municipalities, day care facilities and schools that want to work with food and food policies, and provide advice on what a food and meal policy entails. The squad also provides consultancy services on healthy food in schools and healthy lunch in day care institutions according to the Danish Veterinary and Food Administration guidelines.

During 2008 the flying squad received supplementary education regarding the health benefits of physical activity and exercise. The National Board of Health financed this education. The project is now a permanent part of the running costs within the Danish Veterinary and Food Administration.

Aim & Objectives: The primary goals of Diet in a nutshell – a taste for life are:

- Promote healthy food, meals and physical activity in schools and day care centres and thus influence children’s dietary habits and healthy living;

- Strengthen information on healthy food and healthy living to all citizens so that it is easier for each person to search for usable and reliable information among the vast amounts of data available;
- Collect and continuously update nutrition information;
- Support the work of the flying squad when establishing food schemes, etc.



Figure 19: The nutritional compass representing the 8 nutritional principles

Source: Danish Veterinary and Food Administration

Diet in a nutshell is also responsible for publishing recommendations and inspirational materials on healthy food to day care facilities, schools, after-school schemes and clubs. Methods are designed to disseminate dietary advice and recommendations to the general public. The website contains recipes for healthy dishes prepared by enthusiastic chefs. Cookery books are also available.

Support: The financial support originated from the Ministry of Food, Agriculture and Fisheries own appropriation. The Danish Veterinary and Food Administration under the Ministry of Food, Agriculture and Fisheries launched the project.

Targeted Communities: The project is targeted towards the whole population, i.e. specific age groups such as children and adolescents. The travel squad addresses schools and institutions and is therefore - at least in theory – trying to target all socio-economic groups equally.

However, the flying squad can also be viewed as a structural intervention. In this regard, focus on healthy food and exercise within the Danish institutions where almost every child spend a large part of their day can thus be seen as more beneficial to people from lower socio-economic groups and therefore as an initiative with the potential of narrowing the gap between rich and poor and high and low educated.

Evaluation: Diet in a nutshell and the success criteria are continuously evaluated. Several areas have been evaluated. The website has been evaluated with regard to functionality, relevance and objectivity in relation to a qualitative target group.

The flying squad has been evaluated with regard to work form and the effect of the flying squad's visits. The evaluation reveals that the flying squad performs satisfactorily with the work promoting health in the day care facilities, schools and municipalities that they visit.

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Whole Grain Campaign

“Fuldkornspartnerskabet – Vælg fuldkorn først” | <http://www.fuldkorn.dk>

The Whole Grain Campaign started in 2007 as a public-private partnership with representatives from government, non-governmental health organizations and the milling and bakery industry. The Whole Grain Campaign promote to the general public the dietary advice “Choose whole grain first” / Eat whole grain every day. The message is based on solid scientific evidence on the health benefits of whole grain and a recommendation of eating 75 gram of whole grain a day (for adults with an energy intake of 10 MJ).

It was a new initiative. A 2 year period (2007-2008) preceded the direct launching of the campaign in the media and towards the public by 1 January 2009.

Results achieved are:

- A Partnership including 23 partners and approximately the same number of supporters that contributes and participate in the whole grain campaign
- A scientific basis to identify the benefits of eating more whole grain
- A map of which products provide the amount of whole grain eaten by the Danes today
- An official dietary recommendation for the intake of whole grain that amounts to 75 gram per day for adults
- A Partnership logo that promotes the dietary advice “Choose whole grain first” and which guarantees that a product contains a high percentage of whole grain (the logo can only be used on products that has a healthy nutritional profile in terms of fat, sugar, salt and fibre)
- The logo has been applied on almost 200 products sold in at least 30% of the Danish retail stores and in many local bakers’ shops

- Production of materials for distribution to bakers and retailers as well as for use in the training of employees
- An anthropological study of the Danes perceptions and habits in terms of bread and whole grain
- 8 famous voluntary whole grain ambassadors from the world of sport and media. The Minister of Food, Agriculture and Fisheries supports the campaign by being an ambassador
- Massive support from the media resulting in more than 150 articles and other publicity from the launch in January 2009.

Aim & Objectives: The aim of the Whole Grain Campaign is to create target-oriented and effective interventions to ensure that the Danes eat more whole grain and thereby improve public health.

The Whole Grain Campaign increases the accessibility of whole grain products and increase awareness of the beneficial effects of whole grain. The objective is achieved through a unique partnership across sectors and disciplines including health- and patient organizations, business, government, retail and trade.

Support: Members of the partnership are authorities, health organizations, private business partners and trade associations. All partners contribute financially.

Members by April 2009: Danish Veterinary and Food Administration, The Danish Cancer Society, The Danish Heart Foundation, Clinical Dieticians Association, Danish Diabetes Association, Danish Agriculture and Food Council,, The Confederation of Danish Industry (DI), Lantmännen Unibake, Lantmännen Ceralia, Lantmännen Schulstad, Kohberg, Quacker, Nestlé, Nyker Brød, Skaertoft Mills, Pågen, Easyfood, McDonalds Denmark, The bakery confederation in Denmark, Valsemøllen A/S, Dansk Supermarked A/S, Credin A/S, Wasabröd AB (Valora Trade Denmark A/S).

Trigger: The background for the project is that the intake of whole grain is much too low in Denmark. Rye bread and oat flakes are the main sources of wholegrain

intake in Denmark, but only 6% of the Danes eat the amount of whole grain recommended by the authorities. Particularly young people eat too little.

The project was initiated through idea generation and cooperation between government, industry and health organizations.

Targeted Communities: The partnership will focus on several interventions that should target the lower economic groups, and at best lead to more equity in health:

- The Whole grain logo will make it easier for all consumers to select products with a high content of whole grain
- Initiatives focusing on day care institutions and working places will ensure that all socio economic groups are targeted
- Industry develops delicious products with a high content of whole grain which ensure that the products are actually sold and eaten. New forms and norms for eating whole grain at work should be developed.
- Initiatives are in progress with the aim to increase the content of whole grain in “white bread” products or maybe even in all flour.

Evaluation: Knowledge and data of the message “Choose whole grain first” will be evaluated regularly.

The first evaluation carried out 2 months after the launching of the campaign showed that the knowledge of the logo and message had increased to 20 % of the respondents and the reported consumption of whole grain had also increased slightly (from 1,79 times a day to 1,87 times a day).

Furthermore, the sale of whole grain flour/raw material from the millers to industry will be followed by statistics as well as the actual retail sales of whole grain products.

In the longer term the actual consumption of whole grain will be followed through the studies on diet by the National Food Institute, Technical University of Denmark.

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Finland

(Extra information was provided by the Finish Centre for Health Promotion - EuroHealthNet member)

National Strategy: In 1995, the **Finnish National Nutrition Surveillance System** was launched with the purpose of collecting, analysing, evaluating and distributing data on the nutritional status, and of assessing the need for measures to promote nutrition and health policies. In addition, through this system, nutritional data are communicated to health care professionals, researchers, teachers, journalists and those working in food production, food trade and mass catering (<http://www.ktl.fi/portal/english/>) [53].

The Government Resolution on the **Health 2015 Public Health Programme** (approved in 2002) outlines the targets for Finland's national health policy for the next fifteen years. Health 2015 is a cooperation programme that provides a broad framework for health promotion in various component areas of society. The prevention of obesity is included in the overall picture of the nation's health promotion and one of the targets is reducing health disparities between population groups, i.e. small health differences between genders, socio-economic categories and people living in different regions. More information can be found at: <http://www.terveys2015.fi/english.html>.

Furthermore, the government approved a **resolution on Development of Guidelines for Health-enhancing Physical Activity and Nutrition Promotion**, coordinated by the Ministry of Social Affairs and Health, the Ministry of Education, the Ministry of Agriculture and Forest, the National Nutrition Council and a Committee on Development of Health-Enhancing Physical Activity. The last two actors are having an advisory role, set by the Ministry of Agriculture and Forest and the Ministry of Social Affairs and Health respectively. The main targets of this resolution are the promotion of population health and the prevention of diseases so that e.g.:

- The number of people following nutrition recommendations grows through increasing the intake of vegetables, fruits, and berries and through decreasing the intake of saturated fat, salt and sugar.
- Overweight and obesity as well as other health problems related to nutrition and physical activity decrease.
- Dietary and physical activity habits that promote health become more common especially among population groups with the lowest socio-economic status.

In April 2004, a **policy programme for health promotion** was adopted by the Government, the Ministry of Social Affairs and Health being the responsible actor [65]. The programme targets have divided in different parts. One part concentrates on the prevention of national diseases by impacting the life-style habits (e.g. by decreasing obesity among children, youth and working adults). Health equity is the main target of the whole programme.

One of the aims of the **National Development Plan for Social and Health Care Services** (Kaste Programme 2008-2011) [66] is to impact the use of alcohol, smoking and obesity. By diminishing these three risk factors, the programme aims to influence health equity issues.

National Support: In Finland there are two main actors that influence the issues concerning nutrition and physical activity and thus the prevention of obesity. These are the **Committee on Development of Health-Enhancing Physical Activity** (set by the Ministry of Social Affairs and Health) and the **National Nutrition Council** (which is an expert under the Ministry of Agriculture and Forestry) [67].

National Programmes: The **TEROKA project** [68] aims to develop a knowledge base and tools to promote the attainment of the objective of the Health 2015 public health programme for reducing health inequalities. The TEROKA group

consists of experts on health differences with a variety of academic backgrounds including epidemiology, health services research, social policy, medical sociology and nutritional science. The practical work is carried out by the project group, which has members from the National Institute for Health and Welfare (THL) and the Finnish Institute of Occupational Health (FIOH). The work is supported by a steering group consisting of the senior management of the Ministry of Social Affairs and Health, THL, FIOH, the Finnish Centre for Health Promotion and the Association of Finnish Local and Regional Authorities.

The main aims of the project are to:

- strengthen the knowledge base and follow-up on health inequalities and disseminate information;
- chart and promote co-operation needed for reducing health inequalities;
- encourage policies on tackling health inequalities as well as practical measures;
- advance the use of health impact assessment as a means for health and social policy attempting to reduce health inequalities

The actions of TEROKA set out to realize these aims are:

- compile and publish reports on trends in health inequalities;
- maintain and develop internet services, produce educational material and provide presentations and lectures;
- in co-operation with partners, develop and assess national, regional and local operation models aiming to reduce health inequalities;
- explore possibilities to reduce health inequalities by means of health impact assessment;
- gather material for the basis of a strategy and action plan for reducing health inequalities;
- build practical models for regional health inequality follow-ups

France

(Extra information was provided by the National Institute for Prevention and Health Education - EuroHealthNet member)

National Strategy: In France, there is no specific policy to fight against obesity but a more general policy that promotes a satisfying nutrition (diet and physical activity). A **National Nutrition Health Programme** (PNNS) was adopted in 2000 for the period 2001-2005, but it thus aimed to improve the general health status of the whole French population rather than combating one specific aspect (obesity).

The National Nutrition Programme was revised in 2006 [69]. This second programme re-evaluated the priority targets and several new actions were added. These actions are targeted more specifically at the underprivileged, more focused on obesity and better adapted to neighbourhoods, aiming at better health care and improved detection. Furthermore, a separate **policy document** on physical activity was published in 2003 [70].

The actions of the PNNS are organised according to two main strategic orientations: the promotion of a healthy diet and physical activity through information, communication and education, and the development of environments to enable healthy choices.

The communication, education and information actions are constructed on the basis of a framework elaborated on a strict scientific ground organised by political bodies with experts from the public sector only. Many tools are made on this basis by the French INPES (National institute for health promotion and health education). However, the diversity of needs to address different age ranges, sexes, and levels of education requires adapted tools. Those tools can be made by different actors from associations and local political or economic bodies. They are then submitted to the governing bodies before they receive the agreement to receive the logo of the PNNS. This logo is a proof of quality for customers.

National Support: The **National Institute for Prevention and Health Education** (INPES; Institut National de Prévention et d'éducation pour la santé) is a public establishment created by the law of 4 March 2002 relating to the rights of patients and quality of the health care system. Supervised by the Ministry of Health, the INPES has the following missions:

- Implementing *public health programmes* on behalf of the State and its public establishments (as stipulated in Article L. 1411-6);
- Providing *expertise* and *consultancy* in matters of health prevention and promotion;
- Ensuring the *development of health education* throughout France;
- At the request of the Minister of Health, participating in the *management of emergency or exceptional situations* having consequences on the general population's health, and notably in broadcasting health warnings during emergency situations;
- Establishing *health education training programmes* according to modalities defined by decree.

The actions of the INPES have been taking place in the framework of the PNNS. It is involved in several health promotion programmes, it designs and implements numerous prevention campaigns, and it produces data from research studies and evaluations. More information and an overview of all running programmes can be found on the website of INPES (<http://www.inpes.sante.fr>).

National Programmes: The actions led on a national level give a coherent speech to the whole population, regardless of the level of education or social condition. Specific actions for specific populations are only performed at local level by associations and municipalities. The latter are encouraged to become “**PNNS active cities**”, so as to take part of a national dynamic. Many actions are financed by local political bodies that validate the interest and coherence of the project.



Germany

(Extra information was provided by the Federal Ministry of Health (BMG) and the Dr. Von Hauner Children's Hospital, Ludwig-Maximilians-University of Munich)

National Strategy: The Federal Ministry of Health and the Federal Ministry of Food, Agriculture and Consumer Protection have made the promotion of healthy lifestyles the main health and nutrition policy objective, placing strong emphasis on overweight and obesity [53].

Through a variety of preventive measures, national policy promotes prevention-oriented lifestyles, including a balanced diet, adequate exercise and stress management. Among these measures are legislative initiatives, such as the **Health Care Reform Act** (2000) [2, 53].

The National Action Plan for the prevention of obesity in Germany is called ‘**IN FORM**’ – the German initiative for healthy food choices and more physical activity. The action plan aims to prevent malnutrition, lack of physical activity, overweight and related diseases by motivating people to take care of their own health by means of role models and incentives and to provide concrete offers for individuals and population groups who have little access to health promotion offers. For more information, please visit <http://www.in-form.de>

The **National Food Consumption Survey** (<http://www.was-esse-ich.de>) aims to collect representative data on the current, normal food consumption pattern, the nutritional status and behaviour of the population and levels of physical activity. The identification of special lifestyle types, their potential connection with body weight and height, as well as socio-economic data, offers a valuable approach for prevention programmes. Nationwide data will be collected on the health status of young people, including diet and physical activity.

These measures will provide an evidence base for the development, implementation and evaluation of health promotion and disease prevention strategies [53].

The **Cooperation Consortium** "health promotion in socially deprived and handicapped persons" will build up a consortium of 50 organisations. This initiative of the Federal Centre of Health Education which belongs to the Federal Ministry of Health, created a data bank which enables an overview about running and successful projects, especially for people in a complex and complicated setting.

National Support: The German **Platform for Diet and Physical Activity**, founded in September 2004, is an illustrative example of mobilizing and integrating stakeholders from different groups of society (<http://www.ernaehrung-und-bewegung.de>). The Platform consists of more than 100 members and actively promotes 32 innovative programmes. An expert committee comprising scientists from various areas supports the Platform scientifically. In November 2005, the Platform opened its own office for the coordination of activities. The goal of the Platform is to bring together as many players in society as possible to ensure a balance between healthy nutrition and healthy exercise and thus promote a healthy lifestyle from the outset [53].

The **Federal Centre for Health Education** (BZgA) was established in 1967 with the following tasks:

- the elaboration of principles and guidelines for the contents and methods of practical health education;
- the training and further education of persons active in health education;
- the coordination and strengthening of health education in the Federal Republic of Germany;
- cooperation with agencies abroad

The BZgA implements many projects and measures for prevention and health promotion, and sees these two topics as being tasks for society as a whole. It cooperates with numerous partners in order to be effective both in specific

target groups and across the entire population. For more information, please visit <http://www.bzga.de>.

National Programmes: A high number of projects are running in kindergarten and schools in Germany which focus on healthy lifestyles since the National action plan (IN FORM) was implemented. One description of such a programme - running at national level - was provided by the Ludwig-Maximilians-University of Munich.

Tigerkids - Kindergarten aktiv.

<http://www.tigerkids.de>

"TigerKids", a behavioural intervention programme for Kindergarten settings, was developed by the Child Health Foundation, Munich, the Ludwig-Maximilians-University of Munich, and the Bavarian Health and Food Safety Authority in cooperation with other competent partners to prevent obesity. The evaluation during the pilot phase showed significant intervention effects, especially in eating habits of the children, so that AOK health insurance promotes the actual roll-out in more than 3.500 kindergartens in Germany. In this manner *TigerKids* can reach nearly 175.000 children and their families.

TigerKids elements and materials were designed for kindergarten teachers, children as well as parents to promote healthy lifestyle in the kindergarten setting and at home. At the start of the intervention, all teachers of participating day care centres attended a two day training workshop in which they were introduced into the concept and practical application of the *TigerKids* programme. Parents were informed with the help of newsletters and Tipp-Cards providing messages on health related behaviour. Furthermore, information evenings at each Kindergarten setting and an internet platform are offered for interested parents.

A pilot phase was conducted from October 2003 till July 2006. The nationwide roll-out of the project in all 16 states of Germany started September 2007 and will end presumably 2012. After this time the *TigerKids* programme will go on in all participating kindergartens. From the beginning of 2010 there is a European wide roll-out in eight more countries on the basis of *TigerKids*: Greece, Belgium, the Netherlands, Sweden, Poland, UK, Bulgaria and Spain.

Aim & Objectives: The primary goals of this project are to modify children's regular physical activity as well as food and drink choices. A secondary goal is to limit consumption of television and other electronic media. Modules for use in Kindergarten settings were developed in collaboration with experts in pre-school education, sport and nutrition sciences, and paediatrics.

Key targets are that children should reach:

- Increase in physical activity (at 30 minutes/day), to be more active with the parents and to lower sedentary activities e.g. TV, electronic games (reduction to <1h/day).
- Decrease in energy density of foods, increase consumption of at least two portions/day both of fruits and of vegetables.
- Decrease in consumption of soft drinks, other high energy drinks etc. and to prefer water and non sugared tea.

Support: The development, pilot testing and evaluation of the intervention was financially supported by the Bavarian State Ministry of Environment, Public Health and Consumer Protection. Additional support was provided by AOK Health insurance Bavaria, Lions Club Munich, Südzucker AG Mannheim and Kraft Foods Munich. The actual nationwide roll-out is financially supported by AOK Health insurance Germany.

The following partners are involved in the development of the programme: the Child Health Foundation, AOK Health Insurance, Div. Metabolic Diseases and Nutritional Medicine of the Dr. von Hauner Children's Hospital, Bavarian Health and Food Safety Authority, Institute for Social Paediatrics and Adolescent

Medicine, Ludwig-Maximilians University, Research Centre for Physical Education and Sports of Children and Adolescents, State Institute of Early Childhood Research and the Bavarian State Ministry of Environment, Public Health and Consumer Protection.



Figure 20: Tigerkids

Source: <http://www.tigerkids.de>

Trigger: The observed increase of obesity prevalence already at primary school entry with 5-6 years over the last two decades (Kalies H et al.; 2004) suggests that the basis of obesity development is already established in early childhood. Therefore, the development and implementation of effective prevention strategies at an early age is of utmost importance, but at present only very limited data on the effectiveness of childhood obesity prevention programmes from randomized controlled trials are available, and no generalisable conclusions can be drawn. Bluford et al (2007) identified only five prevention programmes addressing obesity risk in preschool children that were evaluated.

While most of these studies enrolled only relatively small numbers of children (ranging from 40 to 745 subjects) often followed for short periods of time (from between 14 weeks to 1 year), two of the five programs reduced weight or fat status. The authors concluded that there is a need to evaluate more programs aiming at prevention of early childhood obesity with inclusion of objective behavioural measures.

Targeted Communities: Tigerkids reaches nearly 125.000 children in about 2.600 kindergartens in Germany.

Evaluation: The TigerKids intervention programme was evaluated during the pilot study. In July 2004, 64 kindergartens in four Bavarian regions were randomly assigned as intervention or controls in a 2:1 ratio. Samples of 1318 and 1340 children were investigated in the school entrance health examination 6 and 18 months after TigerKids started in the kindergartens.

The main outcome measures were the prevalence of high fruit and vegetable consumption, low consumption of high caloric drinks assessed in food questionnaires filled by parents, of overweight and obesity, and further dietary habits and results of motoric testing. A significant higher consumption of fruits and vegetables reported in the intervention group was found both after 6 and 18 months. Subgroup analyses by gender, overweight and parental education, performed in order to assess consistency of these effects, showed similar results. A significant lower consumption of high caloric drinks and snacks while watching TV was only observed in the TigerKids group after 6 months.

The TigerKids intervention resulted in sustainable positive effects on fruit and vegetable consumption in young children 18 months after start of the programme. A large scale study in ~ 500 Kindergartens in Bavaria to assess whether these and potentially unmeasured effects will also result in a reduction of childhood overweight is therefore warranted. Results are expected April 2009.

Materials from existing intervention programmes, such as the German TigerKids programme, are identified as one of two European model programmes for obesity prevention by the EU White Paper on A Strategy for Europe on Nutrition, Overweight and Obesity related health issues (2007).

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Greece

(Extra information was provided by the Harokopio University in Athens)

National Strategy: In 2002, the Supreme Scientific Health Council of the Ministry of Health and Social Welfare launched the Dietary guidelines for adults in Greece (<http://www.nut.uoa.gr/english/Greekguid.htm>).

In the same year, the Ministry of Health and Social Welfare established the **National Nutrition Policy Committee** [71]. The Committee set priorities and the following initial goals:

- to reduce the consumption of meat;
- to increase the consumption of fish;
- to reduce childhood obesity;
- to increase the consumption of pulses and vegetables;
- to improve the quality and safety of food provided through mass catering services and increase consumer awareness of food quality and safety

In March 2006, the Committee submitted its proposals for the development of a **European Green Paper** on the promotion of healthy diet and physical activity and the prevention of overweight, obesity and other chronic diseases.

In the context of addressing the issue of childhood obesity, the Committee has also developed an **action plan for the implementation of national nutrition guidelines in schools**. Furthermore, dietary recommendations have been formulated for nursery schools and summer camps. The establishment of national obesity clinics and research centres is also under way with the aim of providing free medical and dietetic care to patients who require specialist help and support.

Regarding Primary Education, the National Foundation for Youth and the Ministry of Education has just published two manuals for school based health promotion activities in this field: (a) **Nutrition and Dietary Habits** and (b) **Physical**

Activity and Health Indices Both of these manuals were launched this academic year aiming to provide a bases and guidance for activities in these thematic areas and promote the adoption of a healthier way of leaving among children and their families

National Programmes: The following two examples of scientific studies that run at national level in Greece were provided by the Harokopio University in Athens.

GENESIS Study

The GENESIS Study is an abbreviation for: ‘**G**rowth, **E**xercise and **N**utrition **E**pidemiological **S**tudy In pre**S**choolers’. It is a large-scale epidemiological study conducted in Greece, attempting to assess growth, development and nutritional status of preschool children. Moreover, the study aimed to identify the most vulnerable subgroups in the population and the potential reasons leading to childhood obesity and poor dietary habits.

2.374 children, aged 1 to 5 years old were recruited in the study (response rate was 75%). These children were enrolled from a representative sample of randomly selected public and private nurseries as well as day-care centres within municipalities in five counties of Greece. All nurseries invited to participate responded positively.

Among the total number of nursery schools studied (n=115), 63 were in Attica, 10 were in Thessalonica, 12 were in Halkidiki, 22 were in Aitolokarnania and 8 were in Helia. The sampling of the nurseries was random, multistage and stratified by the total population of children, according to data provided by the National Statistical Service of Greece (Census 1999). The selected counties are

widely scattered over the Greek dominion while their overall local population comprises about 70% of the total population (Census 1999).

After adjusting for parental age and educational level of the population agreed to participate in the study, no significant differences between the overall population characteristics and the study sample within counties, according to data provided by the National Statistical Service of Greece (Census of 1999) were observed.

Aim & Objectives: The Project aimed to increase knowledge and understanding of scientists and public health policy makers on the parameters leading to childhood obesity, and to provide guidance and guidelines that could be used in developing and applying public health approaches for the overall population.

Support: Approval to conduct the study was granted by the Ethical Committee of Harokopio University of Athens and by all municipalities invited to participate in the study. The GENESIS study was supported with a Research Grant from Friesland-Foods Hellas.

Targeted Communities: The study focused on preschool children (one to five years old) in Greece.

Evaluation: Several reports have been published and others are in process. These papers confirm that preschoolers in Greece are characterized by poor dietary habits, sedentary life (TV viewing hours) and increased prevalence of obesity. Moreover, these findings are more common among children from families with low socio-economic status. Several articles have been published up till now [72-76].

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PROGRESS Study

The “**P**rediabetes, **O**besity and **G**rowth Epidemiological Study in Schoolchildren” (PROGRESS study) is an ongoing epidemiological study initiated in September 2007 following a pilot phase in May 2007. The study was completed in June 2009.

It aims to record the prevalence of several clinical conditions related to obesity as well as to identify those lifestyle and behavioural patterns that interact for their manifestation. The under study population comprised primary schoolchildren (10-12 years old).

The sampling of schools was random, multistage and stratified by parental educational level and the total population of students attending schools in six counties from the central, northern, southern and western parts of Greece, namely Attica, Aitolokarnania, Iraklio, Lasithi and Thessalonica. More specifically, all municipalities in these counties were divided into 3 groups based on the average educational level of their adult population (25 to 65 years old) (Census 2001). This procedure yielded two parental education cut-off points that were used to categorize municipalities into 3 categories with different socio-economic level (SEL) i.e. Higher, Medium and Lower SEL.

Consequently, based on data provided by National Statistical Service of Greece, a certain number of municipalities that was proportional to the size of their childhood population (10-13 years old) were randomly selected from each one of these three SEL groups. Finally, an appropriate number of schools were randomly selected from each one of these municipalities in relation to the population of schoolchildren registered in the 5th and 6th class in each municipality (data obtained from the Greek Ministry of National Education).

Until June 2008 signed parental consent forms were collected for 754 children and complete data became available for 729 children.

Aim & Objectives: The primary aim of the current study was to record the prevalence of several clinical conditions (i.e. insulin resistance, hyperlipidemias, hypertension, obesity, metabolic syndrome, iron and other micronutrient deficiencies etc) as well as to identify those lifestyle and behavioural patterns that interact for their manifestation. Increasing our knowledge and understanding on the effect and interaction of such patterns will pave the way for the implementation of appropriate public health initiatives to tackle these adverse health issues early in life.

Support: Approval to conduct the study was granted by the Greek Ministry of National Education and the Ethical Committee of Harokopio University of Athens.

Targeted Communities: The study targets schoolchildren aged 10-12 years attending primary schools located in municipalities within six counties in Greece.

Evaluation: Reports from the preliminary data of the PROGRESS study have indicated a considerably high prevalence of overweight and obesity, hyperlipidemias, insulin resistance, hypertension, metabolic syndrome and iron deficiency in children, specific dietary and physical activity patterns, perinatal indices, socio-economic, cultural and demographic characteristics were some of the parameters that were found to exert a significant effect. Several articles have been published up till now [77-81].

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Hungary

National Strategy: Two of the nineteen goals of the **National Public Health Programme 2003-2013** [82] (Nemzeti Népegészségügyi Program), which was adopted by the Parliament in 2003 under the name “Johan Béla National Programme for the Decade of Health”, deal with nutrition and physical activity. The main objective of the **Healthy Nutrition and Food Safety Programme** is to reduce the prevalence of nutrition-related disorders and to improve the general state of health through healthy nutrition. The **Promoting Physical Activity Programme** aims to promote an active lifestyle in the broadest possible sectors of the population, to make physical exercise an internalised need, and to see participation in sports become a generally accepted community and social programme [2].

In the context of these two priority areas, the **National Nutrition Policy Framework** and the **National Food Safety Programme** were both published in 2005 [2]. The first document was developed by the National Institute for Food Safety and Nutrition (OÉTI) and is based on the recommendation of the nutrition division of the WHO European Office (2000) and analysed the main trends in nutrition habits of the population in details and made recommendations. It underlined the role of education on healthy and conscious nutrition with special respect on children in schools [2, 83]. The focus of the document covering the period 2006-2010 is on the promotion of physical activity, regular training and health education in schools. It consists of a series of activities at governmental level to sustain the Hungarian population with sufficient good quality food and relies on cooperation with other specific areas.

A **National Sport Strategy** “Sport XXI” was launched by the government in 2004. This strategy sets three objectives: improving physical training in schools, promoting the recreational physical activity for everyone and supporting professional sport. Since 2004, the Hungarian government has released tenders which involve infrastructure developments, as well as construction of brand-new sporting facilities [2].

Nutrition-related issues are also addressed in the three major national programmes that were launched in 2006: the **National Cancer Control Programme**, the **National Infant and Child Health Programme** and the **National Programme for the Prevention and Treatment of Cardiovascular Diseases** [2].

Food-based dietary guidelines were developed in 2001. The latest version was published in 2005. The guidelines provide information on the principles of nutrition and advice on food safety for home food preparation and storage. They also provide incentives for and ideas about health-enhancing physical activity. Furthermore, dietary guidelines for special groups of patients were published in 2003 and 2005 [53].

National Programmes: A nutritional survey was carried out among the adult population in 2003–2004 as part of the National Population Health Survey. In addition, a study involving 16 hospitals in the country was carried out on the nature of catering in hospitals. A representative survey on nutrition and lifestyles was conducted among primary- and secondary-school children in Budapest in 2005. Data were collected on dietary habits, energy and nutrient intake, and food consumption, as well as on anthropometry and the measurement of biomarkers of nutritional status.

The Ministry of Health and the Ministry of Education introduced the **National Healthy School Canteen Programme** in 2005. The aim of the programme was to provide healthy choices for children in school canteens. The related legislation was proposed by the Ministry of Education, while recommendations together with educational materials for, inter alia, teachers, parents, students and school medical staff were provided by the National Institute for Food Safety and Nutrition of the Ministry of Health [2].

Several community programmes were carried out within the framework of the National Public Health Programme. Special attention was paid to healthy nutrition and physical activity.

More information is available on the home page of the Ministry of Health at <http://www.eum.hu>

Ireland

(Extra information was provided by the Health Promotion Unit of the Department of Health and Children – EuroHealthNet member, and by the Healthy Food for All initiative)

National Strategy: The **National health promotion strategy 2000-2005** was set up by the Ministry of Health and Children, one of its issues to tackle being lifestyle behaviour / food and nutrition, and exercise. It also recognizes the existence of social variations in health and lifestyle behaviours between the lower and higher socio-economic groups and the challenge for health promotion to narrow this gap [84].

In March 2004 the Minister for Health and Children established the **National Taskforce on Obesity** as a direct response to the emerging problem of overweight and obesity in Ireland, particularly in children. The aim was to develop a strategy to halt the rise in and reverse the prevalence of obesity. The Taskforce report set out a series of recommendations directed at a number of sectors – High level Government, Education; Social & community; Health; Food, commodities, production & supply; and Physical environment [85].

Ninety-three recommendations were made, related to actions across six broad boarders. One of them – ‘Social and Community’ – includes a recommendation (number 8) concerning disadvantaged communities. It states that: *‘Peer-led community development programmes should be fostered and developed to encourage healthy eating and active living. These programmes should be prioritised for lower socio-economic groups, ethnic minority groups, early school leavers, people with learning and physical disabilities and they should be based on the principle of developing self-esteem and empowerment such as is evident for example in the community mothers programme.’*

Also the ‘Physical Environment’ sector refers to lower socio-economic groups in two of its recommendations (number 15 and 20): *‘The private leisure industry should be encouraged to make its facilities more accessible to lower socio-*

economic and minority groups through partnership with local communities, local authorities and health boards.’

‘Community development programmes which encourage healthy eating and active living should be developed in partnership with local authorities and businesses. These programmes should be prioritised for lower socio-economic groups, ethnic minority groups, early school leavers, and people with learning and physical disabilities.’

The Department of Health & Children (DoHC) has recently established an **intersectoral group** to monitor and evaluate implementation of the strategy, and this group is due to report in April 2009.

In accordance with one of the key recommendations of the Taskforce, the DoHC is currently finalising a **National Nutrition Policy**. The aim of the NNP is to achieve better nutritional health for the total population, but it will focus particularly on children and young people, to help halt the increase in obesity and to reduce food poverty.

Food Poverty in Northern Ireland

Around 20% of people in Northern Ireland live in low-income households, with around 25% of children living in poverty (**Joseph Rowntree Foundation 2009**).

59% of adults in Northern Ireland were either overweight (35%) or obese (24%) (**NISRA Health and Social Wellbeing Survey 2005-06**). In 2003/2004, approximately one in five boys and one in four girls in Northern Ireland were overweight or obese in primary one (**DHSSPS 2006**). **Food poverty in Ireland**

The “official” measure of poverty in Ireland is based on a combination of a low-income measure and deprivation indicators – four of the indicators are food related:

- No substantial meal one day in the past two weeks due to lack of money
- Unable to afford a roast (or equivalent) once a week
- Unable to afford a meal with meat (or vegetarian equivalent) every 2nd day
- Unable to afford to have family/friends for drink/meal once a month.

Using this “official” measure the EU Survey of Income and Living Conditions (SILC) for 2006 for Ireland showed:

- Approx. 15% of the Irish population experience some type of “food deprivation” based on the indicators above
- Approx. 35% of those on low income (<60% of median income) experience food deprivation.
- Approx 7% of the low-income population experience “intense” food deprivation (3-4 of the indicators above).

57% of the Irish population is either overweight (39%) or obese (18%). Both the **Obesity Report** (2005) and the **SLAN report** (2008) also found that those in the lower social classes are more likely to be overweight or obese. One in five children aged between five and 12 years old are overweight or obese (**National Children’s Food Survey 2005**), and the same is found for 12 to 17 year olds (**National Teen’s Food Survey 2008**).

National Support: The **Irish Heart Foundation**, Ireland’s national charity for heart health, runs a range of programmes focused on promoting heart health and addressing obesity in schools, workplaces and communities. However these are general programmes and not specifically aiming to target disadvantaged communities. More information can be found at: <http://www.irishheart.ie>.

The **Nutrition and Health Foundation** (NHF) is a multi-stakeholder initiative established by the food and drink industry in Ireland. It brings together industry, government, scientists, health professionals and other relevant stakeholders. The NHS is developing programmes for the workplace and General Practise promoting healthy eating and physical activity [2]. For more information please visit <http://www.nutritionandhealth.ie>.

National Programmes: In 2005, the Irish Government launched a pilot scheme in 150 primary schools across Ireland called **Food Dudes**. Two years later the Irish

Government decided, due to the success of the programme, to introduce it to every primary school in the country. This national roll-out is proving both successful and very popular and is being funded by the Department of Agriculture, Fisheries and Food and managed by Board Bia. More information can be found on the website <http://www.fooddudes.ie>.

Another programme currently running in Ireland is the ‘Healthy Food for All’ project:

Healthy Food for All

<http://www.healthyfoodforall.com>

Healthy Food for All (HFfA) is an all-island multi-agency initiative seeking to promote access, availability and affordability of healthy food for low-income groups. The initiative sets out to demonstrate the relationship between food poverty and other policy concerns such as health inequalities, welfare adequacy, educational disadvantage, food production and distribution, retail planning and food safety. Healthy Food for All aims to end food poverty on the island of Ireland.

The publication and extensive dissemination of the **Food Poverty and Policy Report** (2004) highlighted the issue of food poverty as one of major concern for food and nutrition policy in Ireland. The findings of the report were debated with the government departments (health, agriculture and social welfare), HSE community dieticians, anti-poverty organisations, local authorities, the food sector and other interests.

In line with the recommendations of the report a feasibility study was undertaken on the establishment of a network of community food initiatives. The results of this study were debated at a roundtable of key interests in April

2005. There was broad support at the roundtable for the establishment of the Healthy Food for All initiative. A number of follow-up discussions with key stakeholders were held in order to refine the proposal for the establishment of an initiative to address food poverty. The initiative was funded for an initial developmental phase from September 2006 – December 2007. It is currently in the third year of its Development Plan 2008-2010 and is drafting a development strategy for the next phase of the initiative

Living in poverty and social disadvantage can affect diet in a number of ways:

- **Affordability** affects the choice and amount of food that can be bought.
- **Access** to shops can be problematic, as retail options, transport and storage/cooking facilities are often limited.
- **Availability** of healthy food in local shops may be an issue; they may not stock healthy options, such as fruit and vegetables, for a number of reasons including shorter shelf life, lower profit, a perceived lack of interest or a shortage of storage options.
- **Awareness** of what constitutes a healthy diet affects food consumption. There is a lot of misinformation surrounding nutrition and many people lack the knowledge and skills to prepare and cook a meal from scratch.

Aim & Objectives: The aim of Healthy Food for All is to end food poverty in Ireland. The Healthy Food for All initiative has three key objectives:

1. **Community:** To support community and sectoral initiatives which promote availability and access to healthy and affordable food for low-income groups, with a focus on community food initiatives and direct food provision, including school meals;
2. **Network:** To develop an all-island learning network to identify best practice on promoting healthy food for low-income groups and to develop links with similar organisations in the UK and Europe;
3. **Policy:** To promote awareness of food poverty across all aspects of public policy, with a focus on affordability, access and availability of food.

Support: Crosscare, a founding organisation of the initiative, agreed to house the initiative in its' developmental phase. A project co-ordinator was employed in September 2006 to implement the work plan of the initiative and is supported by both a management committee and an advisory committee. The initiative is funded by the Social Inclusion Division of the Department of Social & Family Affairs, the Health Services Executive (HSE), Food Safety Authority of Ireland and *safefood*.

Community Food Initiatives:

Healthy Food for All is committed to improving the standard of Community Food Initiatives (CFIs) and acts as a central source of expertise providing information and support in their initial set up and development.

Community Food Initiatives provide practical solutions to barriers to healthy eating and can help increase access to safe, sustainable and nutritious food. HfFA provides information on a wide range of initiatives and is a useful resource for local authorities, health professionals, community groups and others interested in food and health.

In 2008 Healthy Food for All was awarded additional funding by *safefood* to set up a **Demonstration Programme of Community Food Initiatives** which provides funding to seven Community Food Initiatives across the island of Ireland. The programme aims to increase the range and effectiveness of CFIs by promoting affordability, access and availability of nutritious food to low income groups using a community development approach. There is a large emphasis on shared learning and identification of the resources and supports necessary for the development of CFIs on a sustainable basis.

HfFA has published a **Good Practice Guide on School Food Initiatives** and is finalising a **Good Practice Guide on Community Food Initiatives** which is due for publication early 2010. These Guides are designed as practical toolkits to assist groups to manage a sustainable food initiative

Trigger: In 2006, 290,000 people or 7% of the population were living in consistent poverty in the Republic of Ireland. Consistent poverty means that they are living on a low income and are deprived of one or more basic necessities, including food related items.

- 11% went without a substantial meal on at least 1 day in the past 2 weeks
- 11% were unable to afford a roast once a week
- 9% were unable to afford a meal with meat, chicken or fish every 2nd day
- 30% were unable to afford to have family or friends around for a meal or drink once a month

Targeted Communities: The initiative was set up to support those who don't have access to healthy food due to poverty and/or social disadvantage.

Evaluation: The initial developmental phase of the initiative was evaluated in 2007 and the findings informed the Development Plan for 2008-2010. The initiative will be evaluated in 2010 and again the findings will be used to inform the future development of the initiative.

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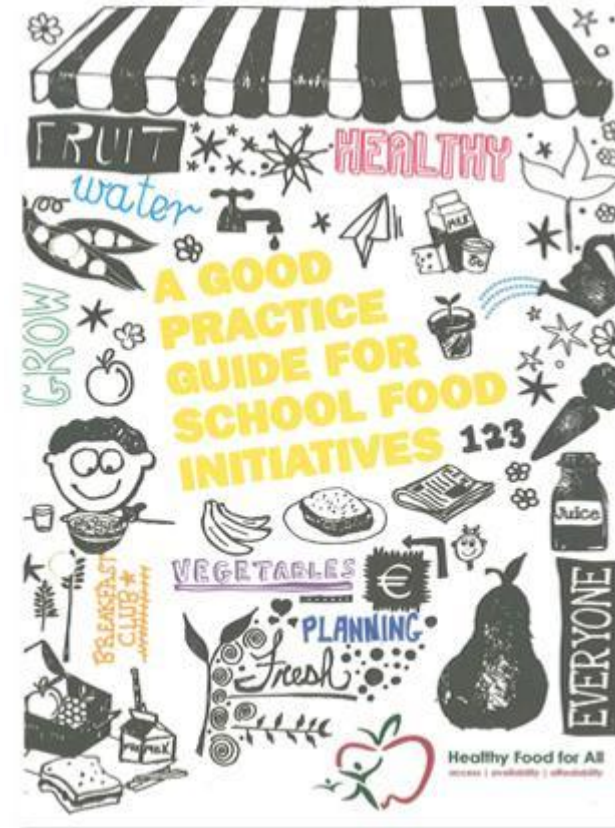


Figure 20: Good Practice Guide for School Food Initiatives

Source: HFfA

The Netherlands

National Strategy: In its policy document, *Living longer in good health 2004–2007* [86], the Dutch Government sets itself the task of halting the increase in the number of overweight adults and, in the case of children, of reversing the trend (WHO report).

Concerning health inequalities the policy document refers to a report, published by the National Institute for Public Health and the Environment (RIVM) in 2006 called *Public Health Forecast 2006* (Volksgezondheid Toekomst Verkenning (VTV) 2006). This report describes major disparities in health due to socio-economic differences among population groups [87].

The National Institute for Public Health and the Environment has also set up a *Monitor* for health inequalities that specifically occur among lower socio-economic communities. Two of the health determinants that are being measured are overweight and physical activity.

To tackle the problem of obesity from a wide range of perspectives, the Ministry of Health, Welfare and Sport drew up the *Covenant on Overweight and Obesity* towards the end of 2004. The covenant (signed in January 2005) is an important pillar of the Ministry's policy to address overweight. The quantitative goals include halting the increase in the number of overweight adults and reducing the number of overweight children by 2010. The Covenant, which is not enforceable by law, and was chosen as the Netherlands' platform for promoting the use of measures other than the more traditional policy-making and implementation instruments for counteracting overweight. In this respect, it emphasizes communication, self-regulation, self-implementation, self-enforcement, implementation based on "real life" scenarios, networks of mutually dependent actors, knowledge and information for effective action [53].

Through their own activities and the roles they play in society, all parties to the Covenant look for ways to contribute to achieving the Government's targets on overweight. Their individual plans have resulted in an *action plan* entitled: *Striking the right energy balance*.

The Action Plan recognizes that - as action targeting the entire population will seldom be effective - two target groups require special attention. Besides children and young people, these are communities with a lower socio-economic status as well. As stated in the report:

"Various studies have shown that excessive weight gain is especially prevalent among people of low socio-economic status (SES). A combination of factors makes this group particularly susceptible. We shall try to develop activities specifically targeting them. This will necessitate cooperation at local level (with municipalities and other local partners)."

More information about this Covenant on Overweight and Obesity can be found in the WHO and EuroHealthNet report [2, 53], or on the website of the Covenant: <http://www.convenantovergewicht.nl/english>

National Support: The *Netherlands Nutrition Centre* (Stichting Voedingscentrum Nederland; <http://www.voedingscentrum.nl>) is an independent organisation, funded by the Netherlands Ministries of Health, Welfare and Sport (VWS) and Agriculture, Nature and Food Quality (LNV). The Centre's key tasks are:

1. to provide scientifically reliable, honest information to consumers about the quality aspects of food and food production and about safe and healthy nutrition;

2. to use active communication campaigns and specific projects to achieve changes in behaviour that lead to healthier and safer eating patterns by consumers and/or concrete health gains;
3. to interact with scientific, commercial, political and public communities in order to further the missions' goal

Apart from conducting many public (mass media) campaigns designed to stimulate healthy and safe eating, the Nutrition Centre published *'The Netherlands in balance: preventing obesity master plan 2005 – 2010'* in 2005. Central to this plan is the promotion of a healthy energy balance (healthy eating and exercise) among Dutch consumers [88].

More can be read about the campaigns from the Nutrition Centre in the WHO report [2].

National Programmes: Many national campaigns are described in the WHO and EuroHealthNet report [2, 53].

A programme running in the Netherlands is the **SchoolGruiten** project, which is the largest free fruit and vegetables scheme for Dutch primary school children. .

Below you can find a general description of this programme. In chapter four an example is given of the programme running in a city of the Netherlands which has a specific focus on lower socio-economic groups.

