



# Study on the evaluation of the EU Action Plan on Childhood Obesity

Final report

Specific contract No HaDEA/2022/P2/02 in the context of the Better Regulation Framework Contract SANTE/2021/OP/0002

Written by Open Evidence, PwC EU Services,  
SAFE Food Advocacy Europe  
February 2025



**EUROPEAN COMMISSION**

Directorate General for Health and Food Safety

Unit B.1: Cancer, Health in all policies

E-mail: [SANTE-CANCER@ec.europa.eu](mailto:SANTE-CANCER@ec.europa.eu)

European Health and Digital Executive Agency (HaDEA)

Department A, Health and Food

Unit A2.001 EU4Health

E-mail: [HADEA-HP-TENDER@ec.europa.eu](mailto:HADEA-HP-TENDER@ec.europa.eu)

B-1049 Brussels

# Study on the evaluation of the EU Action Plan on Childhood Obesity

## Final report

Specific contract No HaDEA/2022/P2/02 in the context of the Better  
Regulation Framework Contract  
SANTE/2021/OP/0002

### **Authors:**

Giovanni Liva (Open Evidence)  
Silvia Grothe i Riera (Open Evidence)  
Giorgia Spolverato (Open Evidence)

PwC EU Services  
SAFE Food Advocacy Europe

**Acknowledgements to the Panel of Experts:** Ourania Kolokotroni (Cyprus University of Technology), Giorgos K. Sakkas (University of Thessaly, Greece), Jacob C. Seidell (VU University of Amsterdam, the Netherlands) and John J Reilly (University of Strathclyde Glasgow, Scotland).

Manuscript completed in February 2025

This report was produced under the EU4Health Programme under a service contract with the European Health and Digital Executive Agency acting under mandate from the European Commission. The information and views set out in this report are those of the author(s) and do not necessarily reflect the official opinion of the Commission/Executive Agency. The Commission/Executive Agency does not guarantee the accuracy of the data included in this study. Neither the Commission/Executive Agency nor any person acting on the Commission's/Executive Agency's behalf may be held responsible for the use which may be made of the information contained therein.

Luxembourg: Publications Office of the European Union, 2025

© European Union, 2025



The reuse policy of European Commission documents is implemented by Commission Decision 2011/833/EU of 12 December 2011 on the reuse of Commission documents (OJ L 330, 14.12.2011, p. 39). Unless otherwise noted, the reuse of this document is authorised under a Creative Commons Attribution 4.0 International (CC BY 4.0) licence (<https://creativecommons.org/licenses/by/4.0/>). This means that reuse is allowed provided appropriate credit is given and any changes are indicated.

PDF ISBN 978-92-95242-02-9 doi:10.2925/4805896 HW-01-25-053-EN-N

# Contents

<b>List of official Member State abbreviations and other acronyms.....</b>	<b>xxix</b>
Official Member State abbreviations.....	xxix
Other acronyms.....	xxix
<b>1 Introduction .....</b>	<b>1</b>
1.1 Policy Context: the EU Action Plan .....	2
1.2 Scope of the study .....	3
1.3 Purpose of the study .....	4
<b>2 Methodological approach.....</b>	<b>5</b>
2.1 Research questions and methodology .....	5
2.2 Areas for Action and Key topics .....	6
2.3 Desk research (Task 1).....	8
2.3.1 Implementation of the EU Action Plan and mapping of national (policy) approaches	8
2.3.2 Obstacles and challenges .....	9
2.3.3 Best practices .....	10
2.4 Consultation activities (Task 2) .....	12
2.4.1 Survey with national authorities.....	12
2.4.2 Interviews and focus groups .....	13
2.5 Validation workshops (Task 3).....	15
2.6 Data analysis and triangulation of sources.....	16
2.6.1 Country profiles.....	16
2.6.2 Colour-code system .....	17
2.7 Reporting and deliverables.....	18
2.8 Limitations of the study and mitigation measures.....	19
<b>3 Prevalence of childhood obesity in Europe .....</b>	<b>20</b>
3.1 Aggregate level of childhood obesity.....	20
3.2 Childhood obesity by country .....	22

3.3	Risk factors for childhood obesity.....	26	
<b>4</b>	<b>Main findings .....</b>	<b>28</b>	
4.1	Mapping and implementation of policies and actions by Member States	28	
4.1.1	National (childhood) obesity action plans and strategies .....	28	
4.1.2	Use of the EU Action Plan in policy .....	30	
4.1.3	Policy priorities with respect to childhood obesity .....	31	
4.1.4	Summary of implementation progress .....	35	
4.1.5	Area 1: Support a healthy start in life .....	40	
4.1.6	Area 2: Promote healthier environments .....	43	
4.1.7	Area 3: Make the healthy option the easier option.....	48	
4.1.8	Area 4: Restrict marketing and advertising to children .....	54	
4.1.9	Area 5: Inform and empower families.....	58	
4.1.10	Area 6: Encourage physical activity .....	60	
4.1.11	Area 7: Monitor and evaluate .....	64	
4.1.12	Area 8: Increase research and financial support .....	66	
4.2	Actions by the European Commission and other international organisations		68
4.2.1	European Commission (legislation, Joint Actions, EU-funded projects)...	68	
4.2.2	International organisations .....	72	
4.3	Current obstacles and challenges to policy implementation.....	74	
4.3.1	General overview .....	74	
4.3.2	Cross-cutting obstacles.....	75	
4.3.3	Obstacles specific to each Area for Action .....	77	
4.3.4	Area 2: Promote healthier environments .....	80	
4.3.5	Area 3: Make the healthy option the easier option.....	82	
4.3.6	Area 4: Restrict marketing and advertising to children .....	83	
4.3.7	Area 5: Inform and empower families.....	85	
4.3.8	Area 6: Encourage Physical Activity.....	86	
4.3.9	Area 7: Monitor and Evaluate.....	87	
4.4	Collection of best practices per Area for Action.....	88	
4.4.1	General overview .....	88	
4.4.2	Best practices per Area for Action.....	89	
4.4.3	Best practices from third countries .....	99	
4.5	Status of monitoring and indicators used .....	101	
4.5.1	Area 1 – Support a healthy start in life .....	102	
4.5.2	Area 2 – Promote healthier environments .....	103	
4.5.3	Area 3 – Make the healthy option the easier option.....	105	
4.5.4	Area 4 – Restrict marketing and advertising to children.....	107	
4.5.5	Area 5 – Inform and empower families.....	108	
4.5.6	Area 6 – Encourage physical activity.....	110	
<b>5</b>	<b>Stakeholders’ views on the EU Action Plan.....</b>	<b>112</b>	
5.1	Member States.....	112	
5.1.1	Impact of the EU Action Plan .....	112	
5.1.2	Stakeholder involvement in policy-making process .....	116	
5.1.3	Perceptions of the EU Action Plan and other EU Actions .....	117	
5.1.4	Member State Recommendations.....	118	

5.2	National and international NGOs.....	119
5.2.1	Public Health NGOs.....	120
5.2.2	Education NGOs.....	121
5.2.3	Sports NGOs .....	122
5.2.4	Parents associations.....	123
5.3	Consumer organisations .....	123
5.4	Food and beverage Industry .....	124
5.5	Marketing and advertisement industry associations.....	124
5.6	Academic experts.....	125
5.7	Summary of stakeholder recommendations .....	126
<b>6</b>	<b>Conclusions.....</b>	<b>129</b>
6.1	Summary of the main takeaways .....	129
<b>7</b>	<b>Bibliography .....</b>	<b>132</b>
<b>8</b>	<b>Annexes .....</b>	<b>137</b>
8.1	Annex I: Description Areas for Action.....	137
8.2	Annex II: Colour-code criteria for Area for Action .....	140
8.3	Annex III: Summary colour-code system.....	158
8.4	Annex IV: Description of efforts by the European Commission and international organisations after 2014.....	160
8.5	Annex V: Country profiles with colour-code.....	170
8.6	Annex VI: Country profiles.....	170
8.7	Annex VII: Obstacles and Challenges.....	170
8.8	Annex VIII: Best Practices.....	170
8.9	Annex IX: Good Practices .....	170
8.10	Annex X: Consultation Materials .....	175
8.11	Annex XI: Synopsis Report .....	175

## Abstract

The EU Action Plan on Childhood Obesity 2014-2020 aimed to curb the increasing rates of overweight and obesity among children and young people in the EU. This study shows that progress was made at national and EU levels compared to before 2014, and the EU Action Plan contributed positively to this progress. Nonetheless, all Member States still fall short of the optimal policy environment to achieve the goals outlined by the EU Action Plan. On average, 64% of the EU Action Plan was implemented at national level. Member States adopted measures on a voluntary basis, and often, this was dependent on the political priorities and capacity of the individual countries. This resulted in a fragmented implementation across the Member States. The inconsistency hindered a cohesive approach, as varying levels of commitment and resources among countries led to uneven progress and gaps in addressing obesity effectively across the region. Across the eight Areas for Action of the EU Action Plan that were analysed, many countries implemented initiatives focused on enhancing school environments, and monitoring and evaluation. The Areas for Action where the least initiatives were implemented related to improving food environments and making healthy choices easier, and restricting marketing and advertising to children — where actions often relied on voluntary measures or agreements. Familiarity with the EU Action Plan was generally high among national authorities surveyed. Of the 40 respondents, 15 indicated a high level of familiarity, while 16 reported a moderate level of familiarity. Notably, 8 out of 38 national authority representatives surveyed felt that the EU Action Plan significantly supported the development of national policies, while 13 out of 38 indicated they did so to a moderate degree. Key challenges identified included poor collaboration across policy areas and limited political will. More than 63 best practices to address childhood obesity were identified throughout the study.

## Abstrakt

Der EU-Aktionsplan gegen Adipositas bei Kindern 2014–2020 verfolgte das Ziel, die steigenden Übergewichts- und Fettleibigkeitsraten bei Kindern und Jugendlichen in der EU einzudämmen. Diese Studie zeigt, dass seit 2014 sowohl auf nationaler als auch auf EU-Ebene Fortschritte erzielt wurden, zu denen der Aktionsplan einen positiven Beitrag geleistet hat. Dennoch bestehen in allen Mitgliedstaaten weiterhin unzureichende politische Rahmenbedingungen, um die im EU-Aktionsplan festgelegten Ziele zu erreichen. Im Durchschnitt wurden 64 % des EU-Aktionsplans auf nationaler Ebene umgesetzt. Die Mitgliedstaaten ergriffen Maßnahmen überwiegend auf freiwilliger Basis, oftmals in Abhängigkeit von den jeweiligen politischen Prioritäten und Kapazitäten. Dies führte zu einer fragmentierten Umsetzung, die einen kohärenten europäischen Ansatz erschwerte. Unterschiedliche Engagements und Ressourcen in den EU-Ländern führten zu ungleichmäßigen Fortschritten und Lücken in der wirksamen Bekämpfung kindlicher Adipositas in der gesamten europäischen Region. In den acht untersuchten Aktionsbereichen des EU-Aktionsplans setzten viele Länder Initiativen zur Verbesserung des schulischen Umfelds sowie zur Beobachtung und Bewertung durch. Die Aktionsbereiche, in denen die wenigsten Initiativen durchgeführt wurden, waren die Bereiche der Verbesserung des Nahrungsmittelumfelds, der Erleichterung gesunder

Kaufentscheidungen sowie der Einschränkung von Marketing und Werbung für Kinder. In diesen Bereichen stützten sich viele Mitgliedstaaten weiterhin überwiegend auf freiwillige Maßnahmen oder Vereinbarungen. Die Vertrautheit mit dem EU-Aktionsplan war bei den befragten nationalen Behörden insgesamt hoch. Von 40 Befragten gaben 15 an, sehr vertraut zu sein, während 16 einen mittleren Vertrautheitsgrad angaben. Unter den 38 befragten Vertretern nationaler Behörden waren 8 der Auffassung, dass der EU-Aktionsplan die Entwicklung nationaler Politiken erheblich unterstützt, während 13 von 38 einen mittleren Unterstützungsgrad angaben. Zu den zentralen Herausforderungen zählten die mangelnde Zusammenarbeit zwischen den Politikbereichen sowie ein mangelnder politischer Wille. Insgesamt konnten im Rahmen der Studie mehr als 63 Vorzeigeprojekte zur Bekämpfung von Adipositas bei Kindern identifiziert werden.

## Résumé

Le plan d'action de l'UE sur l'obésité infantile 2014-2020 visait à freiner l'augmentation des taux de surpoids et d'obésité chez les enfants et les jeunes dans l'UE. Cette étude montre que des progrès ont été réalisés aux niveaux national et européen par rapport à la situation qui prévalait avant 2014, et que le plan d'action a contribué de manière positive à ces progrès. Néanmoins, tous les États membres ne disposent pas encore d'un environnement politique optimal pour atteindre les objectifs définis par le plan d'action de l'UE. En moyenne, 64 % du plan d'action de l'UE a été mis en œuvre au niveau national. Les États membres ont adopté des mesures sur une base volontaire, souvent en fonction des priorités politiques et des capacités de chaque pays. Il en résulte une mise en œuvre fragmentée entre les États membres. Ceci a empêché l'adoption d'une approche cohérente, étant donné que la diversité des niveaux d'engagement et de ressources entre les pays a entraîné des progrès inégaux et des lacunes dans la mise en œuvre d'une politique efficace de lutte contre l'obésité dans l'ensemble de la région. Dans les huit domaines d'action du plan d'action de l'UE qui ont été analysés, de nombreux pays ont mis en œuvre des initiatives axées sur l'amélioration des environnements scolaires, ainsi que sur le suivi et l'évaluation. Les domaines d'action dans lesquels le moins d'initiatives ont été mises en œuvre concernent l'amélioration de l'environnement alimentaire et la facilitation des choix sains, ainsi que la limitation du marketing et de la publicité auprès des enfants, domaines dans lesquels les actions reposent souvent sur des mesures ou des accords volontaires. Les autorités nationales interrogées connaissent généralement bien le plan d'action de l'UE. Sur les 40 répondants, 15 ont indiqué un niveau de connaissance élevé, tandis que 16 ont fait état d'un niveau de connaissance moyen. En particulier, 8 des 38 représentants des autorités nationales interrogés ont estimé que le plan d'action de l'UE soutenait de manière significative le développement des politiques nationales, tandis que 13 sur 38 ont indiqué que c'était le cas dans une moindre mesure. Parmi les principaux défis identifiés, figurent un manque de collaboration entre les différents domaines d'action et une volonté politique limitée. Plus de 63 bonnes pratiques visant à lutter contre l'obésité infantile ont été recensées tout au long de l'étude.

## Executive summary

The prevalence of childhood overweight and obesity in Europe is a significant public health concern.<sup>1</sup> The latest data from the World Health Organisation (WHO) Childhood Obesity Surveillance Initiative (COSI) showed that almost 1 in 3 European children (7-9 years old) were considered overweight (including obese children) between 2018 and 2020.<sup>2</sup> The causes of childhood obesity are multifaceted, involving environmental factors, lifestyle choices (including excessive consumption of energy-dense foods and decreased physical activity), and cultural influences, as well as medications, diseases, trauma, and genetic variations. Childhood obesity has both individual short-term and long-term impacts on a person's life, as well as far-reaching societal consequences. Since obesity develops and becomes more pronounced across the life course, prevention of obesity in critical life-course phases, such as preconception and pregnancy periods<sup>3</sup>, infancy and adolescence, are likely to have the greatest health and cost benefits.<sup>4</sup>

The EU Action Plan on Childhood Obesity 2014-2020<sup>5</sup> (hereinafter referred to as the “EU Action Plan”) was drafted by the former High-Level Group on Nutrition and Physical Activity, a group of government representatives from the 28 EU Member States (formerly including the UK), Iceland, Norway and Switzerland, with support from the European Commission. This guidance document was formally endorsed by the Member States in 2014 as a non-legislative policy instrument in February 2014. The goal of the EU Action Plan was to contribute to halting the rise in overweight and obesity in children and young people by the year 2020. Moreover, it aimed to demonstrate a shared commitment of Member States to address childhood obesity, set out priority areas for action and a possible toolbox of measures and propose ways of collectively keeping track of progress. The EU Action Plan contains eight Areas for Action:

- **AREA 1:** Supporting a healthy start in life
- **AREA 2:** Promote healthier environments (especially in schools and pre-schools)
- **AREA 3:** Make the healthy option the easier option
- **AREA 4:** Restrict marketing and advertising to children
- **AREA 5:** Inform and empower families
- **AREA 6:** Encourage physical activity
- **AREA 7:** Monitoring and evaluation
- **AREA 8:** Increasing research and financial support

---

<sup>1</sup> Buoncristiano, M. et al. (2021). Childhood overweight and obesity in Europe: Changes from 2007 to 2017. *Obesity Reviews*, 22, e13226. Available at: [Link](#)

<sup>2</sup> WHO. (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Available at: [Link](#)

<sup>3</sup> Lecorguillé, M. et al. (2023). Impact of parental lifestyle patterns in the preconception and pregnancy periods on childhood obesity. *Frontiers in nutrition*, 10, 1166981.

<sup>4</sup> Garrido-Miguel, M. Et al. (2019). Prevalence of overweight and obesity among European preschool children: a systematic review and meta-regression by food group consumption. *Nutrients*, 11(7), 1698. Available at: [Link](#)

<sup>5</sup> European Commission. (2014). EU Action Plan on Childhood Obesity 2014-2020. Available at: [Link](#)

The EU Action Plan was evaluated previously through a mid-term evaluation (2014-2018),<sup>6</sup> and this study represents the final evaluation. The objectives of the study included: i) evaluate the progress achieved in the key areas for action in the Action Plan; ii) provide an overview of the efforts carried out by the 27 EU Member States as well as the UK<sup>7</sup> during the period 2014-2020; iii) map planned actions at the national level; iv) identify obstacles and remaining challenges; v) identify best practices; vi) engage stakeholders and collect feedback and opinions.

## **Methodological Approach**

The study was composed of desk research (Task 1), consultation activities (Task 2) and validation workshops (Task 3). The results of each task were subsequently triangulated to generate the study's findings.

### *Desk research (Task 1)*

The goal of the desk research was to collect preliminary information on the implementation of the EU Action Plan across countries, current and planned national (policy) approaches to address childhood obesity, identify specific obstacles and challenges and collect best practices. To this end, resources analysed included official websites of the Member States Competent Authorities, online policy repositories, scientific articles, and official reports from leading health and obesity organisations, such as WHO, Organisation for Economic Co-operation and Development (OECD), or the World Obesity Federation (WOF) and sources of grey literature. The desk research task included the evaluation of the progress of the EU Action Plan's implementation at the national level, by mapping national (policy) approaches adopted in the eight Areas for Action of the Plan after 2010. Secondly, the research assessed obstacles that have emerged or might arise during the implementation of obesity policies. The identified challenges were categorised and linked to specific action areas, identifying recurring themes across countries. Lastly, successful policy practices and interventions in relation to the Areas of Action of the Plan have been collected. Best practices were selected using criteria adapted from the "Criteria to select best practices in health promotion and disease prevention and management in Europe" by DG SANTE.<sup>8</sup>

### *Consultation activities (Task 2)*

A survey and follow-up interviews were conducted with national ministries and officials from national public health authorities. Additionally, interviews and focus groups were held with key stakeholders relevant to childhood obesity, including international organisations, parent and family associations, academics and scientific experts, education NGOs, EU and national public health NGOs, sports NGOs, consumer associations, marketing and advertising industry associations, and food and beverage industry associations. The goal of the task was to fill the evidence gaps from the desk research and to gather insights from various stakeholder groups to effectively address the study goals. The survey received a total of 40 valid responses from the 27 Member States. Moreover, 42 interviews were

---

<sup>6</sup> European Commission, Directorate-General for Health and Food Safety, Pushkarev, N., Hansen, J., Driesenaar, J. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: the childhood obesity study, Publications Office. Available at: [Link](#)

<sup>7</sup> The United Kingdom is included within the scope of the study, as it was still part of the EU when the EU Action Plan was adopted in 2014.

<sup>8</sup> European Commission – Directorate-General for Health & Food Safety. (2017). Criteria to Select Best Practices in Health Promotion and Disease Prevention and Management in Europe. Available at: [Link](#).

conducted with national authorities from 22 countries, while 53 interviews were performed with stakeholders from 19 countries.

### Validation workshops (Task 3)

Four validation workshops were conducted with national authorities and stakeholder groups. The aim of the workshops was to collect further insights and ensure the representativeness and appropriateness of the preliminary findings. Out of approximately 282 stakeholders invited, a total of 51 stakeholders participated in the workshops, divided into four groups (i) 25 national authorities (ii) 6 EU-level industry representatives, (iii) 15 NGO representatives and (iv) 5 academic experts.

### Data analysis and triangulation of sources

The qualitative and quantitative findings collected over the three study tasks were triangulated to compare and validate the information, synthesise and analyse, and draw robust conclusions. A total of 28 country profiles were developed during Task 1 in order to present the findings in a comprehensive manner and highlight initiatives implemented and progress achieved in each country. For each country profile, a traffic light table presenting an assessment of the implementation progress of national measures aligned with the Areas for Action was developed.

## **Study findings**

### Mapping and implementation of policies and actions by Member States

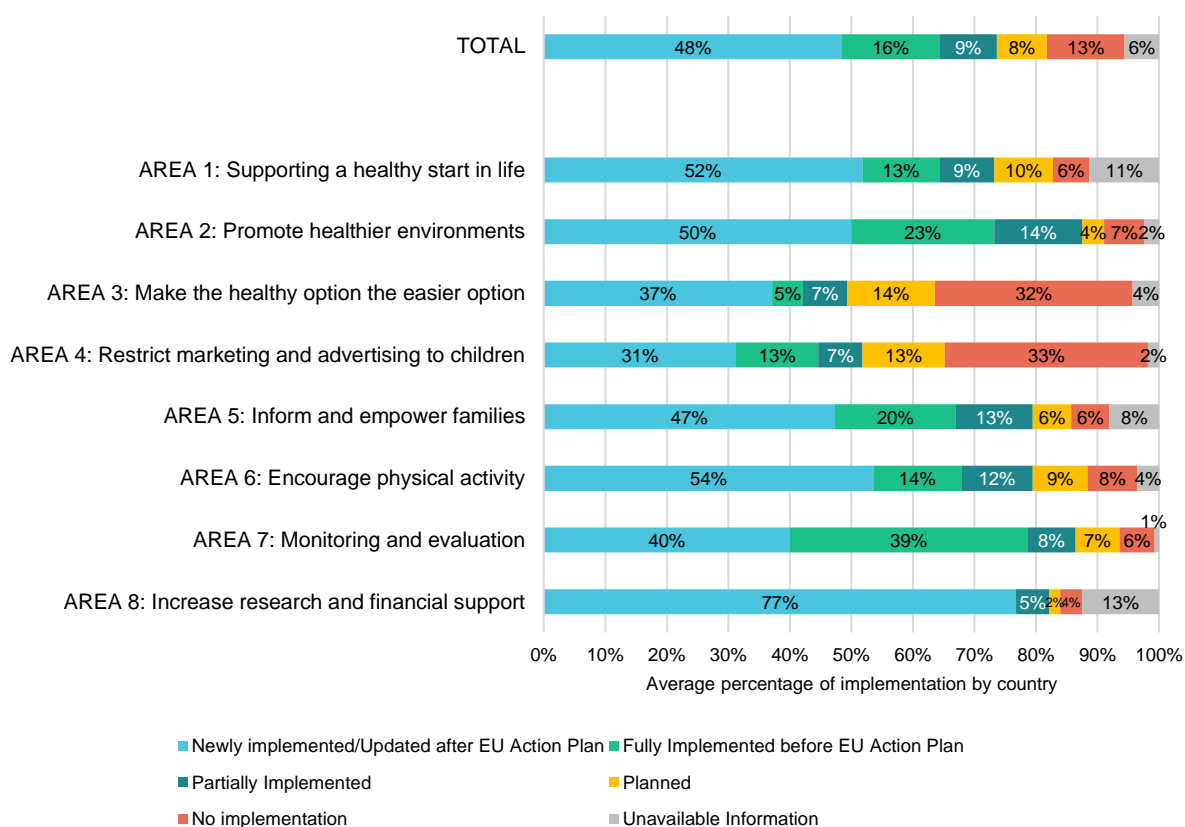
Over 1,500 obesity-related measures were identified in 27 Member States plus the UK, to evaluate the national-level progress in implementing policies across all Areas for Action in the EU Action Plan. From the analysis it emerged that:

- Three countries (EL, ES, UK) have adopted National Childhood Obesity Plans since the EU Action Plan. Eight other countries have broader plans with specific measures for children (HR, DK, FI, FR, IE, MT, SI, ES). All countries have implemented wider initiatives to improve population lifestyles, often through plans focused on nutrition, physical activity, or non-communicable diseases. Belgium, Cyprus, Latvia, and Luxembourg are drafting or negotiating childhood obesity plans. While Sweden lacks a dedicated national plan, it has taken measures such as school-based guidelines and early childhood activity recommendations.
- Seven countries explicitly refer to the EU Action Plan in their policy documents (FI, MT, ES, LT, LU, SK, SI).
- The analysis of implementation showed that Finland, Lithuania and France were the countries that adopted or updated actions covering more key topics since 2014, while the Czech Republic, Cyprus and Slovakia have adopted the less actions. Nonetheless, no country implemented actions addressing all key topics outlined in the EU Action Plan.
- Across countries, efforts to combat childhood obesity largely focused on improving school environments by enhancing school meals, banning vending machines, and updating dietary guidelines (Area 2), as well as promoting breastfeeding (Area 1). Moreover, all countries participated in at least one EU Joint Action related to

childhood obesity, and most engaged in international and national obesity monitoring surveys. However, implementation in policy areas related to improving food environments and making healthy choices easier (Areas 3 and 4) remained limited, with many relying on voluntary agreements with the food industry and private actors in topics regarding food reformulation and restrictions on marketing and advertisement.

- The analysis of this study shows that EU Member States and the United Kingdom cover on average 64% of the key topics of the EU Action Plan, with 48% of topics newly addressed or updated after the adoption of the EU Action Plan.

**Figure 1 – Overview of implementation of EU Action Plan by Area for Action across Member States and the UK**



Source: Authors' elaboration

### Actions by the European Commission and other international organisations

The European Commission's role in childhood obesity prevention is found to be supportive, providing coordination, guidance, and funding. The EU's actions span prevention, diagnosis, research, and policy, using tools like regulations, directives, expert groups action plans and financial support. Key initiatives before 2014 include the EU Platform for Action on Diet, Nutrition, and Physical Activity (2005), the Strategy on Nutrition, Overweight, and Obesity (2007), and the High-Level Group on Nutrition and Physical Activity. Some directives and regulations, implemented before 2014, such as

those on nutrition claims, infant formula, advertising, and food labelling, have links with some specific Areas for Action in the EU Action Plan. After 2014, the Commission supported relevant initiatives like Joint Actions on Chronic Disease (CHRODIS)<sup>9</sup> and CHRODIS+<sup>10</sup>; a Joint Action on Health Equity Europe (JAHEE)<sup>11</sup> and the Joint Action PreventNCD<sup>12</sup> as well as the establishment of the Steering Group on Health Promotion, Disease Prevention and Management of Non- Communicable Diseases (SGPP)<sup>13</sup> and the Expert Group on Public Health.<sup>14</sup>

The EU initiatives to reduce childhood obesity were accompanied by other actions implemented by the World Health Organisation (WHO), Organisation for Economic Co-operation and Development (OECD), World Obesity Federation (WOF), and the European Association for the Study of Obesity (EASO). In this regard, most of the actions implemented by international organisations are cross-cutting among multiple Areas for Action of the EU Action Plan. Additionally, international organisations have implemented few or no measures related to Area 2 (promote healthier environments), Area 3 (make the healthy option the easier option), Area 5 (inform and empower families) and Area 8 (increase research and financial support).

### Current obstacles and challenges to policy implementation

Across all EU Member States and the UK, there are several challenges that impact the ability to halt the rise in childhood obesity. Some of the challenges identified are broad and can be considered cross-cutting, meaning that they are relevant to all the Areas of Action indicated within the EU Action Plan whilst others may be specific to individual Areas for Action of the EU Action Plan. Overall, the following categories of challenges have been identified: lack of formal recognition of obesity as a disease, financial constraints, institutional barriers related to policy implementation including poor collaboration across policies, weaknesses in healthcare systems, behavioural and cultural barriers, and lack of data and effective monitoring systems.

---

<sup>9</sup> Joint Actions on Chronic Disease (CHRODIS). Available at: [Link](#).

<sup>10</sup> CHRODIS+. Available at: [Link](#).

<sup>11</sup> Joint Action on Health Equity Europe. Available at: [Link](#).

<sup>12</sup> PreventNCD. Available at: [Link](#)

<sup>13</sup> European Commission. (n.d.). The Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP). Available at: (Link no longer available)

<sup>14</sup> European Commission. (n.d.). Expert Group on Public Health. Available at: [Link](#).

**Table 1 – Overview of the type of challenges/obstacles concerning each area of the EU Action Plan on Childhood Obesity**

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Institutional	✓	✓	✓	✓	✓	✓	✓
Behavioural/Cultural	✓	✓	✓		✓	✓	
Financial	✓	✓			✓	✓	✓
Healthcare Access	✓						✓
Data & Monitoring			✓				✓
Disease recognition	✓	✓	✓	✓	✓	✓	✓

Source: Authors' elaboration

### Collection of best practices per Area for Action

Across all Member States and the UK, there is a wide range of best practices that have been implemented to address childhood obesity in Areas for Action 1 to 7 of the EU Action Plan. In total, 63 best practices related to specific Areas of Action of the EU Action Plan were identified. 58 were identified in 24 countries across the EU and the UK, whilst five best practices from Australia, Canada, Chile, Israel and the United States of America (USA) have been highlighted to showcase innovative approaches that have not been adopted in the EU before. The selection of best practices shows a wide repartition of policy interventions, particularly in school settings (Area 2: Promote healthier environments), in community-based interventions (Area 5: Inform and empower families) and in physical activity promotion for children (Area 6: Encourage Physical Activity). Small-scale best practices prevail, with only a few large-scale best practices identified.

### Status of monitoring and indicators used

The study found that out of the 28 countries in its scope, 24 of them reported that indicators are in place to monitor the progress of some or many implemented policies and actions to tackle childhood obesity under Areas for Action 1-6 of the EU Action Plan (no information is available on monitoring indicators in place in DK, PL, and RO). With reference to the indicators included in the EU Action Plan, the majority of the indicators suggested per Area for Action are monitored by many countries reporting having monitoring indicators in place.

### Member States views on the EU Action Plan

Consulted national authorities reported the following in relation to the different Areas for Action of the EU Action Plan and its implementation at the national level:

- The majority of the consulted national authorities of the Member States and the UK reported that they are familiar with the EU Action (78%, 31 respondents out of 40).
- 55% of respondents believed that the EU Action Plan facilitated the introduction and/or the strengthening of national policies in the field of childhood obesity (21 respondents out of 38).

- During interviews, several national authorities agreed that the country would probably not have adopted certain policies and achieved certain results if not for the existence of the EU Action Plan, which steered the national agenda and provided information and experiences from other countries.
- National authorities reported involving other stakeholders in their national policy-making process, i.e. educational institutions (22 countries), health professionals (21 countries), universities (21 countries), NGO representatives (20 countries) and industry representatives (14 countries).
- The majority of the national authorities identified the formerly active High-Level Group on Nutrition and Physical Activity as the most useful action of the Commission to support the implementation of the EU Action Plan. Additionally, EU directives and regulations, financial tools and the support and coordination through the EU platform for action on diet, physical activity, and health are also deemed as very useful EU actions.

### Stakeholders' views on the EU Action Plan

Overall, the consulted stakeholders (representing NGOs, parent associations, consumer organisations, the industry, academics) emphasised the need for a comprehensive approach involving education, regulation, supportive environments, and better resource allocation to effectively tackle childhood obesity. Consulted stakeholders reported the following in relation to the different Areas for Action of the EU Action Plan and its implementation at the national level:

- **AREA 1** - Stakeholders expressed concerns about limited health literacy and inadequate training among healthcare professionals to support young families with obesity management. They emphasised the importance of facilitating breastfeeding, which is hindered by insufficient infrastructure and maternity leave policies.
- **AREA 2** - Stakeholders pointed to the limited implementation of policies promoting healthy eating in schools and the widespread availability of unhealthy foods as major challenges. They advocated for educational campaigns and facilities to encourage physical activity, while also addressing conflicts between physical education and academic priorities.
- **AREA 3** – The majority of stakeholders were supportive of front-of-pack nutritional labelling but emphasised the need for consumer education to make labels effective. Surveyed national authorities claimed that front-of-pack nutritional labelling must be based on consumer behaviour research and scientific evidence to ensure its legitimacy, credibility, and effectiveness. Opinions on taxing unhealthy foods were mixed among consulted stakeholders. While some consulted National authorities and representatives from the NGOs supported it as a tool to encourage food reformulation, others emphasised the need for complementary measures such as subsidizing healthy foods and launching awareness campaigns. Lastly, concerns about taxation were expressed in relation to consumers' likely reluctance due to price increases by surveyed national authorities and by the industry due to the fear of decreased revenues.

- **AREA 4** - While many stakeholders called for stricter regulations on marketing unhealthy products to children, representatives from the advertising industry defended self-regulation as effective.
- **AREA 5** - Stakeholders acknowledged efforts to educate families about nutrition and physical exercise but noted insufficient support for vulnerable families in accessing healthy food options.
- **AREA 6** - Concerns were raised about inadequate urban spaces for safe physical activity. Stakeholders stressed the importance of educating parents and enhancing public facilities like schools and sports clubs to promote enjoyable physical activity, not just high-performance sports.
- **AREA 7** - Stakeholders recognised existing large-scale initiatives like the European Childhood Obesity Surveillance Initiative (COSI)<sup>15</sup> and Health Behaviour in School-aged Children (HBSC)<sup>16</sup> but noted challenges such as personnel shortages and a narrow focus on BMI in screening programs. There is also a perceived lack of follow-up actions to support families after public health screenings.
- **AREA 8** - Stakeholders reported varied levels of participation in obesity-related research, with some receiving EU funding, while others expressed concerns about the limited prioritisation of obesity in national policies and funding opportunities.

### **Main takeaways from the evidence collected**

The EU Action Plan on Childhood Obesity 2014-2020 provided a comprehensive framework for reducing childhood obesity in the EU. Overall, this study shows that progress was made across countries compared to the period before 2014, and the EU Action Plan contributed positively to this progress. The implementation of the EU Action Plan was considered 'moderately high'. The EU Action Plan established clear priority areas and provided a toolbox of potential measures. However, despite these achievements, the EU Action Plan only partially achieved its goal of halting the rise in childhood overweight and obesity by 2020. The EU Action Plan acted as a guidance document for Member States to identify and adopt relevant measures on a voluntary basis, according to the political priorities and capacity of the individual countries. This was reflected in the fragmented implementation across Member States, where some countries adopted many new key topics, while others implemented only a few and in limited Areas for Action. The inconsistency hindered a cohesive approach, as varying levels of commitment and resources among countries led to uneven progress and gaps in addressing obesity policy effectively across the region. Moreover, challenges persist and views among stakeholders on how to best address childhood obesity differ, especially regarding policies under Area 3 and Area 4. The findings highlight the need for shared commitment and continued measures to address the rise in childhood obesity across the Member States.

---

<sup>15</sup> [WHO European Childhood Obesity Surveillance Initiative \(COSI\)](#)

<sup>16</sup> [HBSC study | Health Behaviour in School-aged Children study](#)

## Zusammenfassung

Die Verbreitung von Übergewicht und Adipositas bei Kindern in Europa ist ein erhebliches Problem für die öffentliche Gesundheit.<sup>17</sup> Die neuesten Daten der Childhood Obesity Surveillance Initiative (COSI) der Weltgesundheitsorganisation (WHO) zeigen, dass zwischen 2018 und 2020 fast jedes dritte europäische Kind (7–9 Jahre) als übergewichtig galt (einschließlich fettleibiger Kinder)<sup>18</sup>. Die Ursachen für Fettleibigkeit bei Kindern sind vielfältig und umfassen Umweltfaktoren, Lebensstilentscheidungen (einschließlich übermäßigen Verzehrs energiereicher Lebensmittel und verminderter körperlicher Aktivität) und kulturelle Einflüsse sowie Medikamente, Krankheiten, Traumata und genetische Unterschiede. Adipositas bei Kindern hat sowohl individuelle kurzfristige und langfristige Auswirkungen auf das Leben einer Person als auch weitreichende gesellschaftliche Folgen. Da sich Fettleibigkeit im Laufe des Lebens entwickelt und ausgeprägter wird, ist die Prävention von Adipositas in kritischen Lebensphasen wie vor der Empfängnis und Schwangerschaft<sup>19</sup> sowie im Säuglingsalter und in der Jugend voraussichtlich der größte gesundheitliche und kostengünstige Nutzen.<sup>20</sup>

Der EU-Aktionsplan gegen Adipositas bei Kindern 2014–2020<sup>21</sup> (im Folgenden „EU-Aktionsplan“) wurde von der ehemaligen Hochrangigen Gruppe für Ernährung und Bewegung, einer Gruppe von Regierungsvertretern der 28 EU-Mitgliedstaaten (früher einschließlich des Vereinigten Königreichs), Islands, Norwegens und der Schweiz, mit Unterstützung der Europäischen Kommission ausgearbeitet. Dieses Leitliniendokument wurde im Februar 2014 von den Mitgliedstaaten offiziell als nichtlegislatives politisches Instrument gebilligt. Ziel des EU-Aktionsplans war es, dazu beizutragen, den Anstieg von Übergewicht und Fettleibigkeit bei Kindern und Jugendlichen bis zum Jahr 2020 aufzuhalten. Darüber hinaus sollte er das gemeinsame Engagement der Mitgliedstaaten zur Bekämpfung von Fettleibigkeit bei Kindern demonstrieren, vorrangige Handlungsbereiche und ein mögliches Maßnahmenpaket festlegen sowie Vorschläge zur gemeinsamen Fortschrittsverfolgung unterbreiten. Der EU-Aktionsplan enthält acht Handlungsbereiche:

- **BEREICH 1:** Einen gesunden Start ins Leben unterstützen
- **BEREICH 2:** Gesundere Umgebungen fördern (vor allem in Schulen und Vorschulen)
- **BEREICH 3:** Die gesunde Option zur leichteren Option machen
- **BEREICH 4:** Marketing und Werbung auf Kinder beschränken
- **BEREICH 5:** Familien informieren und ihnen Selbstbestimmung vermitteln
- **BEREICH 6:** Körperliche Aktivität fördern
- **BEREICH 7:** Überwachung und Bewertung
- **BEREICH 8:** Forschung und finanzielle Unterstützung verstärken

---

<sup>17</sup> Buoncristiano, M. et al. (2021). Childhood overweight and obesity in Europe: Changes from 2007 to 2017. *Obesity Reviews*, 22, e13226. Verfügbar unter: [Link](#)

<sup>18</sup> WHO. (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Verfügbar unter: [Link](#)

<sup>19</sup> Lecorguillé, M. et al. (2023). Impact of parental lifestyle patterns in the preconception and pregnancy periods on childhood obesity. *Frontiers in nutrition*, 10, 1166981.

<sup>20</sup> Garrido-Miguel, M. Et al. (2019). Prevalence of overweight and obesity among European preschool children: a systematic review and meta-regression by food group consumption. *Nutrients*, 11(7), 1698. Verfügbar unter: [Link](#)

<sup>21</sup> European Commission. (2014). EU Action Plan on Childhood Obesity 2014-2020. Verfügbar unter: [Link](#)

Der EU-Aktionsplan wurde zuvor im Rahmen einer Halbzeitbewertung (2014-2018)<sup>22</sup> evaluiert, und diese Studie stellt die Abschlussbewertung dar. Die Ziele der Studie umfassten: i) die Bewertung der in den wichtigsten Handlungsbereichen des Aktionsplans erzielten Fortschritte; ii) die Bereitstellung eines Überblicks über die von den 27 EU-Mitgliedstaaten sowie Großbritannien<sup>23</sup> im Zeitraum 2014-2020 unternommenen Anstrengungen; iii) die Darstellung der auf nationaler Ebene geplanten Maßnahmen; iv) die Identifizierung von Hindernissen und verbleibenden Herausforderungen; v) die Ermittlung bewährter Verfahren; vi) die Einbeziehung von Interessengruppen und Einholung von Feedback und Meinungen.

### **Methodisches Vorgehen**

Die Studie bestand aus Schreibtischforschung (Aufgabe 1), Konsultationsaktivitäten (Aufgabe 2) und Validierungsworkshops (Aufgabe 3). Die Ergebnisse jeder Aufgabe wurden anschließend trianguliert, um die Erkenntnisse der Studie zu generieren.

#### Sekundärforschung (Aufgabe 1)

Ziel der Sekundärforschung war es, vorläufige Informationen über die Umsetzung des EU-Aktionsplans in den einzelnen Ländern sowie über aktuelle und geplante nationale (politische) Ansätze zur Bekämpfung von Adipositas bei Kindern zu sammeln, spezifische Hindernisse und Herausforderungen zu ermitteln und bewährte Verfahren zu sammeln. Zu diesem Zweck wurden unter anderem die offiziellen Websites der zuständigen Behörden der Mitgliedstaaten, Online-Richtliniendatenbanken, wissenschaftliche Artikel und offizielle Berichte führender Gesundheits- und Adipositasorganisationen wie der Weltgesundheitsorganisation (WHO), der Organisation für wirtschaftliche Zusammenarbeit und Entwicklung (OECD) oder der World Obesity Federation (WOF) sowie Quellen grauer Literatur analysiert. Die Sekundärforschung umfasste die Bewertung des Fortschritts der Umsetzung des EU-Aktionsplans auf nationaler Ebene durch die Kartierung nationaler (politischer) Ansätze, die in den acht Aktionsbereichen des Plans nach 2010 umgesetzt wurden. Darüber hinaus wurden bestehende oder potenzielle Hindernisse bei der Umsetzung von Adipositaspolitiken erfasst, kategorisiert und spezifischen Aktionsbereichen zugeordnet, wobei wiederkehrende Themen in den einzelnen Ländern identifiziert wurden. Schließlich wurden erfolgreiche politische Praktiken und Interventionen in Bezug auf die Aktionsbereiche des Plans gesammelt. Die Auswahl der besten Praktiken erfolgte anhand der von der GD SANTE definierten „Kriterien zur Auswahl der besten Praktiken zur Gesundheitsförderung sowie zur Prävention und Behandlung von Krankheiten in Europa“.<sup>24</sup>

#### Konsultationstätigkeiten (Aufgabe 2)

Es wurden eine Umfrage und Folgeinterviews mit nationalen Ministerien und Beamten der nationalen Gesundheitsbehörden durchgeführt. Ergänzend fanden Interviews und Fokusgruppen mit relevanten Interessenvertretern statt, darunter internationale Organisationen, Eltern- und Familienverbände, Akademiker und wissenschaftliche Experten, Bildungs-NGOs, EU- und nationale NGOs im Bereich der öffentlichen

---

<sup>22</sup> European Commission, Directorate-General for Health and Food Safety, Pushkarev, N., Hansen, J., Driesenaar, J. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: the childhood obesity study, Publications Office. Verfügbar unter: [Link](#)

<sup>23</sup> Das Vereinigte Königreich ist in den Rahmen der Studie einbezogen, da es bei der Verabschiedung des EU-Aktionsplans im Jahr 2014 noch Teil der EU war.

<sup>24</sup> Europäische Kommission – Generaldirektion Gesundheit und Lebensmittelsicherheit. (2017). Kriterien zur Auswahl bewährter Verfahren zur Gesundheitsförderung sowie zur Prävention und Behandlung von Krankheiten in Europa. Verfügbar unter: [Link](#).

Gesundheit, Sport-NGOs, Verbraucherverbände, Verbände der Marketing- und Werbebranche sowie Verbände der Lebensmittel- und Getränkeindustrie. Ziel der Aufgabe war es, bestehende Wissenslücken aus der Schreibtischforschung zu schließen und Erkenntnisse von verschiedenen Interessengruppen zu sammeln, um die Studienziele effektiv anzugehen. Die Umfrage erhielt insgesamt 40 gültige Antworten aus den 27 Mitgliedstaaten. Darüber hinaus wurden 42 Interviews mit nationalen Behörden aus 22 Ländern sowie 53 Interviews mit Interessenvertretern aus 19 Ländern geführt.

### Validierungsworkshops (Aufgabe 3)

Es wurden vier Validierungsworkshops mit nationalen Behörden und Interessengruppen durchgeführt. Ziel der Workshops war es, weitere Erkenntnisse zu sammeln und die Repräsentativität und Angemessenheit der vorläufigen Ergebnisse sicherzustellen. Von etwa 282 eingeladenen Interessenvertretern nahmen insgesamt 51 an den Workshops teil, aufgeteilt in vier Gruppen: (i) 25 nationale Behörden, (ii) 6 Industrievertreter auf EU-Ebene, (iii) 15 NGO-Vertreter und (iv) 5 akademische Expertinnen und Experten.

### Datenanalyse und Triangulation von Quellen

Die im Rahmen der drei Studienaufgaben gesammelten qualitativen und quantitativen Erkenntnisse wurden trianguliert, um die Informationen zu vergleichen, zu validieren, zu synthetisieren und zu analysieren und auf dieser Grundlage tragfähige Schlussfolgerungen zu ziehen. Im Zuge von Aufgabe 1 wurden insgesamt 28 Länderprofile entwickelt, um die Ergebnisse umfassend darzustellen und die in jedem Land umgesetzten Initiativen und erzielten Fortschritte hervorzuheben. Für jedes Länderprofil wurde eine Ampeltabelle entwickelt, die eine Bewertung des Umsetzungsfortschritts der nationalen Maßnahmen im Einklang mit den Aktionsbereichen präsentiert.

## **Studienergebnisse**

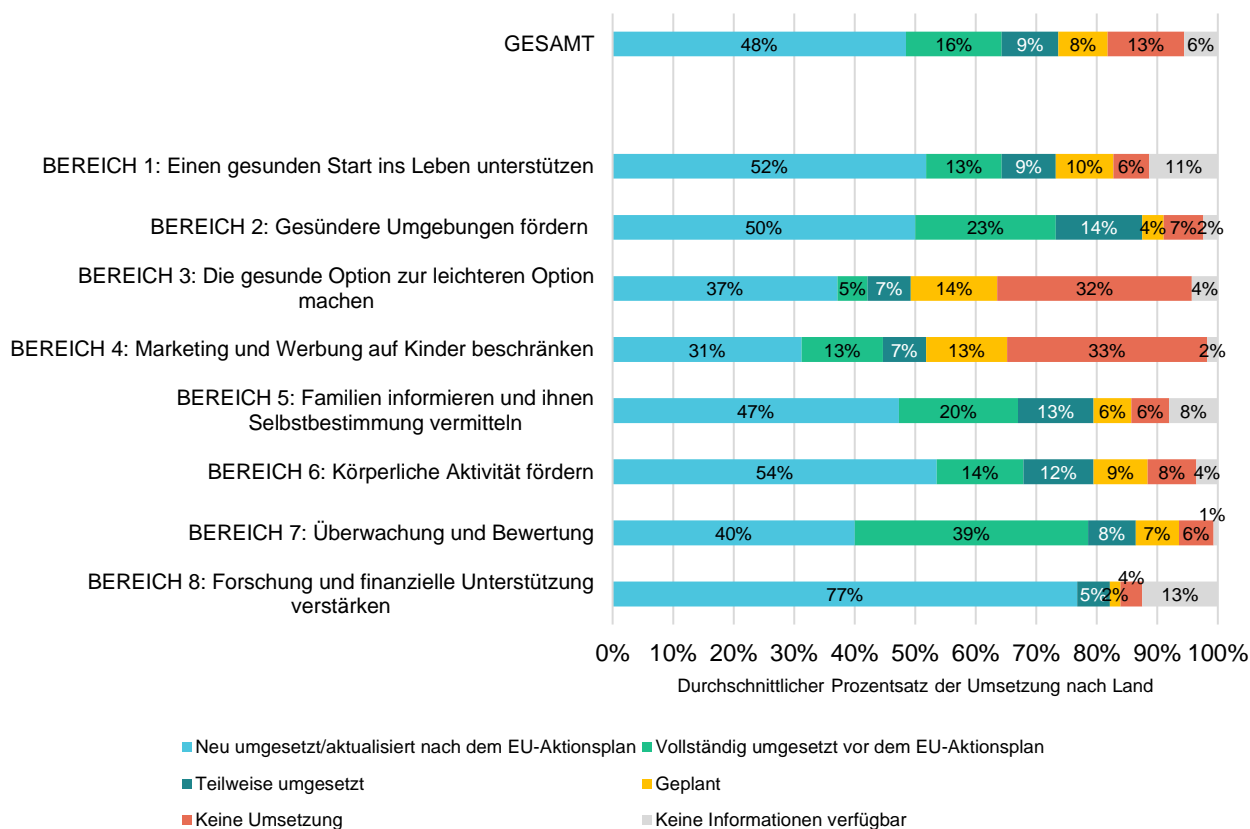
### Kartierung und Umsetzung von Strategien und Maßnahmen durch die Mitgliedstaaten

Über 1.500 adipositasbezogene Maßnahmen wurden in 27 Mitgliedstaaten sowie im Vereinigten Königreich ermittelt, um die Fortschritte auf nationaler Ebene bei der Umsetzung von Strategien in allen Aktionsbereichen des EU-Aktionsplans zu bewerten. Aus der Analyse ging Folgendes hervor:

- Drei Länder (Griechenland, Spanien, Großbritannien) haben seit dem EU-Aktionsplan nationale Pläne gegen Adipositas bei Kindern verabschiedet. Acht weitere Länder (Kroatien, Dänemark, Finnland, Frankreich, Irland, Malta, Slowenien, Spanien) haben umfassendere Pläne mit spezifischen Maßnahmen für Kinder entwickelt. Alle Länder haben umfassende Initiativen zur Verbesserung der Lebensweise der Bevölkerung umgesetzt, oft durch Pläne, die sich auf Ernährung, körperliche Bewegung oder nicht übertragbare Krankheiten konzentrieren. Belgien, Zypern, Lettland und Luxemburg erstellen oder verhandeln derzeit Pläne gegen Adipositas bei Kindern. Schweden verfügt zwar nicht über einen speziellen nationalen Plan, hat jedoch Maßnahmen wie schulbasierte Leitlinien und Empfehlungen für Aktivitäten in der frühen Kindheit ergriffen.

- Sieben Länder beziehen sich in ihren Strategiedokumenten ausdrücklich auf den EU-Aktionsplan (Finnland, Malta, Spanien, Litauen, Luxemburg, Slowakei, Slowenien).
- Die Analyse der Umsetzung zeigte, dass Finnland, Litauen und Frankreich seit 2014 die Länder waren, die Maßnahmen zu mehr Schlüsselthemen ergriffen oder aktualisiert haben, während die Tschechische Republik, Zypern und die Slowakei weniger Maßnahmen ergriffen haben. Dennoch hat kein Land Maßnahmen zu allen im EU-Aktionsplan beschriebenen Schlüsselthemen umgesetzt.
- In allen Ländern konzentrierten sich die Bemühungen zur Bekämpfung von Adipositas bei Kindern weitgehend auf die Verbesserung des Schulumfelds durch Verbesserung der Schulmahlzeiten, Verbot von Verkaufsautomaten und Aktualisierung der Ernährungsrichtlinien (Bereich 2) sowie auf die Förderung des Stillens (Bereich 1). Darüber hinaus nahmen alle Länder an mindestens einer gemeinsamen Aktion der EU zum Thema Adipositas bei Kindern teil und die meisten beteiligten sich an internationalen und nationalen Adipositas-Monitoring-Umfragen. Die Umsetzung in Politikbereichen im Zusammenhang mit der Verbesserung des Ernährungsumfelds und der Erleichterung gesunder Entscheidungen (Bereiche 3 und 4) blieb jedoch begrenzt. Viele Länder verließen sich auf freiwillige Vereinbarungen mit der Lebensmittelindustrie und privaten Akteuren in Themen wie Lebensmittelumformulierung und Beschränkungen von Marketing und Werbung.
- Die Analyse dieser Studie zeigt, dass die EU-Mitgliedstaaten und das Vereinigte Königreich durchschnittlich 64 % der wichtigsten Themen des EU-Aktionsplans abdecken, wobei 48 % der Themen nach dessen Annahme neu behandelt oder aktualisiert wurden.

**Abbildung 1 – Überblick über die Umsetzung des EU-Aktionsplans nach Aktionsbereichen in den Mitgliedstaaten und im Vereinigten Königreich**



Quelle: Ausarbeitung der Autoren

### Maßnahmen der Europäischen Kommission und anderer internationaler Organisationen

Die Rolle der Europäischen Kommission bei der Prävention von Adipositas im Kindesalter wird als unterstützend eingestuft, da sie Koordinierung, Anleitung und Finanzierung bereitstellt. Die Maßnahmen der EU umfassen Prävention, Diagnose, Forschung und Politik und nutzen Instrumente wie Verordnungen, Richtlinien, Aktionspläne von Expertengruppen und finanzielle Unterstützung. Zu den wichtigsten Initiativen vor 2014 zählen die EU-Aktionsplattform für Ernährung, körperliche Bewegung und Gesundheit (2005), die Strategie für Ernährung, Übergewicht und Adipositas (2007) und die Hochrangige Gruppe für Ernährung und körperliche Bewegung. Einige Richtlinien und Verordnungen, die vor 2014 umgesetzt wurden, etwa jene zu Nährwertbezogenen Angaben, Säuglingsanfangsnahrung, Werbung und Lebensmittelkennzeichnung, weisen Verbindungen zu einigen spezifischen Aktionsbereichen des EU-Aktionsplans auf. Nach 2014 unterstützte die Kommission relevante Initiativen wie Gemeinsame Aktionen zu chronischen Krankheiten (CHRODIS)<sup>25</sup> und CHRODIS+<sup>26</sup>; eine gemeinsame Aktion für gesundheitliche Gerechtigkeit in Europa (JAHEE)<sup>27</sup> und die gemeinsame Aktion PreventNCD<sup>28</sup> sowie die Einrichtung der Lenkungsgruppe für Gesundheitsförderung,

<sup>25</sup> Join Actions on Chronic Disease (CHRODIS). Verfügbar unter: [Link](#).

<sup>26</sup> CHRODIS+. Verfügbar unter: [Link](#).

<sup>27</sup> Joint Action on Health Equity Europe. Verfügbar unter: [Link](#).

<sup>28</sup> PreventNCD. Verfügbar unter: [Link](#).

Krankheitsprävention und Management nicht übertragbarer Krankheiten (SGPP)<sup>29</sup> und der Expertengruppe für öffentliche Gesundheit<sup>30</sup>.

Die Initiativen der EU zur Verringerung von Adipositas bei Kindern wurden durch Maßnahmen der Weltgesundheitsorganisation (WHO), der Organisation für wirtschaftliche Zusammenarbeit und Entwicklung (OECD), der World Obesity Federation (WOF) und der European Association for the Study of Obesity (EASO) begleitet. In dieser Hinsicht sind die meisten Maßnahmen internationaler Organisationen bereichsübergreifend und betreffen mehrere Handlungsbereiche des EU-Aktionsplans. Gleichzeitig haben internationale Organisationen nur wenige oder gar keine Maßnahmen in den Bereichen 2 (Förderung gesünderer Umgebungen), 3 (die gesunde Option zur einfacheren Option machen), 5 (Familien informieren und stärken) und 8 (Ausweitung von Forschung und finanzieller Unterstützung) umgesetzt.

### Aktuelle Hindernisse und Herausforderungen bei der Umsetzung politischer Maßnahmen

In allen EU-Mitgliedstaaten und im Vereinigten Königreich gibt es mehrere Herausforderungen, die die Fähigkeit beeinträchtigen, den Anstieg der Adipositasraten bei Kindern aufzuhalten. Einige der ermittelten Herausforderungen sind breit gefächert und können als bereichsübergreifend betrachtet werden, d. h. sie sind für alle im EU-Aktionsplan angegebenen Handlungsbereiche relevant. Andere sind spezifisch einzelnen Bereichen zuzuordnen. Insgesamt wurden folgende Herausforderungen identifiziert: die fehlende formale Anerkennung von Adipositas als Krankheit, finanzielle Einschränkungen, institutionelle Hindernisse bei der Umsetzung politischer Maßnahmen, darunter mangelnde Zusammenarbeit zwischen verschiedenen Politikbereichen, Schwächen in den Gesundheitssystemen, verhaltensbedingte und kulturelle Hindernisse sowie ein Mangel an Daten und wirksamen Überwachungssystemen.