SchoolGruiten

<http://www.schoolgruiten.nl>

SchoolGruiten is a Dutch acronym for 'school fruits and vegetables'. The word 'Gruiten' comes from the two Dutch words 'groenten' and 'fruit' (vegetables and fruits, respectively). It aims to change nutrition behaviour of 4 to 12 year old children. During the Project:

- Children are acquainted with fruits and vegetables in a fun and playful way
- Children will be encouraged to develop their taste
- Children will be showed that healthy food is important – now, and also when they are adults.

Both teachers and schoolchildren will eat vegetables and fruits during two fixed days a week together in the classroom. This behavioural component – eating together – stimulates children to try new things and to distinguish between several varieties. By having two fixed days during the week, their fruit and vegetable consumption will become an integrated part of their daily life. It is important that children not only 'think' about the problem, but that they actually 'act' as well, and thus eat the provided products. In addition, materials such as videos and posters were developed to support the initiative and to provide materials to the schools so that teach the children about healthy nutrition.

One of the conditions for the school to join with this Project is that the whole school (or at least most of the children) is participating, because the strength of SchoolGruiten is eating the fruits and vegetables altogether.

The SchoolGruiten Project started with a pilot phase in February 2003, in which the intervention was tested in a controlled design to study further improvement and implementation needed in order to grow into a successful nationwide campaign. The focus of the Project was primarily to provide free fruits and vegetables to schools in deprived areas.

The pilot took place in seven different cities in the Netherlands; Deventer, Leiden, the Hague, Almelo, Zwolle, Dordrecht and Breda. It thus focused on communities with a low socio-economic status and was providing free fruits and vegetables for a full year. The pilot was financed by the Ministry of Health, Welfare and the Environment.

Based on the pilot, three 'Gruitmodels' were developed for schools to join the initiative, distinguished from each other by the way the portions of fruits and vegetables are reaching the schools (however, so far no school has ever chooses model number two).

Model 1: delivery by a subcontractor (delivery service)

Model 2: the school goes to a subcontractor to get the products their self

Model 3: Parents or child carers give fruits and vegetables to their children to bring to school

When a school decides to cooperate with a subcontractor, one of the conditions is that a participation of at least 100 children is required. Furthermore, at least three quarters of the participating classes should exist of children who are participants of the Project. When a school exists of less than 100 pupils, participation with a high percentage of children is required.

Schools can either select a subcontractor from a list that is provided by the initiative, or it can get in contact with a new delivery service in the neighbourhood of the school. Participation of the program is extended every year automatically.

The basic selection of the fruits and vegetables consists of apples, pears, mandarins, mini cucumbers, small tomatoes, bananas, kiwis and carrots. These fruits and vegetables have been proven to be liked the most by children. When a subcontractor provides kiwis, it needs to provide spoons as well. These spoons need to be kept and recycled by the schools the next time the delivery contains kiwis.

The concept of the Project is that during 40 school weeks, portions of fruits and vegetables are delivered twice a week. Model one is calculating € 0.20 per portion (including taxes), and will thus comes down to a total amount of € 16 euro's a child per year. Model two will cost the parent a bit less, € 0.1625 per portion, and thus a total amount of € 13 euro's per child per year is required.

When a school decides to leave it up to the parents to give their kids fruits and vegetables to bring to school twice a week, it is very important that the school constantly reminds and stimulates the parents to really do so, and to vary in the products they give to their child(ren). As an encouragement and stimulus, Gruitboxes are provided when a school decides to choose Model three. These boxes are having such a shape, that besides a sandwich, an apple fits in as well.

Schools that are structurally and actively participating with the SchoolGruiten Project can request for a SchoolGruiten hallmark. This will distinguish them from other schools that are not participating with the Project.

At the moment 450 schools are registered and are thus participating in the SchoolGruiten Project. However, it is likely that more schools have established a similar scheme, but since they prefer to follow their own rules or did not wanted to bind their selves to SchoolGruiten as there is no registration duty.

Aim & Objectives: The SchoolGruiten project, the largest-scale free fruits and vegetables scheme for Dutch primary-school children, aims to improve accessibility of fruits and vegetables at school by providing a serving of fruit or vegetable to all children twice weekly.

Support: SchoolGruiten is a joint initiative of the Dutch Ministry of Health, Welfare and Sport (VWS), Horticulture manufactures, Holland Produce Promotion and the Dutch Nutrition Centre. It collaborates with the Dutch Ministry of Agriculture, Nature and Food Quality (LNV) and the Dutch Ministry of Education, Culture and Science (OCW).

The Project can be financed in three different ways; by the school itself, by the parents, and by a third party (like a health insurance, municipalities etc.)

If the parents finance the costs of their child(ren), they will receive an authorization form for a one time collection a year. The school will provide and receive those forms. When the school or a third party will finance the project, the money can directly be transferred to the subcontractor.

In order to facilitate the finances and to reduce the administrative work for a subcontractor, the GIS logistic system was developed. Schools can import the data of participating children and the financial details of the parents into this system, which the subcontractor can access and then send to the bank.

Every region in Holland has its own arrangements concerning the financial compensation of the products delivered. Some schools ask for a full coverage from the parents, other schools (for instance in the South of the province Limburg) offer 10 weeks of free fruits and vegetables and after the parents are ask to pay. However, the municipality of Amsterdam decided to fully cover all expenses needed for the Project, and schools are thus providing free fruits and vegetables.

Trigger: Most children in the Netherlands do not comply with recommendations for fruit and vegetable intake. Since 1987, the intake in grams has dropped by 16% (fruits) and 17% (vegetables) (Tak et al. 2008).

Targeted Communities: The programme was set up for all primary schools in the Netherlands who are interested in participating.

Evaluation: SchoolGruiten has already been proven to be effective. From an extensive study at around 300 primary schools with in total around 75.000 children and 7.000 teachers involved in seven different cities, turns out that indeed the children at the Gruitschools are eating more vegetables: From 1.1 portions a day to 1.6 portions a day. Teachers criticize the project as very positive (grade: 8.5/10) and children enjoy eating together in the classroom. By providing them with the possibility of eating together, they dare to try new fruits and vegetables faster as before.



Norway

(Extra information was provided by the faculty of Medicine of the University of Oslo)

National Strategy: The **strategy document**: ‘A healthy diet for good health’ [89], commissioned by the Norwegian Directorate for Health and Social Affairs, was drawn up by the Norwegian National Council for Nutrition and handed over to the Ministry of Health and Care Services in June 2005. Eleven ministries were involved in the development of the document, including the Ministries of Health, Agriculture, Fisheries, Children and Equality, Finance, Industry and Trade, and Education and Research [53].

One of the primary objectives of the work in the areas of nutrition is to reduce social disparities in health. To this end, the National Council for Nutrition has designated the following five high-priority areas.

1. Healthy choices (lowering the prices of fruit and vegetables, raising the prices of energy dense, nutrient-poor foods, and preventing the marketing of unhealthy foods to children and adolescents).
2. Educational institutions (providing free fruit and vegetables in day-care centres and schools, and ensuring basic health literacy, basic cooking skills and good teaching skills).
3. Health and social services (intensifying nutrition-related work in prenatal health services, children’s health clinics, school health services, nursing and care services and primary and specialist health services, and enhancing nutritional knowledge among health care personnel).
4. Research and monitoring (focusing on health-promotion and disease prevention measures that address public health challenges; conducting regular studies of eating habits and diet-related health and disease indicators in the population; and monitoring height, weight, blood pressure and various blood parameters).
5. Communication (placing more emphasis on communication to enhance the public’s knowledge about food, diet and health)

The Norwegian **Action Plan on Nutrition (2007-2011)** 'Recipe for a Healthier Diet' was developed by twelve ministries and serves as a tool for decision makers, professionals, experts and others in the public and private sectors and NGOs that play a role in the population's diet [90]. One of the two main goals of this Action Plan is to reduce social inequalities in diet.

The **Action plan for physical activity 2005–2009**: 'Working together for physical activity' [91] was adopted by the Parliament in 2005. The result of the joint effort of eight ministries, it contains 108 measures spread across diverse areas of the community, such as kindergartens, schools, workplaces, transport and urban planning, and leisure activities. A communication strategy for 2005–2009 was also developed to increase knowledge about physical activity and health and to motivate people to adopt an active lifestyle. A coordinating group, including representatives from all eight ministries, meets regularly to implement the different initiatives of the plan. The Directorate for Health and Social Affairs will coordinate the follow-up of the plan [53]. The Action Plan acknowledges the fact that the number of physically active persons increases according to the level of socio-economic status, and it foresees the challenge is has, to promote physical activity within these groups.

National Programmes: Information about running campaigns can be found in the WHO report and on the website of the government of Norway: <http://www.regjeringen.no>. At the moment none of these programmes are focusing on the communities from deprived areas in Norway specifically.



Portugal

(Extra information was provided by the Ministerio da saude; da Plataforma Contra a Obesidade)

National Strategy: The **National programme against obesity** [92] is integrated in the **National health plan 2004 – 2010** [93], together with other programmes such as the National Programme on Integrated intervention of Health Determinants Related to Lifestyles, the National Programme on Diabetes Control, the National Programme on Prevention and Control of Cardiovascular Diseases and the National Programme against Rheumatic Diseases.

The National programme against obesity aims to contribute to weight loss in the obese and those affected by Type 2 diabetes and cardiovascular diseases, and to combat habits leading to overweight. In general terms, it aims to contribute to the development of a culture that promotes healthy weight in the Portuguese population through intersectorial cooperation. The objective of the programme is, in this way, to reverse the increase in the prevalence of pre-obesity and obesity in Portugal [2, 53]. More information about this national programme can be found in the documents published by EuroHealthNet and the WHO.

National Support: The **National Platform against Obesity** (Plataforma Contra a Obesidade - <http://www.plataformacontraaobesidade.dgs.pt>) has a special focus on the understanding of the socio-economic determinants of obesity. For example, the Platform has a Local Governments based project, which is trying to identify children with increased needs in this area.

National Programmes: One of the running programmes of the National Platform against Obesity is the POZ project.

Projecto Obesidade Zero (POZ)

<http://plataformacontraaobesidade.dgs.pt>

The main purpose of the “Projecto *Obesidade Zero*” (Zero Obesity Project) is to develop a healthy cooking programme and a nutritional guidance programme targeted at low income families with overweight children. This action will be available and articulated with healthcare centres and town halls. Protocols will be established, according to which the healthcare centres and the town hall health offices will direct people to this service.

This project will last one year with the following development stages:

- Planning, defining the calendar and establishing agreements with the different partners.
- Constitution of regional teams for the cooking workshops and of guidance teams for individual and group counselling.
- Field work – organising cooking workshops, therapeutic groups, individual and group counselling.
- Assessment, with regular monitoring of the work done.

The expected results are: 1) Development of competences, within the families, in healthier food selection and preparation, especially in those families with obese children, and 2) Making nutritional guidance available to families with obese children, in a comprehensive and motivational process based on the work of the healthcare centres.

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Romania

National Strategy: The **National Action Programme for Health and the Environment** was adopted in 1998 and included actions on environmental components (e.g. water, radiation protection, social responsibility etc.), but also nutrition and food safety [2, 53].

A **National Strategy on Public Health** was adopted in 2004 and includes health promotion and preventive medical services.

In January 2010, Romanian Health Minister Attila Czeke announced that he will, as first country ever, introduce a fast-food tax in March as a way to improve the country's health programmes and to counteract obesity and other diet-related diseases [94]. The new tax is levied upon producers, importers and processors of unhealthy foodstuffs, with a high content of salt, fats, sugar and additives.

National Programmes: Since 1998, twenty-seven national health programmes have been implemented at national level. One of them is the **National Programme for Health Education and Health Promotion**. All programmes include a health promotion and health education component, and are financed by the Ministry of Health. They consist of annual campaigns and health promotion actions. In 2008 there was a distinct programme called: ‘the National Programme on Health Promotion’, which included the National Strategy on Health Promotion.

Further national action plans for nutrition are found in the **National Public Health Programme** ‘Evaluation of nutritional status of population’ [2].

Increasing access to quality primary prevention services for children and adolescents in Romania

Healthy nutrition and physical activity of children and adolescents of Romania

Aim & Objectives: The overall objective of the project is stopping and reversing the trend of increasing overweight and obesity in children and adolescents in Romania until 2020.

The main goal of the project is: to increase the percentage of children and adolescents that have healthy life style.

Design: The project is implemented by the Implementation Unit, that is the Public Health Centre of Sibiu, and the promoter of the project is the Romanian Ministry of Health. The main partner of the project is the Norwegian Institute of Public Health from Oslo.

The project has two main components:

1. The institutional development component aiming to build sustainable institutional networks, action plans for decreasing risk behaviour amongst young children and adolescents
2. The design, implementation, monitoring and evaluation of the information, education and behaviour change campaign

The project duration is April 2009-April 2011. This project is a new initiative. There was no pilot phase before the actual project was launched.

Support: The project is financed by the Norwegian Government through Innovation Norway and is co-financed by the Romanian Ministry of Health.

The other partners involved in the project are: the Romanian Ministry of Education, Research and Youth, the Foundation Youth for Youth Romania, the

Romanian Association of Health Psychology, the National Sanitary Veterinary and Food Safety Authority.

Trigger: Romanian Authorities working in close collaboration with NGOs have reached agreements that urgent and widely sustainable approaches are necessary to stop the increasing problem of childhood obesity at national level. These actions would address the two main risk factors for the main high prevalence chronic diseases in Romania (coronary heart disease, diabetes, cancer), namely sound nutrition and appropriate physical activity.

In order to trigger for most health gain, the approach the partners had chosen is to focus the intervention on enhancing the quality of the primary preventive services for these two main risk factors: inadequate nutrition and lack of physical activity.

Targeted Communities: The primary target groups chosen are the children, aged 3-14 and adolescents, aged 14-19. The project is not addressed to the most-disadvantaged groups, it targets all children and adolescents, as childhood obesity and overweight reaches alarming dimensions; it is a health issue and our first intention is to improve it. The project is not paying special attention on this issue, it focuses on how to convince as many children and adolescents as possible, to lead a healthier life.

Evaluation: The project has recently started and it has not been evaluated yet.

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Slovakia

(Extra information was provided by the Public Health Authority of the Slovak Republic – EuroHealthNet member)

National Strategy: Slovakia has developed two main strategic documents/declarations, which are oriented on nutrition, physical activity and obesity prevention.

The **Health State Policy of the Slovak Republic** was approved by the Slovakian government in 2000. One of the priorities of the Health State Policy is the **National Program of Health Promotion**. This program was updated by the government in 2005. Based on this program, the National Public Health Authority developed the **National Program on Prevention of Obesity**. In scope of this National program on prevention of obesity will be carried out the following activities:

1. Developing the cooperation between the Consulting Centre of Health Protection and Promotion at Regional Public health Offices and general practitioners for adults, general practitioners for children and youth.
2. Creating partnership and improving a communication and cooperation between health care providers and public health authorities (especially using systematic and legislation tools).
3. Addressing media partners with the request of providing a room for propagation of Consultation Health Centers at Regional Public Health Offices (their work activities and importance of diseases prevention which are linked also to obesity)

More information about these documents, and other thematic documents that were derived as a result can be found in the WHO and EuroHealthNet report [2, 53].

National Programmes: The National Public Health Authority developed the **National Program on Prevention of Obesity** in January 2008. The overall aim of the program is to establish an energy balance by promoting healthy nutrition and physical activity with a consequent reduction in the prevalence of obesity in all population groups. A multidimensional approach has been suggested involving individuals, communities and several policy sectors. It is proposed to take action in community setting, such a school, workplaces, catering services, public health and health care services, and through policy education.

Programs, which are currently running in Slovakia and are not mentioned in EuroHealthNet and WHO documents are:

- "Challenge your hearth towards physical activity" - it is the national campaign focused on adult population to raise awareness of the importance of physical activity
- "Healthy children in healthy families" - targeted for children of age group 7 - 17 years
- "The program of healthy nutrition for Slovak population" - focused on improving of nutrition habits of the population
- "Monitoring of nutritional habits and preferences of selected children population and evaluation of risks connected with particular food consumption"

More information with regard to these programmes can be given by:



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Slovenia

(Extra information was provided by the National Institute of Public Health of the Republic of Slovenia – EuroHealthNet member)

National Strategy: The National Assembly of the Republic of Slovenia adopted in May 2005 the **Food and Nutrition Action Plan for Slovenia** (2005-2010) (FNAP). The main goals of the plan are: to increase the consumption of good quality, locally- and ecologically-produced healthy foodstuff; to stimulate the development of local economies and rural development; to create new market opportunities for local farmers; and to contribute to environmental protection [2, 53]. One of the target groups of the action plan that are being particularly at risk are people from lower socio-economic classes. It therefore aims to 'Strengthen multi-disciplinary programmes and the execution network for health promotion in local communities, especially for socio-economic population groups at risk' [95].

Another strategy that was adopted is the **National Health Enhancing Physical Activity Programme** (2007-2013) (HEPA) [96]. Based on results from the national CINDI study carried out in 2001, the goal of HEPA is to '*encourage all forms of regular physical activity and exercise aiming to enhance health and to be maintained throughout the entire lifetime.*' Regarding disadvantaged communities, one of the aims of the programme is '*strengthening the values, awareness and knowledge of the entire population with regard to physical activities that enhance health, irrespective of their age, gender, educational level, socio-economic status, the functioning of the locomotory system and other factors.*'

Both programs have common goals in counteracting obesity. They have been created in an integral and synergetic manner, with a focus on inter-sectoral cooperation and partnership among those implementing the measures. Those goals are highlighted in the annual action plans, based on both strategies.

Regarding interregional health inequalities, the **Health Promotion Strategy and Action Plan for Tackling Health Inequalities in the Pomurje Region** was set up and provides a strategic plan that identifies the main aims and objectives for the government and other stakeholders to contribute to reducing health inequalities, as well as the strategies to reach these objectives and indicators to monitor progress [97]. The document is developed as a result of a bilateral collaboration between the Institute of Public Health Murska Sobota in Slovenia and the Flemish Institute for Health Promotion and Disease Preventions (VIGeZ), within the co-operation programme between Flanders and the Candidate Member States of Central and Eastern Europe.

The Pomurje regions is the least economically developed region of Slovenia and also has the poorest health indicators, it's population can be considered in general as a risk group for less favourable health compared to the population in central Slovenia. The strategic plan identifies the reduction of interregional and intraregional health inequalities in the Pomurje region as its main goal. To achieve this goal, five aims are proposed.

- The first aim refers to processes which underpin effective interventions, and is concerned especially with raising the awareness of regional stakeholders as well as the general population of the importance of health and health inequalities, and building a strong evidence base on health inequalities and health promotion.
- The second aim provides an important precondition to enable action to reduce health inequalities, and is concerned with community capacity. To increase the community capacity the following conditions must be met: a health support network, an enlarged participation of the community in decision making processes which impact health, and a change from a problem-oriented to a resources-oriented mentality. In addition, an improved capacity of professionals and lay-workers in health promotion is also important for effective health promotion interventions to tackle health inequalities.

- The third is to reduce the interregional health inequalities by developing an effective system of health promotion interventions which encourage a healthy lifestyle and social and emotional wellbeing in the region. Specific efforts to increase the early detection of non-communicable chronic diseases are also involved here.
- The fourth aim addresses intra-regional inequalities by supporting vulnerable groups like young mothers and children, dropouts, unemployed, elderly, people with special needs and ethnic minorities. For each group, specific interventions are identified to encourage a healthy lifestyle and increase their capacities for gaining independence and upward social mobility.
- The final aim focuses on a healthy physical environment. It aims to encourage environment friendly behaviour of the population, and to support environment friendly policies at the local level.

Although the strategic document is specifically designed for the Pomurje region, the strategic plan also provides a valuable input for the national strategy in the field of health inequalities.

National Programmes: Through the **National School Nutrition Programme** children in Slovenia are offered healthy meals as part of their school curricula.

The programme is running in three different schemes:

1. *All kindergartens* in Slovenia offer breakfasts, midmorning snacks, lunches and afternoon snacks. Meals are prepared or cooked in vast majority in their own kitchens.
2. Most primary schools offer breakfasts, midmorning snacks, lunches and afternoon snacks. *All primary schools* offer at least two meals (midmorning snacks and lunches) every school day. Most of them have their own kitchens financed by the Ministry of Education and Sport.

3. In 2008, the Slovene government adopted the decision to finance on healthy cooked meal in *all secondary schools*. These meals are offered by all schools to all secondary school students on a daily basis by different selected providers.

Scheme one and two of the National School Nutrition Programme are running since 1950 in Slovenia. All three schemes are obliged to follow the national guidelines for healthy nutrition (2005). Originally it was launched aiming to ensure that all children ate enough quantities of healthy food, but nowadays it is being used to teach them about healthy eating habits as well.

The programme is subsidized for children from lower socio-economic groups (approximately 35% of all children receive subsidized meals). The subsidies for school meals for pupils/students in 2006-2007 were: €0.55 daily per pupil, and €0.85 daily per secondary school student.

More information about this programme or other running programmes in Slovenia can be provided by:



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Spain

(Extra information was provided by the Spanish Food Safety and Nutrition Agency)

National Strategy: The Spanish Strategy for nutrition, physical activity and the prevention of obesity (**NAOS strategy**) was launched in 2005 and addresses obesity through different working groups. More information about this strategy can be found in the EuroHealthNet and WHO report.

National Support: The **Spanish Food Safety & Nutrition Agency** (Agencia Española de Seguridad Alimentaria y Nutrición – AESAN) launched several actions directed to children. However, these are not specifically targeted to lower socio-economic groups but they are tried to be reached by implementing the interventions in public schools or semi-public schools. The agency has also published a guide about healthy eating directed to immigrants.

National Programmes: Several activities have been undertaken as a result of the NAOS strategy. An overview of programmes can be found in the EuroHealthNet and WHO report. However, none of these national campaigns are aiming to target lower socio-economic communities.

The main project of the agency is the **PERSEO** intervention, which reaches almost 70 schools and more than 12.000 children. The intervention runs during 2008-09 and teaches pupils about healthy eating and it promotes physical activity during and after school hours. The targeted schools are located in low socio-economic districts. More information can be found on the website: <http://www.naos.aesan.msc.es>

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Sweden

(Extra information was provided by the Swedish National Institute of Public Health – EuroHealthNet member)

National Strategy: Sweden has no national action plan or a national strategy regarding the prevention of obesity. The Swedish government wants to implement specific actions regarding diet and physical activity rather than a full action plan. However, there is a **Nordic Plan of Action on better health and quality of life through diet and physical activity** [98] approved July 2006.

However, in 2003, the Swedish Parliament ratified the first **Public Health Bill**, which introduced a public health strategy using health determinants as its starting-point to put focus on factors in both structure of society and people's living conditions and lifestyles that are either good or bad for health. The overarching aim of the policy is to create societal conditions that ensure good health, with equal terms for the entire population. The policy consists of eleven objective domains including a number of established policy areas such as economic policy, social welfare, the labour market, agriculture, transport and the environment. Two of the objective domains; 9 – Physical activity; and 10 – Eating habits and food; directly concern the relevant area.

In 2008, the bill “**A renewed public health policy**” [99] was published. The bill is based on a holistic view of people and contains a greater element of individual responsibility than before. The public health policy covers many different areas, with special focus on for example supporting for parenting; and eating habits and physical activity. The Government's public health bill focuses particularly on children, young people and the elderly. The Bill emphasises that medical care must promote health, that social networks are important as a protective factor that government agencies must be able to cooperate with civil society and that local and regional work is important. It does not specifically target lower socio-economic communities.

National Support: The **Swedish National Institute of Public Health** has been commissioned by the government, to coordinate the monitoring of the eleven objective domains on the national level and is responsible for the collective monitoring of the overarching public health aim.

Specific government assignments includes that the National Institute of Public Health has been instructed, in cooperation with the National Food Administration, to implement and evaluate measures for good eating habits and increased physical activity, with a focus on the problem of overweight. The Government also intends to make it possible for the National Board of Health and Welfare to register information about children's height and weight and develop initiatives to promote good eating habits and physical activity.

The Government is also giving priority to programmes with physical activity on prescription. Current studies indicate that physical activity on prescription leads to a higher level of physical activity and improved self-perceived health. The Government has also set up a dialogue forum where representatives from industry, experts, voluntary organisations, government agencies and media jointly discuss how good eating habits and physical activity can be promoted.

National Programmes: In Sweden there is a focus on intersectional collaboration between the municipalities, national agencies and boards, nongovernmental organizations, etc., as well as between the national, local and regional levels.

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Switzerland

(Extra information was provided by Health Promotion Switzerland – EuroHealthNet member)

National Strategy: The Federal Council's Concept for a **national sports policy** of 2000 [100] sets the basis for the political contribution to creating a culture of physical activity whereby sport is part of social, economic, ecological and sustainable development.

Based on the results of the third and fourth Swiss nutrition reports, a working group established by the Nutrition Council defined the goals and tasks of the **Swiss nutrition policy** for the period 2001-2005. The key goals were to promote healthy body weight through a well-adjusted energy and nutrient balance and to increase the consumption of fruit and vegetables. To achieve these goals, strategies were developed and programmes launched in cooperation with partner organizations [53].

Long-term measures involve influencing political and social conditions in such a way as to ensure a sustainable trend towards the maintenance of a healthy body weight. **The Fifth Nutrition Report** [101] was published in 2005 and will be the basis for setting goals and tasks for a future nutrition policy in Switzerland.

In 2001, the **Action plan on nutrition and health** [102] was approved by the Federal Council in order to: reduce the prevalence of nutrition-related diseases; ensure a supply of safe food of good quality; contribute to the sustainable and environmentally-friendly production and distribution of food; and put consumer interests in the centre of nutrition policy [53].

A parliamentary proposal was made in 2007 on the taxation of energy-dense foods containing excessive amounts of fat and sugar. Although it was rejected by the Government, it was kept as a future option in case other solutions fail. As

regards marketing to children, the food industry is setting up a system of self-regulation to be discussed with different stakeholders [53].

National Programmes: The **Suisse Balance programme**, launched in 2002, is a joint programme of the Swiss Federal Office of Public Health and Health Promotion Switzerland. Its two principal objectives are defined as follows: to considerably increase the proportion of people living in Switzerland with a healthy weight, achieved through physical activity and a healthy diet; and to create the structural conditions needed to allow the stable development of healthy body weight in the population. The programme encourages and supports the development of local, regional and national projects that reinforce healthy behaviour through nutrition and physical activity. This is aimed principally at children and young people (<http://www.suissebalance.ch>) [53].

“**Allez Hop**”, which is running for over 10 years now, is another initiative aimed at increasing physical activity among the population through sport and the in-depth medical and technical training of physical activity teachers. It also offers courses on endurance sports and the transmission of basic knowledge about physical activity and the pleasures associated with being physically active [53].

Low fees make these courses accessible to everyone, thus encouraging also those of low socioeconomic status to be more physically active (<http://www.allezhop.ch>).

In 2004, the **Health-enhancing physical activity (HEPA) Network Switzerland** was created with the objective of promoting health-enhancing physical activity among the Swiss population. The network works according to the following four-phase plan.

1. Distribution of information on the principles of the network to health professionals and policy-makers.
2. Exchange of information and collaboration with partners in the network.

3. Development of tools for action by partners in the network.
4. Integration of physical activity in the overall public health policy.

Information on and support in developing, conducting and evaluating physical activity interventions is provided to the partners in the network (<http://www.hepa.ch>) [53].

Further information about ongoing projects and initiatives, run by Health Promotion Switzerland, can be found on the following websites (available in German or French only):

Gesundes Körpergewicht

http://www.gesundheitsfoerderung.ch/pages/Gesundes_Koerpergewicht/Grundlagen_Wissen/grundlagen.php?lang=d

Children on the Move

<http://www.children-on-the-move.ch/index.php>

akj – Swiss Association for childhood and adolescence obesity

http://www.suissebalance.ch/logicio/pmws/indexDOM.php?client_id=suissebalance&page_id=projekte&lang_iso639=de



United Kingdom

England

National Strategy: In February 2010, a report was published which represents the outcomes of a national review of health inequalities in England [103], based on a series of global recommendations made by the WHO Commission on the Social Determinants of Health [104]. The English national review document, called “*Fair Society, Healthy Lives*”, aims to propose an evidence based strategy for reducing health inequalities from 2010. The review process was led by the international epidemiologist Sir Michael Marmot, who also chaired the WHO Commission.

One of the policy objectives is to ‘give every child the best start of their life’, and addresses the importance of investing in the early years. Because, as the report says: “*What happens during the early years (starting in the womb) has lifelong effects on many aspects of health and well-being— from obesity, heart disease and mental health, to educational achievement and economic status*”. The review therefore recommends to (1) Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient, (2) Support families to achieve progressive improvements in early child development, and (3) Provide good quality early years education and childcare proportionately across the gradient.

A second policy objective highlights the importance of ‘Strengthening the role and impact of ill-health prevention’. The report says that ill-health prevention strategies should be put in the context of the social determinants of health, and that it should require the involvement of multiple stakeholders (local authorities, primary care and third sector). The report recommends to (1) Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient, (2) Implement an evidence-based programme of ill health preventive interventions that are effective across the

social gradient, and (3) Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient.

The **National Obesity Observatory** was established in December 2007 and aims to provide a single point of contact for wide-ranging authoritative information on data and evidence related to obesity, overweight, underweight and their determinants. The Observatory has published many reports and briefing papers, one of them being a document published in November 2009 called: “*Obesity and Overweight Surveillance in England: what is measured and where are the gaps?*” [105], which aims to identify and describe the main sources of national level surveillance data on obesity in England and to highlight gaps in these data sources. It also makes recommendations for the national surveillance of obesity in the future. The report concludes that population surveys are limited by factors such as access to and availability of individuals and the types of measurements collected, and that a more pragmatic approach is needed. Some areas deserve more detailed investigation or larger scale data collection, such as surveys studying the link between ethnicity and obesity.

Reducing obesity is a key priority for the Government. Since 2004, the following strategy and policy steps were taken [2]:

In July 2004, a **PSA (Public Service Agreement) target** specifically on obesity was set. PSAs are high level aims which set out the key improvements that the public can expect from Government expenditure. The obesity target consists in ‘halting the year-on-year rise in obesity among children aged under-11s by 2010 in the context of a broader strategy to tackle obesity in the population as a whole’.

The Department of Health published in November 2004 – in support of the PSA – the **Choosing Health White Paper**, which recognises reducing obesity as one of its six overarching priorities. It set the frame for action, the principles for supporting the public to have healthy lifestyles and the Government commitments in that direction [106].

Half a year later, in March 2005, the **White Paper delivery Plan**, together with two supporting Action Plans focusing on nutrition and physical activity set out how the White Paper commitments will be delivered. The two supporting Actions Plans were:

1. **Choosing a better diet – a food and health action plan**, which brought together all the White Paper commitments relating to food and nutrition, including cross-Government activity [107].
2. **Choosing activity – a physical activity action plan**, which brought together all commitments relating to physical activity in Choosing Health as well as other actions across government that will contribute to increasing levels of physical activity [108].

The **Choosing Health progress report** (May 2006) provides an update on progress of the White Paper commitments and indicates whether action on the relevant commitments have been achieved, are on track or significant was made.

The **Health Challenge England** – next steps for Choosing Health report, published in October 2006, presented the successes of Choosing Health and set out a Strategic Plan for delivery for the following two years.

Healthy Weight, Healthy Lives: A cross-government strategy for England (January 2008) is a policy document which outlines the government's approach to promoting health weight in children across England. A key theme of this £372 million strategy is 'promoting healthier food choices', which outlines out plans to work with the food industry on a Healthy Food Code of Practice.

National Support: An example of collaboration in England is the local strategic partnerships; **Primary Care Trusts** (PCTs) and local authorities bring together local authorities and other public services and private, voluntary and community sector organisations to work with residents to improve local areas and services. They have a key role to play in supporting healthy eating in communities through local retailers, food growing schemes, cooking skills' development, food cooperatives and community lunches. These programmes will be supported by

national and regional action (e.g. the national '5 a day' programme). Many examples of collaborations between PCTs and local authorities can be found in the chapter describing initiatives running at local levels.

The Cheshire and Merseyside Partnerships for Health (**ChaMPs**) is a public health network for primary care trusts local authorities, NHS trusts and wider organisations. The network's mission is to build partnership to promote and protect public health and well-being, and develop capacity and capability in the public sector. ChaMPs was launched summer 2005 and by building partnerships and sharing knowledge and expertise it aims to improve the health of the population. ChaMPs is leading a campaign focusing on the prevention of obesity and health inequalities – the description of this project 'Snack Right' can be found in chapter four. More information about ChaMPs can be found at: <http://www.champs-for-health.net>.

257 innovative projects in England are funded by the National Lottery Fund through the **Health Living Alliance**. This centre is co-ordinating and providing leadership for organisations delivering solutions in the voluntary and community sector that encourage healthy lifestyles and prevent ill-health. It also provides a national voice and drives forward knowledge of preventive healthcare with a view to providing high standards and consistent messages to the public.

Through encouraging people to adopt healthier lifestyles the HLA hopes to reduce and eradicate health inequality. This will be achieved by:

- Identifying individual need and designing holistic health services that acknowledge the links between mental, physical and social well-being
- Giving all people, especially those considered as 'hard to reach' equal opportunity to access appropriate health services
- Providing communities and individuals access to the tools and resources they need to help themselves
- Offering advocacy services to those unable or unwilling to speak for themselves

At national level, HLA is driving forward a new approach to health, and regionally it is developing networks of projects that promote and provide high quality services. Finally, at local level the HLA supports many community-based projects that enable people to make healthier choices. Examples of such projects can be found in chapter four.

For more information, please visit <http://www.healthylivingalliance.org>.

National Programmes: The work on obesity in England builds on existing activity but also public spending on nutrition and physical activity-related programmes. Two examples of campaigns running at national level are the Healthy Start Scheme and Change4Life.

Healthy Start Scheme

<http://www.healthystart.nhs.uk>

The **Healthy Start Scheme** is replacing the Welfare Food Scheme. After it first started in England, it is now live throughout the UK. The new scheme:

- Includes fresh fruit and vegetables as well as milk and infant formula milk
- Supports breastfeeding
- Encourages earlier and closer contact between health professionals and families from disadvantaged groups
- Includes free vitamin supplements for children from 6 months until their 4th birthday, and free vitamin supplements for pregnant woman and woman with babies up to one year old

Healthy Start is open to pregnant woman and families with children under the age of four who are on:

- Income support
- Income-based Jobseeker's Allowance or
- Child Tax Credit with an income of £15.575 a year or less (2008/2009)

Once accepted on the scheme, pregnant woman and families will receive a set of vouchers through the post every four weeks. Each voucher is worth £3.00 and can be exchanged for any combination of milk, fresh fruit, fresh vegetables and infant formula milk in registered shops.

For more information, please visit <http://www.healthystart.nhs.uk>.

Change4Life

<http://www.nhs.uk/Change4Life>

£75 million was committed to a three-year social marketing programme to help the population to make positive lifestyle changes and maintain a healthy weight. This campaign, called **Change4Life**, was launched to the public on 3 January 2009 on TV, in the press, on billboards and online. In the initial stage, families with children aged 5-11 are targeted. Change4Life works in partnership with local grass roots organisations, schools, healthcare professionals, charities and business. It will encourage target families to:

- Be aware of the risk of accumulating dangerous levels of fat in their bodies and understand the health risks associated with this condition
- Reduce overall calorie intake and develop healthier eating habits by:
 - ◆ Cutting down on foods and drinks high in added sugar
 - ◆ Cutting down on foods high in fat, particularly saturated fat
 - ◆ Reducing consumption of unhealthy snacks
 - ◆ Having structured meal times
 - ◆ Eating more fruit and vegetables (increase 5-a-day habit)
 - ◆ Reducing portion size
 - ◆ Increase exercise by engaging in regular physical activity, with particular emphasis on parent/child activities and by avoiding prolonged periods of inactivity or sedentary behaviour.

The campaign is focusing initially on families, with the objective of instigating healthier behaviours amongst their children that will serve them well as they grow up. Within this group, clusters of families have been identified who are most at risk of becoming overweight or obese - including those who are most likely to experience health inequalities. At risk families are invited to join Change4Life, are sent a questionnaire to assess their current behaviour and receive ongoing support, advice and information. For more information, please visit: <http://www.nhes.uk/Change4Life>.

Scotland

(Extra information was provided by NHS Health Scotland – EuroHealthNet member – and the Scottish Grocers’ Federation)

National Strategy: In 1994, the *Scotland’s Health: A Challenge to Us All – The Scottish Diet* was published and it surveyed the Scottish diet, assessed the evidence for the link between diet and health and made proposals for improvement in the Scottish diet.

Two years later in 1996, a key policy document: *Eating for Health: A Diet Action Plan for Scotland* [109], was produced for the development of initiatives to improve the Scottish Diet. This Scottish Diet Action Plan (SDAP) was shaped by the publication in 1994, and it identified practical measures across the food supply chain to support improvement in diet. It also set out dietary targets and a number of recommendations aimed at reducing dietary related morbidity and mortality in Scotland. The key steps of this action plan are targeted on several groups, one of them being low income areas.

‘(...) Help in low income areas, through measures, co-ordinated by a national project officer funded by The Scottish Office ², to encourage local initiatives and to improve access to a range of healthy food at reasonable prices.’

² The Scottish Office is pre devolution, the Scottish Executive is post devolution and the Scottish Government is the current administration

These steps are implemented in recommendations 17 and 21:

‘Supermarkets should examine, in consultation with the proposed national project officer, the feasibility of measures, such as free, or low cost, transport, to facilitate access to their stores by low income consumers within the community. They should also consider, with low income communities, the development of alternative ways in which the healthy food products available in supermarkets could be made more readily available to these communities.’

‘A national project officer should be appointed under the auspices of the Scottish Consumer Council to promote and focus dietary initiatives within low income communities and to bring these within a strategic framework. Resources should be made available by The Scottish Office to fund this post, to support innovative local projects and to sustain and extend successful, effective initiatives.’

For more information, please visit <http://www.healthscotland.com>.

In 2003, a wider framework for action to improve the health of people in Scotland was laid out in the Scottish Executive’s ² Health Improvement paper titled: *Improving Health in Scotland – The Challenge* (2003). This framework supported the processes required to speed up the progress of health improvement and highlighted further actions. [110].

One of the ‘challenges’ that this document summarises is the high levels of inequality in health outcomes for different socio-economic groups (for example in terms of life expectancy, rate of Coronary Heart Disease). It also emphasises the importance of following through with action by the Scottish Executive to improve life circumstances in communities by continuing tackling low income and poverty, as this will have an important impact on health. And thus one of the key conceptual stages in the next phase of work will be: *‘to increase access to healthier food choices, particularly in low income and rural areas’*.

² The Scottish Office is pre devolution, the Scottish Executive is post devolution and the Scottish Government is the current administration

In the same year, the Scottish national strategy for physical activity **Let's make Scotland more active** – was launched. It is a long term action plan (until 2022) and endorses international recommendations for the quantity and quality of physical activity required for a health benefit [111].

During 2008 the strategy was reviewed. The results of the review found no evidence to suggest that the strategy should be substantially revised and that it remains in line with physical activity guidelines issued by WHO and the EU. However the review did highlight a number of key areas where action can be strengthened.

The strategy mentions health inequalities in its background information, and the difficulties one can face if the aim is to increase physical activity among the lower socio-economic communities.

'Within this general picture of inactivity is a major issue of health inequality. The proportion of sedentary adults (doing 30 minutes or less of physical activity on one day a week or not at all) in the lowest socio-economic groups is double that among those from the highest socio-economic groups.'

A number of initiatives focus on areas of high deprivation, disadvantaged and hard to reach groups.

1. Paths to Health The project is a leading delivery agent for the Physical Activity Strategy. Its aim is to develop local walking schemes. Over 200 community based schemes have been supported, over two thirds of which are in deprived areas, with 1,700 Walk Leaders trained to lead walks in communities and up to 20,000 people participating in led walks every week.

2. Jogscotland The focus is to develop jogging groups in three key settings: workplaces, communities and schools/young people focusing on disadvantaged areas where possible. It has over 13,500 members in 300 groups in local communities and in workplaces.

3. Junior jogscotland programme now has over 800 Primary Schools and Youth Groups around the country already with Junior jogscotland resource packs and hundreds of children already taking part in the games based activity programme.

4. Girls on the Move aims to increase the physical activity levels of girls and young women. This initiative is a community based programme that promotes physical activity through participation and leadership programmes and focuses on girls and young women from hard to reach groups.

Another strategic framework for food and health was published in 2004: **Eating for Health – Meeting the Challenge (2004)** [112]. It is a co-ordinated action plan, developed through dialogue and discussion with partner organisations that builds upon the key actions outlined in *Improving Health in Scotland – the Challenge (2003)*.

In December 2006, the First Minister for Scotland launched the **national report on health improvement activities** [113]. The document reports on progress since 2003 towards the vision for health in Scotland by 2020. As one of the next steps, the report recommends to *'Expand on measures in low income communities through Community Food and Health Scotland and a new phase of the Scottish Grocers Federation Healthy Living Programme.'*

The latest development was the publication of the **'Healthy Eating Active Living'** action plan by the Scottish Government ² in June 2008, aiming to improve diet, to increase physical activity and to tackle obesity (2008-2011) [114]. The actions set out in this document are targeted mainly towards those at greatest risk of health inequalities.

In the same year, the Scottish ministerial Task Force on health inequalities published a land-mark policy document: **Equally Well**. The document consists of

² The Scottish Office is pre devolution, the Scottish Executive is post devolution and the Scottish Government is the current administration

recommendations made by the Task Force based on the latest international evidence [115].

The **Equally Well implementation plan** [116] includes information on the establishment of Healthy Weight Community Projects by the Scottish Government, which aim to reduce obesity, particularly amongst children and more deprived groups of people (during 2009-2010). The projects will bring together local stakeholders to raise community-wide awareness of the importance of healthier living, and help make clearer how people can be more active in everyday life and make healthier food choices.

Also, at the end of 2008 the Scottish Government published **Good Places, Better Health**, a strategic document for environment and health that aims to identify evidence and policies that can be taken forward to create environments that promote and nurture good health. One of its first priorities in children's health is obesity [117].

National Support: Both a **Physical Activity and Health Alliance (PAHA)** and a **National Food and Health Alliance** were launched to provide a network for those who are interested.

PAHA provides a focus for action to implement Scotland's physical activity strategy and a national consultative platform where members share knowledge and learning and have an opportunity to inform future policy decisions for health improvement in Scotland. The Alliance has recently had its annually conference which has grown from around 200 delegates three years ago to 400 plus in

The **Scottish Grocers' Federation (SGF)** is the trade association for the Scottish Convenience Store Sector. It promotes responsible community retailing and works with the Government and the media to encourage a greater understanding of the contribution convenience retailers make to Scotland's communities. The SGF brings together retailers throughout Scotland, from most

of the Scottish Co-ops, Somerfield, Spar and local independents who are the largest category of members. It is improving the supply and provision of healthier food choices, focusing on fresh produce, in local neighbourhood shops particularly in low income areas. Participating stores have registered an average increase in sales of fresh fruit and vegetables of between 20% and 30% since the start of the programme which now boasts 550 stores representing around one million transactions per week [114].

Community Food and Health (Scotland) supports initiatives in low income communities which help people take up a healthy diet. It was set up as a result of the recommendations contained in the Eating for Health: a Diet Action Plan for Scotland (1996) and is funded by the Scottish Government. Community Food and Health (Scotland) is ensuring the experience, understanding and learning from local communities informs policy development and delivery through encouraging and enabling communities, policy makers and policy deliverers to have the confidence, enthusiasm and capacity to constructively engage with each other and address food access.

A total of £100,000 is distributed each year through a small grants scheme. Groups and agencies can apply for between £500 and £3000 to develop healthy eating activities with or within low income groups based in Scotland. For more information, please visit <http://www.communityfoodandhealth.org.uk>.

NHS Health Scotland is the national agency for improving the health of the Scottish population. It is a Special Health Board in NHS Scotland and is co-ordinating efforts to support delivery of the priorities for action set out in the Improving Health in Scotland – The Challenge (2003). It aims to provide leadership and work with partners to improve health and reduce health inequalities in Scotland. One of its health improvement targets is physical activity, and it supports several obesity campaigns. For more information, please visit <http://www.healthscotland.com>.

National Programmes: Several public-private partnerships have been created to promote healthy eating and physical activity through several initiatives. However, most of these initiatives are implemented at local level. Examples of national programmes can be found in the EuroHealthNet and WHO report.

The Scottish Grocers' Federation launched the **SGF Healthy Living Programme** in 2004, which aims to provide advice on how to improve the eating habits of customers and offer a better range of healthier food options particularly fruit and vegetables. The programme is part of an extensive focus by the Scottish Government on a healthier lifestyle by the Scottish people and it is one of many programmes aimed at encouraging the population to eat healthier. There is a particular focus on children and addressing health inequalities.

SGF Healthy Living Programme

Aim & Objectives: The aim of the project is to improve healthy eating in community areas of Scotland – particularly within low income areas where the need is greatest.

Design: An initial pilot programme ran before the programme was officially launched, whereby one store was selected from each of the five main convenience retailers in Scotland. The pilot was equally funded by the Scottish Government and each of the five main convenience retailers involved. The Scottish Grocers' Federation was the main partner and acted as the 'banker' of the funds.

The project is a partnership between the Scottish Government and the retail food convenience stores in Scotland. A co-ordinator works with these retailers to discuss ways of how they can improve the range, quality and display of fruit & vegetables to encourage consumers to eat more healthily. The co-ordinator

works no more than 2 days a week and is supported by 2 part time development managers who call on independent retailers to discuss the advantages of developing the fruit & vegetable category within store. Work is also being developed to bring in more "healthier for you products" from other categories.

Support: The programme has been funded each year from 2004 on by the Scottish Government with inward investment from the main retailers. The Scottish Government have approved a phase 4 for this programme which will run until April 2013.

Trigger: The programme was initiated by the Scottish Government through a lead person who initially worked with a major supplier within the Scottish industry and was thus having close contact with the convenience retailer. An initial meeting was set up with the retailers and the individual from the Scottish Government and agreement was reached to run a pilot.

Targeted Communities: Currently, 55% of the stores taking part in the programme are in low income areas. The plan has deliberately included stores within higher socio-economic areas – people who live in these areas do not necessarily eat healthy foods – particularly children.

Evaluation: The programme has been evaluated across each of its phases. It has shown to be very effective with over 550 retailers now having participated. Documents have been published that show evaluation of views from consumers as to whether they are eating more fruit & vegetables and whether the store does try to promote healthier foods. The retailers also give results in terms of sales increases – these have been quite spectacular with retailers who were in phase 1 of the programme still showing good growth year over year.

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Wales

(Extra information was provided by Nutrition Network for Wales, Wales Centre for Health – EuroHealthNet member)

National Strategy: The Welsh Assembly Government has undertaken a range of work to help the people in Wales to eat more healthily and increase their levels of physical activity. The following sub national strategies and policies exist:

- “Food and Well Being, reducing inequalities through a nutrition strategy for Wales” (2003) [118]
- “Climbing Higher” (2005) and “Climbing Higher – Next Steps” (2006) [119]
- “Food and Fitness – Promoting healthy Eating and Physical Activity for Children and Young People in Wales” (2006) [120]
- “Appetite for Life Consultation” (2006) [121]

Further information can be found in the EuroHealthNet document [2] and on the website of the Welsh Assembly Government (<http://cymru.gov.uk>).

National Programmes: An extensive overview of ongoing programmes can be found in the EuroHealthNet document. In addition to this, the following project descriptions were provided by the Wales Centre for Health and the Nutrition Network for Wales:

Physical Activity & Nutrition Network for Wales

<http://www.physicalactivityandnutritionwales.org.uk>

In 2003 the Food Standards Agency (FSA) Wales and the Welsh Assembly Government launched Food and Well Being, the nutrition strategy for Wales. The strategy outlines the actions required by key players to improve the diet, health

and well being of the people of Wales. A key action in the strategy was to ‘develop a nutrition network involving health professionals, teachers, voluntary organisations and others.’

Concurrently, the Physical Activity Network for Wales (PANW) was launched in October 2006 following recommendations laid out in the Welsh Assembly Government Healthy and Active Lifestyles in Wales Action Plan. It included an action to ‘establish an all-Wales physical activity liaison group in order to bring together national and local representatives to identify common objectives to share best practice.’

In 2004 the Food Standards in Wales for the Nutrition Network for Wales and the Welsh Assembly Government for the Physical Activity Network for Wales commissioned the Wales Centre for Health to consult with key stakeholders in Wales and to gather their views on what the structure and the purpose of the Networks should be. Following the consultation the Wales Centre for Health took forward the development and establishment of the Networks.

From 2005 - 2009 was the pilot phase. The Networks are now an on-going project.

Increasingly Welsh Assembly Government Policy has sought to align the nutrition and physical activity agendas to address in particular growing levels of obesity. This was led by the Food and Fitness for Children and Young People 5 Year Implementation Plan. As a result in the summer of 2007 the Welsh Assembly Government asked for the Nutrition Network for Wales and the Physical Activity Network for Wales to work more closely together.

The Networks have been developed and established to facilitate partnership and collaboration and bring together all the individuals and organisations that have a role to play in improving nutrition and physical activity. Partners will benefit from open communication with one another and the ability to share knowledge and good practice.

Current Outputs

There are over 1200 registered members of the Network.

- A website. The website includes information about news and events, policy and strategy, data, research, surveys and evaluation, areas of interest, campaigns, community initiatives including a community initiatives database with over 300 initiatives included, funding, courses, careers and volunteering and a resources database.
- An e-bulletin is circulated bi-monthly.
- A quarterly hard copy newsletter called Bitesize for community initiatives.
- CPD events delivered and workshops regularly facilitated at relevant conferences and events.
- Queries from members and are answered, the Networks act as a resource for identifying and sharing information in the field.

Aim & Objectives: The aim of the project is to identify, engage and support individuals and organisations across Wales in collectively improving the health of the people of Wales by enhancing the nutrition of all, whilst at the same time reducing the health inequalities of those most disadvantaged in our communities.

Its objectives are to:

- Identify, quality assure and disseminate information around the topics of sexual health, nutrition, physical activity and mental
- Establish and maintain databases of 'good practice'
- Provide access to opportunities for learning and professional development
- Provide a forum for sharing learning, experience and ideas
- Promote and support community, local and national inter-sectoral partnerships
- Identify and address gaps in learning, resources and practice
- Facilitate consultation opportunities and provide a system for stakeholders and practitioners to be able to relay information, views and comments back to policy-makers.

Support: The financial support came from the Food Standards Agency and the Welsh Assembly Government.

The Network is guided by an Advisory Board which represents the Network's members, and aims to encourage people to work more collaboratively in Wales. The Advisory Board has an overall remit to advise and support the Network to achieve its objectives.

The Advisory Board contains the following sectors or organizations:

- Welsh Assembly Government
- Professional Groups – All Wales Dietetic Advisory Committee / Chartered Society of Physiotherapy
- National Public Health Service for Wales
- Local Government
- Voluntary Sector – British Heart Foundation and Wellbeing Wales Network
- Academic Sector – University of Wales Institute Cardiff (UWIC) and University of Glamorgan
- Children and Young People – Welsh Network of Healthy Schools Schemes
- National Bodies – Skills Active, the sector skills council for active leisure and learning
- Sports Council for Wales
- Food Standards Agency Wales

Trigger: Through the consultations for the above mentioned policies the project was initiated by practitioners working in the field of nutrition and physical activity.

Targeted Communities: The benefits for this project are for the practitioners involved in improving nutrition and health, which will knock on to the communities. The issue of health inequalities is raised through information provided on the website and in newsletters but because the Networks do not work directly with communities it does not get special attention.

Evaluation: In 2009 an external evaluation of the Networks along with two other public health networks at the Wales Centre for Health was conducted. The evaluation was designed to consider the effectiveness of the networks in achieving their stated objectives, their strengths and weaknesses and to advise on their potential further development.

The results indicated a very high level of satisfaction amongst members of the Network. Of the 70% of members who used the websites, percentages reporting either 'good' or 'excellent' were consistently above 90% for clarity, usefulness, relevance and reliability. There were also a high proportion of responders who identified that the websites had increased their knowledge, improved their service delivery, affected the way they applied health policy and enhanced their collaborative links. There were similarly positive responses with regards to the newsletters. Over 90% agreed that the networks helped them to keep up to date on developments in public health, 87% believed it helped them to help the public, 97% that it helped raise awareness of current issues and trends, 71% that it had helped them to collaborate with others and 76% that it had a positive effect on their job. It was also reported that the networks were cost effective.

Among specific areas that were identified for further development were [122]:

- enhancing the role of the networks in providing access to research, evidence and evaluation;
- providing more information relating to funding;
- supporting training and professional development;
- facilitating focussed conferences.

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4. Projects at Local Level

This section of the report describes examples of projects that have been implemented at local level to counteract obesity among lower socio-economic communities. The first part of the chapter describes initiatives that aim to counteract obesity by promoting healthy nutrition. Programmes that aim to stimulate physical activity are included in the second part of the chapter, and finally, the third part of this chapter describes projects that promote both healthy nutrition and physical activity. It is laid out as follows:

4.1 Healthy Nutrition Projects 103

Belgium

- Cheap, Healthy, Easy to Prepare and Just Tasty
- Healthy Food for Children from the 'Bijzondere Jeugdzorg' (BJZ)
- Healthy Food? It's all over the place!

England

- Bag A Bargain
- Convenience Stores
- Cooking your way to Health
- Snack Right
- Cultivating Health

Hungary

- The HAPPY Project
- 'Healthy Might be Tasty' Programme

Germany

- Eat Healthy with Joy

Ireland

- Ballybane Organic Garden
- The Food and Health Project
- Growing in Confidence
- Limerick City Community Growing Project
- Farmers Have Heart Project - Co Roscommon

The Netherlands

- Healthy Nutrition Doesn't Have to Cost Much
- SchoolGruiten

Scotland

- Bridgend Allotment Community Health Inclusion Project
- Edinburgh Community Food Initiative
- Janny's Hoose Healthy Living Centre
- The Children's Orchard

Wales

- Community Food Co-operative Programme

4.2 Physical Activity Projects 142

Austria

- Walk Healthy – Pharmacy in Motion
- Mobility Management for Schools and Youth

The Netherlands

- Scoring for Health
- Big!Move
- Healthy Playground

- JUMP-In

- Local Active

Scotland

- 60 Minute Kid

Wales

- The SLIMSWIM Programme

4.3 Combined Projects 161

Austria

- In Shape Without Dieting
- At Your Heart's Content – Women in Favoriten are Living a Healthy Life

England

- Tower Hamlets Healthy Borough Programme
- Healthy Weight for London's Children
- Get the Balance Right: Energy In/Energy Out Campaign
- Highfield Healthy Lifestyle CIC
- Community Pharmacy Structured Weight Management Programme
- Fit4Life – Rushmoor Healthy Living
- HEAL Project
- Healthy Living Clinic
- The Chai Centre
- Irish Healthy Living Project

The Netherlands

- The School dietician
- Healthy Weight for Migrant Women
- Equal Health, Equal Chances
- Bridging Strategy Utrecht

Norway

- InnvaDiab Study

Romania

- Sibiu Project

Scotland

- Dundee Healthy Living
- Cambuslang and Rutherglen Community Health Initiative
- Healthy Valleys
- Inverclyde Integrated Community School

Spain

- DELTA Project

4.1 Healthy Nutrition Projects

Belgium

Cheap, Healthy, Easy to Prepare and Just Tasty!

“Goedkoop, Gezond, Gemakkelijk en Gewoon lekker!”

This project, set up by the Logo Zuider/Noorderkempen, is a refinement, specification and integration of already existing methods and materials focusing on healthier nutrition, but now adapted to the needs of disadvantaged groups. The Logo provides these materials and methods to 27 different communities in the region of Turnhout - Geel (province of Antwerp), where they are brought into practice.

Aim & Objectives: The project aims to develop healthy and tasty nutrition habits among their target group, by focussing on the “4G’s”: **Goedkoop, Gezond, Gemakkelijk en Gewoon lekker** (cheap, healthy, easy to prepare and just tasty). They want to achieve this by:

1. Providing local authorities (municipalities or OCMW’s) with information about healthy nutrition guidelines (*‘the active food triangle’ – figure 15*)
2. Bringing these guidelines into practice in a fun and interactive way
3. Teaching the target group how to purchase and prepare healthy food
4. Encouraging the target group to join group activities (e.g. joint cooking classes).

Design: The project consists of several phases:

Phase 1A: Preparation and adaptation of the materials and methods in function of disadvantaged groups.

Phase 1B: Training of project leaders (dietitians and cooks).

Phase 2: Initiation and identification of intermediates for the use of the materials and methods.

Phase 3: Running of the project. The potential participants can compose their own ‘menu of actions’ based on their individual needs and interests. They can join several activities from 5 different modules:

1. *Informative presentations.* Participants can choose to follow a presentation of four different topics: a general nutrition meeting, Diabetes type II, Coronary heart diseases and the ideal weight.
2. *Cooking sessions.* Participants have the option to choose from several cooking classes, all focusing on a different recipe. They all focus on meals that you can prepare relatively easy and with cheap ingredients.
3. *Guided supermarket tour.* Participants are taught how to read food labels, how to compare products and how to choose and recognise the better and healthier product.
4. *Budgeting.* This is an informative meeting about budgeting and purchasing. Advertisements are explained, low-priced food and the rights of a consumer are discussed, and how to compare brands, packaging’s and food quantities.
5. *Interactive game.* This game, ‘the game with the eight tables’- aims to make participants aware of the concept of a balanced diet by using eight tables and 48 accompanying benches (*figure 21*). Every table displays information of one of the eight groups of the ‘active nutrition triangle’ - physical activity, water, potatoes and grain products, fruit and vegetables, milk products, fats, meat, fish, eggs and substitutes and a remainders group. The games can either be played individually or in a group (6-10 persons).



Figure 21: 'Game with the table and accompanying benches'

Source: Logo Zuider/Noorderkempen

At last, a brochure with the title: 'Dieting: a luxury or a necessity?' was developed and can be ordered by the participants as well.

The Logo Zuider/Noorderkempen will make municipalities or local authorities aware of the project. After they have showed their interest, the Logo provides them with the available materials and methods. The organisation and logistics of the actual events are the responsibility of the municipalities and local authorities, and the OCMW's have to recruit the participants. The activities will be guided by the dieticians and cooks, who will be present when the events take place.

The applicant of the project (local authority, OCMW and/or a local organisation) is responsible for the finances of the programme. The implementation costs are 30 euro's per module, and 40 euro's per module when more than six different

courses are chosen. The travel costs of the dietician or cook will then have to be reimbursed by the applicant as well. Some local authorities or OCMW's ask the participants of the programme to make a small contribution themselves. Reason for this is not only to spread the costs, but also to motivate them to actively participate and engage to the project.

Support: Apart from the Logo Zuider/Noorderkempen, parties involved in this project are: *the Koning Boudewijnstichting, Vormingsplus Kempen, Centrum voor Basiseducatie*, participating OCMW committees, dieticians in the arrondissement Turnhout and one cook.

The total budget of the project is €14.700. Apart from its own contribution, Logo Zuider/Noorderkempen gets its financial support from the Koning Boudewijnstichting, Vormingsplus Kempen and the participating OCMW committees.

Trigger: The project was initiated by local authorities and the OCMW's involved.

Targeted Communities: The project specifically targets the lower socio-economic communities in the municipalities described above.

Evaluation: A provisional evaluation will take place during January 2009, and an end evaluation will follow during autumn that year.

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Healthy Food for Children from the 'Bijzondere Jeugdzorg' (BJZ)

This new initiative aims to develop a method for introducing healthy eating habits to children and youngsters from the 'Bijzondere Jeugdzorg' (BJZ) and their communities. BJZ is a child protection organisation for children who are in conflict with the law or children in need of care and protection.

Aim & Objectives: The project aims to modify the food habits of children from 'Bijzondere Jeugdzorg' (special youth care) by offering them healthier food choices. This will be achieved by:

- Change the nutrition content that is offered by BJZ to the children. By training the cooks of BJZ, healthier food will be prepared.
- Give healthy and tasty food workshops to the educators-coaches and directors
- Provide healthy and tasty food workshops and games for the children and their parents

Ultimately the goal is to measure if these interventions have a positive influence on the behaviour and the mood of the children. Not only does this project aim to obtain a better physical health, but also to improve mental health and wellbeing by healthy food habits.

Design: It is currently in the pilot phase where the relevance of the approach and the trainings with the targeted communities are being tested. The pilot phase started with three different workshops for the cooks of seven organizations of the JBZ in the region Brussels-Halle-Vilvoorde.

Support: The project is financially supported by the Erasmus Hogeschool Brussels in the form of a Scientific Research Program (PWO projector 'Project

Wetenschappelijk Onderzoek – Project Scientific Research)'. Other financial support comes from Full Spoon VZW, who received funding for this project from the Koning Boudewijnstichting. The trainings in the pilot phase were giving with the support of Logo Brussels and COOVI (cooking school).

Trigger: Committee 'Bijzondere Jeugdzorg' (special youth care) and Logo Brussels started inquiring about the living habits inside of the organisations in 2006-2007. Based on the results of this inquiry and the demand of the organisations of the BJZ, the project started.

Targeted Communities: Research confirms that people with a low socio-economic status have more health related problems, linked to food habits, which can be deducted by their higher BMI's. The children from the *Bijzondere Jeugdzorg* are almost all from communities with a lower socio-economic status. By targeting those children, the project wants to break the vicious circle by preventing them from developing into 'unhealthy' adults.

Evaluation: The project is still in the pilot phase.

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Healthy Food? It's all over the place!

"Gezonde Voeding? Het 'stuyft' hier rond je oren!"

This project, set up by a Flemish women association – VIVA-SVV – aims to introduce persons from deprived areas in Flanders to preventive healthcare by offering them a health care course. Ultimately, these persons will become contact points – health ambassadors - in their neighbourhood.

Aim & Objectives: The project aims to offer a health education course to persons from deprived areas.

Design: 'Healthy Food? It's all over the place!' is a project set up for, and together with, persons from deprived areas. The VIVA-SVV – a women association in Flanders – works together with a meeting centre ('Open Huis') in the middle of a deprived neighbourhood, to give lower socio-economic groups a one year health care course. After this, these persons become contact points for questions about health in their neighbourhood. They don't serve as doctors, but they are able to give advice and information.

Also, 'healthy vegetable recipes' were made and are distributed among visitors of the food bank – an event that takes place at the 'Open Huis' meeting centre. At the moment the project is still in its pilot phase. During one year, twelve courses are given followed by an examination.

Support: The project is receiving financial support from the King Baudouin Foundation and the National Lottery Fund. Also, VIVA-SVV, the 'Open Huis' meeting centre and health insurance company 'De VoorZorg' use a part of their own budget to finance the costs.

Besides the educational team of VIVA-SVV, a physical therapist, a dietician and two social workers are involved in the project.

Trigger: VIVA-SVV identified insufficient knowledge among their members about health related issues such as blood pressure, the importance of calcium intake etc. After discussing this with the social workers of the 'Open Huis' meeting centre, it was decided to launch a pilot of the programme.

Targeted Communities: The project targets persons living in areas of deprivation in Flanders. They are directly targeted, as the project is running in the middle of their neighbourhood.

Evaluation: The pilot phase of the project will be evaluated in January 2009. However, persons already indicated that they cook healthier more often, pay more attention to their cholesterol levels and blood pressure levels and are more physically active.

The project will continue running on the organisation's own budget, and is planned to be implemented in another deprived area in Flanders as well.

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England

Bag A Bargain

The Bag A Bargain initiative supports people to eat healthily by offering local communities the opportunity to buy cheaper locally grown fruit and vegetables. The project offers low-cost fruit, vegetables and salad for sale at convenient locations in targeted neighbourhoods. Products are delivered to one fixed location and then distributed over several venues. The project is run largely by members of the community - from delivery to distribution.

Aim & Objectives: The Bag A Bargain initiative supports people in deprived areas of Wirral (close by Liverpool) to eat healthier by offering them a bag full of locally grown fruit, vegetables or salad for a low-cost.

Design: This is a project entirely run by members of the community of Wirral, since October 2006. The fruit, vegetables and salads are delivered in crates at one fixed location (Tranmere), where they are bagged by volunteers and then distributed over the multiple venues (churches, schools and community centres) by the residents. The food can be bought for £2.50 a bag.

The majority of food comes from a local Wholesaler. For the first 18 months of the project this was Redbridge, who bought from Liverpool Market. However, following feedback from service users regarding quality, they now use Farm Fresh Supplies, a wholesaler based in North Wales. Although Farm Fresh supplies the majority of the produce, a local allotment scheme often provide seasonal produce that they have grown, although this is 'top-up' the bag and add more value to it.

The number of persons working on the project differs all the time, but there is always one separate lead from each venue. Of these leads, some are voluntary as they are churches/community venues and some are based in schools and children's centres that will have paid staff who lead on this as part of their health promoting role. There are only two staff members who are directly paid through the project funding, and these act as Project Managers. There are approximately another five to six volunteers who work between venues, taking money, banking money, and bagging up the produce when it is delivered on a morning. There isn't anyone from NHS Wirral who works on the project on a daily/weekly basis.



Figure 22: Left: Fruit bag. Right: vegetable bag

Source: Wirral Primary Care Trust

To promote Bag A Bargain, persons use the local press and local organizations. However, spread by word of mouth by residents seems to be the most efficient way. Furthermore they organized a 'freebee week' when they first started with the initiative. If people bought a bag and ordered one for the following week as well, they got one bag for free.

Bag A Bargain is also part of the Healthy Start Scheme, which means that Healthy Start Vouchers can be exchanged for bags of fruit, vegetables or salad at any of the 'Bag A Bargain' venues.

Support: The initiative is financially supported by the lottery funding. This money is used to stock the products and to purchase the bags needed for distribution.

Bag A Bargain was set up as part of the 'Together' Project (short for Together Neighbourhood Management Project), which is led by NHS Wirral and the Riverside Group in partnership with residents.

Trigger: The lack of provision to fresh, quality fruit and vegetables at a reduced price inspired the local residents to start with this initiative. They contacted NHS Wirral in October 2006 to help addressing this issue by starting with this project.

Targeted Communities: The initiative originally operated out of three venues in Wirral. But as it turned out to be a success, the numbers of venues selling the products have nowadays grown to at least nine, and have expanded into other neighbourhoods and schools all across Wirral.

Evaluation: The initiative seems to be a success, as the turnover raised during the first six months from 150 bags a week to 400 bags a week. However, the organizers nowadays see a decline in the amount of bags they sell, which is probably due to the general economic crisis. At the moment they are selling around 200-250 bags a week, and they are therefore considering the possibility of starting to sell small bags of £1,-, to attract more persons.

In 2008, the initiative was joint winner of the Best Practice in Community Involvement Award. This is an award voted by local partners (PCT, Local Authority, residents, etc) on local projects.

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Convenience Stores

<http://www.nhs.uk/change4life>

Convenience Stores was launched in the North East in November 2008, where stores in low-income areas have received funding to improve the availability and sales of fruit and vegetables.

Aim & Objectives: The programme will contribute to the national commitment: *Halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole* (2004 Government PSA target).

To achieve this, the programme aims to:

- increase the consumption of healthy foods (particularly fruit and vegetables), and
- to rebalance marketing, promotion, advertising and point of sale placement, so that there is a reduction of exposure of children to the promotion of foods that are high in fat, salt or sugar, and an increase in the exposure to the promotion of healthy options

Design: To get the programme underway, twelve 'development stores' were launched in November 2008 which showcases a range of initiatives to promote fruit and vegetables. The aim of these development stores is to trial the best initiatives, and to recruit other retailers to the programme. The stores were provided with new chillers, stands and other display items to stock their extended range of fruit and vegetables. The retailers have been encouraged to tie in health initiatives in their communities; this has included advertising free cookery clubs, and sponsoring a local football team.

Shop staff will be offered training in nutrition so that they can pass on knowledge about the health benefits of fruit and vegetables to customers. They will also receive training on the best way to stock and sell the produce to minimise waste.

A project co-ordinator will work with the stores to help them to maximise profits and minimise waste. The co-ordinator will also help retailers tie in with local initiatives such as nutrition training and cookery clubs.

Support: The Convenience Store programme forms part of the Change4Life movement; a £75 million social marketing programme to help us all make positive lifestyle changes and maintain a healthy weight.

The Department of Health (DH) will be providing £800,000 over three years from 2008/9 to 2010/11. The convenience store programme is working in partnership with the Association of Convenience Stores (ACS), and these have agreed to match DH funding to the project.

Trigger: The initiative is based on a similar scheme in Scotland. The Scottish scheme, which started with 10 stores in 2004 and has now more than 500 on board, has seen participating shops benefit from an increase in profits – anything from 20 per cent to 400 per cent on fruit and vegetables. In all focus stores, a 28% increase in fruit and vegetables was experienced.

Targeted Communities: Convenience stores in low-income areas in the North East, where there is relatively poor access to fruit and vegetable, will have the opportunity to participate. The Symbol Groups were asked to nominate candidate stores in low income areas as a priority.

Evaluation: Initial sales data show that sales of fruit and vegetables have increased by between 30 - 300% in every development store so far. An executive evaluation report will be available from January 2009 on.

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Cooking Your Way to Health

Cooking Your Way to is a programme to address health inequalities and improve healthy eating awareness via several 'Grab 5!' activities. These activities are run for 7-11 year olds in 14 different primary schools in Ealing Borough.

Aim & Objectives: This project aims to:

- promote healthy eating by teaching practical ways to adapt familiar meals to increase fruit and vegetable consumption and reduce fat, sugar and salt intake,
- deliver culturally sensitive healthy eating messages to hard to engage groups,
- increase knowledge of the benefits of healthy cooking and eating to schools and community groups of all ages,
- provide training and employment opportunities for members of the local community (Cookery Club Leaders), and to
- improve social cohesion in the community and reduce isolation

Design: This programme has developed several community based food projects to address health inequalities and improve healthy eating awareness. These activities include:

- Cookery Clubs
- Grab 5 workshops for children
- Grab 5 parents talks
- Healthy eating assemblies
- Health Fairs
- Healthy tuckshops
- Grab 5 parents talk
- Healthy eating displays and demonstrations in local businesses, at Ealing PCT health promotion events and in local pharmacies.

With these activities it also improves the knowledge of the target group of how food can affect health and helping people to make realistic improvements to their diet taking into account their potential barriers to change e.g. socio-economic factors, knowledge and skills.

Targeted Communities: This programme targets children and teenagers, groups at high risk of obesity, CHD and diabetes, socially and economically deprived groups, and adult groups at risk of malnutrition e.g. young mothers, elderly people.

Evaluation: Grab 5 was evaluated as a research project through WelRen study: 'Do physical activity and nutrition schemes work for children in Ealing'?

Cooking your way to Health, primary evaluation showed that clubs were effective and sustainable, thus the project funding has been extended through Choosing Health funding until March 2007.

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Snack Right

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The Snack Right campaign, led by the sub-regional ChaMPs Public Health Network, supports parents and carers of pre-school children living in deprived areas of Cheshire and Merseyside (North West of England) to replace at least one unhealthy snack a day in their child's diet with a healthy one.

Aim & Objectives: The goal of this initiative is to increase the proportion of children eating at least one fruit or vegetable snack more than prior to the campaign. The project does not only focus on changing the food (snacking) habits of the children, but it also tries to change the knowledge and attitudes of the parents and carers of the child.

Design: The Snack Right initiative is an example of social marketing and consists of several phases.

Scoping Phase; Partnerships and Funding. The first phase of the initiative - the scoping stage - was set up to gain insight into the target audience and their purchasing behaviour. The results of the scoping stage revealed that an important factor that can influence a family's purchasing decisions was big-brand advertising, since people easily recall specific advertisements and associated characters that appeal to children. The campaign thus needed to wield the same power as the brands that were selling less healthy food. It needed a strong and recognizable identity, and partnership – particularly with retailers - would be vital.

After mapping all possible partners (low budget supermarkets) and studying (Mosaic) consumer profiles, food retailer *Aldi* was chosen as a retail partner in phase one. The supermarket chain had shops in the right geographic areas, it

appealed to the target audience, it had a local supply policy on fresh products and it had signed up to the Government's Healthy Start scheme.

Development Phase; Testing and Refining. During the development stage, the Snack Right brand was developed and the messages of the campaign were stated. A number of factors affecting behaviour around healthy eating choices were set up. These included:

- **Barriers** to healthy eating - a “can't cook, won't cook” attitude; a lack of basic knowledge around nutrition; a belief healthy food was expensive food; preparing healthy food was time-consuming and inconvenient; children were likely to reject it and budgets were too tight to waste food
- **Influencers** of healthy eating - children's centre/nursery workers (generally positive); retailers (often negative at the time); media (both negative and positive)
- **Motivators** – retail offers (voucher promotions, product placement; positive messages at point of sale); pester power of children
- Simply focusing on the health benefits of healthy eating alone wouldn't be effective
- A belief some junk foods led to hyperactivity

Research showed that the negative behaviour could be challenged if an intervention captured the following:

- Healthy snacks benefit long and short-term health
- Fruit and vegetables aren't expensive
- Healthy snacks can be quick and easy to prepare
- Early food preferences stay with you for life
- Healthy snacks can improve kids' behaviour
- Slow release snacks keep child energised longer

It was agreed that snacking should be the focus of the intervention. The key behaviour goal would be for children aged 3 from deprived neighbourhoods to “replace at least one unhealthy snack each day with a healthy one”. Ideally, this would be a fruit or vegetable.

Furthermore, six other, secondary, goals were agreed:

1. Parents and carers would attend a Snack Right event with their children
2. Parents and carers attending Snack Right events would overcome negative perceptions of fruit and vegetables as a snack food for children
3. Every child would have the opportunity to try fruit and vegetables snacks at the events
4. Children would continue to “snack right” through the work of ambassadors (see below), primary care trusts, local authorities, communities, etc
5. Ambassadors were engaged in the process and attend Snack Right events
6. Ambassadors delivered their own events

A network of 150 Snack Right “ambassadors” - who ensured delivery was locally-led and tailored to local needs - was recruited to organise events. There are two types of ambassadors:

Strategic ambassadors (a third of the total amount of ambassadors) supported local plans for delivery of Snack Right and provided staff to support the implementation, including events and passing on messages to target groups. They also worked to embed the Snack Right model through local strategic plans or work plans, and create a legacy for the project

Tactical ambassadors delivered Snack Right messages, promoted and delivered events, supported the delivery of events, and sustain messages with the families they work with.

The project was delivered in two phases – the first in spring/summer 2007 and the second in summer/early autumn 2008.

During the *first phase* of Snack Right a marketing mixture was used. Leaflets promoting healthy snacking were distributed to targeted households via a door-drop to 113,000 families. Secondly, a media campaign in local and regional papers, on radio and a website was used to communicate key messages to parents, carers and the wider community. Finally, fifteen fun Snack Right events were held, mainly at local authority children’s centres. These were aimed at

children but, crucially, were an opportunity to engage with the parents or carers who accompanied them. They were provided with information about the short and long-term health benefits of replacing an unhealthy snack with a healthy one. Giving them information on a one-to-one basis was essential because of low literacy and numeracy in the target families.



Figure 23: Snack Right Campaign

Source: CHaMPs

Besides focusing on the encouragement of the intake of fresh fruits and vegetables, the events also promoted the take-up of Healthy Start vouchers. This is a national food voucher scheme worth up to £5.60 a week for low-income families.

In the second phases of the campaign, the age range for the project was changed to children aged six months to four. This reflected the advice of health professionals and the recognition food preferences started to form before aged three. Between June and September 2008, forty-nine further events were

organized with an emphasis on sustaining Snack Right into the home. This was done through a direct marketing campaign underpinned by the Snack Right 5: a group of fruit and vegetable cartoon characters. Furthermore, legacy materials were developed like folders, books and poster.



Figure 24: Snack Right Five characters

Source: ChaMPs

The events themselves were similar to phase one but with more interactive games using fruit and vegetables, and two life-size versions of two of the SnackRight characters – Pip the Apple and Narna the Banana – were commissioned to attend the events. The events consisted of tasting sessions and games (e.g. making your own fruit face) to give young children the chance to try healthier options. The key difference was professionally photographing each child who attended with parental consent. The photograph was later mailed to their home with a letter and snacking sticker calendar. Children who completed the calendar were mailed a wipe-clean tablemat as a reward. Their parents/carers were also entered into two prize draws and they received other communications such as a recipe for a fruit snack.

Support: The project started a boundary-spanning partnership with health (e.g. public health practitioners), local authority (e.g. children’s centre manager), communications and Third Sector (e.g. Heart of Mersey charity) professionals. It was facilitated by ChaMPs Public Health Network, which works in partnership across Cheshire and Merseyside to promote and protect public health and well-being, and builds capacity and capability across the public sector. By using this

diverse partnership, it enabled the campaign to use a mixture of channels to reach its target audience.

The campaign was funded with £263,000 from the Department of Health Communities for Health Fund and commissioned by Cheshire and Merseyside’s directors of public health, who also contributed £50,000.

Trigger: The ChaMPs social marketing group identified that although much was being done in deprived areas of Cheshire and Merseyside to address health inequalities, there were gaps in services for pre-school children. Children’s centre workers told them during interviews that children generally ate well in day care but were given “junk” snacks as their parents/carers took them home.

Targeted Communities: The campaign focuses on this target group, because:

- there is proportionally less health advice available for this group compared to babies and school-age children
- this is the age at which food tastes are formed for life
- Cheshire and Merseyside has some of the worst health inequalities in England

Evaluation:

Snack Right – Phase 1 The Healthy Start statistical report showed that a significant increase in the number of applications for the Healthy Start vouchers during the first phase of the campaign.

An evaluation of phase one was conducted by Liverpool John Moores University. Their findings and observations in the field of how phase one was received, were used to re-scope and develop phase two. The phase one evaluation demonstrated recognition of Snack Right in the target audience and awareness of healthy snacking. Researchers noted the challenge of isolating Snack Right from the “background noise” of other healthy messages.

Reporting period	No of applications
14th May – 10th June 2007	241
11th June – 8th July 2007	308
9th July – 5th August 2007	210

Snack Right – Phase 2 An evaluation of Phase two was carried out by Liverpool Public Health Observatory. The second academic evaluation indicated the families with whom Snack Right engaged had moved into Prochaska and DiClemente’s “contemplation stage” in relation to giving more fruit and vegetables to their children³. The contemplation stage is part of the Prochaska and DiClemente’s stages of change, or transtheoretical, model H.

- **Snacking behaviour** 41% of children who signed up to Snack Right’s direct marketing programme reported they continued snacking healthily four weeks after the Snack Right event they attended by returning the tear-off slip on their snacking calendar. Significantly, very few arrived before the calendar could have been reasonably completed, suggesting families took healthy snacking seriously;
- **Participation** 3,788 children, parents and carers attended 64 Snack Right events from the targeted families;
- **Direct marketing** 1,003 children – made up of 824 families - signed up to the direct mail programme;
- **Healthy Start** Applications for Healthy Start vouchers in the Merseyside area increased by 25% during phase 1. Forty-six families were signed up at phase 2 events with many others eligible but signing up afterwards;
- **Families’ views** 84% of families attending phase 2 events felt they had picked up new ideas about healthy snacking;
- **Effect on children’s centres** The phase 2 evaluation reported Snack Right had given children centres staff new ideas around promoting healthy

³ The Transtheoretical Model: “Promoting Healthier Behaviour Change” - Developed by Prochaska & DiClemente in the 1980’s. www.changezone.co.uk/STEVE/Transtheoretical%20Model.html

snacking. Practice had changed thanks to Snack Right. Staff had stopped serving biscuits at one centre; another stopped crisps and cake at parties; many others were using learning from the project to develop existing practice or use the Snack Right format for future events.

Snack Right Phase 3 (January 2009-present) A sub-regional approach allowed PCTs to participate in a project at a scale and quality most could not have delivered alone. By working together, effort and expertise was pooled to secure funding and economy of scale which created a readily transferable intervention.

A majority of the eight Cheshire and Merseyside PCTs have committed to developing Snack Right through children’s centres. Their plans include: Annual Snack Right events in all children’s centres; Commissioning new products to support the brand e.g. snack boxes; Top tips for parents on snacking; Examining the practicality of texting families with snacking ideas after events.

To help in this process, the Snack Right project team has (1) produced a tool kit to help with organisation of events, (2) provided training on the concepts underlying Snack Right as well as how to run events effectively (nearly 100 professionals have been trained since the beginning of Phase 3, and (3) published brand guidelines to enable partners (within and without Cheshire and Merseyside) develop their own Snack Right materials.

All these activities will continue the cumulative process of improving nutrition in the early years.

A further evaluation of Snack Right will take place in autumn 2011.

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Cultivating Health

Cultivating Health is creating partnerships with local agencies, aiming to promote local horticulture. At the moment the project is in its infancy but is hoped to be launched on 1st March 2009.

Aim & Objectives: The aim of the Cultivating Health Project is to promote local horticulture and provide more healthy lifestyles of local people.

Design: Cultivating Health involves partnering local people to grow fruit and vegetables in domestic gardens which are currently not being maintained, especially where elderly residents no longer have the mobility to carry out the work involved. The project will recruit families and those with mental or physical health needs without gardens and provide them with the skills to grow their own produce and partner them with a local person with a garden suitable for growing vegetables and fruit.

Cultivating Health is creating partnerships with local agencies such as local health centres, job centres, health support groups, Sure start, etc. who will refer people to the project.

Individuals are assessed for their capabilities, needs and training requirements, where necessary with the input of their carers. The Project is a valuable health intervention within an overall model for social health prescribing, involving a range of therapies and practical activities. The benefits are many; improved access to fresh, home grown fruit and vegetables, the establishment of partnerships and social networks which ease isolation, improved physical activity levels for partnerships, training in basic horticultural skills and the resources of trained professionals for guidance and support.

The project is in its infancy but is hoped to be launched on 1st March and has plans for it to be an ongoing project for at least three years.

Support: The financial support for Cultivating Health was secured by the Bacup Consortium Trust, from the local PCT in the form of a successful bid under Community, Voluntary Faith Sector and Statutory Agencies. The funding so far has been used to employ a part-time project officer and to resource the project initially in the first year.

Other Parties who have expressed a committed interest in becoming involved are: Age Concern. Green Vale Housing, Calico Housing, Rubicon, Sure Start, Burnley Food Links, Local Primary and Secondary Schools, Ewood Day care and the Community Department of Rossendale Council.

Trigger: The original idea was by a member of the Bacup Consortium who was aware of the amount of gardens not being fully utilized and the increasingly large waiting lists for allotments in the local area. Her dream was to see vegetables being cultivated in and around Bacup by the local community who would most benefit from nutritious, fresh local produce.

Targeted Communities: The main target group is the elderly and those with mental health issues or those who have faced unemployment for some time. Even though individuals with a higher socio-economic status are not part of the target group, the emphasis of the project is to promote healthy eating and living community wide.

Evaluation: As this project is as yet in its early stages, there is no evaluation material ready to publish. However, it is included in the project Outline that evaluations and data will be analyzed and published where appropriate.

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Hungary

The HAPPY Project

Reducing soft drink intake by promoting mineral water consumption in primary schools | <http://www.oeti.hu>

The HAPPY (Hungarian Aqua Promoting Programme in the Young) project combines a school-based education program with a simple environmental intervention to decrease soft drink consumption and increase water intake among children. The study was based in 18 classes (Grade I-IV) from six primary schools in Budapest, between March 2007 and May 2007.

Aim & Objectives: The project aimed to evaluate whether promoting water consumption by providing free availability of mineral water could decrease soft drink intake in primary-school children.

Design: This 2-month-long intervention consisted of two main parts: (1) nutrition education and (2) free availability of mineral water in the school.

A 40-minute long education session delivered by dietitians was assigned once for each participating class. The curriculum was designed for students aged between 6 and 10 years and focused on the following areas: availability and utilization of water, adequate (quantity and quality) fluid consumption, signs of dehydration and health effects of beverages. Flyers that summarized the main messages of the education were also given both to the participants and their parents.

Free mineral water (natural, low sodium content, 728 mg/l minerals) was provided in the classrooms by water coolers for 2 months. The amount of mineral water consumption per class was recorded daily by a contact person. In addition, we personally contacted the schools once in every other week. This approach provided an opportunity to discuss problems (regarding to delivery or exchange of empty balloons, etc.), answer questions and reinforce the

instructions. School competitions and health-days for every participating school were also organised to promote healthy lifestyle among children, parents and school staff.

Support: This study was supported by the World Health Organization (BCA-HUN 06-07 project).



Figure 25: The HAPPY Project

Source: The HAPPY Project

Trigger: The prevalence of childhood obesity is increasing markedly in Hungary. Based on international studies, there is a strong relationship between obesity and high carbonated soft drinks consumption. Taking into account the relevant effect of soft drink intake on weight status, HAPPY program was initiated within the framework of a biannual collaboration between WHO and Ministry of Health.

Targeted Communities: In total, 397 children (202 boys, 195 girls; 7-10 yrs) from 6 different schools in Budapest were recruited, 3 of them were from a low income area.

Evaluation: Children filled out questionnaires at baseline and at the end of the trial to assess changes in their knowledge and in their drinking pattern. The

questionnaire had three main parts: (1) knowledge of adequate fluid consumption, (2) beverage consumption habits at school, and (3) a modified Food Frequency Questionnaire (FFQ) about overall beverage intake. The first two topics were self-reported by the students, while FFQ was obtained with the help of a trained school staff.

After the programme, additional questionnaires were designed for parents and teachers. After 1 year a similar questionnaire was sent to each school that formerly participated in the intervention.

Based on the results, the project beneficially influenced the beverage consumption of the participating children, independently of the SES category. Thus, mineral water intake increased, and soft drink consumption decreased significantly after the intervention.

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'Healthy Might be Tasty' Programme

<http://www.fruitveb.hu>

The 'Healthy might be Tasty' program was designed to increase nutritional knowledge and Fruit and Vegetable consumption in primary school children by environmental intervention and education.

Aim & Objectives: The project aimed to increase fruit and vegetable consumption among primary school children and to determine the most effective approach by comparing three different types of intervention.

Design: Participants were divided into three groups: (1) Education only, (2) Education and apple-providing vending machines (0.1 Euro per apple), (3) Education and free availability of fruit and vegetables as a snack.



Figure 26: Healthy Might be Tasty Programme Source: Healthy Might be Tasty Programme

Education in the classroom and leaflets about adequate fruit and vegetable consumption for the children, parents and teachers were also prepared.

The project was a 2-month intervention implemented in spring 2007.

Support: The project was supported by the Ministry of Health and private companies.

Trigger: The project was initiated by NIFNS as several nutritional surveys among children showed a low intake of fruit and vegetables.

Targeted Communities: In total, 750 children from 15 different schools were recruited, 3 of them were living in a low-income areas.

Evaluation: At baseline and after the program, all children filled in questionnaires about nutritional knowledge, and about fruit and vegetable consumption habits (based on the questionnaire used in the ProChildren Study).

The outcomes showed that, at baseline, only one third of the participants were aware of the amount of sufficient daily fruit and vegetable intake. If the children had been educated, the number of correct answers increased up to 55%.

Fruit and vegetable consumption increased significantly among the participants after the program had finished. The largest increment could be observed among those children who had received fruit and vegetables as a free snack.

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Germany

Eat Healthy with Joy "Gesund essen mit Freude"

This is a project initiated by 'Gesundheit Berlin e.V.', a health promoting registered charity. It aims to change eating habits of Turkish children to a healthier option, both through their parents' home and through their school environment.

Aim & Objectives: The aim of the project was to convey healthy eating habits to Turkish children through their parents' home while recognizing cultural habits. The course was carried out in close collaboration with the school so that a second aim was to create a health-promoting school environment.

Design: The general approach was setting orientated, via neighbourhoods and schools in the local area. Nutritionists, social workers, youth workers and teachers acted as multipliers, and a co-operation with a popular Turkish TV-station was established

The course design differs from conventional teaching ("We show you how to do it!") which was reduced to some background information on nutrition and mainly focused on team teaching elements ("Let's see what the group knows!"). As the settings were carefully chosen, the targeted groups were indeed reached. In cooperation with the social worker and the school directors, the school where the project took place provided an area where mothers were given the opportunity to share their personal experiences, e.g. cultural perception of food, eating or cooking habits.

Beyond the intervention goal of improving eating habits of the families the setting lead to participants acting jointly. Project leaders describe this aspect as basic for the success of the intervention: the common activities of the women had, in turn, positive effects on the social structures of the school where the project took place. Gradually participants were in contact with school workers, while they had not done this before due to the lack of German language knowledge. For the first time the Turkish mothers took part in a school party celebrating the inauguration of a new playground.

The initial phase started in September 2004 and finished in July 2005.

Nowadays there is such a high demand that the intervention has expanded from a local initiative to a federal wide one, four editions of the cookbook have been produced and in 2009 the BKK re-launches the cookbook and the course material.

Support: Partners of this project are the Federal association of health insurance companies (BKK), Ministry of consumption (auspices), Turkish ambassador, Turkish TV channel TD.