**Tabelle 2 – Überblick über die Art der Herausforderungen/Hindernisse in den einzelnen Bereichen des EU-Aktionsplans zur Bekämpfung von Fettleibigkeit bei Kindern**

	Bereich 1	Bereich 2	Bereich 3	Bereich 4	Bereich 5	Bereich 6	Bereich 7
Institutionell	✓	✓	✓	✓	✓	✓	✓
Verhaltens-/Kulturell	✓	✓	✓		✓	✓	
Finanziell	✓	✓			✓	✓	✓
Gesundheitsversorgung	✓						✓
Zugangsdaten & Überwachung			✓				✓
Krankheitserkennung	✓	✓	✓	✓	✓	✓	✓

Quelle: Ausarbeitung der Autoren

<sup>29</sup> European Commission. (n.d.). The Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP). Available at: (Link no longer available)

<sup>30</sup> European Commission. (n.d.). Expert Group on Public Health. Verfügbar unter: [Link](#).

### Sammlung bewährter Verfahren nach Handlungsbereichen

In allen Mitgliedstaaten und im Vereinigten Königreich gibt es eine breite Palette bewährter Verfahren, die zur Bekämpfung von Adipositas bei Kindern in den Handlungsbereichen 1 bis 7 des EU-Aktionsplans umgesetzt wurden. Insgesamt wurden 63 bewährte Verfahren in Bezug auf bestimmte Handlungsbereiche des EU-Aktionsplans ermittelt. 58 wurden in 24 Ländern in der EU und im Vereinigten Königreich ermittelt, während fünf bewährte Verfahren aus Australien, Kanada, Chile, Israel und den Vereinigten Staaten von Amerika (USA) hervorgehoben wurden, um innovative Ansätze zu präsentieren, die in der EU bisher noch nicht übernommen wurden. Die Auswahl der bewährten Verfahren zeigt eine breite Streuung politischer Interventionen, insbesondere im schulischen Umfeld (Bereich 2: Gesundere Umgebungen fördern), bei gemeindebasierten Interventionen (Bereich 5: Familien informieren und stärken) und bei der Bewegungsförderung von Kindern (Bereich 6: Körperliche Aktivität fördern). Es überwiegen klein angelegte bewährte Verfahren, während nur wenige groß angelegte bewährte Verfahren identifiziert wurden.

### Stand der Überwachung und verwendete Indikatoren

Die Studie ergab, dass 24 der 28 in den Rahmen einbezogenen Länderangaben, über Indikatoren zu verfügen, um den Fortschritt einiger oder vieler im Rahmen der Aktionsbereiche 1 bis 6 des EU-Aktionsplans umgesetzter Strategien und Maßnahmen zur Bekämpfung von Adipositas bei Kindern zu überwachen (in DK, PL und RO liegen keine Informationen zu vorhandenen Überwachungsindikatoren vor). Mit Bezug auf die im EU-Aktionsplan enthaltenen Indikatoren wird die Mehrheit der pro Aktionsbereich vorgeschlagenen Indikatoren von vielen Ländern überwacht, die angeben, Überwachungsindikatoren vorhanden zu haben.

### Ansichten der Mitgliedstaaten zum EU-Aktionsplan

Die konsultierten nationalen Behörden berichteten in Bezug auf die verschiedenen Aktionsbereiche des EU-Aktionsplans und seine Umsetzung auf nationaler Ebene Folgendes:

- Die Mehrheit der befragten nationalen Behörden der Mitgliedstaaten und des Vereinigten Königreichs gab an, mit der EU-Aktion vertraut zu sein (78 %, 31 von 40 Befragten).
- 55 % der Befragten waren der Ansicht, dass der EU-Aktionsplan die Einführung und/oder Stärkung nationaler Strategien im Bereich Fettleibigkeit bei Kindern erleichtert hat (21 von 38 Befragten).
- Während der Interviews stimmten mehrere nationale Behörden zu, dass das Land wahrscheinlich bestimmte Strategien nicht eingeführt und bestimmte Ergebnisse nicht erzielt hätte, wenn es den EU-Aktionsplan nicht gegeben hätte, der die nationale Agenda lenkte und Informationen und Erfahrungen aus anderen Ländern lieferte.
- Die nationalen Behörden berichteten, dass sie andere Interessengruppen in ihren nationalen Politikgestaltungsprozess einbezogen haben, d. h. Bildungseinrichtungen (22 Länder), Angehörige der Gesundheitsberufe (21 Länder), Universitäten (21 Länder), Vertreter von Nichtregierungsorganisationen (20 Länder) und Vertreter der Industrie (14 Länder).

- Die Mehrheit der nationalen Behörden bezeichnete die früher aktive hochrangige Gruppe für Ernährung und körperliche Bewegung als die nützlichste Maßnahme der Kommission zur Unterstützung der Umsetzung des EU-Aktionsplans. Darüber hinaus werden auch die EU-Richtlinien und -Verordnungen, die Finanzierungsinstrumente sowie die Unterstützung und Koordinierung durch die EU-Plattform für Maßnahmen in den Bereichen Ernährung, körperliche Bewegung und Gesundheit als sehr nützliche Maßnahmen der EU erachtet.

### Ansichten der Stakeholder zum EU-Aktionsplan

Insgesamt betonten die konsultierten Stakeholder (Vertreter von NGOs, Elternverbänden, Verbraucherorganisationen, der Industrie und der Wissenschaft), dass zur wirksamen Bekämpfung von Adipositas im Kindesalter ein umfassender Ansatz erforderlich sei, der Aufklärung, Regulierung, unterstützende Umgebungen und eine bessere Ressourcenzuweisung umfasst. In Bezug auf die verschiedenen Aktionsbereiche des EU-Aktionsplans und seine Umsetzung auf nationaler Ebene berichteten die konsultierten Stakeholder Folgendes:

- **BEREICH 1** – Die Stakeholder äußerten Bedenken hinsichtlich mangelnder Gesundheitskompetenz und mangelhafter Ausbildung von medizinischem Fachpersonal zur Unterstützung junger Familien bei der Behandlung von Adipositas. Sie betonten, wie wichtig es sei, das Stillen zu ermöglichen, das durch unzureichende Infrastruktur und Mutterschaftsurlaubsregelungen behindert werde.
- **BEREICH 2** – Die Stakeholder wiesen auf die unzureichende Umsetzung von Richtlinien zur Förderung gesunder Ernährung in Schulen und die weit verbreitete Verfügbarkeit ungesunder Nahrungsmittel als größte Herausforderungen hin. Sie sprachen sich für Aufklärungskampagnen und Einrichtungen zur Förderung körperlicher Aktivität aus, gingen aber auch auf Konflikte zwischen Sportunterricht und schulischen Prioritäten ein.
- **BEREICH 3** – Die Mehrheit der Interessenvertreter befürwortete die Nährwertkennzeichnung auf der Vorderseite von Verpackungen, betonte jedoch, dass Verbraucheraufklärung notwendig sei, um die Kennzeichnung wirksam zu machen. Die befragten nationalen Behörden behaupteten, dass die Nährwertkennzeichnung auf der Vorderseite von Verpackungen auf Verbraucherverhaltensforschung und wissenschaftlichen Erkenntnissen beruhen müsse, um ihre Legitimität, Glaubwürdigkeit und Wirksamkeit sicherzustellen. Die Meinungen zur Besteuerung ungesunder Lebensmittel waren unter den befragten Interessenvertretern gemischt. Während einige befragte nationale Behörden und Vertreter von NGOs sie als Instrument zur Förderung der Neuformulierung von Lebensmitteln unterstützten, betonten andere die Notwendigkeit ergänzender Maßnahmen wie die Subventionierung gesunder Lebensmittel und die Durchführung von Aufklärungskampagnen. Schließlich wurden Bedenken hinsichtlich der Besteuerung im Zusammenhang mit der wahrscheinlichen Zurückhaltung der Verbraucher aufgrund von Preiserhöhungen durch die befragten nationalen Behörden und durch die Industrie aus Angst vor Einnahmerückgängen geäußert.

- **BEREICH 4** – Während viele Interessenvertreter strengere Vorschriften für die Vermarktung ungesunder Produkte an Kinder forderten, verteidigten Vertreter der Werbebranche die Selbstregulierung als wirksam.
- **BEREICH 5** – Die Interessenvertreter erkannten die Bemühungen an, Familien über Ernährung und körperliche Bewegung aufzuklären, stellten jedoch fest, dass gefährdete Familien nicht ausreichend beim Zugang zu gesunden Lebensmitteloptionen unterstützt würden.
- **BEREICH 6** – Es wurden Bedenken wegen unzureichender städtischer Räume für sichere körperliche Aktivitäten geäußert. Die Interessenvertreter betonten, wie wichtig es sei, Eltern aufzuklären und öffentliche Einrichtungen wie Schulen und Sportvereine zu verbessern, um angenehme körperliche Aktivitäten und nicht nur Hochleistungssport zu fördern.
- **BEREICH 7** – Die Interessenvertreter erkannten bestehende groß angelegte Initiativen wie die European Childhood Obesity Surveillance Initiative (COSI)<sup>31</sup> und Health Behaviour in School-aged Children (HBSC)<sup>32</sup> an, stellten jedoch Herausforderungen wie Personalmangel und eine enge Fokussierung auf den BMI in Screening-Programmen fest. Es wird auch ein Mangel an Folgemaßnahmen zur Unterstützung von Familien nach öffentlichen Gesundheitsscreenings wahrgenommen.
- **BEREICH 8** – Die Interessenvertreter berichteten von unterschiedlich starker Beteiligung an adipositasbezogener Forschung, wobei einige EU-Finanzierung erhielten, während andere Bedenken hinsichtlich der begrenzten Priorisierung von Adipositas in nationalen Politiken und Finanzierungsmöglichkeiten äußerten.

### Wichtigste Erkenntnisse aus den gesammelten

Der EU-Aktionsplan gegen Adipositas bei Kindern 2014–2020 bot einen umfassenden Rahmen zur Reduzierung von Adipositas bei Kindern in der EU. Insgesamt zeigt diese Studie, dass in allen Ländern im Vergleich zum Zeitraum vor 2014 Fortschritte erzielt wurden, und der EU-Aktionsplan trug positiv zu diesen Fortschritten bei. Die Umsetzung des EU-Aktionsplans wurde als „mäßig hoch“ eingestuft. Der EU-Aktionsplan legte klare Prioritätsbereiche fest und lieferte ein Instrumentarium potenzieller Maßnahmen. Trotz dieser Erfolge wurde das Ziel des Aktionsplans, den Anstieg von Übergewicht und Adipositas bei Kindern bis 2020 zu stoppen, jedoch nur teilweise erreicht. Der EU-Aktionsplan diente als Leitfaden für die Mitgliedstaaten, die je nach den politischen Prioritäten und Kapazitäten der einzelnen Länder auf freiwilliger Basis einschlägige Maßnahmen festlegen und verabschieden konnten. Dies spiegelte sich in der fragmentierten Umsetzung in den Mitgliedstaaten wider, wo einige Länder viele neue Schlüsselthemen annahmen, während andere nur einige wenige und in begrenzten Aktionsbereichen umsetzten. Diese Inkonsistenz behinderte einen kohärenten Ansatz, da unterschiedliche Engagements und Ressourcen in den einzelnen Ländern zu ungleichmäßigen Fortschritten und Lücken bei der wirksamen Bekämpfung von Adipositas

---

<sup>31</sup> [WHO European Childhood Obesity Surveillance Initiative \(COSI\)](#)

<sup>32</sup> [HBSC study | Health Behaviour in School-aged Children study](#)

in der gesamten Region führten. Darüber hinaus bestehen weiterhin Herausforderungen, und die Ansichten der Beteiligten darüber, wie Adipositas bei Kindern am besten bekämpft werden kann, gehen teils auseinander, insbesondere in Bezug auf die Politik in den Bereichen 3 und 4. Die Ergebnisse unterstreichen die Notwendigkeit eines gemeinsamen Engagements und fortgesetzter Maßnahmen, um den Anstieg von Adipositas bei Kindern in allen Mitgliedstaaten zu bekämpfen.

## Résumé exécutif

La prévalence du surpoids et de l'obésité chez les enfants en Europe constitue un problème majeur de santé publique.<sup>33</sup> Les dernières données de l'Initiative de surveillance de l'obésité infantile (COSI) de l'Organisation mondiale de la santé (OMS) indiquent qu'entre 2018 et 2020, près d'un enfant européen sur trois âgé de 7 à 9 ans était en surpoids (y compris les enfants obèses).<sup>34</sup> Les causes de l'obésité infantile sont multiples et impliquent des facteurs environnementaux, des choix de mode de vie (notamment une consommation excessive d'aliments à forte densité énergétique et une diminution de l'activité physique), des influences culturelles, ainsi que des médicaments, des maladies, des traumatismes et des variations génétiques. L'obésité infantile a des répercussions individuelles à court et à long terme, ainsi que des conséquences sociétales considérables. Étant donné que l'obésité se développe et s'aggrave tout au long de la vie, la prévention de l'obésité dans les phases critiques de la vie, telles que les périodes de préconception et de grossesse,<sup>35</sup> la petite enfance et l'adolescence, est susceptible d'avoir les plus grands avantages en termes de santé et de coûts.<sup>36</sup>

Le plan d'action de l'UE sur l'obésité infantile 2014-2020<sup>37</sup> (ci-après « plan d'action de l'UE ») a été rédigé par l'ancien Groupe de haut niveau sur la nutrition et l'activité physique, un groupe de représentants gouvernementaux des 28 États membres de l'UE (incluant le Royaume-Uni avant son retrait), de l'Islande, de la Norvège et de la Suisse, avec le soutien de la Commission européenne. Ce document d'orientation a été officiellement approuvé par les États membres en février 2014 en tant qu'instrument politique non législatif. L'objectif du plan d'action de l'UE était de contribuer à enrayer l'augmentation du surpoids et de l'obésité chez les enfants et les jeunes d'ici 2020. En outre, il visait à démontrer l'engagement commun des États membres à lutter contre l'obésité infantile, à définir des domaines d'action prioritaires et un ensemble potentiel de mesures, et à proposer des moyens de suivre collectivement les progrès accomplis. Le plan d'action de l'UE comporte huit domaines d'action :

- **DOMAINE 1** – Favoriser un bon départ dans la vie
- **DOMAINE 2** – Promouvoir des environnements plus sains (en particulier dans les écoles primaires et maternelles)

---

<sup>33</sup> Buoncristiano, M. et al. (2021). Childhood overweight and obesity in Europe: Changes from 2007 to 2017. *Obesity Reviews*, 22, e13226. Disponible sur: [Link](#)

<sup>34</sup> WHO. (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Disponible sur: [Link](#)

<sup>35</sup> Lecorguillé, M. et al. (2023). Impact of parental lifestyle patterns in the preconception and pregnancy periods on childhood obesity. *Frontiers in nutrition*, 10, 1166981.

<sup>36</sup> Garrido-Miguel, M. Et al. (2019). Prevalence of overweight and obesity among European preschool children: a systematic review and meta-regression by food group consumption. *Nutrients*, 11(7), 1698. Disponible sur: [Link](#)

<sup>37</sup> European Commission. (2014). EU Action Plan on Childhood Obesity 2014-2020. Disponible sur: [Link](#)

- **DOMAINE 3** – Faire de l'option saine l'option la plus facile
- **DOMAINE 4** – Limiter le marketing et la publicité auprès des enfants
- **DOMAINE 5** – Informer et responsabiliser les familles
- **DOMAINE 6** – Encourager l'activité physique
- **DOMAINE 7** – Suivi et évaluation
- **DOMAINE 8** – Accroître la recherche et le soutien financier

Le plan d'action de l'UE a fait l'objet d'une évaluation à mi-parcours (2014-2018),<sup>38</sup> et la présente étude en est l'évaluation finale. Les objectifs de cette étude étaient les suivants : i) évaluer les progrès réalisés dans les principaux domaines d'action du plan; ii) donner un aperçu des efforts déployés par les 27 États membres de l'UE ainsi que par le Royaume-Uni<sup>39</sup> au cours de la période 2014-2020 ; iii) cartographier les actions prévues au niveau national ; iv) identifier les obstacles et les défis restants ; v) identifier les bonnes pratiques ; vi) impliquer les parties prenantes et recueillir des commentaires et des opinions.

### **Approche méthodologique**

L'étude comprenait une recherche documentaire (Tâche 1), des activités de consultation (Tâche 2) et des ateliers de validation (Tâche 3). Les résultats de chaque tâche ont ensuite été triangulés pour produire les conclusions de l'étude.

#### Recherche documentaire (Tâche 1)

L'objectif de la recherche documentaire était de recueillir des informations préliminaires sur la mise en œuvre du plan d'action de l'UE dans les différents pays et les approches nationales actuelles et prévues pour lutter contre l'obésité infantile ainsi que d'identifier les obstacles et les défis spécifiques et de recueillir les bonnes pratiques. À cette fin, les ressources analysées comprenaient les sites web officiels des autorités compétentes des États membres, des registres de politiques, des articles scientifiques et des rapports officiels d'organisations de référence dans le domaine de la santé et de l'obésité, telles que l'OMS, l'Organisation de coopération et de développement économiques (OCDE) ou la Fédération mondiale de l'obésité (FMO), ainsi que d'autres sources. La recherche documentaire visait à évaluer les progrès de la mise en œuvre du plan d'action de l'UE au niveau national, en cartographiant les approches nationales adoptées dans les huit domaines d'action du plan après 2010. Deuxièmement, la recherche a évalué les obstacles survenus ou susceptibles de se produire lors de la mise en œuvre des politiques relatives à l'obésité. Les défis identifiés ont été classés par catégories et liés à des domaines d'action spécifiques, ce qui a permis d'identifier des thèmes récurrents d'un pays à l'autre. Enfin, les pratiques et interventions politiques réussies en rapport avec les domaines d'action du plan ont été recueillies. Les bonnes pratiques ont été sélectionnées selon des critères adaptés des « Critères de sélection des bonnes pratiques en matière de

---

<sup>38</sup> European Commission, Directorate-General for Health and Food Safety, Pushkarev, N., Hansen, J., Driesenaar, J. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: the childhood obesity study, Publications Office. Disponible sur: [Link](#)

<sup>39</sup> Le Royaume-Uni est inclus dans le champ de l'étude, car il faisait encore partie de l'UE lorsque le plan d'action de l'UE a été adopté en 2014.

promotion de la santé et de prévention et de gestion des maladies en Europe » de la DG SANTE.<sup>40</sup>

### Activités de consultation (Tâche 2)

Une enquête et des entretiens de suivi ont été menés auprès des ministères nationaux et des responsables des autorités nationales de santé publique. En outre, des entretiens et des groupes de discussion ont été organisés avec les principales parties prenantes concernées par l'obésité infantile, notamment des organisations internationales, des associations de parents et de familles, des universitaires et des experts scientifiques, des ONG actives dans le domaine de l'éducation, des ONG actives dans le domaine de la santé publique au niveau national et européen, des ONG actives dans le domaine du sport, des associations de consommateurs, des associations de l'industrie du marketing et de la publicité, et des associations de l'industrie des aliments et des boissons. L'objectif de cette tâche était de combler les lacunes de la recherche documentaire et de recueillir les points de vue de différents acteurs afin de répondre efficacement aux objectifs de l'étude. L'enquête a reçu un total de 40 réponses valides de la part des 27 États membres. En outre, 42 entretiens ont été menés avec les autorités nationales de 22 pays, tandis que 53 entretiens ont été réalisés avec des parties prenantes de 19 pays.

### Ateliers de validation (Tâche 3)

Quatre ateliers de validation ont été organisés avec les autorités nationales et les groupes de parties prenantes. L'objectif de ces ateliers était de recueillir des informations supplémentaires et de garantir la représentativité et la pertinence des résultats préliminaires. Sur les 282 parties prenantes invitées, 51 ont participé aux ateliers, réparties en quatre groupes (i) 25 autorités nationales, (ii) 6 représentants de l'industrie au niveau de l'UE, (iii) 15 représentants d'ONG et (iv) 5 experts universitaires.

### Analyse des données et triangulation des sources

Les résultats qualitatifs et quantitatifs recueillis au cours des trois tâches de l'étude ont été triangulés afin de comparer et de valider les informations, de les synthétiser et de les analyser, et de tirer des conclusions solides. Au total, 28 profils de pays ont été élaborés au cours de la tâche 1 pour présenter les résultats de manière exhaustive et mettre en évidence les initiatives mises en œuvre et les progrès réalisés dans chaque pays. Pour chaque profil, un tableau de feux tricolores présentant une évaluation de l'état d'avancement de la mise en œuvre des mesures nationales alignées sur les domaines d'action a été élaboré.

## **Résultats de l'étude**

### Cartographie et mise en œuvre des politiques et actions par les États membres

Plus de 1 500 mesures liées à l'obésité ont été recensées dans les 27 États membres plus le Royaume-Uni, afin d'évaluer les progrès réalisés au niveau national dans tous les domaines d'action du plan d'action de l'UE. L'analyse a révélé que :

- Trois pays (Espagne, Grèce, Royaume-Uni) ont adopté des plans nationaux de lutte contre l'obésité infantile depuis le plan d'action de l'UE. Huit autres pays

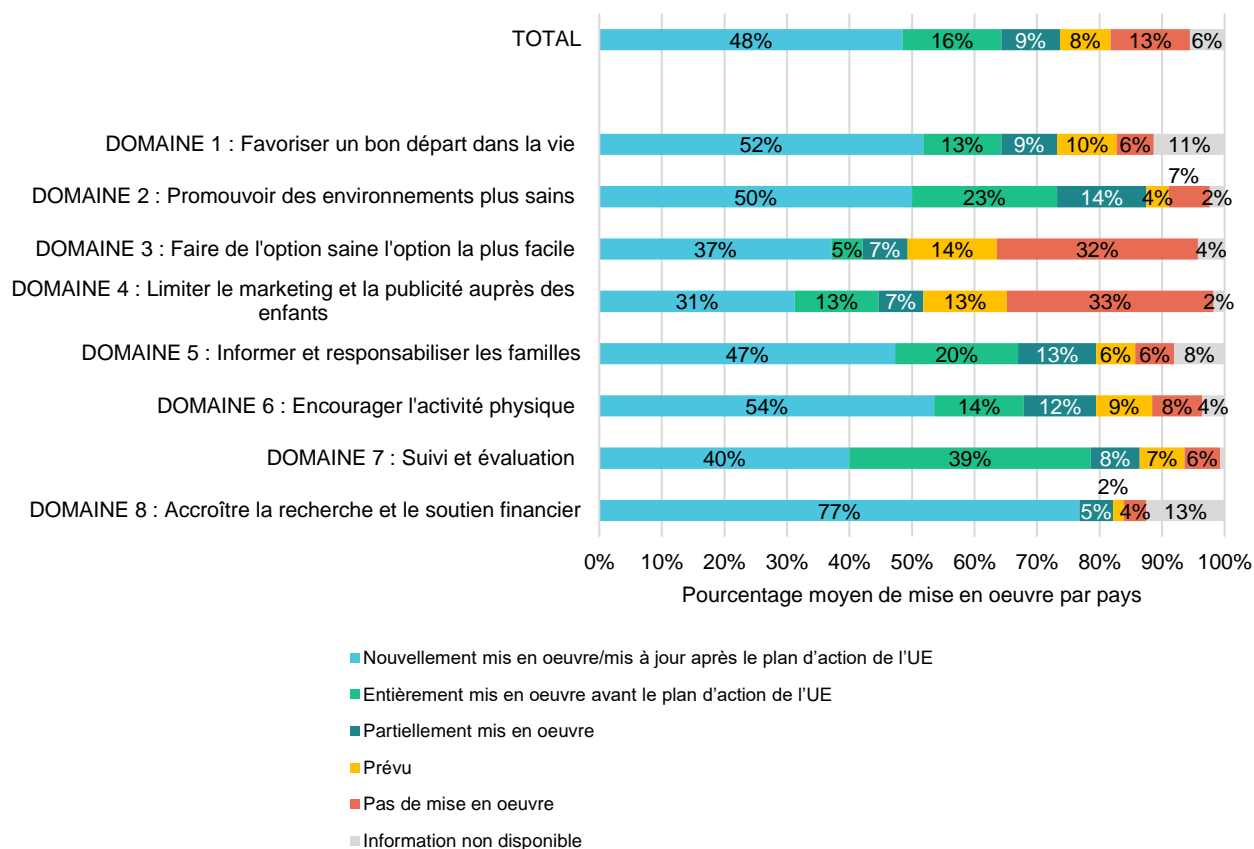
---

<sup>40</sup> European Commission – Directorate-General for Health & Food Safety. (2017). Criteria to Select Best Practices in Health Promotion and Disease Prevention and Management in Europe. Disponible sur: [Link](#).

disposent de plans plus généraux comportant des mesures spécifiques pour les enfants (Croatie, Danemark, Espagne, Finlande, France, Irlande, Malte, Slovénie). Tous les pays ont mis en œuvre des initiatives plus larges pour améliorer les modes de vie de la population, souvent par le biais de plans centrés sur la nutrition, l'activité physique ou les maladies non transmissibles. La Belgique, Chypre, la Lettonie et le Luxembourg sont en train d'élaborer ou de négocier des plans de lutte contre l'obésité infantile. La Suède ne possède pas de plan national spécifique, mais elle a introduit des lignes directrices en milieu scolaire et des recommandations sur l'activité des jeunes enfants.

- Sept pays font explicitement référence au plan d'action de l'UE dans leurs documents politiques (Espagne, Finlande, Lituanie, Luxembourg, Malte, Slovaquie, Slovénie).
- La Finlande, la Lituanie et la France sont les pays ayant adopté ou mis à jour le plus grand nombre d'actions couvrant les sujets clés depuis 2014, tandis que la République tchèque, Chypre et la Slovaquie ont adopté le moins d'actions. Néanmoins, aucun pays n'a mis en œuvre des actions portant sur tous les thèmes clés décrits dans le plan d'action de l'UE.
- Dans tous les pays, les efforts de lutte contre l'obésité infantile se sont largement concentrés sur l'amélioration de l'environnement scolaire en améliorant les repas, en interdisant les distributeurs automatiques et en mettant à jour les directives diététiques (domaine 2), ainsi que sur la promotion de l'allaitement maternel (domaine 1). En outre, tous les pays ont participé à au moins une action commune de l'UE relative à l'obésité infantile, et la plupart d'entre eux se sont engagés dans des enquêtes internationales et nationales de surveillance de l'obésité. Toutefois, la mise en œuvre des politiques visant à améliorer l'environnement alimentaire et à faciliter les choix sains (domaines 3 et 4) est restée limitée, de nombreux pays s'en remettant à des accords volontaires avec l'industrie alimentaire et des acteurs privés dans des domaines tels que la reformulation des aliments et les restrictions en matière de marketing et de publicité.
- L'analyse de cette étude montre que les États membres de l'UE et le Royaume-Uni couvrent en moyenne 64 % des thèmes clés du plan d'action de l'UE, 48 % de ces thèmes ayant été nouvellement abordés ou mis à jour après l'adoption du plan d'action de l'UE.

**Figure 1 – Aperçu de la mise en œuvre du plan d'action de l'UE par domaine d'action dans les États membres et au Royaume-Uni**



Source: *Élaboration des auteurs*

### Actions de la Commission européenne et d'autres organisations internationales

Le rôle de la Commission européenne dans la prévention de l'obésité infantile est principalement de soutien, de coordination, d'orientation et de financement. Les actions de l'UE couvrent la prévention, le diagnostic, la recherche et l'adoption de politiques, en utilisant des outils tels que des règlements, des directives, des groupes d'experts, des plans d'action et un soutien financier. Parmi les principales initiatives antérieures à 2014 figurent la plateforme d'action de l'UE sur l'alimentation, la nutrition et l'activité physique (2005), la stratégie sur la nutrition, le surpoids et l'obésité (2007) et le groupe de haut niveau sur la nutrition et l'activité physique. Certaines directives et certains règlements mis en œuvre avant 2014, tels que ceux relatifs aux allégations nutritionnelles, aux préparations pour nourrissons, à la publicité et à l'étiquetage des denrées alimentaires, ont des liens avec certains domaines d'action spécifiques du plan d'action de l'UE. Après 2014, la Commission a soutenu des initiatives pertinentes telles que les actions conjointes sur les maladies chroniques (CHRODIS)<sup>41</sup> et CHRODIS+<sup>42</sup>; une action conjointe sur l'équité en matière de santé en Europe (JAHEE) et l'action conjointe PreventNCD, ainsi que la création du groupe de pilotage sur la promotion de la santé, la prévention des

<sup>41</sup> Join Actions on Chronic Disease (CHRODIS). Disponible sur: [Link](#).

<sup>42</sup> CHRODIS+. Disponible sur: [Link](#).

maladies et la gestion des maladies non transmissibles (SGPP)<sup>43</sup> et du groupe d'experts sur la santé publique.<sup>44</sup>

Les initiatives de l'UE visant à réduire l'obésité infantile ont été accompagnées d'autres actions mises en œuvre par l'Organisation mondiale de la santé (OMS), l'Organisation de coopération et de développement économiques (OCDE), la Fédération mondiale de l'obésité (FMO) et l'Association européenne pour l'étude de l'obésité (EASO). À cet égard, la plupart des actions mises en œuvre par les organisations internationales sont transversales à plusieurs domaines d'action du plan d'action de l'UE. En outre, les organisations internationales n'ont mis en œuvre que peu ou pas de mesures liées au domaine 2 (promouvoir des environnements plus sains), au domaine 3 (faire de l'option saine l'option la plus facile), au domaine 5 (informer et responsabiliser les familles) et au domaine 8 (accroître la recherche et le soutien financier).

### Obstacles et défis actuels à la mise en œuvre des politiques

Dans tous les États membres de l'Union européenne et au Royaume-Uni, plusieurs obstacles limitent la capacité à enrayer la progression de l'obésité infantile. Certains des défis identifiés sont transversaux, c'est-à-dire qu'ils concernent tous les domaines d'action indiqués dans le plan d'action de l'UE, tandis que d'autres sont spécifiques à des domaines d'action particuliers du plan d'action de l'UE.

Les principales catégories de défis identifiées sont : absence de reconnaissance officielle de l'obésité en tant que maladie, contraintes financières, obstacles institutionnels liés à la mise en œuvre des politiques, y compris une collaboration insuffisante entre les politiques, faiblesses des systèmes de soins de santé, obstacles comportementaux et culturels, et manque de données et de systèmes de suivi efficaces.

**Tableau 1 – Aperçu du type de défis/obstacles concernant chaque domaine du plan d'action de l'UE sur l'obésité infantile**

	DOMAINE 1	DOMAINE 2	DOMAINE 3	DOMAINE 4	DOMAINE 5	DOMAINE 6	DOMAINE 7
Institutionnel	✓	✓	✓	✓	✓	✓	✓
Comportemental/ culturel	✓	✓	✓		✓	✓	
Financier	✓	✓			✓	✓	✓
Accès aux soins de santé	✓						✓
Données et suivi			✓				✓
Reconnaissance des maladies	✓	✓	✓	✓	✓	✓	✓

Source: *Élaboration des auteurs*

### Recueil de bonnes pratiques par domaine d'action

<sup>43</sup> European Commission. (n.d.). The Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP). Disponible sur: (Lien non disponible)

<sup>44</sup> European Commission. (n.d.). Expert Group on Public Health. Disponible sur: [Link](#).

Dans tous les États membres et au Royaume-Uni, il existe un large éventail de bonnes pratiques mises en œuvre pour lutter contre l'obésité infantile dans les domaines d'action 1 à 7 du plan d'action de l'UE. Au total, 63 bonnes pratiques liées à des domaines d'action spécifiques ont été recensées : 58 provenant de 24 pays de l'UE et du Royaume-Uni, et cinq autres venant d'Australie, du Canada, du Chili, d'Israël et des États-Unis, afin de présenter des approches novatrices non encore adoptées dans l'UE. La sélection des bonnes pratiques montre une large répartition des interventions politiques, en particulier en milieu scolaire (domaine 2 : promouvoir des environnements plus sains), dans les interventions communautaires (domaine 5 : informer et responsabiliser les familles) et dans la promotion de l'activité physique chez les enfants (domaine 6 : encourager l'activité physique). Les bonnes pratiques à petite échelle prédominent et seules quelques bonnes pratiques à grande échelle ont été identifiées.

### État du suivi et indicateurs utilisés

L'étude a révélé que, sur les 28 pays couverts, 24 ont indiqué disposer d'indicateurs pour suivre les progrès de certaines ou de nombreuses politiques et actions mises en œuvre pour lutter contre l'obésité infantile dans les domaines d'action 1 à 6 du plan d'action de l'UE (aucune information disponible pour le Danemark, la Pologne et la Roumanie). Pour les indicateurs figurant dans le plan d'action de l'UE, la majorité des indicateurs proposés pour chaque domaine d'action font l'objet d'un suivi dans de nombreux pays.

### Points de vue des États membres sur le plan d'action de l'UE

Les autorités nationales consultées ont fait état des éléments suivants concernant les différents domaines d'action du plan d'action de l'UE et sa mise en œuvre au niveau national:

- La majorité des autorités nationales consultées des États membres et du Royaume-Uni ont indiqué qu'elles connaissaient bien le plan d'action de l'UE (78 %, 31 répondants sur 40).
- 55% estiment que le plan d'action de l'UE a facilité l'introduction et/ou le renforcement des politiques nationales dans le domaine de l'obésité infantile (21 répondants sur 38).
- Au cours des entretiens, plusieurs autorités nationales ont reconnu que le pays n'aurait probablement pas adopté certaines politiques et obtenu certains résultats sans l'existence du plan d'action de l'UE, qui a orienté l'agenda national et fourni des informations et des expériences d'autres pays.
- Les autorités nationales ont déclaré avoir impliqué d'autres parties prenantes dans leur processus d'élaboration des politiques nationales, à savoir des établissements d'enseignement (22 pays), des professionnels de la santé (21 pays), des universités (21 pays), des représentants d'ONG (20 pays) et des représentants de l'industrie (14 pays).
- La majorité des autorités nationales ont identifié le Groupe de haut niveau sur la nutrition et l'activité physique, précédemment actif, comme l'action la plus utile de la Commission pour soutenir la mise en œuvre du plan d'action de l'UE.

### Points de vue des parties prenantes sur le plan d'action de l'UE

Dans l'ensemble, les parties prenantes consultées (représentant des ONG, des associations de parents, des organisations de consommateurs, l'industrie, des universitaires) ont souligné la nécessité d'une approche globale impliquant l'éducation, la réglementation, des environnements favorables et une meilleure allocation des ressources pour lutter efficacement contre l'obésité infantile. Les parties prenantes consultées ont fait part des observations suivantes concernant les différents domaines d'action du plan d'action de l'UE et sa mise en œuvre au niveau national :

- **DOMAINE 1** - Les parties prenantes se sont inquiétées du manque de connaissances en matière de santé et de l'insuffisance de la formation des professionnels de la santé pour aider les jeunes familles à gérer l'obésité. Elles ont souligné l'importance de faciliter l'allaitement maternel, limité par les infrastructures et politiques de congé maternité.
- **DOMAINE 2** - Les parties prenantes ont souligné que la mise en œuvre limitée des politiques de promotion d'une alimentation saine dans les écoles et la disponibilité généralisée d'aliments malsains constituaient des défis majeurs. Elles ont plaidé en faveur de campagnes d'éducation et d'installations visant à encourager l'activité physique, tout en abordant les conflits entre l'éducation physique et les priorités académiques.
- **DOMAINE 3** - La majorité des parties prenantes sont favorables à l'étiquetage nutritionnel sur le devant des emballages, mais soulignent la nécessité d'éduquer les consommateurs pour que les étiquettes soient efficaces. Les autorités nationales interrogées ont affirmé que l'étiquetage nutritionnel sur le devant des emballages devait être fondé sur des études du comportement des consommateurs et des preuves scientifiques pour garantir sa légitimité, sa crédibilité et son efficacité. Les avis sur la taxation des aliments malsains sont divisés parmi les parties prenantes consultées. Tandis que certaines autorités nationales consultées et des représentants d'ONG ont soutenu cette mesure en tant qu'outil pour encourager la reformulation des aliments, d'autres ont souligné la nécessité de mesures complémentaires telles que la subvention d'aliments sains et le lancement de campagnes de sensibilisation. Enfin, des inquiétudes concernant la fiscalité ont été exprimées par les autorités nationales interrogées en ce qui concerne la réticence probable des consommateurs face aux augmentations de prix, et par l'industrie en raison de la crainte d'une diminution des revenus.
- **DOMAINE 4** - Alors que de nombreuses parties prenantes ont appelé à une réglementation plus stricte de la commercialisation de produits malsains auprès des enfants, les représentants de l'industrie de la publicité ont défendu l'efficacité de l'autorégulation.
- **DOMAINE 5** - Les parties prenantes ont reconnu les efforts déployés pour éduquer les familles en matière de nutrition et d'exercice physique, mais ont constaté que les familles vulnérables ne bénéficiaient pas d'un soutien suffisant pour accéder à des options alimentaires saines.
- **DOMAINE 6** - Des inquiétudes ont été exprimées quant à l'inadéquation des espaces urbains pour une activité physique en toute sécurité. Les parties prenantes ont souligné l'importance d'éduquer les parents et d'améliorer les installations publiques telles que les écoles et les clubs sportifs afin de promouvoir une activité physique agréable, et pas seulement des sports de haut niveau.

- DOMAINE 7 - Les parties prenantes ont reconnu l'existence d'initiatives à grande échelle telles que l'initiative européenne de surveillance de l'obésité infantile (COSI)<sup>45</sup> et les comportements de santé chez les enfants d'âge scolaire (HBSC),<sup>46</sup> mais ont relevé des difficultés telles que le manque de personnel et l'accent mis sur l'IMC dans les programmes de dépistage. Il y a également un manque perçu d'actions de suivi pour soutenir les familles après les dépistages de santé publique.
- DOMAINE 8 - Les parties prenantes ont fait état de niveaux variés de participation à la recherche sur l'obésité, certaines bénéficiant d'un financement de l'UE, tandis que d'autres ont exprimé des inquiétudes quant à la priorité limitée accordée à l'obésité dans les politiques nationales et les possibilités de financement.

### Principaux enseignements des données recueillies

Le plan d'action de l'UE sur l'obésité infantile 2014-2020 a fourni un cadre global pour réduire l'obésité infantile dans l'UE. Dans l'ensemble, cette étude montre que des progrès ont été réalisés dans tous les pays par rapport à la période antérieure à 2014, et que le plan d'action de l'UE a contribué positivement à ces progrès. La mise en œuvre du plan d'action de l'UE a été jugée comme « modérément élevée ». Le plan d'action de l'UE a établi des domaines prioritaires clairs et a fourni une boîte à outils de mesures potentielles. Cependant, malgré ces réalisations, le plan d'action de l'UE n'a atteint que partiellement son objectif de mettre un terme à l'augmentation du surpoids et de l'obésité chez les enfants d'ici 2020. Le plan d'action de l'UE a servi de document d'orientation aux États membres pour identifier et adopter des mesures pertinentes sur une base volontaire, en fonction des priorités politiques et des capacités de chaque pays. Cela s'est traduit par une mise en œuvre fragmentée entre les États membres, certains pays ayant adopté des mesures couvrant de nombreux nouveaux thèmes clés, tandis que d'autres n'en ont mis en œuvre que quelques-unes et dans des domaines limités. Cette incohérence a entravé la mise en place d'une approche cohérente, car les niveaux d'engagement et de ressources variables d'un pays à l'autre ont entraîné des progrès inégaux et des lacunes dans la lutte contre l'obésité dans toute la région. En outre, des défis persistent et les parties prenantes ont des opinions divergentes sur les stratégies les plus efficaces pour lutter contre l'obésité infantile, en particulier en ce qui concerne les politiques relevant des domaines 3 et 4. Les résultats soulignent la nécessité d'un engagement commun et de mesures continues pour lutter contre l'augmentation de l'obésité infantile dans les États membres.

---

<sup>45</sup> [WHO European Childhood Obesity Surveillance Initiative \(COSI\)](#)

<sup>46</sup> [HBSC study | Health Behaviour in School-aged Children study](#)

## List of official Member State abbreviations and other acronyms

### Official Member State abbreviations

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

(\*) Since 31 January 2020 the UK is no longer an EU Member State.

### Other acronyms

Acronym	Extended form
Best– ReMaP	Joint Action on Implementation of Validated Best Practices in Nutrition
BMI	Body Mass Index
COSI	Childhood Obesity Surveillance Initiative
CHRODIS+	Joint Action on Chronic Diseases
DG SANTE	Directorate-General for Health and Food Safety
EASO	European Association for the Study of Obesity
EU	European Union
FOPNL	Front-of-pack nutrition labelling

Acronym	Extended form
JAHEE	Joint Action on Health Equity Europe
JANPA	Joint Action on Nutrition and Physical Activity
HBSC	Health Behaviour in School-aged Children
HFSS	High Fat, Sugar or Salt
KoM	Kick-off Meeting
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
PreventNCD	Joint Action Prevent Non-Communicable Diseases and Cancer
TFEU	Treaty on the Functioning of the European Union
VAT	Value Added Tax
VPA	Vigorous Physical Activity
WHO	World Health Organisation
WOF	World Obesity Federation

# 1 Introduction

Childhood obesity in Europe remains a significant public health concern.<sup>47</sup> It has been increasing since the 1980s, with annual increases accelerating in the recent decade. The latest data from the World Health Organization (WHO) Childhood Obesity Surveillance Initiative (COSI) 2018-2020 showed that almost 1 in 3 European children (7-9 years old) were overweight or obese.<sup>48</sup> The prevalence rates also vary significantly across regions and socioeconomic groups.

Within the context of this study, childhood obesity is defined as “abnormal or excessive fat accumulation that may impair health in persons under 18 years old”, following the WHO definition.<sup>49</sup> This can be measured using the WHO recommended Growth Reference.<sup>50</sup> The causes of childhood obesity are multifaceted, involving environmental factors, lifestyle choices (including excessive consumption of energy-dense foods and decreased physical activity), and cultural influences, as well as medications, diseases, trauma, and genetic variations.

The issue of **childhood overweight and obesity threatens the health of current and future generations**. Since obesity develops and becomes more pronounced across the life course, prevention of obesity in critical life-course phases, such as preconception and pregnancy periods,<sup>51</sup> infancy and adolescence, is likely to have the greatest health and cost benefits.<sup>52</sup> Likewise, preventing obesity from a young age holds the most significant promise for breaking the intergenerational cycle of obesity and dietary inequalities.<sup>53</sup> Childhood obesity can have short and long-term effects on an individual’s life. In the short term, it can lead to orthopaedic, neurological, pulmonary, and endocrine conditions, as well as social and psychological issues affecting self-esteem and body image.<sup>54</sup> Long-term effects include increased risk of cardiovascular disease, type 2 diabetes, hypertension, certain types of cancer and premature mortality in adulthood.<sup>55</sup> The societal impacts of obesity are widespread, including substantial direct and indirect costs that put a considerable strain on healthcare and social resources.<sup>56</sup> According to a 2019 report on

---

<sup>47</sup> Buoncristiano, M., et al. (2021). Childhood overweight and obesity in Europe: Changes from 2007 to 2017. *Obesity Reviews*, 22, e13226. Available at: [Link](#)

<sup>48</sup> WHO. (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Available at: [Link](#)

<sup>49</sup> In pre-school children aged 0-5 years, overweight and obesity are defined as the proportion of children with a sex- and age-specific body mass index-for-age value above +2 Z-score and above +3 Z-scores of the 2006 WHO recommended Growth Standards, respectively. In school age children and adolescents aged 5-19 years, overweight and obesity are defined as the proportion of children with a sex- and age-specific body mass index- for-age value above +1 Z-score and above +2 Z-scores of the 2007 WHO recommended Growth Reference, respectively. Available at: [Link](#)

<sup>50</sup> WHO. (n.d.) Overweight and Obesity. Available at: [Link](#)

<sup>51</sup> Lecorguillé, M., et al. (2023). Impact of parental lifestyle patterns in the preconception and pregnancy periods on childhood obesity. *Frontiers in nutrition*, 10, 1166981.

<sup>52</sup> Garrido-Miguel, M., et al. (2019). Prevalence of overweight and obesity among European preschool children: a systematic review and meta-regression by food group consumption. *Nutrients*, 11(7), 1698. Available at: [Link](#)

<sup>53</sup> WHO. (2022). WHO European Regional Obesity Report 2022. Available at: [Link](#)

<sup>54</sup> Orio, F., et al. (2014). Lifestyle changes in the management of adulthood and childhood obesity. *Minerva endocrinologica*. Available at: [Link](#)

<sup>55</sup> Kelsey, M. M., et al. (2014). Age-related consequences of childhood obesity. *Gerontology*, 60(3), 222-228. Available at: [Link](#)

<sup>56</sup> Dee, A., et al. (2014). The direct and indirect costs of both overweight and obesity: a systematic review. *BMC research notes*, 7, 1-9. Available at: [Link](#)

the economic burden of obesity,<sup>57</sup> between 2020 and 2050, OECD countries will spend, on average, 8.4% of their entire annual health budget on treating the consequences of overweight (including obesity).

No single intervention can halt the growth of obesity on its own; the literature points in the direction that action is needed with a comprehensive approach to protect the future health and well-being of European populations.<sup>58</sup> Curbing overweight and obesity rates involves societal changes to obesogenic environments,<sup>59</sup> including reducing calorie intake from fats and sugars, increasing consumption of whole foods, plant-based foods and fruits, increasing regular physical activity and sleep and reducing exposure to screens.

In 2022, the prevalence of children who are overweight or obese (based on WHO growth reference) was 25% among 11-year-olds, 22% among 13-year-olds, and 20% among 15-year-olds.<sup>60</sup> Moreover, prevalence tends to be higher among boys than girls. A social gradient further compounds childhood overweight and obesity rates and its associated risk factors, disproportionately affecting those from lower socioeconomic groups, lower levels of educational attainment, and underserved areas.<sup>61</sup> Significant differences were reported in the prevalence of overweight and obesity between EU countries, with the highest observed in Malta, Hungary and Romania.

## 1.1 Policy Context: the EU Action Plan

In response, preventing obesity, and especially childhood obesity, is a priority area for the European Union (EU). Since 2007, the European Union (EU) has adopted different measures, such as the White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity-related Health issues.<sup>62</sup> In February 2014, the result of a commitment of EU Member States to addressing childhood obesity, supported by the Commission in the context of the (former) High-Level Group on Nutrition and Physical Activity,<sup>63</sup> the EU Action Plan on Childhood Obesity 2014-2020<sup>64</sup> (hereinafter referred to as the “EU Action Plan”) was developed. The goal of the EU Action Plan was to contribute to stopping the rise in overweight and obese children and young people by the year 2020. Moreover, it demonstrated a shared commitment of Member States to address childhood obesity, set out priority areas for action and a possible toolbox of measures and propose ways of collectively keeping track of progress.

Within the Action Plan, eight key areas for action were identified:

- **Area 1: Supporting a healthy start in life** – covers measures aimed at promoting healthier behaviours by mothers before, during and after pregnancy, as well as

---

<sup>57</sup> OECD. (2019). *The Heavy Burden of Obesity: The Economics of Prevention*, OECD Health Policy Studies, OECD Publishing, Paris. Available at: [Link](#)

<sup>58</sup> Hernández-Quevedo, C., Gauci, C., Rechel, B. (2019). Childhood obesity in Europe and policies to address it. *Eurohealth*, 25(1), 7-10. Available at: [Link](#)

<sup>59</sup> Verde, L., et al. (2024). Obesogenic environments as major determinants of a disease: It is time to re-shape our cities. *Diabetes/Metabolism Research and Reviews*, 40(1), e3748. Available at: [Link](#)

<sup>60</sup> WHO (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Available at: [Link](#)

<sup>61</sup> Uljaszek, S. J. et al. (2017). Inequality and childhood overweight and obesity: a commentary. *Pediatric Obesity*, 12(3), 195-202. Available at: [Link](#)

<sup>62</sup> European Commission. (2007). *Nutrition, overweight and obesity — EU strategy*. Available at: [Link](#)

<sup>63</sup> European Commission. (n.d.). High Level Group on Nutrition and Physical Activity. Available at: [Link](#)

<sup>64</sup> European Commission. (2014). *EU Action Plan on Childhood Obesity 2014-2020*. Available at: [Link](#)

programmes aimed at improving support and counselling from healthcare providers. Area 1 also emphasises better support for low-income families.

- **Area 2: Promote healthier environments (especially in schools and pre-schools)** – recommends that implementing comprehensive policies in schools, including promoting healthy meals, limiting access to unhealthy snacks, changing education curriculums, and encouraging physical activity, is essential for fostering lifelong healthy habits and addressing childhood obesity.
- **Area 3: Make the healthy option the easier option** – emphasises the need for facilitating easier access to healthy options in supermarkets, through local producers, markets, restaurants, various retailers, and schools. Area 3 covers policies on food reformulation (e.g. limiting salt, sugar, saturated fat content and calories) or initiatives on portion sizes, introducing easy-to-understand nutritional labelling on pre-packed foods or menus as well as taxation and subsidy initiatives.
- **Area 4: Restrict marketing and advertising to children** – relates to policies that restrict marketing and advertising to children, e.g. through mandatory or voluntary restrictions and the prohibition of marketing food and drinks high in fat, sugar and salt (HFSS) in schools.
- **Area 5: Inform and empower families** – deals with initiatives informing and empowering families to lead healthier lifestyles on by improving nutrition and engaging in physical exercise, e.g. through campaigns, community-based interventions, and targeted support to disadvantaged families.
- **Area 6: Encourage physical activity** – relates to policies that encourage physical activity, e.g. through improving infrastructure for physical activity where children can do extracurricular sports, ensuring safe, easy and active mobility as well as communicating national physical activity guidelines.
- **Area 7: Monitoring and evaluation** – promotes up-to-date, reliable, and comparable data on health indicators, health outcomes and health risk factors on childhood obesity.
- **Area 8: Increasing research** – calls for improvements in research agendas and funding for childhood obesity.

The EU Action Plan is a non-binding measure that provides a basis for countries to develop policies on tackling childhood obesity. Defining national health policies remains the exclusive competence of Member States according to Article 168 of the Treaty on the Functioning of the European Union (TFEU). Therefore, any actions that resulted from the EU Action Plan were taken by Member states voluntarily and according to their own national contexts and priorities.

## 1.2 Scope of the study

The study covers the 2014-2020 programming period when the EU Action Plan on Childhood Obesity was implemented and builds upon the findings of the mid-term

evaluation from 2018.<sup>65</sup> Moreover, the study takes into consideration ongoing and planned policies that extend beyond the 2014-2020 timeframe. Besides national plans, the study also considers regional/local interventions and public-private partnerships. The geographical scope of the study is EU27 Member States and the United Kingdom. The United Kingdom is included within the scope of the study, as it was still part of the EU when the EU Action Plan was adopted in 2014.

The EU Action Plan concluded in 2020, while this evaluation study was conducted in 2024, creating a time lag between the end of the plan and this report's release. Despite this gap, the guidance provided by the plan remains relevant and continues to serve as a crucial framework for driving action and informing policy efforts.

### 1.3 Purpose of the study

The objectives of the study were the following:

- **Evaluate the progress achieved across the EU in the key areas of the Action Plan.** This required an in-depth analysis and review of the areas of action covered. It includes providing an aggregate perspective highlighting the European dimension of the progress.
- **Provide an overview of the efforts** carried out by the EU Member States in these key areas for action during the period 2014 – 2020 to have a comprehensive overview of national approaches, objectives, and experience towards tackling childhood obesity.
- **Map for each Member State the ongoing and/or planned actions on childhood obesity** by providing an exhaustive review of the most recurring objectives, interventions, and actions implemented by the Member States. This includes providing a comparative perspective as well as an assessment of their alignment with the EU Action Plan.
- **Identify obstacles and remaining challenges in addressing the key areas for action in the Action Plan** through the analysis both at the EU and the national level and highlighting the underlying causes.
- **Identify best practices** and assess their replicability across the Member States.
- **Propose possible next steps that could be taken to effectively reduce the rates of childhood obesity in Europe** by elaborating policy options based on the key findings of the study.
- **Engage stakeholders and collect feedback and opinions** by developing an inclusive consultation strategy and implementing several stakeholders' engagement activities such as surveys, interviews, and workshops.

---

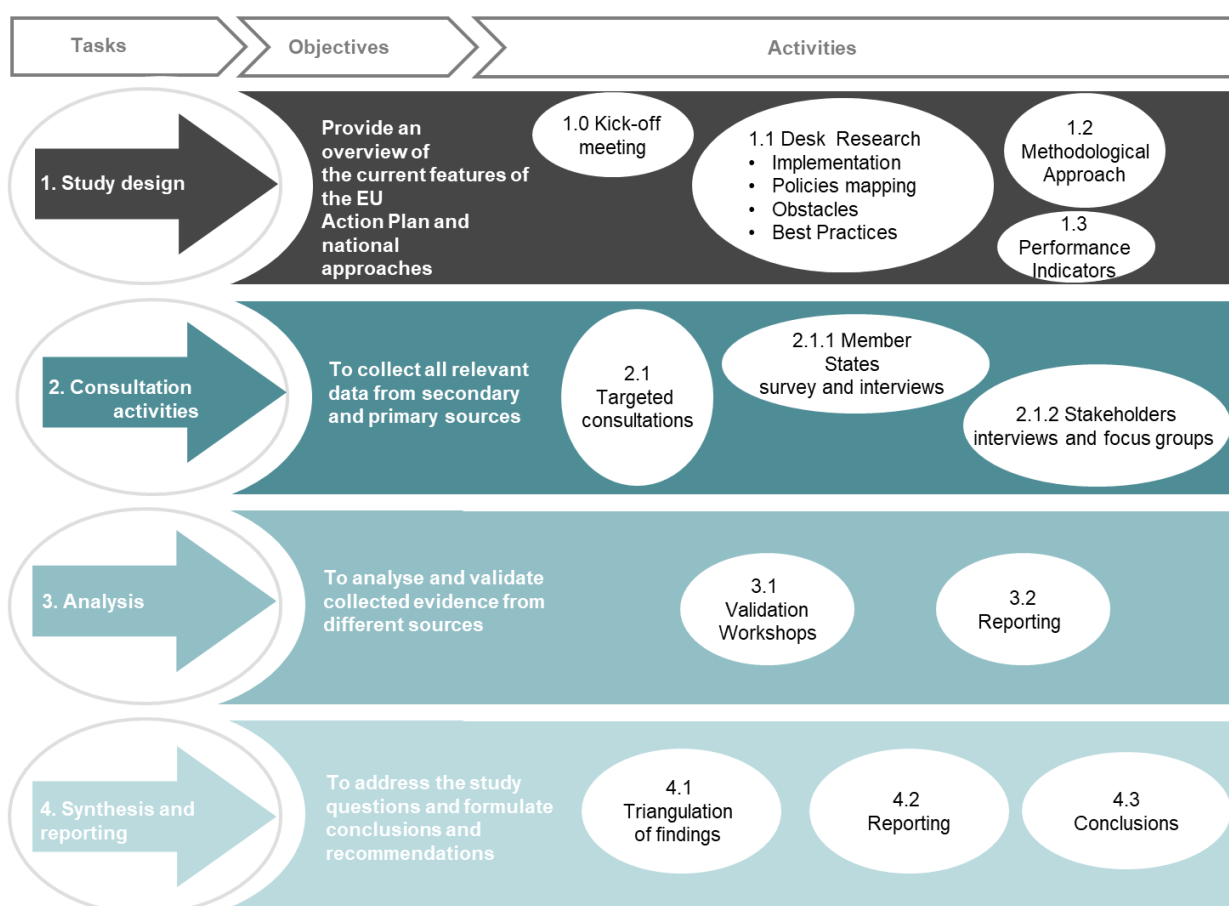
<sup>65</sup> European Commission, Directorate-General for Health and Food Safety, Pushkarev, N., Hansen, J., Driesenaar, J. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: the childhood obesity study, Publications Office. Available at: [Link](#)

## 2 Methodological approach

### 2.1 Research questions and methodology

The study was composed of three key steps: desk research (Task 1), consultation activities (Task 2) and validation workshops (Task 3). The results of each task were subsequently triangulated to generate the study's findings. Within each task, the study examined the current state of implementation of the EU Action Plan, identified obstacles and challenges, and highlighted best practices. Figure 2 shows the adopted methodological approach of the study.