Gesundheit Berlin e.V. is a health promoting registered charity with a long history of successful and innovative pilot projects in the fields of health promotion and setting orientated approaches especially for socially excluded people.

Trigger: Turkish children have an above average tendency to suffer from obesity; this is documented by school enrolment medical examinations. In adult age, these persons suffer more often from coronary heart and other diseases. Healthy nutrition during childhood can prevent these. While conventional measures to improve nutrition in the Turkish population haven't been very successful, especially due to language barriers, this intervention was created that explicitly integrates Turkish culture and tradition.



Figure 27: 'Eat Healthy with Joy'

Source: Gesundheit Berlin e.V.

Targeted Communities: In general, young adults (19-29 years), adults (30-59 years), persons with a relatively low socio-economic status, as measured by education (e.g. secondary school degree, school drop-out) income (e.g. below average income, on social benefits) and migrants (e.g. asylum seekers, immigrants) belong to the target group.

Since Turkish mothers play a key role in the nutrition of their families, they are approached as multipliers. In discussion groups and cooking courses they were introduced to healthy cooking.

Through these measures Turkish mothers did not only serve as a target group for opening access for health promotion into families with a Turkish migration background but also widened the scope of these women in other matters: By

cooking together the groups developed further social adhesion and indeed the measure can also be termed successful under the aspect of community building.

Evaluation: The intervention was rated as very positive so that a bilingual cookbook and a course manual have been developed that leads to spreading the intervention to other Turkish communities.

Internal evaluation exists: participant-oriented assessment by questionnaire. External evaluation was carried out by Team Gesundheit, an organisation which collaborates with Duisburg University for evaluation in the area of health promotion.

The project has been identified as "Good Practice" in the fields of "innovation and sustainability", "setting approach" and "participation" by the Kooperationsverbund "Gesundheitsförderung bei sozial Benachteiligten", a German network of more than 50 organisations supporting health promotion for socially disadvantaged people.

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Ireland

Ballybane Organic Garden

<http://www.galwayhealthycities.ie/html/organicgarden.asp>

This is a partnership project, aiming to teach persons from the most disadvantaged areas of the country about organic gardening processes and healthy eating. It also provides nutritional education and cooking skills.

Aim & Objectives: The aim of the project is to provide a supportive environment where participants from the local area can learn about the organic gardening processes and healthy eating. Advice and information are given at each stage from growing through to harvesting. Examples of foods been grown include potatoes, corn, lettuce, tomatoes, scallions, coriander and runner beans.

In addition, the Community Nutrition Department (HSE West) and Home Management Department (HSE West) provide nutritional education and cooking skills as part of the overall learning process of the project.

Design: The Ballybane Organic Garden was set up in March 2006. The garden is continually developing and expanding. In the first year there was one morning a week session with the gardener. This has been expanded to one morning and one evening to facilitate others to participate. Future plans for the garden include developing a composting scheme to involve people in the wider community.

In addition the garden is been extended to facilitate access and usage for a great number of people. City Council has provided extra land to develop an orchard, have more vegetable plots, develop a play area and put in a clay oven and BBQ.

Key target groups are being expanded through engagement with the local crèche and also an older person's day centre located near the garden.

The promotion and recruitment of participants in the local community is ongoing through local newsletters and also the celebration of work through an annual Harvest Day.

Support: It is a partnership project between Galway City Council, Health Service Executive West, Ballybane Community Development Project, City of Galway Vocational Education Committee, Ballybane Community and RAPID.

The RAPID (**Revitalising Areas through Planning, Investment and Development**) programme specifically targets the most disadvantaged areas of the country and it is intended that these areas should receive prioritised investment and development by central government departments. The programme is delivered locally by a multi-disciplinary team –An Area Implementation Team (AIT).

Funding on a yearly basis is provided through the Health Service Executive West Health Promotion Department, RAPID and City of Galway Vocational Education Committee as there are community, education and health benefits. This was the first community organic garden project in Galway City. Community garden projects have since been set up in two other RAPID areas based on the success of the Ballybane project.

Trigger: Health Promotion Services of the HSE became aware of the potential for such a project in Galway City following learning about the experiences of a similar project in the North West of Ireland. In 2005 Health Promotion approached the Galway City Rapid group who were very interested in supporting this initiative. Following a presentation from Health Promotion Services it was agreed that such an initiative would be piloted in one of the Rapid areas and it

was agreed that Ballybane would be a suitable location. Following on from this the Community Development project in the area were approached by the Health Promotion Services HSE West which is the lead partner of the Galway Healthy Cities Forum and ideas to progress the project were explored. A small steering group was set up and work commenced on establishing the Ballybane Community Organic Project.



Figure 28: Ballybane Organic Garden

Source: Galway Healthy Cities

Targeted Communities: The target group is lower socio-economic groups and this is achieved through focusing on RAPID areas in the City. The programme is delivered to areas including Galway City Council, State Agencies, Galway City Partnership, and residents' representatives from each of the five RAPID areas –

Ballybane, Ballinfole, New Mervue, Bohermore and Westside. It is implemented locally through the RAPID Co-ordinator, Galway City Council.

Evaluation: An evaluation was completed after at the end of 2007. The evaluation found that the project has developed a new and different community facility or resource and is a major infrastructural enhancement to the local area. The garden is being used as a catalyst for community development activities for local men's group and older people's day centre located across the road. It promotes healthy lifestyles through outdoor exercise, learning about growing their own vegetables and also cooking and nutrition classes. The garden is also a community point providing an informal space for local people to meet and socialize through gardening. Finally, it was found that the key success of the garden is built on the partnerships of all involved engaging with the local community.

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The Food and Health Project

This project targets communities from areas of deprivation in the Midlands of Ireland and provides them with practical information about healthy nutrition. The disadvantaged groups were selected by using a screener form.

Aim & Objectives: The overall aim is to improve the access of low income groups in the Midlands of Ireland to good quality practical information about healthy eating

Design: Healthy Food Made Easy, a training pack for use with peer instructors was first developed in Dublin as a pilot program. The Department of Health and Children then produced the program for use throughout Ireland. In the Midlands, the project was first started in 1999. The Midland Health Board funded a community dietician with a remit for disadvantaged groups. The first Food and Health project was set up in 1999 as a joint initiative between the Health Service Executive, Dublin Mid Lenister (HSE DML) and the Westmeath Community Development (WCD).

Initially the project trained peer instructors to facilitate the Healthy Food Made Easy program to groups in counties Longford/ Westmeath and North Offaly. In 2003, funding became available and a second Food and Health project was set up in partnership with the Mountmellick Development Association. Therefore at present the Athlone project covers Counties Longford and Westmeath; with Mountmellick covering counties Laois and Offaly (and Kildare although this is only since 2007).

Other programs have been developed for use with other disadvantaged groups who could not access the Healthy Food Made Easy program. Cooking for Health was developed as a more practical program which is facilitated by the instructors to groups with learning difficulties or attention span issues. The Cool Dude Food program was developed for use with children's groups.

Support: The majority of funding is received from HSE DML; however each participating group makes a contribution towards the costs of the course. The aim is that 25% of funding is non-HSE.

Trigger: Evidence would suggest that there is a poorer diet in people experiencing poverty – the Food and Health project addresses this issue.

Targeted Communities: The Midlands of Ireland is largely a rural area. Geographical indices could not be used to determine that the participant would be disadvantaged, thus a screener form (adapted from one used by Nelson et al 2003) was used. Each group fills in the screener form – this form asks re material deprivation indices; we have also included questions on ethnicity and education. If a person shows 3 or more indices of material deprivation they are deemed to be disadvantaged; if a group has at least 70% in their group scoring 3 or more.

Evaluation: In 2009 focus group testing was carried out on a sample of participant completing the Healthy Food Made Easy course. This focus group looked at the peer led approach, effect the course had on participant attitude to healthy eating and the acceptability of the course to groups. Results were very positive.

The approach of using peer instructors has been well received as illustrated by this comment: *'She <peer instructor> was more believable because she was like the rest of us you know at our level'.*

This evaluation showed a positive effect on both attitude and confidence regarding healthy eating. *'This got me back into having different foods, more healthy ways of cooking like as opposed to having loads of oil in the pan or salt or stuff'.*

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Growing in Confidence

http://www.theorganiccentre.ie/community_food_project

Growing in Confidence is a community food project in the North West of Ireland, which recognises the need to promote healthy food production and healthy eating as a means of reducing health risks and as a means of improving quality of life for members of local communities.

Aim & Objectives: The aim of the project is to increase knowledge, awareness and skills among target groups in relation to fruit and vegetable production, preparation and consumption and to promote positive health and well-being. The specific objectives are to:

- improve participants' knowledge of and skills in relation to vegetable and fruit growing
- enhance participants' skills in preparing and cooking fruit and vegetables
- increase participants' consumption of fruit and vegetables
- increase participants' knowledge of the nutritional value of fruit and vegetables
- develop more positive attitudes towards consumption of fruit and vegetables
- provide opportunities for physical activity outdoors
- provide opportunities for positive social interaction and development

Design: This project seeks to improve the access of people on a tight budget to fresh fruit and vegetables, by encouraging and helping them to become involved in growing their own, organically. In cooperation with local agencies and community groups, participants were recruited in Sligo town and in rural Leitrim, and were given the opportunity to meet regularly with professional and experienced gardeners from the Organic Centre.

The project consisted of weekly or fortnightly organic gardening sessions, on plots provided by the Organic Centre and by the St Michael's Family Life Centre in Sligo. This was backed up by some classroom instruction in gardening techniques and knowledge and by cooking demonstrations by HSE 'Eat Well, Be Well' tutors.

It initially started in 2004 at 2 sites, one rural and one urban and this has increased to a current number of 7 sites. In addition concurrent funding from other sources to the Organic Centre has allowed for the development of schools garden projects and a number of other cross border (with Northern Ireland), community food initiatives.

The project runs for an 8 month period from March to October. Each plot site has a maximum of 15 participants who are recruited through community groups and organisations. The participants meet weekly for two hours and:

- Learn how to grow organic vegetables and fruit;
- Get to know their food and the seasonality of food;
- Grow what they and their families like to eat;
- Learn how to prepare and cook fresh produce and make interesting and economical meals for their families;
- Learn how to store and preserve;
- Learn about the nutritional benefits of fruit and vegetables;
- Are able to cut costs.

An experienced gardener from The Organic Centre guides and helps the participants to grow the food and a trained tutor is present during the cooking sessions to show exciting new ways to cook what has been grown. Participants share the products and take them home afterwards.

Growing in Confidence is a programme that can be used to achieve a number of key recommendations within the Obesity Taskforce Report including:

- 3.8 Peer led community development programmes should be fostered and developed to encourage healthy eating and active living.
- 3.9 Community skills based programmes should be developed which provide skills such as food preparation, household budgeting, and those skills which have the potential to promote physical activity
- 3.10 Building on the work undertaken by community groups, community initiatives should be developed to tackle the issues of food poverty and accessibility through local food programmes and co-operatives
- 4.1 The health services should advocate and lead a change in emphasis from the primacy of individual responsibility to environments that support healthy food choices and regular physical activity.
- 4.3 The Department of Agriculture and Food together with the Department of Health should promote the implementation of evidence-based healthy eating interventions

Support: Initially in 2004 and 2005 the project was funded by the Health Promotion Department of the North Western Health Board (NWHB, now part of the Health Service Executive HSE) via the national Cardio-Vascular Strategy, in conjunction with the Organic Centre, a non-profit making company located in Rossinver, Co. Leitrim. However, since 2006 funding has been from the Obesity Taskforce.

The project is managed by a multidisciplinary steering committee that produced a comprehensive How-to-guide for groups looking to set up similar projects in 2006 and made available to interested groups / organizations.

Trigger: Growing in Confidence is a Community Food Project based in the North West of Ireland. The North West is one of the most deprived areas of Ireland with higher disability and unemployment levels than seen nationally.

The Community Food Programme commenced as a consequence of discussions about how best to address contemporary issues related to food, nutrition and health, especially for those who were managing limited budgets. It was a

response to evidence that in Ireland, as in many other western societies, those on a limited income have less access to fresh fruit and vegetables. Yet dieticians and other health professionals know that inclusion of such foods as part of the daily diet can provide significant protection against ill health and can enhance wellbeing. Community gardening projects – usually in cities – have been a response across the world to the challenges of what has been identified as a poverty of food choice for certain groups in society, including those on limited incomes.



Figure 29: Growing in Confidence

Source: Health Service Executive West

Targeted Communities: The project includes socially disadvantaged members of the community such as: parents managing on a tight budget, asylum seekers, elderly people and people with a disability. It is thus wide ranging and inclusive. Participants are drawn from a variety of social backgrounds and this creates a matrix of social interests and combines varying skills and talents.

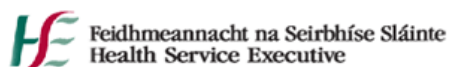
Evaluation: Since 2004, an external evaluator has been commissioned to complete yearly evaluations (Share and Duignan 2005, Share 2006, Burke 2007, Burke 2008 (in press)).

Recent independent evaluation found that 86% of participants reported eating more healthily since taking part in the project and fruit and vegetable consumption was increased. In addition, 83% had begun growing fruit and vegetables in their own garden at home at the time of the evaluation. This demonstrates clearly the efficacy of the project in terms of promoting fruit and vegetable production leading to subsequent increased dietary intake among the population.

The manual labour involved in the project provides an opportunity for physical activity among the participants, both during the project sessions and through encouraging participants to garden at home. This represents an additional benefit of the project in terms of promoting the prevention of obesity and other diseases. 91% of participants reported that they were more active.

The project provides an opportunity for participants to socialise with other people from a diverse range of backgrounds. In addition, learning a new skill also helps to foster feelings of confidence and self-worth. This in conjunction with increased physical activity and healthier eating patterns can contribute to an improved mood and sense of well-being. The evaluation showed that 81% of participants felt less stressed and many feel happier with their lives.

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Limerick City Community Growing Project

The Limerick City Community Growing Project is a City-wide Community Garden initiative to develop Community Garden and Growing schemes in disadvantaged areas across the city.

Aim & Objectives: The aims and objectives of the project are:

- To improve access and availability of fruit and vegetables.
- To provide a learning opportunity on basic garden skills and techniques that can be mainstreamed and made accessible for all in the community particularly those facing difficulties in accessing healthy affordable food.
- To insure the development and maintenance of allotments with ownership and participation by the community enabling recreational and therapeutic activity for residents.
- To promote environmental awareness and provide opportunities for training in recycling organic waste and water re-use.
- To provide a focus for the community. We intend that these community growing initiatives will serve as a setting for community education, and will be inclusive in helping to reduce isolation and to provide meeting places for young and old, and those with disabilities.

Design: Limerick City Community Growing Project” is a City-wide Community Garden initiative to develop Community Garden and Growing schemes in disadvantaged areas across the city. The project will play a lead role in the creation of community gardens and allotments as part of the Regeneration process in Limerick. There will be a strong educational emphasis where it is intended learning at the community gardens will be transferred to participants own homes. In addition, participants will have the opportunity to participate in the Cook It programme.

'Cook it!' is a six week nutrition education programme which aims to provide practical information on healthy eating and improve skills by showing participants ways to provide healthy, nutritious, low cost meals and snacks for their families. It also puts the healthy eating guidelines into practice in an easy, relaxed and fun way. The healthy eating message to eat more fibre, eat less fat, sugar and salt is incorporated into all the dishes prepared and sampled during the course. Those taking part in 'Cook It!' learn from each other and get the chance to experiment with dishes that are quick and easy to prepare. At the end of a session food prepared may be eaten and enjoyed by adults and children alike.

Support: The Community Gardens are at the early stage of development and are working in tandem with the Regeneration Agency, Communities and supported by the Limerick Food Partnership.

Funding was sought and secured from Health Promotion HSE late in '08 and funding for the ground work was received early '09.

Trigger: A Health Impact Analysis of the Regeneration areas of Limerick identified that these proposed areas of high density urban communities would benefit from community gardens and growing spaces. The project arises from the work of the Limerick Food Partnership and it was decided to seek out communities interested in becoming involved.

Evidence suggests that people living in disadvantaged communities are found to have:

- Less healthy diet experience
- More health inequalities
- Less Physical Activity
- Have less access to fresh fruit and vegetables

Targeted Communities:

- Lower Socio-Economic Groups in the Limerick Regeneration Area
- Women's groups and men's groups
- Older people in day care groups
- Residents in homeless hostels;
- Mother and toddler groups
- Young/ single parents;
- Teenagers and Youth clubs
- Young people leaving residential care

Evaluation: Participants are asked to fill in an evaluation form on completion of the Cook It programme and the evaluation of the growing project will be ongoing, including a pre and post nutritional knowledge questionnaire.

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Farmers Have Heart Project - Co Roscommon

In Ireland and elsewhere cardiovascular disease is a particular problem among men. The 'Farmers Have Heart' project was developed to address this issue. It is a multidisciplinary project providing free cardiovascular health-screening to 2 separate groups: the rural farming community of Co Roscommon and participants at the National Ploughing Championships. The livestock marts and the national agricultural championships are traditional locations where large numbers of men and women gather. This project facilitated their attendance at the marts and at the Ploughing days without interfering with their usual day while at the same time accessing heart health screening service. While the project targets men, women are welcome and have participated.

The project aims to create an awareness of cardiovascular disease by focusing on the importance of prevention and the promotion of heart health. It identifies clients with risk factors that contribute to cardiovascular / disease ill-health and encourages them to engage in positive health behaviours. A recall service is also provided.

Aim & Objectives: The aim of the project is to raise awareness of heart health for all those attending the project and to bring screening to participants rather than participants to screening.

The objectives of the project are to:

- Have a coordinated approach to the delivery of the project;
- Provide user friendly access to the project;
- Increase awareness of heart disease for all who participated;
- Raise awareness of the risk factors of heart disease;
- Identify individuals at high risk of heart disease;
- Provide on-going support for individuals identified;
- Provide a follow up services after 6 months.

Design: The project consists of 4 simple steps on the day. The first step involves the health promotion professional registering the client, explaining the project to the client and completing a lifestyle questionnaire with them.

The second step involves the nurse taking a finger prick blood test for cholesterol and blood sugars. Their blood pressure is taken. The results are discussed and a printed copy is given to the participant.

The third step involves the dietician taking measures for height, weight, waist circumference and a general dietary assessment. The participant then decides on simple, attainable changes he / she is able to do at home.

The fourth step involves the physical activity professional assessing the blood results provided and carrying out a physical activity assessment. The participant decides on simple, attainable changes he / she is able to make at home concerning physical activity.

Each participant's risk status is categorized according to the British CVD Guidelines.

The follow up consists of:

- At 1 month after the first visit a confidential questionnaire is sent to each participant for completion to analyse their self perception of their heart health;
- At 3 months a support letter is sent to each participant encouraging them to adhere to their agreed changes;
- At 4 months the National Ploughing Championships participants in categories 1 to 4 receive a telephone questionnaire and no recall visit due to the geographical spread of the participants;
- At 6 months a recall letter is sent to each participant in categories 1 to 4 inviting them to attend for a recall visit;
- At 7 months a confidential final questionnaire is sent to each participant who attended their recall visit to assessment the changes and to promote maintaining the changes.

Support: The project is funded on a yearly basis by Health Service Executive through Health Promotion Services and Primary Care Services. Evaluations have been completed with both groups; Roscommon Community Groups and the National Ploughing Championship Group.

Trigger: This project was set up based on the recommendations of many strategies, best practice guidelines, and research evidence of cardiovascular disease in Ireland.

Targeted Communities: The project had two different targeted groups. The first group involved collaboration between Health Promotion Services HSE West, the Nutrition and Dietetic Services HSE Roscommon and nurses. The Community group consisted of Roscommon Mart, Elphin Mart, Castlerea Mart, a local Men's Group, Rahara Co. Roscommon Ploughing Day, and a Work Place setting.

The second group involved collaboration between Health Promotion Services HSE West, Nutrition and Dietetic Services HSE West Roscommon, a researcher with the Department of Public Health HSE West and nurses. The National Ploughing Championship group consisted of participants both men and women who were attending the National Ploughing Championships in 2007 and 2008.

Evaluation: Both group projects have been evaluated and the published reports are available. The project has targeted and reached participants through a non traditional primary care setting.

The indications are that it is cost effective, efficient, friendly and relaxed atmosphere. Access is simple. No cost to the participant. There is no form filling, which is essential due to low literacy levels. Participants have reported having made significant changes at home.

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The Netherlands

Healthy Nutrition doesn't have to cost much

"Goede voeding hoeft niet veel te kosten"

This intervention is embedded in to an already existing budgeting course for persons having debts. Two out of twelve obligatory meetings are focussing on nutrition, with the aim to show that healthy and tasty food doesn't always have to be expensive.

Aim & Objectives: The main goal of this initiative is to learn participants how they can buy healthy food with a limited budget. Besides this, the project aims to increase the variety in meal contents of the participants. It aims to decrease the intake of saturated fat, and to increase the daily consumption of fruit and vegetables.

Design: While the title of the project invalidates the presumption that healthy, good nutrition is always expensive, it also emphasises the subject 'money'. The intervention aims to target communities with a low income or even having debts. By linking the health aspect to costs, the target group is probably much more interested.

The project is part of a course for clients of the Integral Debt Assistance – a budgeting course. Participants are obliged to attend 12 meetings, and one group consists of 6 – 12 persons of either man, woman or couples. Topics that are discussed during the course can either be: how to deal with debts, purchasing and budgeting, supermarket tour, saving money, healthy and inexpensive food, and many more. Two out of 12 meetings are focussing on healthy nutrition, with duration of 2 – 2.5 hours each.

During the first nutritional meeting, a dietician gives information about healthy nutrition in general and gives examples of how to purchase and prepare food in a healthy and cheap way. Participants can also discuss the difficulties they experience when they want to buy healthy food, and how to deal with this. Also, labels of food packages, daily amounts of fruits and vegetables and inexpensive alternatives are discussed. The meeting also contains a taste exercise.

The second meeting about healthy nutrition partly takes place in a supermarket. Participants get a supermarket tour whereby they learn how to read labels and compare different brands according to the price/quality relation. Furthermore they receive tips how to make healthy and inexpensive choices about buying food.

After the course, a leaflet named 'top ten healthy nutrition' is distributed among participants even as the brochure 'Healthy and tasty food for less money', that explains how you can compose healthy weekly menus with the minimum amount of money (€ 53 for two adults and € 82 for a family with two children. They also receive an information file with background information, two homework assignments (one about the information meeting and the other one about the supermarket tour), taste sessions and a free food package.

At the moment this course is taking place in Maastricht, Heerlen and Sittard-Geleen, three cities in the south of Holland, in the province of Limburg.

Support: The theoretical meeting and the supermarket tour are both led by an official dietician.

The budgeting course (including the two meetings of the project 'Healthy nutrition doesn't have to cost much', is financed by the local authority of Maastricht, department of Socio-Economic Affairs.

The costs for participating in the budgeting course are €339,-. This course is organized and coordinated by the Limburg Credit Bank, in cooperation with the Local Authorities. Furthermore, the dietician has to be paid, but the supermarkets cooperate on a voluntary basis. The materials that are used during the course are available on the website of the Regional Public Health Organisation of South Limburg and are free of charge.

Trigger: This intervention was developed on request of the Limburg Credit Bank, because they frequently noticed that their clients – who were having debts – were saving on food. A whole week of eating junk food was normal, because it was cheap, easy to prepare and tasty. The aspect ‘health’ is often not an issue for these people, as healthy food is more expensive most of the time.

To show persons that healthy food can also be inexpensive, the Limburg Credit Bank therefore asked the Regional Public Health Organisation of South Limburg to develop a module to inform persons about this possibility.

Targeted Communities: The participants of the budgeting course are having an income of 94% of social security level for at least 3 years. Approximately 50% of these participants are having a low socio-economic status (internal data of the Limburg Credit Bank). Because the intervention hitched on to this obligatory course, the target group – who is normally difficult to reach – is rather easily reached. Furthermore with this set up it is therefore not necessary to start separated courses that need separate financing as well.

Evaluation: A non-randomised quasi-experimental study (Van Assema et al., 2005) has directly proven that the ‘Healthy nutrition doesn’t have to cost much’ project has an intervention effect on fat consumption (the consumption of saturated fat during the main meal significantly decreased) and fruit juice consumption (the fruit juice consumption significantly increased). Furthermore, almost all of the participants of this study reported to be more interested in healthy nutrition after following the course. However, no effect was

demonstrated on the fruit and vegetable consumption before and after the intervention took place.

Another study by Geerts (2003) showed that persons with a low socio-economic status prefer practical activities to listening or reading. The supermarket tour is a good example of such practical activity, and this design has proven to be effective during other interventions as well (Baic and Thompson 2007). Participants of this last study changed their purchasing behaviour towards a healthier choice and learned how to read the labels. On the long term the supermarket tour had a positive effect on the consumption of saturated fats and fruit and vegetables (Baic, 2008).

A strong element of this intervention is furthermore that the approach is focused on money and not primarily on health, because of the budgeting course. With this point of view, an appealing design is created for persons with a low socio-economic status.

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SchoolGruiten

<http://www.schoolgruiten.nl>

Aim & Objectives: The programme aims to stimulate healthy nutrition among children by offering pupils (class 3, 4, 5) from primary schools in deprived areas of Amsterdam free fruit and vegetables twice a week.

Design: The SchoolGruiten – Amsterdam programme started in 2006, and currently 59 schools are participating. These schools were approached by the Municipality Health Authority (GGD) Amsterdam itself, based on their socio-economic status (SES). Only schools with low SES could participate. The schools were offered the possibility of providing their pupils (class 3 and 4) free fruit and vegetables twice a week during a full school year for as long as there is financing.

These free fruit and vegetables for class 3 and 4 are only given to the school, if they will stimulate class 5 to eat fruit or vegetables twice a week as well, during the morning break. This can either be done via Model 1 (delivery by a subcontractor – the school or the parents pay the costs) or Model 3 (parents or child carers give fruit and vegetables to their children to bring to school).

Support: The Local Authority of Amsterdam will finance the costs to provide fruit and vegetables for class 3 and 4 of the participating schools for one full year. Often the support of the GGD Amsterdam is needed to help the school with the communication to the parents and the implementation of health policy and regulations in the school itself. The GGD provides therefore promotion materials and thus stays involved, also for the evaluation of the project.

Trigger: The SchoolGruiten project is part of the integral approach to prevent overweight and obesity among children of the age 0-12 years old. The local authority of Amsterdam asked GGD Amsterdam to develop the programme.

Targeted Communities: The programme is targeting schools with pupils from low socio-economic groups who are at risk of becoming overweight or obese.



Figure 30: SchoolGruiten Programme

Source: GGD Amsterdam

The programme is targeting children from class 3 and 4, as the probability of drop out (due to movement to another city or changing schools) is significantly lower at this age. Also, the sooner the children get familiar with the programme, the greater the effect will be and thus the more likely that children will indeed start eating fruit and vegetables for at least twice a week.

Evaluation: The participating schools are receiving a yearly questionnaire so that the GGD Amsterdam can verify that the schools are indeed providing fruits and vegetables to the children of the 5th grade and higher. Also, the GGD collects general information on the progress of the programme and data about the schools (number of children, etc.).

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Scotland

Bridgend Allotment Community Health Inclusion Project

The Bridgend Allotment Community Health Inclusion Project (BACHIP) is both an education and therapeutic resource, aiming to promote healthy nutrition by creating an organic community allotment.

Aim & Objectives: The project was established with the following aim: 'To create a productive, organic community allotment with an emphasis on the promotion of health and well-being, with the primary involvement of the local communities of South Edinburgh Craigmillar.'

To establish a full programme of activities and events promoting the links between gardening and health, several objectives were set up. Participants would learn:

- how to grow healthy food locally
- how gardening and gardens can promote a profound sense of well-being
- how gardening can be central to structured prescribed plans for (physical) activity for those requiring rehabilitation how gardening can increase confidence and how it incorporates many transferable and life skills
- how organic gardening can increase biodiversity and environmental sustainability and improve the quality of green spaces
- the value of gardening as a group and family activity: the links between gardening and growing food, healthy eating, cooking and eating together
- how to create a sustainable community resource for the future, through effective monitoring and evaluation of the project with full involvement of all, especially community, stakeholders

Design: The project began in June 2006 as a one year pilot project of Edinburgh Council's Parks unit and NHS Lothian. The Project occupies 4 plots within a new organic allotment site comprising around sixty plots, is a referral scheme for social and therapeutic horticulture. It provides opportunities for people to improve their mental and physical health, through a mixture of physical activity, healthy diet, and social interaction.

The project addresses health and social inequalities by fully involving local volunteers, groups and referrals in specified and appropriate gardening activities. It also emphasising the productive elements of the project (gardening is seen as 'work'), it contributes to consumption through the planting, growing and consumption of food, all of which enhance the quality of life and it provides increased social opportunities, and the possibility for reciprocal relationships to develop within the community for those who share an interest in gardening, vegetable growing, cooking, or simply being outdoors. At last it encourages all people involved to contribute to the running and development of the project, encouraging participation at community level.

The project has been open to participants for two days per week between 10am and 3.30 pm since April 2006, when the allotment site was completed. It has been run as a drop-in facility, with participants deciding on the hours they attend and the frequency. This can vary from participant to participant and from week to week. The maximum attendance has been two full days. In June 2006 the project became available for groups at the site, including e.g. high school children, a group of Sikh women, participants with mental health problems and young homeless women with children.

Support: The project is funded by the Big Lottery's Fresh Futures Fund. It links in with established groups and organisation, feeding information and findings up to policy and strategic levels. The groups and organisation involved are NHS Lothian, City of Edinburgh Council, Community Regenerations Partnerships, health practitioners, schools, community organisations concerned with linking food, health, physical activity and well-being, National and local voluntary

organisations concerned with social and therapeutic horticulture, and national environmental and organic gardening organizations.



Figure 31: Bridgend Allotment Community Health Inclusion Project

Source: Gracemount Medical Centre

Targeted Communities: The location of the project is exactly on the boundary between Craigmillar and South Edinburgh. While these communities are very different: Craigmillar having a distinctive unitary identity, and South Edinburgh being a larger, loosely linked collection of areas: Gilmerton, the Inch, Burdiehouse etc, significant numbers of people experience deprivation and health inequalities in both areas.

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Edinburgh Community Food Initiative

<http://www.ecfi.org.uk>

Edinburgh Community Food Initiative (ECFI) is a citywide, community-based charity, supporting local groups to run their own food co-ops, training local volunteers in the community and facilitating networking of community groups with each other. ECFI also buys food on behalf of over 40 community groups and local agencies across Edinburgh, ensuring that they receive healthy, good quality, fresh and affordable food for sale within their communities.

Aim & Objectives: The project aims to enable health improvement in relation to poor diet, particularly for people living in low-income areas, by support local groups to set up new projects, help them to be self sustaining, and to encourage them to become aware of what is grown around them and when it's in season. It thus aims to improve the supply of quality food (getting food to people) and secondly to tackle barriers to quality food consumption, such as cooking skills (getting people into food).

Design: Edinburgh Community Food Initiative (ECFI) – launched in 1996 - is a citywide, community-based charity and company limited by public guarantee. The project is managed by a Board of Directors, the members of which have an active connection to local community food activities, or have related experience or expertise in this field.

The main focus of the work is on reducing health inequalities relating to diet. Early activities included an examination of the barriers to healthier eating for people living in low-income areas of the city. This showed that there were a number of external factors that inhibited positive dietary change. These were understood to be inter-related, to a varying extent systemic, and largely outwit the control of individuals. These factors can be characterised as:

- *Access*; to adequate and appropriate shopping opportunities
- *Availability*; of a range of desired food items
- *Affordability*; of foods required for a healthier diet
- *Aptitudes*; or the skills, knowledge and confidence required to source and prepare appropriate foods
- *Attitudes*; feelings, habits and ideas we have developed and become accustomed to in relation food issues

In more precise terms, a significant proportion of people in low-income situations feel that supermarkets do not provide a service that meets their needs, either because supermarkets might be difficult to access physically or that their shopping needs are not catered for by them.

It was in order to address these issues that ECFI developed its *Provide & Promote* methodology. This entails acting as a wholesaler and delivery service to allow a wide range of high quality fresh fruit and vegetables being made available at affordable prices to local communities, schools, childcare organisations and other projects.

Community food outlets include local volunteer operated food co-operatives, which are typically located within local community facilities such as neighbourhood or community centres, G.P. surgeries, church halls, etc. ECFI delivers a comprehensive range of fresh produce at cost price on a sale or return basis to most of the groups it supports, as well as administrative and developmental support. Operating from its warehouse in the Leith area of Edinburgh, ECFI bulk buys produce from a range of suppliers. These include the local fruit and vegetable market as well as a variety of local farms and producers.

Every week, three full-time and one part-time staff collate and deliver up to around two hundred orders every week. It has a large and wide ranging customer base that includes: sixteen local community food co-operatives, around thirty smaller scale community food access initiatives such as fruit stalls and 12

Children and Family Centres across the city as well as responding to frequent requests to support local community events and projects.

The community programme's basic order form is made up of around 80 different items of fresh produce, which is supplemented by a range of seasonal items throughout the year. The local food co-ops are supplied on a sale or return basis. This allows them to experiment with more unusual fruits and vegetables as well as to display an abundant amount of produce, helping to create an attractive display. The range covers everything from everyday items of the apples, bananas, tomatoes and potatoes type stuff, ranging through the Mediterranean vegetables like aubergines, capsicums and courgettes to the positively exotic okra, Karela, mooli and physallis and lots more in between.

It is absolutely vital to recognise that information alone will not effectively enable people, particularly those in low-income circumstances, to make positive changes to their dietary habits. Therefore, within the community programme an ongoing programme providing education and group work opportunities helps community groups and other projects to gain an insight into addressing food issues. The main promotional activity involving the food co-ops is the Seasonal Promotion Programme. Co-ordinated and delivered by ECFI, this takes place four times a year and involves all of the food co-ops.

Each promotional event highlights the benefit of a specific fruit or vegetable and each food co-op user is given a free sample of this along with information, recipes and often a chance to sample the featured fruit or vegetable. This allows people to try something that might be unfamiliar to them or to introduce new ways to use familiar fruits and vegetables. Breaking down barriers in this way helps expand the range of healthy foods that people feel comfortable buying.

Support: The Project was launched using grant funding that had been secured by community activists involved in local food co-ops. Nowadays, a partnership arrangement between the City of Edinburgh Council and Lothian NHS Board provides basic funding for ECFI. A number of other funding partners including

Sure Start, the Craigmillar Partnership and Community Regeneration Forums in Leith and Lochend and additional funding from CEC Children and Families Department enable the project to run its range of specialist programmes.

Much of this work is done in partnership with other agencies; one of many examples of this is the presence at the Edinburgh Mela along with the Khush Dil project. ECFI and Khush Dil dipped their collective toe into providing a fruit, smoothie and information stall at the 2004 Mela and subsequently built on this experience at the 2005 event, where the British Heart Foundation was an additional partner.

Trigger: The initial funding proposal was the result of discussions between representatives from four local community food co-ops who had come together to look at commonly held issues and challenges. Each of the food co-ops was operating on a very small budget with restricted access to transport. This limited the quantity, variety and type of food that could be stocked. Providing fresh produce was particularly difficult due to a number of factors: e.g. lack of capital; lack of appropriate storage facilities; unsuitable environment; the inability to afford stock wastage; lack of funding for advertising/promotion. The problems expressed by the food co-ops were of a largely practical nature, primarily related to supply issues. The grant funding though, provided for a project that had the potential to bring a wider and more developmental approach to tackling community food issues across the city.

Targeted Communities: Targeted communities are low-income families, elderly people and people from ethnic minority groups across Edinburgh.

Evaluation: Evaluations are in progress and get monitored on a quarterly basis.

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Janny's Hoose Healthy Living Centre

The Janny's Hoose is a developmental health initiative with an initial focus on the needs of families with children of primary school aged living in an area of Inverness (Merkinch) with the highest levels of identified social and health need in Highland.

Aim & Objectives: Janny's Hoose Healthy Living Centre is focussing on four different themes; Oral health, Nutrition, Mental Well-being and Parental Support. The targets of these four themes were:

- A 10% improvement in children's DMFT scores and a 10% improvement in parental registration with a local dentist
- An increase in the consumption of fresh fruit and vegetables in 50% of local families with children at Merkinch Primary School
- An involvement of all children of Merkinch Primary School and 50% of parents in activities aimed at 'feeling good/positive'
- At least 100 places will be provided at 'Incredible Years' or 'Positive Parenting' courses and at least 500 opportunities for informal drop-in information and advice sessions.

Design: The Janny's Hoose Healthy Living Centre was set up in January 2003 in an area of multiple deprivations (the 7th most deprived council ward in Scotland at that time). It was set up by a partnership of the local council and NHS and utilised the empty Janitor's House at the local primary school - hence the use of the name 'Janny's Hoose'.

The Janny's Hoose uses a person-centred approach to all its work. It predominantly uses the social model of health and looks at each person's health holistically. Although activities are carried out in the Janny's Hoose, these are

not an end in themselves but a vehicle for improving people's confidence, self-esteem and general health.

People are thus encouraged to take responsibility for their own health, because tackling obesity can be counterproductive; people know when they are obese, but there are more complex issues around obesity than just overeating. With this project, people's awareness is raised about healthy eating and it raises their self-esteem so that they are more likely to eat a healthy diet and look after themselves.

From the outset the facility was designed to be used (and has been used) by a number of professionals from agencies to conduct clinics to fulfil the original intention that the Janny's Hoose would be a multi-purpose community facility. For example, clinics in ante-natal care, child health, and smoking cessation have regularly been held in the Janny's Hoose.

The main activities of Janny's Hoose are:

1. Reducing social isolation: going out and about - in the playground, street and door-to-door. People are encouraged to come in to get the support they need, firstly by one-to-one and also as part of small groups. Many people are unable to trust anyone as they have had such negative experiences of life.
2. Encouraging people to take part in small group activities: reducing mental ill-health through giving people a reason to get up in the morning. The specific activity is often irrelevant although participants should have input at the organising stage. Encouraging social networks, improving self-esteem and confidence.
3. Encouraging people to move on through providing supported informal volunteering opportunities in the Hoose and training opportunities. This gives encouragement to re-enter more formal education, return to work, take part in mainstream volunteering activities, or join other community groups.

4. Working with other agencies and groups on health promotion. Includes teachers in the school, school nurse, health visitors, midwives, NCH, MP33, Afterschool club, nurseries, Women's Aid, family centre, dietician and smoking cessation worker.

Many different nutrition-related activities involving parents have taken place under the aegis of the Janny's Hoose over the 5 years ranging from a veggie barrow scheme selling vegetables and fruit to cooking classes and taking in group discussions on diet and the provision of healthy foods at community events. The Janny's Hoose has undoubtedly increased the profile of the campaign to increase the consumption of fruit and vegetables in an area of town where nutrition needs are the greatest in Inverness. It has worked with the Merkinch Primary School staff to enable all the children to sample different fruits and vegetables and breads and that work in itself increases the consumption of wholesome food.

As there is currently no prospect of further funding, the Janny's Hoose project is expected to finish on 31 March 2009.

Support: In 2003 it was funded for 5 years principally by the national lottery fund, with contributions from Highland Council and NHS Highland.

Janny's Hoose was initially led by two part-time staff (a 30 hour a week co-ordinator and a 15 hour a week administrator). These positions were later to be supplemented by sessional workers, the engagement of volunteers and, for a period, another part-time staff member. When the project has to finish, the three staff members will either be made redundant or redeployed within the council.

Trigger: The genesis of the Janny's Hoose project stemmed from two established partnerships – the local New Community School initiative and the Merkinch Social Inclusion Partnership. In developing the Janny's Hoose Business Plan and accompanying application to NOF, a similar partnership approach as existed

within these two entities was developed involving several different statutory and voluntary organisations.

Targeted Communities: All the promotion and publicity has been targeted at the area of most need. As the publicity has been very specific about the target group, this has aided in concentrating on this community.

Evaluation: Via its Annual Reports to the NOF/Big Lottery the Janny's Hoose project regularly demonstrated that it had exceeded its targeted outputs for the year under review. With the small, part-time and sessional staffing complement at its disposal it has tackled the planned range of initiatives and it has delivered on the numbers. The project has also won the trust and confidence of the vast majority of those with whom it has worked closely.

There has been much attention given over the last 5 years to promoting healthy schools so it is impossible to ascribe these changes to the influence of the Janny's Hoose alone. But what can be said is that the Janny's Hoose has contributed significantly to a set of changes designed to improve the nutrition of the children.

The school has thus benefited from the Janny's Hoose support in promoting healthy eating. However there is a justifiable feeling that more could have been accomplished with parents and children via this route if there had been greater involvement of the Janny's Hoose in the life of the school.

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The Children's Orchard

<http://www.childrensorcharard.co.uk>

The Children's Orchard aims to encourage schools, community groups, local authorities and individuals to set up, maintain and use community orchards, for a range of benefits and purposes. The aim is to encourage local ownership of orchards, but linked with a common ethos and purpose.

Aim & Objectives: The aims of the project are to improve children's and public health through better diet, to create any educational resource, that fires the imagination of young people, to create better local environments and improve community cohesion.

Design: The Orchard developed since 2004 with the first planting at the Children's Garden in Glasgow Botanics. The Children's Orchard developed as an outreach project from the Children's Garden working across Glasgow and across other parts of Scotland. It has grown, and now operates as a social enterprise with a Scotland wide remit. There was a pilot phase in 2005 with work on delivery of the orchard concept across Glasgow. The strength of the orchard model is that it is cheap and simple, and fits well with the school year.

Support: Finance came from a range of small grants, donations, and contributions from the community organisations the orchard supports. Our observation is that when local communities and schools raise money themselves to plant their orchards – they are much more involved and determined that the orchards succeed.

Part of what we do is to broker partnerships and networks. These are varied – from individuals, to community groups, schools, local authorities, and central government agencies of various sorts.



Figure 32: the Children's Orchard

Source: The Children's Orchard

Trigger: It was triggered by John Hancox, a journalist, environmentalist, and social entrepreneur– who saw the scope for bringing fruit trees into the urban landscape, and for picking and using considerable amounts of fruit which would otherwise be wasted. It was also triggered by the many children who loved to get their hands dirty planting and digging and trying out planting growing and eating food plants – all with a big smile.

Targeted Communities: The orchard tries to be very open and inclusive, and encourages as many schools, communities and agencies to take community orchards forward as possible.

Evaluation: There is on-going evaluation of the project – and perhaps the best measure of the success of both the Children's Orchard and the Children's Garden is through the number of similar initiatives it has generated. On the back of the Children's Garden, Glasgow City Council introduced policies encouraging schools to have allotments, and the Children's Orchard is currently in discussions (as we speak) with the Scottish Government over an ambitious plan to roll out the Children's Orchard concept across Scotland. The Commonwealth Orchard plan has now been launched – <http://www.commonwealthorchard.com> - looking to encourage a wide range of schools and communities across Scotland to get growing.

Evaluation techniques have been used – based on the participatory appraisal model – which works well with children involved in doing the evaluation, and interpreting the results. This gives a way in which participants can reflect and improve.

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Wales

Community Food Co-operative Programme

<http://wales.gov.uk>

The Community Food Co-operative Programme in Wales provides quality, affordable fruit and vegetables to communities through sustainable local food distribution networks.

Aim & Objectives: The aims and objectives of the project are:

- To provide quality, affordable fruit and vegetables to communities through sustainable local food distribution networks.
- To increase citizen's consumption of fruit and vegetables and help reach the UK target of 5 portions of fruit and vegetables a day.
- To create supply chain efficiencies, reduce the environmental impact of food production and support a Welsh / local food industry.

The programme supports the Welsh Assembly Government's local sourcing action plan and encourages more sustainable practices and fosters better links between urban and rural areas.

Design: The food co-ops work by linking local volunteers, who run the food co-ops, to a local supplier, who is a grower and/or local wholesaler. A simple payment and delivery system is agreed which enables the volunteers to order and pay weekly in advance for the fruit and vegetable bags. Customers then collect their fruit and vegetables at an agreed venue during food co-op opening times and place their orders (and pay) for the following week.

In April 2004 a two-year pilot scheme to develop community food co-operatives in North and Southeast Wales commenced. The pilot area covered a diversity of rural and urban areas including a significant proportion of the South Wales Valleys. The key focus of the pilot was to supply, from locally produced sources

as far as possible, quality affordable fruit and vegetable to disadvantaged communities through the development of sustainable local food distribution networks. A partnership was formed between the Welsh Assembly Government and the Rural Regeneration Unit. A grant from the Welsh Assembly Government funded two Community Food Development Officers to develop a minimum of 26 sustainable food co-operatives.