**Figure 2 – Overview of the methodology**



Source: Authors' elaboration

Specific research questions have been developed to guide the study (see Box 1). These questions served as a framework for exploring key issues, gathering relevant data, and assessing the outcomes in alignment with the study's objectives.

### Box 1 – Study research questions

**Q1.** To what extent has each EU Member State implemented actions and reached objectives as set out in the priority areas for action of the EU Action Plan on Childhood Obesity during the period from 2014 to 2020?

- Q1.1. Are there any Areas for Action which are more commonly addressed by Member States' actions?
- Q1.2 Are there any Areas for Action which are often omitted in Member States' actions?
- Q1.3 Which types of indicators are being monitored to assess the attainment of objectives?
- Q1.4 Are the monitored indicators in line with those mentioned in the Action Plan?

**Q2.** Which policies, legislation, instruments, and other interventions have the Member States implemented to address and reduce childhood obesity in each priority area for action?

**Q3.** Which were the main successes and challenges (breakdown in general, per country and per priority area)?

**Q4.** Which further (policy) actions are currently being developed in each Member State to reduce childhood obesity and what are their (expected) strengths and weaknesses?

**Q5.** Which are the best practices in policy approaches in each of the priority areas for action in preventing and reducing childhood obesity, especially among children in disadvantaged situations?

**Q6.** What are the views of key European and national stakeholders on childhood obesity, on the best policy (and other) approaches to reduce childhood obesity, and on key elements of the study?

**Q7.** Based on the results and analysis of the abovementioned questions, what are the follow-up actions that need to be taken by EU and national policymakers, stakeholders and citizens to effectively reduce childhood obesity, especially among children in disadvantaged situations?

## 2.2 Areas for Action and Key topics

The mapping and analysis of national approaches were guided by the eight Areas for Action of the EU Action Plan, which were divided into 41 specific key topics to provide a more granular analysis. The comprehensive list of areas for action and related key topics was based on an adaptation of sub-dimensions available in the mid-term evaluation<sup>66</sup> and agreed upon with the Directorate-General for Health and Food Safety (DG SANTE). A detailed description of every Area for Action and Key Topic is available in Annex I.

**Table 3 – List of Areas for Action and key topics**

#### AREA 1: Supporting a healthy start in life

- 1.1 Guidance before and during pregnancy on maternal nutrition and physical activity
- 1.2 Promote and protect breastfeeding
- 1.3 Guidance on complementary feeding
- 1.4 Training for healthcare and childcare professionals
- 1.5 Improvement of childhood obesity management
- 1.6 Promotion of healthy habits among vulnerable pregnant women and infants

<sup>66</sup> European Commission, Directorate-General for Health and Food Safety, Pushkarev, N., Hansen, J., Driesenaar, J. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: the childhood obesity study, Publications Office. Available at: [Link](#).

## AREA 2: Promote healthier environments

- 2.1 Physically active school environments
- 2.2 Policies on vending machines (healthy snacks)
- 2.3 Policies on sweetened beverages and energy drinks
- 2.4 Integration nutrition education
- 2.5 Integration physical activity education
- 2.6 Healthy lunches at school canteens

## AREA3: Make the healthy option the easier option

- 3.1 a) Food reformulation: salt
- b) Food reformulation: total and/or saturated fats
- c) Food reformulation: sugar
- d) Food reformulation: calories or portion sizes<sup>67</sup>
- 3.2 Monitoring food reformulation
- 3.3 Mandatory or voluntary easy to understand nutrition labelling
- 3.4 Taxation
- 3.5 Subsidies and affordability initiatives
- 3.6 Promotion of freshwater intake
- 3.7 Nutritional training for food providers and producers

## AREA 4: Restrict marketing and advertising to children

- 4.1 Mandatory restrictions on marketing
- 4.2 Voluntary restrictions to restrict marketing
- 4.3 Nutrient criteria to reduce marketing
- 4.4 Marketing activities in schools

## AREA 5: Inform and empower families

- 5.1 Campaigns on diet & physical activity targeting children and their families
- 5.2 Implementation community– based interventions
- 5.3 Targeted support for disadvantaged families
- 5.4 National nutritional guidelines

## AREA 6: Encourage physical activity

- 6.1 Physical activity promotion for children
- 6.2 National physical activity guidelines
- 6.3 Infrastructure for physical activity
- 6.4 Safe and easy active mobility

## AREA 7: Monitoring and evaluation

- 7.1 National diet and nutrition survey
- 7.2 National physical activity and sports survey
- 7.3 a) Participation international survey: COSI

---

<sup>67</sup> Changes to portion sizes is not a form of food reformulation. Changing portion sizes involves adjusting the amount of food served or packaged, but it does not alter the actual content or ingredients of the food itself. Nonetheless, adjusting portion sizes can be a strategy to help consumers manage their calorie intake and promote healthier eating habits.

7.3 b) Participation international survey: HBSC

7.4 Screening for childhood overweight and obesity

## AREA 8: Increase research and financial support

8.1 Participation in European Joint research actions

8.2 Financial support for obesity programmes

Source: Authors' elaboration

## 2.3 Desk research (Task 1)

Data collection for Task 1 was based exclusively on desk research. The goal of this task was to collect preliminary information on the implementation of the EU Action Plan, current and planned national (policy) approaches to address childhood obesity, identify specific obstacles and challenges and collect best practices.

Desk research was conducted between October 2023 and May 2024, consulting official websites of the Member States Competent Authorities, online policy repositories, published scientific articles, and official reports from leading health and obesity organisations, such as WHO, Organisation for Economic Co-operation and Development (OECD), or the World Obesity Federation (WOF). Sources of grey literature, including but not limited to policy implementation reports, white papers, and press releases, were also consulted. In addition, information available in the mid-term evaluation was revised and included.

Desk research was conducted using both English and the EU national languages in combination with a translation software. Annex X: Consultation materials presents a list of sources consulted and the organisations publishing them.

### 2.3.1 Implementation of the EU Action Plan and mapping of national (policy) approaches

The purpose of this activity was to collect and analyse the existing evidence to evaluate the progress and achievements in the implementation of the EU Action Plan across EU countries (plus the UK). The mapping and analysis of national strategies were guided by the eight Areas for Action of the EU Action Plan (see Table 3). Furthermore, a list of inclusion and exclusion criteria was developed to guide the selection of approaches to include in the policy mapping (see Table 4). The desk research primarily concentrates on mapping approaches implemented post-2010. This date was chosen as a cut-off point to reflect the national efforts carried out to address childhood obesity in the ten-year period preceding the end of implementation of the EU Action Plan (2020); however, relevant pre-2010 policies which pertain to the eight Areas for Action of the EU Action Plan were also included, in order to provide a comprehensive view of the Member States's efforts on childhood obesity.

**Table 4 – Overview of inclusion and exclusion criteria for the selection of relevant national policy approaches**

Inclusion	Exclusion
<ol style="list-style-type: none"> <li>1. National approaches that specifically target infants, children, or adolescents.</li> <li>2. Approaches that promote physical activity, healthy nutrition, or better healthcare.</li> <li>3. Approaches implemented at the national level.</li> <li>4. Legislation, action plans, strategies, policies, voluntary agreements, programmes, studies, guidelines, frameworks, roadmaps, standards, protocols, recommendations, declarations, and conventions.</li> </ol>	<ol style="list-style-type: none"> <li>1. Approaches focused solely on adult populations without a clear impact on childhood obesity (e.g. workplace policies).</li> <li>2. Approaches that primarily address other issues, such as economic development, cultural initiatives or workforce health.</li> <li>3. Initiatives initiated by individual citizens or private entities without clear endorsement by national governing bodies.</li> <li>4. Initiatives limited to specific regions without broader national coordination.</li> </ol>

Source: Authors' elaboration

Information for each country was systematically collected in a standardised database. For each policy, the relevant Area(s) for action and key topics from the EU Action Plan that it impacted were identified and recorded.

### 2.3.2 Obstacles and challenges

The goal of the task was to develop a comprehensive assessment of existing and potential obstacles and challenges that have emerged or might emerge during the implementation of policies and interventions on childhood obesity. Each obstacle and challenge identified was allocated to a specific Area for Action and a key topic of the EU Action Plan. In some cases, the challenge was described in a way that could be considered to impact all areas of the EU Action Plan. In this case, the challenge is considered as “cross-cutting”. The challenges were categorised based on an analysis of the identified issues, with recurring themes emerging across different countries and areas of the EU Action Plan.

**Table 5 – Categories for classifying obstacles and challenges**

Category	Description
<b>Institutional</b>	Refers to the role and responsibilities of schools, government bodies, and organisations in implementing measures that support healthy lifestyles in children.
<b>Behavioural/Cultural</b>	Relates to the individual habits, attitudes, and cultural norms surrounding the lifestyles of children.
<b>Financial</b>	Encompasses economic challenges faced by both families and governments in accessing or funding resources for obesity prevention
<b>Healthcare Access</b>	Pertains to the availability, accessibility and affordability of healthcare services focused on obesity prevention and treatment
<b>Data &amp; Monitoring</b>	Involves the collection, analysis, and tracking of data related to childhood obesity rates, causes, and interventions, essential for informed policy-making and effective program implementation.

Category	Description
Disease recognition	Refers to the acknowledgment of childhood obesity as a complex health condition that can lead to severe health issues.

An overview and discussion of the challenges is provided in Section 4.3. A detailed description of the challenges identified in desk-research and reported by national authorities and stakeholders can be found in Annex VII.

### 2.3.3 Best practices

The goal of this task was to identify, collect and share best practices in policy approaches and other interventions in each of the priority areas for action. Special attention was paid to the situation of children in disadvantaged situations.

Best practices represent a significant repository of evidence derived from the practical implementation of effective public health interventions in real-world contexts.<sup>68</sup> Within the context of this study, best practice is defined as “*a relevant policy or intervention implemented in a real life setting which has been favourably assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes*”.<sup>69</sup> Nonetheless, it is crucial to distinguish between a ‘best practice’ and a ‘good practice’. A ‘good practice’ denotes a policy measure that has been deployed in a real-life setting and may serve as inspiration for others yet has not attained widespread implementation or comprehensive evaluation.<sup>70</sup> Many countries and policy documents cite instances of successful policies based solely on anecdotal evidence, lacking systematic and evidence-based evaluation. In this report, good practices presented by the different stakeholders and reported throughout the study are available in Annex IX: Good practices.

The identification of best practices was conducted based on an adaptation of the guidelines established by the “Criteria to select best practices in health promotion and disease prevention and management in Europe” published by DG SANTE.<sup>71</sup> The guidelines outline a framework to select best practices according to core, exclusion,<sup>72</sup> and qualifier criteria.<sup>73</sup> For this study, the core criteria of the DG SANTE guide as well as the exclusion criteria were used.

- The **core criteria** entail the assessment of the effectiveness and efficiency of the practice as well as how the practice has addressed equity issues.

<sup>68</sup> Ng, E., & De Colombani, P. (2015). Framework for selecting best practices in public health: a systematic literature review. *Journal of public health research*, 4(3). Available at: [Link](#).

<sup>69</sup> European Commission – Directorate-General for Health & Food Safety. (2017). Criteria to Select Best Practices in Health Promotion and Disease Prevention and Management in Europe. Available at: [Link](#).

<sup>70</sup> European Commission. (n.d.). Best Practices. Available at: [Link](#).

<sup>71</sup> European Commission – Directorate-General for Health & Food Safety. (2017). Criteria to Select Best Practices in Health Promotion and Disease Prevention and Management in Europe. Available at: [Link](#).

<sup>72</sup> The exclusion criteria assess if the current public health needs are supported by the practice, produce beneficial results for the population in need in a scientifically sound manner and are free from any commercial benefits of any individual entity.

<sup>73</sup> The qualifier criteria evaluate the transferability of the practice to other settings and contexts, its sustainability, the ability of the practice to foster collaboration among different sectors and the inclusion of stakeholders through the whole cycle of the practice.

- The **exclusion criteria** from DG SANTE guide assess if the current public health needs related to childhood obesity are supported by the practice and are free from any commercial benefits of any individual entity.

In light of the limitations inherent to desk research, which did not yield sufficient information for an in-depth evaluation of all the **qualifier criteria** outlined in the DG SANTE guide, these criteria were not assessed, with the exception of the transferability criteria.

The potential for transferability of the best practices is based on the assessment of whether interventions have already been transferred elsewhere, the type of setting in which they are implemented (i.e. schools, municipalities), and the financial and human resources required. Nonetheless, the structure and length of the report do not allow for a case-by-case analysis of the country that has adopted the best practice and the country that is expected to implement it.

**Table 6 – Criteria for selecting best practices**

	Criteria	Explanation
Exclusion	Relevance	A priority public health area, a strategy or a response to an identified problem at Local/Regional level, National level or European level, and/or put in place to support the implementation of legislation.
	Intervention characteristics	Measures that do not target infants, children or adolescents or their families/environments will be excluded. Additionally, other issues, such as economic development, cultural initiatives, or workforce health will also be excluded. Moreover, methodology is well described, the objectives are clear and indicators to measure objectives are clearly described.
	Ethical aspects	Interventions presenting conflicts of interest of with a potentially harmful impact will be excluded.
Core	Effectiveness, efficiency, or pertinence of the intervention	The intervention was successful in reducing childhood obesity or addressing some of the risk factors of childhood obesity (e.g. physical activity, nutrition, sedentary lifestyles) in an optimal way.
	Equity	The intervention takes into account the needs of the population (i.e. children, families, healthcare or education professionals) when allocating the resources and reducing health inequalities and childhood obesity.
Qualifier	Transferability	The intervention and the outcomes of its implementation are structured, enabling transfer to different countries or expansion to wider populations or geographic areas; it also takes into consideration whether the practice has already been transferred to other countries or expanded.

Source: Authors' elaboration based on criteria to select best practices in health promotion and disease prevention and management in Europe (DG SANTE)

Section 4.4. provides a brief overview of the best practices identified. Annex VIII shows a detailed overview of each best practice, which includes a summary of the relevance of childhood obesity and the intervention/policy characteristics, an assessment of the

evidence of effectiveness and its potential to address health and social inequalities. Additionally, the potential transferability of the practice to other settings is also presented.

## 2.4 Consultation activities (Task 2)

Building on the results of the desk research (Task 1), a survey and follow-up interviews were conducted with national authorities. Additionally, interviews and focus groups were held with key stakeholders related to childhood obesity, following the Better Regulation Guidelines to ensure thorough and consistent data collection. The goal of Task 2 was to fill the evidence gaps from the desk research and to gather insights from various stakeholder groups to effectively address the evaluation questions. While the interviews and survey allowed for an in-depth exploration of stakeholder perspectives and a more nuanced understanding of their views, the focus groups provided a broader, comparative perspective on the issues. The consultation activities were conducted based on the consultation strategy agreed by the Contracting Authority and the Commission. The survey questionnaire, and the interview guides are included in Annex X: Consultation materials.

National authorities included representatives from designated ministries such as the Ministry of Health, Ministry of Education, and Ministry of Finance, as well as officials from national public health authorities. Stakeholders relevant to childhood obesity encompassed a wide range of groups, including international organisations, parent and family associations, academics and scientific experts, education NGOs, EU and national public health NGOs, sports NGOs, consumer associations, marketing and advertising industry associations, and food and beverage industry associations.

### 2.4.1 Survey with national authorities

#### 2.4.1.1 Survey development

The online survey with national authorities was designed to gather information on the current and planned national (policy) approaches to address childhood obesity, identify specific obstacles and challenges and collect best practices. The survey consisted of 14 sections with a total of 47 questions. The questionnaire included predefined answers to possible adopted measures (referred to as 'key topics') and challenges in order to make completing the survey easier for respondents. Possible answers were based on the EU Action Plan and the findings of desk research (Task 1). The questionnaire covered the eight Areas for Action of the EU Action Plan. Additionally, the survey asked about the Member States' policy-making and implementation processes, monitoring efforts and use of indicators, and their view on EU measures. The questionnaires were delivered in English. The survey questionnaire was agreed upon by the Contracting Authority and the Commission. Further details are included in the project deliverable 'Synopsis Report' (Annex XI).

The online survey was launched on 19th February 2024 and remained open until 19th April 2024, for a total of nine weeks. The survey questionnaire was delivered on the Qualtrics platform. Invitations were sent via Outlook and Qualtrics, and they were always accompanied by the Accreditation letter of the study and the Data Protection Notice

informing the respondents of the use of their data and expressed opinions. Survey data have been processed with Microsoft Excel and following the General Data Protection Regulation (GDPR) Regulation.<sup>74</sup>

The survey targeted three representatives from each EU Member State - two from designated ministries and one from the national public health agency, totalling 84 representatives. At the end, a total of **40 valid responses**<sup>75</sup> from the 27 Member States were collected.<sup>76</sup> The Table below provides an overview of the survey participation.

**Table 7 – Overview of participation in the survey**

National authority	Number of valid responses	Geographic Scope
Ministries of Health	26	AT(4), CY, CZ, DK, EE, DE, EL, HU, IE(2), IT, LV, LT, LU(2), MT(3), PT(2), SK, SI, ES
National Public Health Agency	9	AT, BG, HR, EE, FI, IE, LV, NL, SE
National Research Institute	2	FR, RO
Food Safety Agency	1	ES
Other	2	BE, PL
<b>TOTAL</b>	<b>40</b>	<b>27 Member States</b>

Source: Authors' elaboration

## 2.4.2 Interviews and focus groups

**The interviews and focus groups aimed at gathering views and opinions from (i) national authorities, (ii) academic experts, and (iii) stakeholders.** First, to integrate the survey results, in-depth individual interviews were conducted with national authorities. Second, academic experts were also consulted individually to review the evidence collected during Task 1. Third, to engage a large number of stakeholders from different categories (NGOs, industry associations, parents' associations), focus groups were organised to facilitate thematic discussions and gather different opinions on the EU Action Plan. Finally, to ensure coverage of all countries who did not participate to oral interviews, written contributions were collected.

Eight discussion guides for interviews and focus groups were drafted for the different stakeholder groups and one common for national authorities. Further details are included in the project deliverable 'Synopsis Report' (Annex XI).

Questions for stakeholders were selected according to the Areas for Action within the EU Action Plan that specific stakeholder groups were most familiar with, to gather insights according to their specific areas of expertise. At the end of the focus group/interview,

<sup>74</sup> [Regulation - 2016/679 - EN - gdpr - EUR-Lex](#)

<sup>75</sup> The survey received 54 partial responses (0 to 5% of the survey completed), which were excluded to avoid unbalanced samples for different survey questions.

<sup>76</sup> At the time of closing the survey, contributions representing the UK were not submitted. Yet, the team interviewed representatives from England later.

stakeholders were asked for their concluding recommendations for future follow-up actions that may be considered to combat childhood obesity.

**The invitation process** for consultation activities differed between national authorities and other stakeholders.

- **National authorities** were invited to participate in an interview at the end of the survey. This approach allowed for immediate discussion of any potential misalignments and timely addressing of evidence gaps. If the national authority agreed to participate, the time and date were agreed, and an invitation was sent via email. The interviews took place from April to October 2024.
- **Stakeholders** (NGOs, industry associations, parents' associations), interviews and focus groups were conducted between February and August 2024. A total of 170 individual stakeholders were initially invited to participate.

A total of **95 individuals** representing national authorities (42) and stakeholders (53) from 26 Member States<sup>77</sup> were involved in an interview or a focus group. Table 8 and Table 9 show the breakdown of interviews by type of national authority and stakeholder group.

**Table 8 – Overview of participation in interview by national authorities**

Authority	Number of oral interviews	Number of written responses	Total number of national authorities consulted	Geographic Scope
Ministries	17	7	24	AT, BE, CY, CZ, EE, EL, IE (2), IT (2), LV, LT, LU (2), NL, PT, SL, ES, UK
National Public Health Agency	9	4	13	BG, HR, DK, FI, IE (2), LV (2), NL, SK (3), SE
Food Safety Agency	2	1	3	DK, ES (2)
Other	2	/	/	BE (2)
<b>TOTAL</b>	<b>30</b>	<b>12</b>	<b>42</b>	<b>22 MS</b>

Source: Authors' elaboration

**Table 9 – Overview of participation in focus groups/interviews by stakeholders**

Stakeholder Group	Number of focus group participants	Number of interviews/ written responses	Total number of stakeholders consulted	Geographic Scope <sup>78</sup>
<b>International Organisations</b>	0 <sup>79</sup>	N/A	N/A	N/A
<b>Parents and Families Associations</b>	3	2	5	EU, PT, IE, IT (2)
<b>Academics and Scientific Experts</b>	4	4	8	HR, EE, BE, EL (2), DK, LV, MT

<sup>77</sup> Representatives from France, Germany and Poland did not reply to our request for consultation.

<sup>78</sup> Numbers indicate circumstances where more than 1 stakeholder per country provided feedback.

<sup>79</sup> Of the international organisations, 1 declined, and 3 did not reply.

Stakeholder Group	Number of focus group participants	Number of interviews/ written responses	Total number of stakeholders consulted	Geographic Scope <sup>78</sup>
Education NGOs	3	2	5	PT, LU, IT, AT, IE
EU and National Public Health NGOs	13	8	21	EU (6), UK, IT (2), EL (2), HR, HU, BE, ES (2), DK, SK, RO, SE, IE
Sports NGOs	3	2	5	EU, PT, HR, CZ, IT
Consumer Associations	2	N/A	2	EU (2)
Marketing and Advertisement Industry Associations	2	N/A	2	EU (2)
Food and Beverage Industry Associations	5	N/A	5	EU (5)
<b>TOTAL</b>	<b>35</b>	<b>18</b>	<b>53</b>	<b>19 MS</b>

Source: Authors' elaboration

## 2.5 Validation workshops (Task 3)

Four validation workshops were conducted to present the preliminary findings of the study (Task 1 and Task 2) to national authorities and other stakeholder groups. The aim of the workshops was to collect further insights and ensure the representativeness and appropriateness of the preliminary findings. The content of the workshops and discussion questions were tailored for the different groups, but all following the same structure. The workshop guides are included in Annex X: Consultation materials.

Stakeholders were divided into four main groups: i) National authorities, which included representatives from various ministries, national public health agencies and health institutes; ii) EU-level industry representatives, which included representatives from marketing and advertisement industry and food and beverage industry associations at European level; iii) consumer organisations and NGO representatives, which included representatives from education and sports NGOs as well as parent and families associations and public health NGO both at national and European level; iv) academic and experts.

All individuals who had previously participated in the study, either through a survey, interview, or focus group, received an email invitation to the validation workshop, accompanied by the data protection notice and an endorsement letter. Subsequently, the invitation was also extended to national authorities and stakeholders who had not participated in the earlier consultation activities, but who had been originally approached for their input.<sup>80</sup> Specifically, 78 representatives of national authorities, 9 industry representatives, 160 among NGOs and consumer organisations, and 35 academics were invited.

<sup>80</sup> This excludes national authorities and stakeholders that already participated in the consultation activities explicitly mentioned that they did not want to be contacted again in the context of the study.

The workshops, each with a duration of three hours, were held online between 11<sup>th</sup> June and 20<sup>th</sup> June 2024. The workshops were led by the study team in collaboration with the study experts. Representatives from DG SANTE and the Contracting Authority were present in the workshops as observers. Participants were given the opportunity to provide written feedback following the workshop. Table 10 provides the participation rate and geographical distribution for each of the workshops.

**Table 10 – Overview of participation in validation workshops**

Stakeholder Group	Number of focus group participants	Geographic Scope
National Competent Authorities	25	AT, BE, CY, CZ (3), FI, FR, HU (2), IE (2), IT, LV, LT (2), MT, PL, PT, RO, ES (4), SE
EU-level industry representatives	6	EU
Consumer organisations and NGO representatives	15	International (2), EU (11), NL (2), HU, MT,
Academic and scientific experts	5	NL, EL (2), LT, SI
<b>TOTAL</b>	<b>51</b>	<b>20 MS</b>

Source: Authors' elaboration

## 2.6 Data analysis and triangulation of sources

The qualitative and quantitative findings collected over desk research (Task 1), consultation activities (Task 2) and validation workshops (Task 3) were triangulated to compare and validate the information, synthesise and analyse, and draw robust conclusions. In order to present the findings in a summarised and comprehensive manner, 28 country profiles were developed during Task 1, and complemented over the course of the study.

Data triangulation employed a mixed-methods approach, a standard practice in social science research. This approach combines various data sources and collection methods to enhance the robustness and reliability of the analysis. The triangulation process began with the findings from desk research, which were then compared and integrated with new information obtained through consultation activities and revisions of the country profiles (see section 2.8). This integration aimed to complement and validate the research findings. Furthermore, the guides for the interviews with the Member States' authorities were drafted with the intention to clarify and expand the information provided in the survey.

### 2.6.1 Country profiles

Country profiles provide a comprehensive overview of the measures implemented and planned for childhood obesity within each EU Member State and the United Kingdom. Each country profile comprises a short summary box highlighting key points from the

document. This is followed by an in-depth analysis of the state of childhood obesity using data from the Health Behaviour in School-aged Children (HBSC) survey,<sup>81</sup> alongside other relevant statistics. The document proceeds with a narrative overview of the most important developments in the country (i.e. an explanation of the main plans implemented and policies) and points out any participation in international surveys and EU Joint Actions. The core part of the country profiles are text boxes that contain a detailed overview of each of the action plans and strategies relevant to childhood obesity (e.g. year of implementation and implementing authority). The table differentiates between implemented and planned policies. Implemented measures refer to those that have been achieved and effectively put into place as foreseen in already-dated/established national strategies. On the other hand, planned measures are those that are expected to be put into place at a future date but have not yet been implemented. Country profiles contain an additional section called “other policies” that presents measures that do not fall into either of the national plans presented but are still relevant initiatives to tackle childhood obesity. Regarding the measure’s dates of implementation in the country profiles, if not otherwise specific, the measure is assumed to be still ongoing.

All country profiles are available in Annex VI: Country profiles.

## 2.6.2 Colour-code system

To evaluate the extent to which each country has implemented actions and met the objectives outlined in the priority areas of the EU Action Plan, a colour-code table was developed for each country, drawing on data from the respective country profiles (see Annex VI). The table uses a colour system to represent the level of implementation for each key topic of the Action Plan, with the criteria for each colour delineated in Table 11. Additionally, Annex II provides a comprehensive explanation of the criteria used to assign colours to each of the 41 key topics. Each colour-code table also includes a rationale for the assigned colour, based on a selection of key policies identified in the country profiles.







All countries participating in the study, except Cyprus,<sup>82</sup> submitted a revised version of the colour-code country profiles. On several occasions, colour-code country profiles were revised by two separate authorities (i.e. IT, NL, PT, DK).

---

<sup>81</sup> Inchley J., et al. (2023) Health Behaviour in School-aged Children (HBSC) Study Protocol: background, methodology and mandatory items for the 2021/22 survey. Glasgow: MRC/CSO Social and Public Health Sciences Unit, University of Glasgow.

<sup>82</sup> Although national authorities did not review the country profile, a study expert with specialised knowledge of Cyprus conducted a thorough review to ensure the accuracy and reliability of the evidence.

**Table 11 – Summary colour-code criteria**

Status	Definition
	<b>Fully Implemented:</b> National measure already implemented before the adoption of the EU Action Plan in 2014; or policy document confirms the existence of relevant measure, but original policy, as well as the date of implementation, has not been identified.
	<b>Partially Implemented:</b> Measure is available, but implementation is not comprehensive (only covers certain products, social groups, or regions). Partially implemented status is also awarded if National authorities self-reported that existing measures are insufficient to award fully implemented status.
	<b>Newly implemented/Updated:</b> Measure is considered “fully implemented” and this measure has been updated/revised or newly implemented after 2014. This does not necessarily mean that the action is undertaken as a result of the EU Action Plan.
	<b>Planned:</b> Policy documents confirm that measures expected to be put into place at a future date but have not yet been implemented. Adoption may still be contingent on policy process. Planned status is assigned to key topics where there is no other fully implemented policies.
	<b>No Implementation:</b> Policy documents confirm that there is no implementation of policies. However, actions may be undertaken on initiative from local authorities, NGOs, or private parties.
	<b>Unavailable Information:</b> Desk research and consultation activities did not yield any information regarding the status of measures in the country.

Source: Authors' elaboration

## 2.7 Reporting and deliverables

As part of the study, several deliverables and reports have been prepared. Table 12 shows the status of each deliverable and reports foreseen by the Terms of Reference.

**Table 12 – Status of deliverables and reports**

Name	Description
Inception report	Present the methodological approach and research tools, including the final evaluation framework and consultation strategy.
Draft reports on the desk research	<ul style="list-style-type: none"> <li>• Draft report on the progress of implementation of the Action Plan on Childhood Obesity (D2)</li> <li>• Draft report on mapping of national policies on childhood obesity (D3)</li> <li>• Draft report on obstacles and challenges (D4)</li> <li>• Draft report collection of best practices (D5)</li> </ul>
Report on consultations with the Member States	Report on Member States survey and interviews (D6)
Report on interviews/focus groups with other stakeholders	Report on Stakeholder interviews and focus groups (D7)
Synopsis Report	Covering all the stakeholder consultation activities conducted (D8)
Interim Report	Presents an overview of the status of the study project with all the preliminary findings, including the barriers identified and risk mitigation measures
Workshop reports	Four reports highlighting the findings of the four validation workshops (D10)

Name	Description
Workshop summary report	Summary report of the four validation workshops (D11)
Final report	Presents the final results of the study across all study tasks, along with factually based conclusions.

Source: Authors' elaboration

## 2.8 Limitations of the study and mitigation measures

This study is subject to some methodological limitations, which are crucial to consider when interpreting its findings. These limitations primarily concern the processes of data collection, stakeholder engagement, and reporting accuracy.

**Data Collection Limitations (Task 1):** the research was affected by discrepancies in data quality and availability across EU Member States and the United Kingdom. While some countries provided clear policy information on ministry websites or in international reports, other countries had limited or inaccessible data. These disparities impacted the comparability of findings across countries to some extent. Moreover, concerning the impact of the implementation of policies, only a few countries have published comprehensive evaluations of their action plans and policies implemented. As a result, based on the information that was retrieved through desk research, it was not feasible to assess in this study the impact of the implemented measures in addressing childhood obesity.

**Stakeholder Engagement Limitations (Task 2):** the study team conducted several interviews with Member States representatives and relevant stakeholders with the aim of filling the evidence gaps from the desk research conducted in Task 1, as well as gathering the views of different stakeholder groups to address the evaluation questions. However, achieving the initial consultation target was challenging due to low response rates. As a result, the Consortium implemented **extensive mitigation measures** between early March and mid-April 2024 and again between June and July 2024. These measures included efforts such as the revision of country profiles by national authorities and allowing stakeholders to provide written feedback instead of participating in an interview.

An additional limitation of the study pertains to **reporting bias**, whereby Member States selectively report on actions and interventions that showcase positive outcomes or achievements. To address this, the information provided was carefully cross-validated between desk research findings and interview data to ensure an accurate mapping of policy measures. Furthermore, the information collected on nationally implemented or planned policies, best practices, monitoring indicators, and policy implementation obstacles cannot be considered exclusive. It is possible that additional relevant data may exist that did not emerge from the literature or was not reported by the consulted national representatives and relevant stakeholders.

Despite the limitations, **this study exhibits significant strengths that ensure the representativeness of the results and robust and evidence-based conclusions.** During the validation workshops (Task 3) with all the relevant stakeholder groups, the findings of the study were considered valid and representative by a vast majority of participants.

## 3 Prevalence of childhood obesity in Europe

This section provides a general assessment of the status of the prevalence of childhood obesity and some of its associated risk factors in the EU. Moreover, each country profile in Annex VI contains a country-specific description of the status of childhood obesity.

### 3.1 Aggregate level of childhood obesity

Overall, childhood obesity rates in the EU are high, around 23%, on average and increasing in certain age groups<sup>83</sup>. Moreover, there are notable differences across countries.

There is scarce data on the prevalence of childhood overweight and obesity in infants and children under 6 years old. A 2017 study reported that the pooled prevalence of overweight and obesity in European children aged 2–7 years between 2006 and 2016 was 17.9%, with obesity specifically at 5.3%.<sup>84</sup> The fifth round of the WHO European COSI, conducted between 2018 and 2020, is the latest report on childhood obesity with data from 33 European countries and 411,000 children aged 6-9. The data shows that 29% of European children were overweight (including obesity), meaning almost 1 in 3, and the prevalence was higher among boys (31%) than girls (28%). The overall prevalence of obesity was 12% for European children of both sexes and is also more common among boys (14%) than girls (10%).<sup>85</sup>

The latest Health at a Glance report (2024)<sup>86</sup> underscores the profound and lasting impact of childhood obesity on health and well-being. Overweight or obese children experience an elevated risk of developing poor health outcomes, a risk that continues into adulthood. In the short term, it can lead to orthopaedic, neurological, pulmonary, and endocrine conditions, as well as social and psychological issues affecting self-esteem and body image.<sup>87</sup> Long-term effects include increased risk of cardiovascular disease, type 2 diabetes, hypertension, certain types of cancer and premature mortality in adulthood.<sup>88</sup> Beyond physical health, childhood obesity is closely associated with a range of psychosocial challenges, including diminished self-esteem, exposure to bullying, and struggles with academic performance. These issues might affect economic opportunities and wellbeing for the individual in later life.

The literature on childhood obesity reported that the COVID-19 pandemic significantly impacted childhood obesity rates and its associated risk factors in Europe.<sup>89</sup> Contributing

---

<sup>83</sup> The latest results of the OECD Health at Glance (Available at: [Link](#)) report shows that in 2022 one in five (21%) 15-years-old on average across the EU countries were classified as either overweight or obese.

<sup>84</sup> Garrido-Miguel, M., et al. (2019). Prevalence of overweight and obesity among European preschool children: a systematic review and meta-regression by food group consumption. *Nutrients*, 11(7), 1698.

<sup>85</sup> WHO. (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Available at: [Link](#)

<sup>86</sup> OECD/European Commission (2024), Health at a Glance: Europe 2024: State of Health in the EU Cycle, OECD Publishing, Paris. Available at: [Link](#)

<sup>87</sup> Orio, F., et al. (2014). Lifestyle changes in the management of adulthood and childhood obesity. *Minerva endocrinologica*. Available at: [Link](#)

<sup>88</sup> Kelsey, M. M., et al. (2014). Age-related consequences of childhood obesity. *Gerontology*, 60(3), 222-228. Available at: [Link](#)

<sup>89</sup> WHO. (2024). Report on the impact of the COVID-19 pandemic on the daily routine and behaviours of school-aged children: results from 17 Member States in the WHO European Region. Available at: [Link](#)

factors include reduced physical activity, increased sedentary behaviour, poor dietary habits, and increased screen time.<sup>90</sup> School closures and disrupted routines have exacerbated these issues.<sup>91</sup> Additionally, the pandemic has worsened mental health, socioeconomic stress, and food insecurity, further contributing to obesity risk.

Socio-economic factors significantly influence childhood obesity rates. Across all EU countries, children from affluent families are less likely to be overweight or obese than those from lower-income families<sup>92</sup>. There is evidence from many EU countries (e.g. Germany<sup>93</sup> or Denmark<sup>94</sup>) and the United Kingdom<sup>95</sup> of socio-economic inequalities in the prevalence of obesity in children/adolescents - whereby obesity is levelling off or slightly declining for groups with higher socio-economic status and increasing in groups with lower socio-economic status.<sup>96</sup>

The HBSC survey also provides valuable self-reported data on childhood overweight (including obesity) prevalence. Figure 3 illustrates the aggregate prevalence of overweight and obesity among boys and girls between 11 and 15 years old in 2014 and 2022. The data shows that across all age groups, boys consistently had higher rates of overweight and obesity than girls in both years. Additionally, the overall prevalence increased by approximately two percentage points across all age groups from 2018 to 2021, with the most significant rise observed among 13-year-old boys.

---

<sup>90</sup> Eftychia, F., et al. (2023). The Impact of the COVID-19 Pandemic on Childhood Obesity: A Review. *Cureus*, 15(9).

<sup>91</sup> Stavridou, A., et al. (2021). Obesity in children and adolescents during COVID-19 pandemic. *Children*, 8(2), 135.

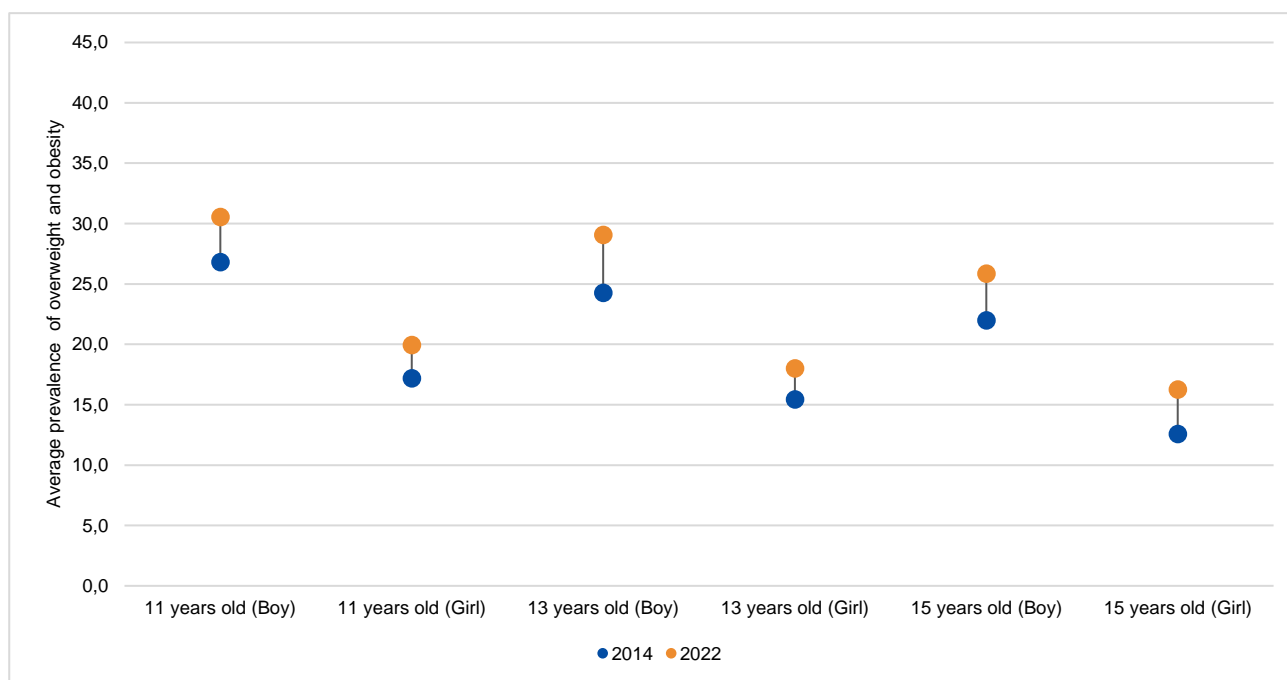
<sup>92</sup> Ulijaszek, S. J. et al. (2017). Inequality and childhood overweight and obesity: a commentary. *Pediatric Obesity*, 12(3), 195-202. Available at: [Link](#)

<sup>93</sup> Hoebel, J., Waldhauer, J., Blume, M., & Schienkiewitz, A. (2022). Socioeconomic Status, Overweight, and Obesity in Childhood and Adolescence: Secular Trends from the Nationwide German KiGGS Study. *Deutsches Ärzteblatt International*, 119(49), 839.

<sup>94</sup> Rasmussen, M., Damsgaard, M. T., Morgen, C. S., Kierkegaard, L., Toftager, M., Rosenwein, S. V., & Holstein, B. E. (2020). Trends in social inequality in overweight and obesity among adolescents in Denmark 1998–2018. *International journal of public health*, 65, 607-616.

<sup>95</sup> Keaver, L., Pérez-Ferrer, C., Jaccard, A., & Webber, L. (2020). Future trends in social inequalities in obesity in England, Wales and Scotland. *Journal of Public Health*, 42(1), e51-e57.

<sup>96</sup> Sares-Jäske, L., Grönqvist, A., Mäki, P., Tolonen, H., & Laatikainen, T. (2022). Family socioeconomic status and childhood adiposity in Europe-A scoping review. *Preventive medicine*, 160, 107095.

**Figure 3 – Aggregate prevalence of childhood overweight (including obesity) in the EU by age and year**

Source: HBSC

**Note:** Data for England, Ireland and Romania missing. HBSC data utilises the WHO definition of overweight and obese children:<sup>97</sup> Overweight is indicated by a BMI-for-age greater than 1 standard deviation above the WHO Growth Reference median, while obesity is indicated by a BMI-for-age greater than 2 standard deviations above the WHO Growth Reference median.

## 3.2 Childhood obesity by country

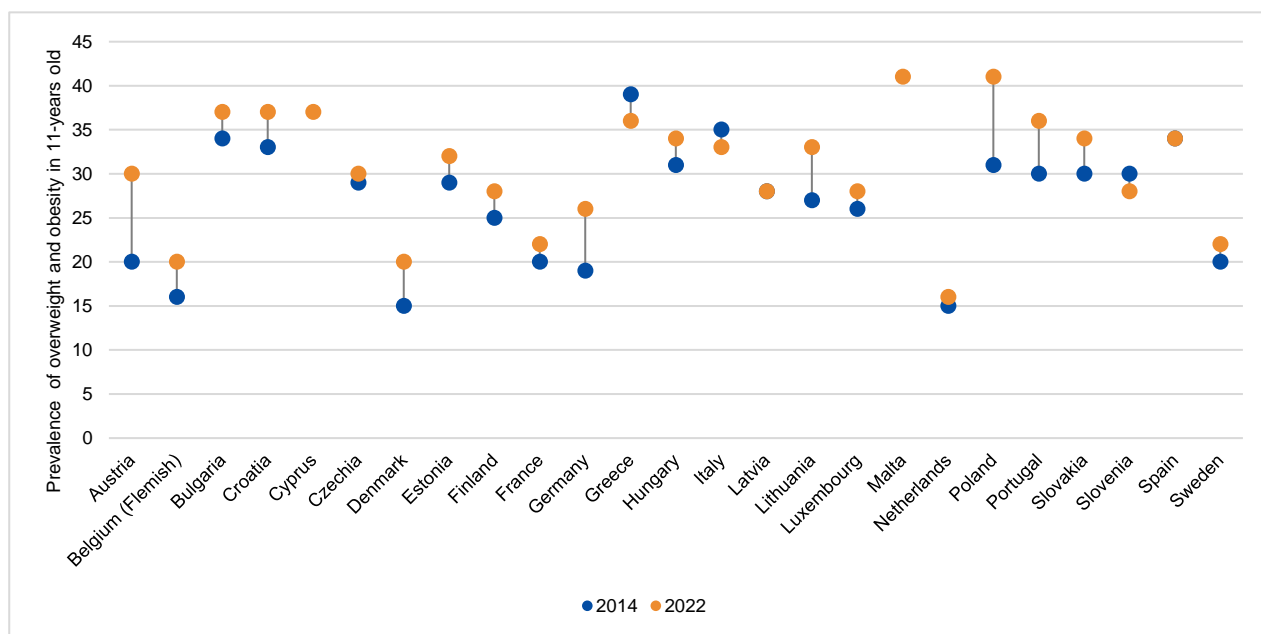
Figure 4 to Figure 9 depict the prevalence of overweight (including obesity) among boys and girls in various European countries. Each graph corresponds to a different age group (11 years, 13 years, and 15 years), and they compare data between the years 2018 and 2021. The graphs show variations in obesity and overweight prevalence between countries, with some countries showing significant changes between the two years. The graphs illustrate that boys consistently exhibit higher overweight and obesity rates than girls across almost all countries and age groups. This trend is noticeable in all three figures, indicating that gender disparities persist in the prevalence of overweight and obesity as children grow up. Moreover, there is an overall increase in overweight and obesity prevalence from 2018 to 2021 across all age groups and most countries. Malta, Romania, Hungary, and Greece consistently ranked high for childhood overweight and obesity across all age groups in both 2014 and 2022, highlighting a persistent issue in these countries. However, Malta, Greece, and Italy showed decreases in prevalence between 2014 and 2022.

For 11-year-olds, there seems to be a rise in obesity prevalence in most countries from 2018 to 2021. In countries like Malta, Romania, and Hungary, boys show a higher increase in overweight and obesity rates compared to girls. The 13-year-old age group shows a similar trend with increasing rates in 2021, especially for boys. Notable rises are

<sup>97</sup> WHO (2014). Obesity and overweight. Available at: [Link](#)

seen in countries like Portugal, Romania, and Poland. For 15-year-olds, the trend remains consistent with an overall increase in 2021. The highest rates in 2021 are observed in countries like Malta, Greece, and Hungary, where both boys and girls have a significant proportion of overweight and obesity.

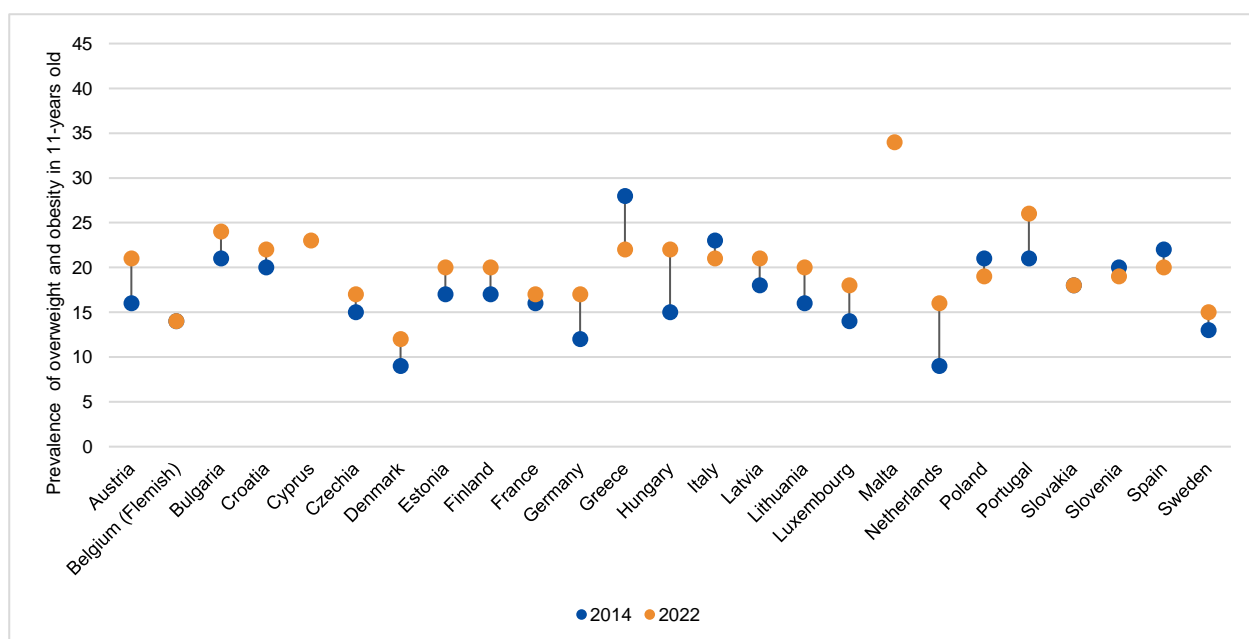
**Figure 4 – Prevalence rates of overweight (including obesity) for boys aged 11 in 2014 and 2022**



Source: HBSC

Note: Data for UK, Ireland, Romania missing.

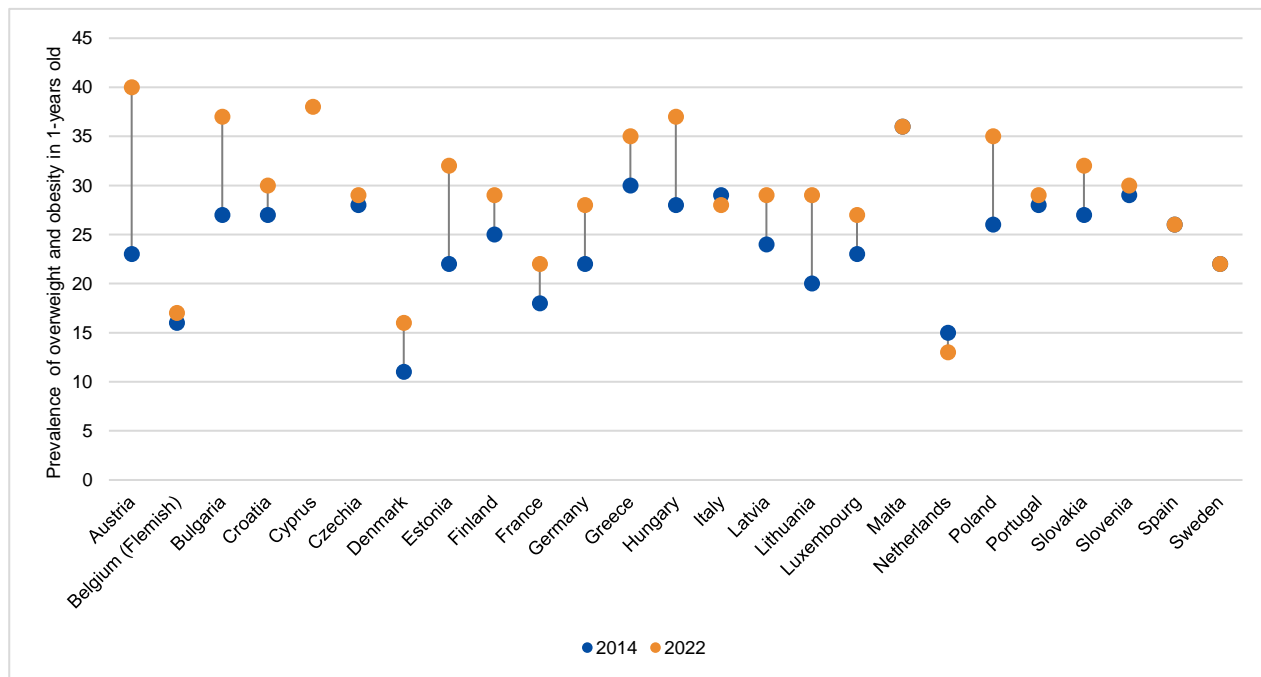
**Figure 5 – Prevalence rates of overweight (including obesity) for girls aged 11 in 2014 and 2022**



Source: HBSC

Note: Data for UK, Ireland, Romania missing.

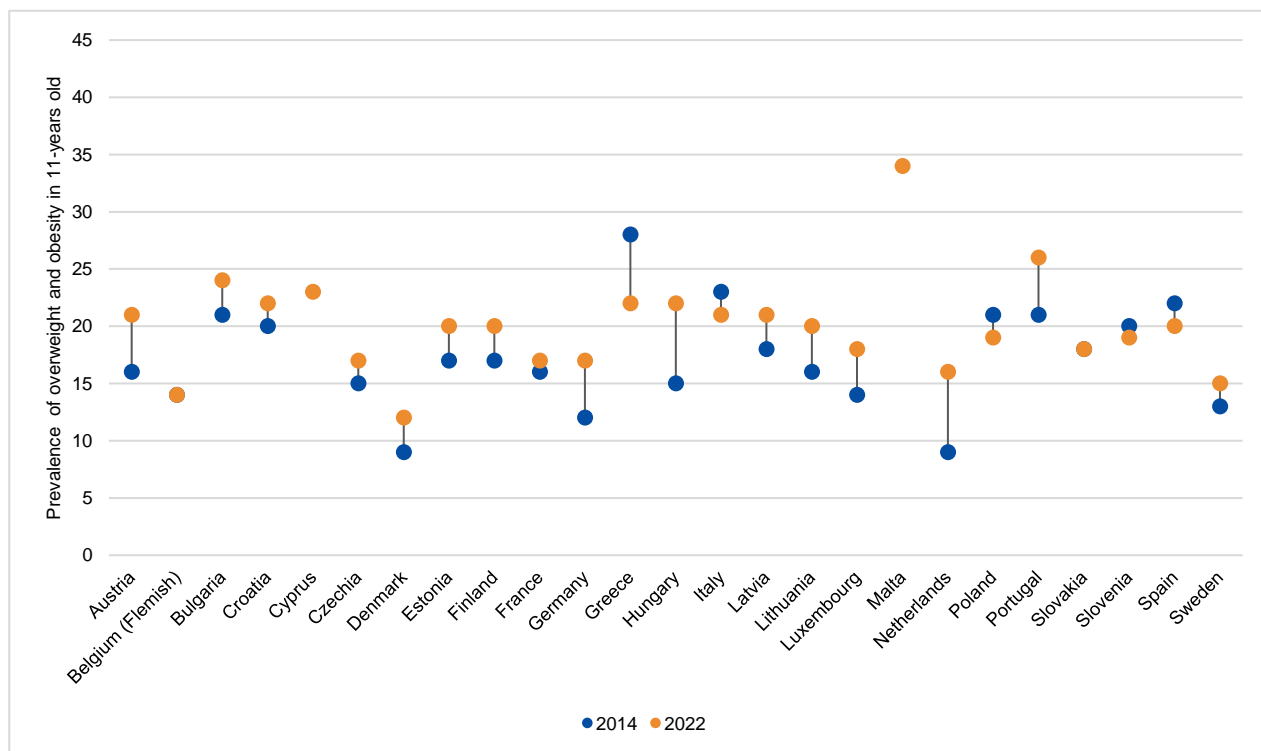
**Figure 6 – Prevalence rates of overweight (including obesity) for boys aged 13 in 2014 and 2022**



Source: HBSC

Note: Data for UK, Ireland, Romania missing.

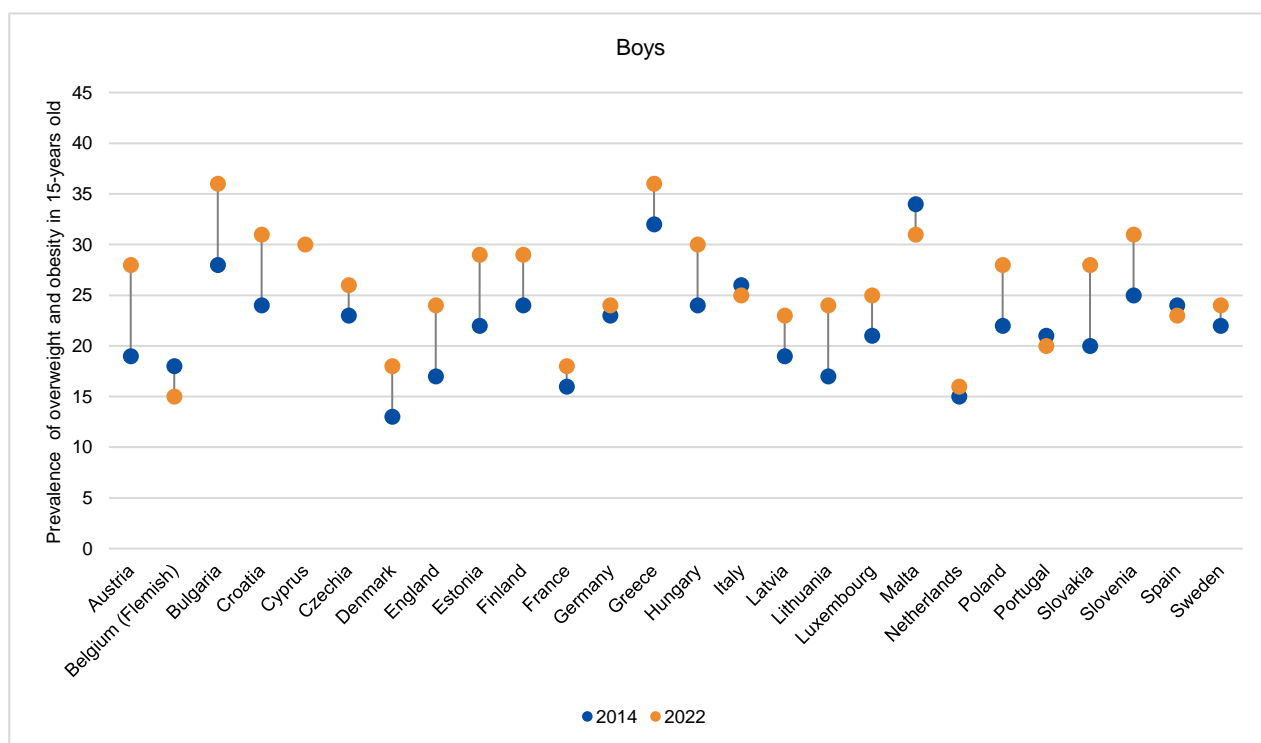
**Figure 7 – Prevalence rates of overweight (including obesity) for girls aged 13 in 2014 and 2022**



Source: HBSC

Note: Data for UK, Ireland, Romania missing.