Figure 33: Community Food Co-operative Programme Source: Welsh Assembly Government

The pilot focused on socially disadvantaged communities. The project aimed to develop and introduce sustainable practices to improve health through collaborative action, and direct efforts at a local level linking farmers to consumers. A total of 77 food co-operatives were set up in the two-year period.

Support: The pilot was first funded through Welsh Assembly Government Inequalities in Health funding. The programme was, and is, subsequently funded by the Welsh Assembly Government's Health and Social Services and Rural

Affairs' Departments and delivered through a grant to the Rural Regeneration Unit.

Trigger: Consumption of fruit and vegetables in Wales is considerably lower than the UK recommended level of five portions a day. In 2004 only 41% of all adults in Wales reported eating five or more portions of fruit and vegetables a day and this level was only 37% for manual workers and 30% for the long-term unemployed. As part of a range of initiatives to address this issue, the two-year pilot of the community food co-operatives was set up. The programme had been run in Cumbria by the Rural Regeneration Unit and in 2004 this model was introduced to Wales, later becoming a national programme.

Targeted Communities: Food Cooperatives are helping people in the most deprived areas of Wales to get easy access to fruit and vegetables. The community food co-operative programme supports the Communities First agenda with a target of a minimum of 75% of food co-ops based in Communities First areas. In 2006 the community food co-operative programme won a World Health Organization counteracting obesity award for activities in promoting fruit and vegetables with a focus on vulnerable consumers.

The successful development and sustainability of co-ops is dependent in large measure upon the extent to which they are networked into a broad range of community interventions/programmes. Contact with outside agencies is important to sustain the momentum and morale of those associated with the co-ops and offers mutual practical support.

Evaluation: The pilot was evaluated by Cardiff Institute of Society, Health and Ethics and the North East Wales Institute and it concluded that most people buying from the co-ops were eating more fruit and vegetables. Other benefits highlighted included changes to the quality of social lives and connections to other people, perceived improvements to health and understanding of health related issues. Changes in attitudes to fruit and vegetables were reported for other beneficiaries: in families, in schools and in the community as a whole. A further evaluation was commissioned in March 2010, with findings due in

October 2010 and March 2011. In addition to the evaluation, the programme has won two awards:

WHO Counteracting Obesity

In November 2006 the Community Food Co-operative programme won a World Health Organization award for counteracting obesity for activities in promoting fruit and vegetables, with a focus on vulnerable consumers. The programme was selected from 202 applications from 35 countries. It was later presented as an example of good practice at a World Health Organization conference on community initiatives for increasing healthy eating and physical activity.

Welsh Rural Sparks Champion

In April 2009 the programme won a Carnegie UK Trust Rural Sparks award. The awards are for rural champions who have made a real difference in the areas where they live. There are five top Rural Sparks from Scotland, England, Wales, Northern Ireland and the Republic of Ireland and 10 runners up. The winning programmes and projects were selected on the basis of innovation, sustainability and transferability. The Carnegie UK Trust is one of the UK's leading independent not for profit foundations.

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4.1 Physical Activity Projects

Austria

Walk Healthy – Pharmacy in Motion

“Geh!sund Bewegte Apotheke”

Walk Healthy is an activity programme initiated by A Heart for Vienna part of Health Promotion in Vienna which provides participants with health promoting information and tips on daily physical activities, using a sustainability concept to ensure people continue to walk once the programme has run its course.

Aim & Objectives: Physical inactivity and insufficient physical fitness are two risk factors capable on their own of contributing to the development of cardiovascular diseases. Providing an attractive choice of activities to target the physically inactive can markedly reduce the risk of contracting these diseases.

Design: With these essentials in mind we developed our activity programme for a set period of time (4 - 6 weeks), giving participants the option to get started at their own convenience. Health-promoting information and tips on “physical activities as a daily routine”, such as doing an extra 3000 steps a day for your health are communicated as part of the Nordic Walking course. To make sure the project is a lasting we also came up with a sustainability concept, training dedicated participants in the district to become multipliers.

Interested women and men meet for Nordic Walking lessons once a week. Following the professional instructions of “Geh!sund”(walk healthy) fitness trainers they are able to feel how their body reacts to “more” activity. Their heart and circulation are boosted. The programme is a soft approach for all those who engaged in little or no physical activity before: they can start ‘right from their doorstep’ and are spurred on by the group experience. A ‘Walking Pass’

provides additional motivation: each stamp in the pass is a small incentive to carry on.

The programme is targeted at inactive women and men 50 plus, many of them socially disadvantaged. They are well integrated by the group and the ‘Walking Euro’ charged each time does not pose a hindrance either. Usually, by the end of the programme small groups will have got together and continue to walk regularly. They stick to the same schedule as before (meeting place, time) and maintain contact with the pharmacy.

Trigger: Experience to date has shown that low-threshold affordable fitness programmes run over several weeks are well able to motivate people to stay active in the long run – even without professional instructions – provided the motion sequences are fairly easy to learn and come with a group experience. It is also important that participants have something, in our case the pharmacy, to go on for support and motivation during and especially after the guided activity.

Targeted communities: The activity programme was devised for older, fairly healthy persons who do not necessarily require regular medical treatment, who lack the energy to engage in regular physical activity, who need a professionally looked-after group to be motivated and who do not have sufficient funds to participate in the different courses otherwise available. Having a base location (i.e. pharmacies) ensures that socially disadvantaged persons in particular are addressed.

To reach our programme’s target group we entered into cooperation with pharmacies in Vienna. Walking sticks are distributed free of charge for the duration of the course by the Vienna Sports Office.

Evaluation: The number of participants varied between 10 and 44, depending on which pharmacy and date (weather) were picked. The majority of them were women (approx.90%). Roughly half attended a Nordic Walking cycle more than twice.



Figure 34: Walk Healthy – Pharmacy in Motion

Source: Ein Herz für Wien

First results und sustainability

The project's success very much depends on pharmacists' commitment and the motivation of participants. The psycho-social element – motivation in the group, solidarity among participants and with the team of trainers – becomes increasingly evident towards the end of the course. Up to 20 persons meet at participating pharmacies to walk together now that the guided Nordic Walking units have been completed. "Newcomers" are welcome too and are given instructions by the more experienced among participants – to the best of their abilities. Pharmacies support and motivate these groups as well.

With the experience drawn from the pilot run we developed a sustainability concept. The idea was to train dedicated participants as multipliers so that they can support the "Geh!sund" fitness trainers during the Walking units and ultimately accompany Nordic Walking groups on their own.

Multipliers may attend two Nordic Walking training seminars with the additional option of participating in workshops on other health promoting topics. Workshops on "Humour – laughter inside", as well as on nutrition plus taste training and nutrition quiz proved most popular.

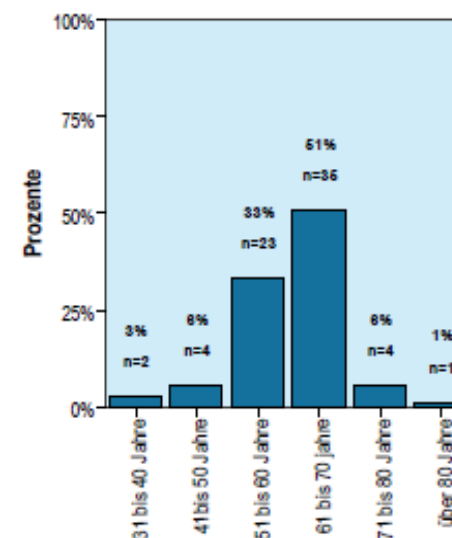


Figure 35: Participants by age

Source: Ein Herz für Wien

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Mobility Management for Schools and Youth

„Mobilitätsmanagement für Schulen und Jugend – Klima!aktiv mobil“

<http://www.klimaaktivmobil.at>

Aim & Objectives: This programme aims to reduce car-traffic on the way to schools and it encourages making use of friendly means of transportation (bus, walking and cycling). It cooperates with other organisation in the field and communities to improve structural condition and to raise awareness for the negative health effects of air pollution and the decreasing amount of space to perform physical activities due to car traffic.

Design: This programme was developed base on the EU PROVIDER Project (2001/2002; European network for Mobility Management in Schools) and the EU TRENDSETTER Project (2002-2005; pilot scheme „Mobility Management“ in 4 primary schools in the city of Graz). An Austrian Pilot Programme ran from 2003 until 2006 in sixteen Austrian high schools. The wide implementation of the „klima:aktiv mobil: mobility management for schools“ Project started in 2006.

A basic package of information and teaching materials is provided to 500 schools or teachers in Austria, and 100 schools benefit from a more intensive programme. This means that over the course of a year, a mobility manager helps children, teachers and parents to find local solutions for their mobility problems. Road safety measures can be taken or innovative approaches such as roundtables with children and community members, including transport company staff can be set up. Also, since 2008 a special workshop and material is offered to teenagers regarding this topic.

All these interventions will result in better mobility options for children to go to school as there is less car traffic around the schools, more awareness of children's need for physical activity, a clean air and more pleasant journeys.

Support: The project is financed by the Federal Ministry of Agriculture, Forestry, Environment and Water Management. Many interest groups are involved (e.g. communities, parents, teachers, police force, doctors and the Federal States).



Figure 36: Mobility Management for Schools and Youth

Source: klima:aktiv

Trigger: Motorised mobility is a growing problem for climate protection in Austria and Europe. The transport volume is rising and more and more children are taken to school by car. This leads to an increase in traffic and risk for accidents, and therefore parents are tempted to take their children to school by car. Mobility management wants to break this spiral.

Targeted Communities: It targets all regions in Austria; schools from both rural and urban settings are participating.

Evaluation: The health effect has not directly been analysed. But in between December 2005 and November 2007, around 190.000 daily rides by car to 50 schools have been transformed into a more climate friendly way.

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The Netherlands

Scoring for Health

“Scoren voor Gezondheid” | <http://www.scorenvoorgezondheid.nl>

This is a project in which football players of the Dutch Premier League promote a healthy lifestyle among primary school children (aged 9-12 years) and their parents. Football players are often a role model for children. With the project Scoring for Health professional football players show children that it is fun to be physically active and to feel fit.

Aim & Objectives: By using Dutch Premier League football players as role models, this project aims to convince children that it is fun to be physically active and to feel fit.

Design: The first pilot year of Scoring for Health started in October 2006 and lasted until April 2007, since 2007-2008 it has become a regular programme, in which all 18 Dutch Premier League clubs join together. In the season 2006-2007 927 children participated from 25 schools aided by 9 Football clubs, in 2007-2008 1.633 children participated from 49 schools from 18 clubs. In the season 2008-2009 we expect about 6.000 children from about 120 schools will join the programme.

The programme starts with a physical activity clinic and a fitness test for the participating children from the primary schools in the Netherlands. They signed an official Lifestyle contract with one of the players in which they stated that they would keep-up or improve their life-style. At school several healthy lifestyle issues such as exercise and healthy nutrition were promoted.

The programme lasts for 20 weeks. The following themes are considered in the 20-weeks:

- Sporting is cool
- Eating breakfast every day
- Healthy physical activity (with attention to: active transport to school, playing outside instead of sitting behind the computer)
- Healthy nutrition (eating 2 pieces of fruit and sufficient vegetables a day, drinking 1,5 litre fluid – especially water - every day)
- Being member of a sports club



Figure 37: Edgar Davids, star player of Ajax Amsterdam during a school visit.

Source: Association 'More than Football'

After 20 weeks the project is concluded with a second clinic and fitness test and the children receive a diploma by the same football player.

All 18 Premier League clubs have assigned (at least) two (ex-) players or trainers as ambassador Healthy lifestyle to the project. They visit schools, and promote

our message to the public. During the project the referees and their linesmen walk on the pitch hand-in-hand with Kids Club members of the home playing team with the logo on their shirt during every Premier League match. All the players of the Premier League have the logo of project ('Scoren voor Gezondheid') on their right sleeve during all games.

Halfway the season there is a Scoring for Health weekend. It is organized by The Dutch Premier Division, the Sponsor Bingo Lottery, and the 18 clubs. In the former season this has been filled in as follows:

- There was a full page add about the project in one of the national newspapers (Algemeen Dagblad);
- All the Premier League clubs in the Netherlands paid attention to the project. They projected a video of the starting clinics of the project on the huge screens in the stadia. They paid attention to the project in their programme books in the weekend.
- The players walked onto the pitch in a polo with the logo of the project, until they have presented themselves to the audience;
- There is also a Scoring for Health newspaper, which is full colour, and offers information about the project. It is spread house-by-house (for free) in the surroundings of the stadia and the participating schools; every city had its own edition of the paper (Rotterdam had three Premier Division clubs, and thereby has three different editions). The total number of newspapers spread was about 1.000.000 in 2007-2008. The newspaper is spread in an amount of about 1.5 million over the country.

In this manner the project receives a lot of media - and therefore public - attention.

Support: The project is carried out in cooperation with 6 Schools for Higher Education (teachers PE / Sports management), and several Municipality Health Authorities (GGD's), local and regional/provincial sports federations.

TNO Quality of Life is responsible for the monitoring of effects, and it is coordinated by the Health Institute NIGZ, the Netherlands Institute for Physical Activity and Sports (NISB), and the Association "More than Football".



Figure 38: Koen van der Laak, captain of FC Groningen during a school lunch.

Association 'More than Football'

Trigger: The project is an initiative of the Ministry of Public Health, Welfare and Sports (VWS) of the Netherlands, de Eredivisie CV (the organization of the Netherlands Premier League), and the Sponsor Bingo Lottery, the social partner of the Dutch Premier League.

Targeted Communities: The project targets children from lower socio-economic status groups, as the programme is offered primarily to schools in the lower SES suburbs.

Evaluation: Of the participating children in the 1st year 41%, and the 2nd year even 51% belonged to minority groups. The project Scoring for Health has reported significant positive health effects on physical activity behaviour (increases in compliance to the Health Enhancing Physical Activity guidelines, the duration of time spent in sports participation), and nutrition (there was a decrease of number of children drinking soft drinks every day, and eating more than three snacks a day; there was a significant increase in vegetables, and fruit consumption).

Evaluation reports are published by De Vries et al. (Evaluation of Scoring for Health 2006-2007. Leiden: TNO, 2007. TNO rapport KvL/B&G 2007.090) and Schermers et al. (Evaluation of Scoring for Health 2007-2008. Leiden: TNO, 2008. TNO rapport KvL/P&Z 2008.707).

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Big!Move

<http://www.bigmove.nu>

Big!Move is a health promotion method in a local setting, focusing on healthy behaviour and human power. During the course, participants are encouraged to participate in local activities and to organise activities themselves. People, children, all ages, can participate in dance activities at local community centres or in swimming, walking or cycling groups. There are also special groups for elderly people, which convene in residential homes.

Aim & Objectives: Big!Move aims at helping people to become more conscious of the influence they can have upon their own life. This consciousness, together with the understanding and experience that one gains more with healthy behaviour, leads to a healthier lifestyle. The focus is on the person, health, empowerment, and development instead of on symptoms and diseases.

Design: The programme started in 2003. The word 'big' in Big!Move is the abbreviation of 'beweging in gedrag' ('behaviour on the move').

Both the vision of the health care organisation and the Big!Move method are based on the scientific knowledge of the WHO on health promotion: 'the process of enabling people to increase control over and to improve their health'. Although the WHO knowledge is the most important, other theoretical models are used as well: the Theory of Complexity (Pisek, 2003), the Trans-theoretical model, and a developmental approach, all used in contrast to the rational, managerial approach (Van den Nieuwenhuizen).

The programme Big!Move forms a bridge between health care and individual participation in local activities in the neighbourhood. The main setting is a city area or neighbourhood, because in principle, the programme is directed towards

all inhabitants of such an area. Within this area, the programme settings are the health care centre, community centres, residential homes, schools, et cetera.

The general practitioner (or another health care worker) informs, advises, and motivates a patient with lifestyle, behavioural or functional problems to actively counter his or her lifestyle factors. When the patient is sufficiently motivated, the GP then refers him or her to a health promotion organisation. Sometimes, the patient first needs the in-between step of attention being paid to his or her symptom as a way to get activated. The patient gains insight in his/her own part in and responsibility for his/her health.

Next, the intake is carried out, based on the ICF, the International Classification of Functioning. A blueprint is made of the patient's functioning, divided into objective measures on the one hand and subjective measures on the other, which we state as the most important as it represents the patient's view. Together with the person doing the intake, the patient sets goals for his/her change. He/she chooses between an individual trajectory or inclusion in a Big!Move group (or another offer), pays the mandatory modest contribution and becomes a participant. The intake is a crucial part of the process as this is often the moment when the patient sees possibilities for increasing his or her health and makes a commitment to participate.

Big!Move consists of three phases and an optional fourth phase. After the intake, people enter phase 1. In this phase, people participate in a group activity, with intensive counselling by two supervisors. In addition to their physical strength, they try to improve the mental and emotional strength of the participants as well. After 12 weeks, an evaluation is carried out based on the intake and another blueprint is made. Participants can now choose to go on to phase 2. The participants are encouraged to get more active in their own environment; they are invited to engage in other activities in the neighbourhood. In phase 3, participants are encouraged to keep on moving and exercising more, independent of but in relation with the organisation. Besides this, the

organisation organises some group activities to let participants reflect upon their own experiences. In the fourth phase, the participants organise a group or an activity themselves; they become social entrepreneurs. More and more people reach this stage.

The programme reaches most people during their visits to the general practitioner or another of the Centre's health care workers (the physiotherapist, dietician, or a general practice assistant). The Venserpolder health care centre in Amsterdam has 7000 registered patients. Sometimes, participants to the programme have also been stimulated to take part by other professionals, such as social workers or school teachers. The general practitioner refers inhabitants (with health problems like diabetes, overweight, cardiovascular diseases, stress and tiredness) to the programme.

The Foundation Big!Move Institute has been founded for the dissemination of the Big!Move method and the vision on health promotion, and for supporting the transference of local knowledge and experiences. By now, Big!Move is being carried out at six other locations in the Netherlands; four new areas are being currently trained. In addition, it will be started in a number of (disadvantaged) neighbourhoods in Amsterdam as part of the municipal programme 'Move Better'. Other cities and regions are showing an interest as well in starting with the method.

Support: Until now, the participants, Health Care Insurer Agis, and the district council provided the funds for Big!Move. The participants pay a (small) contribution, 60 Euros in total (10 for the intake, 20 for phase 1, and 30 Euros for phase 2). Thus, people pay for phase 3 themselves. This might consist of swimming, for example, to which e.g. the municipality contributes a small subsidy for the rent of the swimming pool, making this a feasible undertaking. Phase 3 can consist of any regular activity on offer or under development in a neighbourhood. Usually, hiking groups are for free, or they have some small fund. Venserpolder has a hiking and training group, the participants of which pay

10 Euros a month as a stimulus, which enables them to engage a trainer of to go on an outing.

Stakeholders involved in the programme are the health care centre and its workers (general and paramedical professionals). In the area, other health care-, social care-, and social organisations are involved, like residential homes, social work, community centre, or housing corporations. These stakeholders are involved with an eye to the goals of the programme. Furthermore, on the local policy and funding level, stakeholders are a health care insurance organisation (Agis), the municipality, and the district council. These stakeholders are involved in order to achieve a broader dissemination of the programme, as well as its structural embedding and funding.



Figure 39: Big !Move

Source: Pfizer, Bart Versteeg

Trigger: Health Centre Venserpolder in Amsterdam started the programme in 2003. It was initiated and developed by a general practitioner and physiotherapist working at the centre. Most inhabitants of the Venserpolder in Amsterdam are socio-economically disadvantaged and/or from migrant groups (mostly Surinamese and Antillean). In city areas where these populations live, more people suffer from more illnesses and diseases and die earlier. The

Venserpolder health care centre services many patients with symptoms and diseases related to an unhealthy lifestyle, such as obesity, cardiovascular diseases, diabetes, or mental disorders.

Targeted Communities: In principle, the programme aims to address all the inhabitants of a city area or neighbourhood, all ages.

Evaluation: Three evaluation studies were carried out, all three with a different character.

The evaluation in 2004 consisted of a qualitative description of the Big!Move programme; of the programme's effects on its participants, professionals, and the organisation; of the organisation itself; of communication and expenses; it also examined the programme's feasibility and transferability (Overgoor & Aalders, 2004).

Results: This study showed that the most important effect is the behavioural change in the participants: of the 100 participants, 84 exercise more than they did before starting with the programme. Eighty-eight percent has become more active in daily life, 69% has independently started to do a sport; 51% has become a member of a community centre or local association.

Hardly any objective indicators could be found during this study to establish a direct, causal relation between the activities of the project, through awareness-raising and behavioural change, and a measurable health gain. For this reason, an evaluation study on the experiences with the project's ongoing processes and programmes on offer in the Venserpolder was conducted.

An evaluation study in 2006 examined the experiences of those involved with the ongoing processes and programmes on offer in the Venserpolder project (Wieringen & Thomas, 2006).

Results: Many (former) participants have kept on exercising, still have more social contacts than before, and/or feel better. For this group of participants, we can consider this to be a very positive result; it is a (generally obese) group of

people, who are hard to get to exercise, among other things because of their bad health, lack of social contacts, and low socio-economic status. However, for a number of Big!Move participants, the programme has not been successful in making them aware of their own options for behavioural change.

Almost all respondents were positive about both the organisation and the content of the programme. The participants have enjoyed taking part, are sorry that the programme has ended for them, will keep on exercising, et cetera. The pleasure in the group and the support of the trainers seem to have been the most important motivators for the participants.

The third study evaluated the dissemination of Big!Move to three locations under the authority of Health Care Insurer Agis (Overgoor, et al, 2007).

There is much interest in Big!Move, both from health organisations and policy makers. Big!Move has been chosen in May 2008 by the Innovation platform, an initiative of the ministry of Healthcare, as one of the ten most groundbreaking projects within the Dutch healthcare system. It has also been referred to in a number of policy-making and professional publications as a good example, e.g. in four of eight essays on prevention in the health care insurance for The Health Care Insurance Board (CVZ) (CVZ, 2007). At last, Big!Move has been nominated for several awards. In November 2006, Big!Move won the Cees Korver Award. This is a regional award for innovative projects within health care.

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Healthy Playground

“Gezonde Playground”

The project ‘Gezonde Playground’ or Healthy Playground (HP) is intended to develop a programme for the development of healthy outdoor sports- and play grounds that stimulate healthy exercise, eat and drink habits, and healthy behaviour, especially directed at the neighbourhoods with high low-income groups and migrant youth.

Aim & Objectives: To develop an effective way to stimulate healthy behaviour that can have a positive effect on the wellbeing of individual as on the neighbourhood.



Figure 40: Healthy Playground

Source: RKF; Geert Cox

Design: A pilot phase has started the 1st of December 2008 and will last till April 2009. In this period the Healthy Playground programme is developed based on literature study, meetings with experts, and questionnaires to experts. Two pilot locations have been chosen: the Krajicek Playground at the Hondiusstraat in The Hague (Valkenboskwartier Segbroek), and the public schoolyard at the Amstelmeerschool in Amsterdam (Nieuwendam, Noord). These two locations will be developed according to the findings on Healthy Playground, and will give input for the further development of the programme.



Figure 41: Healthy Playground

Source: RKF; Geert Cox

Support: Local parties are involved as (primary) schools, kindergartens, the community, etc. On the national level Covenant Overgewicht, NISB (the Netherlands Institute for Sport and Physical Activity) and the Richard Krajicek Foundation (RKF) are involved.

The Covenant Overgewicht instituted by the Ministry of Health, has given the NISB a small budget (€ 17.000) for the first phase. Other costs will be funded by the NISB and RKF. For local implementation of the Healthy Playground in a city, the local government will have to provide funding.

Trigger: The project was initiated by the Richard Krajicek Foundation as part of their programme. The RKF has been developing playgrounds since 1998. The focus of the playgrounds is besides the hardware, very much on the 'software': the people that provide a socially secure surrounding through guidance as sports instructors, schoolteachers, volunteers, youth from the community, etc. The aim of the foundation is to constantly improve the Krajicek Playgrounds concept. One of the targets is that more and other (girls, inactive children) children can be stimulated to be more active on the playgrounds, especially by learning healthy behaviour and habits.

Targeted Communities: The Krajicek Playgrounds are benefiting disadvantaged communities.

Evaluation: The programme is still in its pilot phase, so no evaluation has been carried out yet.

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JUMP-in is a systematically developed primary-school-based intervention that focuses on the use of theory, environmental changes, parental influences and cooperation with multilevel parties in intervention development. Six school-based programme components were set up to promote physical activity.

Aim & Objectives: The programme aims to promote physical activity among primary school children in deprived areas in Amsterdam, and to make them more aware of the influence of nutrition on your body.

Design: The project, which started in 2002, is a joint project involving municipal authorities, local sport services, primary schools and local sport clubs. It focuses on primary school children in Amsterdam, from 4-12 years old. Special attention is given to the children with a low socio-economic status. The parents belong to the target group as well, since their knowledge of the importance of physical activity and the way how they can support their children to improve their fitness is minimal most of the times. Parents are thus actively involved as well, also since they are the first ones responsible for the health of the children.

According to the Norm of Healthy Physical Activity (Kemper, 2000), children up to 18 years old should be physically active at a moderate level of intensity for at least sixty minutes a day, and at least twice a week. These activities should aim to improve the physical fitness and they should focus on power, flexibility and coordination.

With this norm in mind, six school-based programme components (both activities and instruments) were developed, in order to bring all parties together (the school, pupils, teachers, parents, sport clubs, neighbourhoods and the municipal). Each component is separately organized, but together they form the

total programme of the JUMP-in initiative. This is the power of the Project: cooperation between different parties, and a structural implementation of the programme.

The six school-based programme components focus on action points at both personal level and physical and (social) environments (e.g. family members, friends and peers in the classroom), and were designed for permanent use during one school year. These JUMP-in components are:

1. School sports activities
2. A pupil follow-up system
3. The Class Moves!® (in-class exercises)
4. Choose your Card! (lessons aimed at increasing awareness)
5. Parental information services
6. Activity-week

Description of the components of the JUMP-in programme [123]:

1 School sports activities

Easy accessible school exercise activities are offered in or near to the school premises. During school hours children get acquainted with a variety of sports, each sport a number of times in several weeks. Subsequently they can join the club out of school hours. School sport activities are characterized by continuity. As far as possible, use will be made of the normal local range of physical activities and existing sports activities in the area, and the school child care centres in the school. 'School sports activities' is designed to be adopted in the regular school policy, in order that school sport activities will be available all school year long.

2 Pupil follow-up system

The physical education (PE) teacher monitors the pupils once a year, in order to stimulate pupils in a structured way in their development in the areas of sport

and physical activity and in attaining the physical activity recommendation for youth (i.e. at least 60 min of moderate-intensity physical activity on most, preferably all days of the week, including twice weekly activities that aim at increasing or maintaining physical fitness (Kemper et al., 1999). In cases where support or care is required, use is made of the existing school network channels.

3 The Class Moves! ® (De klas beweegt! ®)

This programme offers during normal lessons regular breaks for physical activity, relaxation and posture exercises. The aim is to make physical activity a daily habit, to give the children pleasure, awareness and more self-esteem, and to contribute to a healthy sensor-motor development. The Class Moves consists of calendars; each grade had its own calendar. The calendars contain exercises separated on 10 themes, each for every school month. Teachers need to be trained to use 'the Class Moves!®'

4 Choose your Card!

This is a newly developed card game approach that works with assignments to be done in the class and at home. The method is especially aimed at raising awareness on the importance of physical activity for health and one's own physical activity behaviour, self-efficacy, social support, planning skills, of both the children and their parents. The cards can also be used to prepare an Activity-week and an exhibition. The development of 'Choose Your Card' was supported by a group of experts on the terrain of physical activity determinants and the implementation of health promotion in schools, and the Dutch Heart Foundation. The cards are used to prepare for an Activity-week and are linked to an exhibition.

5 Parental information service

A service in which the importance of physical activity and sports for children and the role played by parents in supporting and stimulating such activity among their children is emphasized. The information can be given in the parents' own

language by specially trained information officers. 'Parental information service' will take place at least once a year.

6 Activity-week

In the Activity-week some components of JUMP-in are brought together. Parents play an important role in this week. Some examples of activities in this week are: a sport and activity exhibition where products of 'Choose your Card' are presented, sports activities and during the week, a warming-up session for parents and children and a sport market where parents and children meet local sport clubs. In this week parental information services will be carried out. 'The Activity-week' will take place once a year.

Every school will set up these sports and activities program individually, based on the composition of the pupils and the need of physical activity.

From 2002 until 2004, the pilot of the JUMP-in project was launched in two parts of Amsterdam (Slotervaart and Amsterdam North) at four different primary schools. At those schools, 36% of the children were obese. The pilot study resulted in an improvement of the school-based programme components and the development of materials to support the introduction of the Project at new schools. JUMP-in is nowadays active in seven different parts of Amsterdam, covering 60 schools in total.

A team of the JUMP-in Project goes to the schools on a yearly basis to report and register data of all pupils of sport, fitness, and weight in proportion to length. This data are put in a database and used for follow up of every child separately, to see which specific component needs extra stimulation. When the data is indicating that the child needs professional support and help, the school will contact the school nurse. The two parties will together decide whether or not to refer the child should be send to the Youth Health Service (JGZ). After discussing the possibilities with the parents, a final decision is made. In case the parents

decide to send their kid to the Service, the outcomes of the consults will be sent to the school and the JUMP-in follow-up database. This results in a feedback system.



Figure 42: JUMP-In

Source: GGD Amsterdam

Posters, folders and other promotion materials are used to inform the parents about the Project. Workshops are organized as well, to show the parents what is expected from their children, what kind of booklets and instructions will be used and given to teach them about the importance of physical activity and the parents will learn about simple assignments they can do together with their children at home.

Within the JUMP-in Project, there are several smaller initiatives that are implemented by external relations. These programmes are offered as a support of JUMP-in. Several examples of such initiatives are:

- **On-site Kids fitness**, by Sport Access; this gives both pupils and teachers the possibility to do fitness in a mobile fitness centre. This centre can be situated at the school for a maximum of two weeks. While doing sports,

they will also learn about healthy and unhealthy food, their heartbeat and the meaning of calories and fats.

- **Course Healthy Food**, by the Amsterdam homecare; this is a course for parents of a child between 4 and 8 years old who is likely to become overweight. During a couple of meetings, parents will get information about nutrition and how to support their child with healthy eating and physical activity.

Support: There are several possibilities for the reimbursements of the costs that are possibly needed for the sport activities organized by the school. Examples of reimbursements that can be used for sport contributions are:

- Pupil reimbursement; this is an agreement by the Service Work and Income (DWI) that parents can request for, if their child is between 4 and 18 years of age and living in Amsterdam. The maximum amount is € 225 a year per child.
- Fund of sports for Youth; the mission of this fund is to offer to as many children as possible (4-18 years old, living in Amsterdam) the possibility to do sports, if they can't – because of financial reasons – become a member of a sport club. Maximum amount is € 225 per child, which will be used for the reimbursement of the membership costs, but it might also be used for the sport cloths that have to be bought. The money is directly put on the account of either the school or the sport club.

Trigger: The immediate cause of the JUMP-in Project was the rising amounts of signals of a decrease in physical activity, inactivity and youth obesity. In 2002, at least a quarter of all children living in Amsterdam were not doing any sports outside school.

Targeted Communities: The inclusion criteria for participation of schools are:

- A trained physical education teacher should be present
- The majority of the pupils should have with low socio-economic status

- A location should be present where school sport activities could be organized in the school or in the vicinity
- It should be possible to create extra time to integrate extra-curricular activities
- Personnel should be willing to commit to the Project.

The aim of the Project – to promote physical activity among primary-school children – applies to *all* children. Thus, also the children that are already sport-minded and are not obese can join the activities. However, there are several conditions:

- When there is a lack of spots, the children that are not doing any sports will have priority to the children that are already physically active on a regular basis.
- The children that are already doing sports can only join an activity when there is not enough interest at the group of non-sporting children.
- Non-sporting children who are not overweight (yet) and don't have any problems in their motoric development, will get priority upon registration.
- The non-sporting children who are overweight and/or show a problem with their motoric development or their socio-economic status, are a risk group and can get via their schools an adjusted program (for example Club Extra or lessons in Motoric Remedial Teaching).
- Obese children with serious physical handicaps will be send to the health services and will get the proper treatment.

The following figure is an example of the composition of a participating school (figure 43).

Evaluation: The effects of the JUMP-in project are currently studied by the Municipal Health Services of Amsterdam, whereby nine intervention schools and ten control schools are involved.

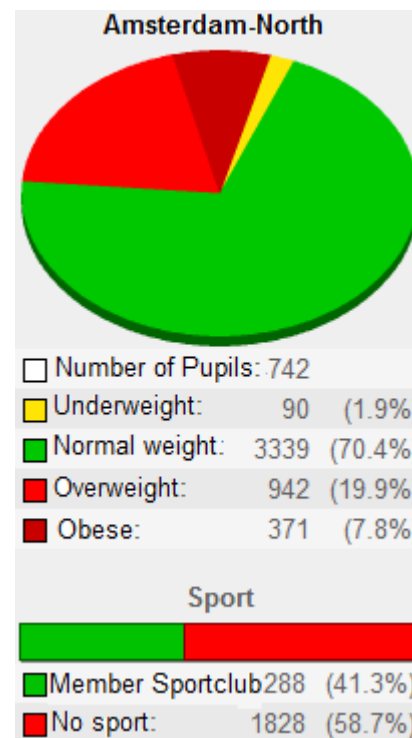


Figure 43: One of the participating schools of the JUMP-IN project.

Source: www.jumpin.nl

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Local Active

“Lokaal Actief” | <http://www.lokaalactief.nl>

Local Active is a working method in which a Local Action Plan Health Enhancing Physical Activity is developed in a city. Special interest is in promoting more intersectoral co-operation.

Aim & Objectives: The project aims to prevent obesity and overweight by promoting local inhabitants of to be (more) physically active and by informing them about the Dutch guidelines of Health Enhancing Physical Activity (NNGB).

Design: An intersectoral working group was built up consisting of: local government, regional public health service, Sport councils and sport club, primary and secondary schools, hospitals, dietician, community health centres, general practitioners, physiotherapists, and companies.

The strength of Local Active is the cooperation between all these parties – working with both regional and local networks. By using this integral approach, joined forces and the input of different experts, successful local projects can be set up. The local government has an important role in agenda setting and taking the initiative to start with the Local Active project.

The ways of working are diverse. This can either consist of:

- Formation of workgroups per target group
- Education of inhabitants through newspapers, radio and internet
- Creation of optimum conditions to exercise and an active lifestyle
- Promotion of existing activities (playgrounds, sport association, etc)
- Create support among organisations and inhabitants
- Organize diverse local events
- If necessary: develop activities.



Figure 44: Local Active

Source: NIGZ

The design of the Local Active project can be split into the following steps:

- 1 Exploration; orientation of the problem (insufficient physical activity), resulting in a project proposal
- 2 Organisations; to design a project structure, to develop, organise and plan the actual approach of the initiative, bring regional and local parties together and eventually develop an action plan.
- 3 Implementation; start with the Local Active project and monitor it.
- 4 Evaluation; evaluate the effect of the project, the organisation and the implementation.
- 5 Anchoring; continue with the project in the city on a regular basis.

Support: For the set up and implementation of Local Active, local already existing budgets are used.

Targeted Communities: The activities are targeting citizens – especially those with a low socio-economic status - who are having an insufficient physical activity and who are obese. The programme can be used for the following groups:

- Youth;
- Adults/employees;
- 50+ / persons with chronic diseases or who are physically impaired.

Evaluation: The project has already turned out to be successful in five cities in Holland (Woerden, Purmerend, Urk, Waddinxveen and Maarssen). These cities all differ from each other when looking at citizen number, physical activity policy, budgeting and cooperation between local and regional organisation.

A process evaluation has been carried out by Kraakman E. (Evaluation of Local Active, Vrije Universiteit Amsterdam Gezondheidswetenschappen. Woerden/Amsterdam 2007). This study concludes that the working method works quite well as the participating local organizations are satisfied with it.

Furthermore, an effect evaluation on Local Active is carried out at the moment (2008-2012).

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60 Minute Kid

Aim & Objectives: The aim of the project is to promote the physical activity health message (60 minutes of moderate daily activity) for primary aged children.

Design: In 2005 it became apparent that pupils in Fife were not aware of, nor understood the physical activity health message in the same way that they understand the 5 a day healthy eating message. It was decided by the Active Schools Manager and the Physical Activity Coordinator to market physical activity and thus devise a marketing tool.

After working with an illustrator and graphic designer, the “60 minute kid” logo was adopted and was used by the 18 Active School coordinators on letterheads, flyers, promotional activity and as a logo on uniform. The logo was introduced over a 6 month period during which time pupils began to recognise it and ask what it was for and if they could meet it. With pupils asking about “60 min kid” frequently it was decided to commission a full size mascot that could visit schools and events to promote physical activity.

The project is ongoing, and new illustrations have been developed, including adult illustrations and now the Active Family Mascots.

Support: The project has been jointly funded between Fife Council, Community Services, Education Services and NHS Fife. These departments were also the main bodies involved in developing and using the marketing tool. The “60 minute kid” programme is jointly coordinated by Education Services, Community Services (fife council) and NHS Fife.

Trigger: The project was triggered by work being developed in the 143 primary schools in Fife by the Active School Coordinators whose main role is to develop

and coordinate programmes to encourage kids to be “more active, more often”. The coordinators looked for assistance in promoting physical activity and wanted something that was eye catching and fun. Thus the “60 minute Kid” was born.



Figure 45: “60 Minute Kid” leading the Dunfermline Gala

Source: Fife Council

Targeted Communities: It is important that pupils in Fife understand the health benefits of being active and know how to achieve these. To this end all pupils are targeted and not just those living in disadvantaged communities.

Evaluation: In 2007 an impact evaluation was commissioned by Scottish Government and Fife council to assess if pupils in Fife knew the physical activity message. The evaluation showed that 68% of pupils in Fife understood the 60 minute a day physical activity message compared to only 42% in control schools out with Fife.

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The SLIMSWIM Programme

The Slimswim programme was originally developed in 1999 as part of a community heart health physical activity initiative in a socially and economically deprived community in Merthyr Tydfil, South Wales. Targeting overweight and obese women 'Slimswim' aims to build on peer support mechanisms linked to a 'safe' ladies only environment and balancing a healthy eating programme with a low impact, low risk physical activity: aqua-aerobics. Slimswim deliberately sets out to counter the 'diet' mentality, by helping people to understand how nutrition works, providing the skills and knowledge to make healthy choices and emphasising the critical role of physical activity both in theory and in practice, by providing an integral activity component.

Aim & Objectives: The aim of the project is to increase the levels of physical activity amongst overweight, obese and/ or sedentary women.

Its objectives are to:

- To provide a 'safe' environment for potentially sensitive clients to undertake physical activity.
- To provide a structured programme of healthy eating advice.
- To provide a safe, supervised programme of aquaerobics.
- To improve individuals perceptions of self image and self esteem.
- To reduce the total amount of body fat in individuals participating in the programme over 10 weekly sessions.
- To reduce the weight of individuals participating in the programme over 10 weekly sessions.
- To improve the fitness of individuals participating in the programme over 10 weekly sessions.

- To provide regular written feedback to all programme participants.
- To encourage long term increases in levels of physical activity.



Figure 46: The SLIMSWIM Programme

Source: The SLIMSWIM Programme

Design: Following a 'pilot' scheme in 1999 subsequent schemes took place during the summers of 2002 - 05 using the pool at a local comprehensive school in Merthyr Tydfil. The programme is delivered as a series of 2hr sessions, the first half of which includes 'Healthy Eating' advice following a structured weekly educational programme covering a range of topics such as 'Food Labelling', 'Cooking Methods', 'What are Carbohydrates/ Fats etc'. This advice is supplemented with written materials. Activities including food diaries, quizzes and taster sessions are also programmed in. A locally trained community worker delivers this part of the programme. The second half of the session is an hour's 'aqua-aerobics' under the guidance of a qualified instructor. The whole process is carried out in a 'ladies only' environment and runs during the summer term time when the school's swimming facilities are available after school hours.

Support: The class is provided free of charge, supported by project funding from the Welsh Assembly Government, local community funding, assistance from the community education service, crèche provision from the Integrated Children's Centre and resource & management support from the local public health team. A 'Tumble Tots' activity crèche with fruit and fruit juice for the children was provided from 2004. Given the education focus of the programme, a voluntary OCN (Open College Network) exercise & nutrition education module was introduced in 2005. 13 participants benefited from this in the first year.

Evaluation: It has become very evident that the benefits of the Slimswim programme extend well beyond the original physiologically focussed parameters that were identified when the programme was initially launched. At an individual level it has shown that self-confidence, self-esteem and self-worth are all appreciably enhanced as evidenced by both the SF36 data and the range of additional activities that the women have taken forward to the extent of formalising themselves into a constituted organisation.

This in turn has had significant community benefits in an area acknowledged as having serious socio-economic disadvantages, there are now an increasing number of locally accessible activities led by people within the community and responding to local need. Through a combination of luck, design, commitment, partnership working and social inclusion the Slimswim programme has evolved from a service led weight management programme into an example of community development in action, using and enhancing social capital.

The evident empowerment that participation has conferred on many of the women has led to them establishing a range of additional activities which the programme does not directly support. These include the formation of a walking group, an aerobics class and a swimming class during the winter months and culminating in the establishment of a formally constituted organisation 'Women in Action' who have continued to develop a range of activities benefiting, not only themselves, but hopefully the wider community.



Figure 47: The SLIMSWIM Programme

Source: The SLIMSWIM Programme

Structural problems with the pool effectively curtailed the Slimswim programme for the last 3 years although the activities established by 'Ladies in Action' have continued to evolve. Its original programme was re-established in 2009 after the pool was re-instated following considerable improvement work.

The Slimswim programme was evaluated on an annual basis providing a wide range of quantitative and qualitative data in locally produced reports. The evaluations indicate a wide range of benefits ranging from physiological and health improvements to wide ranging social impacts.

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4.1 Combined Projects

Austria

In Shape without Dieting

“Schlank ohne Diät”

“In shape without dieting” is a scientifically tested method assessed as effective in sustainable weight reduction on the premises of modifying people’s eating and physical activity behaviour. In the course of the programme participants are given instructions by trained therapists on how to change their eating and physical activity behaviour. They also receive working material (“in shape without dieting”- book and workbook, “in shape without dieting”- calorie manuals 1 and 2) which is used in the courses. A five-month follow-up stage with monthly meetings ensures sustainability of the programme.

Design: In the course of the project “in shape without dieting in Favoriten” a total of 18 “in shape without dieting” courses were held between October 2007 and June 2008, which 15 women and men respectively participated in.

Weekly physical activity programmes are offered alongside the “in shape without dieting” courses: Nordic Walking as well as indoor activities, all of them designed as moderate cardio-vascular training which is easy on the locomotor system, with the option of transferring some of the exercises and motions to everyday life. By popular request from participants the courses were extended beyond the project’s duration and were completed as late as December 2008.

The courses are further complemented by cooking classes where participants get to know new and healthier recipes for use at home.

Experience has shown how important role models are in developing a number of health problems and life-style factors. To address this issue we included gender sensitisation inputs with each course which we created homogenous gender settings for.



Figure 48: in Shape without Dieting

Source: Ein Herz für Wien

Support: The project is funded through the “A Heart for Vienna” programme. Final drafts were prepared by “A Heart for Vienna” in cooperation with university lecturer Dr. Ingrid Kiefer and the health centre for men in Vienna’s 10th district. While the health centre for men is responsible for the implementation, public relations, scientific guidance and assessment are still very much done in

cooperation with the above organisations. A steering group was set up which meets at regular intervals.

Targeted communities: Scientific consultation, course drafts, as well as selection, guidance and training of therapists are effected in cooperation with the working group Nutrition under university lecturer Dr. Ingrid Kiefer. Emphasis is placed on adapting nutrition logs and notes to meet the needs of socially weaker members of society who often have limited access to education.

Course fees were 15 Euro per participant for the first courses. This was considered low enough to keep the courses attractive and affordable for socially weaker persons while at the same time implying a sense of commitment to the course. All “in shape without dieting”-courses and physical activity programmes offer child care facilities which is an added bonus for single parents in particular. The venue of the courses is Vienna’s 10th municipal district, chosen deliberately because it is strongly affected by social disadvantages, making it possible to reach this target group at the roots.

Evaluation: Continuous assessment of the project is provided by the NPO institute at the Vienna University of Economics.

95% of the 264 participants were able to reach their goal and lose weight, a total of 679 kilograms were shed altogether. Each participant lost four kilograms on average, and some lost as many as fifteen kilograms.