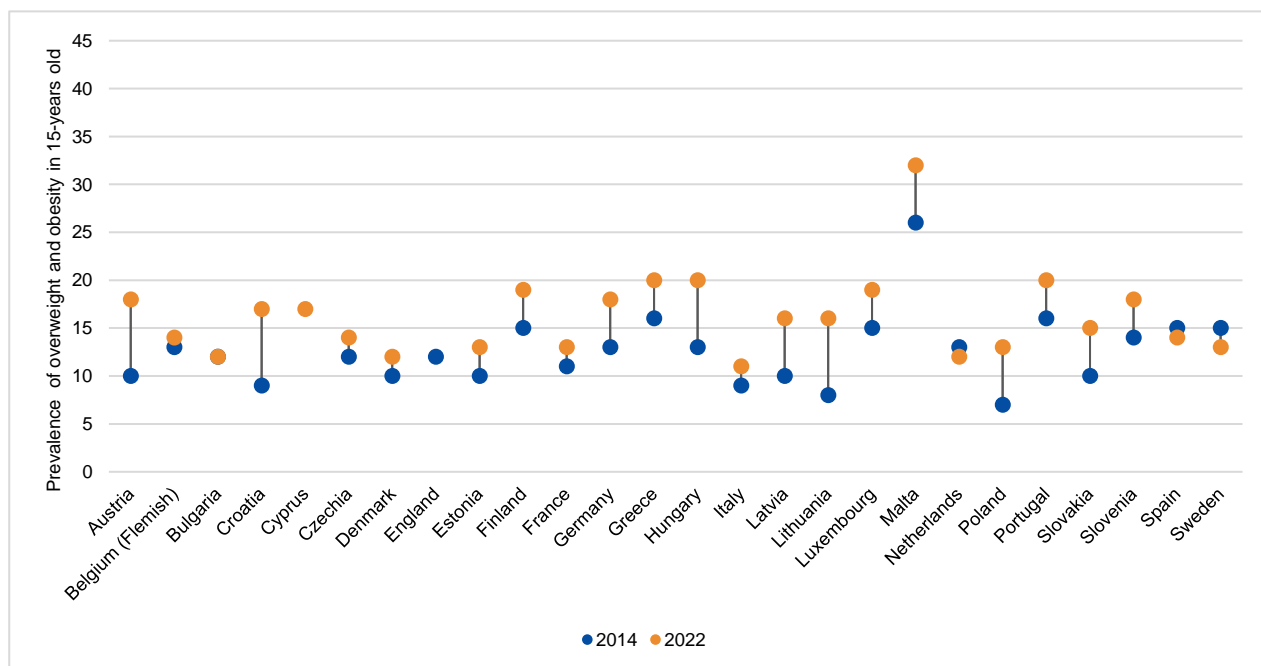
**Figure 8 – Prevalence rates of overweight (including obesity) for boys aged 15 in 2014 and 2022**



Source: HBSC

Note: Data for Ireland and Romania missing.

**Figure 9 – Prevalence rates of overweight (including obesity) for girls aged 15 in 2018 and 2022**



Source: HBSC

Note: Data for Ireland and Romania missing.

### 3.3 Risk factors for childhood obesity

Figure 10 illustrates the changes in prevalence rates of key obesity risk factors from 2010 to 2021 across all EU Member States and the UK, focusing on children aged 11 to 15 years. The graph reveals that boys consistently engaged in higher levels of vigorous physical activity (VPA) compared to girls. However, both groups experienced a decline over time, with the steepest drop occurring in 2021, possibly due to the COVID-19 lockdowns, which limited outdoor activities and organised sports. In terms of dietary risk factors, the average daily intake of fruits and vegetables remained relatively stable for both genders. Daily fruit consumption hovered between 30% and 40%, with no significant changes throughout the period. On the other hand, there was a gradual yet positive trend in vegetable intake, particularly among girls, who saw an increase from 30% in 2010 to approximately 35% in 2021, consistently maintaining higher levels than boys. Notably, the consumption of sugary drinks decreased substantially over the same period. Both boys and girls exhibited similar trends, with daily intake dropping from around 30% in 2010 to roughly 15% by 2021, indicating a positive shift towards healthier beverage choices.

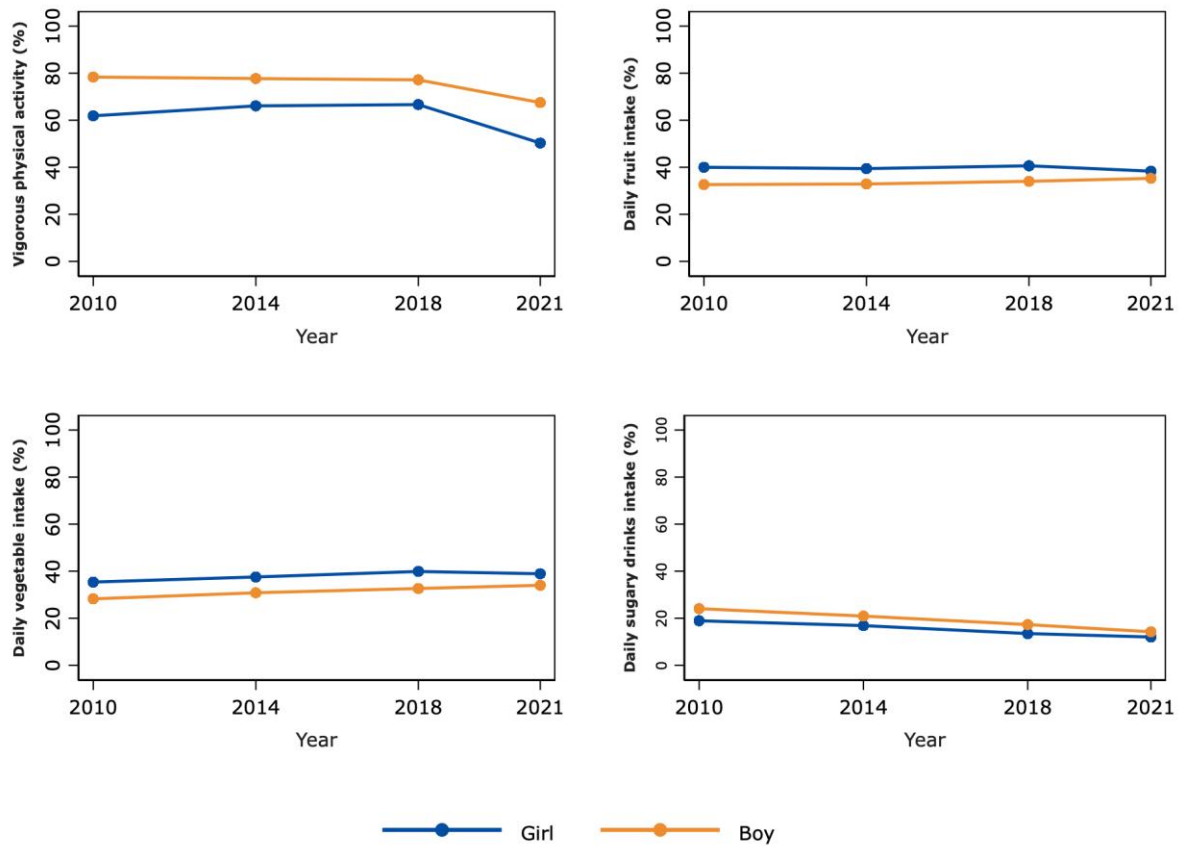
There is also other risk factors associated with childhood obesity such as breastfeeding rates.<sup>98</sup> The breastfeeding situation in Europe is difficult to survey, as there are differences in reporting across countries. Studies across multiple European countries reveal that exclusive breastfeeding rates at 6 months range from 13% to 39%, with large differences across countries.<sup>99</sup>

---

<sup>98</sup> Rito, A. I. et al. (2019). Association between characteristics at birth, breastfeeding and obesity in 22 countries: The WHO European Childhood Obesity Surveillance Initiative–COSI 2015/2017. *Obesity facts*, 12(2), 226-243.

<sup>99</sup> Theurich, M. A., et al. (2019). Breastfeeding rates and programs in Europe: a survey of 11 national breastfeeding committees and representatives. *Journal of pediatric gastroenterology and nutrition*, 68(3), 400-407.

**Figure 10 – Average prevalence rates of major risk factors to childhood obesity**



Source: HBSC

**Note:** Vigorous physical activity: "How many times a week do you usually eat or drink vegetables?" (Responses of once daily or more than once daily are coded as 1, otherwise 0); Daily Fruit Intake: "How many times a week do you usually eat or drink fruit?" (Responses of once daily or more than once daily are coded as 1, otherwise 0); Daily Vegetable consumption: "How many times a week do you usually eat or drink vegetables?" (Responses of once daily or more than once daily are coded as 1, otherwise 0). Daily sugary drinks: "How many times a week do you usually drink sugary beverages?" (Responses of once daily or more than once daily are coded as 1, otherwise 0). Aggregated data for children aged 11, 13 and 15 years old.

## 4 Main findings

### 4.1 Mapping and implementation of policies and actions by Member States

This section provides an analysis of the progress achieved at the national level towards implementing policies for all Areas for Action of the EU Action Plan. Policy implementation is deemed to have occurred when measures (such as action plans, strategies, guidelines, campaigns, or initiatives) have been proposed and executed at the national level in a specific area aligned with the EU Action Plan. It is important to note that the scope of this report does not include the evaluation of the impact and effectiveness of implemented policies at the national level. In this study, more than 1.125 measures adopted in 27 Member States and the UK were identified and are described in Annex VI: Country profiles, which includes 28 country profiles ordered alphabetically by country name. In Annex V: Country profiles with colour-code, each country profile contains a colour-code table, which monitors the progress of implementation of national policies that align with each of the Areas for Action laid out in the EU Action Plan.

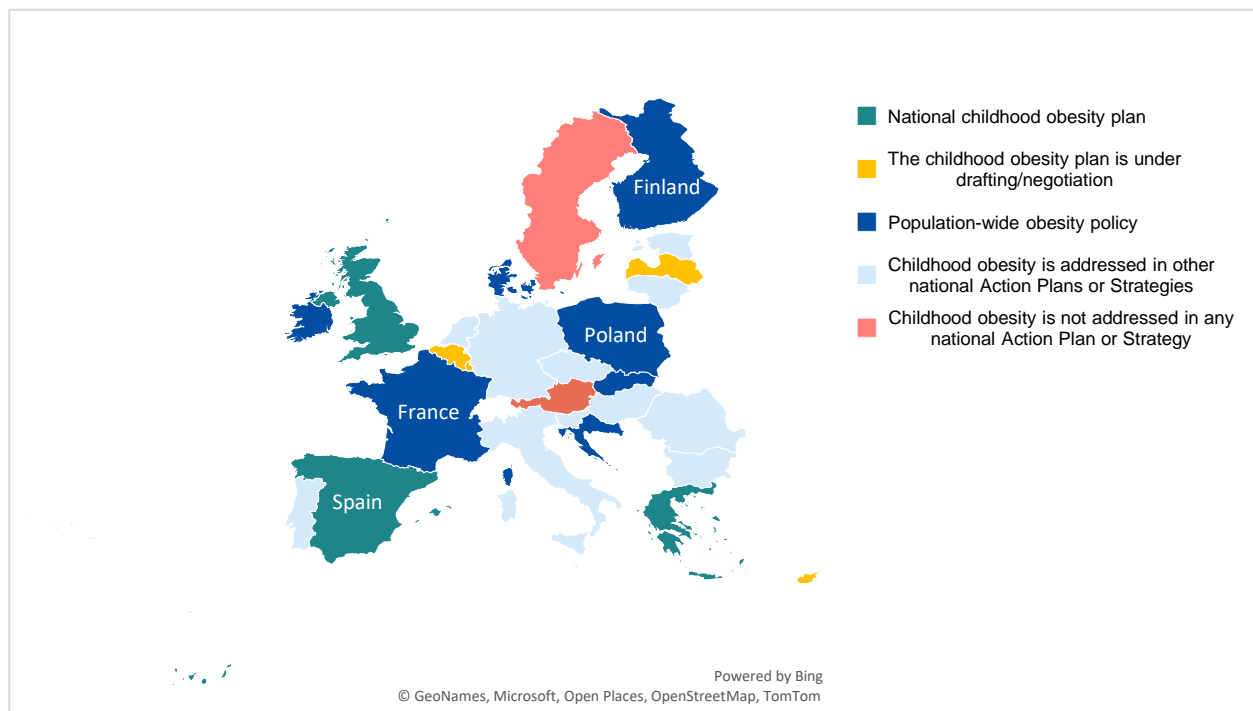
#### 4.1.1 National (childhood) obesity action plans and strategies

The results of the study showed that three countries (EL, ES, UK) have a National Childhood Obesity Plan adopted after the EU Action Plan. The presence of a childhood obesity plan represents a distinct commitment to addressing childhood obesity, aligning with the objectives outlined in the EU Action Plan. Additionally, eight countries have a population-wide plan in which specific measures for children are included. All countries, including those that have an action plan on obesity, have adopted broader measures to improve the population's lifestyle, including children, and are generally implemented through action plans focused on nutrition and physical activity or addressing non-communicable diseases. In Belgium, Cyprus,<sup>100</sup> Latvia and Luxembourg national authorities reported during consultation activities that there is a plan on childhood obesity under drafting or negotiation. Representatives from Sweden reported that childhood obesity is not included in any national action plan or strategy; however, country profiles indicate that some actions have still been taken to address the issue, such as school-based guidelines for screening, recommendations for early childhood physical activity, and the integration of obesity prevention efforts within broader health and education programs. Figure 11 provides an overview of relevant national approaches, examining whether countries have a dedicated national childhood obesity plan or population-wide obesity policy.

---

<sup>100</sup> Representative from Cyprus claimed that following their involvement in the drafting of the EU Action Plan, they worked on a childhood obesity strategy but it never reached the final approval stage. A new initiative is currently underway for a new plan.

**Figure 11 – Overview of (childhood) obesity policies in Member States and the UK**



Source: Authors' elaboration

**Table 13 – Overview of national (childhood) obesity policies**

	Country	Policy
<b>Countries with a national childhood obesity plan</b>	Greece	National Action Against Childhood Obesity (2023–2025) <sup>101</sup>
	Spain	National Plan for the Reduction of Childhood Obesity (2022– 2030) <sup>102</sup>
	United Kingdom	“Childhood Obesity: A Plan for Action (2016–2026)” <sup>103</sup>
<b>Countries with a population-wide obesity policy that includes actions for children</b>	Croatia	Action plan for the prevention of obesity (2024-2027) <sup>104</sup>
	Denmark	National Action Plan Against Obesity (2003) <sup>105</sup>
	Finland	National Obesity Programme (2012-2018) <sup>106</sup>

<sup>101</sup> Ministry of Health. (2023). Presentation titled: Turning the page of childhood obesity – National Action Against Childhood Obesity in Greece 2023– 2025. Available at: [Link](#).

<sup>102</sup> Ministry of Health. (2022). National Plan for the reduction of childhood obesity. Available at: [Link](#).

<sup>103</sup> HM Government. (2016). Childhood Obesity: A Plan for Action. Available at: [Link](#).

<sup>104</sup> Ministry of Health (2024). Action plan for the prevention of obesity 2024-2027. Available at: [Link](#).

<sup>105</sup> National Board of Health. (2003). National action plan against obesity. Available at: [Link](#).

<sup>106</sup> National Institute for Health and Welfare. (2018). Wellbeing through healthy nutrition and physical activity. Available at: [Link](#).

	Country	Policy
	France	Roadmap on obesity management (2019-2022) <sup>107</sup>
	Ireland	A Healthy Weight for Ireland: Obesity Policy and Action Plan (2016-2025) <sup>108</sup>
	Malta	Healthy Weight for Life: A National Strategy for Malta (2012-2020) <sup>109</sup>
	Slovakia	National Action Plan on Obesity Prevention (2015-2025) <sup>110</sup>
	Spain	National Strategy for Nutrition, Physical Activity and Prevention of Obesity (2005, updated 2018) <sup>111</sup>

Source: Authors' elaboration

Note: The table only shows the Action Plans that were valid during the EU Action Plan between 2014 and 2022, and beyond.

#### 4.1.2 Use of the EU Action Plan in policy

Seven countries explicitly refer to the EU Action Plan in their policy documents, which is an approximate measure to capture to what extent Member States use the Action Plan when developing their policies to tackle childhood obesity. Nonetheless, it is important to note that some countries might not explicitly mention the EU Action Plan but may still draw inspiration from it due to its similarities in topics and implementation dates.

**Table 14 – List of policies that explicitly refer to the EU Action Plan**

Country	Policy document	Area for Action
Finland	<b>Finnish nutrition commitments (2020)</b> <sup>112</sup> - supports and motivates food business operators and stakeholders to enhance the nutritional quality of the Finnish diet and promote nutritionally responsible practices. A goal-oriented and measurable commitment serves as an effective tool for companies and organisations to boost their own nutritional responsibility. This includes focus areas such as: salt, quality of fats, sugar, vegetables and fruits, products for children and portion and package.	Area 3
Malta	<b>A whole school approach to a healthy lifestyle: Healthy Eating and Physical Activity policy (2015)</b> <sup>113</sup> - aims to make school environments healthier through encouraging physical activity and promoting healthy foods in school canteens, making changes to the curriculum to include physical activity and nutrition education, and empowering children to make informed choices about their lifestyles	Area 2
Spain	<b>Strategy for Nutrition, Physical Activity and Obesity Prevention (2005, updated versions 2018)</b> <sup>114</sup> – aims to strengthen surveillance and monitoring of	Area 2, Area 7

<sup>112</sup> Finnish Food Authority. (n.d.). Nutrition commitments. Available at: [Link](#)

Country	Policy document	Area for Action
	the dietary intake and nutritional status of the population, disseminate nutritional information and include nutrition education in schools.	
	<b>National Plan for the Reduction of Childhood Obesity (2022– 2030)</b> <sup>115</sup> . aims to address food systems, influence leisure and sports spaces and routines, and modify cultural norms	All
Lithuania	<b>National Health Strategy (2014– 2025)</b> <sup>116</sup> - aims to improve maternal and child health, achieving healthier eating habits in school– aged children, integrating a healthy lifestyle into non– formal education programme, fostering optimal physical activity habits in school– aged children, and encouraging companies to reformulate food to reduce salt, sugar, and fat.	Area 1, Area 2, Area 3, Area 6
Luxembourg	<b>Eat Healthy, Move More (GIMB) National Framework Plan (2018– 2025)</b> <sup>117</sup> - proposes the promotion of physical, psychological, and social wellbeing as well as the prevention and reduction of overweight and obesity through fostering motor skills of young children (0– 12), carrying out initiatives to promote breastfeeding, integrating nutrition education and physical in the school curriculum	Area 1, Area 2
Slovakia	<b>Action Plan for Food and Nutrition (2017– 2025)</b> <sup>118</sup> - aims to curb the prevalence of overweight and obesity, particularly in children, by reducing the exposure of marketing to HFSS foods, increasing awareness of children on the importance of choosing healthy diets and increasing the consumption of fruit and vegetables.	Area 3, Area 4, Area 5
	<b>National Action Plan for the Promotion of Physical Activity (2017– 2020)</b> <sup>119</sup> - aims to support physical activity during pregnancy and early childhood and support recreational physical activity in children and adolescents.	Area 6
Slovenia	<b>National Programme on Nutrition and Physical Activity for Health (2015– 2025)</b> <sup>120</sup> - ensure that all residents of Slovenia have good eating and exercising habits, as well as access to healthy choices for eating and physical activity. This includes reducing the proportion of overweight residents, reducing the proportion of those who are physically inactive, increasing the proportion of breastfed children, and more	Area 1, Area 2, Area 3

#### 4.1.3 Policy priorities with respect to childhood obesity

Given the broad scope of the EU Action Plan on Childhood Obesity, countries may prioritise certain policy areas over others based on their specific national contexts and needs. In this section, we present the findings from interviews with national

<sup>108</sup> HSE. (2016). A healthy weight for Ireland. Obesity Policy and Action Plan. Available at: [Link](#).

<sup>109</sup> Ministry for Health, the Elderly and Community Care (2012). A Healthy Weight for Life: A National Strategy for Malta 2012-2020. Available at: [Link](#).

<sup>110</sup> Public Health Authority. (2015). National action plan in the prevention of obesity for the years 2015-2025. Available at: [Link](#).

<sup>111</sup> AESAN. (2005). Estrategia para la Nutrición, Actividad Física y Prevención de la Obesidad. Available at: [Link](#).

<sup>112</sup> Finnish Food Authority. (n.d.). Nutrition commitments. Available at: [Link](#)

<sup>113</sup> Ministry for Education, Youth and Employment (2015). A Whole School Approach to a Healthy Lifestyle: Healthy Eating and Physical Activity Policy. Available at: [Link](#)

<sup>114</sup> AESAN. (2005). Estrategia para la Nutrición, Actividad Física y Prevención de la Obesidad. Available at: [Link](#)

<sup>115</sup> Ministry of Health. (2022). National Plan for the reduction of childhood obesity. Available at: [Link](#)

<sup>116</sup> Database of the Parliament of the Republic of Lithuania (2014). Lithuanian Health Strategy 2014– 2025. Available at: [Link](#)

<sup>117</sup> Ministry of Health. (2018). Plan cadre national "Gesond iessen, méi beweegen" 2018– 2025. Available at: [Link](#)

<sup>118</sup> Slov– Lex. (2017). LP/2016/1069 Food and Nutrition Action Plan 2017–2025. Available at: [Link](#)

<sup>119</sup> UVZSR – Public Health Authority of the Slovak Republic (2017). National Action Plan for the Promotion of Physical Activity for 2017–2020. Available at: [Link](#)

<sup>120</sup> Ministry of Health. (2015). National Program on Nutrition and Physical Activity for Health 2015–2025. Available at: [Link](#)

representatives, who discuss their key priority areas regarding childhood obesity and how these align or diverge from the priorities outlined in the EU Action Plan. Most countries reported concentrating their efforts on improving school environments (Area 2) and addressing the broader food environments influencing healthy choices for children (Area 3). In contrast, areas concerning marketing regulations (Area 4) and monitoring and evaluation (Area 7) were given lower priority by national governments.

#### 4.1.3.1 Countries prioritising efforts in Area 1

The representative from **Cyprus** reported that the country has a national Breastfeeding committee that recently renewed its 5-year strategy aiming at promoting breastfeeding.<sup>121</sup> The representative from **Lithuania** explained that, currently, newborn children's nutrition is one of the policy priorities. The **Croatian** authorities reported that policy priorities are set on achieving a healthy start in life. Additionally, in **Bulgaria**, efforts have been made to promote activities and policies aiming to support a healthy start in life with guidance on maternal nutrition and physical activity before and during pregnancy, breastfeeding and complementary feeding. Those have become priority areas for a number of reasons, including but not limited to the scientific evidence for the effectiveness of such an approach, the emphasis on promotion and building on previous expertise in the field. In the **Netherlands**, national authorities explained that adequate care and support for children with obesity via a comprehensive approach combining both health and social care services is one of the priority areas of work. A representative from **Italy** reported that a healthy start in life, as included in the EU Action Plan, is believed to be important to prevent childhood obesity.

#### 4.1.3.2 Countries prioritising efforts in Area 2

During the interview, the representative from **Portugal** revealed that over the past decade, the Ministry of Health has prioritised changing the food environments where children are raised. They have implemented various policies, particularly within schools, including regulations governing canteen food and school vending machines. The **Slovenian** representatives claimed that the country's policy priorities concern healthy nutrition at school. To this end, coordination to prepare on-site school meals that comply with national nutrition guidelines is in place.

According to the **Finnish** representative, the most important actions to protect children's health and address childhood obesity are implemented at daycare facilities for children. During their stay at daycare centres, children are entitled to free meals, which have to comply with the healthy nutrition criteria of the country and which the public catering providers need to observe. In addition, daycare facilities implement the SAPERE food education programme,<sup>122</sup> which aims at teaching children how to eat and experience a variety of foods to avoid picky eater habits. The programme also involves nutrition educators.

In **Lithuania**, policy priorities at the time of the implementation of the action plan were childhood nutrition at school and in educational settings as well as physical activity classes at school, for at least three hours per week. In this regard, in 2018, new requirements in

---

<sup>121</sup> Reported by project expert.

<sup>122</sup> SAPERE. Available at: [Link](#)

the legal act on the matter were introduced. Given the difficulties with implementing such norms, the promotion of active mobility to and from school was introduced to increase the amount of physical activity of children. Representatives from **Estonia** mentioned that they prioritised work in schools, by making changes to school curricula and increasing opportunities for physical activity during school hours. Representatives from the **Netherlands** explained that the focus is on both collective and individual prevention including different policy goals and instruments (ranging from information/education to (self-)regulation, monitoring and evaluation). Priority areas include (pre-)school and sports facilities.

In **Bulgaria**, some of the priority areas for Bulgaria with respect to childhood obesity in the last 15 years in which measurable progress has been achieved are the policies aimed to promote healthier environments with a special focus on improved nutrition in schools, kindergartens and nurseries. Moreover, a representative from **Slovakia** described that healthy nutrition and exercise are crucial as they allow for the improvement of health in both elementary and secondary schools. By collaborating with the Ministry of Education, they influence children's and adolescents' health through school meal programs. Additionally, they provide nutritional education and training for professional school catering staff, ensuring a strong focus on hygiene and well-prepared meals.

Furthermore, representatives from **Luxembourg** described that efforts to address childhood obesity in schools have included measures to reduce stigma and improve body perception.

#### 4.1.3.3 Countries prioritising efforts in Area 3

The **Portuguese** representatives also revealed that a significant concern is the high consumption of sugary beverages, particularly among teenagers and children. Therefore, fiscal measures, such as a sugar tax on sweetened beverages, have been introduced, alongside a reformulation plan targeting food category commonly consumed by children, such as breakfast cereals, yoghurts, and juices. **Luxembourg** representatives explained that while they have not specifically targeted one particular Area for Action, they have allocated substantial resources to initiatives such as implementing a sugar tax, introducing front-of-pack nutritional labelling (specifically the Nutri-score), and adopting marketing restrictions. Furthermore, a representative from **Cyprus** reported that actions have been focused on healthy eating promotion at school canteens. The representative from **Lithuania** explained that, currently, food reformulation is one of the policy priorities. Additionally, another representative for **Spain** added that some efforts in the past years have been focused on the reformulation of foods high in salt, sugar, and fat. The **Croatian** authorities reported that policy priorities are set on creating environments in which healthy choices will be made easier and more available.

**Czech** authorities identified several priority areas in addressing childhood obesity, focusing on both prevention and intervention strategies. These priorities are driven by the need to curb the rising rates of obesity among children, which poses significant long-term health risks and economic burdens. Among the priorities, improving nutrition and dietary habits were mentioned first. This is a priority due to the poor dietary habits, including high consumption of sugary drinks, processed foods, and snacks high in fat and sugar, are major contributors to childhood obesity in the Czech Republic. Thus, improving the nutritional quality of children's diets is crucial to preventing obesity and related health issues.

#### 4.1.3.4 Countries prioritising efforts in Area 4

The **Czech** authorities contributing to the study also observed that reducing exposure to unhealthy food marketing is among the country's priorities. Children are highly influenced by marketing, and exposure to advertisements for unhealthy foods can drive poor dietary choices. Controlling this exposure is believed essential to fostering healthier eating habits from a young age. The **Slovenian** representatives claimed that the country's policy priorities concern marketing restrictions. Therefore, guidelines to limit the effects of marketing on children have been adopted.

#### 4.1.3.5 Countries prioritising efforts in Area 5

Representatives from **Austria** stressed that the Austrian Federal Ministry of Health has placed particular attention on prevention, specifically targeting nutrition in children and their families and adopting nutritional standards in schools, as well as encouraging physical activities. Additionally, the representative from **Cyprus** reported that the country has recently been promoting nutrition education at different levels (educating parents and teachers on nutrition and educating children at schools). According to the **Czech** national authorities, raising awareness about the dangers of childhood obesity and educating the public on healthy lifestyle choices are fundamental to preventing the condition. Informed parents and communities are better equipped to support children's health. Representatives from the **Netherlands** explained that collective prevention is one of the priority areas of work.

#### 4.1.3.6 Country prioritising efforts in Area 6

**Czech** national authorities also emphasized the promotion of physical activity is a priority for the Czech Republic government. Indeed, sedentary lifestyles, driven by increased screen time and lack of safe outdoor spaces for physical activity, contribute significantly to obesity. Encouraging regular physical activity is thought of as essential for maintaining a healthy weight and overall well-being. The **Slovenian** representatives claimed that the country's policy priorities concern the encouragement of physical activity. To this end, multidisciplinary teams in health promotion centres have been appointed to work on approaches for obese and overweight children and teenagers (e.g. 12-week camps), with a special focus on vulnerable children coming from disadvantaged socioeconomic backgrounds. These actions were showing good results before COVID-19, which then disrupted the improving trends in childhood obesity. Lastly, a revision of the school curriculum to increase the amount of physical activity at school is ongoing.

#### 4.1.3.7 All Areas

The representative from **Spain** argued that the high rates of childhood obesity in the country are leading the topic forward in the political agenda. Their objective for the upcoming years is to tackle the issue through a Health-in-all-policies approach, aimed at involving various government ministries. The representative of **Ireland** explained that in Irish politics, there are numerous competing priorities, making obesity a challenging issue to address politically. Nonetheless, they noted that obesity has gained traction in recent years, often grouped with cancer and cardiovascular diseases. A representative from

**Sweden** argued that there has not been particular attention to childhood obesity policy per se, but there have been many actions implemented nationally to promote children's health, like physical activity and mental health programmes. The **Belgian** representative reported that the country's political priorities on the matter of childhood obesity are nutrition, physical activity, parenting, and general health as well as the environment.

Representatives from **Denmark** reported that they prioritised policies in all areas except Area 4. The **Greek** authorities explained that Childhood obesity prevalence in Greece is extremely high, and one of the highest in the EU. Therefore, decreasing the prevalence has been of high priority during the last few years. The promotion of healthy nutrition and physical activity is included in the National Action Plan for Public Health 2021-2025 while decreasing the prevalence of obesity among children, adolescents and adults is one of the strategic goals of the annual governmental plan. According to the objectives of the EU Action Plan, Greece has prioritised Area 1, Area 2, Area 3 and Area 6. Representatives from **Latvia** explained that for the Ministry of Health, combating obesity is a two-step exercise: promotion of healthy eating and physical activity and treatment of people with obesity. Representatives from the **United Kingdom** explained that tackling childhood obesity requires a multi-pronged approach, ranging from advertising restrictions to healthier school environments, to robust monitoring and evaluation frameworks. There is no single priority area of intervention that alone could address childhood obesity, and therefore the UK has taken action in all areas covered in this action plan.

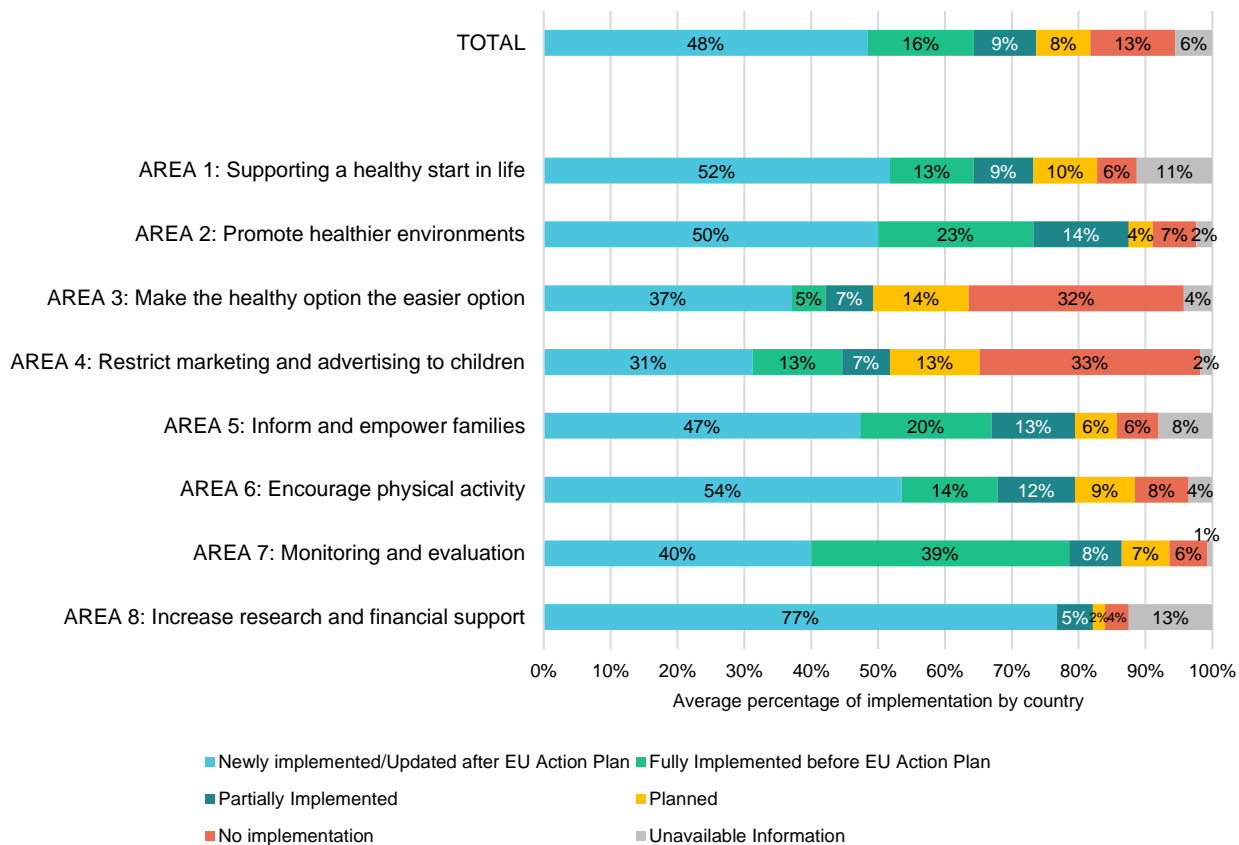
#### 4.1.4 Summary of implementation progress

The findings of the study indicate that countries have implemented a broad spectrum of policies in line with the Areas for Action of the EU Action Plan. Countries' implementation of the EU Action Plan is moderately high. The analysis of this study shows that EU Member States and the United Kingdom cover on average 64% of the key topics of the EU Action Plan, with **48% of topics newly addressed or updated after the adoption of the EU Action Plan**. Nonetheless, there are significant differences between Areas for Action. High implementation levels of the EU Action Plan was found in Area 7 (79%), Area 8 (77%), and Area 2 (73%). Notably, the adoption of Area 8 is very high because it is only composed of 2 key topics and all Member States have participated in a joint action related to childhood obesity after 2014. Moderate implementation was recorded in Area 6 (68%), Area 5 (67%), and Area 1 (64%). In contrast, low implementation is observed in Area 3 (42%) and Area 4 (45%), reflecting considerable disparities in progress across the different areas. Figure 12 below shows the average percentage of implementation by Member States and the United Kingdom of each Area for Action and the EU Action Plan as a whole.

Figure 13 shows a summary figure of the implementation of all key topics. The key topics where countries have fully implemented more actions, excluding participation in EU Joint Actions, are promoting and protecting breastfeeding (key topic 1.2) and adoption of healthy lunches at school canteens (key topic 2.6) with 23 countries adopting or updating their guidelines after 2014 (82%). This is followed by the adoption of national nutritional guidelines (key topic 5.4) and participation in a national diet and nutrition survey (key topic 7.1), with 22 countries (78%) implementing these topics. Nonetheless, it is worth noting that implementation after 2014 does not necessarily indicate that the action is undertaken as a result of the EU Action Plan. The key topics where EU countries have made the least implementation progress since the adoption of the EU Action Plan are subsidies and affordability initiatives (key topic 3.5) and provision of nutritional training for food providers

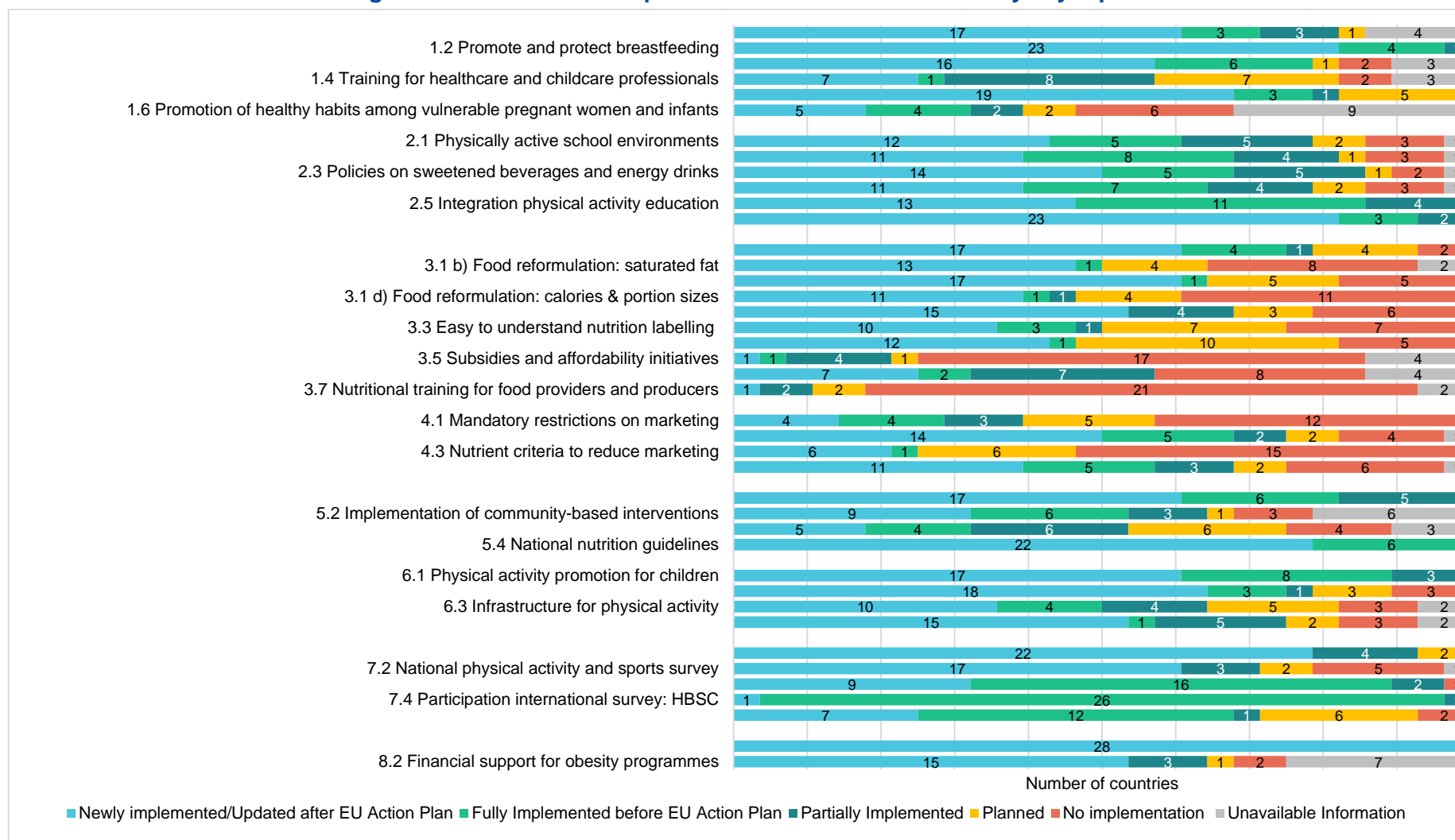
and producers (key topic 3.7), with only one country adopting these key topics respectively.

**Figure 12 – Overview of implementation of EU Action Plan by Area for Action across Member States and the UK**



Source: Authors' elaboration

**Figure 13 – Overview of implementation of EU Action Plan by key topic**



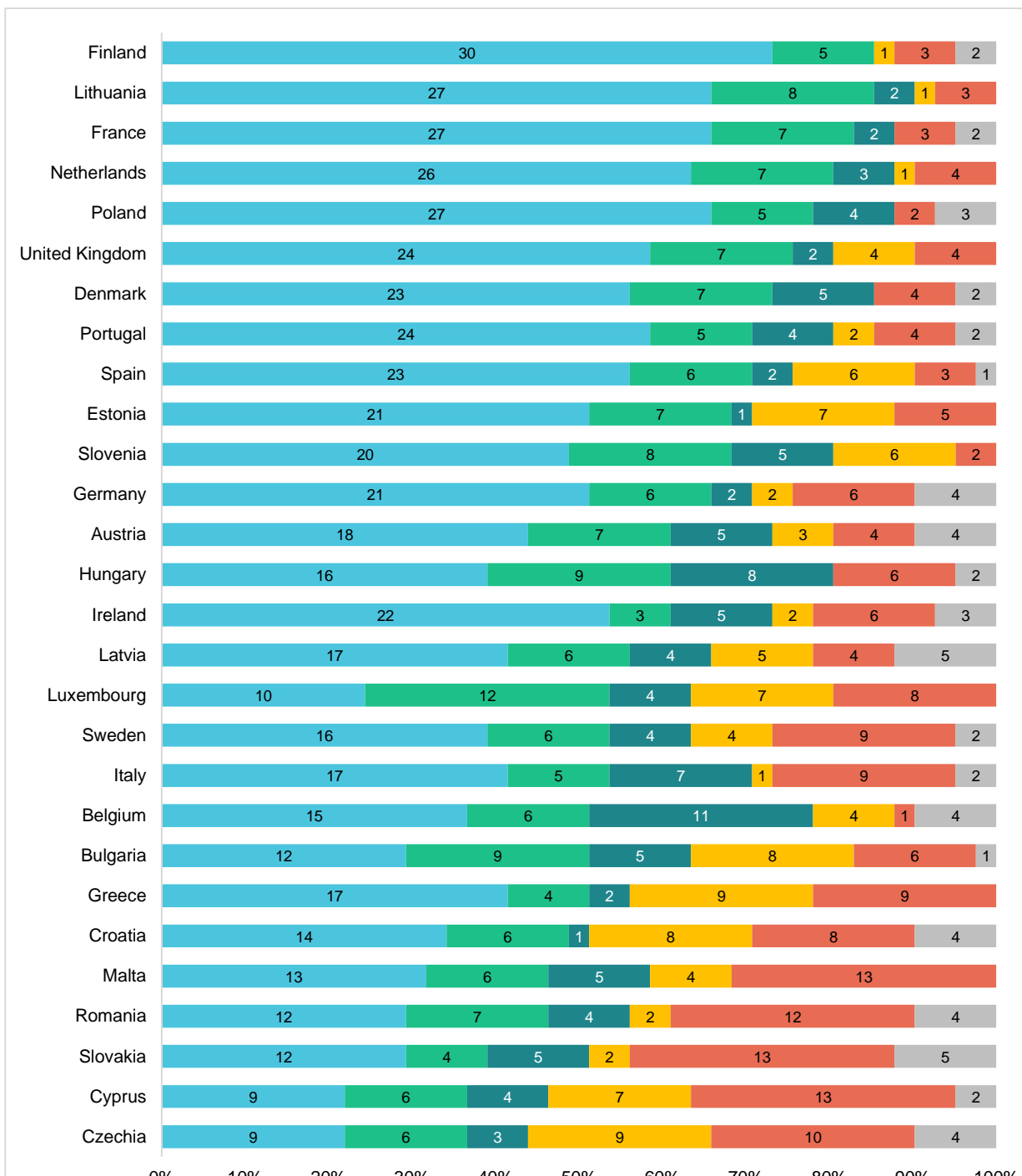
Source: Authors' elaboration

There are also significant differences in the implementation of the EU Action Plan by countries. Figure 14 shows that Finland and Lithuania stand out as the countries with the highest implementation of the EU Action Plan, covering 35 out of the 41 key topics (85%). In contrast, Cyprus and the Czech Republic have the lowest implementation, with only 15 out of 41 key topics covered (36%). However, when considering the implementation of key topics after the inception of the EU Action Plan, Finland remains the country with more implemented new actions (73% - 30 out of 41), followed by Lithuania and France (66% - 27 out of 41). In contrast, Cyprus and Czechia are also the countries that implemented fewer actions after the adoption of the EU Action Plan in 2014 (22% - 9 out of 41).

In this implementation analysis, it is crucial to note that equal weight is assigned to all key topics. However, implementing different types of policies varies significantly in complexity. For instance, introducing nutritional guidelines or conducting a water consumption campaign might be less complex than adopting taxation policies or food reformulation measures, which require the involvement of multiple stakeholders and present more significant political challenges. As a result, some countries may exhibit extensive policy implementation in certain areas, while others may have implemented fewer policies that are more complex and challenging to adopt. Therefore, the number of policies alone is only an approximation on the overall effort and alignment with the EU Action Plan.

**Figure 14 – Overview of implementation of EU Action Plan by Member States and the United Kingdom**

## Study on the evaluation of the EU Action Plan on Childhood Obesity: Final report



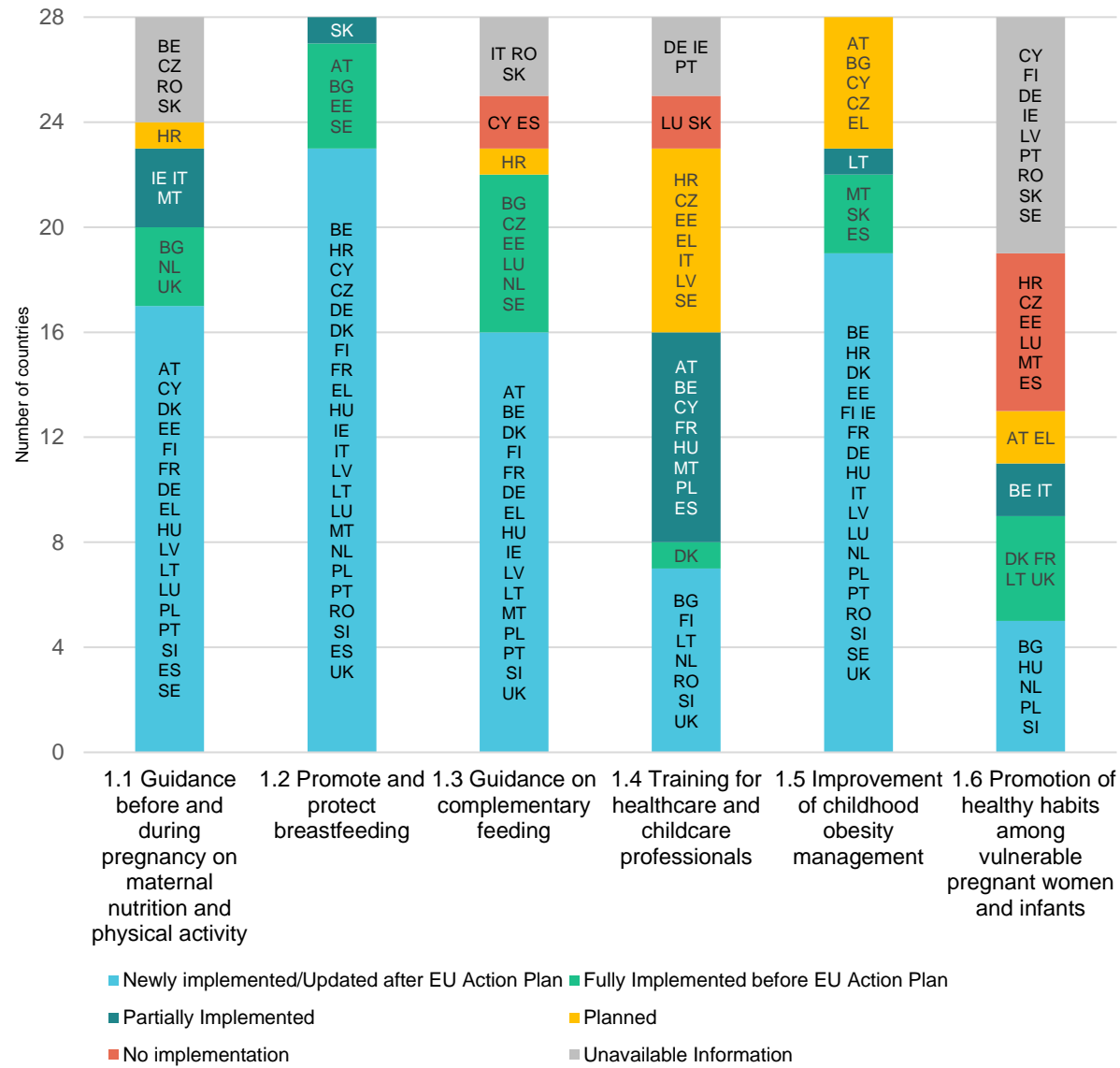
**Note:** Numbers inside the bars represent the number of key topics covered by country.

*Source: Authors' elaboration*

#### 4.1.5 Area 1: Support a healthy start in life

The EU Action Plan emphasises supporting mothers and their infants during pregnancy and after. Simultaneously, it advocates for developing healthcare systems and training education and healthcare professionals to address risk factors and facilitate early detection of childhood overweight and obesity. Area 1 also emphasises better support for low-income families. Area 1 is one of the most addressed areas of the EU Action Plan, where most countries have implemented actions. Figure 15 shows the progress achieved by Member States and the UK towards implementing key topics under Area 1.

**Figure 15 – Overview of implementation of EU Action Plan for Area 1**



Source: Authors' elaboration

After the adoption of the EU Action Plan, 17 countries (60%) implemented or updated their **guidance for pregnancy for maternal nutrition and physical activity**. At the same time, three maintained their pre-EU Action Plan measures. Member States addressed the key topic by providing dietary and physical activity guidelines to patients (AT, BG, DK, EE, FI, FR, EL, LV, LT, LU, PT, SI, ES, SE, UK), or health care professionals (LV), adopting strategies and schemes to protect pregnant women (DK, DE HU, NL, PL), hosting lectures for new parents (CY) or having mass awareness campaigns (ES). For instance, Germany adopted the End Obesity – First 1000 Days strategy (2021– 2024)<sup>123</sup> which implements and evaluates innovative, multidisciplinary strategies to prevent childhood obesity by addressing family-based lifestyle factors in the preconception period, during pregnancy and in early infancy, i.e. in the first 1000 days of life. Three countries (IE, IT, MT) still have a partial implementation of maternal guidance, primarily due to guidelines focusing solely on diet or physical activity or guidance being provided only during a certain stage of pregnancy rather than throughout. In Croatia, national authorities reported that measures are planned to be implemented in the future.

The numerous health benefits of breastfeeding are widely recognised both for the mother and their children. Breastfeeding is associated with lower rates of childhood obesity. All Member States implemented at least one policy measure to **empower and support women to breastfeed**. In total, 23 countries (82%) have implemented or updated their guidelines and action plans on breastfeeding since the implementation of the EU Action Plan, while four maintained their pre-EU Action Plan measures. Many countries address this key topic through participation in the WHO–UNICEF Baby Friendly Hospital Initiative (BFHI)<sup>124</sup> launched in 1991 by WHO and UNICEF (AT, BG, CY, CZ, BE, EE, FI, EL, HU, IT, LT, LU, NL, PL, PT, RO, SK, SI, ES, SE, UK). From the BFHI, four countries (HR, SK, SI, RO) developed further actions such as the Breastfeeding friendly city (2021-2025)<sup>125</sup> in Slovenia, which is based on the document "10 Steps to a Breastfeeding-Friendly Place". The goal of the initiative is to increase the breastfeeding rates across Slovenian cities. Romania and the Netherlands reported providing training for healthcare professionals on breastfeeding. Some countries have adopted guidelines for health professionals (DK, EE, EL, ES, BG), while others have developed guidelines targeted to parents (FR, IE, LV, LU). Five countries (HR, FR, EL, PT, ES) have launched campaigns to promote breastfeeding. Once a year, Croatia<sup>126</sup> celebrates the National Breastfeeding Week to continuously take positive steps in promoting breastfeeding as the healthiest diet from the moment of birth. In 2017, Poland launched the Coordinated Care for Pregnant Women,<sup>127</sup> which provided funding for hospitals that introduced changes for improving care for pregnant women, e.g. providing future mothers childbirth classes, pregnancy management support, specialist examinations or specialist care for newborns, and encouragement of breastfeeding. In Slovakia, implementation is partial because National authorities reported that the country has adopted policies to provide counselling during maternity to mother and their children, but this has not been very successful because there is a lack of paediatricians and a deficit of young doctors.

---

<sup>123</sup> Federal Office of Education and Research. (2021). Strategies to prevent overweight and obesity in children in the first 1000 days of life. Available at: [Link](#)

<sup>124</sup> WHO (n.d.). Implementation of the Baby-friendly Hospital Initiative. Available at: [Link](#)

<sup>125</sup> UNICEF. (2010). Breastfeeding Friendly City. Available at: [Link](#)

<sup>126</sup> Croatian Institute for Public Health. (2023). For breastfeeding together: Promoting breastfeeding through the National Healthy Living Program. Available at: [Link](#)

<sup>127</sup> The Polish Journal of Laws Database. (2017). Amending the Ordinance on defining the terms of conclusion and implementation of contracts in the type of separately contracted health services. Available at: [Link](#)

**Guidance on complementary feeding** includes clear guidance on introducing solid foods alongside continued breastfeeding or formula feeding, as well as ensuring proper nutrition and dietary diversity for infants from 6 months of age up to 24 months or beyond. Out of 28 countries, 22 (78%) provide guidance on complementary feeding. Guidance on complementary feeding is either adopted by countries within dietary guidelines for children or as stand-alone guidelines. Moreover, in some countries, guidelines are aimed at healthcare professionals (BG, DK, IE). For instance, Ireland provides advice to both health professionals<sup>128</sup> and parents,<sup>129</sup> through guidelines incorporated into a parenting course and peer-led support for optional infant feeding. Ireland and the UK report providing the material online for information to be easily accessible to parents. In the Netherlands, the Dutch Centre Youth Health Care<sup>130</sup> and Netherlands Nutrition Centre<sup>131</sup> target all children, young people and their (future) parents/carers. They provide (free) advice, information and support to families for raising children and ensuring a healthy growth.

Implementation of measures related to **training healthcare and childcare professionals** on overweight and obesity risk factors is mixed across Member States and the UK. Examples of policies include education and training programs, workshops, seminars, and access to informational resources covering a broad spectrum of factors contributing to overweight and obesity, and teaching evidence-based practices for prevention, intervention, and management. Since the implementation of the EU Action Plan, seven countries (25%) have either implemented at least one measure that provides new training or updated existing ones for healthcare professionals or teachers at a national level, while Denmark maintained their measures before 2014. In Slovenia, since 2021, under the Program Now - Health Today for Tomorrow (ZDAJ)<sup>132</sup> regular training on obesity and related risk factors is provided to health staff employed in the Health Promotion Centre. The Netherlands and the UK provide training via web-based training platforms to healthcare professionals, while Lithuania and Romania do not specify it. Four countries reported providing training to teachers (BG, FR, FI, PL). For instance, in Bulgaria, the National Programme for the Prevention of Chronic Non-communicable Diseases (2014– 2020) conducted training for medical and non-medical specialists to introduce educational programmes on healthy nutrition for children in kindergartens and schools. In eight countries (28%), the policy is partially implemented. In some cases, training focuses on a single topic, like breastfeeding or complementary feeding (AT, CY, HU). In other instances, the training addresses broader risk factors rather than being specific to childhood obesity (FR, MT, PL, ES). Additionally, in Belgium, the policy is only adopted in certain regions of the country. In Luxembourg and Slovakia, national authorities reported that they do not provide training for healthcare or childcare professionals on the topic of childhood obesity. In eight countries policies are not yet implemented, but adoption is planned in the future.