Measurements also show a reduction in abdominal girth of between 0.5 and fifteen centimetres. In total participants lost 731 centimetres of abdominal girth which is an average 4.3 centimetres per person.

We are especially pleased to report that almost all participants (90%) lost weight due to fat loss. Moderate weight loss also makes sense in the long run because experience has shown that people are better able to keep their weight this way.

Due to popular demand continuation of the programme has been proposed, project management “A Heart for Vienna” at Health Promotion for Vienna,

however, has not set a date for the re-launch yet. In the meantime the Institute for Men’s and Women’s Health is offering similar courses, with deductibles for participants slightly higher than those for the original courses.



Figure 49: In Shape without Dieting

Source: Ein Herz für Wien

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At your heart's content – Women in Favoriten are living a healthy life

“Nach Herzenslust – Favoritner Frauen leben gesund”

The project “Nach Herzenslust – Favoritner Frauen leben gesund” (At your heart's content – women in Favoriten are living a healthy life) was implemented between September 2005 and August 2007 as a multidisciplinary and intercultural intervention project for health promotion and the prevention of cardiovascular diseases in adult women with their residence in the 10th district of Vienna.

Aim & Objectives: The principal project objective was to provide information and raise awareness on the subject of “cardiac health” amongst women, multipliers, and the general public.

Design: A large-scale sensitising and awareness raising campaign was launched in Vienna's 10th district (with a starting event in a heavily frequented pedestrian area, promotion days on the subject of “Einkaufen nach Herzenslust” (Shopping at your heart's content) mainly in Turkish supermarkets, the preparation and distribution of multi-language, culture-specific information folders, low-threshold telephone and email service, media work and public relations).

To promote women's health, a woman's jogging group and a Nordic walking group were implemented in the Favoriten district, which have been open and free of charge for all women who have been interested in joining in. Women from the target group could furthermore also take part in the three-month cardiac program “Leben nach Herzenslust” (Living at your heart's content) (nutrition and sports course, counselling, cooking workshops). Offers close to home, target group friendly dates, low participation costs, as well as child care options could guarantee access to socially disadvantaged women. In order to

reach migrants, the events were offered also in Turkish and Serbian/Croatian/Bosnian language.

The central element of the project was a continuous on-going evaluation, documenting the expectations, satisfaction, and target achievements of the participants. Therefore it was possible to show necessary changes, and the program could be directly tailored to the requirements of the participants.

In order to ensure a broad basis for the project, an interdisciplinary and multi-professional strategy group accompanied the project. An essential part of the project also was networking and cooperation with those institutions which are relevant for the subject and the district.

At the end of the project, 60,000 multi-language information folders were prepared and distributed, the homepage was used on a regular basis, and continuous media articles on the project ensured a high publicity. The project also included a total of four shopping event weeks, during which multilingual consultants provided the women with information on healthy shopping in central places and in supermarkets. Multipliers were trained and sensitised within the framework of district doctor's meetings, project presentations and cooperation. Networking with institutions that are relevant for the district and the subject took place at regular intervals at several levels and in different settings.

Support: The project was funded by: Fonds Gesundes Österreich, dieSie – Vienna program for women's health and Wiener Gebietskrankenkassa. The project was sponsored by the Favoriten municipal administration, BAWAG, Novartis, and Guidant.

Trigger: According to the Vienna Health Report 2000, women under the age of 75 years in the 10th, 11th and 12th districts have an increased mortality rate due to the high death rate from cardiovascular diseases. Despite awareness raising and information campaigns, both the knowledge about symptoms and risk factors for cardiovascular diseases as well as the exhaustion of the potential of preventive

actions seem to be unsatisfactory. In addition, traditional strategies for health promotion and prevention do hardly reach socially disadvantaged women with a high risk potential for cardiovascular diseases (women with low levels of education and income, migrants, single mothers, unemployed persons...).



Figure 50: At your Heart's Content

Source: Herzenslust

Targeted Communities: The project focused on socially disadvantaged women with a high risk potential for cardiovascular diseases.

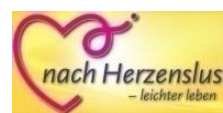
Evaluation: The project was evaluated and showed good results. First of all, the project was able to reach the target group: 10,000 direct contacts with socially disadvantaged women (low household income, predominantly low level of education, 70% without regular employment) with an increased cardiovascular risk (overweight, stress, lack of exercise, unhealthy eating habits) could be made. The jogging and Nordic walking groups enjoyed constantly participation, 253 women could be recruited for the “heart” of the project, the long-term course program “*Leben nach Herzenslust*” (Living at your heart's content). The group of participants was exceedingly multicultural; more than half of the course contacts were made with foreign language speaking women (56%).

As their major objectives participants listed the achievement of healthier eating habits as well as more exercise and sports. These objectives were reached by the major part of the participants in the long term. Average body weight was reduced by 3.1 kg, satisfaction with own exercise and eating habits as well as the self-esteem and the well-being of participants increased significantly. These effects could be proven even after three to six months. In particular, the importance of being in a group and spending time with other women was emphasised time and again.

In summary; the project's women-oriented, target group specific and holistic approach has proved successful, and has managed to prove the often-quoted inaccessibility of the target group wrong. The great interest in health promotion subjects and the high motivation on the part of our participants have been significant, in particular regarding migrants. It is possible to adequately promote health issues for the target group of socially disadvantaged women – albeit subject to certain premises. The experiences gained from the “*Nach Herzenslust*”– *Favoritner Frauen leben gesund*” project has been translated into recommended actions for working with socially disadvantaged women. This policy should and may serve as a basis for similar projects.

At last, demand for the “*Nach Herzenslust*”– *Favoritner Frauen leben gesund*” project has also shown that Vienna has a great need for low-threshold exercise and group offers that are tailored to the target group of socially disadvantaged women. These women are aware and interested in health issues – now it is up to the stakeholders to offer support and to allow for long-term changes in their lifestyles.

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England

Tower Hamlets Healthy Borough Programme

<http://www.onetowerhamlets.net>

Aim & Objectives: The aim of the project is to transform Tower Hamlets into a place that promotes and supports health and well being and makes it easier for children, families and the wider community to be more physically active, eat well and maintain a healthy weight throughout their lives.

Design: The multi agency Healthy Borough Programme (HBP) started in December 2008 as one of 9 'Healthy Towns' in England charged with testing and evaluating new ways of tackling the social and environmental causes of obesity.

The HBP takes a whole systems approach to tackling the environmental causes of obesity through three overarching themes - healthy environments, healthy organisations and healthy communities – which are crossed by three strands: active travel, active lives and healthy food.



Figure 51: Whole systems approach of the HBP through 3 overarching themes which are crossed by three strands

Source: HBP



Figure 52: Tower Hamlets Healthy Borough Programme

Source: HBP

'Healthy Environments' includes:

- New planning initiatives, e.g. on 'green grid' and fast food outlets
- Active Travel Routes – new and improved walking and cycling routes
- Active Lives – promoting physical activity in parks and open spaces, active play and access to swimming for women and girls
- Healthy Food Outlets – e.g. a pilot awards scheme for restaurants

'Healthy Organisations' is about creating organisational environments which promote healthy food, physical activity and active travel in three settings: early years, schools and colleges and workplaces.

'Healthy Communities' includes opportunities for third sector organisations and local people to put forward their solutions. We are doing this through a community grant schemes, active travel projects for different communities, parenting initiatives and social marketing and communications.



Figure 53: Tower Hamlets Healthy Borough Programme

Source: HBP

Support: The project received £4.68 million new national funding from December 2008 up to April 2011. Similar level match funding in cash and kind locally, including £2.5 million cash match funding from NHS Tower Hamlets.

Partners of the project are: NHS Tower Hamlets, the local authority, voluntary and community organisations, private sector and local people.

Trigger: In 2008, the Public Health Directorate of NHS Tower Hamlets facilitated the completion of a multi agency obesity strategy, Healthy Weight, Healthy Lives in Tower Hamlets. This set out the challenge of rising rates of child and adult obesity in Tower Hamlets and the need to re-orientate commissioning and partnership working in line with the Foresight report (Tackling Obesity: Future Choices, 2007). A multi agency conference in March 2008 got all partners involved in shaping the vision and identifying priorities for action.

The HBP started in December 2008 following a successful bid to the Healthy Community Challenge Fund administered by the Cross Government Obesity Unit.

Targeted Communities: The project targets children and families in Tower Hamlets, particularly Bangladeshi children and families (as 60% of children and young people in Tower Hamlets are from the Bangladeshi community), Somali children and families (who have the highest prevalence of obesity but relatively small numbers) and children and families from low income groups in all communities. All adults (including those without children) also benefit through healthy workplace initiatives.

We target the most disadvantaged communities through outreach and capacity building local grass roots interventions ('community led projects') as well as geographical targeting of services to most built up and deprived areas, e.g. social housing estates.

More people will be physically active and eat more healthily because of:

- The HBP reached communities at greatest risk of poor health outcomes
- Observable changes in environment
- Improved access to physical activity, e.g. women only swimming
- More organisations (workplaces, schools, early years settings) promoting physical activity, healthy food and active travel
- Local communities & community and voluntary organisations delivering 'bottom up' solutions
- Greater knowledge and skills and healthier behaviours



Figure 54: Tower Hamlets Healthy Borough Programme

Source: HBP

Evaluation: Different evaluations are in progress – initial results are expected in July 2010 and final results in July 2011, including: equity audit, focus groups with diverse communities, evaluation of strategic and cultural impact of HB, community led projects, and active travel including interventions on housing estates.

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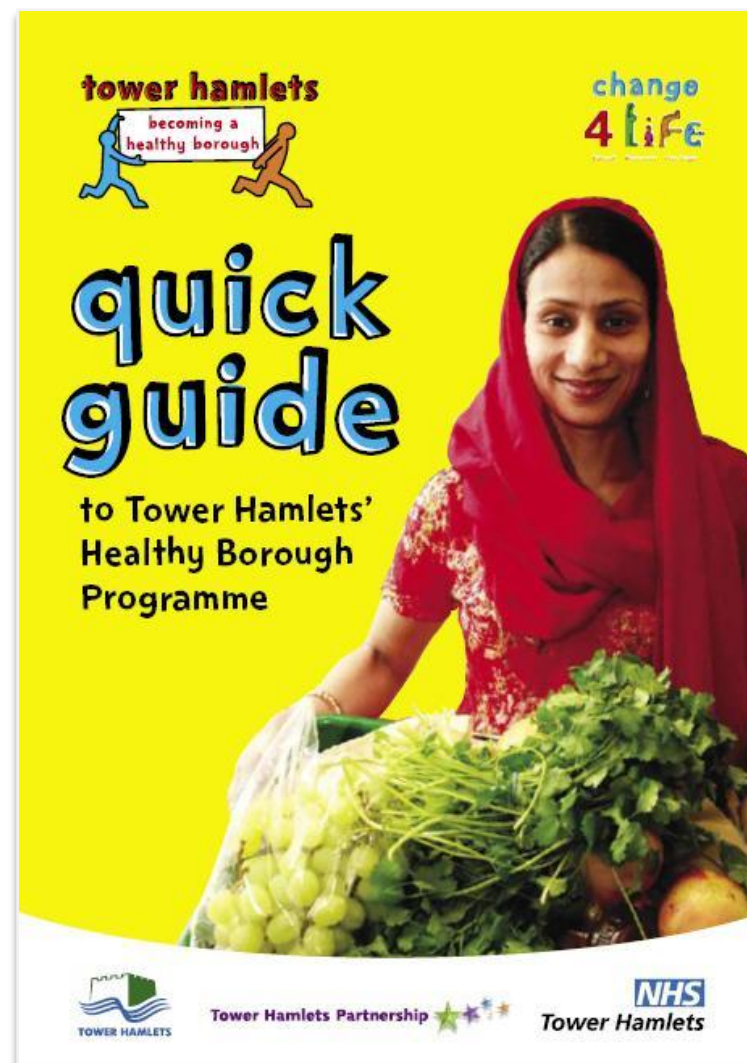


Figure 55: Quick guide to Tower Hamlets Healthy Borough Programme

Source: HBP

Healthy Weight for London's Children

City & Hackney have among the highest rates of childhood overweight in London – and so will be one of the first areas to run a new series of training events across London, targeting healthy weight in children.

Aim & Objectives: The aim is that participants will be able to take the information and skills gained at the session back to their workplace and so promote healthy weight in children in the course of their daily activities.

Design: The training days – to be run in November 2009 - will teach City & Hackney participants how to raise the issue of healthy weight with children and their families. They will include information about obesity, nutrition and physical activity, and advise how to best help children and their parents to access local help and services.

Support: The training, which has been commissioned by the Department of Health in England, will be run by the *London Teaching Public Health Network*: <http://www.ltphn.org.uk> in conjunction with City & Hackney PCT and is supported by the National Healthy Living Alliance

Trigger: City & Hackney have among the highest rates of childhood overweight in London.

Targeted Communities: Rather than being exclusively for health professionals, participants will be welcomed from a diversity of backgrounds: from practice nurses and school staff to voluntary sector staff to local sports coaches.

The only things participants will have in common are that they have regular contact with children and their families, and are keen to help maintain and improve children's health.

We recognise that it is not only health professionals who are able to influence the health of children and families – other workers from public, private and voluntary sectors also have important roles to play⁴.

Evaluation: The project is not evaluated yet, as it has just started.

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⁴ As part of the government's Healthy Weight, Healthy Lives strategy (published January 2008), one of the themes, 'Building Local Capabilities' aims to "ensure that all those working at a local level – both health and non-health professionals – are aware of their role in promoting the benefits of a healthy weight".

Get the Balance Right: Energy In/Energy Out Campaign

This campaign aims to make persons aware that it's not just food and not just physical activity but both which is required to maintain an energy balance. Posters, leaflets and other campaign materials were used to raise awareness.

Aim & Objectives: The campaign aims to raise awareness of overweight and obesity through promoting a healthy balance in nutrition and physical activity. In order to do so, campaign material was developed to show balance of energy in/energy out, and the importance of balance with food eaten and energy expended was demonstrated.

Design: The campaign was launched with a road show on 19th of January 2008 in South Sefton and 26th January 2008 in North Sefton. The road show stopped at strategic points and information was distributed by Food & Health Workers. The road show on 26th also incorporated a food demonstration by a local North West chef, Brian Mellor.

From these dates on, the campaign was advertised on mobile Ad vans, bus stop adshells and taxis as well as distributing posters and leaflets to relevant partner agencies. The adshells were displayed on vans just for 3 days to promote the campaign, on the adshells for 2 months (January and February 2008), and on the taxis for one year from (January 2008 – January 2009). The posters and leaflets were distributed to GP practices, community centres, community pharmacies, workplaces and some secondary schools. The campaign was heavily promoted for the first 4 weeks and then continued through use of posters and leaflets which are still being given out. Prior to launch, there was a focus group testing all the materials.

Five graphics have been developed to demonstrate how much energy needs to be expended after eating an item of food e.g. if eaten a medium sausage roll need to brisk 30 minute walk with a dog.

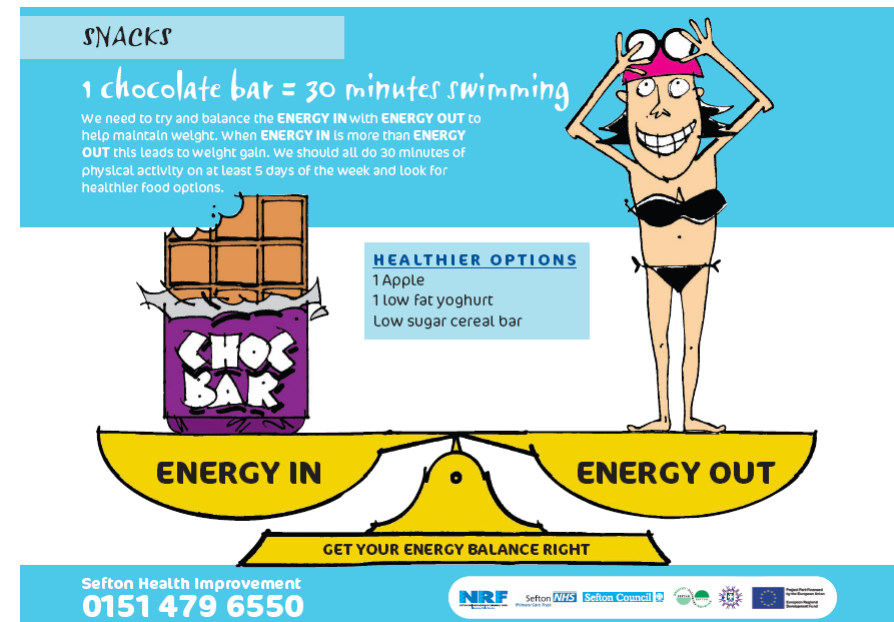


Figure 56: Get the Balance Right: Energy In/Energy Out

Source: NHS Sefton

Linked into the 'Get the Balance Right' is the Sefton Pedometer Challenge which was launched w/c 4th February 08. The Sefton wide programme offers a free pedometer and information up to 500 participants. Participants were given an induction and information before given a pedometer.

Support: The campaign was funded through Neighbourhood Renewal Funding (NRF) funding. Furthermore, there is a local public health food partnership with Sefton PCT, local authority and community and voluntary organisations.

Trigger: The campaign was initiated by Sefton PCT in response to helping to tackle obesity agenda and making people aware of energy balance concept.

Targeted Communities: During the campaign, it was made sure that the bus stop adshells and taxis displaying the images were in our low socio-economic areas and also in these areas car ownership rates are low so taxis and buses are used by groups in these areas. The posters were also displayed in locations within these areas.

Evaluation: An evaluation was conducted by Sefton Primary Care Trust (PCT). 400 face-to-face interviews were carried out in local shopping centres, and 50 interviews in each of the sampling points apart from the more densely populated towns of Southport and Bootle, where 75 interviews were carried out.

In short; one in three respondents had seen, hear of read information about nutrition and physical activity recently. Furthermore, the TV, local radio and leaflets at supermarkets were the most frequently named places respondents had come across the information.

Half of the respondents stated that the campaign they had seen was promoting healthier options. But just under half stated that they had passed the information they had received on, or discussed it with other people. And one in eight respondents had seen the specific promotional material before the interview.

One in three respondents normally accessed health information from their GP or health centre. Magazines, word of mouth, the internet and TV were other frequently given responses. Two in five of those who had seen the campaign before stated that it had made no difference to their eating and drinking behaviour. However one in five stated that it had made them change their

consumption of foods and drinks with high calorie content. One in two stated that it had at least made them think about what the food and drink they consume. Three in five of those who hadn't seen the campaign before felt it was unlikely that what they had seen would change their eating or drinking behaviour. However one in six felt that what they had seen would change their consumption of food and drink with high calorie.

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Highfield Healthy Lifestyle CIC

<http://www.healthylifestyle.ik.com>

This health centre delivers Open College Network accredited courses at level one and level two in disadvantaged communities across Bradford. Subject areas include diet, nutrition and exercise.

Aim & Objectives: This project aims to reduce health inequalities in the area of Bradford, contribute to a better standard of living by promoting healthier living through increased awareness, and provide beneficial activities which are fun and popular.

Design: Highfield Healthy Lifestyle was established in 2001 as a Healthy Living Centre funded through the New Opportunities Fund (the Big Lottery). The programme initially for 5 years was set up to reduce health inequalities in Holme Wood and Bierley, Bradford, both areas in the top 10% of the Governments Index of Deprivation (2001). From 2008 on the organisation changed the status to a Community Interest Company, Limited by Guarantee.

Seven years of development have enabled the centre to build on levels of expertise and also to build strong links within the communities of South Bradford and beyond. The challenges are to development these links further to residents who cannot access our service e.g. people at work.

There is a core staff team of 6, with sessional workers giving added support. There are also volunteers attached to projects who give support to the core team. The core staff team each have responsibility for specific areas of work, whilst also multi tasking to provide a seamless service across all the projects.

In 2006, Healthy Lifestyle started running accredited courses. Prior to that the offered courses were not accredited and thus there was a development

opportunity through this. The accredited courses have now developed up to level two.

The courses are interactive and fun; some are family learning and also involve the young children participating with their parents. The people living in the communities where the work is delivered often have poor educational attainment levels and poor basic skills. Getting these people into education as ‘adults’ can be difficult, because of negative experiences they have had in the past. The courses are overcoming barriers to education, whilst addressing the need to educate people to improve their health and attitude to diet and nutrition. Many learners enjoy the courses so much that they ask to go onto the further courses.

As well as the obvious benefits around education the learners/residents about diet and nutrition, leading to a healthier lifestyle, there is also the added bonus of improving the confidence and self esteem of those taking part. This can have far reaching consequences and for some learners it has involved them returning to employment and further education.

Support: Healthy Lifestyle centre is funded until 2011 to run a range of projects for the Primary Care Trust. Furthermore, Family Learning, Education Bradford funds the project to deliver accredited and non accredited courses in primary schools across the Bradford District. The centre receives funding from the Football Foundation to work with primary school children and their families to reduce obesity and promote sport, and the Older People’s Wellbeing Fund are funding a Wellbeing Café and support group for the visually impaired. At last, the centre also takes on a range of freelance work throughout the year by request.

The partners of Healthy Lifestyle include the P.C.T., Family Learning “ Education Bradford, National and Regional Healthy Living Centre Alliances, South Bradford Sports Alliance, Holme Wood Community Council and all community groups working within the South Bradford Area. These partnerships are developed through regular attendance at meetings. The centre contributes to

the partnerships through an involvement in decision making processes and posts on various boards.

Trigger: As a Healthy Living Centre which started in 2001 funded through the New Opportunities Fund, the need through consultation with residents and other statutory/non statutory partners was identified to improve the diet of the community where we were working.

Targeted Communities: The majority of the work is in the Bierley and Holme Wood areas of Bradford - two areas of high deprivation.

However, through some of the work there was a mixture of socio – economic communities and this has worked very well in breaking down barriers. One example was the running of a level 1 course in a predominately white British area of Bradford and another course in a predominately south Asian community in another area of Bradford. A level 2 course was put on and brought members of both these groups together for the numbers required to run the course. The groups started off working separately, however by the end of the 12 weeks they were working closely together, totally mixed and sharing recipes and confidences.

Evaluation: Other than the weekly session plans and end of course short evaluations, there are no further evaluations.

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Community Pharmacy Structured Weight Management Programme

This service is a structured patient centred programme based on delivering brief interventions and using motivational interviewing techniques to bring about behaviour change by setting achievable goals over a 12 month period and following up on maintenance up to 24 months (based on NICE guidelines).

Aim & Objectives: The aim of the project is to reduce obesity levels in people over the age of 18 years who have a BMI greater than 25 but less than 40 - or whose waist circumference puts them at risk of developing long term conditions. It is also intended to increase access to and choices of weight management services, as well as identifying those who may be at risk but who are not registered on GP registers. Overall the service is aimed at improving quality of life and longevity of life.

Design: This community pharmacy service is an integrated part of the overall PCT weight management care pathway and another intention is to promote increased partnership working between GPs, community pharmacists and other healthcare professionals for public benefit.

Furthermore, a patient survey indicated that people wanted to be able to access weight management services which were local, provided flexibility, were medically endorsed and free of charge. So the pharmacy service was a good fit.

This programme will initially be delivered by community pharmacists though trained technicians who can assess the “readiness to change” of clients before they are enrolled into the programme. Accredited training underpins the service including knowledge of obesity and behaviour change skills.

Over the 12 month programme clients’ BMI, waist measurement and blood pressure are taken at varying intervals. At different sessions, different aspects of healthy lifestyle improvement are focused upon e.g. diet, nutrition, physical

exercise, etc. Referral protocols to GPs are in place as well as signposting clients to other services which may be helpful within their locality e.g. fitness clubs, local walks, cooking classes, etc.

A previous pharmacy pilot service had been successfully evaluated in Coventry PCT but this service also included cholesterol testing and diabetes testing. The GPs consulted in the development of the Central Lancashire PCT service did not want to include these tests so it was agreed that the focus would be on behaviour change as the first tier of service. It was important to get multi - professional agreement. Future tiers of service may include pharmacological support via patient group direction (PGD). This weight management service can also be easily integrated into the forthcoming government vascular screening programme.

A pilot project in 12 community pharmacies began in September 08 and was developed as the result of a partnership approach between Central Lancashire Local Pharmaceutical Committee (LPC) and the PCT. Service development was underpinned by a Leadership Programme and the PCT team consisted of a range of personnel from various professional backgrounds e.g. GP, pharmacists, public health, dietician, commissioning, finance. Two community pharmacists were also involved.

Support: PCT funding came from savings made by effective medicines management services. Based on successful evaluation, funding is available to roll out to another 12 pharmacies targeted at areas of health inequality. The service is now written in to the PCT strategic commissioning plan as part of CVD primary prevention and hopefully the service will eventually be rolled out to all pharmacies within the PCT.

Trigger: Data estimated that in Central Lancashire PCT there were 85,000 people with a BMI over or equal to 30. That meant that potentially around 53,000 people who are 16 years and over and who have a BMI greater than 30 are not registered as obese on any GP practice register. Life expectancy in males and females in Lancashire is significantly worse than average in England. The trigger

for this project came from community pharmacists who were aware of national, regional and local government targets and who recognised that obesity is the second most preventable cause of death, after smoking.

Targeted Communities: Community Pharmacy is often considered a more informal venue than GP practices and there is evidence that it can attract people who would not normally visit traditional primary care e.g. men. As pharmacies are situated in all localities (including areas of health inequality) where people live and work – and as they are often open for extended hours, they can also be easier to access for example, by working people who do not want to take time off work.

Evaluation: Robust evaluation of the service is planned in conjunction with local Institutes of Higher Education using validated tools including patient surveys. Public health data will be collated for all people assessed for “readiness to change” including those registering on to the programme so a better understanding will be gained of which people are registered on to the service. The intention is also to link with SHA/PCT social marketing campaigns to target specific communities.

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Fit 4 Life - Rushmoor Healthy Living

<http://www.rhl.uk.com>

Aim & Objectives: The project aims to improve the participants self esteem and show them how they can change their lifestyle to improve their weight, health and ability to improve their educational results

Design: In response to the growing concern surrounding obesity rates, Fit 4 Life works primarily with disadvantaged overweight/ obese teenagers who have low self-esteem and poor self-confidence. It supports them to make positive lifestyle changes and encourages them to adopt a healthy lifestyle which they will then take on to adulthood.

The project commenced in April 2008, following a successful pilot from January to July 2007 in one school. Fit 4 Life is delivered in three phases, each taking place over the period of a school term:

STAGE 1 “Recruitment”: This phase focuses on recruiting participants on the scheme. As there can only be a limited number of participants, it is vital that we target the young people who will benefit most from the project. This will be a key consideration for personal trainers when reviewing the referrals received and deciding who to accept. The selected participants will have a 1:1 interview with the trainer, the main component being a ‘get to know you’ questionnaire. The final stage of the recruitment phase is a fitness test, whereby statistical data (e.g. height, weight, BMI, etc.) are being measured

STAGE 2 “Core”: This stage incorporates a number of various session based challenges in the gym, fun team based games and activities in the school hall/field, nutritional advice, quizzes and holiday challenges to complete when the school is on holiday. The trainers also organize a breakfast club half-way through the scheme, and just before the end. This involves the children arriving an hour before school begins, participating in a 20 minute gym session, followed by stretches and a healthy breakfast of their choice. A selection of cereals,

yoghurts, fruit juices and fresh fruit for smoothies are provided. This allows the children to experiment with new flavours and provides ideas for how they can eat breakfast at home.

STAGE 3 “Reduced”: This is the exit strategy. The participants are offered a similar level of support to the core phase throughout the contact period. By offering a core and then reduced level of support, the new project aims to help prepare the children for their exit from the project. As per the pilot, each child will also be supported in looking at ways to carry on their new healthy lifestyle themselves – for example by encouraging them to join after or out of school sports clubs. Where necessary the activity fund will be available to help those who are unable to afford equipment or clothing needed for a specific sport.

Support: Funding was provided by Pfizer (main source), Big Lottery Community Fund, NE Hants School Sports Partnership and a County Councillor grant. This enabled RHL to commence the project in April 2008, delivering it in three schools.

The partners involved in delivering the project are: the three participating schools (Wavell, Connaught and Samuel Cody), the School Sports Partnership and RHL.

Trigger: The concept was thought of by an RHL staff member and then, about a year later, a conversation between RHL and the Schools Partnership triggered a formal project proposal. It is an entirely new concept, but based upon data linking health to educational achievement. This can only be brought about by one to one support.

Targeted Communities: The project can target any area, but schools within disadvantaged communities contain a higher number of young people with unhealthy lifestyles resulting in obesity. Also, they achieve lower exam pass grades and they suffer higher pupil absence rates.

RHL does work hard to address health inequalities and it targets services to these regions. However, in general RHL addresses health issues in all geographical areas.

Evaluation: Fit 4 Life was initially piloted at the Wavell School between January and July 2007. Follow-up evaluation relating to the pilot’s participants took place in February 2008 in order to assess the longer-term impacts of the pilot programme. Further to the success of the pilot it was decided to roll-out the project to three schools commencing January 2008. An interim evaluation report was published containing the initial results from the roll-out in September 2008.

During the last evaluation various forms of data was collected. Primary assessment looked at whether there were beneficial physical changes for those who participated in the project. Additional assessment evaluated whether factors such as attendance, behaviour and confidence levels had improved over the length of the project. At last, observation notes from teachers and trainers were used to evaluate the project’s success.

In short, the report at the conclusion of the project found that:

- Pupils lost weight and/or reduced their waist measurement over the time of the course;
- Attendance levels at school improved;
- Behaviour in class improved;
- The combination of better attendance and behaviour enabled better than expected educational achievement;
- Overall personal wellbeing improved, positively impacting upon self esteem;
- Fitness levels increased;
- Where parents became involved in the course, they expressed pleasure with their child’s achievement, which not only enhanced the bond but enabled the child to sustain their progress post course completion.

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HEAL Project (Healthy Eating Active Lifestyle Project)

The HEAL project (Healthy Eating Active Lifestyle) is funded for three years through the Reaching Communities strand of the Big Lottery Fund. The project is aimed at residents of South West Burnley and the ward areas covered fall into the top 10% most deprived, on the indices of multiple deprivation.

Aim & Objectives: The project aims to address health inequalities in South West Burnley by supporting residents to make lifestyle changes to improve their own health, by providing a range of “healthy eating, active lifestyle” activities targeted at people who live in health deprived areas or come from disadvantaged groups covering the ward areas of Trinity, Rosegrove with Lowerhouse and Coalclough with Deerplay.

Design: The HEAL project is a new concept which was initiated by the Chief Officer of the Enterprise Centre. The project runs from the Enterprise Centre building, which is a diverse community facility, offering many services including a fully equipped UK online IT suite and a large catering kitchen. The HEAL project enhances these existing services and serves to attract more local residents to the centre.

The project was chosen as health inequalities are a serious issue within South West Burnley alongside high levels of social isolation, unemployment and high numbers of incapacity benefit claimants. The HEAL project aims to empower residents to improve their lifestyle so they can enjoy improved health, reduced social isolation and increased feelings of self esteem and confidence. The HEAL project also provides free accredited courses, including qualifications in food safety. The aim being is to up-skill local residents to enhance their employability.

The community benefits greatly from the project as they are being offered a wide variety of physical activity sessions, practical cook and eat sessions and accredited courses, which are all free of charge and which have free crèche provision. The activities are delivered at the Enterprise Centre which is a local and accessible facility and courses have also been delivered off site at venues such as local children’s centres to ensure the whole community has access to the services offered. On an individual basis we have seen increased self confidence and self esteem, reduced levels of social isolation and increased skills and knowledge relating to healthy eating, cooking healthy food from scratch and cooking on a budget. We have also supported many local residents in achieving qualifications, including food safety and nutrition and health awareness. The project offers a number of outings each year to venues that include organic growing projects, farms and other attractions that tie in with the health theme. The outings are free to local residents and free transport is provided. Residents are also supported and encouraged to try different activities on offer at other venues in the local area. The health access worker accompanies groups to other activities and free transport is provided with this service.

Support: Big Lottery funding was allocated in November 2007 following successful submission of the funding bid.

The HEAL project is delivered in partnership with a large number of organisations and agencies, these include; Freshfields, Greenspace, Homestart, East Lancashire Primary Care Trust (in particular Howard Street Community Health Centre and the Health Trainer initiative), Age Concern, Burnley Borough Council Healthy Lifestyles Team, Burnley Youth Intervention Programme, Burnley Borough Council Neighbourhood Management, Burnley Food Forum and a number of local residents groups.

Trigger: The need for the project was evidenced through the results of questionnaires, which were distributed to the local community. The responses to the questionnaires identified that residents felt the HEAL project would

provide much needed local and accessible services and support that would help them to achieve positive improvements in their health and lifestyle.

Targeted Communities: The HEAL project effectively targets the most disadvantaged areas as the Enterprise Centre is located in the heart of these communities. Trust is a huge hurdle when it comes to getting people to ‘step through the door’. As the Centre is a local facility, already well known and used by many residents, the barriers of the “unknown” are already removed and word of mouth between local residents is one of the most effective tools in engaging people with the project.

Whilst the HEAL project is aimed primarily at the disadvantaged and health deprived areas of South West Burnley, geographically the boundaries of the project also cover areas where residents enjoy higher socio-economic status. We do not turn anyone away from the activities offered on the grounds that they do not live in a disadvantaged or deprived location. As poor health issues are not exclusive to deprived communities and healthy living is something which practically the whole nation needs to address it is not considered that the project could serve to “widen the gap” between socio-economic groups.

Evaluation: Monitoring and evaluation of the HEAL project is ongoing and a formal evaluation of the project, from conception to completion, will be carried out in the months prior to the end of the project.

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Healthy Living Clinic

The Healthy Living Clinic is a free drop in clinic in Whitehaven, one of the most deprived wards in Cumbria. It operates on a weekly basis where a qualified practice nurse provides blood pressure, cholesterol, blood sugar monitoring and height/weight assessment for indications of obesity.

Aim & Objectives: The aim is to provide support, information and advice to people on a Drop In basis. To enable individuals to make informed choices about their own health and well being to reduce social exclusion and health inequalities through the provision of a free service which also encourages social integration.

Design: The Senhouse Centre ‘A Place for Healthy Living’ opened in 2000. The purpose of the centre was to empower the whole community to improve their health through the provision of a large range of services aimed at helping the local community to make positive choices about health and well being and promote healthy living in the community. This holistic approach to health has been achieved by the use of the centre by a variety of therapists, counsellors and community groups using the facilities that supply a range of treatments and services.

When North Cumbria was designated as one of the first Health Action Zones in the country due to the average death from early heart disease and stroke being a major problem, funding was made available for projects that would have a direct impact on reducing death from these causes and in tackling obesity in the community which is on the increase and a major contributor to early death. The Whitehaven Community Trust set up a working group to create a service at the Senhouse Centre that could provide assistance to the community to achieve the governments health objectives.

The Healthy Living Clinic commenced in September 2001 and is a free drop in clinic that has operated on a weekly basis where a qualified practice nurse provides blood pressure, cholesterol, blood sugar monitoring, and height/weight assessment for indications of obesity. Advice is provided on healthy eating and exercise and a wide range of leaflets and information is available. The practice nurse will refer the client to their GP or another agency if the health screening identifies anything that requires further investigation.

The Healthy Lifestyle Clinic is based in a central location easy to pop into when doing other business in town. The clinic offers an informal non medical setting where appointments are not necessary and time is available to discuss problems. The clinic has been well used since its inception providing a free service that is much needed in an area of deprivation.

Support: The Healthy Lifestyle Clinic commenced in September 2001 through funding from New Opportunities, a further three years funding was granted on the basis of the success of the project from the Northern Rock Foundation.

Trigger: The Borough of Copeland is in the most deprived local authority list, unemployment is high and the area faces an uncertain economic future. Case studies and statistics show the effectiveness of 'The Healthy Life Style Clinic' in early detection of problems such as cholesterol, blood pressure, diabetes and heart problems from the subsequent referrals to GP's. The literature and advice given at the clinic aims to promote good health and wellbeing among all local people, often resulting in users linking up to other services within the centre such as smoking cessation, menopause workshops and counselling which meets the aims of the project to empower local people to take responsibility for their own health and wellbeing and to reduce social exclusion and health inequalities through the provision of a free service which also encourages social integration.

Targeted Communities: The clinic provides a service to anyone who attends the clinic however we promote and target the service in the areas of most deprivation through local groups and other organisations working in the areas of

deprivation. We ask all service users to provide us with a postcode on the register so that we can analyse the areas that our clients live to ensure that the service is meeting the needs of the deprived communities in the area.

Evaluation: The project has been carefully monitored throughout, on uptake and client profile and continues to be well used with the attendance figures for 2009, in the first 10 months, seeing 428 clients attending the clinic and could well exceed 500 by the end of the year. A comprehensive review is undertaken as the period comes to end on the monitoring data and through undertaking case studies on clients who attended with the outcomes both of which indicate that the project is successful in meeting a community need.

The health of the people in Copeland has improved since the project was set up but is still generally worse than the England average with death from early heart disease and stroke being a major problem (Copeland Health Profile-The Association of Public Health Observatories 2008). There are health inequalities by gender and level of deprivation, with both men and women from the most deprived area having a nearly seven year shorter life span than those from the least deprived areas ((Copeland Health Profile-The Association of Public Health Observatories 2008).

As there has been a move towards better health in the area and our clinic has been successful in providing a service that identifies the major causes of early death from heart disease and stroke, the Trust feels that the evidence gathered shows the effectiveness of the service in contributing to the improvement of the health of the community in which it serves.

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The Chai Centre

<http://www.eastlancspct.nhs.uk/patients/services/chai-centre>

The Chai Centre is a new initiative that has proved a massive success with the community. By providing several services, it aims to improve health and quality of life and to reduce health inequalities.

Aim & Objectives: The Centre aims to improve the health and quality of life of individuals and communities in Daneshouse & Stoneyholme, and reduce health inequalities, this area being amongst the most deprived wards in the country.

Design: The project is a community-led initiative that started in 2004. It was a new initiative that has proved a massive success with the community. The Chai Centre is a combined Sure Start Children's Centre and Healthy Living Centre, located in the Daneshouse and Stoneyholme area of Burnley.

Services include:

- Children's Centre services, including group sessions and family support
- Café Culture (open to the public)
- Gym (membership open to the public)
- Exercise classes
- Sauna and Steam Room
- Little Acorns Day Nursery
- Ante-natal care (by appointment)
- North Health Visiting Team
- Women's health clinic (by appointment)
- Complementary therapies (by appointment)
- Welfare Rights advice (by appointment)
- Smoking Cessation (by appointment)
- Opportunities for volunteering

- Soups and Salads project (healthy eating and cooking skills, by appointment)

Benefits to the community include:

- A healthy living/well-being centre that offers comprehensive services run by staff based on site or other services hosted by the centre that tackle the wider determinants of health
- Volunteering and employment opportunities
- A neutral venue for all sections of the community

Benefits to individuals include improvements in:

- Employment and job opportunities
- Parenting skills
- Health of children
- Access to services
- Fitness levels
- Healthy eating and cooking skills
- Social networks
- Mental well-being and stress management
- Physical health indicators such as weight management and blood pressure

Support: The Daneshouse Economic Development Trust - DCEDT (a community organisation) came up with the idea and approached East Lancashire NHS (then Burnley, Pendle and Rossendale Primary Care Trust) who agreed to work in partnership and became the accountable body. Other agencies involved included; New Opportunities Fund (Big Lottery Fund); Bradford & Northern Housing; Daneshouse & Stoneyholme Sure Start & Burnley Borough Council.

The financial support initially came from Burnley Borough Council and Bradford & Northern Housing then proceeded with funding from the Big Lottery Fund – Healthy Living Centre Initiatives and East Lancashire NHS. The project has now

come to the end of its Big Lottery Funding and has recently been mainstreamed by East Lancashire NHS.

Trigger: As above, the idea for the centre was community led and thought up by the community organisation (DCEDT) who identified the opportunity while considering the needs of the local community that were not being met.

The community consultation supported the identified need and was linked to the evidence base through various statistics such as census and public health data which clearly portrayed the poor health of the residents in the ward.

The project was chosen because it was innovative and able to target those communities most in need by delivering healthy living and well-being services on resident's door steps.

Targeted Communities: Anyone interested in using the centre or accessing our services is welcome; however, we specifically target residents living in our ward.

Evaluation: An end of funding Big Lottery evaluation was performed which described the success of the Chai Centre. In the future, the café will continue to offer its services and the gym and physical activity facilities are expanding to allow more people to access those. A wider variety of activities will be provided within the expanded facilities to include weekend activities in an attempt to target more family units to access the centre together.

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Irish Healthy Living Project

<http://www.irishcentre.org>

This project was an initiative of the London Irish Centre to increase the health of the older and disadvantaged Irish Communities living in London.

Aim & Objectives: The Irish Healthy Living project was set up to increase the health and health awareness of the older and disadvantaged Irish Community in London.

Design: The project was initiated by the London Irish Centre in 2003. It is based in the London Irish Centre, which is the largest Irish Centre in London and has been in existence for 54 years. This location was chosen since the London Irish Centre has a good reputation among the Irish community.

The Initiative provides a range of services that aim to improve from physical and mental health, through engaging clients in activities which they enjoy, e.g. allotment project and providing a safe and supportive environment e.g. literacy and numeracy project.. Other activities include: advice, volunteering, missing persons, survivors service, day centre activities and lunch club.

Support: The Centre received a five years funding from the BIG Lottery fund (i.e. the National Lottery). Furthermore, Camden Primary Care Crust is providing interim funding.

Partners of the Irish Healthy Living Project are the Irish Centre Housing (ICH), Kasiros, ICAP, High & Dry social club, and Job Powerhouse.

Trigger: Several reports found that the Irish in England have a shorter life expectancy in the host country and access medical services to a lesser degree than the host population. As a general rule migrants live longer in the new host country – this is not so in the case of the Irish.

Targeted Communities: The project mainly targets the older and disadvantaged Irish community in London.

Evaluation: The Project instructed an independent consultant to carry out a midterm evaluation covering the period November 2003 to December 2006. The evaluation concluded “the project is implementing activities directly with its target beneficiaries, providing health living information to individuals and groups and encouraging other service providers to address the health needs of the Irish community”. Further, the BG lottery fund has approved the final monitoring form.

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The Netherlands

The School dietician

“De Schooldiëtist” | <http://www.rotterdamlekkerfit.nl>

Aim & Objectives: The School dietician project contributes to the general objective of the ‘Urban Action programme Rotterdam Lekker Fit!’ which is: to promote healthy nutrition and physical activity among the youth in Rotterdam to reduce overweight and physical inactivity.

Design: In 2003, the service Sport and Recreation (SenR), the service Youth Education and Society (JOS) and the Municipal Health Service (GGD Rotterdam-Rijnmond from 2007 on), started a cooperation to prevent overweight and physical inactivity among the Rotterdam youth.

Since September 2004, the Preventive Youth Health Care (JGZ) uses a national signalling protocol during preventive health examinations to identify overweight youth. In 2007, the JGZ started with the implementation of the national ‘bridging strategy overweight’ (minimum intervention strategy for the prevention of overweight) in Rotterdam. To offer as many overweight children as possible an intervention, dieticians started working on selected schools during the school year 2007/2008 parallel to this program.

The School dietician project is an intervention that is part of the ‘Lekker Fit! Programme’, a school based intervention developed to reduce overweight and inactivity in children at primary schools (grade 1 - 8). The schools that run this programme are selected based on a high prevalence of overweight and the willingness of the schools to implement the programme. The Lekker Fit! Programme consists of an educational package, parental information hours and the introduction of a professional physical education teacher who provides physical activity hours during and after school.

Also, children from grade 3 to 8 have a fitness test at least once a year, including a screening for overweight/obesity (BMI). The individual results are communicated to parents and children. Children, whose BMI can be improved, are offered the possibility of visiting a school dietician with their parents.

The School dietician intervention includes the actual signalling of overweight and the guidance of the parents and the child towards healthier nutrition and increased physical activity. The intake consult takes 45 minutes, and the costs are reimbursed by the School dietician intervention. If a second consult is requested, the parent and the child need to visit a general practitioner first for a formal referral to the dietician. After this, following consults can take place at the school (max 4 hours per child per year), and the costs are paid by the health insurance of the child.

Support: The programme is supported by the Urban Action programme Rotterdam Lekker Fit!. The dieticians work closely together with Municipal Health Service Rotterdam-Rijnmond and the Service Sport and Recreation.