---

<sup>128</sup> Food Safety Authority of Ireland. (2013). Best Practice for Infant Feeding in Ireland - A Guide for Healthcare Professionals. Available at: [Link](#)

<sup>129</sup> HSE. (2005). Infant Feeding Guidelines for direct provision centres in Ireland. Available at: [Link](#)

<sup>130</sup> NCJ. (n.d.). About the NCJ. Available at: [Link](#)

<sup>131</sup> Netherlands Nutrition Center. (n.d.). All about the first bites. Available at: [Link](#)

<sup>132</sup> National Institute of Public Health. (2023). Child and Adolescent Preventive Health Care Program - NOW Program. Available at: [Link](#)

In total, 22 countries (78%) have adopted measures to enhance **management services for childhood obesity**. For this key topic to be considered fully implemented, countries should have implemented at least one national measure on evidence-based interventions or weight loss programs tailored specifically for children, covering aspects such as dietary interventions, physical activity promotion, behavioural counselling, and support services. These programs should be accessible, effective, and inclusive, addressing the diverse needs of overweight and obese children across different settings. Overall, 19 countries (67%) have either implemented new processes or updated existing ones since the implementation of the EU Action Plan. Countries have adopted different policy tools to implement this key topic. Most countries developed guidance for health professionals on the management of childhood obesity (DE, DK, EE, FI, IE, FR, DE, HU, NL, RO, ES, UK). Four countries (BE, LU, LV, MT, SI) created new hospital units specialised in childhood obesity. For instance, in Luxembourg, children are referred to the CHL Childhood Obesity Clinic<sup>133</sup> by healthcare professionals, including school health services). The coordinating nurse schedules an initial visit with children and their parents where the child's health is assessed by both the nurse and a paediatric endocrinologist to establish a treatment plan. Three countries (FR, NL, PT) have developed new models of care for childhood obesity. For example, the Netherlands in 2016 established the National model integrated care for childhood overweight and obesity<sup>134</sup> where the health and social domains in a municipality work together to guide children with overweight and obesity. Poland, Slovenia and Croatia have specialised centres that provide advice on obesity and its risk factors. Policies are planned in five countries (AT, BG, CY, CZ, EL).

The EU Action Plan calls for policies that actively encourage **healthier food habits and physical activity among pregnant women and infants from vulnerable groups**, such as ethnic minorities or people with low socioeconomic status.<sup>135</sup> These initiatives should be comprehensive, address the specific needs and challenges faced by these groups and be accessible and culturally sensitive in promoting behavioural change. For four countries initiatives were identified as fully implemented before 2014 and five after 2014. Different approaches are adopted by Member States that address this key topic. France (MALIN programme<sup>136</sup>), the Netherlands (Solid Start programme<sup>137</sup>) and the United Kingdom (Sure Start programme<sup>138</sup>) adopted similar programmes that focus on supporting healthy diets for mothers and infants from vulnerable populations. This includes providing discount vouchers on healthy products adapted to the age of the child and the family. Some countries (LT, PL, HU) have adopted health promotion strategies to inform vulnerable women, especially on increasing breastfeeding rates or consumption of fruits and vegetables. In Bulgaria, within the National Programme for Improving Maternal and Child Health (2021-2030)<sup>139</sup> a brochure was prepared to support the Roma community to improve maternal and child health and raise awareness of the importance of healthy nutrition and a healthy lifestyle. In Italy and Belgium, implementation is partial because

---

<sup>133</sup> Reported by National authorities during consultation activities.

<sup>134</sup> Halberstadt, J., et al. (2023). The development of the Dutch "National model integrated care for childhood overweight and obesity". BMC Health Services Research, 23(1), 359. Available at: [Link](#)

<sup>135</sup> "Universal interventions, targeting whole populations, are not ideal for addressing specific health inequalities and have also been shown to widen inequalities" ([Yuan et al, 2014](#)).

<sup>136</sup> MALIN programme. Available at: [Link](#)

<sup>137</sup> Ministry of Health, Welfare and Sport. (2018). Solid start. Available at: [Link](#)

<sup>138</sup> NHS. (n.d.). Get help to buy food and milk (the Healthy Start scheme). Available at: [Link](#)

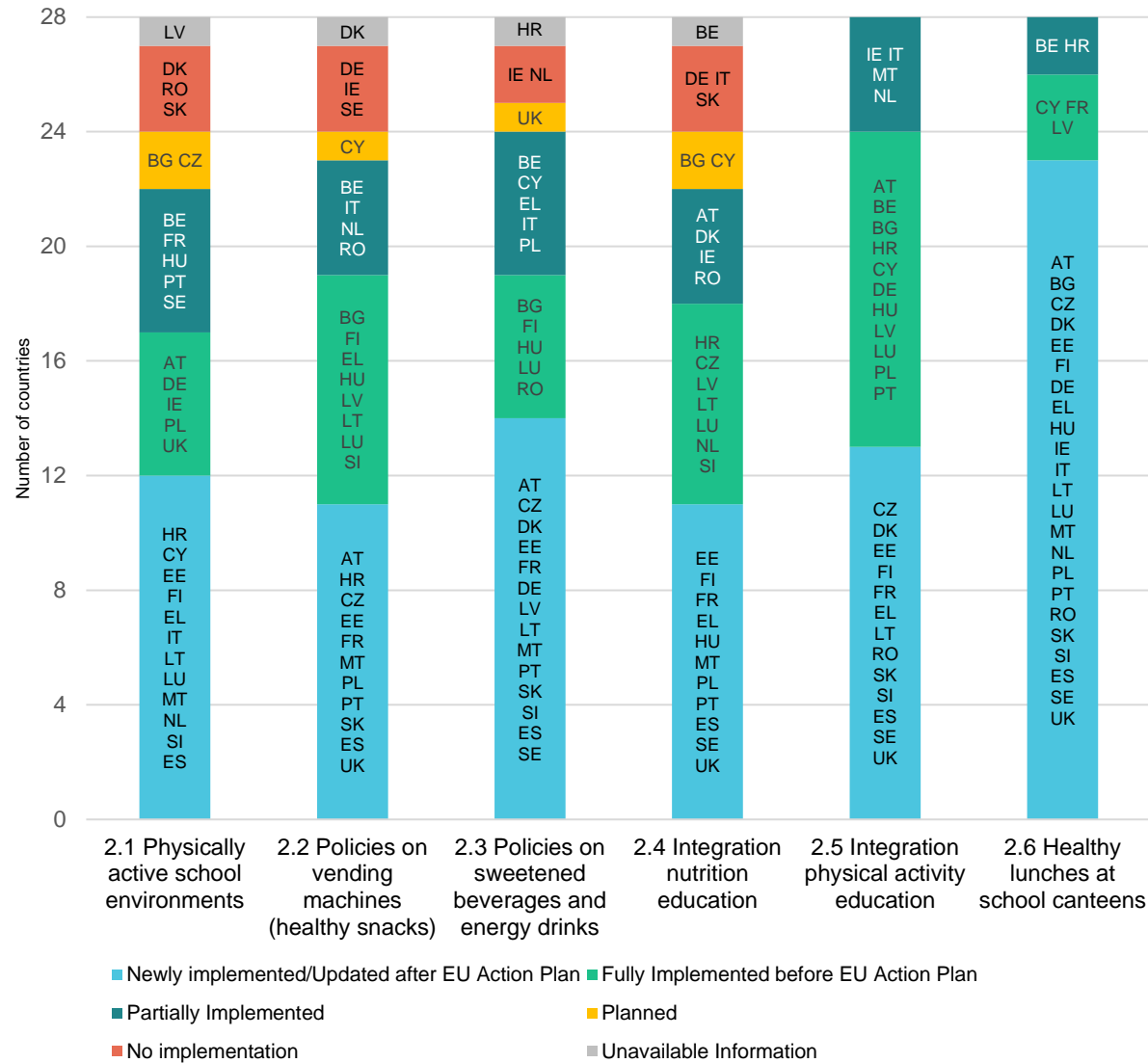
<sup>139</sup> Ministry of Health. (2014). National Programme for Improving Maternal and Child Health. Available at: [Link](#)

certain strategies for disadvantaged families are in place, but there are limitations in terms of coverage as only a few regions have implemented such initiatives. In Portugal, Bulgaria and Cyprus national authorities reported that disadvantaged families might indirectly benefit from the actions adopted under Child Guarantee national programmes. In six countries (21%), national authorities reported through the survey that policies on this key topic have not yet been adopted. Policies are planned in Austria and Greece.

#### 4.1.6 Area 2: Promote healthier environments

Children and young people spend a significant portion of their day at school. This Area for Action aims to enhance school environments by improving the adoption of healthy and high-quality school meals, restricting access to unhealthy snacks on school premises e.g. through the provision of healthy lunches, instating policies to promote the intake of tap water and reducing or banning the consumption of sweetened beverages/soft drinks (including energy drinks). Additionally, it underscores the importance of incorporating physical education and nutrition lessons into the school curriculum. All Member States have implemented at least one approach to promote healthier school environments. Figure 16 shows the progress achieved by Member States and the UK towards implementing key topics under Area 2.

Figure 16 – Overview of implementation of EU Action Plan for Area 2



---

Source: Authors' elaboration

Many countries have implemented policies to make **school environments more active** by promoting active breaks, active commuting to and from school, and other opportunities for physical activity throughout the school day. For the key topic to be considered fully implemented, the initiatives have to be implemented across most schools nationally and be supported by resources, training, and infrastructure to ensure their effectiveness. A total of 17 countries (60%) have implemented policies to make schools more physically active. Notably, 12 countries (43%) have either implemented new policies or updated existing ones after the implementation of the EU Action Plan. Three countries have adopted specific guidelines for schools (FI, EL, SI). For example, in Slovenia, the **professional guidelines for physical activity during school breaks and during lessons**<sup>140</sup> aid teachers in designing and carrying out the activities. On the other hand, ten countries have launched specific programmes (HR, CY, DE, EE, IT, IE, LU, PL, ES, MT). An illustrative example of this kind of policy is in Spain with the “Give me 10: active breaks through physical exercise” initiative,<sup>141</sup> which provides short physical activity breaks, each lasting between 5 to 10 minutes, designed to be integrated into school classes. Malta, UK, and the Netherlands participate in the Daily Mile,<sup>142</sup> which is a physical activity intervention designed to increase physical activity and fitness in children. This encourages kids to move for 15 minutes every day during schools' hours. Some countries (IT, LT, LV, PL, ES, UK) are part of the European Network of Health Promoting Schools.<sup>143</sup> The schools in the Network are committed to being a “health-friendly environment” through actions (evidence-based) of an educational/training nature (life skills, thematic programs, etc.), social activities (listening, collaboration, participation, etc.), organizational/resource changes (canteens, snack vending machines, fruit for snacks). In Belgium, changes to school environments were only implemented regionally, representing partial implementation, while in France, Hungary, Portugal and Sweden activities are adopted, but do not cover all aspects to consider them as fully implemented. In three countries (10%) (DK, RO, SK), national authorities reported through the survey that policies on this key topic have not yet been adopted. Policies are planned in Bulgaria and the Czech Republic.

Policies on **vending machines** are popular among Member States to reduce the consumption of HFSS foods and drinks in children. In total, 19 countries (67%) have policies in place, with eight of them having updated or implemented new policies since the inception of the EU Action Plan. Member States take various approaches, including voluntary guidelines (AT, HR, EE, FI, LT, PT, ES) that may involve industry commitments or school catering recommendations. In Finland, the Snacks at School recommendation<sup>144</sup> recommends that sweets, soft drinks or sugary juices should not be regularly sold in schools and educational institutions and vending machines or kiosks must offer products that are recommended for the health and growth of schoolchildren. Alternatively, some countries use legislation (BG,

---

<sup>140</sup> University of Ljubljana. (2016). Action Plan Activities in the Field of Exercise and Nutrition Manual For Preventive Times for Performing Activities in Pilot Testing. Available at: [Link](#)

<sup>141</sup> Ministerio de educación y formación profesional. (2014). ¡Dame 10! Descansos activos mediante ejercicio físico. Available at: [Link](#)

<sup>142</sup> Daily Mile. Available at: [Link](#)

<sup>143</sup> European Network of Health Promoting Schools. (2006). Developing a health– promoting school. Available at: [Link](#)

<sup>144</sup> Finnish National Agency for Education. (n.d.). Snack at school. Available at: [Link](#)

CZ, EL, FR, HU, MT, PL, PT, LV, SK, SI, UK). For instance, Portugal has voluntary guidelines on school buffets<sup>145</sup> adopted in 2012 and a regulation on food available in school buffets and vending machines adopted in 2021.<sup>146</sup> Many countries, like Bulgaria, Greece, Poland, and the UK, regulate vending machines through school catering rules. Another approach, supported either by voluntary or mandatory measures, is regulating the products inside the vending machines (LV, LT, MT, RO) or the presence of vending machines in schools altogether (all other countries). In Hungary, since 2021, under the EMMI Decree on the Operation of Educational Institutions,<sup>147</sup> the head of the educational institution has to consult the school health service prior to entering into agreements with vending machine operators or food businesses to sell food and beverages within the school grounds. Belgium and Luxembourg have signed declarations to sell healthier snacks in vending machines in schools, yet in Belgium, adoption is partial because it is only adopted in some regions. In Romania, restrictions only apply to energy drinks. In Italy and the Netherlands, voluntary guidelines and programmes only apply to primary schools. National authorities from Cyprus reported that there are plans for new measures to regulate the availability of vending machines in schools. In three countries (DE, IE, SE) national authorities confirmed there are no measures in place.

Some Member States have adopted measures to reduce the consumption of **sweetened beverages in schools**. In total, 19 countries (67%) have adopted initiatives, 14 of which since the adoption of the EU Action Plan. These include either voluntary (AT, HR, DK, EE, FI, SE) or mandatory measures (BG, FR, HU, LV, MT, ES). Similar to vending machines, some countries regulate the consumption of sweetened beverages in schools through their school catering rules and recommendations (AT, CZ, DE, LV, LT, MT, PT, RO, SK, SI, ES). Some countries provide specific measures on energy drinks, which might be either voluntary (ES, SI, CY, EL) or mandatory (LV, LT, PL). For instance, in Lithuania<sup>148</sup> and Latvia,<sup>149</sup> there has been a ban on the sale of energy drinks to minors since 2014. In Poland, Cyprus and Greece this topic is partly implemented because measures only focus on energy drinks. In Belgium, it is partially implemented, but in the region of Flanders there is a voluntary agreement with the parents about bringing sweets (e.g. treats) and beverages (such as soft drinks) to school.<sup>150</sup> In the UK measures are planned, while in Ireland and the Netherlands, national authorities reported that measures have not been adopted.

Many EU Member States have recognised the importance of integrating **nutrition education into the school curriculum** as a key policy to promote healthier eating habits among children. These programs aim to teach students about balanced diets, the importance of nutritious foods, and the long-term benefits of healthy eating. In total, 18 countries (64%) have officially incorporated nutrition education

---

<sup>145</sup> Direção-Geral da Educação (2012). Bufetes escolares orientações. Available at: [Link](#)

<sup>146</sup> Diário da República. (2021). Estabelece as normas a ter em conta na elaboração das ementas e na venda de géneros alimentícios nos bufetes e nas máquinas de venda automática nos estabelecimentos de educação e de ensino da rede pública do Ministério da Educação. Available at: [Link](#)

<sup>147</sup> Wolters Kluwer Hungarian Legislation Database. (2012). A nevelési-oktatási intézmények működéséről és a köznevelési intézmények névhasználatáról. Available at: [Link](#)

<sup>148</sup> Database of the Parliament of the Republic of Lithuania. (2014). Lietuvos Respublikos maisto įstatymo Nr. VIII-1608 2 straipsnio pakeitimo ir įstatymo papildymo 6-1 straipsniu įstatymas. Available at: [Link](#)

<sup>149</sup> Parliament. (2016). Law on the Circulation of Energy Drinks. Available at: [Link](#).

<sup>150</sup> Joint Research Centre, Institute for Health and Consumer Protection, Kardakis, T., Storcksdieck genannt Bonsmann, S., Nelson, M. et al., Mapping of national school food policies across the EU28 plus Norway and Switzerland. Available at: [Link](#)

into their educational systems, with 11 countries integrating new content or updating curricula since 2014. In some countries, nutrition education is taught as a standalone subject. For example, Sweden offers a dedicated course called "Home and Consumer Knowledge."<sup>151</sup> In others, such as the Netherlands<sup>152</sup> and Portugal,<sup>153</sup> nutrition education is integrated into broader subjects. Countries like Austria, Hungary, and Spain have developed supporting materials for their mandatory nutrition education programs. In Spain, where nutrition education has been mandatory since 2011,<sup>154</sup> a specific program for pre-schools and primary schools was introduced in 2017.<sup>155</sup> This program equips educators with resources and guidance to effectively incorporate food and nutrition knowledge into the curriculum. In Finland, nutrition education is recommended within the school meal regulations.<sup>156</sup> In four countries (AT, DK, IE, RO), the implementation of nutrition education is only partial, with some school grades not receiving it. In three countries (DE, IT, SK), national authorities report that nutrition education is not integrated into the national school curriculum at all.

**Physical activity education** is considered a critical component of promoting healthy lifestyles among children and adolescents. 24 countries (85%) have made physical activity mandatory in their school curriculums, spanning both primary and secondary levels. Nonetheless, recommendations are varied across the EU: while some Member States recommend 45 minutes of daily physical activity (e.g. DK<sup>157</sup>), other countries recommend performing minimum one hour of physical activity once per week (e.g. SI,<sup>158</sup> RO<sup>159</sup>). Spain and the UK have developed additional guidance to support the provision of physical activity education in schools. In Spain, the Active Didactic Units<sup>160</sup> adopted in 2014, were developed by teachers specialised in the subject and aimed at increasing the percentage of moderate to vigorous intensity physical activity during physical education classes to at least 50% of the duration of the class in order to approach the international recommendations for physical activity in children and adolescents. In four countries (IE, IT, MT, NL), the implementation is only partial as mandatory physical education only apply to primary school grades.

Most children in Europe have at least one of their three main meals in schools. All countries have enacted some form of measure to promote **healthy eating in school canteens**. In total, 23 countries (82%) have either updated existing policies or implemented new ones since the adoption of the EU Action Plan, while three countries have maintained their pre-EU Action Plan measures. Countries employ a diverse range of approaches to providing healthy meals in schools, with some opting for voluntary guidelines, others implementing formal

<sup>151</sup> FAO. (n.d.). School food global hub – Sweden. Available at: [Link](#)

<sup>152</sup> Wageningen University. (n.d.). Taste Lessons. Available at: [Link](#)

<sup>153</sup> República Portuguesa – Educação. (2017). Referencial de Educação para a Saúde. Available at: [Link](#)

<sup>154</sup> Agencia estatal boletín oficial del estado. (2011). Ley 17/2011, de 5 de julio, de seguridad alimentaria y nutrición. Available at: [Link](#)

<sup>155</sup> The Spanish Nutrition Foundation. (2017). The Programme on Food, Nutrition and Gastronomy for Primary Schools and Pre– schools. Available at: [Link](#)

<sup>156</sup> Finnish National Agency for Education and National Institute for Health and Welfare. (2017) - Eating and Learning Together - Recommendations for school meals. Available at: [Link](#)

<sup>157</sup> Koch, S., et al. (2021). Exploring implementation of a nationwide requirement to increase physical activity in the curriculum in Danish public schools: a mixed methods study. BMC Public Health, 21(1), 1-13. Available at: [Link](#)

<sup>158</sup> Ministry of Education, Science, Culture and Sports. (2024). Act on Amendments to the Basic School Act (ZOsn-K). Available at: [Link](#)

<sup>159</sup> Ministry of Education. (2017). The curriculum for discipline Physical Education and Sport 5th - 8th Grades. Available at: [Link](#)

<sup>160</sup> Ministerio de Salud. (2014). Active didactic units. Available at: [Link](#)

regulations, and some adopting a combination of both. Twelve countries have adopted voluntary measures (AT, DK, FI, EL, HU, IE, IT, LU, NL, PT, SI, SE). An illustrative example is found in Denmark, where the “Dietary advice for meals in schools and canteens”<sup>161</sup> provide concrete guidance on how to serve healthy and climate-friendly meals in accordance with the food-based dietary guidelines. Additionally, 17 countries have mandatory regulations on the foods served in schools which include food procurement policies and defined school food standards (BG, CY, CZ, EE, FI, FR, EL, LV, LT, MT, PL, PT, RO, SK, SI, ES, UK). For instance, in Bulgaria the “Ordinance for healthy nutrition in school”<sup>162</sup> sets specific restrictions for the standards (and nutrient content) of school foods. The ordinances had a specific goal of reducing the levels of salt, fat, and sugar available in school food and restricting the sale of certain items. At least four countries (BG, HR, LT, PL) provide recommended menus for school canteens to follow, while in three countries (CZ, LV, PL) school caterers receive additional training on healthy nutrition and how to follow recommendations. In order to ensure that kids are able to eat in schools, some countries provide free school meals to all students (HR, EE, FI, LT, SE), while others provide subsidised or free meals for low-income students (MT, HU, RO, EL, IE). In Croatia, guidelines for school canteens only apply to primary schools and not secondary, while in Belgium there are geographical disparities in implementation.

#### 4.1.7 Area 3: Make the healthy option the easier option

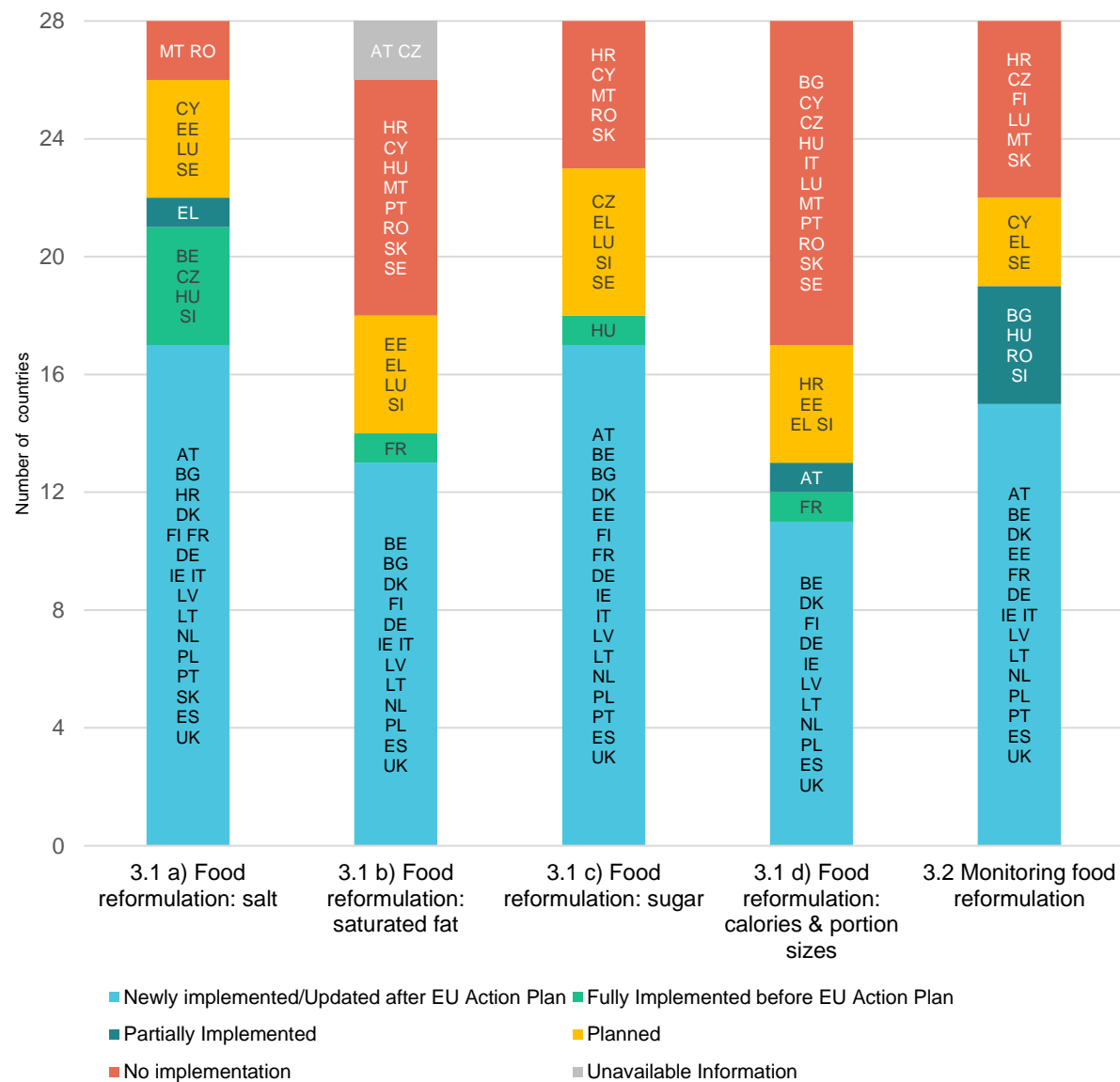
The EU Action Plan calls for urgent new initiatives to improve both children’s and parents’ eating habits. To achieve this goal, it emphasises the need to facilitate easier access to healthy options in supermarkets, through local producers, markets, restaurants, various retailers, and schools. Area 3 covers policies on food reformulation (e.g. limiting salt, sugar, total and/or saturated fat content and calories) or initiatives on portion sizes, introducing easy-to-understand nutritional labelling on pre-packed foods or easy-to-understand menu labelling as well as taxation and subsidy initiatives. Adoption of Area 3 is the lowest among all the Areas for Action, and within it, key topics on providing subsidies and affordability initiatives (key topic 3.5) and nutritional training for food producers and providers (key topic 3.7) are the least addressed. Figure 17 and Figure 18 show the progress achieved by the Member States and the UK towards implementing the key topics under Area 3.

---

<sup>161</sup> Danish Veterinary and Food Administration. (2022). Dietary advice for meals in schools and canteens. Available at: [Link](#)

<sup>162</sup> Ministry of Health. (2009). 3. Ordinance No. 37 (2009) on the healthy nutrition of schoolchildren, issued by the Ministry of Health (promulgated SG No. 63 of August 7, 2009). Available at: [Link](#)

**Figure 17 – Overview of implementation of EU Action Plan for Area 3 (Key topics 3.1 and 3.2)**



Source: Authors' elaboration

Several countries have implemented policy initiatives to **reformulate food products** available on their national markets with the goal of reducing the amount of salt, saturated/total fats, and sugar and making healthier products. Reformulation strategies are pursued through either voluntary agreements with the industry (e.g. AT, BE, DK, EE, FI, FR, HU, SI, ES) or mandatory standards enforced by responsible food authorities (often on salt content limits) (e.g. BG, HR, FI, NL, SK). In Italy, the Ministry of Health in 2015 issued the document for “the shared objectives for the improvement of the nutritional characteristics of food products”<sup>163</sup> with particular attention to the child population (3 to 12 years old), which for each food area identifies critical points and targeted interventions. The food industry agreed to voluntarily reformulate a wide range of products available on the market containing sugars, saturated fats, salt, trans fatty acids, starting from bread, but also frozen ready-to-eat meals, soups and frozen vegetable purée in order to improve nutritional content of foods towards healthier products. In 2021, Ireland adopted a “A Roadmap for Food Product Reformulation”<sup>164</sup> which committed to the reduction of salt, saturated fats, added sugars, calories and portion sizes. Salt reformulation is the most common type of food reformulation among countries, while reformulation of calories and initiatives on portion sizes the least addressed.<sup>165</sup>

For countries that have adopted comprehensive reformulation initiatives, the majority have mechanisms in place to **monitor food reformulation**. Out of 28 countries, 15 (54%) have adopted or updated food reformulation monitoring systems after 2014. Monitoring of food reformulation can happen as independent surveys conducted on a regular basis (e.g. DK, EE, NL, PT, ES, UK) or systematic monitoring (e.g. AT, BE, FR, DE). For instance, in the Netherlands, RIVM (Dutch National Institute for Public Health and the Environment) monitors the composition of groups of foods. RIVM published a report in 2020,<sup>166</sup> and will give an update on the improvement of food products in 2026, 2028, 2031.<sup>167</sup> In 2008, France created the French Food Quality Observatory (Qgali),<sup>168</sup> which monitors changes in the nutritional quality of processed foods, analysing data based on nutritional composition, labelling, and economic factors (i.e. average prices and sales volumes). In four countries (BG, HU, RO, SI) implementation is partial because only one type of food reformulation is monitored, most commonly only salt content. Nine countries are still lacking implementation of a food reformulation monitoring system, yet in three (CY, EL, SE) adoption is planned.

---

<sup>163</sup> Ministry of Health. (2015). Shared goals for improving the nutritional characteristics of food products food with special attention to the child population (3-12 years). Available at: [Link](#)

<sup>164</sup> Ministry of Health (2021). A Roadmap for Food Product Reformulation in Ireland. Available at: [Link](#)

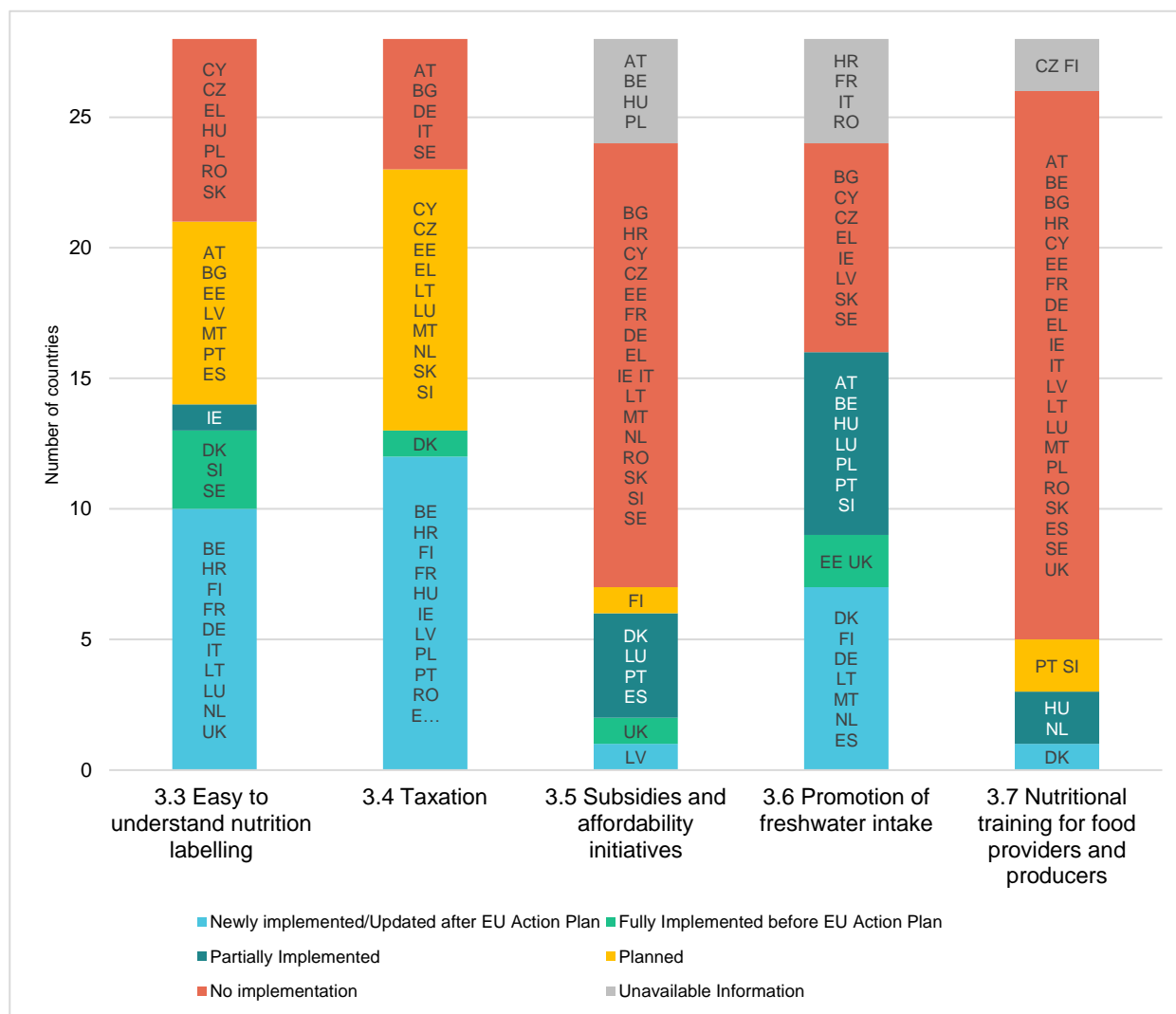
<sup>165</sup> Changes to portion sizes is not a form of food reformulation. Changing portion sizes involves adjusting the amount of food served or packaged, but it does not alter the actual content or ingredients of the food itself. Nonetheless, adjusting portion sizes can be a strategy to help consumers manage their calorie intake and promote healthier eating habits.

<sup>166</sup> RIVM. (2021). Salt, saturated fat and sugar levels in processed foods. RIVM Reformulation Monitor 2020. Available at: [Link](#)

<sup>167</sup> Reported by national authorities during consultation activities.

<sup>168</sup> Legifrance. (2018). Article 54 de la loi n° 2018-938 du 30 octobre 2018. Available at: [Link](#)

**Figure 18 – Overview of implementation of EU Action Plan for Area 3 (Key topics 3.3 to 3.7)**



Source: Authors' elaboration

**Mandatory or voluntary easy-to-understand nutrition labelling** can be useful tools to inform and help consumers make healthier choices<sup>169</sup>. Moreover, front-of-pack nutrition labelling can provide incentives to the food industry to reformulate their products to improve nutritional quality<sup>170</sup>. This key topic is considered fully implemented if a national policy is in place adopting easy to understand front-of-pack nutritional labelling (FOPNL), including interpretative and non-interpretative schemes, on pre-packaged foods nationwide. To meet this criterion, FOPNL should be recommended by the government (thus not driven by private industry initiatives). The policy can be considered fully implemented regardless of whether a national policy is in place for menu labelling in restaurants or food outlets to provide information on the nutritional content of menu items in a clear and concise manner.<sup>171</sup> The key topic is considered partially implemented if a public policy is recommending FOPNL only in certain regions or food categories, or if only menu labelling is available without complementary easy-to-understand FOPNL on pre-packed foods.

Among 28 countries, 13 (46%) have adopted mandatory or voluntary easy-to-understand nutrition labelling.<sup>172</sup> Ten of these countries have adopted or updated labelling schemes after 2014. The most common form of nutritional labelling are the Nutri-Score<sup>173</sup> and Keyhole logo.<sup>174</sup> Croatia has the "Living Healthy" Guarantee Mark,<sup>175</sup> Slovenia the Protective Food logo, also known as "Little Heart" logo<sup>176</sup> and Finland the Heart Symbol (2000).<sup>177</sup> The United Kingdom<sup>178</sup> has the multiple "traffic light" FOPNL scheme. Italy has an easy-to-understand *non-interpretative* FOPNL, the NutriInform battery label.<sup>179</sup> Ireland adopted menu labelling without complementary easy-to-understand FOPNL. Seven countries<sup>180</sup> have not taken action on this key topic, while policies are planned in seven countries<sup>181</sup>.

Fiscal measures, such as taxation and subsidies, can play an important role in reducing the consumption of unhealthy foods (i.e. those high in fat, sugar, and salt) and promoting the intake of healthy foods. Additionally, subsidies can make food more affordable to low-income families. Figure 18 shows that the progress made in these two key topics is very low. Regarding **taxation**, 13 countries have

<sup>169</sup> Storcksdieck Genannt Bonsmann, S., Marandola, G., Ciriolo, E., Van Bavel, R. and Wollgast, J., Front-of-pack nutrition labelling schemes: a comprehensive review, EUR 29811 EN, Publications Office of the European Union, Luxembourg, 2020, ISBN 978-92-76-08970-4, doi:10.2760/180167, JRC113586. Available at: [Link](#)

<sup>170</sup> Nohlen, H., Bakogianni, I., Grammatikaki, E., Ciriolo, E., Pantazi, M., Alves Dias, J., Salesse, F., Moz Christofolletti, M., Wollgast, J., Bruns, H., Dessart, F.J., Marandola, G. and Van Bavel, R., Front-of-pack nutrition labelling schemes: an update of the evidence, EUR 31153 EN, Publications Office of the European Union, Luxembourg. Available at: [Link](#)

<sup>171</sup> Rationale: FOPNL on prepacked foods has a broader impact / is more visible than only menu labelling; therefore, only menu labelling should not be indicated as "fully implemented".

<sup>172</sup> BE, HR, DK, FI, FR, DE, IT, LT, LU, NL, SI, SE and UK.

<sup>173</sup> Ministère de la Santé et de la Prévention. (2017). Nutri-Score : un étiquetage nutritionnel pour favoriser une alimentation équilibrée. Available at : [Link](#)

<sup>174</sup> Swedish Food Agency. (n.d.). The Keyhole. Available at: [Link](#)

<sup>175</sup> Croatian Institute for Public Health. (2016). "Living Healthy" logo. Available at: [Link](#)

<sup>176</sup> European Parliament. (2020). Nutrition labelling schemes available in Member States. Available at: [Link](#)

<sup>177</sup> Heart symbol. (n.d.). Heart Symbol: A Better Choice. Available at: [Link](#)

<sup>178</sup> England Department of Health, Food Standards Agency UK, Welsh Government, Food Standards Scotland. (2016). Guide to creating a front of pack (FoP) nutrition label for pre-packed products sold through retail outlets. Available at: [Link](#)

<sup>179</sup> NutriForm Battery. (2017). Available at: [Link](#)

<sup>180</sup> CY, CZ, EL, HU, PL, RO, SK

<sup>181</sup> AT, BG, EE, LV, M,T, PT, ES

adopted national taxation measures on products contributing significantly to population intakes of added/free sugars, saturated fat (excluding trans– fat) and/or salt, or those not adhering to nutritional guidelines, with nine of these countries adopting taxation policies after 2014 (BE, HR, DK, FI, FR, HU, IE, LV, PL, PT, RO, ES and UK). Most national taxation policies focus on products high in sugar (e.g. taxation of sugar-sweetened beverages which contribute a lot to the intake of free sugars). In Hungary, the tax also applies to other specific products, including excessively salty snacks,<sup>182</sup> whilst in Denmark there is a tax specifically on ice cream and chocolate.<sup>183</sup> More than half of the countries (53% - 15 out of 28) currently lack taxation policies on unhealthy foods, and ten of these are planning to introduce taxation measures in upcoming years.

Since the implementation of the EU Action Plan, progress has been limited in terms of providing **subsidies** for healthy foods. These policies encompass various measures such as vouchers, coupons or reductions to Value Added Tax (VAT) for fruits, vegetables, whole grains, lean proteins, and other healthy options (foods low in fat, sugar and salt). The EU School Fruit and Vegetable Scheme and the EU School Milk Scheme are excluded from this key topic. Only the United Kingdom and Latvia fully implemented subsidies or initiatives to increase access to healthy foods after the implementation of the EU Action Plan. In Latvia, all food products are taxed at 21%, with exceptions made for fruit and vegetables which were initially taxed at 5%. However, in 2022, the rate of products taxed at 5% increased to 12%. In four countries implementation is partial (DK, LU, PT and ES). In Denmark, subsidies are only provided for plant-based foods since 2021 in order to support the green transition.<sup>184</sup> Portugal<sup>185</sup> and Spain<sup>186</sup> adopted, in response to increases in food prices, lower VAT rates, yet national authorities from both countries reported that currently there is no other policy to make healthy foods more affordable to families. Luxembourg opened in 2009 the “Social grocery shops for disadvantaged groups”<sup>187</sup> with the aim of fighting exclusion by offering fresh, high–quality food to people affected by poverty, at discounted prices, yet there are only a few shops with this offer across the country. In 17 countries (60%) there are no available subsidies and affordability initiatives to support low-income families, and according to national authorities, new policies are only planned in Finland.

**Promoting safe drinking water** in schools and other public places is a measure that partly aims at reducing the consumption of sugar-sweetened beverages. The country profiles showed that currently, nine countries (32%) have adopted policies to promote safe drinking water, and seven of them adopted new policies or updated their measures after 2014. Countries have adopted different approaches to

---

<sup>182</sup> The tax applies to: pre-packaged sweetened products such as sweets, biscuits, confectionery products, bakery products and cocoa-containing products; soft drinks with added sugar; fruit jams and similar sweetened preserves; flavoured beer with added sugar; “alcopops” (alcoholic soda beverage); alcoholic beverages; energy drinks; and excessively salty snacks. Source: [Link](#)

<sup>183</sup> European Commission, European Health and Digital Executive Agency. (2022). SC 2097106, Mapping of pricing policies and fiscal measures applied to food, non-alcoholic and alcoholic beverages: final implementation report, Publications Office of the European Union. Available at: [Link](#)

<sup>184</sup> The Plant Foundation. Available at: [Link](#)

<sup>185</sup> Diário da República. (2023). Lei n.º 17/2023, de 14 de abril. Available at: [Link](#)

<sup>186</sup> Agencia estatal boletín oficial del estado. (2024). Real Decreto-ley 4/2024, de 26 de junio, por el que se prorrogan determinadas medidas para afrontar las consecuencias económicas y sociales derivadas. Available at: [Link](#)

<sup>187</sup> Caritas. (n.d.). Social Grocery Shops. Available at: [Link](#)

address this key topic. The most common are measures in schools in the form of campaigns to promote drinking water (e.g. AT, BE, HU, LU, NL, PL, PT, SI) or specific sections within the legislation on standards for school caterings (e.g. EE, LT, DE, MT, UK). In seven countries measures are partially implemented because they are only adopted in some regions or national campaigns are in place to promote freshwater intake, without an accompanying improvement of drinking areas/facilities. In the Netherlands, the Association of Dutch Catering (Veneca) signed a voluntary agreement in 2018 to ensure that water is available free of charge in restaurants.<sup>188</sup> That same year, the Ministry of Health launched a grant program to subsidise the installation of water taps in schools, promoting easy access to free drinking water for students.<sup>189</sup> By 2021, approximately 900 water taps had been installed in schools across the country, contributing to efforts to encourage healthy hydration habits and reduce the consumption of sugary drinks among children. In Denmark, Prevention Package – Food and Meals (2018)<sup>190</sup> support the municipality's work on promoting healthy habits, and one of the lines of work includes that access to fresh water should be established.

**Encouraging nutritional training for staff** working in restaurants and cafes, as well as **food producers**, is important to ensure appropriate portion sizes for children and to encourage the use of healthy recipes and servings, yet few countries have adopted measures on this topic. This does not include training for school canteen staff. Most countries (82% - 23 out of 28) do not have initiatives in place to train food producers and providers, yet Portugal and Slovenia are planning to adopt measures in the future. Hungary and the Netherlands have some initiatives in place, but they do not comprehensively cover all areas or sectors. An illustrative example is found in the Netherlands, where in 2018, a training module was implemented for 750 retail employees on healthy eating, food composition, and how to make products healthier.<sup>191</sup> Since the inception of the EU Action Plan, only Denmark fully implemented this key topic. The Danish Food Partnership for Health and Climate<sup>192</sup> since 2019 has arranged 'lunch & learn' activities for partners including food providers and producers. Topics covered are e.g. Food Based dietary guidelines and reformulation.<sup>193</sup>

#### 4.1.8 Area 4: Restrict marketing and advertising to children

To tackle overweight and obesity in children and young people, the Action Plan stresses the importance of addressing the issue of marketing foods high in fat, sugars and salt targeting those age groups. Area 4 relates to policies that restrict marketing and advertising to children, e.g. through mandatory or voluntary restrictions and the prohibition of marketing food and drink high in fat, sugar and salt

---

<sup>188</sup> VENECA. (2018). Strategies follow from Healthy Company Restaurant survey. Available at: [Link](#)

<sup>189</sup> Reported by national authorities during consultation activities. No link provided.

<sup>190</sup> Danish Health Authority. (2018). Prevention package – Food and Meals. Available at: [Link](#)

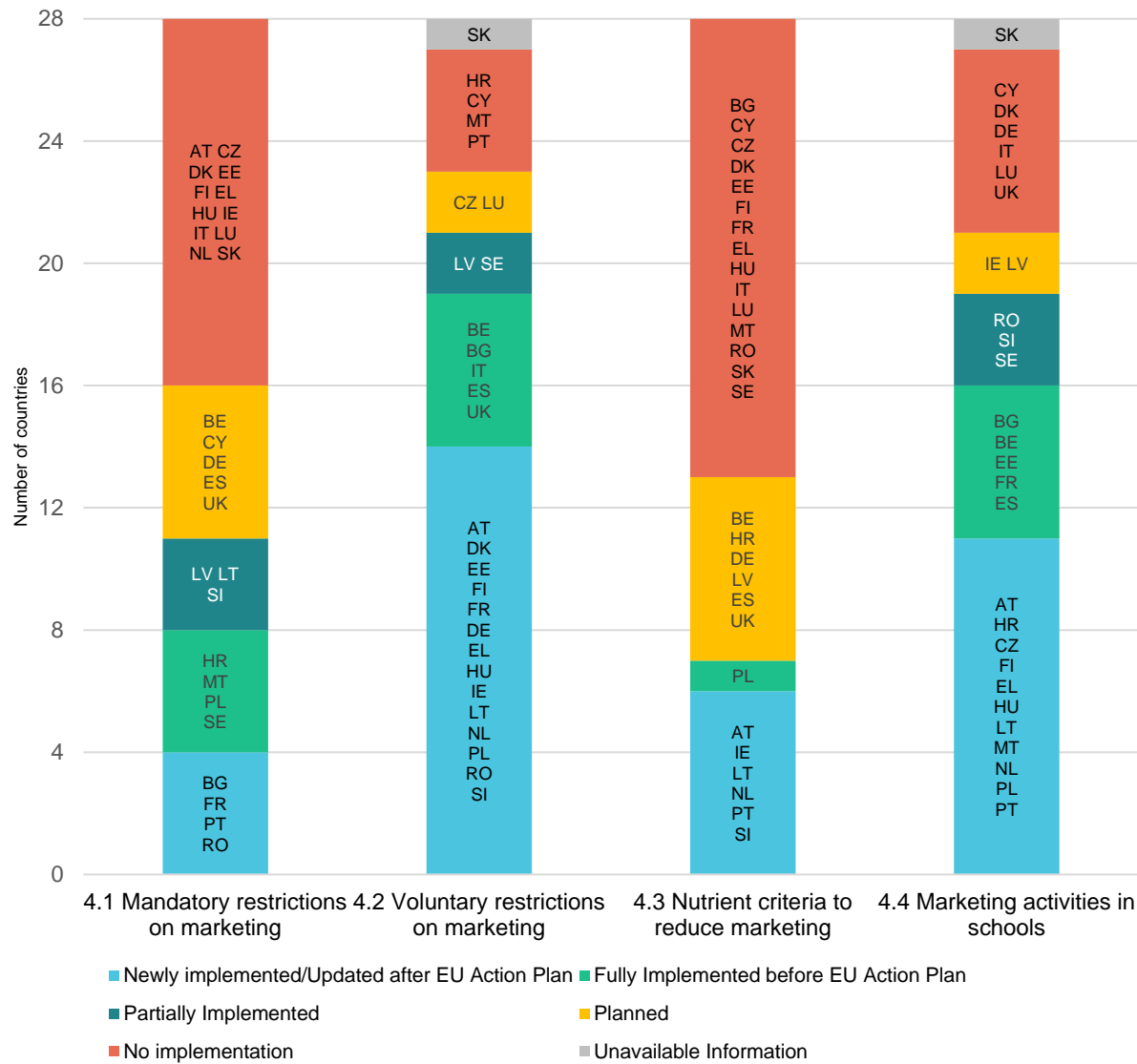
<sup>191</sup> Ministry of Health. (2018). National Prevention Agreement 'Nationaal Preventie Akkoord'. Available at: [Link](#)

<sup>192</sup> Danish Veterinary and Food Administration (2019). Danish Food Partnership for Health and Climate. Available at: [Link](#)

<sup>193</sup> Reported by national authorities during consultation activities. No link provided.

(HFSS) in schools. This can include the consolidation of nutrition criteria or nutrient profiles to enable the classification of food and drink products to determine if they are unhealthy (HFSS) and therefore need to be restricted from being advertised to children. Figure 19 depicts the progress achieved by Member States and the UK towards implementing key topics under Area 4. The most commonly adopted topic for Area 4 is the voluntary restriction on marketing.

Figure 19 – Overview of implementation of EU Action Plan for Area 4



Source: Authors' elaboration

**Mandatory restrictions on marketing to children** legally require producers to restrict the promotion of unhealthy foods (food that does not fit the nutrient criteria to be marketed) during children's television programming or other advertising channels. These restrictions are legally binding and actively enforced, reducing children's exposure to unhealthy food and drink marketing. The policy can be considered "fully implemented" regardless of whether legislation considers internet and social media restrictions. The country profiles show that eight countries (28%) have enacted legally binding legislation on this key topic, with four after the EU Action Plan. An example of a mandatory ban is in Portugal, where in April 2019, "Law No. 30/2019"<sup>194</sup> was introduced to restrict food advertising of products high in energy, salt, sugar, and fats to children under 16. Another example is in France, where the Gattolin law (2016)<sup>195</sup> aims at protecting young audiences from the pervasive influence of commercial advertising on public television. The law targets explicitly programs broadcast for children, with the intent to mitigate the impact of advertising, which is believed to contribute to issues such as childhood obesity. Four countries have implemented policies partially where restrictions apply only to specific products or policies are not comprehensive enough. For instance, in Latvia<sup>196</sup> and Lithuania,<sup>197</sup> marketing restrictions only apply to energy drinks. In 17 countries (60%), no measures are adopted, yet in five of them (BE, CY, DE, ES, UK), national authorities report that measures are planned.

In contrast, some countries have implemented **voluntary restrictions**, which involve self-regulated agreements with industry in response to public concern. The policy can be considered "fully implemented" regardless of whether the agreement considers internet and social media restrictions. The country profiles show that 19 countries (68%) have voluntary agreements to restrict advertisements of unhealthy food and drinks to children, with 14 of them implementing new measures or updating existing ones since the inception of the EU Action Plan. The EU Pledge<sup>198</sup> is a voluntary initiative led by food and beverage companies in Europe aimed at limiting the advertising of foods and drinks to children under 13 years old. Launched in 2007, it seeks to address concerns about childhood obesity by ensuring that advertising for products high in sugar, salt, or fat is not targeted toward young audiences unless the product meets specific nutritional criteria (see Annex IX: Good practices). Belgium<sup>199</sup> and Greece<sup>200</sup> developed their national versions of the EU Pledge in 2012 and 2022, respectively. Another illustrative example is the Hungarian Code of Advertising Ethics (2015),<sup>201</sup> which stipulates voluntary indirect restrictions on marketing unhealthy foodstuffs to children by focusing on fair and adequate marketing principles. The implementation is regarded as partial in Latvia and Sweden, as the agreements are restricted to certain types of

<sup>194</sup> Diário da República. (2019). Lei n.º 30/2019, de 23 de Abril. Available at: [Link](#)

<sup>195</sup> Legifrance. (2016). LOI n° 2016– 1771 du 20 décembre 2016 relative à la suppression de la publicité commerciale dans les programmes jeunesse de la télévision publique (1). Available at : [Link](#)

<sup>196</sup> Parliament. (2016). Law on the Circulation of Energy Drinks. Available at: [Link](#)

<sup>197</sup> Database of the Parliament of the Republic of Lithuania. (2015). Law on Advertising. Available at: [Link](#)

<sup>198</sup> EU Pledge. (2024). About the EU Pledge. Available at: [Link](#).

<sup>199</sup> Belgian Advertising Ethics Jury. (2012) Belgian Pledge. Available at: [Link](#)

<sup>200</sup> Federation of Hellenic Food Industries. (2023). The Greek Pledge: a voluntary initiative to change food advertising to kids. Available at: [Link](#)

<sup>201</sup> National organisation of marketing communication. (2015). The Hungarian Code of Advertising Ethics. Available at: [Link](#)

beverages: soft drinks in Latvia and energy drinks in Sweden. Regarding voluntary marketing restrictions, six countries (21%) have not implemented this key topic, while in two of them (CZ, LU), voluntary agreements are planned according to national authorities.

Country profiles show that 25 countries (89%) have implemented voluntary or mandatory measures, or both, to regulate advertising to minors. Cyprus, Czechia, and Luxembourg are the only exceptions, as they do not have any such schemes in place. In contrast, Bulgaria, France, Poland, and Romania have implemented both schemes, with voluntary measures often preceding mandatory regulations. For example, in Bulgaria, the Framework for Responsible Commercial Communication of Food and Drinks (2010)<sup>202</sup> was introduced first, bringing together private food industry stakeholders to establish voluntary guidelines to limit the advertising of unhealthy foods and drinks to children. This was followed by the 2018 Food Act,<sup>203</sup> which mandates restrictions on advertising and marketing unhealthy foods—including genetically modified foods—to children across television, print, and online media.

Establishing **nutrient criteria** is a valuable tool for countries as it allows for classifying food and drink products and helps determine if foods are unhealthy and should be restricted from being advertised to children. For this key topic to be considered “fully implemented” countries must have implemented criteria at national level. Out of 25 countries that have either mandatory or voluntary measures, seven (28%) have adopted a nationally developed nutrient criterion for marketing purposes, with six of them having updated or introduced new criteria since the inception of the EU Action Plan. For instance, Austria developed in 2012, the Austrian Nutrient Profile for the Guidance of Food Advertising to Children in Audiovisual Media (2021).<sup>204</sup> The nutritional profile was tested using the food database “Food in the Spotlight”<sup>205</sup> and adapted to the Austrian product range. It is free to use on a voluntary basis. According to the country profiles (Annex VI: Country profiles), some countries utilise nutrient criteria established by international bodies, such as the WHO Nutrient Profile Model (WHO NPM), to regulate advertising. While certain countries have adapted these criteria to their local contexts (e.g. PT, SI) and others plan to do it in the future (e.g. DE, ES), others have implemented them without modification (e.g. EE).

**Marketing prohibitions on school premises** and other places for children (e.g. sports clubs, recreational spaces) is an increasingly popular measure in Member States, but many countries still lack legislation or voluntary agreements with industry. The country profiles reveal that 16 countries (57%) have adopted measures, with 11 introducing new or updated measures since 2014. Approaches to addressing this issue vary across countries. Some countries integrate schools into broader voluntary agreements with industry (e.g. BE, HR, EL, NL, HU) or establish voluntary agreements targeting schools (e.g. FI). In 2021, the Finnish Competition and Consumer Authority released guidelines to inform businesses about how to operate within the limits set by consumer protection law concerning schools, educational institutions, and early childhood education.<sup>206</sup> Others implemented mandatory regulations, either through school catering

---

<sup>202</sup> National Council for Self-regulation. (2010). Framework for responsible commercial communication of food and drinks. Available at: [Link](#)

<sup>203</sup> Bulgarian Parliament. (2018) Food act. Available at: [Link](#)

<sup>204</sup> BMSGPK. (2021). Österreichisches Nährwertprofil zur Lenkung von Lebensmittelwerbung an Kinder in Audiovisuellen Medien. Available at: [Link](#)

<sup>205</sup> AGES. (2018). Lebensmittel unter der Lupe. Available at: [Link](#)

<sup>206</sup> Finnish Competition and Consumer Authority. (2021). Marketing and commercialism in schools, educational institutions and early childhood education. Available at: [Link](#)

regulations (e.g. CZ, EL, LT, MT, PL, ES), marketing restrictions specific to schools (e.g. AT), broader regulations covering educational institutions (e.g. HR, HU), or more extensive marketing regulations (e.g. EE, FR, PT, HU). Some countries combine voluntary and mandatory schemes (e.g. EL, HR, HU). In Greece, the School Canteen Hygiene Rules and Product Regulations (2013)<sup>207</sup> prohibit the marketing or advertising of any products not listed in the policy. Additionally, the Greek Pledge (2022)<sup>208</sup> further restricts food and beverage advertising in primary schools, except when specifically requested by or agreed upon with the school administration for educational purposes. Four countries have partially implemented this key topic, as efforts have been made to restrict the marketing of foods and drinks. Nonetheless, coverage is limited as restrictions only apply up to certain grades or children's spaces such as sports clubs or recreational areas (RO, SI) and national authorities report that adoption has not been successful (SE). Implementation is missing in eight countries (28%), out of which two are planning to adopt new measures. Some countries have measures that address children's advertisement (key topics 4.1 and 4.2) but do not have measures on school specifically (DK, DE, IE, IT, UK), leaving a gap in the protection of children against advertisement practices.

#### 4.1.9 Area 5: Inform and empower families

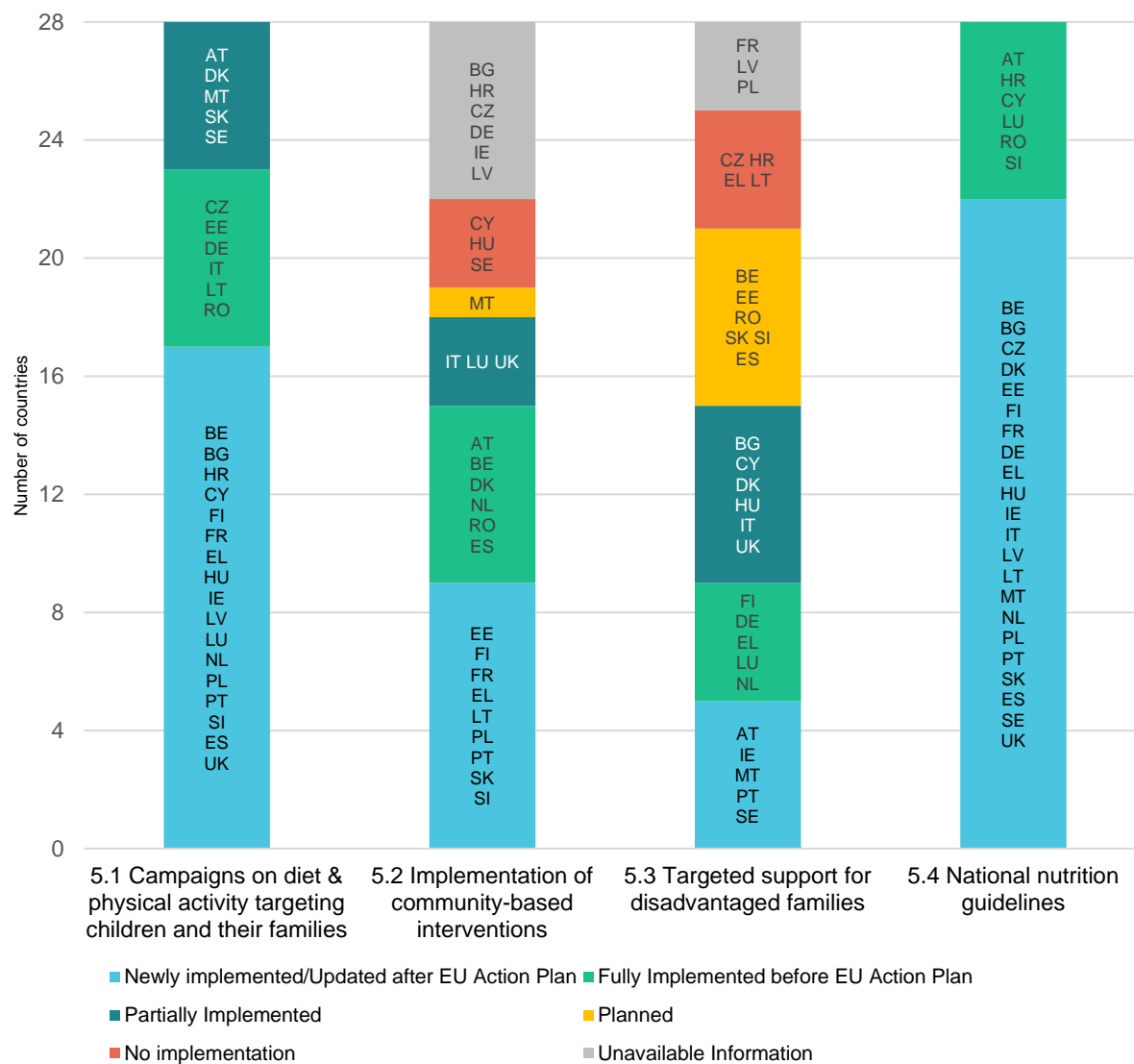
The Action Plan recognises that families are crucial in shaping lifelong preferences and health behaviours. Area 5 deals with informing and empowering families to lead healthier lifestyles by improving nutrition and engaging in physical exercise, e.g. through campaigns, community-based interventions, and targeted support to disadvantaged families. Furthermore, it underscores the importance of making nutritional information more useful, accessible and easily understandable. Figure 20 shows the progress achieved by Member States and the UK towards implementing key topics under Area 5. This Action Area is the most frequently addressed within the EU Action Plan; however, fewer than half of the countries report fully implementing targeted support measures for disadvantaged families.

---

<sup>207</sup> Governmental Gazette. (2013). Hygiene Rules for School Canteens and Kiosks (Permanent), Dining Areas within Schools, and Specification of Products Offered by Them in Public and Private Primary and Secondary Schools – Article 9. Available at: [Link](#)

<sup>208</sup> Federation of Hellenic Food Industries. (2023). The Greek Pledge: a voluntary initiative to change food advertising to kids. Available at: [Link](#)

Figure 20 – Overview of implementation of EU Action Plan for Area 5



Source: Authors' elaboration

Countries have achieved significant progress in adopting national **campaigns focusing on diet and physical activity** since the implementation of the EU Action Plan. These campaigns are crucial tools to inform individuals about nutrition and physical activity. This key topic is considered fully implemented if countries have implemented at least one successful national campaign to educate and support families in making healthy choices and promoting physical activity. Out of 28 countries, 17 have implemented new policies or updated existing ones since 2014, while six had policies in place before 2014. While some countries have independent initiatives that focus on diet and physical activity (e.g. BE, NL, PT, UK), other countries have comprehensive campaigns that cover both (e.g. IT, IE, LU, PL, RO, SI, ES). For example, in Portugal, in 2019 two separate campaigns the “Eating better, a recipe for life” (2019)<sup>209</sup> and “Physical activity is calling you” (2019)<sup>210</sup> were adopted. On the other hand, in Ireland, from 2012 to 2016, the Let's Take on Childhood Obesity campaign<sup>211</sup> aimed at reducing childhood obesity and addressed parents of children aged 2-12. The campaign urged parents to make practical changes to everyday lifestyle habits, which would greatly benefit their children's future health. All countries have adopted some form of campaigns on a diet or physical activity. Yet, in five countries, implementation is partial as the identified campaigns might only focus on diet (AT, DK, MT, SK) or on physical activity (SE).

Addressing obesogenic environments requires concerted efforts involving multiple stakeholders, including schools, supermarkets, and families. In total, 15 countries (53%) have implemented nationwide **community-based interventions** that provide valuable and accessible resources, guidelines, and incentives to encourage these stakeholders to actively participate in obesity prevention efforts, with nine countries introducing new or updated interventions since 2014. An illustrative example is the Netherlands, which implemented the Jongeren Op Gezond Weight (JOGG) programme (2010)<sup>212</sup> and the Amsterdam Healthy Weight Approach (AHWA) (2012).<sup>213</sup> Both programmes aim to reduce the prevalence of childhood overweight and obesity via a “Health in All Policies” approach. Accomplishing this involves a range of stakeholders from both the local public authorities and the private sectors. In three countries (LU, IT, UK), implementation is considered partial, as some measures are in place, but coverage is limited, with only a few regions having adopted such initiatives. In four other countries, national authorities have confirmed the absence of community-based interventions; however, Malta has indicated plans to adopt a program in the future.

The EU Action Plan stresses that countries should support **disadvantaged families** in making healthy choices by ensuring that healthy options are readily available, accessible, and affordable. Measures to help disadvantaged families do not include providing free school

---

<sup>209</sup> Vidaativa. (2019). “Comer melhor, uma receita para a vida”: DGS promove alimentação saudável. Available at: [Link](#)

<sup>210</sup> Silva, M. N., et al. (2020). “Follow the Whistle: Physical Activity Is Calling You”: Evaluation of Implementation and Impact of a Portuguese Nationwide Mass Media Campaign to Promote Physical Activity. *International journal of environmental research and public health*, 17(21), 8062. Available at: [Link](#)

<sup>211</sup> CHORDIS. (2017). Let's Take on Childhood Obesity – The Childhood Overweight and Obesity on the Island of Ireland campaign Ireland. Available at: [Link](#)

<sup>212</sup> OECD. (2022). Healthy Eating and Active Lifestyles: Best Practices in Public Health. OECD Publishing. Available at: [Link](#)

<sup>213</sup> Municipality of Amsterdam. (n.d.). Amsterdam Healthy Weight Programme. Available at: [Link](#)

meals to low-income students in schools. Nine countries (32%) have implemented policies, strategies, or initiatives to address this key topic, with five of them after 2014. In Ireland, the Sláintecare Healthy Communities (SHC) Programme (2021)<sup>214</sup> provides targeted health and well-being services in 19 deprived community areas across Ireland. It aims to address social deprivation and inequalities by linking people to clinical services and local programmes. As part of the programme, a food and nutrition officer has been established in each Healthy Community. They organise local cooking groups, food parcels, and physical activity education programmes. In Portugal, the Operational Programme to Support the Most Deprived (POAPMC) (2017)<sup>215</sup> provides food assistance to over 80,000 people across various regions, ensuring half of their daily nutritional needs are met. Working with the National Programme for the Promotion of Healthy Eating (PNPAS), it aligns with Portugal's dietary guidelines, the “Roda dos Alimentos”.<sup>216</sup> In six countries, adoption is partial as there are only some measures in place. Still, coverage is limited, with only a few regions having adopted such initiatives or measures focusing only on one aspect of childhood obesity (BG, CY, DK, HU) or specific populations (IT, UK). In ten countries (35%), there are no measures in place to support disadvantaged families; however, in six, there are plans to adopt new policies.

**Nutritional guidelines** help promote health by setting evidence-based recommendations on dietary patterns for the public or specific demographic groups. Currently, all countries have national dietary guidelines. Out of these, 22 countries have either updated or implemented new guidelines since 2014. While some countries have developed specific documents outlining nutritional guidelines for children (e.g. FR, CY, EL, IE), in other countries, recommendations for children are part of the broader population guidelines (e.g. BE, BG, CZ, DK, EE, SK, DE). Moreover, there is diversity in the age ranges that countries select to show nutrition guidelines. While guidelines in Luxembourg are provided for three distinct age groups—little infants (13 to 36 months),<sup>217</sup> infants (3 to 12 years),<sup>218</sup> and adolescents (13 to 18 years)<sup>219</sup>—other countries, such as England, define a broader age range that spans from 1 to 18 years.<sup>220</sup> Furthermore, there are different ways dietary guidelines are provided, for instance, using a food pyramid (e.g. AT, RO, PL) or a food wheel (e.g. PT). Some countries specifically mention adapting their nutritional recommendations to local diets, such as Portugal<sup>221</sup> and

---

<sup>214</sup> HSE. (2021). Sláintecare Healthy Communities. Available at: [Link](#)

<sup>215</sup> Po APMC. (2017). Quem somos. Available at: [Link](#)

<sup>216</sup> Direção-Geral da Saúde. (2016). Food-based dietary guidelines. Portugal. Available at: [Link](#)

<sup>217</sup> GIMB. (n.d). Besoins nutritionnels de chacun - Petite enfance (12-36 mois). Available at: [Link](#)

<sup>218</sup> GIMB. (2013). Manger et bouger entre 3 et 12 ans. Available at: [Link](#)

<sup>219</sup> GIMB. (n.d). Besoins nutritionnels de chacun - Adolescent. Available at: [Link](#)

<sup>220</sup> Public Health England. (2016). Government Dietary Recommendations. Available at: [Link](#)

<sup>221</sup> Direção-Geral da Saúde. (2016). Food-based dietary guidelines. Portugal. Available at: [Link](#)

Malta<sup>222</sup> to the Mediterranean Diet. Other countries such as Germany,<sup>223</sup> Spain<sup>224</sup> and Sweden<sup>225</sup> have updated their nutritional guidelines to integrate sustainability objectives.

#### 4.1.10 Area 6: Encourage physical activity

Physical activity plays a vital role in maintaining good health and preventing obesity. Area 6 relates to policies that encourage physical activity, e.g. through improving infrastructure for physical activity where children can do extracurricular sports, ensuring safe, easy and active mobility, and communicating national physical activity guidelines. All countries have implemented at least one approach to encourage physical activity among children, which may include physical activity campaigns or the endorsement of physical activity guidelines. Figure 21 depicts the progress achieved by Member States and the UK towards implementing key topics under Area 6.

---

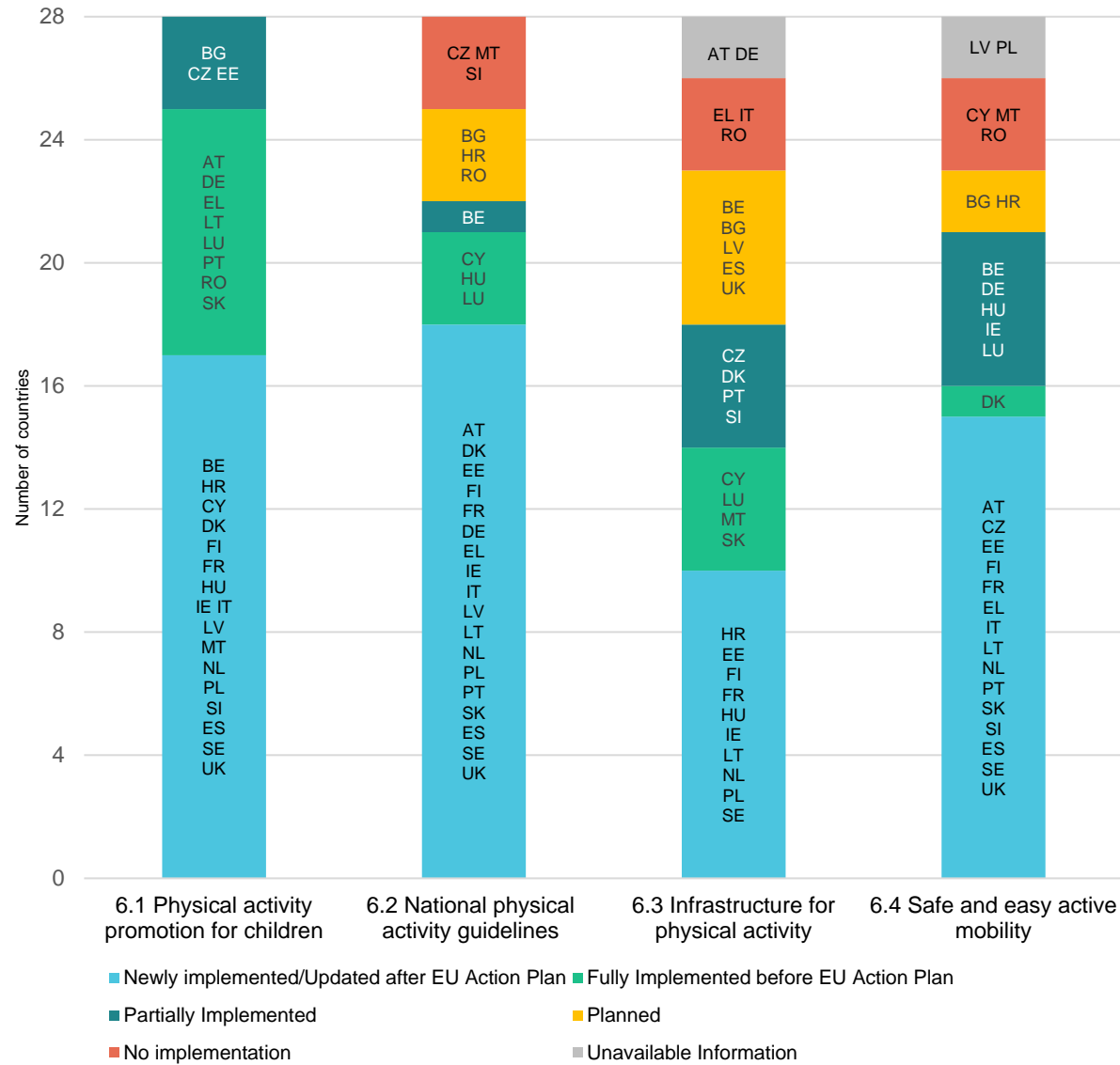
<sup>222</sup> Ministry of Health. (2015). Dietary Guidelines for Maltese children- Healthy eating the Mediterranean way! Available at: [Link](#)

<sup>223</sup> Schäfer, A. C., et al. (2024). Wissenschaftliche Grundlagen der lebensmittelbezogenen Ernährungsempfehlungen für Deutschland. *Ernährungs-Umschau*, 71, M158-66. Available at: [Link](#)

<sup>224</sup> Ministerio de sanidad. (2022). Recomendaciones dietéticas saludables y sostenibles. Available at: [Link](#)

<sup>225</sup> Swedish Food Agency. (2015). Swedish Dietary Guidelines. Available at: [Link](#)

Figure 21 – Overview of implementation of EU Action Plan for Area 6



Source: Authors' elaboration

Numerous national initiatives aimed at **promoting physical activity** among children, with a focus on raising awareness and increasing knowledge about its benefits, were identified in the country profiles. Since the inception of the EU Action Plan, 17 out of 28 countries (61%) have either updated or newly implemented policies in this area, while eight countries have continued with pre-EU Action Plan measures. Some countries have introduced specific Action Plans or Strategies to promote physical activity among children (DK, MT, NL, SK, SE). In Malta, the National Policy for Sport in Malta & Gozo (2017– 2027)<sup>226</sup> aims to increase physical activity from preschool to tertiary education, promoting active breaks and increasing sports during and after school hours. Other countries have adopted programs within schools and beyond (e.g. AT, BE, CY, EE, FI, EL, PT). Meanwhile, some countries have launched public health promotion campaigns (e.g. BG, HR, DE, UK, IE). In the UK, the Annual School Sports Week, held yearly since 2008,<sup>227</sup> emphasises the importance of physical education, sport, and play in schools. Schools that register receive free resources, lesson plans, and classroom activities co-designed by young people for young people. In Italy, under the Regional Prevention Plan 2020-2025,<sup>228</sup> municipalities are encouraged to implement programs promoting physical activity for all age groups (children, teenagers, adults, and the elderly), as well as at least one integrated intervention to create and enhance urban environments conducive to an active lifestyle. In three countries, implementation has been partial, with desk research indicating weak implementation (BG, CZ) or that actions have only been adopted in a few regions (EE).

**Physical activity guidelines** play a key role in promoting health by providing evidence-based recommendations for the general public or specific demographic groups. A total of 21 countries (75%) have adopted national physical activity guidelines, with 18 of these countries either updating or newly implementing their guidelines since the EU Action Plan's inception. Some countries have developed specific guidelines for children (e.g. FI, LT, LU, IE, PL), while others include recommendations for children as part of broader population guidelines (e.g. DK, EE, FR, DE, HU). For example, in 2016, Finland adopted recommendations for physical activity in early childhood.<sup>229</sup> These recommendations cover the quantity and types of physical activity suitable for children under eight years old, as well as the influence of physical, psychological, and social environments. Countries also vary in how they address different age groups. While Ireland<sup>230</sup> provides guidelines for three distinct age groups— Infants aged less than a year, children aged 1-2 years, children aged 3 - 4 years, and children and adolescents aged 5-17 years —other countries, such as Slovakia,<sup>231</sup> offer recommendations for the broader age range of 5 to 17 years. Some countries have introduced frameworks to make physical activity guidelines easier for the public to understand. For instance, Flanders (Belgium)<sup>232</sup> and Lithuania<sup>233</sup> use the concept of the physical activity pyramid. However, in Belgium,

<sup>226</sup> Ministry for Education, Youth and Employment. (2016). National Policy for Sport in Malta & Gozo 2017-2027. Available at: [Link](#)

<sup>227</sup> Youth Sports Trust. (n.d.). National School Sports Week. Available at: [Link](#)

<sup>228</sup> Department of Prevention. (n.d.). PP02 – Active Communities. Available at: [Link](#)

<sup>229</sup> Ministry of Education and Agriculture. (2016). Joy, play and doing together – Recommendations for physical activity in early childhood. Available at: [Link](#)

<sup>230</sup> Department of Health. (2024). Every Move Counts – National Physical Activity and Sedentary Behaviour Guidelines for Ireland. Available at: [Link](#)

<sup>231</sup> WHO. (2021). Slovakia Physical Activity Factsheet. Available at: [Link](#)

<sup>232</sup> Institute of Healthy Living. Physical activity triangle. Available at: [Link](#)

<sup>233</sup> Institute of Hygiene. (2018). Pyramid of physical activity for children and adolescents. Available at: [Link](#)

the implementation is partial, as guidelines are only available for the Flanders region. Six countries do not have physical activity recommendations, yet some follow the WHO guidelines on Physical Activity and Sedentary Behaviour<sup>234</sup> (BG, CZ, MT, SI). Three countries (BG, HR, RO) plan to adopt national physical activity guidelines in the future.

The EU Action Plan highlights that it is essential to **improve sports infrastructure** to reduce sedentary lifestyles and increase opportunities for children to be active. These efforts include measures to increase accessibility to safe green spaces for children to engage in sports and other physical activities or increase the number of facilities to practice sports (e.g. sports halls and swimming pools). Some countries have taken proactive steps to enhance their national infrastructure for physical activity. In total, 15 countries (54%) have implemented changes to urban layouts or invested funds to improve physical activity facilities, with ten adopting new policies after 2014. Countries have adopted various approaches to address this key topic. Some have committed funds to build new sports infrastructure or improve existing facilities (e.g. EE, LU, MT, NL, FR, HU, CY, PL). For instance, in Estonia, government funding has been allocated since 2019<sup>235</sup> under the Estonian Sports Policy<sup>236</sup> for the renovation of sports centres and outdoor leisure facilities, such as for ball games. As of 2024, 23 centres out of 30 that applied for the funding have been renovated. Other countries, like Croatia, have focused on providing better sports equipment. In Croatia, the "Polygon for Physical Activity of Schoolchildren" (2014)<sup>237</sup> supplies physical education materials to schools without gym facilities, allowing children to engage in regular physical activity. Other countries, such as Finland and Sweden, have developed guidelines on how to improve the design of schoolyards and sports facilities that meet the needs of different ages and promote exercise for children and young people. Finally, some countries have included infrastructure improvements in broader sports policies (e.g. IE, HU, SK, LT). For example, Hungary, through the National Sports Strategy in 2014, initiated the "National Public Education Infrastructure Development Programme"<sup>238</sup> to create new sports facilities. In the first year of the project, 25 swimming pools and 26 gymnasiums were constructed. In four countries, measures are only partially implemented. These measures target specific populations, such as low-income families in Denmark and Portugal, or focus solely on pre-schools, as in Czech Republic. In Slovenia, while measures exist, they are not comprehensive enough. In eight countries (29%), no measures have been implemented to address this key topic, though five countries have included plans to address it in future policy programs.

The EU Action Plan also advocated for initiatives promoting **safe and easy mobility**, such as providing pavements and pedestrian zones, adequate lighting or improvements to walking and biking infrastructure. Out of 28 countries, 16 (57%) have implemented policies to cover this key topic, with 15 countries doing so after 2014. Country profiles indicate that nations have adopted diverse approaches to address this key topic, from developing guidelines (FI, LT, SI, ES) and launching campaigns (CZ, SI), to introducing new school initiatives

---

<sup>234</sup> WHO. (2021). WHO guidelines on physical activity and sedentary behaviour: at a glance. Available at: [Link](#)

<sup>235</sup> Ministry of Culture. (2022). Estonian Sports Policy 2030 Implementation report 2022. Available at: [Link](#)

<sup>236</sup> Riigi Teataja (2015). Eesti spordipoliitika põhialused aastani 2030. Available at: [Link](#)

<sup>237</sup> Krtalić, S., et al. (2020). Applicability and quality assessment of the set of equipment in the project "Polygon for physical activity of school-aged children "in primary schools without gymnasia. *Kinesiology*, 52(01), 134-142. Available at: [Link](#)

<sup>238</sup> Wolters Kluwer Hungarian Legislation Database. (2014). A Nemzeti Köznevelési Infrastruktúra Fejlesztési Program. Available at: [Link](#)

on active mobility (AT, LT, IT, SI, SE). For instance, Italy adopted in 2015 the Pedibus Scheme,<sup>239</sup> which aims to increase physical activity among children by promoting walking to school. Pedibus functions like a school bus, but children walk in groups accompanied by two adults. Many countries have focused on promoting active mobility by enhancing cycling infrastructure (e.g. CZ, DK, FR, DE, HU, LU, NL, PT, SK, SE). In contrast, others have targeted walking and cycling (NL, PT, SI, ES). The Netherlands launched the City Deal Space for Walking (2021)<sup>240</sup> and City Deal Cycling for Everyone (2023),<sup>241</sup> partnering with local actors to promote walking and cycling. Many of these initiatives align with green agenda objectives (e.g. SE, LT). In five countries, this key topic is only partly implemented, with measures adopted in a few cities/regions (BE, IE), targeting only specific age groups (HU) or being insufficiently comprehensive (DE, LU). This key topic is not yet covered in five countries (18%), though new measures are planned in two countries.

#### 4.1.11 Area 7: Monitor and evaluate

To address childhood obesity, it is essential to have up-to-date, reliable, and comparable data on health indicators, health outcomes and health risk factors. Such data can be collected through national representative surveys, and many countries are also involved in international surveys such as the WHO COSI and HBSC. Figure 21 depicts the progress achieved by Member States and the UK towards implementing key topics under Area 7.

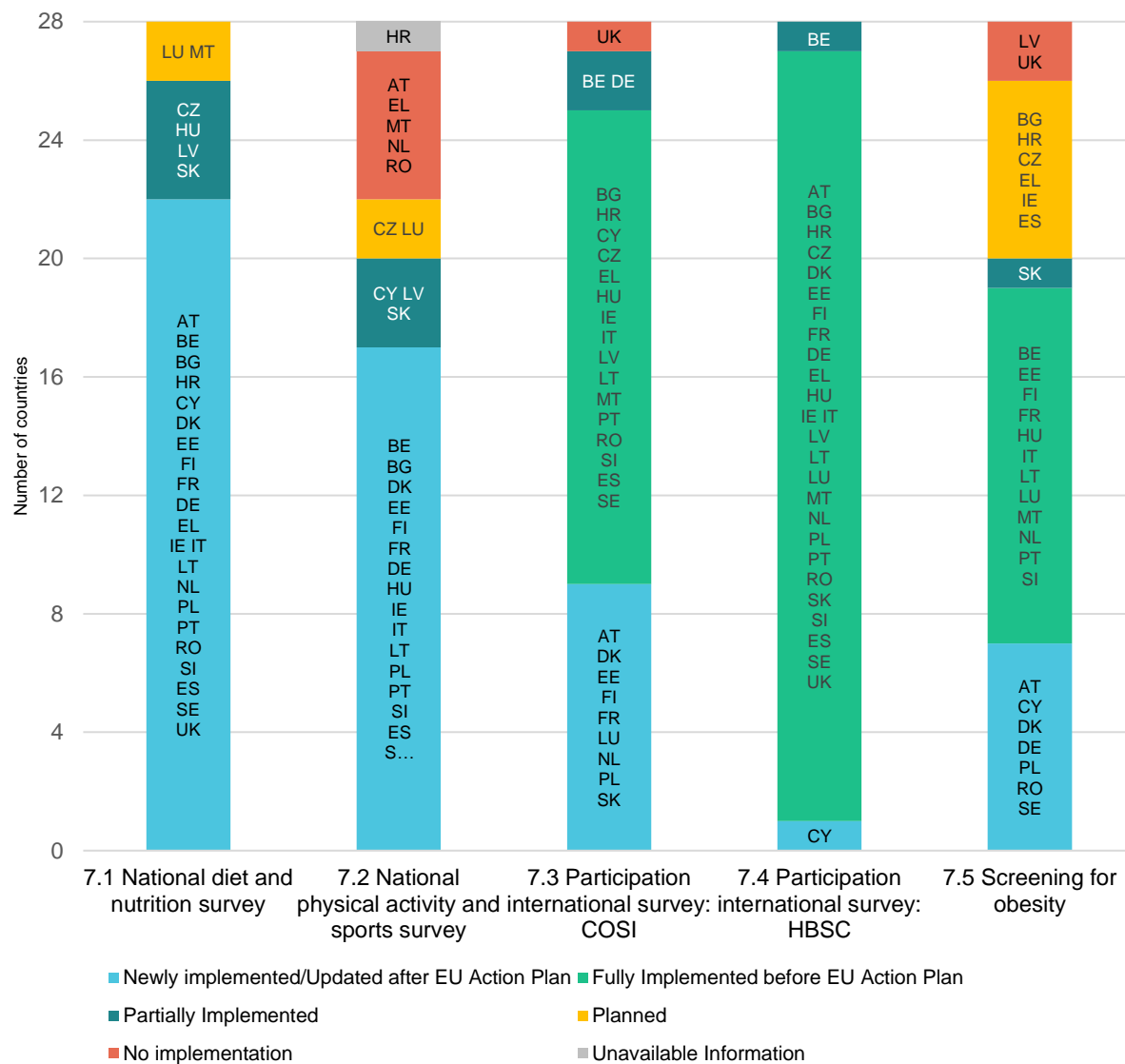
---

<sup>239</sup> Piedibus. (n.a.). The project of Piedibus. Available at: [link](#)

<sup>240</sup> Government Gazette of the Kingdom of the Netherlands. (2021). City Deal Space for Walking. Available at: [Link](#)

<sup>241</sup> Central Government. (2023). Deal text City Deal Cycling for Everyone. Available at: [Link](#)

Figure 22 – Overview of implementation of EU Action Plan for Area 7



Source: Authors' elaboration

Different national diet and nutrition surveys have been identified in country profiles. These tend to cover both adult and child nutrition habits and aim to provide insights into the consumption of foods and the intake of macro– and micronutrients. This key topic can be considered fully implemented if the country has successfully deployed at least one round of a national diet and nutrition survey for the general population (where children are included) or to children since 2014, ensuring that data collection is representative of the entire population. In total, 22 countries (78%) cover this key topic. For instance, The **Croatian national food consumption survey** on children from 3 months to 9 years<sup>242</sup> was conducted between 2017 and 2022, and for adolescents and adults,<sup>243</sup> from 10 to 99 years was conducted between 2018 and 2023. Four countries cover this key topic partially, as the surveys are only implemented regionally (HU), the survey only covers adolescents (SK), or the survey round has not been conducted since 2014 (CZ, LV). Additionally, in Malta and Luxembourg, implementation is planned, as currently they lack a nationally representative diet and nutrition survey for children.

Additionally, **national physical activity and sports surveys** help assess the levels of physical activity in the population and, in some cases, what type of activities people perform. Coverage for a nationally representative physical activity survey is lower than for diet and nutrition surveys. In total, 17 countries (60%) cover this key topic. For example, in France, The National Institute of Youth and Popular Education (INJEP) carried out in 2020, with the Sports Department, a major statistical survey on physical and sporting activities in France.<sup>244</sup> Following the two surveys carried out in 2000 and 2010, the National Survey on Physical and Sporting Practices (ENPPS)<sup>245</sup> is the only source allowing a precise and harmonised description of the population's physical activity patterns. Three countries cover this key topic partially, as the surveys is still in the pilot phase (CY), the survey only covers adolescents (SK), or the survey round has not been conducted since 2014 (LV). Additionally, seven countries (25%) currently lack national physical activity and sports surveys, and only two countries (CZ, LU) plan to adopt one. Some countries merge diet and physical activity surveys (e.g. BG, DK, FI, DE, IT, LT, PT, HU, IE, ES). An illustrative example is “Okkio alla Salute (2008)”<sup>246</sup> from Italy, which is a surveillance programme where anthropometric parameters on the eating habits and physical activity of primary school children (6– 10 years) are systematically collected. In the spring of 2019, more than 50,000 third-grade primary schoolchildren responded to the Okkio alla Salute national surveillance questionnaire.

Participation in surveys such as COSI and HBSC is useful for systematically collecting data across EU Member States, evaluating trends, and facilitating comparisons between countries. The COSI survey collects information on children's Body Mass Index (BMI), while the HBSC survey collects self-reported weight and height and data on dietary and physical activity behaviours. The full participation rate of Member States in the **COSI survey** stands at 89% (25 out of 28 countries). Notably, nine countries have joined the COSI survey since

<sup>242</sup> Sokolić, D., et al. (2022). Croatian national food consumption survey on children from 3 months to 9 years of age. EFSA supporting publications, 19(12), 7724E. Available at: [Link](#)

<sup>243</sup> Sokolić, D. et al. (2024). Croatian national food consumption survey on adolescents and adults from 10 to 99 years of age. *EFSA Supporting Publications*, 21(1), 8577E. Available at: [Link](#)

<sup>244</sup> INJEP. (2020). Les pratiques physiques et sportives en France. Available at: [Link](#)

<sup>245</sup> Ibid.

<sup>246</sup> Ministry of Health et al. (2019). OKkio alla Salute: the results 2019. Available at: [Link](#)

2014. However, in the two countries, participation is partial and limited to specific regions (BE, DE). The UK has never participated in the COSI survey. In contrast, all countries participated in the **HBSC survey**, although only one region of Belgium participated. Cyprus is the only country that has joined the HBSC survey after 2014.

The EU Action Plan calls for an established **individual-based paediatric screening** in Member States to identify and prevent overweight and obesity in children. In a few countries, there are established routine screening programmes for childhood overweight and obesity conducted in primary care or school settings. Children's BMI is calculated based on weight and height during these appointments, and fat fold measurements are taken. According to country profiles, 19 countries (68%) have obesity screening procedures in place, seven establishing the procedures after 2014. In eight countries (AT, HU, LU, MT, PL, RO, SI, SE), screenings occur in the school setting. Denmark<sup>247</sup> and Sweden<sup>248</sup> have developed specific guides for schools to conduct screening for children. In Austria and Sweden, screening can happen in primary care and school settings. Screening is conducted primarily within the primary care system in the remaining countries. In Cyprus, enhanced health services for children between 0 and 6 years old are provided as part of the “National Strategy for Children’s Rights in Health”.<sup>249</sup> This initiative includes conducting screening tests and assessing physical development. The personnel provide individual counselling to students regarding healthy nutrition, specifically focusing on children with weight-related issues.<sup>250</sup> In Sweden, the “Swedish Child Healthcare Services (CHS)”<sup>251</sup> includes universal team-based visits with a nurse and a physician who perform such visits at the age of 4 weeks, six months, 12 months, and 2.5 to 3 years, as well as targeted team-based visits to address additional needs. The 60-minute universal 4-year health visit includes surveillance of the child's health and development and the identification of overweight and obesity by calculating BMI. In eight countries, national authorities confirmed that no effective measures are in place for screening children. However, six of these countries have plans to introduce such measures in the future.

#### 4.1.12 Area 8: Increase research and financial support

The EU Action Plan also calls for improvements in research agendas and funding for childhood obesity. Area 8 encompasses policies intended to increase research and financial support, either through support for national obesity programmes or by participation in European Joint Research Actions or Joint Actions funded through the health work programme to work together on policy proposals and implementation in relation to tackling childhood obesity. Figure 22 depicts the progress achieved by Member States and the UK towards implementing key topics under Area 8.

---

<sup>247</sup> Danish Health Authority. (2014). Tracking overweight and early intervention for children and young people of school age - Guidance for the school health service. Available at: [Link](#)

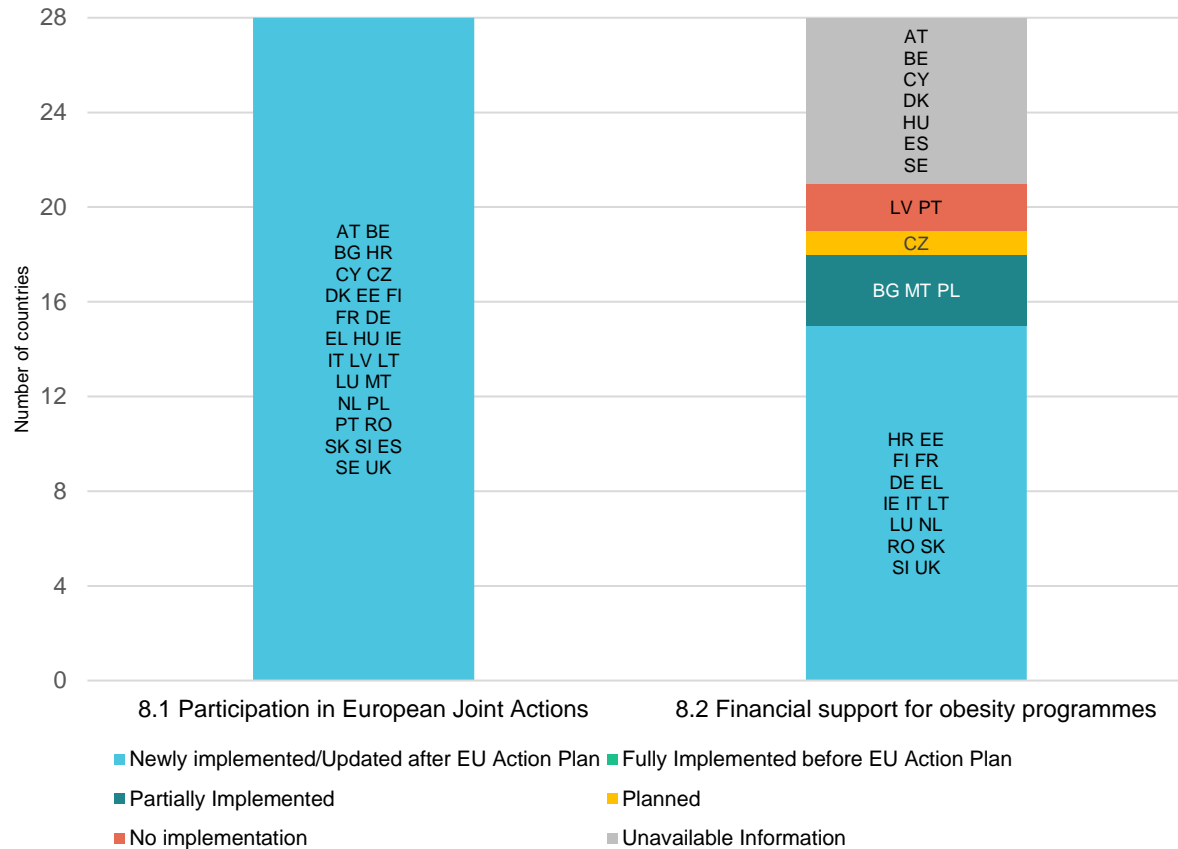
<sup>248</sup> National Board of Health and Welfare. (2014). Guidance for student health. Available at: [Link](#)

<sup>249</sup> Ministry of Health (2017). National Strategy for Children’s Rights in Health. Available at: [Link](#)

<sup>250</sup> Ministry of Health. (2017). Health visitor services. Available at: [Link](#)

<sup>251</sup> Nygren, U. S., et al. (2021). Team-based visits within Swedish child healthcare services: a national cross-sectional study. Journal of interprofessional care, 1-18. Available at: [Link](#)

Figure 23 – Overview of implementation of EU Action Plan for Area 8



Source: Authors' elaboration

All countries participated in at least one **EU Joint Action** addressing the topic of nutrition and obesity. These include the following Joint Actions: Joint Action on Nutrition and Physical Activity (JANPA)<sup>252</sup> from 2015 to 2017, the Joint Action on Health Equity Europe

<sup>252</sup> Joint Action on Nutrition and Physical Activity (JANPA) (2015– 2017). Available at: [Link](#)

(JAHEE)<sup>253</sup> (2018-2021), Joint Action on Chronic Diseases (CHRODIS+) (2017-2020),<sup>254</sup> the Joint Action on Implementation of Validated Best Practices in Nutrition (Best- ReMaP) (2019– 2023)<sup>255</sup> and the Joint Action on Non-communicable Diseases and Cancer (Prevent NCD) (2024-2027).<sup>256</sup>

**Table 15 – Participation in Joint Actions**

Joint Action	Participating countries
JANPA	FR, AT, BE, BG, HR, CZ EE, FI, DE, EL, HU, IE, IT LV, LT, LU, MT, PL PT, RO, SI, SK, ES
JAHEE	UK, IT, EL, DE, IE, BE, SE, ES, CZ, NL, PL, FI, HU, FR, LV
CHRODIS +	ES, HR, FR, DE, EL, HU, IE, IT, BE, LT, MT, NL, SK, SI, BG, FI, PT, PL
Best-ReMap	AT, BE, BG, HR, CY, DK, EE, FI, FR, DE, EL, HU, IE, IT, LV, LT, MT, NL, PL, PT, RO, SI
Prevent NCD	AT, BE, BG, HR, CZ, DK, EE, FI, FR, DE, EL, HU, IE, IT, LT, MT, PL, PT, SL, ES, SE

Source: Authors' elaboration

It is difficult to track **financial support** commitments to childhood obesity programmes. However, the country profiles show that some countries declare some form of financial commitment as part of their obesity or childhood action plans/strategies. More than half (54% - 15 out of 28 countries) report having **funding support for obesity programs** in their strategies or action plans. For instance, Slovenia reported that the funding has increased since the adoption of the EU Action Plan with more funding for Integrated health promotion centres<sup>257</sup> and School of Healthy Lifestyle programme.<sup>258</sup> Implementation is partial in three countries as funding is targeted to measures only addressing physical activity (BG, MT, PL). Czech national authorities reported that funding is planned under new action plans.<sup>259</sup> In three countries, national authorities explicitly reported that funding has not increased since the EU Action Plan. For seven countries information was unavailable, or it could not be confirmed that there is no financial support for obesity programmes.

<sup>253</sup> Joint Action on Health Equity Europe. Available at: [Link](#).

<sup>254</sup> CHRODIS+. Available at: [Link](#).

<sup>255</sup> Best-ReMap. Available at: [Link](#)

<sup>256</sup> Joint Action Prevent Non-Communicable Diseases and Cancer. Available at: [Link](#)

<sup>257</sup> Reported by national authorities during consultation activities.

<sup>258</sup> Children's Hospital in Šentvid pri Stični. (n.d.). School of healthy lifestyle. Available at: [Link](#)

<sup>259</sup> Ministry of Health of the Czech Republic. (2020). Health 2030: Strategic Framework for Healthcare Development in the Czech Republic until 2030. Available at: [Link](#)

## 4.2 Actions by the European Commission and other international organisations

This section provides an overview of the efforts of the European Commission and other several international organisations in tackling childhood obesity in the EU before and after the adoption of the EU Action Plan.

### 4.2.1 European Commission (legislation, Joint Actions, EU-funded projects)

The European Commission's role in the prevention of childhood obesity is multifaceted yet limited by the legal basis for the adoption of health policy measures. Indeed, in the domain of public health, the EU can only intervene through non-binding measures having a supporting function to the actions of the Member States (Article 168, TFEU). Thus, while the organisation and finance of health services and medical care is a Member State competence, the EU can ensure helpful organisation and coordination of measures and provide scientific and technical guidance and financial tools. Nonetheless, the EU has taken a wide range of actions in the areas of prevention, diagnosis and treatment, research and monitoring, and infrastructure and policy to curb the rising prevalence non-communicable diseases, such as obesity. Efforts have been carried out using different policy tools such as regulations, directives, action plans, guidelines, strategies, campaigns and funding Joint Actions and research. Some actions taken by the EU fall beyond health and include food safety, trade, and agricultural policy, as well as financial investments and infrastructural support.

Obesity first entered the EU political agenda under the Commission leadership of José Manuel Barroso (2004-2014) with the **Green Paper on promoting healthy diets and physical activity (2005)**.<sup>260</sup> The green paper pushed for the creation of the **EU Platform for Action on Diet, Nutrition, and Physical Activity (2005)**.<sup>261</sup> The Platform brought together stakeholders from across Europe, all of whom are undertaking actions to improve the health of European citizens. The goal was to “*provide a common forum for all interested actors at the European level where they can share their experiences and plans to contribute to healthy nutrition, physical activity and the fight against obesity*”. The **Strategy on Nutrition, Overweight, and Obesity-related Health Issues (2007)**<sup>262</sup> was implemented to address the issues of overweight and obesity, focusing on reducing risks associated with poor nutrition and limited physical exercise while addressing the issues of health and social inequalities across Member States. In the same year, the European Commission set up the **High-Level Group on Nutrition and Physical Activity (2007)**,<sup>263</sup> which comprised representatives of national governments from all 27

---

<sup>260</sup> European Commission. (2005). Green Paper - "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases". Available at: [Link](#)

<sup>261</sup> European Commission. (n.d.). EU platform for diet, physical activity, and health. Available at: [Link](#)

<sup>262</sup> European Commission. (2007). Nutrition, overweight and obesity — EU strategy. Available at: [Link](#)

<sup>263</sup> European Commission. (n.d.). High Level Group on Nutrition and Physical Activity. Available at: [Link](#)

EU Member States, Norway, and Switzerland. The High–Level Group offered an overview of all government policies on nutrition and physical activity, as well as helped share policy ideas and improved liaison between governments and the EU Platform for Action on Diet, Nutrition, and Physical Activity.

Several key directives and regulations were implemented before 2014, of which some aspects have a direct link with the Areas for Action outlined in the EU Action Plan. These are still in force and include:

- **Regulation 1924/2006 on nutrition and health claims made on foods** (2006)<sup>264</sup> – provides the legal framework used by food business operators when they want to highlight the beneficial effects of their products, in relation to health and nutrition, on the product label or in its advertising (related to Area 3).
- **Directive 2006/141/EC on infant formulae and follow– on formulae** (2007)<sup>265</sup> – lays down compositional and labelling requirements for infant formulae and follow– on formulae intended for use by infants in good health. It also implements the International Code of Marketing of Breast– milk Substitutes dealing with marketing, information, and responsibilities of health authorities (related to Area 1).
- **Directive 2010/13/EU concerning the provision of audiovisual media services** (2010)<sup>266</sup> – ensures the free movement of audiovisual media services within the EU while promoting cultural diversity and consumer protection. The directive also sets out rules on advertising, sponsorship, and product placement in audiovisual media services. The directive addresses the advertising of unhealthy food and beverages in children’s programmes (related to Area 4).
- **Regulation No 1169/2011 on the provision of food information to consumers** (2011)<sup>267</sup> – lays down the general principles governing the right of consumers to information, with particular regard to food labelling. These provisions apply to business operators at all stages of the food chain, where their activities concern the provision of food information to consumers. The

---

<sup>264</sup> Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods. Available at: [Link](#)

<sup>265</sup> Commission Directive 2006/141/EC of 22 December 2006 on infant formulae and follow-on formulae and amending Directive 1999/21/EC Text with EEA relevance. Available at: [Link](#).

<sup>266</sup> Directive 2010/13/EU of the European Parliament and of the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Audiovisual Media Services Directive). Available at: [Link](#)

<sup>267</sup> Regulation (EU) No 1169/2011 of the European Parliament and of the Council of 25 October 2011 on the provision of food information to consumers, amending Regulations (EC) No 1924/2006 and (EC) No 1925/2006 of the European Parliament and of the Council, and repealing Commission Directive 87/250/EEC, Council Directive 90/496/EEC, Commission Directive 1999/10/EC, Directive 2000/13/EC of the European Parliament and of the Council, Commission Directives 2002/67/EC and 2008/5/EC and Commission Regulation (EC) No 608/2004. Available at: [Link](#)

Regulation requires the vast majority of pre-packed foods to bear a nutrition declaration and sets out the rules for front-of-pack nutrition labelling (related to Area 3).

#### 4.2.1.1 Childhood Obesity in the European Commission before 2014

Before 2014, the European Commission had released various measures aimed at addressing obesity. These measures included guidelines, as well as funded research projects related to the issue. Some examples include:

- **CHOPIN project** (2002-2006)<sup>268</sup> – examined whether formula-fed babies were more prone to obesity later in life than their breastfed peers.
- **EU Physical Activity Guidelines** (2008)<sup>269</sup> – guidelines to promote physical activity in the EU by addressing sport, the public health sector, schools, transport and environment, workplace, and senior citizens.
- **I– FAMILY study** (2012-2017)<sup>270</sup> – investigated the determinants and factors influencing dietary and lifestyle choices in European children, adolescents and families, and their impact on lifelong health.
- **EARLYNUTRITION project** (2012-2017)<sup>271</sup> – investigated how early nutrition programming and lifestyle factors impact the rates of obesity and related disorders.
- **SELECTIONPREDISPOSED** (2012-2018)<sup>272</sup> – identified novel obesity-risk genes as tools for the detection of early childhood obesity.

#### 4.2.1.2 Childhood Obesity in the European Commission after 2014

Childhood obesity was not addressed specifically in EU policy until the adoption of the EU Action Plan on Childhood Obesity in 2014. The EU Action Plan includes prescriptions for Member States as well as for the European Commission. Key tasks for the European Commission include:

---

<sup>268</sup> CHOPIN project. Available at: [Link](#)

<sup>269</sup> European Commission: EU Physical Activity Guidelines: Recommended Policy Actions in Support of Health-Enhancing Physical Activity. Available at: [Link](#)

<sup>270</sup> I-FAMILY study. Available at: [Link](#)

<sup>271</sup> Long-term effects of early nutrition on later health. Available at: [Link](#)

<sup>272</sup> Novel Tools for Early Childhood Predisposition to Obesity. Available at: [Link](#)

1. Support and coordinate through the High–Level Group on Nutrition and Physical Activity and the EU Platform for Action on Diet, Nutrition, and Physical Activity. Includes the facilitation of the exchange of information and guidance on best practices.
2. Promote the utilisation of existing instruments (e.g. EU Health Programme).
3. Integrate health into other EU policies (e.g. Common Agricultural Policy).

The European Commission has several instruments to address actions outlined in the EU Action Plan, which include coordination and support measures, and provide scientific and technical guidance and financial tools. Figure 24 illustrates the range of European Commission’s measures implemented that cover Areas for the Action of EU Action Plan. The figure is based on Table 27, in Annex IV, which maps every policy implemented since 2014. A detailed description of every action is available in Annex IV: Description of efforts by the European Commission and international organisations after 2014. Figure 24 shows that either through coordination or/and scientific and technical guidance the European Commission has acted in all Areas for Action of the EU Action Plan. The figure also reflects that many of the efforts from the European Commission are concentrated in Area 5 (Inform and empower families) and Area 6 (Encourage physical activity), related to nutrition and physical activity. Area 8 is not represented in the graph because it focuses on the adoption of Joint Actions and financial support for obesity programs, which are key topics intersecting with other Areas for Action. Instead, these topics have been incorporated into the specific Area for Action (e.g. Joint Action Best-ReMap under Area 3). It is worth mentioning that the graph shows the number of actions adopted, which does not provide information on the size and impact of the interventions in addressing childhood obesity.

- **Coordination and support:** The European Commission has adopted numerous measures to enhance coordination and collaboration among Member States and stakeholders in addressing obesity. However, Areas 1 (Supporting a healthy start to life) and 7 (Monitor and evaluation) have not received as many supporting measures since the inception of the EU Action Plan. Conversely, Areas 5 (Inform and empower families) and 6 (Encourage physical activity) have received substantial policy focus and support. An example of a great coordination measure is the “European Week of Sports”,<sup>273</sup> an EU–wide campaign that encourages participation in sport and physical activity and aims to raise awareness about their numerous health benefits.
- **Scientific and Technical guidance:** The European Commission supports the progress towards reducing childhood obesity by providing their own independent research through the JRC, and financing research programmes and studies. Scientific and technical guidance is provided in each of the Areas for Action of the EU Action Plan, except Area 8. For instance, the JRC “Report on school food and nutrition in Europe (2014)”<sup>274</sup> was a great tool to map food policies that affect children in the EU.

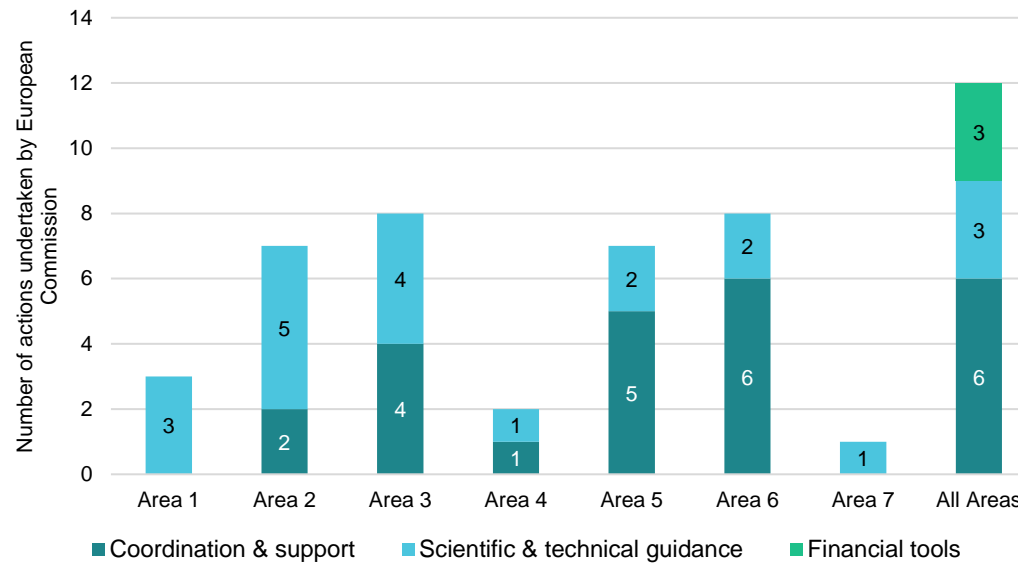
---

<sup>273</sup> European Commission. (n.d.). European Week of Sport. Available at: [Link](#)

<sup>274</sup> Joint Research Centre, Institute for Health and Consumer Protection, Kardakis, T., Storcksdieck genannt Bonsmann, S., Nelson, M. et al., Mapping of national school food policies across the EU28 plus Norway and Switzerland. Available at: [Link](#)

- **Financial Tools:** The European Commission provides funding for EU-wide projects and initiatives via several EU programmes (e.g. EU Health Programme, FP7 and H2020, Erasmus+).

**Figure 24 – Overview of European Commission efforts after 2014**



**Note:** The graph shows the number of actions the European Commission has implemented in each of the Areas for Action of the EU Action Plan since 2014. Area 8 is not represented in the graph because it focuses on the adoption of Joint Actions and financial support for obesity programs, which are key topics intersecting with other Areas for Action. All Areas refer to topics that cover Areas 1 to 7.

Source: Authors' elaboration

## 4.2.2 International organisations

The **WHO** promotes and supports policies that allow people to improve their diet, physical activity, and overall health. The WHO supports the use of WHO-recommended interventions to reduce the obesity epidemic, through the WHO's "Best– Buys".<sup>275</sup> These comprise a total of 88 interventions, including overarching/enabling policy actions, that are considered the most cost-effective interventions in addressing non-communicable diseases, including obesity. Member States have access to this support and guidance; therefore, it is important that efforts from WHO and the European Commission are seen as complementary towards achieving the implementation of EU Areas for Action outlined in the EU Action Plan. Moreover, in 2014, the WHO set up the Commission on Ending Childhood Obesity (ECHO)<sup>276</sup> and published the report on WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases, which might have also influenced the adoption of national policies (2013-2020).<sup>277</sup>

The **OECD** promotes and supports policies that improve the economic and social well–being of people around the world. It offers a forum where governments collaborate to exchange experiences and address shared challenges. This involves, among other activities, analysing and comparing data to anticipate future trends. These insights inform policy recommendations aimed at enhancing people's quality of life.

The **World Obesity Federation** (WOF) is a membership organisation that brings together relevant stakeholders dedicated to solving the problem of obesity. The organisation's main work strands are to improve food systems, improve healthcare systems, and tackle childhood obesity.

The **European Association for Childhood Obesity** (EASO) is a federation of professional membership associations from 36 European countries. It represents professionals working on obesity (scientists, health care practitioners, physicians, public health experts), patients and regional and national obesity organisations from all around Europe.