Trigger: Overweight and obesity are major public health issues. Overweight is an increasing problem, also among children. In Rotterdam, almost one out of five children in the second grade of the primary school is overweight; 6.4% is severely overweight – obese.

Targeted Communities: The School dietician project is running on Lekker Fit! schools in Rotterdam. These schools have – in general – a high prevalence of overweight and most of the parents are from foreign descent.

Evaluation: The School Dietician project was evaluated during the school year 2007/2008 to study its usability and effectiveness. The scope of the project, the number of children who were (severely) overweight before and after the start of the project, the number of participants who requested further consultation and the development of the Body Mass Index (BMI) and waist dimension were measured with quantitative methods. The usability of the project was measured with qualitative methods.

Results of the Eurofit test, which were administered by trained staff among the participating schools (N=21), show that 1 in 3 children are likely to be (severely) overweight. The turnout percentage of children who went to see the dietician for a consultation was 42%. The outreach of the project is satisfactory, but can be further improved. Furthermore, among the participants a positive development regarding their BMI and waist dimension was observed.

The usability and appreciation of the project were measured by using semi-structured interviews with dieticians and school managements. Results show that strong points of the project are that it is easily accessible; advice is given about both healthy nutrition and physical activity, and the experience that physical improvement can also lead to improved (psycho) social behaviour.

The School dietician project is a project offering a strong basis which is positively received by the participating parties. Important conditions to reach success seem to be good communication between the school and the dietician, a clear role for the dietician at school and a personal approach of the parents by the school.

Based on these results, the project will continue until 2010 and possibly thereafter. All 88 primary schools that participated in the Urban Action Programme Rotterdam Lekker Fit have nowadays the access and possibility to work together with a school dietician.

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Healthy Weight for Migrant Women

Gezond Gewicht voor Allochtone Vrouwen

Aim & Objectives: Weight reduction is the ultimate goal of this programme. In order to realise this, it is important that participants:

1. Gain insight into the relation between overweight, nutrition and physical activity and the role of social pressure, emotions and cultural habits,
2. Gain knowledge about, and abilities in healthier nutrition and an increased physical activity
3. Start to increase their physical activity and start to eat healthier during and after the course.

Design: The course, set up for a maximum of 12 women, consists of a physical activity programme and an information programme about nutrition. During thirteen weeks, the women will get twice a week physical activity training guided by a physiotherapist. They will train their condition in several ways. Furthermore, the women will have an information meeting during fourteen weeks. Eight meetings will focus on healthy nutrition, given by a dietician and will be led by a migrant chairman, and four meetings will focus on motivation and reflection and will be given by a migrant chairman alone. At last, two meetings will discuss psychological aspects of overweight, given by a prevention staff member of the GGZ and a migrant chairman.

During the period between spring 2007 and July 2008, seven courses were given in three neighbourhoods in Utrecht. It was given three times to Turkish women, and four times to women from a Moroccan descent. Around 80 women participated in this healthy lifestyle programme in total.

Support: This programme is financed by several organisations: Agis health insurances, the Local Authority of Utrecht, Aveant (allowance ZONMw), Portes (community wealth organisation), and GGZ Utrecht.



Figure 57: Healthy Weight for Migrant Women

Source: GG&GD Utrecht

Trigger: Overweight is an increasing problem, also among migrant women. More than 60% of all Turkish and Moroccan women living in Utrecht are overweight, and until the start of this project there was no effective method for the prevention available. However, the need was there. Portes received requests from Turkish and Moroccan women, and the GG&GD had monitored the problem and noticed as well that a considerable part of the migrant women living in Utrecht wanted help and information with regard to losing weight. Also general practitioners and physiotherapists noticed the need for a separate information programme for these women, and the regular guidance of a dietician or general practitioner was often even deficient.

At that time there was a community study held in Amsterdam among migrant women and they reported the need for a special programme as well. On a national level there was not yet a successful intervention developed.

Therefore, the GG&GD Utrecht developed in 2006 this lifestyle programme in the format of a course that focuses on healthy lifestyle habits. The course was developed in cooperation with Aveant (dieticians), Indigo (GGZ), physiotherapy practices and the community wealth organisation (Portes).

Targeted Communities: The health of migrant women is relatively worse than the average citizen of Utrecht. Often this group is hard to target for the prevention message of a healthy lifestyle. However, by offering this course close to their own environment, the target group was reached.

The programme does not specifically focus on communities with a lower socio-economic status. Nevertheless this group was mainly targeted.

Evaluation: At the start of the programme, almost every participant was overweight – 46% was obese and 32% morbid obese. After following the programme, these numbers went down to 41% and 26% respectively. The weight of the participants had decreased on average by 2.2 kilo's after three months and the waist contour was 4 cm less. The women had also less physical complaints and their knowledge concerning healthy nutrition, eating habits and physical activity increased. At last, the usage of saturated fat, sugar, and the amount of daily meals decreased and participants drank more water and less soft drinks.

These results will be officially published in the beginning of 2009. It can be concluded that the programme had an influence on certain relevant lifestyle habits of the participants in regard of overweight. It has proven to be a programme that is interesting to further develop and implement. Currently the reimbursement of the course is being discussed with the health insurance.

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Equal Health, Equal Chances

“Gelijke Gezondheid, Gelijke kansen”

As from 2001 on, a community-based project called ‘Equal Health, Equal Chances’ started in Tilburg – a city in the South of the Netherlands.

Aim & Objectives: The following strategic (intermediate) goals were formulated:

- to support cooperation and synchronisation between wealth- and health organisations
- to expand the basis and participation of communities

The ‘Referentiekader Gezondheidsbevordering’ and the model of Lalonde were used as a theoretical framework.

Design: The project – *Gelijke Gezondheid Gelijke Kansen* - was set up in 2001 with a 10-year programme aiming to decrease avoidable health differences and to counteract health inequalities. By providing information, raising awareness and changing behaviour, it influences health related aspects within communities in a positive way.

Most of its activities are ‘to do’-activities, since these motivate lower socio-economic communities the most. Examples are a walking club, cooking classes and a cooking cafe. During lunch meetings for elderly people, information provision is successfully combined with social gathering.

Support: Equal Health Equal Chances is a cooperation between: GGZ Midden Brabant (mental health institution), Thebe (home care), NIGZ (Netherlands Institute for Health Promotion and Disease Prevention), local authority of Tilburg, the foundation de Twern (social-cultural work) and GGD Hart voor Brabant (Municipality Health Service). At a later stage, Novadic-Kentron (addiction care) joined as well. All the organisations put manpower into the programme and it is

led by a project leader from the Municipality Health Authority ‘Hart voor Brabant’. The local authority of Tilburg provides a budget for the inset of community health personnel.

Trigger: At the end of 1999, Thebe, GGD Midden-Brabant (Municipality Health Service), NIGZ and GGZ Midden-Brabant decided to jointly work on the diminishment of socio-economic health differences. Apart from these four parties, the local authority of Tilburg and the foundation de Twern were prepared to structurally contribute to this project as well. To gain insight in the different goals and grounds of the groups involved, discussions were held with all parties.

Targeted Communities: The programme was set up for the lower socio-economic communities living in the neighbourhood of ‘Koninghaven’ in the city of Tilburg. This neighbourhood consists of several sub neighbourhoods: Broekhoven, Fatima, Hoogvenne and Jeruzalem. This neighbourhood is targeted since there are living many disadvantaged communities and there were – at the time the project started – no ongoing health projects and initiatives.

Evaluation: The NIGZ has evaluated the project in 2007 while studying the results of the period between 2004 and 2006. In this period, the project succeeded in setting up several structural activities in the neighbourhood. As often is the case – the start of the project (until 2003) was a bit chaotic, but from 2004 a clear choice was made for one theme: obesity, and one determinant: lifestyle. Circa 70 percent of the activities are now designed to promote healthy nutrition and/or physical activity. Three quarters of the interventions are lifestyle based.

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Bridging Strategy Utrecht

"Overbruggingsplan Utrecht"

This project was set up by GG&GD Utrecht to improve the health of youth (in relation to obesity and overweight) living in four different neighbourhoods in Utrecht.

Aim & Objectives: The targets of the project are:

- to reduce the level of overweight youth in four different neighbourhoods in Utrecht to the level reached in 2005;
- to stabilize the percentage of overweight youth at this level and if possible reduce it even more;
- to bring study results into practice and to form a basis for further development of public health policies and interventions of the municipality of Utrecht; and
- to create a balanced, fully covering and closing approach for early signalling of overweight children and children who tempt to become overweight

Design: Epidemiological studies show that overweight among youth in Utrecht is a significant problem. Since the city of Utrecht was lacking a programme for the early detection of overweight and an approach to counteract overweight among risk groups (children who are already – slightly – overweight), Agis Health insurances and the GG&GD Utrecht (Municipality Health Authority Utrecht) set up this project. They jointly agreed to reduce overweight among youth in four different areas in Utrecht, and signed a convention for four years on the 5th of July 2006: the Convention Overweight among Youth.

The programme exists of the following components:

- the detection and signalling of overweight and obese youth according to the Nationally developed signalling protocol - This part is done by Aveant

(home care organisation) and the GG&GD Utrecht (Municipality Health Authority);

- offering guidance to children (and their parents) who are overweight according to the Nationally developed signalling protocol - Aveant and the GG&GD Utrecht are also responsible for this second component;
- setting up a community approach whereby primary and secondary prevention is aimed at collectives;
- development of a protocol to be able to refer a child to other health authorities;
- implementation of an evaluation study

Support: 70% of the costs are covered by AGIS health insurance, and the remaining 30% are financed by the GG&GD of Utrecht. Besides these two organisations the Aveant home care organisation is involved as well. Within the GG&GD Utrecht, the departments of Youth Health Care and Health Education & Epidemiology are working on this project.

Trigger: The project is a new initiative in Utrecht, but the concept is based on a National plan developed by *Kenniscentrum Overgewicht*.

Targeted Communities: Children in these four specific neighbourhoods in Utrecht are targeted, since the percentage of overweight and obese children is significantly higher compared to other areas. Furthermore, the intervention only aims at overweight children from schools in deprived neighbourhoods.

Evaluation: The first reports are expected to be published in 2009.

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Norway

Intervention to prevent type II Diabetes/ metabolic syndrome among Pakistani immigrants

InnvaDiab Study

The InnvaDiab intervention study was set up in 2006 to improve dietary habits and physical activity in Norwegian-Pakistani woman living in Norway, in order to reduce the risk of type 2 diabetes and metabolic syndrome.

Aim & Objectives: The aim of the study is to influence risk factors related to lifestyle, such as dietary habits and physical activity in order to reduce the risk of type 2 diabetes and metabolic syndrome in Norwegian-Pakistani women.

Design: The InnvaDiab study is an intervention conducted in Oslo. Data collection started in 2006 and ended in May 2008. Two hundred women of Pakistani descent were included and randomised into a control group (100 women) and an intervention group (100 women). The intervention group was offered group sessions and individual counselling that focused on diet and lifestyle changes with regard to diabetes prevention. In addition, the women attended organized walking groups. The dietary advice given to the intervention group was adapted to the Pakistani culture, to study its effects on the women's knowledge, intentions and dietary habits recommended for this group. There was a pilot phase before the actual project was launched where the intervention methods and the questionnaires were tried out. The financial support came from The Norwegian Research Council, the Health and Rehabilitation in Norway, and the University of Oslo.

Support: The project was initiated by researchers in Norway, Margareta Wandel and Gerd Holmboe-Ottesen at University of Oslo and Kåre Birkeland at Aker University Hospital in Oslo. Two doctoral students are employed for working on the project: Benedikte Bjørge who is in charge of the dietary part of the project, and Victoria Telle Hjelset who is in charge of the physical activity part.

Trigger: The reason for starting this project is that people from Pakistan constitute the largest ethnic minority group in Norway. South Asians are at higher risk of developing the metabolic syndrome and diabetes type 2 than other population groups. It has been reported that the prevalence of diabetes type 2 in South Asians in Norway is high compared to the rest of the population. In addition, Pakistani women in Norway generally have a higher body mass index (BMI), waist circumference and incidence of diabetes than their men. Furthermore, they are less integrated compared to children and men, and thus, much more difficult to reach. Earlier studies indicate that life style interventions may increase the knowledge of nutrition and health among different ethnic groups and decrease the risk of diabetes and other chronic diseases.

Targeted Communities: Woman of Pakistani descent living in Norway.

Evaluation: Evaluation of the intervention is presently being carried out with regard to: dietary patterns and dietary intakes, knowledge and attitudes to nutrition and health, fasting plasma glucose, serum insulin, oral glucose tolerance test (OGTT), HbA1c, triglycerides, total cholesterol, HDL-cholesterol, LDL cholesterol, weight, felt barriers for attendance to the group sessions and felt barriers for changing diet. Publications from the evaluation are planned.

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Romania

Sibiu Project

<http://www.cpsibiu.ro>

This programme for the adoption of a healthy lifestyle developed by the Public Health Centre of Sibiu was conceived as an interdisciplinary and complex programme for the promotion of a healthy lifestyle and for the prevention of certain affections with a major impact on the health condition.

Aim & Objectives: The aim of the programme is to promote a healthy lifestyle, by changing the food customs and fighting against the sedentary life by improving the physical activity.

Design: The programme has been developed since 1997 and it continued as an on-going programme. At the beginning, the programme included a pilot project.

The programme is structured on the following basic activities: education training courses for a healthy lifestyle, individual nutritional counselling, monitoring the somatometric parameters and kinetoprophylaxis. The people who participate in this project receive education training materials, leaflets, booklets etc. containing information on obesity, cholesterol, healthy food, physical activity etc.

The general framework of the programme has been the same since the beginning, but there is a series of new elements introduced, in order to comply with the European actions in the field of healthy nutrition and physical activity.

Support: The Public Health Centre was the only partner in the development of this project but it collaborated with different family physicians, school physicians and specialist physicians. All the financial support came from the state budget, as the Public Health Centre is a budgetary institution.



Figure 58: Sibiu Project

Source: Public Health Centre of Sibiu

Trigger: The project was initiated by the Public Health Centre of Sibiu, a medical research institution under the direct coordination of the Romanian Ministry of Public Health. The launch of the programme was seen as one of the missions of the Public Health Centre of Sibiu, which is to identify and promote better health conditions for the local community. The programme was seen as a public health action and the Public Health Centre was the only institution which participated in setting up the project and its implementation, with the consent of the Romanian Ministry of Public Health.

Targeted Communities: The project is addressed to the most disadvantaged communities, especially to the people with a low socio-economic status. The most important benefits of this project are that it is free of charge and that people may come directly, of their own initiative, hearing from others who have participated in this programme. The health status of the targeted people is assessed either by their family or school physician or by the specialist physicians

who send them to the Public Health Centre, or by the physicians of the Public Health Centre, for the people coming of their own initiative.

The programme for the adoption of a healthy lifestyle is not a restrictive programme. It targets indeed the most disadvantaged groups, but it does not exclude anyone. However, from previous experience, it was noticed that the addressability of the group of people with a higher socio-economic status is quite reduced. Therefore, this project is mainly addressed to those with a low socio-economic status.

Evaluation: The project has already been evaluated and it proved effective, although cases evolution and in dynamics certify that certain component parts of an unhealthy lifestyle can hardly be changed (nutritional customs, smoking) and may reoccur after individual attempts of changing them in a positive way. The reduction and the stabilization of the body weight, by combining the measures for changing the lifestyle, proved to be a realistic objective.

The best results were registered among the persons with a continuous participation in the activities included in the programme (healthy food training courses, kinetoprophyllaxis, individual counselling).

As a result, we may say that the trend of the mortality due to cardio-vascular diseases, tumours is decreasing in the county of Sibiu.

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Scotland

Dundee Healthy Living

<http://www.dundeehealth.co.uk>

Dundee Healthy Living Initiative is a community led health organisation working within disadvantaged areas to reduce health inequalities issues and improve health using a community development approach. Local people and volunteers are an integral part of the project, from helping direct the work of the project to running activities within their own communities.

Aim & Objectives: The key aims of the project are to:

- Develop local activities to improve health
- Help bring health services into the community
- Provide local access to health advice, information and screenings
- Involve local people in decisions about health

Design: The Dundee Healthy Living Initiative has a pedigree of over 15 years, growing from a small community development and health project to become a large organisation with almost 20 staff. Essentially, the approach was tested on a small scale for a number of years and proved to be an effective way of engaging with people in disadvantaged areas to tackle local health needs and issues.

Support: It is a partnership project with support from NHS Tayside and Dundee City Council, and has a multidisciplinary team of community workers and nurses.

Initially, the Dundee Healthy Living Initiative was established after a successful bid to the Big Lottery Fund, which brought almost £1 million of new money to the city.

Nowadays the project is supported financially from a number of sources including the Fairer Scotland Fund, Keep Well, NHS Tayside, Dundee Community Health Partnership, Dundee City Council, and smoking cessation funding. The Management Group is made up of officers from Dundee City Council, NHS Tayside, Dundee Community Health Partnership, the Voluntary Sector and local people.

Trigger: Dundee Healthy Living Initiative came about as a result of an application to the Big Lottery Fund in 2002. The Healthy Living Centre funding programme looked to fund initiatives that reduced health inequalities and supported the health improvement of those people experiencing deprivation and disadvantage. Community health needs investigations had been carried out in Dundee in 1998/9 which enabled 1,400 residents of disadvantaged communities to identify their own health needs and solutions. Results showed that social isolation, poor mental wellbeing, access to affordable exercise opportunities, healthy eating on a budget, adverse life circumstances, and the need for smoking cessation support were key factors for local people in poorer communities trying to adopt healthier lifestyles. These issues formed the basis of the successful bid to the Big Lottery fund.

Targeted Communities: The Dundee Healthy Living Initiative built on the success of the smaller project and extended its reach to additional disadvantage areas. The areas the project covers house 54,000 residents – almost half Dundee's population.

The benefits gained by local people living in project areas include opportunities to increase social contact, learning new skills and gaining confidence, influencing decision making processes, participating in a wide range of healthy activities, and improved mental and physical health and wellbeing. The initiative ensures that the health gap is not widened by offering activities only in disadvantaged areas in the city.

Evaluation: The Dundee Healthy Living Initiative underwent an external evaluation in its first 3 years of funding. From 2003-6 a Doctor of Social Anthropology was sited within the project to assess the impact of using a community development approach to tackling health inequalities issues and improving health. Findings demonstrated that this trust-generating, egalitarian approach encouraged local people to become involved and was successful in promoting confidence and self efficacy to address factors affecting health and wellbeing.

Current evaluation is ongoing within the programme for specific activities and pieces of work relevant to funding accountabilities, reflective practice and quality assurance. The project was awarded the Dundee Partnership prize for Health and Care in 2005, a COSLA Bronze Award in 2004, and the Institute of Sports, Parks and Leisure award for innovation in physical activity in 2008. It was also part of the social marketing partnership which received a runner up prize at the Scottish Health Awards in 2008.

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Cambuslang & Rutherglen Community Health Initiative

<http://www.healthynhappy.org.uk>

This Community Health Initiative has been working for the past four years alongside local people and agencies to develop an infrastructure which promotes local health improvement activities in the area of Cambuslang and Rutherglen.

Aim & Objectives: The Community Health Initiative (CHI) aims to provide local people with opportunities to take an active part in ensuring their own, their family's and their community's health and well-being

Design: The Cambuslang and Rutherglen Community Health Initiative started in August 2004 as the result of a merger between the Cambuslang and Rutherglen Health and Food Project and the Cambuslang and Rutherglen Healthy Living Initiative.

For the past 3 years the CHI has been working alongside local people and agencies to improve health and well-being in the area and to work towards a healthier and happier culture in Cambuslang and Rutherglen.

The areas of work the initiative undertakes are based on needs that have been identified through extensive work with local communities and other stakeholders. CHI seeks to complement and add to existing local strategies and services. They work in partnership with local people, existing community, voluntary and statutory organisations to develop an infrastructure which promotes local health improvement activities and enables people and communities to plan ahead together.

A range of activities and services are delivered within the following themes: Volunteering; Communication, Information and Dialogue; Fitness and Exercise;

Diet and Healthy Eating; Substance Misuse; Mental and Emotional Health and Well-Being. The initiative thus seeks to improve health in its widest sense. However, two of its major themes are Diet and Nutrition and Fitness and Exercise. These two themes are of particular importance in the struggle to tackle obesity. Listed below are some examples of the programmes and services that CHI operates in this area.



Figure 59: Children's Food Handling Training

Source: Cambuslang and Rutherglen CHI

Weaning Workshops; Programme of workshops designed to inform and raise awareness of the benefits of weaning babies with homemade food.

Kids Food Handling; Course designed by CHI targeted at upper school primary children. The basics of food hygiene, preparations, health & safety and presentation are taught in order for the groups to run their own healthy tuck shop within their school.

Healthy Mums; Programme designed to supply pregnant women with free fruit and vegetables from a local fruit barra for the duration of their pregnancy from 12 weeks to birth. The programme has now rolled out into a wider programme, supporting mothers to access a range of support and activities such as stress management, first aid and alternative keep fit.

Junior Jog; Junior jog is offered to all groups in the local area to come together to train and gain confidence in taking part in groups running in the local area. The aim of the group is to inform and raise awareness of alternative fitness options.

Jogging/Walking Groups; CHI support local jogging/walking groups and offer training and support to the local community to become leaders and participants. The aim of the groups is to bring together local communities to participate in safe walking in order to raise fitness levels.

Health Issues in the Community; A course delivered in the local area to tackle various health issues in the community using a community development approach. Topics covered include inequality, discrimination and prejudice.

Fruit Family Game; The fruit game was designed specifically for pre 5s. The purpose of the game is to encourage children to eat a variety of fruit and vegetables with no cost to the nurseries.

Gardening Project; We support local schools and communities to plan, implement and maintain gardens which in turn harvest fruit, vegetables and flowers to be either distributed or sold in the local area. The projects also offer volunteer and training opportunities for parents and local people.

Camglen 5K; The first local community fun run will take place in May 2009. This is to encourage the community to come together and become involved in

walking, jogging, running or generally participating in community events. If successful, this will become a regular annual event.

These actions were set up aiming to have the following outcomes: People have increased access to information; People have access to healthier choices and make use of them; There are structures and networks that promote dialogue and information exchange in and between local people, community groups and local and national organisations; There are a range of activities which support and ensure local involvement; People are more involved, more skilled, more confident and less stigmatized; Community groups have ownership of activities in order to support individual and community well-being, contributing to the regeneration of the local area; Mainstream services are more responsive to the needs and wishes of local people.

Support: The Initiative has support and commitment from a range of funders and is seeking to continue these relationships and develop relationships with new funders in the future. During the first 5 years over £2 million of funding was brought into the area.

Trigger: Cambuslang and Rutherglen Community Health Initiative (CHI) was formed as a result of a merger between Cambuslang and Rutherglen Healthy Living Initiative (HLI), formed in 2002, and Cambuslang Health and Food Project (CHAF), established in 1997. The two organisations and their funders agreed that a newly merged organisation would have greater capacity to improve community health, and in August 2004 they became Cambuslang and Rutherglen Community Health Initiative (CHI).

Targeted Communities: Cambuslang and Rutherglen have a combined population of over 57,000. Poverty and inequality are apparent throughout the area. According to the SIMD (2006) 56 datazones in South Lanarkshire fall into the worst 15% in Scotland: 21 of these datazones are in Cambuslang and Rutherglen.



Figure 60: Women from the Jogging Network after their 6K race

Source: Cambuslang and Rutherglen CHI

There are a higher number of people in receipt of income support, disability living and housing benefits in this area than in wider South Lanarkshire. There is also a higher rate of people deprived of employment than the national average; with 23% of children living in households where no adults work. The impact of these statistics is reflected in South Lanarkshire health indicators. They evidence that there are comparatively high numbers of people living with limiting long term illness in Cambuslang & Rutherglen, incidences of cancer and coronary heart disease are significantly higher than the national average, as are the numbers of hospital admissions related to alcohol and drug misuse.

Evaluation: An interim Evaluation was carried out over the period of April 2005 until March 2007. The purpose of this interim evaluation was to examine how effectively the CHI was in meeting the outcomes set in 2005.

In short, it concludes that since 2005, the CHI has made excellent progress in achieving its outcomes. This was evidenced through the number of people using CHI services and testifying to the difference they make to their lives. It was corroborated by evidence from local practitioners in a wide range of services in both the statutory and voluntary sectors, who were very appreciative of the work of the CHI and noticed the impact it has made on the area.

The CHI has worked strenuously to involve local people in every aspect of its work and to be clearly seen as responsive to local need. At the same time it has forged strong partnerships with other agencies working in the area and its approach has made a clear impact on mainstream services.

However there is always room for improvement. During the course of gathering and analysing the information the team discovered several areas of work they were keen to address and improve into the future.

- The CHI recognises that it needs to improve its profile in the community. Volunteers, board members and staff themselves feel that organisation is still unknown to too many local people. The radio and media projects are attempting to address this issue and it is recommended that the focus on this area of work continues.
- The board consists of local people and the FMR evaluation found that the CHI is “very much community driven”. It is recommended that the CHI maintains this track record and keeps striving to involve more people from the community at board level. Younger people, despite being a key focus of the work of the CHI, are not represented at the board.
- Local ownership of groups and activities happens over time and with the right support. It is recommended that the CHI continues to focus on encouraging this over the next year and into the future.

- It is recommended that younger people are more involved, not only at board level, but also in accessing and delivering services.
- The evidence shows that there are more healthy choices available now in Cambuslang and Rutherglen, than there were in 2005, but it is recommended that the CHI undertakes some research over the next year to find out both whether they think that there are more healthy choices available and also whether they think that services are more responsive to local need than they were.
- More evidence is needed to show whether local people are more involved in strategic and working groups. It is recommended that the CHI gathers some data to show if this is happening.
- Volunteering is proving to be a successful way to involve people and there is evidence to suggest that it is also successful in aiding people to move on. It is recommended that opportunities for volunteering are expanded and that ways of measuring the impact of people’s journeys are investigated and implemented.
- The mental health and emotional well-being theme uses scales to assess the difference its interventions make to the people who make use of them. It is recommended that similar scales are used in other areas of CHI work so that an overall picture of changes for individuals can be built up.
- Story gathering provides excellent case studies about individual’s experiences and progressions through their involvement with the CHI. It is recommended that the CHI increase the number of stories gathered and involve more focussed questions that are linked to outcomes.

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Aim & Objectives: Healthy Valleys aims to:

- *Tackle health inequalities:* Healthy Valleys is committed to providing an integrated programme of services which tackle the wider determinants of health and ameliorate deprivation;
- *Address local health needs:* Healthy Valleys endeavours to address the health needs of local residents in a holistic fashion. This involves assessing need in a broad fashion and extending a range of healthcare options to clients in order that all of their needs are addressed;
- *Promote Community Involvement:* Healthy Valleys continually looks for new and innovative means to increase community involvement in the planning, development, delivery and evaluation of community health services;
- *Work in Partnership:* Healthy Valleys continues to work with mainstream services, private, voluntary and community sector agencies in pursuit of its organisational objectives;
- *Offer Additionality and strive for Sustainability:* Healthy Valleys endeavours to deliver services that respond to unmet demand and which are sustainable over the long term.

Design: Healthy Valleys is a voluntary organisation and registered charity, established in 1999. Through its many programmes and projects the Initiative engages with disadvantaged children and families and the methodology deployed is underpinned by the Social Model of Health. Partnership working is essential to address the wider determinants of health and well being. Healthy Valleys is embedded in community development and is governed by a Board of Volunteer Directors, 8 of who are local people and the other two from the local authority and NHS Lanarkshire. Due to the success of Healthy Valleys the organisation now covers the whole of rural South Lanarkshire.

Healthy Valleys adopts a community development approach to health improvement; participation, engagement, involvement and empowerment are essential ingredients to community led health improvement. With this approach, it aims to tackle four main health themes: (1) Positive Mental Health and Wellbeing, (2) Coronary Heart Disease and Obesity, (3) Sexual Health, and (4) Addictions.

The Rural Access to Recreation and Education Project (RARE) is an amalgamation of two successful programmes namely the Combating Obesity Programme (COP) and the Get Active Programme. The Combating Obesity Programme is a variety of healthy eating courses, namely 'Healthy Weaning Initiative' for parents with new born babies, 'Ready, Steady get Cooking' (targets primary aged children aged between 11 and 12 years, and 'Feeding the Family' which involves parents/guardians of vulnerable families.

The success of the COP is mainly due to the 'hands on' approach to nutrition. Participants learn how to cook healthy meals using fresh ingredients and try new foods. The COP is delivered by locally trained volunteers.

Adding to this is the Get Active Programme which offers a range of physical activity opportunities for people to improve their physical well being, this ranges from armchair aerobics to salsa dancing.

Support: Healthy Valleys is funded by the BIG Lottery (previously known as New Opportunities Fund, (NOF)), South Lanarkshire Council & NHS Lanarkshire. Funding was initially granted to develop programmes in eight villages within the Douglas & Nethan Valley areas, the villages are former coalmining communities.

Trigger: Healthy Valleys was established in 1999 with the coming together of a steering group of representatives from the community, voluntary and public sector agencies to consider the 1996 'Lanarkshire Health and Lifestyle Survey'. This survey indicated a number of serious health related issues affecting the Douglas and Nethan Valley areas, among them a higher than average morbidity from coronary heart disease, suicide, homicide and accidents.



Figure 61: Healthy Valleys

Source: Healthy Valleys

The steering group led an initial community consultation workshop, following on from which, and from the interest shown in improving access to enhanced and additional health care opportunities in the local area. The concept emerged to create a Healthy Living Community and a planning group was formed to take forward ideas from the local community and to submit a funding application.

Targeted Communities: Healthy Valleys works with communities and facilitates new opportunities for people who would not readily access mainstream service provision. Through consultation with rural communities gaps in service provision were identified and an action plan developed to fill the opportunity gap. Involving local people at the outset ensured that communities were on board and supported the initiative. To ensure the most vulnerable people are reached Healthy Valleys works in partnership with a variety of statutory and non statutory

agencies (for example, Social Work, Community Health Partnership and Locality, Employability agencies, Housing Services, etc).

Evaluation: Healthy Valleys is continually evaluating and reviewing services delivery via a number of methods including written evaluation completed by participants, focus groups, case studies and follow up telephone calls. Strathclyde University completed an evaluation in 2007 which can be seen online. Furthermore, a database has been developed which allows the programme to track progress and development of every participant.

From the beginning, the participants are required to complete a health questionnaire to establish a baseline of information which is then followed up by an interim questionnaire in order to measure impact. In effect, the physical and mental health are monitored and well being of the individual.

The outcomes of evaluation, related to the RARE project were:

- Increased/improved fitness for all ages
- Improved self confidence and self esteem
- Increased levels of community participation
- Increased service provision for children, young people and adults
- Participants are more informed of what to eat
- Participants more able to prepare healthy meals for themselves and their families
- Improved knowledge of preparing food safely
- Increased knowledge of fats, salt intake and sugars
- Less feeling of isolation
- Learnt new skills & feel less stressed or anxious

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Inverclyde Integrated Community School

This is a multi disciplinary project, providing high quality support for young people and their families, to ensure that they make most of the educational opportunities on offer.

Aim & Objectives: The project aims to:

- provide high quality support for young people and their families
- encourage a positive attitude to learning which will help young people to make the most of their opportunities in life
- be active in the promotion of a healthy lifestyle through the curriculum, the whole school and the wider community
- work with parents more closely to provide opportunities for lifelong learning and support before, during and beyond the school day

Design: New Community Schools was a Scottish Office initiative and was launched in 1998. The first pilot started in 1999 with two subsequent pilot phases in 2000 and 2001. Within this Authority there was a phase I pilot and a phase III pilot these were merged in 2006 to form one project, however it was not until 2008 that the staff were given permanent contracts as up until that time the project had been funded on a short term basis. Originally the pilot projects were based on the American concept of the full service school and was a new initiative in Scotland.

The project is a multi disciplinary one with the team made up of Health Development Workers, Home/School Link Workers, Social Workers and Attendance Officers. The team is managed by an Integration Manager and work

in all primary and secondary schools within the authority. The programme is also involved in some Special Needs Schools and in some Early Years Establishments.

The staff members work with pupils, their families and school staff to ensure that the child or young person makes the most of the educational opportunities on offer. This can involve supporting the young person, child or family through a short or long term crisis, acting as an advocate in discussions with the school, health professionals, social work and Children's Panels. The team work closely with a wide range of statutory and voluntary partner agencies. Programmes are delivered both in school and after school basis. They also organise a range of holiday provision as well as specific programmes for young people moving from primary to secondary school and who have been identified as likely to face significant challenges when making this move.

Some programmes that have been set up and their benefits to those the project has targeted are:

Breakfast Club provision in fifteen primary schools giving the children a healthy nutritious start to the day. Head teachers have noted improved performance, better behaviour and more settled and learning ready children. The children enjoy the company of their peers and friendly helpful staff underlining the social aspect of food. The children are king and a provision of the highest quality is made available to them.

Healthy cooking classes for primary children (Cookery Bookery) enabling them to learn to cook basic healthy meals which they share with the other children. They also make enough that they can take some home for the evening meal and during the week they have to try out a similar recipe and say how they managed the next week.

Cookery Classes for young people who are Looked After and Accommodated in order that when they leave care they will be able to cook healthy meals also similar classes for those leaving school to go to College.

Parent Cookery Classes to give parents basic cooking skills to help them prepare healthier meals for their families.

Tasting sessions in schools for children from nursery to P7 to enable them to taste and try different foods.

Consequences a programme about the social, economic, emotional and educational disadvantages of becoming pregnant whilst still at school

Baby sitting programme giving a first step in basic child care

Programmes of Emotional Literacy and Emotional Intelligence to help children and young people cope better with their feeling and to understand the implications of their actions

Programmes on bereavement and loss to help children and young people cope with separation due to death, divorce or prison.

Programmes of parenting to support parents to put in place appropriate boundaries and to have realistic expectations of their children and young people.

Out of school programmes in practical skills to support those young people who find it difficult to sustain a place in fulltime education.

Programmes of anger and behaviour management, self esteem and confidence building to support young people and children in becoming effective contributors, responsible citizens, successful learners and confident individuals

Steps to fitness targeting children and young people who are overweight and working with parents to improve their general health and fitness.

Support: Initially the funding for the programme was ring fenced and could only be used for the development of Community School provision and this was the case until 2008. The funding up until that time came in the form of grants from the Scottish Executive and latterly the Scottish Government. In 2008 all grant

funding was amalgamated into the core education revenue budget for the Authority.

In setting up the project partnerships were forged with Social Work, Health, Community Learning and Development and schools.



Figure 62: Inverclyde Integrated Community School

Source: Inverclyde Integrated Community School

Trigger: The trigger for the project was the realisation by the then Scottish Office that, “for too long, too many children have been condemned to repeat the cycle of deprivation, educational underachievement and failure. Their life chances are reduced at an early stage. The disaffection with school which follows has been tolerated. The wider barriers to learning that can prevent children realising their true potential have not always been addressed in a properly co-ordinated

fashion. Access to the necessary support has not been available where and when it is needed. New Community Schools will embody the fundamental principle that the potential of all children can be realised only by addressing their needs in the round – and that this requires an integrated approach by all those involved. A range of services is necessary to assist children overcome the barriers to learning and positive development - family support, family learning and health improvement”.

Targeted Communities: In all phases of the pilot, provision was targeted at those areas where the challenges were/are greatest. Within Inverclyde the two pilot areas exhibited some of the highest indicators of social deprivation. Inverclyde as an area has some of the worst indices of multiple deprivations in Scotland. These related to health, housing, educational qualification and employment/unemployment. As the indicators were particularly high in the areas selected for the project there was little danger of overspill and the accessing of services by those in less deprived circumstances.

Although the programme is a universal service, they do target provision at those with greatest need and there is an appreciation by head teachers that referrals to the service or provision which are made should in the first instance be for the most at risk groups.

Evaluation: There has been a national evaluation of Community School Projects; ‘The Sum of Its Parts’ published in 2004. The findings of this evaluation were less than positive but in some views fairly inconclusive. Within their own project there have been a number of small in house evaluations and these have always been very positive. Also as each school is inspected, the programme’s contribution to the establishment is evaluated and to date these have highlighted a high quality of service targeted at the most needy children, young people and families and which improves the quality of life for those involved with the Integrated Community School Project.

The general view by those who are involved in this programme is that Integrated Community School offers an effective service. The proof of this can be seen in increased consumption of fruit and vegetables, children who are willing to eat a variety of food, children and young people who understand the need for a healthy diet and regular exercise. There is also recognition from those in the slight to moderately overweight category that minor changes in lifestyle can bring about significant health improvement.

However it has to be said that the programme is part of a much bigger health picture and there have been a range of other inputs by organisations other than Integrated Community School which will have contributed to these changes. The programme has only been involved in one piece of work in relation to obesity and that had limited success in changing attitudes and habits long term. In many instances the issue for the children, young people and families with whom the project works is not obesity but mal-nourishment.

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DELTA Project

The Delta Project is defined as a group of proposals, strategies and didactic materials aimed to the promotion of healthy eating habits and physical activity, in a broader context of education for health.

Aim & Objectives: The project promotes healthy life styles among the population with more emphasis on healthy diet and physical activity. Its specific objectives are to promote community participation - especially in the education sector, nutrition industry, mass media, etc. - into the development of the strategies, and to promote the implication of the government institutions and NGO's into the activities of the Project.

Design: From 1992, the General Directorate for Public Health of the Canary Islands Health Service has been developing the Program for the Promotion of Healthy Eating (PAS, "Promoción de Alimentación Saludable").

Due to changes in the social scenarios until 2005 (e.g. increasing, and virtually universal, progression of the epidemic phenomenon of overweight, creation of the European and Spanish agencies for food safety, edition of the Green Paper of the European Communities Commission) among other reasons, made it advisable to realign the methodological proposals of the PAS, which then became the actual "Delta Project on Nutritional Education" that was formally presented on December 2005.

The Delta Project is defined as a group of proposals, strategies and didactic materials, and it establishes three principles for action: (1) it started as an integrating, not excluding, consensus proposal, (2) it is intended to reach first

those who most need it, and (3) it is based on a founded technical and scientific basis.



Figure 63: Fiestas de Mayo 2006

Source: DELTA Project

Support: The Project has been financed by the Government of the Canary Islands. Parties involved are the Regional Government of Education, Culture and Sports, City Councils, Sports Clubs, Industries from the nutrition sector, etc.

Trigger: The project was an initiative from the Regional Government.

Targeted Communities: The Project targets the general population, but makes an especial focus on vulnerable groups. However the interventions are for all.

Evaluation: The objectives of the health plan, the ministerial guidelines, the questionnaires about the activities carried out, and the monitoring epidemiologic studies are evaluation indicators that are taken into account. Other indicators evaluate the impact, coverage and results. In addition to that, the Delta Project is

developing a protocol to be applied in two municipalities for a period of three years, in order to evaluate the methodology and internal and external validity, with the participation of relevant academic authorities and well-known scientists.



Figure 64: Feria de la Juventud 2006

Source: DELTA Project

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5. Projects at International level

This chapter describes several examples of projects and initiatives that are running at the international level. The information was collected from people who had expressed their interest in the report after the publication of its first edition in July 2009, and who were willing to make a contribution. The overview given is thus not extensive, nor is that the aim of this chapter. The descriptions included can be used to further stimulate debate, to provide new ideas, and to highlight interesting approaches implemented outside Europe.

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Global level

MEND

<http://www.mendcentral.org>

MEND is an abbreviation for **M**ind, **E**xercise, **N**utrition...**D**o it! It is an organisation dedicated to reducing global childhood overweight and obesity levels by working in partnership with local, regional, national and international partners from the private, public and voluntary sectors. MEND provides evidence-based, family-oriented programmes to prevent and treat obesity, and is training frontline staff in obesity management to build local capacity and skills.

MEND provides clinically proven community-based child weight management services to operate in a scalable and cost-effective manner. Activities are supported by very successful research to date, including a feasibility study, pilot and Randomised Controlled Trial (RCT). MEND's activities are informed by a 20 year research partnership with the world renowned Great Ormond Street Hospital for Children NHS Trust and the University College London Institute of Child Health. To date, over 30,000 families have taken part at more than 300 programmes locations across the UK every school term as well as in Australia, New Zealand Denmark and the United States.

Free community-based healthy living programmes are offered to families, based on the age of the children. MEND offers bespoke child weight management services for families with children aged 7-13; for families with children aged 5-7; and for families with infants aged 2-4 year olds, irrespective of their weight. In addition, researchers at MEND are developing a new post-natal weight management programme. This will be piloted in 2010.



Figure 68: The MEND 7-13 Programme

Source: <http://www.mendcentral.org>

The **MEND 7-13 Programme** runs twice a week after school in two-hour sessions over 10 weeks. Developed by child health experts, the MEND 7-13 programme helps and supports children and their families to manage their weight by teaching them how to change their behaviours around healthy eating and physical activity. The 20 MEND 7-13 Programme sessions each include an hour's workshop for children and parents, and an hour's exercise for the children whilst the parents have an adult discussion. Measurements are taken before and after the Programme and there is follow-up contact including a graduate website (<http://www.mendworld.org>), newsletters, reunion events and telephone support.

Developed by experts in child health, the **MEND 2-4 Programme** is a healthy lifestyle course for parents or carers with children of a pre-school age. It offers a fun and creative environment for families to learn how to make healthier lifestyle choices and ensure their children have the best possible start in life. Each lasting 90 minutes, MEND 2-4's ten weekly sessions combine parent-toddler active play, parent discussion groups and children's crèche-style creative play activities. They take place during the daytime at community venues such as leisure centres and Sure Start Children's Centres.



Figure 69: The MEND 2-4 Programme

Source: <http://www.mendcentral.org>

The MEND 2-4 Programme encourages young children to try new things and shows parents creative ways to get their children to taste and enjoy different

fruits, vegetables and other healthy snacks. Also, the active play sessions provides ideas and tips for games which will keep the children moving and occupied. As well as helping to improve agility, balance and co-ordination, the programme also works on building their confidence.

Other services provided by MEND to improve population health

Further to these services for children, MEND works in partnership with the Fitness Industry Association to provide facilitated self-help **adult weight management** services. Approved by The UK Department of Health, MEND's 'More Active Health' Programme carries the branding of the national social marketing campaign 'Change4Life'. MEND is working with employers to incorporate 'More Active Health' into company **workplace wellness** schemes.

MEND also provides **Training Seminars** to public health professionals and other community-based staff. This equips frontline workers, like school nurses and health trainers to respond effectively to childhood obesity. MEND offers two distinct one-day training programmes:

- Raising awareness of childhood obesity and providing efficient, effective responses to it.
- Raising the issue of child weight with families so that they are motivated to engage positively with treatment services.

Finally, MEND provides **educational resources for schools** to improve child health. The Move It! campaign (<http://www.mendmoveit.org>) offers fun materials for teachers of children age 7-11 to stimulate greater levels of physical activity among their pupils. THE PHSE Citizenship curriculum provides informative, engaging resources for 11-14 year olds to promote the adoption of healthy lifestyles.

MEND in the UK

MEND Programmes have been running in the UK since 2005. They are available in more than 300 locations every school term including sites in Wales, Scotland and Northern Ireland. They usually take place after school, in schools and leisure centres. A smaller but growing number of Mini-MEND Programmes are also running. These run in community venues such as Sure Start Children's centres and typically take place during the day.

MEND in the US

The MEND Foundation delivers child weight management services to low income families in the states of Texas California and New York. Research partners include Baylor College of Medicine, University of Texas School of Public Health, RTI International and Duke University.



Figure 70: The MEND 7-13 Programme

Source: <http://www.mendcentral.org>

MEND in Australia

MEND provides child obesity treatment services in the States of Victoria, New South Wales, ACT and Queensland. MEND has been selected by NSW Health as its sole provider of child weight management services for 7-13 year old overweight and obese children and their families. A Randomised Control Trial of MENND 2-4 is being undertaken at Deakin University in collaboration with Professors Boyd Swinburn and Marita McCabe with funding from the Australian Research Council.

MEND in Denmark

The MEND 7-13 Programme has been adapted for use in Denmark in partnership with the Oxford Health Alliance (OxHA). Child weight management services are being delivered in the municipality of Halnaes. The pilot project has been sponsored by the Central Government.

Aim & Objectives: The organisation's mission is to enable a significant, measurable and sustainable reduction in global childhood overweight and obesity levels. They aim to achieve this by:

- Developing effective and research-based obesity prevention and treatment programmes, training and resources;
- Working alongside partners from the private, public, voluntary and academic sectors to make our services available at a community level on the widest possible scale;
- Training people who come into contact with overweight and obese children so they can provide families with the best possible support
- Building one of the largest bodies of evidence worldwide on child obesity prevention and treatment

Support: The organisation has a 20-year research partnership with Great Ormond Street Hospital for Children NHS Trust and University College London Institute of Child Health. Sponsors include The Big Lottery Fund, Legal and General, Nutricia, Britvic, Sainsbury's, Johnson & Johnson, Sport England, Youth Sport Trust, and the National Sports Foundation.