**Figure 25 is based on**

---

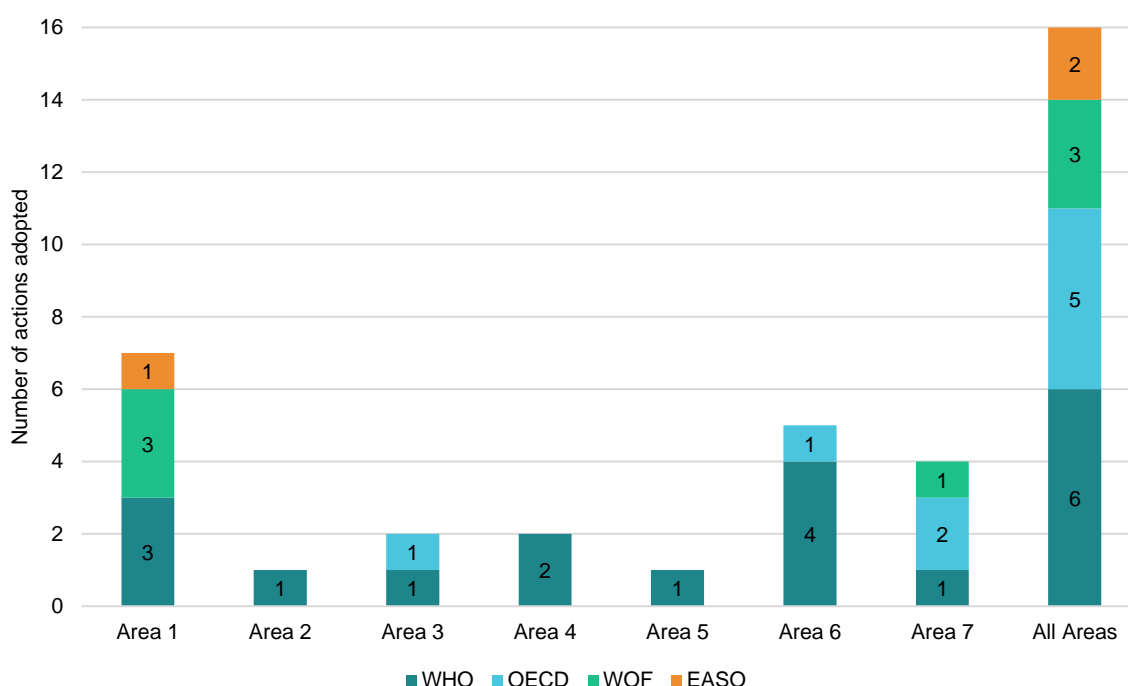
<sup>275</sup> WHO. (2017). Tackling NCD: 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Available at: [Link](#)

<sup>276</sup> WHO. (2016). Report of the commission on ending childhood obesity. Available at: [Link](#).

<sup>277</sup> WHO. (2013). Global action plan for the prevention and control of NCDs. Available at: [Link](#).

Table 28 in Annex IV and shows EU-wide and obesity-related initiatives implemented by WHO, OECD, WOF and EASO. A detailed description of every policy is provided in Annex IV. The figure shows that most of the actions implemented by international organisations are cross-cutting among multiple Areas for Action of the EU Action Plan. Additionally, it shows that international organisations have not implemented, or have very few measures related to Area 2 (promote healthier environments), Area 3 (make the healthy option the easier option), Area 5 (inform and empower families) and Area 8 (increase research and financial support). It is worth mentioning that the graph shows the number of actions adopted, which does not provide information on the size and impact of the interventions in addressing childhood obesity.

**Figure 25 – Overview of efforts from international organisations**



*Note:* The graph shows the number of actions that international organisations have implemented in each of the Areas for Action of the EU Action Plan since 2014. Area 8 is not represented in the graph because it focuses on the adoption of Joint Actions and financial support for obesity programs, which are key topics intersecting with other Areas for Action. All Areas refer to topics that cover Areas 1 to 7.

Source: Authors' elaboration

### 4.3 Current obstacles and challenges to policy implementation

The research shows that across all EU Member States and the UK there are several challenges that impact the ability to halt the rise in childhood obesity. Some of the challenges identified are broad and can be considered cross-cutting, meaning that they are relevant to all the areas of action indicated within the EU Action Plan on Childhood Obesity. These obstacles include the **lack of formal recognition of obesity as a disease, financial constraints, and institutional barriers** related to policy implementation, including **poor intersectoral collaboration** and **weaknesses in healthcare systems**. In addition, challenges that may be considered as specific to individual areas of the EU Action Plan on Childhood Obesity are identified, according to

both the Area(s) for Action they impact and the category of challenge to which they belong.

### 4.3.1 General overview

There is already a vast literature on the challenges in addressing childhood obesity. In 2022, a systematic review conducted at the EU level comprising 78 studies analysed and presented the following examples of challenges/obstacles impeding progress toward addressing the problem of childhood obesity in Europe:<sup>278</sup>

- Challenges related to **Access to Healthcare** – In the form of a lack of a well-trained, adequately skilled healthcare workforce, lack of multidisciplinary teams, insufficient collaboration among sectors, fragmentation of care and inadequate reimbursement.
- Challenges related to **Data and Monitoring** – The irregularity of health and nutrition surveys across many nations makes it difficult to monitor changes in the prevalence of childhood overweight and obesity.
- **Institutional Challenges** – such as slow and inconsistent policy implementation, a lack of multi-sectorial collaboration, and the need for policy adaptation to regional contexts.

Similar reflections were reported in 2023 by the European Association for Childhood Obesity with the MEP Interest Group on Obesity and Health Systems Resilience, which convened a technical working session<sup>279</sup> to discuss how to overcome policy barriers to improve care for people with obesity.<sup>280</sup> The working group identified several additional barriers:

- Challenges related to **Clinical Care** and **Access to Healthcare** – such as poor alignment on guidelines for the diagnosis and treatment of obesity and lack of skilled healthcare professionals due to a lack of adequate training on obesity respectively.
- Challenges related to **Financial aspects** – such as lack of affordable care for those living with obesity and lack of reimbursement for treatment of obesity.

### 4.3.2 Cross-cutting obstacles

Some of the obstacles and challenges identified in this study are not area-specific, but they have impacts that could be considered to span all areas of the EU Action Plan on

---

<sup>278</sup> Chrissini M., Panagiotakos D. (2022). Public health interventions tackling childhood obesity at European level: A literature review. Available at: [Link](#).

<sup>279</sup> The meeting was attended by almost 40 key stakeholders, including members of the European Commission's DG SANTE (Strategy Unit and Health Promotion and Disease Prevention) and DG REFORM, the European Parliament Subcommittee on Public Health (SANT) Secretariat, national policymakers, Patient Rights advocates, legal professionals, Pharma and MedTech industry representatives, scientists, researchers, healthcare professionals. Case studies from Germany, Spain and France as well as further examples from The Netherlands and Belgium were discussed.

<sup>280</sup> European Association for the Study of Obesity. (2023). FLASH REPORT: Overcoming policy barriers to improve care for people living with obesity: EU added value. Available at: [Link](#).

Childhood Obesity. These include the lack of disease recognition, financial challenges and institutional challenges, presented below.

#### 4.3.2.1 Lack of Disease Recognition

A study published by the World Obesity Federation in 2021 indicated that **most EU countries do not recognise obesity as a disease**,<sup>281</sup> but rather as a personal failure. Some national representatives (AT, BE, IE, IT, LU) confirmed this during consultations. According to three consulted EU-level stakeholders, **actions should look beyond diet and nutrition initiatives and treat obesity as a chronic disease**. Representatives of EU-level NGOs participating in a validation workshop organised in the course of the study highlighted that the ICD-11 definition of obesity does not reflect the current knowledge of this disease and that unsystematic definitions entail the possibility that clinicians will not diagnose the respective disease and/or that the diagnosis is deemed clinically irrelevant. Until these definitions are updated, there is no legal competence to act on obesity, only on physical inactivity and nutrition. It is hypothesised that the recognition of obesity as a disease could have several impacts including enhanced public understanding, reduction of stigma, and improvements in prevention, treatment, and education of healthcare professionals.<sup>282</sup> At present, only Portugal (2004),<sup>283</sup> Italy (2019)<sup>284</sup> and most recently Germany (2020)<sup>285</sup> recognise obesity as a disease, although there is a lack of data to demonstrate a benefit from this recognition or an impact on obesity prevalence.<sup>286</sup> In 2021 the EU Commission published a dedicated brief on the prevention of obesity recognising it as a chronic relapsing disease,<sup>287</sup> a definition which according to the EASO represents *“the start of a collaborative drive to effectively address obesity as a chronic relapsing disease that embraces policy interventions that can go beyond primary prevention.”*<sup>288</sup>

#### 4.3.2.2 Financial Challenges

Another challenge is the **lack of funding for obesity prevention, treatment, and management**. This issue has been reported by almost every consulted national representative and also highlighted in the literature concerning several countries such as Bulgaria,<sup>289</sup> Greece<sup>290</sup> and Portugal<sup>291</sup> where **limited financial support is reported for prevention policies**, while in Cyprus<sup>292</sup> and the UK<sup>293</sup> the barrier is described as **uneven**

---

<sup>281</sup> World Obesity Federation. (2021). Health Systems. Available at: [Link](#); Consultations conducted with Ireland and Italy.

<sup>282</sup> Rathbone et al. (2022). How conceptualizing obesity as a disease affects beliefs about weight, and associated weight stigma and clinical decision making in health care. Available at: [Link](#).

<sup>283</sup> ECPO. (2004). Obesity in Portugal. Available at: [Link](#).

<sup>284</sup> OPEN Italy. (2019). Key Achievements. Available at: [Link](#).

<sup>285</sup> EASO. (2020). German Parliament Recognises Obesity as a Disease. Available at: [Link](#).

<sup>286</sup> Luli et al. (2023) The Implications of defining obesity as a disease: a report from the Association for the Study of Obesity 201 annual conference. Available at: [Link](#).

<sup>287</sup> European Commission Health Promotion and Disease Prevention Knowledge Gateway. (2021). Obesity Prevention. Available at: [Link](#).

<sup>288</sup> European Association for the Study of Obesity. (2021). EASO reacts to European Commission Update on Obesity Prevention Brief. Available at: [Link](#).

<sup>289</sup> World Obesity Federation. (2020). Health systems. Bulgaria. Available at: [Link](#).

<sup>290</sup> World Obesity Federation. (2020). Health systems. Greece. Available at: [Link](#).

<sup>291</sup> WHO. (2016). The Portuguese National Programme for the Promotion of Healthy Eating: 2012–2015. Available at: [Link](#).

<sup>292</sup> International Journal of Caring Sciences. (2013). Interventions for Childhood Obesity Control in Cyprus: An analysis and Evaluation of Programmes and Protocols. Available at: [Link](#).

<sup>293</sup> World Obesity Federation. Health Systems. United Kingdom. Available at: [Link](#).

**distribution of resources** either regionally, thus exacerbating health inequalities, or across initiatives. Additional financial barriers are indicated in Germany<sup>294</sup> and Luxembourg<sup>295</sup> where limited funding reduces the scope and efficacy of both childhood and adult obesity-related initiatives and policies and thus has an impact on the implementation of national plans as well as the support of local actions promoting physical activity and healthy eating. As reported by many consulted stakeholders, the shortage of funding also concerns effective data and monitoring processes and healthcare systems and offered services.

#### 4.3.2.3 Institutional Challenges

The **complexity of policy coordination and implementation** is a recurring theme across several countries in Europe. The **poor intersectoral collaboration** is highlighted in Germany<sup>296</sup> with respect to health promotion networks for children and youths and in Portugal<sup>297</sup> with respect to food and nutrition policies, emphasising the **need for a more integrated and multisectoral** approach. In Slovenia,<sup>298</sup> in addition to the need for more systematic monitoring of policy implementation, there is additional focus on the need for more effective intersectoral work. In Belgium,<sup>299</sup> the root cause of the **poor regional collaboration** on nutritional policies is attributed to the lack of an overarching framework policy at the federal level. Countries such as Luxembourg<sup>300</sup> and Malta,<sup>301</sup> despite having national strategies in place, report the ineffective implementation of policies because of a **lack of internal and external visibility of the strategy** and the **lack of political will and direction respectively**. Almost every national authority consulted confirms that poor collaboration and lack of political will are hard barriers to the adoption and implementation of policies and initiatives under the Areas for Action 1 to 7 of the EU Action Plan.

#### 4.3.3 Obstacles specific to each Area for Action

In addition to cross-cutting obstacles and challenges, several challenges were identified that impact specific areas of action as mapped within the EU Action Plan on Childhood Obesity. The table below depicts the variations of the categories of challenges per area of the EU Action Plan.

---

<sup>294</sup> World Obesity Federation. (2020). Health systems. Germany. Available at: [Link](#); Böhm, K., Gehne, D. (2018). Health promotion networks for children and youth on the local level: An overview of the status quo in Germany. *Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz*, 61, 1208-1214. Available at: [Link](#).

<sup>295</sup> Ministry of Health. (2018). Plan cadre national "Gesond iessen, méi beweegen" 2018-2025. Available at: [Link](#).

<sup>296</sup> Böhm, K., Gehne, D. (2018). Health promotion networks for children and youth on the local level: An overview of the status quo in Germany. *Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz*, 61, 1208-1214. Available at: [Link](#).

<sup>297</sup> WHO. (2016). The Portuguese National Programme for the Promotion of Healthy Eating: 2012–2015. Available at: [Link](#).

<sup>298</sup> Bizjak T. et al. (2020). Evaluating the success of Slovenia's policy on the health of children and adolescents: results of an audit. Available at: [Link](#).

<sup>299</sup> Peuch. (2022). What does nutrition mean from a right to food perspective and how is nutrition monitored in Belgium? Available at: [Link](#).

<sup>300</sup> Government of Luxembourg and GIMB. (2021). Activity Report. Available at: [Link](#).

<sup>301</sup> NAO. (2023). A review of the implementation of Sustainable Development Goal 2: Addressing pre-obesity and obesity. Available at: [Link](#).

**Table 16 – Overview of the type of challenges/obstacles concerning each area of the EU Action Plan on Childhood Obesity**

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Institutional	✓	✓	✓	✓	✓	✓	✓
Behavioural/Cultural	✓	✓	✓		✓	✓	
Financial	✓	✓			✓	✓	✓
Healthcare Access	✓						✓
Data & Monitoring			✓				✓
Disease recognition	✓	✓	✓	✓	✓	✓	✓

Source: Authors' elaboration

The sections below explore some of these common challenges across multiple EU Member States and the United Kingdom. Notably, no challenges were identified for Area 8 of the EU Action Plan. Area 1: Support to a Healthy Start in Life

#### 4.3.3.1 Challenges related to Clinical Care and Healthcare Access

Regarding maternal nutrition and breastfeeding some countries report obstacles with respect to maternal and newborn medical care (BG, HU, LU). In Bulgaria, **limited access to free medical check-ups during pregnancy** is reported, which consequentially reduces the opportunity to provide counselling to expecting mothers on nutrition and breastfeeding.<sup>302</sup> In Hungary, reports highlight that the use of **outdated medical practices** presents a challenge in promoting breastfeeding.<sup>303</sup> Lastly in Luxembourg, despite the overall perception of a high quality of maternal and newborn care, in a 2022 study, 43% of women highlighted that **doctors do not take enough time in their explanations when it comes to newborn care.**<sup>304</sup> Limited access to essential medical check-ups for women before, during and after pregnancy were reported as obstacles to policy implementations under Area 1 by the consulted Austrian and Belgian national authorities.

Additionally, several Member States report challenges when it comes to the improvement of management services for childhood obesity and training for healthcare/childcare professionals. This is largely attributed to a reported **scarcity of specialised professionals** in numerous countries including Austria,<sup>305</sup> Estonia,<sup>306</sup> Denmark,<sup>307</sup> Ireland,<sup>308</sup>

<sup>302</sup> UNICEF. (2022). Un/Equal Childhood: Deep Dive in Child Poverty and Social Exclusion in Bulgaria. Available at: [Link](#).

<sup>303</sup> Mandiner. (2020). Miért alapítottak nemzeti bizottságot a szoptatás támogatására?. Available at: [Link](#).

<sup>304</sup> International Journal of Gynaecology & Obstetrics. (2022). Quality of maternal and newborn care around the time of childbirth in Luxembourg during the COVID-19 Pandemic: Results of the IMAGiNE EURO study. Available at: [Link](#).

<sup>305</sup> WHO. (2022). Time to accept that obesity is a disease – Austria is building a national system to treat it. Available at: [Link](#).

<sup>306</sup> European Observatory on Health Systems and Policies. (2021). Estonia Health system review. Available at: [Link](#).

<sup>307</sup> Ditlevsen, K., Reventlow, S., & Nielsen, A. (2016). From policy to reality: early overweight, structural barriers, and the allocation of responsibility in the Danish health care system. *Critical Public Health*, 26(5), 566-577. Available at: [Link](#).

<sup>308</sup> Kelleher, E. et al. (2017). Barriers and facilitators to the implementation of a community-based, multidisciplinary, family-focused childhood weight management programme in Ireland: a qualitative study. *BMJ open*, 7(8). Available at: [Link](#); World Obesity Federation (2020) Health Systems. Ireland. Available at: [Link](#).

Italy<sup>309</sup>, Luxembourg,<sup>310</sup> Spain<sup>311</sup> and Sweden.<sup>312</sup> Based on articles retrieved, it is reported in Ireland,<sup>313</sup> Bulgaria<sup>314</sup> and Croatia,<sup>315</sup> that people experience **unequal regional availability of health services** which negatively impacts the ability of low-income households to access obesity management services. The scarcity of specialised professionals and uneven geographical distribution of services have also been lamented by many consulted national authorities (AT, BE, BG, HR, EE, IE, IT, LV, SI, SE). Meanwhile, in Romania,<sup>316</sup> Ireland,<sup>317</sup> Germany and Latvia,<sup>318</sup> this is described as **fragmentation in the healthcare system**, which often results in **long waiting times** for the first visit and between referrals and presents an obstacle for people to receiving treatment for obesity. This has been confirmed during consultations (AT, BE, EE, LV, LU, PT, SE).

#### 4.3.3.2 Institutional Challenges

Additional challenges raised in other countries include a **lack of breast-feeding friendly environments (MT)**<sup>319</sup> and the impact of aspects such as **lower maternal education** which in Greece was linked to a decreased likelihood of breastfeeding.<sup>320</sup> Also, consulted authorities from Belgium claimed that promoting breastfeeding among parents and healthcare workers is difficult because mothers tend to feel conflicted about breastfeeding when returning to work.

**Obstacles in communication on obesity prevention and treatment and outreach to vulnerable women and children** to such a purpose are highlighted as a further challenge to the implementation of successful policies under this area by multiple national authorities consulted (AT, BE, BG, HR, CY, FR, DE, EL, HU, IE, IT, LV, PT, NL, SE). In this respect, Austrian authorities reported a **lack of awareness of obesity prevention and treatment programmes** across the population.

#### 4.3.3.3 Financial Challenges

Desk research found that **limited investment into childhood obesity management services** has led to regional disparities in the treatment that is available in some countries

---

<sup>309</sup> World Obesity Federation. (2020). Health Systems: Italy. Available at: [Link](#).

<sup>310</sup> International Journal of Gynaecology & Obstetrics. (2022). Quality of maternal and newborn care around the time of childbirth in Luxembourg during the COVID-19 Pandemic: Results of the IMAGiNE EURO study. Available at: [Link](#).

<sup>311</sup> World Obesity Federation. (2020). Health Systems. Spain. Available at: [Link](#).

<sup>312</sup> Sjunnestrang, M. et al. (2019). Planting a seed-child health care nurses' perceptions of speaking to parents about overweight and obesity: a qualitative study within the STOP project. BMC Public Health, 19(1), 1-11. Available at: [Link](#).

<sup>313</sup> Ferdous, F., et al. (2023). Addressing child and adolescent obesity management in Ireland: identifying facilitators and barriers in clinical practice. Frontiers in Paediatrics, 11. Available at: [Link](#).

<sup>314</sup> UNICEF. (2022). Un/Equal Childhood: Deep Dive in Child Poverty and Social Exclusion in Bulgaria. Available at: [Link](#).

<sup>315</sup> UNICEF. (2021). Deep Dive Analysis of Policies, Programs, Services, Sources of Financing and Mechanisms Aimed at Preventing Poverty and Social Exclusion of Children in Croatia. Available at: [Link](#).

<sup>316</sup> Lacrimioara Serban, C. et al. (2021). Making Childhood Obesity a Priority: A Qualitative Study of Healthcare Professionals' Perspectives on Facilitating Communication and Improving Treatment. Available at: [Link](#).

<sup>317</sup> Ferdous, F., et al. (2023). Addressing child and adolescent obesity management in Ireland: identifying facilitators and barriers in clinical practice. Frontiers in Paediatrics, 11. Available at: [Link](#).

<sup>318</sup> WHO. (2019). Mapping the health system response to childhood obesity in the WHO European Region: an overview and country perspectives. Available at: [Link](#).

<sup>319</sup> "Breastfeeding obstacles need to be eliminated" (2014) Times of Malta. Available at: [Link](#).

<sup>320</sup> National Library of Medicine. (2023). Factors Associated with Breastfeeding Initiation and Duration in Greece: Data from the Hellenic National Nutrition and Health Survey. Available at: [Link](#).

(IT<sup>321</sup>, IE<sup>322</sup>). Underfunding of the healthcare system is critical according to several consulted national authorities (AT, BE, BG, EE, FI, EL, IE, LV, LU, PT, SI, ES, SE). **Gaps in healthcare coverage** have also resulted in difficulties in accessing comprehensive obesity care because patients must pay out of pocket for treatment, a challenge that was highlighted in the literature for Latvia<sup>323</sup> and Belgium.<sup>324</sup> **Insufficient public structures dedicated to obesity treatment** have been claimed also as a challenge by Austrian national authorities consulted during the study.

#### 4.3.3.4 Behavioural/Cultural Challenges

Austrian, Danish and Lithuanian representatives consulted during the study stated that it is difficult to address behavioural barriers, such as the **lack of follow-up from parents to the regular check-ups for obesity cases conducted at schools**. An additional factor hampering policy implementation towards supporting a healthier start in life, and in particular breastfeeding, is the existence of **negative perceptions of long-term breastfeeding** (PL).<sup>325</sup>

### 4.3.4 Area 2: Promote healthier environments

#### 4.3.4.1 Institutional Challenges

Desk research revealed common **challenges in promoting physical activity within the school environment due to a high focus on academic achievements** in the Netherlands,<sup>326</sup> Ireland,<sup>327</sup> France,<sup>328</sup> Denmark<sup>329</sup> and the UK.<sup>330</sup> As a result, the **academically demanding timetables of children are indicated as not allowing sufficient time for physical activity**. During consultations, some national authorities reported that the **time allocated to health and physical education within school curricula is insufficient** (AT, BG, HR, CZ, EE, FR, EL, HU, IE, IT, LV, LU, MT, PT, NL, SI, UK).

Moreover, consulted stakeholders also claimed **insufficient human resources** (AT, BE, BG, HR, EE, EL, HU, IE, LU, PT, SI, ES, UK) and a **lack of training of school staff** (AT, BG, HR, CZ, FR, EL, IE, IT, LV, LU, PT, UK).

---

<sup>321</sup> World Obesity Federation. (2020). Health Systems: Italy. Available at: [Link](#).

<sup>322</sup> World Obesity Federation. (2020). Health Systems. Ireland. Available at: [Link](#).

<sup>323</sup> WHO. (2019). Mapping the health system response to childhood obesity in the WHO European Region: an overview and country perspectives. Available at: [Link](#).

<sup>324</sup> World Obesity Federation. Health Systems. Belgium. Available at: [Link](#).

<sup>325</sup> Polish Lactation Science Center. (2021). Raport na temat długiego karmienia piersią w Polsce. Available at: [Link](#).

<sup>326</sup> Van Nassau, F., et al. (2016) Barriers and facilitators to the nationwide dissemination of the Dutch school-based obesity prevention programme DOIIT. Available at: [Link](#).

<sup>327</sup> Hayes, C. B., et al. (2019). Barriers and facilitators to adoption, implementation and sustainment of obesity prevention interventions in schoolchildren—a DEDIPAC case study. BMC Public Health, 19(1), 1-13. Available at: [Link](#).

<sup>328</sup> Ministère de la santé. (2021). Programme national nutrition santé (PNNS) – Professionnels. Available at : [Link](#).

<sup>329</sup> Koch, S., et al. (2020). Barriers to implementation of physical activity in Danish public schools. Journal of Teaching in Physical Education, 40(3), 493-502. Available at: [Link](#).

<sup>330</sup> Clarke, J., et al. (2015). Obesity prevention in English primary schools: headteacher perspectives. Available at: [Link](#).

#### 4.3.4.2 Financial Challenges

An additional obstacle frequently referenced with respect to schools is **insufficient state financing**. In Spain,<sup>331</sup> Hungary,<sup>332</sup> the United Kingdom<sup>333</sup> and Lithuania<sup>334</sup> a lack of funding **impacts the availability of facilities and sports equipment** to facilitate physical education for children. In Croatia,<sup>335</sup> Ireland<sup>336</sup> and Italy<sup>337</sup> constraints in state funding to schools result in a significant **divide between urban and rural areas**. Indeed, the consulted Finnish representatives reported that it is costly to provide free meals in schools in the more remote areas of the country. Research showed that many schools in low-income neighbourhoods from these countries may not be equipped with adequate canteen facilities and, are thus less able to provide hot, nutritious lunches for students. **Funding constraints** reducing the success of the implementation of policies under Area 2 have been reported by consulted authorities too (AT, BE, BG, HR, CY, CZ, FR, EL, HU, IE, LV, LU, PT, RO, NL, ES, UK).

#### 4.3.4.3 Behavioural/Cultural Challenges

Several studies carrying out surveys directed towards teachers and parents of school children have found that some **children present a lack of motivation to engage in physical activity**, including at school, and tend to have a **sedentary behaviour**, also due to increased screen time (DE,<sup>338</sup> UK,<sup>339</sup> IT,<sup>340</sup> HU, BE, BG, FI, EL, ES).<sup>341</sup> Consulted stakeholders from Greece, Luxembourg, and Portugal confirmed that; adding that it is often accompanied by increased screen time and digital addiction. Furthermore, school staff is affected by a **lack of motivation to sustain children's healthy habits** (AT, HR, CZ, EL, HU, IE, LV, LT, PT, NL, SI, UK). Likewise, **parents and families may lack support to adopt and maintain healthy habits** in children (AT, BE, BG, HR, CZ, EL, IE, IT, LT, ES, SE). Moreover, countries such as Luxembourg,<sup>342</sup> Croatia<sup>343</sup> and Slovakia<sup>344</sup> registered **preferences toward the consumption of unhealthy foods** and snacks. Such preferences are believed to be partly influenced by **peer pressure amongst children**, as if eating unhealthily can often be perceived as “cooler”, particularly among adolescents.

<sup>331</sup> World Obesity Federation. (2020). Health Systems. Spain. Available at: [Link](#).

<sup>332</sup> Iskolakultúra. (2021). A testnevelés tanításának lehetőségei a teremellátottság tükrében. Available at: [Link](#).

<sup>333</sup> Clarke, J., et al. (2015). Obesity prevention in English primary schools: headteacher perspectives. Available at: [Link](#).

<sup>334</sup> The Ministry of Health Protection of the Republic of the Republic of Lithuania (2020) Vaikų sveikatos stiprinimo priemonių įvairiuose sektoriuose 2019 metais Apžvalga. Available at: [Link](#).

<sup>335</sup> UNICEF. (2021). Deep Dive Analysis of Policies, Programs, Services, Sources of Financing and Mechanisms Aimed at Preventing Poverty and Social Exclusion of Children in Croatia. Available at: [Link](#).

<sup>336</sup> Hayes, C. B., et al. (2019). Barriers and facilitators to adoption, implementation and sustainment of obesity prevention interventions in schoolchildren—a DEDIPAC case study. BMC Public Health, 19(1), 1-13. Available at: [Link](#).

<sup>337</sup> UNICEF. (2022). Deep Dive Child Guarantee Analysis of politics, programmes, budgets addressing child poverty and social exclusion in Italy. Available at: [Link](#).

<sup>338</sup> Koch, S., et al. (2020). Barriers to implementation of physical activity in Danish public schools. Journal of Teaching in Physical Education, 40(3), 493-502. Available at: [Link](#).

<sup>339</sup> University of Bristol (2023) Study shows children's inactivity remains an issue in wake of pandemic. Available at: [Link](#).

<sup>340</sup> JANPA. (2016). Peer educator mothers. Available at: [Link](#).

<sup>341</sup> Van Stappen, V. et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. The Feel4Diabetes Study. International Journal of Environmental Research and Public Health, 15(12), 2840. Available at: [Link](#).

<sup>342</sup> L'essentiel. (2019). Ils aiment les chips et les sodas car "c'est cool". Available at: [Link](#).

<sup>343</sup> UNICEF. (2021). Deep Dive Analysis of Policies, Programs, Services, Sources of Financing and Mechanisms Aimed at Preventing Poverty and Social Exclusion of Children in Croatia. Available at: [Link](#).

<sup>344</sup> M. Schwarzova, Fatrcova-Šramková, T. Juríková. (2023). Consequences of the COVID-19 pandemic on the eating habits of school-aged children in Slovakia. Available at: [Link](#).

These represent personal preferences that challenge the ability of Member States to promote healthier lifestyles.

### 4.3.5 Area 3: Make the healthy option the easier option

#### 4.3.5.1 Behavioural/Cultural Challenges

The EU REformulation MOonitoring (EUREMO) report<sup>345</sup> highlights common obstacles across countries, related to consumer behaviour that present challenges to food reformulation. Firstly, **a lack of consumer education on healthy habits** has been found to play a crucial role in their ability to make healthier choices. In Greece, France, Slovenia and Romania, the literature highlights that food reformulation alone has not been enough to instil healthier habits among consumers, stating that the education of the general population towards healthier dietary habits is also necessary. Additionally, for Greece and Slovenia, sources indicate challenges related to **limited consumer education on labels**, stating that improved education is necessary as consumers may struggle with identifying healthy choices through the labels. Irish and Portuguese representatives consulted during the course of this study confirmed this. Lastly, consulted national authorities reported that the implementation of food reformulation and HFSS food taxation policies finds **resistance from consumers for fear of price increases** (CY, EE, FR, IE, IT, LV, MT, NL, ES).

#### 4.3.5.2 Institutional Challenges

To date, 12 EU countries have introduced some form of “unhealthy” food product taxation (DK, NL, LV, HU, FI, HR, FR, PT, ES, PL, BE, IE), with 10 Member States (excluding DK and the NL) taxing sugar-sweetened beverages (SSBs). In addition to SSBs, Hungary also introduced a tax on salty snacks, while Denmark only has a tax on ice cream and chocolate).<sup>346</sup> In the Netherlands, a flat rate “consumer tax” is in place for all soft drinks.<sup>347</sup> Within this context, studies published by the European Journal of Public Health<sup>348</sup> taking a policy analysis lens to the introduction of sugar-sweetened beverage taxes in Europe have found that taxes received **strong pushback from the food and beverage industry which impacted the design of the tax** (specifically in the case of BE, FI, IE, PT, LV and the UK). Most countries excluded products such as fruit and vegetable juices and/or milk from the tax (IE, HU, FR, BE, LV, PT, UK). Imposing higher taxes on unhealthy foods and beverages have been found to be generally beneficial for decreasing the consumption of high in HFSS foods as well as spurring food reformulation. In Portugal, whilst higher taxes only resulted in a short-term decrease in consumption which was not sustained there was positive pressure applied to reformulation for drinks on the market to contain less sugar

---

<sup>345</sup> European Union. (2022). EU REformulation MOonitoring (EUREMO) Feasibility study for a monitoring system on reformulation initiatives for salt, sugars and fat: final report. Available at: [Link](#).

<sup>346</sup> European Journal of Public Health. (2022). Corporate political activity in the context of sugar-sweetened beverage tax policy in the WHO European Region. Available at: [Link](#).

<sup>347</sup> European Commission. SC 2097106: Mapping of pricing policies and fiscal measures applied to food, non-alcoholic and alcoholic beverages. Available at: [Link](#).

<sup>348</sup> European Journal of Public Health. (2022). Sugar-sweetened beverage taxes in Europe: learning for the future. Available at: [Link](#); European Journal of Public Health (2022) Corporate political activity in the context of sugar-sweetened beverage tax policy in the WHO European Region. Available at: [Link](#).

(with respect to sugar-sweetened beverages). This resulted in a decrease in the proportion of drinks on the market within the highest sugar tax bracket.<sup>349</sup>

According to some industry representatives consulted with a focus group, there is **little evidence of the impact of food reformulation and taxation of unhealthy foods** on the health status of the population. This has also been claimed by some national authorities (from EE, PT, SE) as a barrier to take action in this regard. Further, national authorities and industry stakeholders considered that a key challenge in developing and implementing food reformulation is the **fear of the industry that reformulated products would decrease sales** due to consumer aversion. National authorities and representatives from the NGOs consulted also highlighted the resistance from the industry to policies in this area for fear of decreases in sales (mentioned national authorities and representatives from the NGOs from AT, BG, HR, CY, CZ, EE, FI, FR, DE, HU, IE, IT, LV, LT, LU, MT, PT, NL, SI, ES, SE, UK). It has also been claimed that **resistance from the industry about front-of-pack nutrition labelling schemes** originates from the fear of changes in brand identity and costs (mentioned by national authorities and other stakeholders from AT, CY, FR, DE, IE, LV, LU, PT, ES). Lastly, according to industry representatives participating in the validation workshop, defining what is “healthy” is challenging due to differences in what is considered healthy or not across different countries and regions. Given the complexity of diets and lifestyles, considering food as healthy or unhealthy may be too simplistic. **Industry influence on policymaking and poor collaboration between policy areas** have been claimed as the two most relevant barriers to the reduction of childhood obesity through actions related to food reformulation and food taxation by an NGO participating in a validation workshop. Other NGOs also shared that industry involvement hinders policymaking when it comes to matters of health, as the focus tends to be on profit rather than positive health action. On the topic of collaboration, they highlighted a lack of cross-sector collaboration and disconnection between policies to be a significant barrier. This is supported by consulted national authorities and most stakeholders from almost every country in the scope of the evaluation.

#### 4.3.6 Area 4: Restrict marketing and advertising to children

##### 4.3.6.1 Institutional Challenges

Research conducted as part of this study showed that the **predominant responses to restricting marketing to children are through self-regulatory codes of practice** which in some cases, despite reflecting good corporate social responsibility, can be considered vague and more permissive (see Section 4.1.8). To date, 14 Member States have voluntary agreements in place to restrict the advertisement of unhealthy products to children in a broad sense (BE, BG, DK, EE, FI, DE, EL, IT, NL, PL, RO, SI, ES) meanwhile 11 also have mandatory policies (BG, FR, HU, MT, PO, RO, SI, ES, SE, UK, IE).

The evidence retrieved shows that in some countries the impact of self-regulation is variable and in isolation has not succeeded in preventing children from being exposed to the marketing of unhealthy products. This was echoed during the Workshop on Food

---

<sup>349</sup> Nutrimento.pt. (2022). Relatório do Programa Nacional para a Promoção da Alimentação Saudável 2022. Available at: [Link](#).

Marketing Codes of Practices held as part of Best-ReMaP Joint Action by Belgium, France, Germany, and Greece<sup>350</sup> as well as Spain<sup>351</sup> in a separate study, highlighting that the wording of the self-regulatory codes is often vague and “open”, and that the impact of violations is limited, therefore there is **no strong incentive for compliance by the industry**. Additionally, few countries have adopted nutrient profiles for defining for which products marketing to children would be restricted or forbidden. In relation to this, Greece and Portugal<sup>352</sup> highlighted **significant industry pushback and non-compliance** in adopting their nutrient profile models on the grounds that it is too restrictive.

According to many national authority representatives, main pushbacks in relation to restricting food marketing products to children comes from the industry. National representatives specified this is due to the industry’s **reluctance to reduce their marketing activities to a part of the target audience** (AT, DE, BE, BG, HR, CY, EE, IE, LV, MT, PT, NL, SI, ES, SE, UK) and to accept limits **to what can be advertised** (national authority representatives from AT, DE, BE, BG, HR, CY, EE, DE, IE, LV, MT, PT, SI, ES, UK). Restricting the marketing of HFSS food is **difficult due to the access to social media displaying marketed products** (FI, SI). Thus, national authorities reported a **perceived low effectiveness of laws on marketing to children** (AT, IE, LV, LT, SI).

In the case of mandatory restrictions to the advertisement of unhealthy products to children, during the workshops held as part of Best-ReMaP, Belgium and Ireland<sup>353</sup> expressed **challenges with fostering coordination between different ministries** for the harmonisation of rules and definitions e.g. defining media, distinguishing what is an advertisement for a child from an adult and how to define rules in relation to media or nutrients. This is supported by consulted stakeholders from almost every country in the scope of the evaluation.

#### 4.3.6.2 Data and monitoring

With respect to mandatory restrictions on the advertisement of unhealthy products to children, there has been **limited assessment of the efficacy** of these policies to date.<sup>354</sup> The assessments that have been made so far (as part of Best-ReMaP as well as independent research), have reported mixed findings as to whether the policies resulted in reductions in unhealthy food advertising in affected media. For Portugal,<sup>355</sup> desk research found challenges related to **limited resources for continuous monitoring**, while the monitoring of online and digital marketing compliance specifically was reported as a challenge in the UK.<sup>356</sup> A consulted NGO representing Croatia also confirmed that monitoring the compliance of marketing restriction policies is challenging.

---

<sup>350</sup> Best-ReMaP. (2022). Meeting Minutes. Available at: [Link](#).

<sup>351</sup> MDPI. (2019). Food Advertising and Prevention of Childhood Obesity in Spain: Analysis of the Nutritional Value of the Products and Discursive Strategies Used in the Ads Most Viewed by Children from 2016 to 2018. Available at: [Link](#).

<sup>352</sup> European Union. (2022). EU REformulation MOnitoring (EUREMO) Feasibility study for a monitoring system on reformulation initiatives for salt, sugars and fat: final report. Available at: [Link](#).

<sup>353</sup> Best-ReMaP. (2022). Meeting Minutes. Available at: [Link](#).

<sup>354</sup> McGale, L et al. (2022) Systematic review of the effect of policies to restrict the marketing of foods and non-alcoholic beverages to which children are exposed. Available at: [Link](#).

<sup>355</sup> Figueira, M., Araújo, J., Gregório, M.J. (2023). Monitoring Food Marketing Directed to Portuguese Children Broadcasted on Television. Available at: [Link](#).

<sup>356</sup> Best-ReMaP. (2022). Meeting Minutes. Available at: [Link](#).

## 4.3.7 Area 5: Inform and empower families

### 4.3.7.1 Behavioural/Cultural Challenges

The main obstacles this area identified through desk research have been a **lack of motivation among parents** to engage their children in physical exercise as well as a **general preference for sedentary activities** among children as mentioned previously (DE,<sup>357</sup> the UK,<sup>358</sup> IT,<sup>359</sup> HU, BE, BG, FI, EL, ES).<sup>360</sup> The lack of motivation among parents has been reported also by consulted national representatives (AT, CY, EL, IE, LV, LT, MT, PT, SI, ES).

Consultations with academics and NGOs also informed that **low health literacy and poor communication on health** contributed to low adherence to healthy habits (EL, HU, IE, LV).

### 4.3.7.2 Institutional Challenges

A **lack of cooperation between the numerous sports organisations** that arrange exercise events poses **challenges for the organisation of campaigns on physical activity for children** in countries such as Estonia,<sup>361</sup> Finland,<sup>362</sup> Luxembourg<sup>363</sup> and Greece.<sup>364</sup> The issue of **low cooperation between national, regional, and local stakeholders** has been highlighted by national consulted stakeholders (AT, FI, FR, IE, LV, SL, SE). Moreover, consulted national authorities reported that **families are not sufficiently informed of the subsidies available to them** (AT, DK, EL, IE, IT, PT), due also to **obstacles in communication and outreach to vulnerable women and children** (BE, BG, HR, CY, CZ, EE, FR, DE, HU, IE, IT, LV, LU, PT, NL, SI, ES, UK).

### 4.3.7.3 Financial Challenges

A reported **shortage of funding** between organisations that arrange exercise events impacts the organisation of campaigns on physical activity (including those for children) in

---

<sup>357</sup> Koch, S. et al. (2020). Barriers to implementation of physical activity in Danish public schools. *Journal of Teaching in Physical Education*, 40(3), 493-502. Available at: [Link](#).

<sup>358</sup> University of Bristol. (2023). Study shows children's inactivity remains an issue in wake of pandemic. Available at: [Link](#).

<sup>359</sup> JANPA. (2016). Peer educator mothers. Available at: [Link](#).

<sup>360</sup> Van Stappen, V. et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. *The Feel4Diabetes Study*. *International Journal of Environmental Research and Public Health*, 15(12), 2840. Available at: [Link](#).

<sup>361</sup> Ministry of Culture. (2021). Liikumisharrastuse kontseptsioon. Available at: [Link](#).

<sup>362</sup> Van Stappen, V. et al. (2018). Barriers from Multiple Perspectives Towards Physical Activity, Sedentary Behaviour, Physical Activity and Dietary Habits When Living in Low Socio-Economic Areas in Europe. *The Feel4Diabetes Study*. Available at: [Link](#).

<sup>363</sup> Ministry of Health. (2018). Plan cadre national "Gesond iessen, méi beweegen" 2018-2025. Available at: [Link](#).

<sup>364</sup> Van Stappen, V. et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. *The Feel4Diabetes Study*. *International Journal of Environmental Research and Public Health*, 15(12), 2840. Available at: [Link](#).

countries such as Estonia,<sup>365</sup> Finland,<sup>366</sup> Luxembourg<sup>367</sup> and Greece.<sup>368</sup> Particularly in some countries such as Croatia<sup>369</sup>, Cyprus<sup>370</sup>, Greece<sup>371</sup>, Bulgaria<sup>372</sup> and the UK.<sup>373</sup> The shortage of funding has been confirmed during consultations with national representatives (AT, BE, BG, CY, EE, FI, EL, IE, LV, LU, PT, RO, SI, ES, UK).

The scarcity of funding is specifically described regarding disadvantaged communities, which creates an **uneven distribution of access to healthy choices** and/or awareness-raising campaigns across communities, contributing to health inequalities. This has been confirmed by many consulted national authorities as well (AT, BG, HR, CZ, EE, FI, FR, IE, LT, PT, ES, UK). This is exacerbated by a **lack of affordability of healthy choices** highlighted by several national representatives (AT, BG, CZ, EE, FI, FR, IE, IT, LV, LU, PT, ES, SE).

### 4.3.8 Area 6: Encourage Physical Activity

#### 4.3.8.1 Financial and Institutional Challenges

Desk research conducted identified that **inadequate infrastructure for sports** (both within and outside the school environment) is a commonly reported barrier among several Member States. The **inadequacy of sports structures also concerns their safety and maintenance** as reported by consulted multiple stakeholders (AT, HR, CZ, EE, IE, IT, LV, LU, MT, PL, SI, SE).

In the case of Belgium,<sup>374</sup> Bulgaria,<sup>375</sup> Italy,<sup>376</sup> and Slovenia,<sup>377</sup> this is reported to be due to **inadequate government financing**, particularly in lower-income neighbourhoods, resulting in old and unmaintained sports facilities for extracurricular activities. Consulted stakeholders also claimed a **lack of financial support to disadvantaged families and**

---

<sup>365</sup> Ministry of Culture. (2021). Liikumisharrastuse kontseptsioon. Available at: [Link](#).

<sup>366</sup> Van Stappen, V. et al. (2018) Barriers from Multiple Perspectives Towards Physical Activity, Sedentary Behaviour, Physical Activity and Dietary Habits When Living in Low Socio-Economic Areas in Europe. The Feel4Diabetes Study. Available at: [Link](#).

<sup>367</sup> Ministry of Health. (2018). Plan cadre national "Gesond iessen, méi beweegen" 2018-2025. Available at: [Link](#).

<sup>368</sup> Van Stappen, V. et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. The Feel4Diabetes Study. International Journal of Environmental Research and Public Health, 15(12), 2840. Available at: [Link](#).

<sup>369</sup> UNICEF. (2021). Deep Dive Analysis of Policies, Programs, Services, Sources of Financing and Mechanisms Aimed at Preventing Poverty and Social Exclusion of Children in Croatia. Available at: [Link](#).

<sup>370</sup> International Journal of Caring Sciences. (2013). Interventions for Childhood Obesity Control in Cyprus: An analysis and Evaluation of Programmes and Protocols. Available at: [Link](#).

<sup>371</sup> Cambridge University Press. (2023). Socio-economic and demographic determinants of childhood obesity prevalence in Greece: the GRECO (Greek Childhood Obesity) study. Available at: [Link](#).

<sup>372</sup> UNICEF. (2022). Un/Equal Childhood: Deep Dive in Child Poverty and Social Exclusion in Bulgaria. Available at: [Link](#).

<sup>373</sup> World Obesity Federation. Health Systems. United Kingdom. Available at: [Link](#).

<sup>374</sup> Van Stappen, V. et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. The Feel4Diabetes Study. International Journal of Environmental Research and Public Health, 15(12), 2840. Available at: [Link](#).

<sup>375</sup> Van Stappen, V. et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. The Feel4Diabetes Study. International Journal of Environmental Research and Public Health, 15(12), 2840. Available at: [Link](#).

<sup>376</sup> WHO. (2019). Mapping the health system response to childhood obesity in the WHO European Region: an overview and country perspectives. Available at: [Link](#).

<sup>377</sup> Morrisom, S. et. al. (2023). Challenges of social change: The 2021 Republic of Slovenia report card on physical activity of children and adolescents. Available at: [Link](#).

**children in practising a sports activity** (AT, HR, CZ, EE, FI, EL, IE, IT, LV, LT, MT, PL, SI, ES) and in general a **lack of funding for facilities** (HR, CZ, IT, LT).

Some countries present an overall **lack of access to facilities** (BE, HR, CY, EE, IE, IT, LV, LT, LU, MT, PL, ES, SE), and **inadequate city planning** (BE, HR, CZ, DK, EE, FR, IE, IT, LU, MT, PL, SI, ES, SE) to ensure active lifestyles, while others reported obstacles in the promotion of activities mostly due to **schools not being properly equipped** with e.g. indoor gyms and sports equipment, as reported in Finland,<sup>378</sup> Greece,<sup>379</sup> Spain,<sup>380</sup> Denmark<sup>381</sup> and Hungary.<sup>382</sup> In the Netherlands<sup>383</sup> and Malta,<sup>384</sup> **urbanisation was also considered to be a contributing factor for increased sedentary behaviour among children**, with the dense buildings and busy traffic in cities offering little space and opportunity to play outside or cycle to places safely. Consulted representatives (IT, IE, SI) reported that the lack of measures to decrease screen time exacerbates even more sedentary behaviours.

#### 4.3.8.2 Behavioural/Cultural Challenges

Also, some national representatives (AT, CY, EE, IT, LV) reported a generalised **lack of education and motivational support for children to practice sports** as diminishing the effectiveness of physical activity promotion initiatives.

### 4.3.9 Area 7: Monitor and Evaluate

#### 4.3.9.1 Data and Monitoring Challenges

In several countries, the reported obstacles relate to the **insufficiency of data collection** on nutrition and/or weight of children – in that it is **either collected irregularly or not at all** (UK,<sup>385</sup> ES,<sup>386</sup> HU,<sup>387</sup> FI, SK, AT, SI).<sup>388</sup> For example, it is reported that in Austria, Finland, Slovakia, and Slovenia<sup>389</sup> specifically, data is not collected on children under the age of 5 and, therefore, it is hard to assess whether countries are on course to prevent childhood

---

<sup>378</sup> Van Stappen, V., et al. (2018). Barriers from Multiple Perspectives Towards Physical Activity, Sedentary Behaviour, Physical Activity and Dietary Habits When Living in Low Socio-Economic Areas in Europe. The Feel4Diabetes Study. Available at: [Link](#).

<sup>379</sup> Ibid.

<sup>380</sup> Government of Spain. (2022). Plan estratégico nacional para la reducción de la obesidad infantil (2022 - 2030). Available at: [Link](#).

<sup>381</sup> Koch, S. et al. (2020). Barriers to implementation of physical activity in Danish public schools. Journal of Teaching in Physical Education, 40(3), 493-502. Available at: [Link](#).

<sup>382</sup> Van Stappen, V., et al. (2018). Barriers from multiple perspectives towards physical activity, sedentary behaviour, physical activity and dietary habits when living in low socio-economic areas in Europe. The Feel4Diabetes Study. International Journal of Environmental Research and Public Health, 15(12), 2840. Available at: [Link](#).

<sup>383</sup> De Vries, S., et al. (2005). Kinderen in prioriteitswijken: lichamelijke (in)activiteit en overgewicht. Available at: [Link](#).

<sup>384</sup> Cauchi D., Rutter H, Knai C. (2015) An obesogenic island in the Mediterranean: mapping potential drivers of obesity in Malta. Public Health Nutr. 2015 Dec;18(17):3211-23. Available at: [Link](#).

<sup>385</sup> World Obesity Federation. Health Systems. United Kingdom. Available at: [Link](#).

<sup>386</sup> Gasol Foundation. (2022). Estudio Pasos 2022. Available at: [Link](#).

<sup>387</sup> Global Nutrition Report. (n.a.) Nutrition Profiles: Croatia. Available at: [link](#); Chrissini, M., Panagiotakos, D. (2022) Public health interventions tackling childhood obesity at European level: A literature review. Preventive Medicine Reports, 30, 102068. Available at: [Link](#).

<sup>388</sup> M. Chrissini, D. Panagiotakos (2022) Public health interventions tackling childhood obesity at European level: A literature review. Available at: [Link](#).

<sup>389</sup> Ibid.

overweight and obesity from increasing. The **lack of monitoring requirements** and **inadequate data collection tools** exacerbate the issue, according to many authorities consulted (AT, BG, EL, IE, LV, LT, LU, MT, PT, SI, ES, SK, SE). Through consultations with national authorities (AT, CZ, EE, LV, PT, UK), it emerged that the **lack of paediatric and obesity specialists** is a further challenge in the data collection to sustain effective childhood obesity reduction policies. Lastly, Austrian and Hungarian authorities reported **inadequate funding for national data collection**, which is difficult to secure because the monitoring exercise does not bring instant results but it has more of a long-term scope.

## 4.4 Collection of best practices per Area for Action

The following section presents a collection of best practices related to Areas for Action 1 to 7 of the EU Action Plan on Plan on Childhood Obesity identified through desk research and consultation activities during the study.<sup>390</sup>

The findings show that across all Member States and the UK, there is a wide range of best practices that have been implemented to address childhood obesity in Areas for Action 1 to 7 of the EU Action Plan. In total, **63 best practices** related to specific Areas of Action of the EU Action Plan on Childhood Obesity were identified, with 58 identified in the EU and the UK. Each of the best practices was examined against a selection criterion (see Section 2.3.3), specifically an assessment of the effectiveness and equity of the intervention. The selected interventions are not intended to be exhaustive. Instead, they reflect key policies that can serve as examples to other countries who are considering adopting similar approaches. The selection of best practices shows a wide repartition of policy interventions, particularly in school settings (Area 2: Promote healthier environments), in community-based interventions (Area 5: Inform and empower families) and in physical activity promotion for children (Area 6: Encourage Physical Activity). Small-scale best practices prevail, with only a few large-scale best practices identified. Moreover, the research extends its scope beyond the EU, showcasing best practices from **Australia, Canada, Chile, Israel and the United States of America (USA)** that are innovative and have not been adopted in the EU or with a much more extensive policy deployment. These international best practices that can help address childhood obesity in Europe.

### 4.4.1 General overview

The results of the mapping of best practices are summarised in this section. First, a brief description of the geographical coverage of the best practices identified is provided. Subsequently, a detailed description of the best practices is presented, categorised according to the seven key Areas for Action and key topics outlined in the EU Action Plan on Childhood Obesity. Lastly, a summary of best practices identified in third countries is provided, emphasising how they are innovative approaches that could be transferred to EU countries.

The criteria used to select best practices focus on **effectiveness** and **equity**. The evaluation of interventions based on these criteria is easier and more common for individual-based lifestyle interventions compared to broader societal policies like taxation

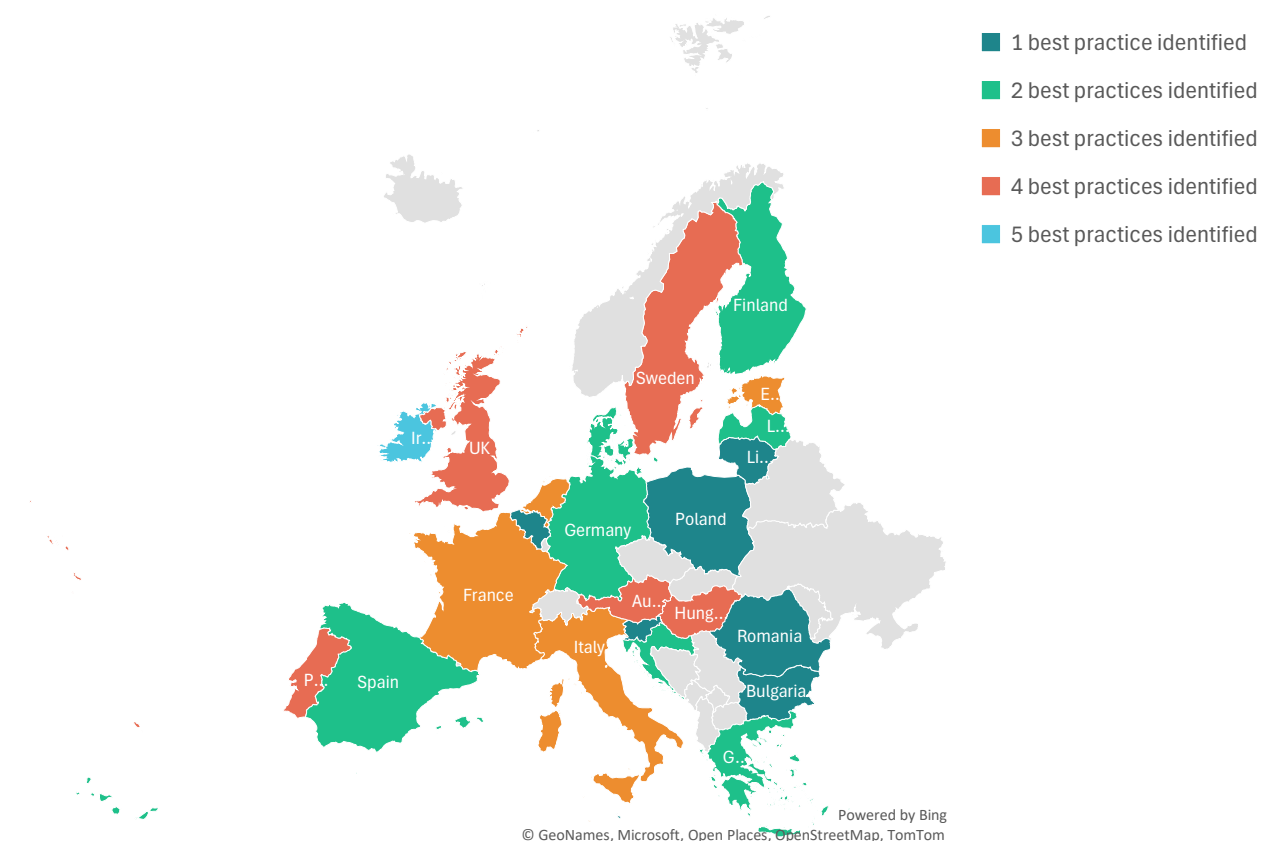
---

<sup>390</sup> No best practices explicitly related to Area 8 of the EU Action Plan on Childhood Obesity have been retrieved through desk research or fieldwork.

or nutritional labelling. Consequently, most best practices identified in this report target individual lifestyle behaviours as opposed to structural policies that address broader societal issues, which are inherently more challenging to evaluate.

The research identified **58 best practices implemented in 24 countries** in the European Union and the UK (Figure 26). Notably, no measures fulfilling the selection criteria were identified for Cyprus, Czechia, Luxembourg and Slovakia. Ireland, Hungary, Sweden, and the UK stand out as the countries with the highest number of best practices. On average, two best practices were identified per country in the EU.

**Figure 26 – Geographical distribution of best practices**



Source: Authors' elaboration

#### 4.4.2 Best practices per Area for Action

A total of 58 best practices aligning with specific Areas of Action outlined in the EU Action Plan on Childhood Obesity were identified across the Member States and the UK. Certain best practices may pertain to multiple Areas of Action. Notably, no best practices were identified for Area 8, which focuses on increasing research and funding. The section below lists the best practices identified per Area of Action and presents a table (Table 24) including best practices falling under more than one Area of Action.