Trigger: Currently there are 155 million overweight and obese children worldwide, 3 million of whom live in the UK and 25 million in the United States. Obesity causes needless suffering, as well as massive financial and social consequences. But it can be prevented and treated. Thousands of families have proved this through MEND's life-changing programmes.

Targeted Communities: The MEND 7-13 and MEND 5-7 programmes target children whose weight is above the healthy range for their age and height. The MEND 2-4 programme is suitable for all toddlers, irrespective of their weight.

Evaluation: The programme is supported by very successful research to date, including a feasibility study, pilot and Randomised Controlled Trial (RCT). This Trial shows that the MEND Programme helps children lose weight, increases their physical activity levels and self esteem and reduces their sedentary behaviours e.g. screen time. These results continue to improve over time after the end of the core Programme. Children demonstrate sustained health improvements 12 months after starting the MEND Programme and the RCT concluded that: *'The sustained benefits of the MEND intervention suggest that this is an effective and feasible community-based programme for childhood obesity'* [124]. For a summary of MEND's research, please see:

<http://www.mendcentral.org/aboutmend/ourresearch>.

Currently the organisation is conducting a second, larger RCT at University College of London Institute of Child Health to follow families for longer periods to obtain longer-term follow-up data. The programmes that are running in Denmark and Australia have demonstrated that the MEND is effective in other countries and languages as well.

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Diabetes Prevention Directory

<http://www.activeindiabetesprevention.com>

Type 2 diabetes is becoming a major public health concern worldwide. However it has been demonstrated that prevention programs can significantly reduce the risk of developing diabetes. People who are interested in diabetes prevention are therefore warmly invited to register for the worldwide network "Who is Active in Diabetes Prevention", at www.activeindiabetesprevention.com. So far the directory has over 3000 members from more than 130 countries worldwide.

Aim & Objectives: The aim of this global online network is to bring people together to exchange ideas and expertise in the field of diabetes prevention, to create new ideas and hypotheses, and to improve the implementation of diabetes prevention programs. Furthermore, the directory puts emphasis on issues which are often forgotten: how can socially deprived minority groups can be reached in developing countries with a high diabetes risk.

Design: The initiative was set up in 2009 by Professor Peter Schwarz together with several international colleagues. It is a non-profit initiative lead by researchers and health educators at the University of Dresden. One of the things the network does is discussing a practice guideline for the prevention of diabetes mellitus through its members. Regularly (every 7 to 10 days) ideas are exchanged via a newsletter which highlights practical experiences and sciences in diabetes prevention. This newsletter also introduces different prevention strategies used in practice worldwide. The Network is free for registration, membership and use.

Together a dynamic discussion might start and the prevention of diabetes might finally become a realistic commitment within our communities. As more people are registered the more powerful and useful the network can be.

Trigger: Diabetes mellitus is one of the most common chronic diseases. The United Nations adapted by the general assembly resolution 61/225 to "Unite for diabetes" and to address the challenge of the chronic disease diabetes mellitus

worldwide. Prevention of chronic diseases is the key and with this worldwide network people are brought together to address this issue.

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The Equity Channel

<http://www.equitychannel.net>

The Equity Channel is an initiative run by EuroHealthNet (a public network based in Brussels), and supported by an international collaboration with initial funding from the Department for Health for England. It brings together people and groups who are interested in improving health equity by working to address the social determinants of health and mainstreaming health in all policies – private and public. The Equity Channel has been set up as a way of sharing knowledge and evidence online, and to develop strong partnerships to help influence policy processes and work towards fair health for all.

Many studies have shown that there is a strong link between health inequalities and obesity and overweight as this condition especially affects disadvantaged communities. If there are too few shops selling affordable nutritional foods, healthy eating is problematic. If there are too few safe green spaces in communities, exercise becomes too difficult. If some people have poor reading skills, detailed labelling on food packets makes little difference. Obesity, agriculture and land use is therefore one of the important issues the Equity Channel works on to achieve better health for all. Health inequalities are unfair and avoidable and action is needed to address the problem.

At www.equitychannel.net you can find useful information about action for health equity worldwide and you will be able to sign up for an online community that allows you to:

- Have direct access to fast information on EU policy developments affecting health and equity;
- Have your say at the Equity Channel Forum;
- Share evidence and knowledge with people working in your field and outside your sector;

- Connect with others worldwide working on health equity and relevant approaches in other fields;
- Stay Informed by receiving the latest updates about work on the social and economic determinants of health.



Figure 71: Cartoon by Simon Kneebone, published by Fran Baum (2007), IJHP&E, XIV, 2, 90-95. Reproduced with permission. Source: <http://www.equitychannel.net>

Aim & Objectives: The Equity Channel cartoon (figure 71) shows that tackling inequities needs both policy changes *and* pressure from community actions. The Equity Channel aims to build both, by stimulating and supporting changes in policies at international, national and local levels, and by bringing together people from all background and communities.

Trigger: In August 2008, the WHO Commission on the Social Determinants of Health (CSDH) brought together in a single report the collective knowledge from around the world on the social determinants of health. The report was called “Closing the gap in a generation”, and presented evidence on the causes of health inequity which was collected by a diverse group of leading policy-makers, scientists, practitioners and civil society leaders, who together made up a series of different “knowledge networks” based around specific themes (e.g. globalization, employment, health systems, early child development).

In the light of this evidence, the report produced three overarching recommendations:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action

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Australia

(Extra information was provided by the Obesity Policy Coalition of the Cancer Council Victoria, Diabetes Australia. This is a WHO Collaborating Centre for Obesity Prevention)

Overweight and Obesity in Australia

The **National Health Survey** (NHS) of Australia measured in 2007-2008 for the first time since 1995 also the height, weight, hip and waist circumference of respondents aged 5 years or older. Results of this survey revealed that 61.4% of the Australian population are either overweight or obese. For adults, 42.1% of males and 30.9% of females were classified as overweight (Body Mass Index between 25.0 and 30.0 kg/m²) and 25.6% of males and 24% of females were classified as obese (Body Mass Index > 30.0 kg/m²) (ref: 1Australian Bureau of Statistics 2008, National Health Survey 2007-08, Cat 4364.0).

For children and adolescents, the 2007-08 National Health Survey results indicate that 24.9% of children aged 5–17 years are overweight or obese. In addition, 25.8% of boys and 24.0% of girls are either overweight or obese. These results are similar to the results of the **Australian National Children's Nutrition and Physical Activity Survey** which was carried out in 2007 and released in October 2008. This survey measured food intake, physical activity participation and physical measurements of almost 4500 children aged 2-16 years.

In addition to the National Health Survey, the Australian Government is planning the implementation of an ongoing **National Health Risk Survey Program** (HRS). This survey will collect nutrition, physical activity, physical measurement and chronic disease risk factor data in the Australian population. The first HRS is expected to commence in mid 2010 and will focus on Australian adults [125].

More information about the survey's mentioned above can be found on the website of the Australian Government, Department of Health and Ageing: www.health.gov.au/nutritionmonitoring

Overweight and Obesity Strategies

Australia has a **National Preventative Health Taskforce** which examined future steps to prevent health threats such as overweight and obesity. In 2009 the Taskforce published a **National Preventative Health Strategy** [126] called "Australia: The healthiest country by 2020", which is a roadmap for action and includes a number of recommendations for future steps to halt and reverse the rise in overweight and obesity in Australia by 2020. In order to achieve this, the Taskforce has set the following medium and long-term targets:

- Increase the proportion of children and adults with healthy body weight by 3% within 10 years;
- Increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15% within six years;
- Help assure Australian children a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the newborn.

The following ten **key action areas**, when combined, will provide the most effective roadmap to address the three overall obesity prevention targets: (1) Drive environmental changes throughout the community that increase levels of physical activity and reduce sedentary behaviour, (2) Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products, (3) Embed physical activity and healthy eating in everyday life, (4) Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing, (5) Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages, (6) Strengthen, upskill and support the primary healthcare and public health workforce to support people in making healthy choices, (7) Address maternal and child health, enhancing early life and growth patterns, (8) Support low-income communities to improve their levels of physical activity and healthy eating, (9) Reduce the obesity prevalence and

burden in Indigenous communities, and (10) Build the evidence base, monitor and evaluate effectiveness of actions.

More information about the National Preventive Health Strategy and its obesity prevention recommendations can be found on their website: <http://www.preventativehealth.org.au>.

Commonwealth of Australian Governments (COAG) National Partnerships on Preventive Health has committed to fund a substantial investment in health promotion. The focus is on reducing the harms from tobacco, obesity and excessive consumption of alcohol. The partnership with the states and territories comes with the investment of \$871 million over six years to prevent lifestyle risks that cause chronic disease.

The areas of funding focus on healthy children, healthy workers, social marketing and enabling infrastructure. Through the agreement \$72 million has been allocated over the next four years (2009-10 – 2012-13) to support Local Government Areas (LGAs) in delivering effective community-based physical activity and dietary education programs as well as developing a range of policy environments to support healthy lifestyle behaviours. The agreement also establishes a preventative health agency to advise Australian governments on health promotion programs.

A list of other useful reports and guidelines published by the Australian Government, Department of Health and Ageing can be found here: <http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/publications>

Concerns about the increasing levels of overweight and obesity in Australia have also prompted the formation of the Obesity Policy Coalition (OPC) in 2006. The OPC was established with the aim of influencing change in policy and regulation to support obesity prevention, particularly in Australian children, at a local, state and national level. The Coalition was established by Cancer Council Victoria,

Diabetes Australia – Victoria, VicHealth, and the World Health Organisation Collaborating Centre for Obesity Prevention at Deakin University.

The major areas of policy interest are to (1) analyse and prioritise policy initiatives that are likely to have an impact on reducing obesity, particularly in children, (2) undertake research to provide the evidence base for policy proposals, (3) encourage all levels of government to support evidence-based policy initiatives to address the overweight and obesity epidemic, and (4) provide leadership to guide and assist researchers and policy professionals working on obesity and overweight issues in Australia.

The OPC recognises that overweight and obesity are influenced by an individual's physical, social and economic environment. Therefore, individuals are viewed within the broader context of his/her neighbourhood, school, and community, together with policy at the local, state and national level. The OPC opts to make a change in policy and regulation through a number of processes, including:

- Writing position papers and preparing submissions around policy and regulatory issues, and
- Making complaints about breaches of self-regulatory codes and regulations, particularly in relation to practices used to market unhealthy food to children.

More information about the OPC can be found on their website: <http://www.opc.org.au>.

Overweight and Obesity Programmes

The Collaboration of Community-based Obesity Prevention Sites (CO-OPS Collaboration) is an initiative funded by the Australian Government Department of Health and Ageing which aims to support community-based obesity prevention initiatives through a collaborative approach to promoting best

practice, knowledge translation and by providing networking opportunities, support and advice. These CO-OPS aim to:

- To identify and analyse the lessons learnt from a range of community-based obesity prevention initiatives aimed at tackling obesity;
- To identify the elements that make community-based obesity prevention initiatives successful and share the knowledge gained with other communities.

A number of community based programs have been evaluated well across different socio-economic groups. More information about the CO-OPS can be found on the following website: <http://www.co-ops.net.au>.

There are several national obesity prevention programmes that are currently running in Australia. Besides the examples given below, an outline of ongoing campaigns and initiatives can be found on the website <http://www.healthyactive.gov.au>.

Stephanie Alexander Kitchen Gardens National Program

<http://www.kitchengardenfoundation.org.au>

This scheme, which was initially not established as an obesity prevention initiative, provides resources and funding for schools to establish school gardens and cooking programs. It began in July 2001, at Collingwood College in inner Melbourne.

In the Kitchen Garden Program children across Years 3 to 6 spend a minimum of 40 minutes a week in an extensive vegetable garden which they have helped design, build and maintain on the school grounds according to organic gardening principles. They also spend one and a half hours each week in a kitchen classroom preparing and sharing a wonderful variety of meals created from their

produce. The program employs two part-time specialist staff; a gardener and a cook, to run these sessions.



Figure 72: East Maddington Primary students in the garden- August 2008

Source: <http://www.kitchengardenfoundation.org.au>

There are two special factors about the Kitchen Garden Program. The first is the intrinsic link between the garden, the kitchen and the table. The emphasis is on learning about food and about eating it. No part of the Program can exist without the other. The second is the program is embedded in the curriculum. It is a part of the school's program for four years of a child's life.

One school in each state and territory (except Victoria which already has a demonstration school) has been selected as a demonstration school to be the focus of the Stephanie Alexander Kitchen Garden National Program in their state/territory and act as a model for participating and interested schools to visit.

Aim: The aim of the Program is pleasurable food education for young children. The underlying belief is that by teaching primary school students how to grow, cook and share fresh food, this approach will provide a better chance of

positively influencing children's food choices and to encourage healthy eating habits.



Figure 73: East Maddington Primary students with Minister Roxon, Ian Parmenter and Stephanie Alexander - August 2008

Source: <http://www.kitchengardenfoundation.org.au>

Support: The Australian Government has committed \$12.8 million over four years to implement the Program in up to 190 Government primary schools nationally. The Government will provide grants of up to \$60,000 per school participating in the program to cover infrastructure costs associated with building kitchens and gardens. Schools that receive a grant from the Australian Government will need to demonstrate a commitment to continue the project for two years, and in the longer term, work towards integrating the project into the school curriculum.

The Program is a national partnership between the Australian Government and the Stephanie Alexander Kitchen Garden Foundation.




Targeted Communities: The focus of this national-wide initiative is on primary school students in Years 3 – 6. Both State and Territory Government primary schools in nominated States and Territories can every year apply for funding.

The Parents Jury

<http://www.parentsjury.org.au>

The Parents Jury is an online network of parents and grandparents who collectively advocate for improvements in the food and physical activity environments of Australian children. It currently has 4300 members.

Aim & Objectives: The Parents Jury aims to:

- **Improve children's nutrition** by: promoting the consumption of fruit and vegetables, explaining food packaging labels, campaigning for the introduction of the food traffic light labelling system and encouraging restaurants to offer healthy food options to children.

- **Create healthy schools** by: improving the availability of healthy foods and drinks at school and providing supportive environments for healthy eating. This includes improving access to healthy foods in school canteens, encouraging healthy school fundraising and finding healthy alternatives to traditional, less healthy fundraising. We do this by running media campaigns and responding to issues in the news about food in schools, and supplying materials and information to parents and schools on healthy food choices.

- **Encourage physical activity** by: commenting on built-up environments and infrastructure changes in local communities, promoting physical activity during after school hours and at home, supporting active transport models as alternatives to car travel, and discouraging junk food promotion and sales in sporting facilities frequented by children.


- **Focus on food marketing to children** by: organising member polls and subsequent award programs regarding food marketing to children that is unclear and deceptive and encourages consumers to purchase products based on slick marketing campaigns which feature toys and animations but have minimal attention paid to the food product.



- **Advocate for healthy checkouts** by: campaigning that 50 per cent of supermarket checkouts, and their immediate vicinity do not stock junk food products. This involves working with academics in behavioural research, communicating with retail outlets, and managing media campaigns.



Support: The Parents Jury receives support from Cancer Council Australia, Diabetes Australia Victoria and Queensland, the Australian and New Zealand Obesity Society, VicHealth and YMCA Victoria.

Trigger: In 2004, 12 committed and motivated parents came together to form a membership organisation body that could influence key decision makers on children's nutrition and physical activity environments and also give like-minded parents a platform from which they could perform important advocacy work on these issues in their own communities.

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Figure 74: The Parents Jury – website screenshot

Source: <http://www.parentsjury.org.au>

Brazil

(Extra information was provided by the Ministry of Health of Brazil and the Brazilian Center of Food Habits - OBHA)

Overweight and Obesity strategies

The **Ministry of Health of Brazil** focuses both on the promotion of healthy eating and on the promotion of a healthy lifestyle, and has developed **National Nutrition Policies** as well as **National Policies for Promoting Health**. In addition to these policies, sets of intersectional actions aim to contribute to improving social inclusion, decreasing poverty, and promoting the right to adequate food.

On the one hand, changes in eating patterns in Brazil have been favourable for improving poor nutrition problems, since there has been a raising movement of calories per capita availability as well as an improvement of animal food-kind consumption. However, on the other hand, there has been an increase in prevalence of certain diseases such as anaemia, vitamin A deficiency, obesity and other non-communicable diseases (NCD). These unfavourable changes are related to the massive raise of sugar and both animal and non-animal fat consumption, whereas a decreasing consumption in cereal, fruits and vegetables is observed. All of these (unfavourable) changes are associated with sedentary behaviour and can explain overweight and obesity prevalence numbers in Brazil (Brazilian Ministry of Health, 2006).

According to the literature, there is a vast range of strategies that can be used for setting up intervention strategies that focus on obesity prevention and the promotion of healthy eating habits. A great part of the physicians prefer to use nutritional education and dietary guidance methods in order to stimulate behavioural changes, and to be able to adapt those tools to different settings (individual, family-like or collective one). However, besides interventions used by physicians, political strategies are needed as well in order to support both

economic and social development. In this way communities can be autonomous when it comes down to health eating management.

In order to achieve this, it is of great importance to create easy access to and availability of information and education. Studies have shown that once a community is aware of the risks of bad habits and the benefits of healthy eating, they will be willing to improve their life styles and thus improve the quality of their health (Buss, 2000; Zacan, L. & Bodstein, 2002).

Health education, in the context of social practice, is based on dialogue, i.e., knowledge exchange, facilitating the comprehension of health-disease process, as well as contact and trade of information between scientific and common knowledge (Briceño-León, 1996). Educative strategies, which are interactive and thus involve both the individual and its family, are therefore needed for the promotion of healthy eating; thereby stimulating its citizen rights (Torres et al., 2003).

The programme described below, “Healthy Growing Up”, aims to takes all of these factors into account.

The **Brazilian Center of Food Habits** (Observatório Brasileiro de Hábitos Alimentares - OBHA) has its headquarter located in Oswaldo Cruz Foundation – FIOCRUZ, and it is characterized as a research laboratory, focusing on knowledge related to social, economic and cultural issues, which involve the eating habits of every society. The main goal of OBHA is to make wider the discussion about eating habits, as well as spreading knowledge related to this area through research, teaching, extension, technologic development and innovation.

Besides the technical support provided for Brazilian Ministry of Health (and other associated agencies), OBHA is welcoming projects that are interested in technical cooperation with international organisms or institutions, related to research and technologic development, education, and dissemination of information. From the Feeding, Nutrition and Culture Program, which its headquarter is also located

in FIOCRUZ, with the support of Brazilian Ministry of Health, OBHA has developed a range of teaching activities, focusing in Policy Management for Food and Nutrition. Besides that, the Program develops researches concerned to healthy eating promotion, as well as feeding and culture.

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Overweight and Obesity programmes

Healthy Growing Up

The main goal of this strategy is to build and develop information, education and communication methods based on strategies used by families living in suburbs of cities, and to guarantee the nutritional and feeding safety of these families. The individual, who is the main target of this study, is seen as an active subject that bases its knowledge on both its own personal experience and its interaction with the educative strategies presented. This will lead to a reinterpretation and new point of view of its own lifestyle and the effects of its feeding habits on it. This strategy, “Healthy Growing Up”, is expected to improve both the quality of life and the autonomy of the individual and, consequently, of its family and social environment.

Aim & Objectives: The main objective of the project is to offer an intervention model which focuses on educative health and nutrition actions, targeting both kids and young people. It acts on promoting healthy eating habits and lifestyle through a multidisciplinary intervention with kids and teenagers’ family. In addition, the project intends to stimulate the active participation of the community as well as the participation of communities’ social representatives.

Design: The interventions require at least eight meeting, which must be realized fortnightly in designated places, such as schools, health centers and certain social institutions.

During the first meeting the work crew is presented and the group is sensitized. Also, a nutritional anthropometrical evaluation is carried out, and the presence of anemia and/or hypertension among the young people is being studied. Through interactive sessions the project aims to understand the real needs of the group, its health condition, and nutritional and socioeconomic situation.

The other meetings focus on nutrition and health, and include playful activities and recreational games that stimulate reflection about the best feeding choices, and incentivize regular physical activities, while taking the environment into consideration. By the end of each meeting, the kids and teens are stimulated to think about how the activities and the presented contents can contribute to their own health and daily life.

Local authorities that can potentially help in the process of improving the lifestyle of the kids and teenagers are stimulated to participate in the process as well. As those authorities help to turn the process into something permanent, this leads to an improvement of the subject’s lifestyle. Participants who show specific personal skills are turned into special agents and continue to be involved in the educative process. Finally, the project is also linked to professional training projects, income increase, and local cooperative trade incentivizing.

During the last meeting a nutritional diagnoses is carried out in order to investigate possible nutritional changes.

Support: The project consists of a multidisciplinary team of specialists in the fields of obesity, epidemiology, nutrition, physical activity, public health and health promotion from Oswaldo Cruz Foundation. The project is coordinated by the Colaborating Center in Feeding and Nutrition/ National School of Public Health Sergio Arouca/Oswaldo Cruz Foundation and financially supported by Brazilian Ministry of Health.'

Evaluation: So far there are no published reports available describing the results and outcomes of the project. However a paper is expected to be submitted soon. The intervention seemed effective in terms of alimentary and physical activity behaviour. Obesity outcomes have not been assessed so far.

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Canada

Overweight and Obesity in Canada

The number of Canadians who are overweight or obese has steadily increased over the last 25 years, with 23.1% and 36.1% of adult Canadians being obese or overweight respectively. In addition, 26% of Canadian children and adolescents aged 2-17 are overweight or obese [127]. Physical inactivity costs the Canadian health care system at least \$2.1 billion annually in direct health care [128] costs and an estimated annual economic burden of \$5.3 [129] million. In 2001, 21% of Canadians reported their eating habits as fair or poor compared with 17% in 1997 and 15% in 1994 [130].

Overweight and Obesity Strategies

The need for a pan-Canadian healthy living approach was expressed in 2002 by the Federal, Provincial and Territorial (F/P/T) Ministers of Health, who sought a collaborative and coordinated approach to reducing non-communicable diseases by addressing their common risk factors and the underlying conditions in society that contribute to them.

In 2005 *The Integrated Pan-Canadian Healthy Living Strategy* (La Stratégie pancanadienne intégrée en matière de modes de vie sains) [127] was therefore published by The Secretariat for the Intersectoral Healthy Living Network in partnership with the Federal/Provincial/Territorial Healthy Living Task Group and the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security (ACPHHS).

This intersectoral Strategy was developed in collaboration with NGO's, private sector and all levels of government. Its goals are to improve overall health outcomes and to reduce health disparities. Populations that are at high risk of poor health, chronic disease, inequities that influence health practices and early death include individuals and families with low incomes, people with disabilities,

Aboriginal Peoples, people who live in the North and some rural areas, and other population groups that are socially and/or economically disadvantaged, excluded or marginalized [127].

The Strategy puts an emphasis on healthy eating, physical activity, and their relationship to healthy weights. In addition, the Strategy includes three healthy living targets:

- By 2015, increase by 20% the proportion of Canadians who make healthy food choices according to the Canadian Community Health Survey, and Statistic Canada/Canadian Institute for Health Information health indicators
- By 2015, increase by 20% the proportion of Canadians who participate in regular physical activity based on 30 minutes/day of moderate to vigorous activity as measure by Canadian Community Health Survey, and Physical Activity Benchmarks/Monitoring Program
- By 2015, increase by 20% the proportion of Canadians at a "normal" body weight based on a Body Mass Index of 18.5 to 24.9 as measured by the National Population Health Survey, Canadian Community Health Survey and Statistic Canada/Canadian Institute for Health Information health indicators

Although Quebec shares the general goals of The Integrated Pan-Canadian Healthy Living Strategy, it has not been subscribed to this Canada-wide strategy in this area. As Quebec intends to remain solely responsible for developing and implementing programs for promoting healthy living within its territory, it published its own action plan in 2006.

"Investing for the future – Governmental action plan for the promotion of healthy lifestyle and prevention of weight-related problems 2006-2012" [131], is an action plan by the Ministry of Health and Social Services of Québec which aims to promote a healthy diet and an active lifestyle as well as preventing weight-related problems and their consequences among both individuals and society. The objectives of the action plan are to lower the prevalence of obesity among youth and adults by 2% by 2012, and to lower the prevalence of overweight among youth and adults by 5% by 2012.

United States of America

Overweight and Obesity in the U.S.

During the past 20 years there has been a great increase in obesity prevalence in the United States. In 2005, almost one in four American adults was obese, and the condition was even more prevalent among Hispanic and black adults (26.5% and 33.9% respectively) [132]. In addition, in 2008, there was only one state (Colorado) in the United States with a obesity prevalence less than 20%, and thirty-two states had a prevalence of at least 25% (six of these states had a prevalence of obesity equal to or greater than 30%) [133].

Also obesity among children aged 6-11 has dramatically increased – going from 6.5% in 1980 to 17% in 2006. And the rate among adolescents aged 12-19 has more than tripled – going from 5% in 1980 to 17.6% in 2006 [133].

Regarding physical activity, less than half of the American adults in 2007 engaged in enough physical activity to provide health benefits. Also, in 2005 only 33% consumed fruit two or more times per day and only 27% consumed vegetables three or more times a day [133].

A study by Wang and Dietz (2002) demonstrated that among all hospital discharges, the proportion of discharges with obesity-associated diseases has increased enormously between 1979 and 1999. Based on the 2001 constant U.S. dollar value, the obesity-associated annual hospital costs for youth between six to seventeen years old, have increased more than threefold; from \$35 million (0.43% of total hospital costs) during 1979-1981 to \$127 million (1.7% of total hospital costs) during 1997 – 1999 [134]. In addition, the total cost of obesity among adults in the United States was estimated in 2000 to be \$117 billion (\$61 billion for direct medical costs and \$56 billion for indirect costs) [133].

Overweight and Obesity programmes

There are many ongoing obesity prevention initiatives running in the United States. The approaches described below are just a few examples of many ongoing projects.

Washington: Healthy Communities Moses Lake

<http://ci.moses-lake.wa.us>

In 2001, the Washington State Department of Health (DOH) received funding from the Centers for Disease Control and Prevention (CDC) to develop a program aimed at the promotion of nutrition and physical activity for the prevention of chronic diseases and obesity. The DOH formed the Nutrition and Physical Advisory Group (NPAAG), which consisted of nutrition and physical activity professionals and representatives from potential collaborating agencies, organizations and health systems.

After conducting formative research, identifying target populations, defining data sources and identifying specific strategies, the Washington State Nutrition and Physical Activity Plan was developed by the NPAAG together with the DOH. This State Plan aims to promote environmental and policy changes that encourage healthy eating and physical activity. The Washington State Nutrition and Physical Activity Plan was revised in 2008.

In 2002, the City of Moses Lake was selected by the DOH to be the first community to pilot concepts that are outlined in the State Plan. A series of interventions collectively known as “Healthy Communities Moses Lake”, promote healthy nutrition and physical activity behaviours through environmental and policy change. This will be accomplished through three strategies selected by the community: (1) the development of a trails system, (2) community gardens, and

(3) environmental and policy changes that support breastfeeding. Each strategy includes a goal statement and action steps.

For example, the city decided to replace a railroad that runs through the downtown area with a path for biking and walking [133]. The county also put in place a plan for creating walking and biking trails alongside irrigation canals, and county zoning ordinances now require wider sidewalks that will increase accessibility for both pedestrians and cyclists.



Figure 75: One of the Moses Lake Community Garden Plots in 2004

Source: http://ci.moses-lake.wa.us/index.php?page_id=245

The community garden project has been incorporated into the city's parks and recreation department work plan and is building capacity through integration with county nutrition activities and youth wellness team projects. The garden

project has established links with local school groups and chefs to make the garden both a food source and educational tool for the community.

Educating the community is a priority as well for the Moses Lake Breastfeeding Coalition, whose planned activities include discussions with local business about breastfeeding policies in the workplace, day care-provider workshops and continuing educational forums, and various community advertising and promotion efforts.

Aim & Objectives: The vision of the Moses Lake action plan is that residents in the area enjoy active, healthy lifestyles that include nutritious foods, recreation and positive interactions with each other.

Support: The initiative is funded by the Centers for Disease Control and Prevention (CDC). Partners of the project are: Washington State DOH, Healthy Communities Project Advisory Committee & Leadership Team, City of Moses Lake, Parks and Recreation Department, Grant County Health District, Columbia Basin Job Corps, local service clubs, and Moses Lake community members.

Trigger: Nearly 60% of all adults living in the state of Washington are overweight or obese. Improved eating habits and increased physical activity are keys to reversing this trend, but numerous barriers exist in (small) communities to making these healthful changes. Moses Lake needed additional resources to make physical activity safe and accessible for all of its residents, and therefore awarded funding.

Targeted Communities: Residents of the Moses Lake area, especially: low income seniors and families, young adults and teens, children in schools, people using the trail system.

Evaluation: As a result of the positive steps Moses Lake took, the DOH selected in 2003 a second pilot community, the City of Mount Vernon. This city has adopted a Healthy Communities action plan of its own to encourage habits of healthy eating and physical activity.

Active Living By Design

<http://www.activelivingbydesign.org>

Active Living By Design (ALBD) creates community-led change by working with local and national partners to build a culture of active living and healthy eating. It provides technical assistance and strategic consultation to communities, professionals, non-profit agencies and philanthropic organizations across the United States. The level of involvement can range from targeted phone consultations to long-term engagements and from serving in an advisory capacity to full collaboration as a strategic partner in creating a strong partnership, successful grants program and healthy community.

Community demonstration projects have long been used as a funding strategy to determine the feasibility and effectiveness of specific change approaches or intervention outcomes. ALBD is a community change project created to demonstrate the ability of interdisciplinary partnerships to enhance built environments to increase active living and healthy eating. The ALBD approach is based on numerous studies of successful prevention and physical activity interventions that employ comprehensive multilevel approaches supported by diverse community stakeholders.

Public health literature has shown that physical activity intervention programs that are organized within an ecologic framework can have the biggest potential to improve the health of populations. An ecological framework stresses the importance of addressing health problems at multiple levels and recognizes that behavioural determinants range from individual and interpersonal factors to community norms, environments, and policies. The ALBD Community Action Model (CAM) uses an ecological approach with the intent of coordinating complementary individual, interpersonal and environmental/policy strategies.

ALBD has identified five strategies that address partnerships and the ecologic influences on physical activity behaviours: preparation, promotions, programs, policies and physical projects. These “5P strategies” provide the intervention framework for each of the ALBD community partnerships.

The Active Living By Design’s community action model depicts how active living and healthy eating supports can be incorporated into a community and should ultimately result in increased physical activity and healthy eating. The model emphasizes a socio-ecological approach to change, as well as community partnerships that work across disciplines. The community action model follows a local active living movement from its establishment and strategies to short-, middle- and long-term changes.

The model is based on a logic model concept, using a diagram to illustrate a process of community change.

Active Living by Design Community Action Model

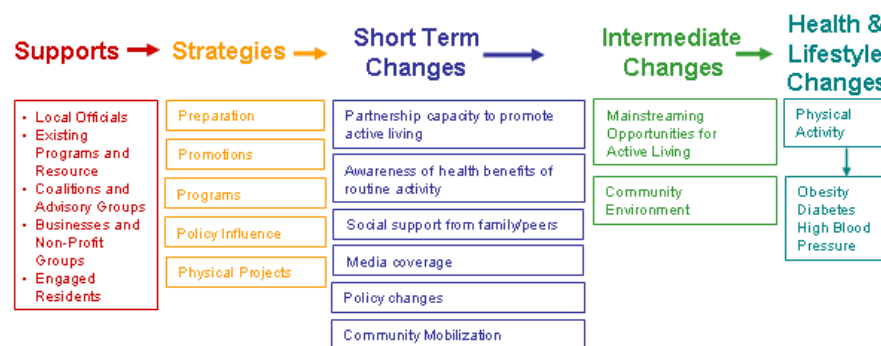


Figure 76: Active Living By Design Community Action Model

Source: <http://activelivingbydesign.org/our-approach/community-action-model#>

Active Living by Design's original call for proposals required applicants to address four strategies:

1. Create and maintain an interdisciplinary partnership that addresses active living;
2. Increase access to and availability of diverse opportunities for active living;
3. Eliminate design and policy barriers that reduce choices for active living;
4. Develop communications programs that create awareness and understanding of the benefits of active living.

Twenty-five community partnerships receive Active Living by Design grants. Their tactics vary but most include efforts such as increasing the number of parks, trails, and community gardens; promoting transit and bicycle-commuting possibilities; changing local zoning laws to require sidewalks in new developments and redesigning street standards; developing walking clubs and programs such as Safe Routes to School; encouraging employers to provide bike lockers, showers, and gym memberships for their employees; engaging local elected officials and the media; and raising public awareness about the relationship between inactivity and the built environment.

An overview of all communities involved in the Active Living By Design Program can be found on the website www.activelivingbydesign.org. One example of a community that has received a grant is the community in Chicago, IL:

The Active Living Logan Square partnership focuses on creating an environment that promotes physical activity and health in the southwest corner of Chicago's Logan Square neighbourhood. This partnership represents a community-organizing model for active living that emphasizes resident leadership and decision making and a partnership with the Logan Square Neighbourhood Association, a grassroots organization in a predominantly Latino urban community.



Figure 77: Active Living Logan Square, Chicago IL

Source: <http://activelivingbydesign.org/communities/profiles/chicago-il>

The partnership conducted an asset-based community survey focused on physical activities such as dancing, cycling, walking, and gardening. The survey identified safety concerns as a major barrier to physical activity. In response, the partnership helped initiate a walking school bus program and created a safety committee which brings together seven schools, two police districts, four Aldermen, and ten community-based organizations to collaborate on safety issues. Another challenge to physical activity is the lack of open space in Logan Square. The partnership is advocating for the development of the Bloomingdale Trail/Linear Park, an elevated rail-to-trail conversion. In doing so, it is helping to ensure city officials hear local residents' ideas and concerns. Since conducting the survey, the partnership organized "Ayuda Mutua" initiatives to create opportunities for residents to teach, learn, and engage in physical activities that are fun, and easily incorporated into daily life, and welcome participation by the whole family.

Active Living Logan Square's vision is that residents will implement a strategic plan that emphasizes the community's priorities, such as working with a local school to reinstate recess, increasing walking and cycling, creating an environment where neighbours know each other, and sharing skills that promote physical activity. To celebrate, residents will participate in "Sunday Parkways,"

where miles of Chicago's beautiful boulevards are closed to cars and open to pedestrians and bicyclists. These efforts will help make Logan Square a healthier, more vibrant community.

So far, the community has:

- *Completed a door-to-door asset-based survey in Spanish of over 400 residents focused on barriers and opportunities for physical activity.*
- *Received \$89,000 from the state health department and corporate funding for programs.*
- *Graduated 110 families from the Salsa, Sabor y Salud program in 2004-2005, designed to promote healthy diets and physically active lifestyles among Latino families.*
- *Sponsored two Safety Summits with representatives of seven schools, two police districts, ten community organizations, and four Aldermen to address school safety issues.*
- *Worked with City of Chicago Commissioner of Public Health to champion Sunday Parkways.*
- *Partnered with Ames Middle School to create a permanent bike space in the school building, and partnered with the Chicagoland Bicycle Federation and After School Matters to hold bike repair/safety classes for local youth.*

Aim & Objectives: The vision of Active Living By Design is healthy communities, where routine physical activity and healthy eating are accessible, easy and affordable to everyone.

Support: Active Living By Design is established by the Robert Wood Johnson Foundation, and is part of the North Carolina Institute for Public Health at the UNC Gillings School of Global Public Health in Chapel Hill, North Carolina.

Active Living By Design works with multiple funders in communities throughout the United States and with a large concentration in our home state of North

Carolina (BlueCross BlueShield of Minnesota, BlueCross BlueShield of North Carolina Foundation, W.K. Kellogg Foundation, North Carolina Health Wellness Trust Fund, Robert Wood Johnson Foundation).

The Foundation's initial investment in the program was nearly \$5 million, and the financial contributions to the community partnerships are \$200,000 over five years for each site. Through the first five years of the program, community partnerships secured \$129 million from other sources to support Active Living initiatives in their project areas.

Trigger: Active Living By Design was established as a national program office of the Robert Wood Johnson Foundation in late 2001. The grant program funded and provided technical assistance to 25 action oriented, multidisciplinary community partnerships that developed and implemented local projects to support physical activity and active living.

Evaluation: Scientific support of the effectiveness of the 5P strategies can be found in various studies, many of which were summarized by the federal Task Force on Community Preventive Services, which recommended physical activity interventions with informational, behavioural, and environmental and policy approaches. These interventions included community-wide campaigns, tailored behaviour change programs, point-of-decision prompts, school-based physical education and enhanced access to places for physical activity, combined with informational outreach activities.

6. Overview of Responses

All the 97 projects described in this report aim to address and tackle the obesity problem across the gradient, with a specific focus on lower socio-economic groups. In order to achieve this there are, however, differences in methodologies, target groups reached, settings, scale and scope. The following chapter therefore lays out what common core approaches were used by the interventions described to reduce obesity, and which designs were implemented to specifically focus on the promotion of healthy nutrition or physical activity. It gives an overview of the responses, classifies the different elements that can be used and lays out possible innovative and promising approaches.

Target Group Many of the practices described focus on the prevention of obesity and promotion of health equity among one or more specific target groups. The following groups can be identified that were targeted by the interventions described in this publication:

1. Children (and their families)
2. Ethnic minorities
3. Women / gender inequalities
4. Older people
5. People with a low educational background
6. People living in deprivation – rural areas
7. People living in deprivation – city districts
8. Additional groups (e.g. persons having debts)

Setting/Access to information The following settings were used by the practices described to reach the target group and make them aware of the possibility to get involved and participate in the different health promoting activities:

1. Contacting directly
2. Low-threshold centres (e.g. healthy living centres, drop-in clinics)
3. Schools / youth centres
4. Media (e.g. leaflets, newspapers, add shells)
5. Multi language, culture specific distribution materials
6. Medical authorities (e.g. pharmacies, general practitioners)

The following persons acted as intermediates:

1. Experts (e.g. dieticians, physiotherapists)
2. Role models /peer educators (e.g. professional football players)
3. Intercultural mediators (e.g. migrant chair person)

General Methodologies Notably, all interventions described in this publication focus on the promotion of healthy lifestyle activities, and not on the prevention and reduction of unhealthy products or environments. These projects could therefore be seen as additional to addressing the structural determinants of social inequality.

The following methodologies described were used to develop health-promoting interventions. Most projects incorporate more than one of these methodologies.

Provision of Information and change of attitudes

1. **Provide practical information and tips on healthy nutrition and/or (daily) physical activity** – e.g. what is the daily amount of fruit and vegetables a person should take, how many minutes a day should you be physically active and how can you prepare a healthy but cheap meal.
2. **Provide information in a fun and interactive way** – e.g. using games, workshops, tasting sessions etc.
3. **Provide opportunities for the target group to share information and discuss personal experiences** – e.g. give participants the possibility to reflect upon their own experiences, to discuss difficulties, and to promote dialogue and information exchange in and between individuals and groups.
4. **Enhance and improve the knowledge of the target group about the importance of an increased fitness in relation to medical conditions** – e.g. diabetes, cardiac health, metabolic syndromes etc. Put emphasis on the aspect that it will be a life-long benefit to improve your fitness.
5. **Develop a more positive attitude towards the consumption of fruit and vegetables and physical activities** – e.g. healthy nutrition doesn't have to be expensive and doesn't have to require a lot of time to prepare.
6. **Gain insight into relation between overweight, nutrition and physical activity and the role of social pressure, emotion and cultural habits**

Empowerment and participation of the target group

1. **Empowerment of the target group** - Increase their sense of control, self-esteem and self-confidence and make them recognise their ability and capacity to improve their own personal circumstances and that of their relatives.
2. **Improve social cohesion** – Encourage the target group to join group activities (e.g. eat jointly together) and to become more actively involved in the community. Establish social networks to ease social isolation and facilitate networking among community groups.

3. **Involve participants in the whole process of the intervention** – let the target group contribute to the development and running of the project and encourage their participation and involvement. E.g. train (dedicated) participants to become multipliers/co-trainers.
4. **Provide health training and education or employment opportunities**

Access and availability

1. **Improve access to services** – e.g. promote locally grown products, improve the supply of healthy food to people or create healthy playgrounds in the neighbourhood of the targeted communities.
2. **Improve availability of healthy food and physical activity** – provide a wide range of food and physical activity events that the target group can choose from. E.g. encourage local retailers to promote healthy, low-cost food options and encourage schools to organise sport events.
3. **Organise theme based consults/activities** – e.g. mental health, healthy nutrition, fitness and exercise, well being and emotional health.

Additional methodologies – Nutrition The following methodologies were used when the aim of the interventions was to promote and increase in consumption of healthy food.

1. **Provide learning/training opportunities on gardening skills and techniques** – Enhance knowledge and skills in relation to fruit and vegetable growing (gardening processes). Learning inside the garden will hopefully be transferred to participants' own homes.
2. **Provide nutritional education and enhance the participants cooking and preparation skills of healthy nutrition** – e.g. providing opportunities to 'cook and try' (cooking clubs, workshops, tasting sessions etc.)
3. **Emphasise on the financial aspect** – healthy nutrition doesn't have to be expensive (e.g. provide household budgeting skills, providing the target group with a menu for a limited budget for a week)

4. **Develop purchasing activities** – e.g. organise supermarket tours, enhance the knowledge of the target group on how to read food labels.

Additional methodologies – Physical activity The following methodologies were used when the aim of the interventions was specifically to promote and increase physical activity among the target group.

1. **Involve the parents of participating (obese) children** - enhance their knowledge of the importance of increasing their children's physical activity and explain how they can support their kids to improve their fitness. Show them the importance of the role they can play.
2. **Measure indicators of obesity to motivate the target group to change their lifestyle** – e.g. blood pressure, cholesterol levels, blood sugar monitoring, height/weight assessments.
3. **Motivate the target group to continue with physical activities by rewarding them** – e.g. using stamps each time they finished a specific task, give participants a diploma at the end.
4. **Motivate the target group by continuously monitoring and evaluating their performances** – e.g. fitness test/ follow up system/ database/blueprint the participants functioning. Stimulate them in a structured way.
5. **Let the participants make a commitment to participate** – set goals for change. Let them work towards a certain point/goal.

7. Conclusions and Discussion

Obesity prevention strategies are mainly set up to either encourage individuals to modify their lifestyle, to modify the obesogenic environment, or to develop legislative changes [135]. However, to date it is dubious how often such approaches take health equity into account and what strategies are required when addressing obesity in relation to health inequalities. This report has tried to address these questions by collecting relevant information and has concluded the following:

- The implementation of projects at **local level** plays an important role when the goal is to target disadvantaged communities. This result is confirmed by previous studies, as they have shown that lower socio-economic groups are less likely to respond to programmes implemented at national level. In addition, mass media and health education campaigns have higher dropout rates among disadvantaged communities compared to high socio-economic classes [12, 136-137].
- **Community-based** health promotion efforts can be effective to address health issues among groups at local level. These approaches show the importance of **involving** vulnerable communities during the development, implementation and evaluation of a project. By approaching and engaging people from more vulnerable groups directly, they tend to be more effectively reachable and willing to change their behaviours positively.
- The information collected further identified the importance of the **development of partnerships** when preventing obesity. Not all parties involved necessarily need to be active within the health sector; external stakeholders are often crucial, including economic operators, as long as transparent and ethical public health values are observed. Many practices described used such a cross-sectoral approach, and have proven to be successful as a behavioural change was often identified among the target group. It is thus important to address the obesity problem from different sectors and angles [138].
- Even though 97 examples of projects were included in this report, only a few of them have been properly **evaluated**. This will not be acceptable if scaling up on international levels is to be achieved. Controlled intervention programmes are needed to examine their effect on different socio-economic groups and their effect on a long term basis. Also, European level comparisons of the impact of support from local health services on the prevention of obesity among communities from deprived areas, would bring added value. They have improved the processes of care, but a definite proof of improved disease outcomes is still lacking [12].
- Finally, as most of the prevention projects targeting communities are implemented at local level, it is likely that they will not be noticed at national level. **Monitoring** and **accessibility** of data and information of local initiatives is a precondition to scaling up and horizontal transferability. By monitoring the initiatives via - for instance - umbrella organisations (a good example is the Community Food and Health organisation in Scotland), evidence, experience and knowledge can be shared and exchanged within and between countries at a European level.

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