## Area 1: Support to a healthy start in life

7 best practices from 7 countries (AT, BE, DK, EE, IE, LV, UK) were identified under Area 1 of the EU Action Plan (Table 17). See also Table 24 for additional best practices under Area 1, key topics 1.5 (Improvement of childhood obesity management) and 1.6 (Promotion of healthy habits among vulnerable pregnant women and infants).

**Table 17 – Best practices for Area 1**

Best practices	Country
<b>1.1 Guidance before and during pregnancy on maternal nutrition and physical activity</b>	
<b>Parent-child-pass (1975)</b> <sup>391</sup> - A comprehensive healthcare program designed to monitor and support the health of pregnant women and their children up to the age of five. It ensures that expectant mothers receive a series of free medical check-ups throughout their pregnancy.	AT
<b>1.5 Improvement of childhood obesity management</b>	
<b>Paediatric Multidisciplinary Obesity Management Centres (PMOCs) (2010)</b> <sup>392</sup> - The centres are part of a three-tier care pathway established by the Belgian government addressing four health domains and staging obesity severity.	BE
<b>Children's Obesity Clinic Protocol (TCOCT) (2007)</b> <sup>393</sup> - The primary objective of the TCOCT protocol is to help the patient lose weight through individualised behaviour-changing techniques targeting both the patient and parents/families.	DK
<b>Personalised Approach to Obesity Management in Children (2014-2017)</b> <sup>394</sup> - A comprehensive, clinical, family-based and personalised childhood obesity intervention targeting children aged seven to 17 years.	EE
<b>Model of care for the Management of Overweight and Obesity (MOC) (2021)</b> <sup>395</sup> - The model is a structured framework designed by the Health Service Executive (HSE) to provide comprehensive care for individuals with overweight and obesity. It adopts a multidisciplinary, patient-centered approach that integrates prevention, early intervention, and treatment across different levels of care.	IE
<b>Weight correction program at the Clinical University Hospital (2017)</b> <sup>396</sup> - A specialised initiative focused on addressing childhood obesity and overweight issues. It is designed to help children and adolescents (ages 5-17) reduce excess weight through a combination of medical supervision, lifestyle interventions, and long-term monitoring.	LV
<b>1.6 Promotion of healthy habits among vulnerable pregnant women and infants</b>	
<b>Healthy Start Scheme (2006)</b> <sup>397</sup> - The scheme is financed by the government and helps vulnerable populations such as socioeconomically disadvantaged women more than 10 weeks pregnant or families with children under 4. Beneficiaries are sent vouchers that can be used to buy milk, and fresh or frozen fruit and vegetables.	UK

<sup>391</sup> Government of Austria. (2024). Parents-child health passport medical examinations during pregnancy. Available at: [Link](#).

<sup>392</sup> Available at: [Link](#).

<sup>393</sup> Most S.W. et al. (2015). Adoption of the children's obesity clinic's treatment (TCOCT) protocol into another Danish pediatric obesity treatment clinic. *BMC Pediatrics*. 2015 Mar 1;15(1). Available at: [Link](#).

<sup>394</sup> OECD. (2023). Personalised Approach to Obesity Management in Children. Available at: [Link](#).

<sup>395</sup> Health Service Executive. (2021). Model of Care for the Management of Overweight and Obesity. Available at: [Link](#).

<sup>396</sup> Children's Clinical University Hospital. (n.d.). Weight correction programme. Available at: [Link](#).

<sup>397</sup> NHS. (n.d.). Get help to buy food and milk (the Healthy Start scheme). Available at: [Link](#).

No best practices have been identified to promote breastfeeding (key topic 1.2), offering advice on complementary feeding (key topic 1.3) and training healthcare and childcare professionals (key topic 1.4).

## Area 2: Promote healthier environments

Out of the 58 best practices identified, 12 pertain to Area 2 of the EU Action Plan and originate from 11 Member States (Table 18). Several school-based interventions combine efforts to enhance physical activity within school environments while simultaneously incorporating education on nutrition. See also Table 24 for additional best practices under Area 2, key topics 2.1 (Physically active school environments), 2.2 (Policies on vending machines), 2.3 (Policies on sweetened beverages & energy drinks), 2.4 (Integration of nutrition education), and 2.5 (Integration of physical activity education).

**Table 18 – Best practices for Area 2**

Best practices	Country
<b>2.1 Physically active school environments and/or 2.4 Integration nutrition education</b>	
<b>CLASS2000 (1991)</b> <sup>398</sup> - It is a comprehensive teaching programme for promoting health and life skills targeted at children from 6 to 10 years old.	DE
<b>Active School initiative (2019) and Health promoting initiative (1992)</b> <sup>399</sup> - The goal of Health Promoting Schools is to promote the physical, mental and spiritual health of students and other members of the school community. Stemming from this endeavour, the Active School Initiative was started to provide schools with a framework to guide, support and incentivise the creation of a microclimate favourable for physical activity.	LT
<b>The Healthy Primary School of the Future</b> <sup>400</sup> - The Healthy Primary School of the Future has been developed to teach children healthy habits at school.	NL
<b>MOVI Program (2003-2012)</b> <sup>401</sup> - MOVI is a successful regional programme that aims to reduce health risks in 9 to 10-year-old kids by organising non-competitive sport activities during extracurricular hours.	ES
<b>Mobile-based intervention (MINISTOP) (2013)</b> <sup>402</sup> - The intervention is a Health program designed to prevent obesity among healthy Swedish pre-schoolers. The web-based application assists parents in promoting healthy dietary habits and physical activity in their children.	SE
<b>Hungarian School Sports Day (2007)</b> <sup>403</sup> - The Hungarian School Sports Day is a national campaign established in 2007, run yearly by the Hungarian School Sports Federation. It seeks to encourage regular physical activity among children, thereby decreasing the risk of cardiovascular disease as well as obesity.	HU

<sup>398</sup> Klasse2000. Available at: [Link](#).

<sup>399</sup> Institute of Hygiene. (2022). Sveikatą stiprinanti mokykla. Available at: [Link](#).

<sup>400</sup> The Healthy Primary School of the Future. Available at: [Link](#).

<sup>401</sup> European Commission. (2016). MOVI program. Available at: [Link](#).

<sup>402</sup> Alexandrou, C. et al. (2023). Effectiveness of a Smartphone App (MINISTOP 2.0) integrated in primary child health care to promote healthy diet and physical activity behaviors and prevent obesity in preschool-aged children: randomized controlled trial. *International Journal of Behavioral Nutrition and Physical Activity*, 20(1), 1-16. Available at: [Link](#).

<sup>403</sup> Hungarian Student Sport Federation. (n.d). Amire büszkék vagyunk. Available at: [Link](#); The Hungarian Sports Federation (2018). About HSSF. Available at: [Link](#).

Best practices	Country
<b>2.2 Policies on vending machines (healthy snacks)</b>	
<b>Milk and Cornul Programme (2002)</b> <sup>404</sup> - The programme aims to provide healthy food choices to all Romanian pre-school to secondary school students (age 5 to 15) by offering, at lunch time, a bottle of milk/yoghurt and a croissant/bagel/pretzel.	RO
<b>2.5 Integration physical activity education</b>	
<b>Public Act on Education (2012)</b> <sup>405</sup> - The Act was passed to increase the physical activity of children and lower the prevalence of obesity. It aims to improve the quality of life of the Hungarian population by developing stronger systems for sporting activities, and investing in physical education.	HU
<b>2.6 Healthy lunches at school canteens</b>	
<b>Provision of free school lunches (1948)</b> <sup>406</sup> - The system aims at ensuring that all children receive a nutritious, balanced meal during the school day, free of charge.	FI
<b>Programme on Food Aid and Promotion of Healthy Nutrition – DIATROFI (2012)</b> <sup>407</sup> - The programme provides food-aid to tackle food insecurity and hunger, which are proven to affect the health and development of children.	EL
<b>Food Dudes (2005)</b> <sup>408</sup> - The programme aims to increase sustained fruit and vegetable consumption amongst primary school children through their regular provision and tastings over a 16-day intervention period with the support of accompanying measures in the form of role models (Food Dudes Heroes) and small rewards (followed by a home phase where fruit and vegetables are supplied from home).	IE
<b>Nutrition training workshops (2012)</b> <sup>409</sup> - The workshops aimed at improving the healthiness and quality of nutrition of children in nurseries, kindergartens and schools via providing education to staff responsible for nourishment in educational facilities.	PL

Best practices were identified for all the key topics under Area 2.

### Area 3: Make the healthy option the easier option

**Eight best practices were identified under Area 3 of the EU Action Plan and originating from seven different countries (FR, HR, DK, IE, PT, SE and UK) (**

<sup>404</sup> European Commission – Best Practices Portal. (2016). Milk and Croissant. Available at: [Link](#)

<sup>405</sup> Wolters Kluwer Hungarian Legislation Database. (2012). A nemzeti köznevelésről. Available at: [Link](#).

<sup>406</sup> Finnish National Agency for Education. (n.d.). School meals in Finland. Available at: [Link](#).

<sup>407</sup> European Commission. (2023). Best Practises Portal – Greece, Programme on Food Aid and Promotion of Healthy Nutrition – DIATROFI. Available at: [Link](#).

<sup>408</sup> UCD Dublin. (2016). Food Dudes Evaluation 2016. Available at: [Link](#).

<sup>409</sup> Database of the Parliament of the Republic of Poland. (2015). Ustawa z dnia 28 listopada 2014 r. o zmianie ustawy o bezpieczeństwie żywności i żywienia. Available at: [Link](#).

Table 19). See also Table 24 for additional best practices under Area 3, key topics 3.1 (Food reformulation), 3.4 (Taxation) and 3.7 (Nutritional training for food providers and producers).

**Table 19 – Best practices for Area 3**

Best practices	Country
<b>3.2 Monitoring food reformulation</b>	
<b>French Food Observatory - OQALI (2008)</b> <sup>410</sup> - The purpose is to monitor the quality of the food supply by objectively measuring changes in nutritional quality.	FR
<b>3.3 Mandatory or voluntary easy to understand nutrition labelling</b>	
<b>Healthy living logo (2016)</b> <sup>411</sup> - The logo is a voluntary front-of-pack nutrition label, it can be applied to products that fulfil specific nutrient criteria based on maximum or minimum levels of nutrients per 100 gr of the food defined for different food categories.	HR
<b>Danish whole grain logo (2007)</b> <sup>412</sup> - the logo is designed to help consumers easily identify whole grain products.	DK
<b>The Nutri-Score System (2017)</b> <sup>413</sup> - The Nutri-score is placed on a voluntary basis on the front of pre-packaged foods by companies. Its overall objective is to improve consumer's understanding of the nutritional content, increase healthier food choices in the population, encourage reformulation, and thus reduce obesity and its related diseases.	FR
<b>Keyhole logo (1989)</b> <sup>414</sup> - The keyhole logo is a voluntary nutrition label that identifies the healthier choice within 33 defined food groups.	SE
<b>3.4 Taxation</b>	
<b>Sugar Sweetened Drinks Tax (2018)</b> <sup>415</sup> - The Tax applies to water and juice-based drinks as well as certain plant protein drinks and drinks containing milk fats.	IE
<b>Tax on sugary drinks (2017)</b> <sup>416</sup> - The tax on sugary drinks aims at encouraging lower sugar content in drinks. Milk, soy, and certain fruit and vegetable drinks were exempt.	PT

<sup>410</sup> Menard, C. et al. (2011). OQALI: A French database on processed foods. *Journal of food composition and analysis*, 24(4-5), 744-749.

<sup>411</sup> Croatian Institute of Public Health. (2016). "Healthy Living" Guarantee Mark. Available at: [Link](#).

<sup>412</sup> Lourenço, S. et al. (2019). "The Whole Grain Partnership—How a Public–Private Partnership Helped Increase Whole Grain Intake in Denmark", *Cereal Foods World*. Available at: [Link](#).

<sup>413</sup> Ministère de la Santé et de la Prévention. (2017) Nutri-Score: un étiquetage nutritionnel pour favoriser une alimentation équilibrée. Available at: [Link](#).

<sup>414</sup> The Danish Ministry of Food, Agriculture and Fisheries. (2009) A statutory order on use of the Keyhole label. Available at: [Link](#).

<sup>415</sup> Irish Tax and Customs. (2018). Sugar Sweetened Drinks Tax (SSDT). Available at: [Link](#).

<sup>416</sup> Diário da República. (2016): Lei n.º 42/2016. Available at: [Link](#).

Best practices	Country
<b>Soft Drinks Levy (2018)</b> <sup>417</sup> - The levy applies to the packaging and importation of soft drinks containing added sugar.	UK

No best practices were identified relating to subsidies aimed at making healthy foods more affordable for families (key topic 3.5), and promotion of freshwater intake (key topic 3.6).

#### Area 4: Restrict marketing and advertising to children

In relation to Area 4, only one best practice on mandatory restricting advertising of HFSS foods was identified from the UK (Table 20). See also Table 24 for two additional best practices from Latvia and Greece to restrict the marketing of unhealthy foods in schools, key-topic 4.4 (Marketing activities in schools).

**Table 20 – Best practices for Area 4**

Best practices	Country
<b>4.1 Mandatory restrictions on marketing</b>	
<b>Ban on HFSS advertising (2009)</b> <sup>418</sup> - The UK Code of Broadcast Advertising was updated in 2009 to address childhood obesity by restricting the advertising of foods high in fat, salt, and sugar (HFSS), referred to as 'less healthy' food and drink products.	UK

No best practices were identified regarding voluntary marketing restrictions (key topic 4.2), and nutrient criteria to reduce marketing (key topic 4.3).

#### Area 5: Inform and empower families

Four best practices in four countries (IE, UK, FR, DE) were identified that cover solely key topics under Area 5 (Table 21). See also Table 24 for additional best practices under Area 5, key topics 5.1 (Campaigns on diet & physical activity targeting children and their families), 5.2 (Implementation community-based interventions) and 5.3 (Targeted support for disadvantaged families).

**Table 21 – Best practices for Area 5**

Best practices	Country
<b>5.1 Campaigns on diet &amp; physical activity targeting children and their families</b>	
<b>Let's Take on Childhood Obesity (2013-2016)</b> <sup>419</sup> - It is a public health campaign aimed at reducing childhood obesity and addressed to parents of children aged 2-12.	IE

<sup>417</sup> Legislation Government UK. (2018) Soft Drinks Industry Levy 2018 No. 264. Available at: [Link](#).

<sup>418</sup> CAP broadcast. (n.d.) The BCAP Code: The UK Code of Broadcast Advertising. Available at: [Link](#).

<sup>419</sup> CHORDIS. (2017). Let's Take on Childhood Obesity – The Childhood Overweight and Obesity on the Island of Ireland campaign Ireland. Available at: [Link](#).

Best practices	Country
<b>Better Health Campaign (2022)</b> <sup>420</sup> - The campaign aims at helping families eat better, ensuring that children are raised eating a more nutritiously rich diet.	UK
<b>5.2 Implementation community- based interventions</b>	
<b>EPODE methodology (1992)</b> <sup>421</sup> - EPODE is a coordinated, capacity-building strategy designed to combat childhood obesity through a societal process. It aims to create local environments, childhood settings, and family norms that promote healthy lifestyles in children, including enjoying healthy eating and active play.	FR
<b>5.3 Targeted support for disadvantaged families</b>	
<b>Grünau moves – “Grünau bewegt sich” (2015-2019)</b> <sup>422</sup> - It is a community-based health promotion intervention that aims to address obesity among children and adolescents in districts with particular social deprivation in the city of Leipzig. The intervention consists of multiple long-term smaller interventions that focus on social work and community integration.	DE

No best practices were identified for the provision of national nutrition guidelines (key topic 5.4).

## Area 6: Encourage Physical Activity

Five best practices that encourage physical activity have been identified in five countries (EE, HU, PT, IT, MT) under Area 6 (Table 22). See also Table 24 for additional best practices under Area 6, key topics 6.1 (Physical activity promotion for children), 6.3 (Infrastructure for physical activity) and 6.4 (Safe and easy active mobility).

**Table 22 – Best practices for Area 6**

Best practices	Country
<b>6.1 Physical activity promotion for children</b>	
<b>Liikuma kutsuv kool – Active travel to school (2017)</b> <sup>423</sup> - It is a science-driven education innovation programme aimed to develop and implement practices that support the physical activity of students and teachers.	EE
<b>Hungarian School Sports Day (2007)</b> <sup>424</sup> - The Hungarian School Sports Day is a national campaign established in 2007, run yearly by the Hungarian School Sports Federation. It seeks to encourage regular physical activity among children, thereby decreasing the risk of cardiovascular disease as well as obesity.	HU
<b>FITescola® (2016)</b> <sup>425</sup> - FITescola® program is responsible for monitoring the physical fitness of all students who attend elementary and high school in Portugal.	PT

<sup>420</sup> Department of Health & Social Care. (2022) New campaign launched to help parents improve children’s diet. Available at: [Link](#).

<sup>421</sup> Van Koperen, T. M. et al. (2013). Characterizing the EPODE logic model: unravelling the past and informing the future. *Obesity reviews*, 14(2), 162-170. Available at: [Link](#).

<sup>422</sup> GRÜNAU MOVES - „GRÜNAU BEWEGT sich“. Community-based health promotion and obesity prevention for children and adolescents in a district with particular social challenges in Leipzig, Germany. Available at: [Link](#).

<sup>423</sup> Available at: [Link](#).

<sup>424</sup> Hungarian Student Sport Federation. (n.d). Amire büszkék vagyunk. Available at: [Link](#)

<sup>425</sup> Fitescola. Available at: [Link](#).

Best practices	Country
<b>Pedibus scheme to go to school walking (2015)</b> <sup>426</sup> - The "Pedibus" is a walking school bus initiative in Italy where groups of children walk to school together under the supervision of adult volunteers, such as parents or guardians.	IT
<b>On the move programme (2015-2018)</b> - Initiative launched in 2015 to promote physical activity in schools during the break time.	MT

No best practices were identified regarding national physical activity guidelines (key topic 6.2).

## Area 7: Monitor and Evaluate

One best practice adopted in Estonia was identified to relate only to Area 7 (Table 23). See also Table 24 for additional best practices under Area 7, key topic 7.4 (Screening for childhood overweight and obesity).

**Table 23 – Best practices for Area 7**

Best practices	Country
<b>7.4 Screening for childhood overweight and obesity</b>	
Pay-for-performance system for family physicians (2006) – A voluntary programme that provides financial rewards to primary health care physicians when they reach service provision targets in disease prevention and management.	EE

No best practices were identified regarding national nutrition or physical activity surveys (key topics 7.1 and 7.2) or participation in international surveys (key topic 7.3).

## Best practices under more than one Area for Action

Several identified best practices touch upon two or three of the Areas for Action of the EU Action Plan. We have reported them in the table below.

**Table 24 – Best practices under more than one Area for Action**

Best practices	Country	Key topics under Areas for Action addressed
<b>Smart Family (2017-2018)</b> <sup>427</sup> - The project aimed at counteracting the increase of childhood obesity in Finland through lifestyle counselling by providing professionals with methods and tools to be used to support families with a wide range of information on child care and development.	FI	1.5, 5.2, 6.1

<sup>426</sup> Piedibus. (n.a.). The project of Piedibus. Available at: [Link](#).

<sup>427</sup> Neuvokas Perhe. (2021). Smart Family. Available at: [Link](#).

Best practices	Country	Key topics under Areas for Action addressed
<p><b>The BORIS registry: a national registry for childhood obesity in Sweden (2005)</b><sup>428</sup> - BORIS is a database for paediatric treatment of childhood obesity, administered by the National Centre for Childhood Obesity at Karolinska University Hospital. It aims at concentrating, evaluating and following up the outcomes of obesity treatments for children under 18 years old in the long-term, offering support to medical centres on how to best treat obesity in their patients.</p>	SE	1.5, 7.4
<p><b>Physical Activity on Prescription (PAP) (2000)</b><sup>429</sup> - The initiative allows health professionals to prescribe individualised prescriptions for physical activity in primary care based on the patient's health status, motivation, prior experiences, and preferences.</p>	SE	1.5, 6.1
<p><b>Frühe Hilfen - Early Help/Early Aid (2015)</b><sup>430</sup> - The intervention aims at reaching and helping families in need during pregnancy or within the first three years of a child's life. Frühe Hilfen adopts a multi-professional and multi-sectoral approach, prioritising networking with health and social services to strengthen family support systems.</p>	AT	1.6, 5.3
<p><b>Mothers as peer educators in a low socio-economic school setting in Southern Italy (2016)</b><sup>431</sup> - This local project aims to raise awareness about diet, physical activity, and sedentary lifestyle through mothers' involvement as "peer educators" in socio-economically disadvantaged contexts to improve childhood obesity. Mothers involved in this intervention transmit their skills to other mothers, which helps them gain knowledge on health promotion themes like a healthy diet, promotion of physical activity and reduction of sedentary behaviour.</p>	IT	1.6, 5.3
<p><b>SALzburg Together Against Obesity (SALTO) (2014-2017)</b><sup>432</sup> - The programme aimed to increase the proportion of pre-schoolers with a healthy body weight upon entering school, develop healthy lifestyles from a young age and reduce overweight and obesity by focusing on health literacy among kindergarten teachers and parents.</p>	AT	2.1, 2.4, 5.2, 6.1
<p><b>Toy-Box Study (2012-2013)</b><sup>433</sup> - Toy-Box is an intervention delivered in schools to children aged 3-4 years of age with the aim of promoting healthy lifestyles to prevent obesity.</p>	BG	2.1, 2.4, 5.2, 6.1
<p><b>Active School Flag (ASF) (2009)</b><sup>434</sup> - The ASF initiative takes a "whole school approach" to enhance physical activity levels for children between 5 and 17 years old. The ASF identifies four 'pillars' which are supportive of physical activity promotion in schools, and which schools are required to address in order to achieve the flag.</p>	IE	2.1, 2.4, 6.1

<sup>428</sup> WHO. (2019). Mapping the health system response to childhood obesity in the WHO European Region: an overview and country perspectives. Available at: [Link](#).

<sup>429</sup> OECD. (2022). Chapter 4. Physical Activity on prescription. Healthy eating and active lifestyle: best practices in public health. Available at: [Link](#).

<sup>430</sup> Available at: [Link](#).

<sup>431</sup> JANPA. (2016). Peer educator mothers. Available at: [Link](#).

<sup>432</sup> Ring-Dimitriou S. (2018). SALTO Update of a Community Oriented Core Setting Approach of Health Promotion in the Kindergarten. Available at: [Link](#).

<sup>433</sup> ToyBox Study. Available at: [Link](#).

<sup>434</sup> Chróinín, D. N., Murtagh, E., & Bowles, R. (2012). Flying the 'Active School Flag': Physical activity promotion through self-evaluation in primary schools in Ireland. *Irish Educational Studies*, 31(3), 281-296. Available at: [Link](#).

Best practices	Country	Key topics under Areas for Action addressed
<b>Jongeren Op Gezond Gewicht (JOGG) (2010)</b> <sup>435</sup> - JOGG is a community-based programme targeting children from 0 to 19 years old. The goal of the programme is to change food environments that children live in, to address excess weight and obesity.	NL	2.1, 2.4, 5.2, 6.3, 6.4
<b>Amsterdam Healthy Weight Approach/Programme (AHWA) (2012)</b> <sup>436</sup> - The programme aims to reduce the prevalence of childhood overweight and obesity in the city of Amsterdam over the course of 20 years via a “Health in All Policies” approach.	NL	2.1, 2.4, 5.2, 6.3
<b>Program Obesity Zero (POZ) (2009)</b> <sup>437</sup> - The program is designed to address health disparities by assisting overweight children aged 6-10 from low-income families. The programme consists of three different types of interventions delivered over a 6-month period in different settings.	PT	2.1, 2.4, 5.2, 6.1
<b>Healthy Lifestyle Programme (2011-2018)</b> <sup>438</sup> - The Healthy Lifestyle Programme aims to provide daily, regular, and high-quality structured sports exercise for youths aged 6 to 14 years old.	SI	2.1, 2.4, 6.1
<b>Polygon For Physical Activity of School-Aged Children (2014-2015)</b> <sup>439</sup> - The program provided schools with 25 moveable elements that are safe and fun for children to use during physical activity classes.	HR	2.1, 2.4, 6.1
<b>Target snack (2008)</b> <sup>440</sup> - The project aims to promote the consumption of healthy snacks among children between 6 and 11 years old by raising awareness and educating local paediatricians and primary school teachers.	IT	2.2, 5.1
<b>Total ban on unhealthy foods in schools (2006)</b> <sup>441</sup> - The ban aims at restricting the marketing of beverages and foods of limited nutritional value (such as soft drinks, confectionery, chewing gum and savoury snacks containing specific additives) in preschool institutions and schools, and to create conditions for making healthy foods easily available.	LV	2.3, 4.4
<b>Public Health Product Tax (2011)</b> <sup>442</sup> - The aim of the law was to promote healthier food choices, to facilitate food reformulation, and enhance the health status of the population through the income deriving from the applied taxation on food products (revenue earmarked to Public Health).	HU	2.3, 3.4

<sup>435</sup> Organisation for Economic Co-operation and Development. (2022). Healthy Eating and Active Lifestyles: Best Practices in Public Health. OECD Publishing. Available at: [Link](#).

<sup>436</sup> Gemeente Amsterdam (n.d.) Amsterdam Healthy Weight Programme. Available at: [Link](#).

<sup>437</sup> Rito, A. I. et al. (2013). Program Obesity Zero (POZ) – a community-based intervention to address overweight primary-school children from five Portuguese municipalities. Public Health Nutrition, 16(6), 1043–1051. Available at: [Link](#).

<sup>438</sup> Jurić, P. et al. (2022). Effectiveness of a population-scaled, school-based physical activity intervention for the prevention of childhood obesity. Available at: [Link](#).

<sup>439</sup> Krtalić, S. et al. (2020). Applicability and quality assessment of the set of equipment in the project “Polygon for physical activity of school-aged children” in primary schools without gymnasia. Kinesiology, 52(01), 134-142. Available at: [Link](#).

<sup>440</sup> JANPA. (2016). Target Snack. Available at: [Link](#).

<sup>441</sup> European Public Health Alliance. (2007). Junk food: Evolution of the legislation in European countries. Available at: [Link](#).

<sup>442</sup> Hungarian National Legislation Database. (2011). A népegészségügyi termékadóról. Available at: [Link](#).

Best practices	Country	Key topics under Areas for Action addressed
<b>School Canteen Hygiene Rules and Product Regulations (2013)</b> <sup>443</sup> - The act specifies the range of products that can be sold in canteens, with particular emphasis on nutritional labelling criteria such as their sugar and fats (including trans-fats) content.	EL	2.6, 4.4
<b>Public Catering Decree (2014)</b> <sup>444</sup> - The Decree sets requirements on energy/nutrition per portion sizes of food served as well as limits to salt, sugar, and fat.	HU	2.6, 3.7
<b>National Programme for the Promotion of Healthy Eating – “PNPAS” (2012)</b> <sup>445</sup> - The National Programme for the Promotion of Healthy Eating (PNPAS) is a strategic initiative to enhance nutritional health and encourage healthy eating habits.	PT	3.1, 5.2
<b>The EDDY Study (2017-2018)</b> <sup>446</sup> - The intervention aims to address childhood obesity through a 1-year lifestyle intervention in adolescents.	AT	5.2, 6.1, 7.4

#### 4.4.3 Best practices from third countries

The study identified some best practices from countries outside of the EU. These practices intend to reflect innovative approaches that have not been adopted in EU countries and are worth noting. The search for best practices was specifically targeted at high-income countries facing challenges similar to those experienced by the EU in addressing childhood obesity. This focused approach ensures that the identified best practices are potentially transferable and applicable to the context of the EU.

Five relevant best practices have been identified across **Australia, Canada, Chile, Israel** and the **United States** (Table 25). In Australia, mandatory menu labelling provides transparency regarding calorie information, empowering consumers to make informed choices about their food intake (Area 3: Make the healthy option the easier option). In Europe, Ireland, the UK, Finland and Slovenia adopted voluntary menu labelling in restaurants. However, the Australian menu labelling is considered a best practice over the European examples because of the mandatory regulatory framework and clear guidelines that food businesses receive to help them comply with the labelling requirements. Chile's implementation of food warning labels and advertising bans aims to promote healthier dietary choices by consumers (Area 3: Make the healthy option the easier option). While there is no single policy fully integrating both labelling and marketing bans into one cohesive framework, Chile's approach comes closest by combining both strategies in a comprehensive effort to promote healthier eating habits. Chile's warning sign system has been recognised by international health organisations, including the World Health Organization, as a model for other countries. It has inspired similar initiatives in countries like Peru, Mexico, and Israel. Canada's Breastfeeding Buddies (BFB) Programme offers support and guidance to mothers, encouraging and facilitating breastfeeding, which is a

<sup>443</sup> European Commission. (2023). Best Practises Portal – Greece, Greek school canteen policy. Available at: [Link](#).

<sup>444</sup> European Commission Best Practice Portal. (2016). Public Catering Act - EMMI Decree 37/2014. (IV.30). Available at: [Link](#).

<sup>445</sup> European Commission. (2017). Best Practices Portal – National programme for the Promotion of Healthy Eating. Available at: [Link](#).

<sup>446</sup> K. Wildhalm, O. Helk, O. Pachinger. (2018). The Viennese EDDY Study as a Role Model for Obesity: Prevention by Means of Nutritional and Lifestyle Interventions. Available at: [Link](#).

key determinant to preventing childhood obesity (Area 1: Support a healthy start in life). European countries have developed other community-based peer-feeding support initiatives, often through the Baby Friendly Hospital initiative, community healthcare services or paediatric hospitals. Nonetheless, the BFB program’s community development approach stands out by its scale and because it focuses on non-judgmental support, helping to create a welcoming and inclusive environment, as well as encouraging more mothers to seek help and practice breastfeeding goals. Israel’s Intensive Family Intervention Clinic provides targeted support and resources for families to address obesity and related health issues through personalised interventions (Area 1: Support a healthy start in life). While several European countries (IE, DK, and MT) have recently adopted new models to improve obesity management services in primary care, Israel’s model places a strong focus on empowering families in the process of treating childhood obesity, recognising the role of family dynamics in managing obesity, an approach that other EU countries are still lacking in their models. In the USA, the Healthy Food Financing Initiative (HFFI) aims to increase access to nutritious foods in low-income communities with limited access to fresh foods (“food deserts”), by providing financial incentives (one-time grant) to set up healthier food outlets (Area 3: Make the healthy option the easier option). The study’s research has not identified any policies that are similar to the HFFI in Europe, as many of the European approaches have focused on broader food security, nutrition policies, and community-based efforts through the Common Agricultural Policy (CAP) and the EU Green Deal.

**Table 25 – Best practices from third countries**

Best practices	Country
<b>Area 1: Support a healthy start in life</b>	
<b>Breastfeeding Buddies Programme (2001)</b> <sup>447</sup>	Canada
<b>Intensive Family Intervention Clinic (2006)</b> <sup>448</sup>	Israel
<b>Area 3: Make the healthy option the easier option</b>	
<b>Calories in menu labelling (2011)</b> <sup>449</sup>	Australia
<b>Food warning labels and advertising bans (2016)</b> <sup>450</sup>	Chile
<b>Healthy Food Financing Initiative (2014)</b> <sup>451</sup>	USA

<sup>447</sup> Breastfeeding Buddies. Available at: [Link](#).

<sup>448</sup> Endevelt, R. et al. (2014). An intensive family intervention clinic for reducing childhood obesity. *The Journal of the American Board of Family Medicine*, 27(3), 321-328. Available at: [Link](#).

<sup>449</sup> Food Ministers. (2011). Principles for introducing Point-of-Sale nutrition information at standard food outlets. Available at: [Link](#).

<sup>450</sup> Ministerio de Salud. (2019). Hoja Informativa. Evaluación ley de alimentos No20.606. Available at: [Link](#).

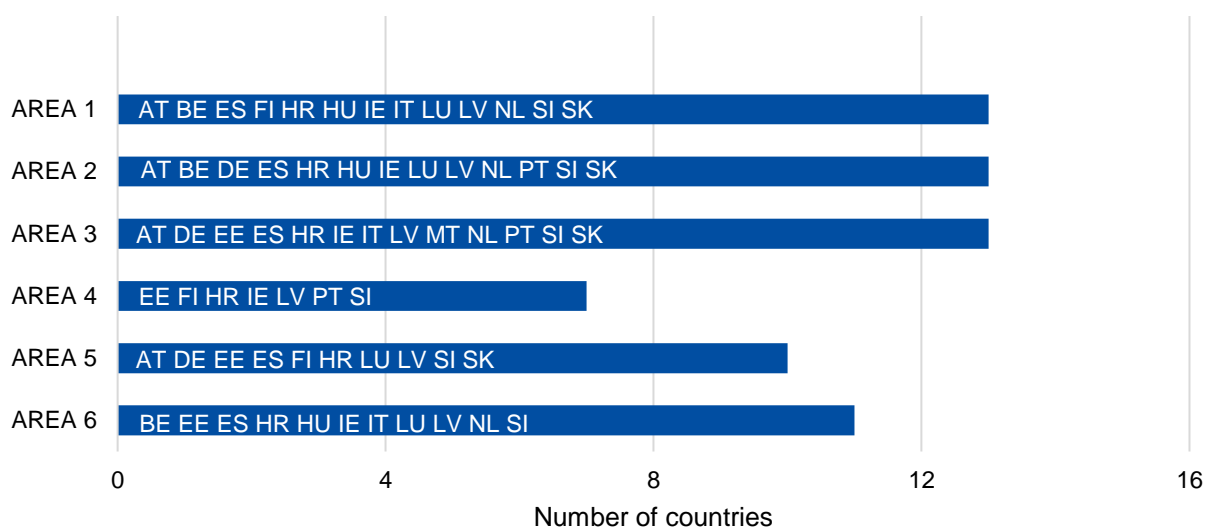
<sup>451</sup> The Food Trust. (n.d.). The Healthy Food Financing Initiative (HFFI). An Innovative Public-Private Partnership Sparking Economic Development and Improving Health. Available at: [Link](#).

## 4.5 Status of monitoring and indicators used

This section provides an overview of the indicators adopted by countries to monitor the implementation progress of policies and actions to address Areas 1 to 6 of the EU Action Plan.

Out of the 28 countries in the scope of the study, 25 of them reported that indicators are in place to monitor the progress of some, or many implemented policies and actions to tackle childhood obesity (see Figure below).

**Figure 27 – Overview of countries reporting to monitor indicators**



*Source: Authors' elaboration*

In Denmark, Poland, and Romania desk research did not yield any information regarding the status of monitoring. When national authorities were asked about their status in the survey consultation, they replied “I don’t know”. With reference to the indicators included in the EU Action Plan, the majority of the indicators suggested per Area for Action are monitored by countries reporting having monitoring indicators in place. Policies pertinent to Areas 1, 2 and 6 have a variety of other indicators to monitor their implementation.

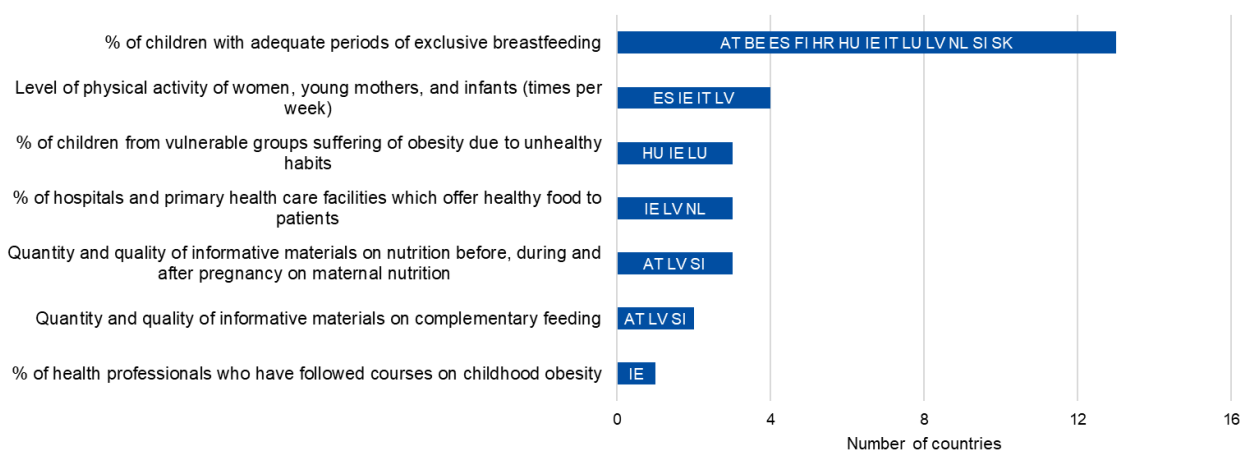
In Italy and Slovakia, monitoring of childhood obesity-related policies usually happens at the regional level, including the collection of data on dietary habits and weight status of the young population. Croatia, Ireland, Portugal and Spain regularly monitor the implementation of childhood obesity-related policies, including the impact of food reformulation policies. In Portugal, laws on restrictions on food marketing and national healthy eating programs are also monitored for progress. Luxembourg regularly monitors certain initiatives such as the GIMB (gesund iessen, méi bewegen). In the case of Austria, it was explicitly stated that this is not systematically done due to budgetary constraints. Furthermore, many of the standards developed for nutrition are voluntary, which makes implementation very weak and monitoring almost impossible. However, it is recognised that good policy monitoring systems can demonstrate their effects, and it would be much easier to argue in favour of further implementation or the expansion of certain policies. Interviewed representatives from the Netherlands reported that the government commissions research into the programmes they launch on a regular basis. For instance,

the National Prevention Agreement and the JOGG programme<sup>452</sup> have been monitored and evaluated.<sup>453</sup> Representatives from the United Kingdom, informed that national regulatory policies are subject to mandatory ‘post-implementation reviews’, which assess the effectiveness of a given policy measure after it has been implemented and in operation for a period of time. Among the evaluated policies, they mentioned the UK Soft Drinks Industry Levy,<sup>454</sup> being subject to an expansive evaluation. Lastly, Greek representatives informed that progress is currently monitored regarding the implementation of the legislation on the food standards for preschool premises and that the new National Action Against Childhood Obesity includes a working package on monitoring initiatives.

#### 4.5.1 Area 1 – Support a healthy start in life

In the survey consultation, a total of 13 country representatives claimed that in their country at least one of the monitoring indicators listed in Figure 28 below is kept track of to monitor progress in the implementation of policies/actions under Area 1 of the EU Action Plan.<sup>455</sup> The table shows that all of them monitor the ‘% of children with adequate periods of exclusive breastfeeding’.

**Figure 28 – Concerning Area 1, which of the following indicators does your country keep track of?**



Source: Authors' elaboration

Germany specified that they are developing a systematic breastfeeding monitor. Additionally, survey respondents reported that in Slovakia the number of kindergartens with nutrition education and the number of mothers receiving education and counselling are also monitored. In Hungary, several indicators are compulsory to be monitored within the framework of the home nurse system and the school-health system, as well as in the primary health care, e.g. % of children overweight/obese at schools, and % of newborns under 4 months for whom formula has been prescribed and bought. Czech national authorities claimed that under the Health 2030 – Strategic Framework for Healthcare

<sup>452</sup> Ministry of Sport. (n.a.). Werkt de JOGG-aanpak? Veranderingen in overgewicht en beweeggedrag bij kinderen en jongeren Available at: [Link](#).

<sup>453</sup> RIVM. (2021). Progress report National Prevention Agreement 2020. Available at: [Link](#) and [Link](#).

<sup>454</sup> Legislation Government UK. (2018) Soft Drinks Industry Levy 2018 No. 264. Available at: [Link](#).

<sup>455</sup> In total, 15 countries replied to this question and 12 countries (EE, PT, PL, BG, LT, DK, CY, EL, SE, RO, MT, and CZ) did not provide an answer. France replied with ‘I don’t know,’ while Germany selected the ‘Other’ option.

Development in the Czech Republic until 2030<sup>456</sup> some indicators relevant to the monitoring of policies under Area 1 are collected, including the number of persons supported by health promotion and screening programmes and the number of health promotion concepts at the municipal and regional level (see CZ country profile, Annex VI). Cypriot representatives reported that under the Strategy for Protection, Promotion, and Support of Maternal Breastfeeding in Cyprus,<sup>457</sup> maternal breastfeeding rates based on indicators from the WHO and UNICEF are collected (see CY country profile, Annex VI). Likewise, the Finnish National Action Plan for Breastfeeding Promotion<sup>458</sup> prescribes the collection of indicators relevant to the EU Action Plan objectives related to breastfeeding by the Finnish Institute for Health and Welfare (THL) and local and regional authorities but the data collected are not published (see FI country profile, Annex VI). The Estonian Public Health Development Plan<sup>459</sup> every few years collects indicators relevant to the implementation of policies under Area 1 of the EU Action Plan such as the share of infants aged 6 months partly or fully being breastfed (see EE country profile, Annex VI). Under the Italian National Prevention Plan,<sup>460</sup> Italian authorities monitor the prevalence of exclusive breastfeeding for babies under 6 months, and the percentage of women who breastfeed in the 12 months period after giving birth (see IT country profile, Annex VI). Lastly, the Luxembourgish National Breastfeeding Plan<sup>461</sup> foresees the monitoring of the prevalence and duration of breastfeeding in babies aged 4, 6 and 12 months (see LU country profile, Annex VI).

#### 4.5.2 Area 2 – Promote healthier environments

A total of 13 country representatives claimed that in their country at least one of the monitoring indicators listed in Figure 29 below is kept track of to monitor progress in the implementation of policies/actions under Area 2.<sup>462</sup> The table shows that all of them monitor the ‘% and/or number of schools that implemented the EU School Fruit scheme or similar’ and 11 countries monitor the ‘% and/or number of schools that implemented the EU Milk scheme or similar’. Luxembourg reports monitoring all the suggested indicators.

---

<sup>456</sup> Ministry of Health of the Czech Republic. (2020). Health 2030: Strategic Framework for Healthcare Development in the Czech Republic until 2030. Available at: [Link](#).

<sup>457</sup> Ministry of Health. (2011). Strategy for Protection, Promotion, and Support of Maternal Breastfeeding in Cyprus. Available at: [Link](#).

<sup>458</sup> National Institute for Health and Social Welfare. (2018). National action program for the promotion of breastfeeding for the years 2018-2022. Available at: [Link](#).

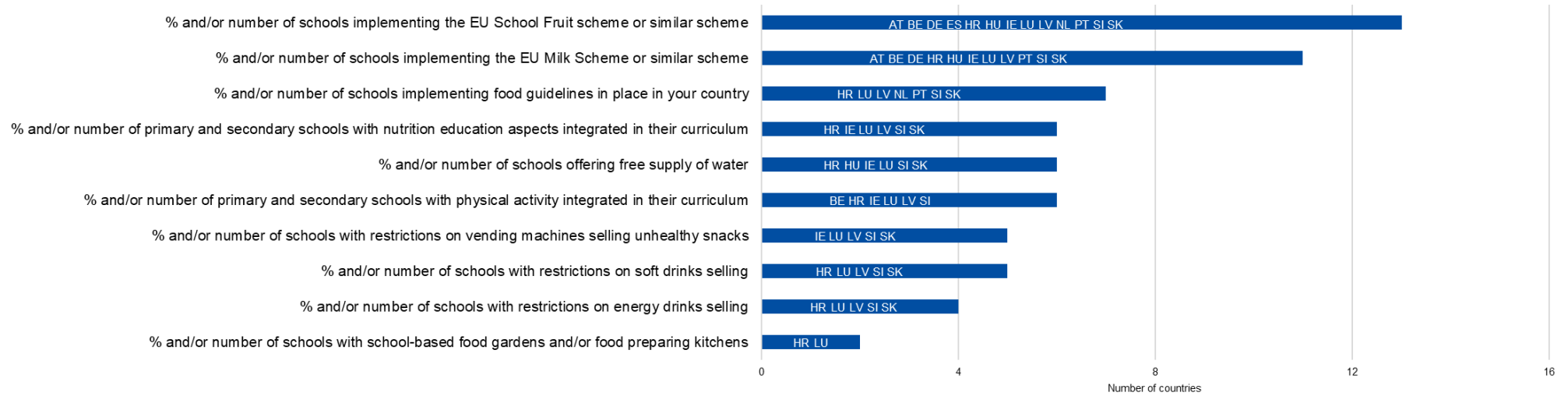
<sup>459</sup> Ministry of Social Affairs. (2020). Rahvastiku tervise arengukava 2020– 2030. Available at: [Link](#).

<sup>460</sup> Ministry of Health. (2020). National Prevention Plan. Available at: [Link](#).

<sup>461</sup> GIMB. (2019). National Breastfeeding Plan. Available at: [Link](#).

<sup>462</sup> 15 countries replied to this question and 12 countries (EE, PL, BG, LT, DK, CY, MT, FI, EL, SE, RO, and CZ) did not provide an answer. France and Italy replied with ‘I don’t know’.

**Figure 29 – Concerning Area 2, which of the following indicators does your country keep track of?**



Source: Authors' elaboration

A survey respondent representing Slovakia reported that the country also keeps track of the number of schools with integrated nutrition education; schools and school facilities implementing the school feeding framework<sup>463</sup>; schools implementing community-wide health promotion programmes; schools involved in school feeding development projects; establishments where no corrective measures have been imposed as a result of state health surveillance; and schools providing nutrition education to school catering staff. Additionally, survey respondents from Slovenia reported monitoring the number of primary schools implementing the Standards and Recipes for School Meals programme<sup>464</sup> as quality standards for school meals. Interviewed Finnish authorities reported collecting relevant indicators to the implementation of policies under Area 2 of the EU Action Plan on Childhood Obesity through the Eating and Learning Together – recommendations for school meals,<sup>465</sup> e.g. attendance at meals, customer feedback received and results of school meal survey, proportion of pupils who eat salad, proportion of “yes” answers to “it is nice to come to the school meal”, compliance with school meal recommendations (see FI country profile, Annex VI). Under the National Prevention Programme 'Spyros Doxiadis',<sup>466</sup> Greek authorities collect data regarding the percentage of schools that incorporate and implement education and health promotion actions as well as the percentage of students participating in sports activities outside the school curriculum program (see EL country profile, Annex VI).

#### 4.5.3 Area 3 – Make the healthy option the easier option

A total of 13 country representatives claimed that in their country at least one of the monitoring indicators listed in Figure 30 below is kept track of to monitor progress in the implementation of policies/actions under Area 3.<sup>467</sup> The table shows that nine countries indicated tracking the number of food reformulation agreements to reduce the salt content in foods. Slovenia is the country that is tracking most indicators, with data on six out of the nine predefined indicators.

---

<sup>463</sup> [Slovak 2021 final.indd.](#)

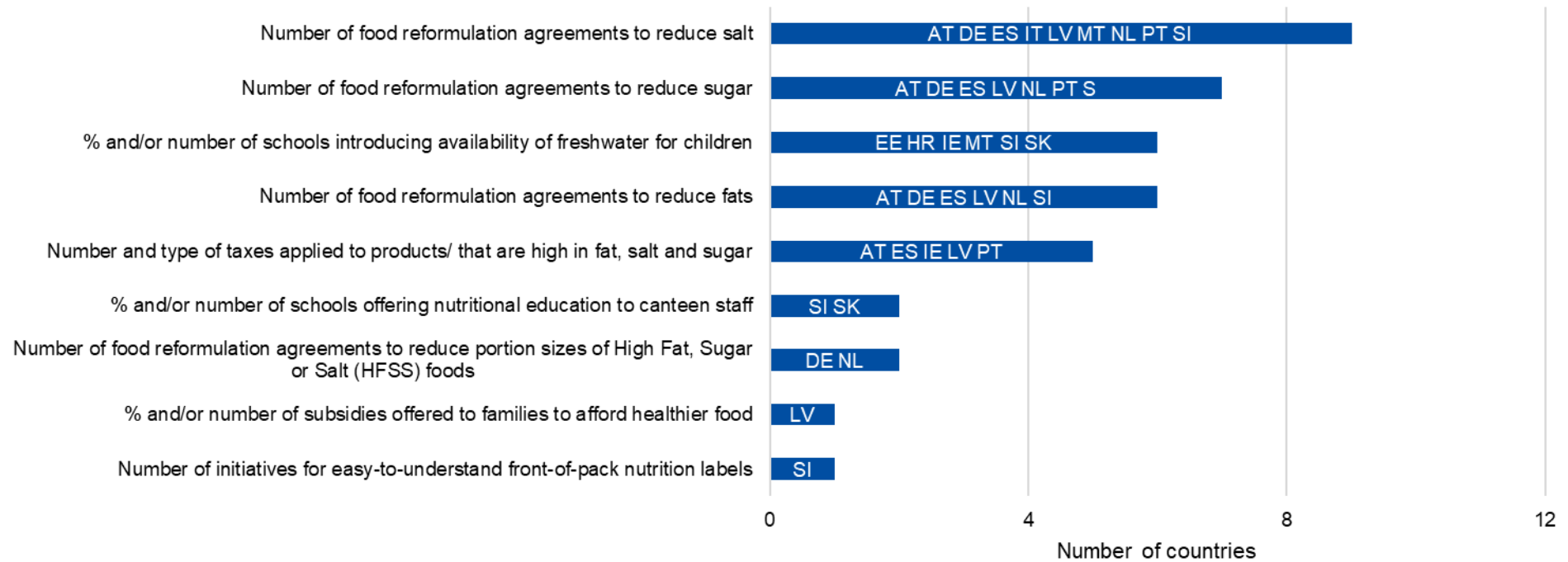
<sup>464</sup> [SI Slovenia FactSheet.](#)

<sup>465</sup> Finnish National Nutrition Council. (2017). Eating and Learning Together – Recommendations for school meals. Available at: [Link](#).

<sup>466</sup> Ministry of Health. (2020). National Prevention Program Spyros Doxiadis. Available at: [Link](#).

<sup>467</sup> 16 countries replied to this question and 11 countries (BE, PL, BG, LT, DK, EL, LU, SE, RO, CZ, FI) did not provide an answer. France and Cyprus replied with 'I don't know', while Hungary marked the option 'other'.

**Figure 30 – Concerning Area 3, which of the following indicators does your country keep track of?**



Source: Authors' elaboration

Survey respondents for Hungary reported that they are also tracking the ‘annual % and/or number of schools/students participating in the HAPPY Program (Hungarian Aqua Promoting Program in the Young)<sup>468</sup> and Aqua Challenge’. Moreover, Ireland set up a food reformulation task force working with industry to monitor voluntary food reformulation. Also, under the A Healthy Weight for Ireland: Obesity Policy and Action Plan 2016 – 2025,<sup>469</sup> Irish authorities keep track of salt, sugar, saturated fats, and calories reduction in food products (see IE country profile, Annex VI). Survey respondents representing Slovakia reported that the country also monitors the number of products included in the labelling scheme. Lastly, the German authorities replying to the survey reported that in the country, the reductions of sugar, fat, or salt in food products are also monitored as well as the number of food business operators (FBOs) including their brands that have registered for the FOP-Label Nutri-Score. According to consulted national representatives, the Dutch National Institute for Public Health and the Environment (RIVM) monitors the composition of groups of foods following voluntary agreements with the industry within the “National Prevention Agreement”.<sup>470</sup> RIVM will give an update on the improvement of food products in 2026, 2028 in 2031. Also, the UK interviewed representatives reported the UK Soft Drinks Industry Levy to have undergone an expansive evaluation process whereby the effectiveness of the tax was under exam.<sup>471</sup> In this respect, the French National Nutrition and Health Programme – PNNS<sup>472</sup> prescribes the collection of indicators such as the number of catering companies having implemented the Nutri-Score, as well as the number of commitments to framework specifications for federations and organisations concerning healthier food in vending machines (see FR country profile, Annex VI). Greek authorities under the National Action Plan on Food Reformulation<sup>473</sup> conduct food analysis and collect self-reported data from the industry and from food labelling (see EL country profile, Annex VI). Lastly, the Lithuanian National Health Strategy (implementing the National Public Healthcare Plan 2012– 2026),<sup>474</sup> includes the monitoring of consumption of vegetables and fruits per capita and the number of health-promoting foods labelled with the keyhole symbol (see LT country profile, Annex VI). The Portuguese National Programme for the Promotion of Healthy Eating<sup>475</sup> includes the monitoring of (i) the monthly evolution in total sales of sugary and sweetened beverages, (ii) the evolution of the average sugar content per 100ml, (iii) average price evolution (€ per litre) of sugary drinks, (iv) the evolution of the weighted average salt content (g) per 100 g of food, by food categories and (iv) the evolution of sugar content per 100g/100ml of food, by food categories (see PT country profile, Annex VI).

#### 4.5.4 Area 4 – Restrict marketing and advertising to children

A total of 7 countries' representatives claimed that in their country at least one of the monitoring indicators listed in Figure 31 below is kept track of to monitor progress in the

<sup>468</sup> National programme to promote water drinking for young people | Pedagogical journals. Available at: [Link](#)

<sup>469</sup> HSE. (2016). A healthy weight for Ireland. Obesity Policy and Action Plan. Available at: [Link](#).

<sup>470</sup> MVO Nederland. (2018). National Prevention Agreement 'Nationaal Preventie Akkoord'. Available at: [Link](#).

<sup>471</sup> Pell, D. et al. (2019). Support for, and perceived effectiveness of, the UK soft drinks industry levy among UK adults: cross-sectional analysis of the International Food Policy Study. *BMJ open*, 9(3), e026698. Available at: [Link](#).

<sup>472</sup> Ministère de la santé et de la prévention. (2019). Programme National Nutrition Santé (PNNS). Available at: [Link](#).

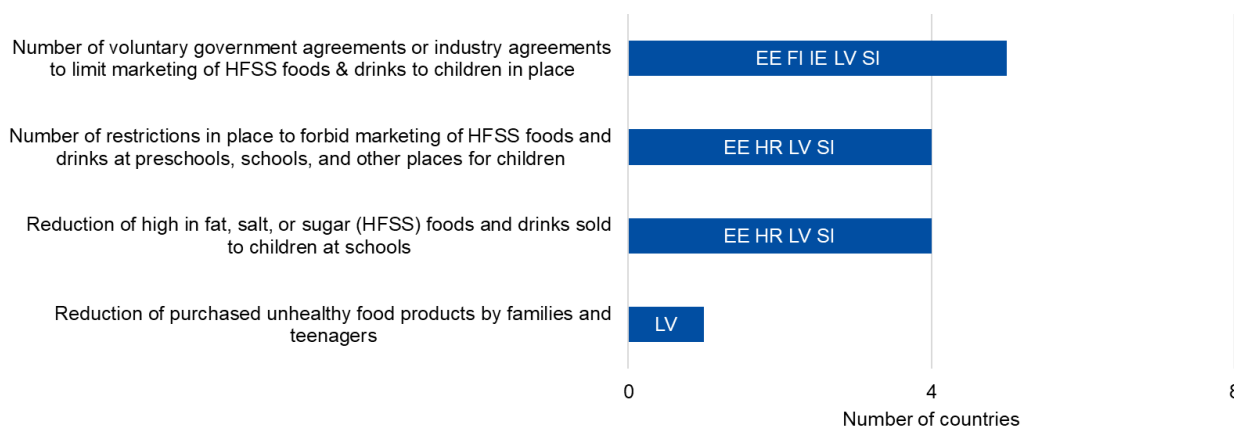
<sup>473</sup> Ministry of Health. (2017). Greece's National Action Plan on Food Reformulation. Available at: [Link](#).

<sup>474</sup> Database of the Parliament of the Republic of Lithuania. (2015). Dėl nacionalinės visuomenės sveikatos priežiūros 2016–2023 metų plėtros programos patvirtinimo. Available at: [Link](#).

<sup>475</sup> Alimentacao Saudavel. (2012). Conheça o PNPAS. Available at: [Link](#).

implementation of policies/actions under Area 4.<sup>476</sup> The table below shows that a total of five countries monitor the 'number of voluntary agreements or industry agreements to limit marketing of HFSS food and drinks to children in place'. Latvia reports monitoring the four suggested indicators under Area 4.

**Figure 31 – Concerning Area 4, which of the following indicators does your country keep track of?**



Source: Authors' elaboration

The interviewed Croatian representative highlighted that the monitoring of compliance with marketing restrictions on HFSS products is challenging. In Luxembourg the Eat Healthy, Move More (GIMB) National Framework Plan<sup>477</sup> prescribes the monitoring of activities implemented for the restriction of advertising and marketing of certain food products (see LU country profile, Annex VI).

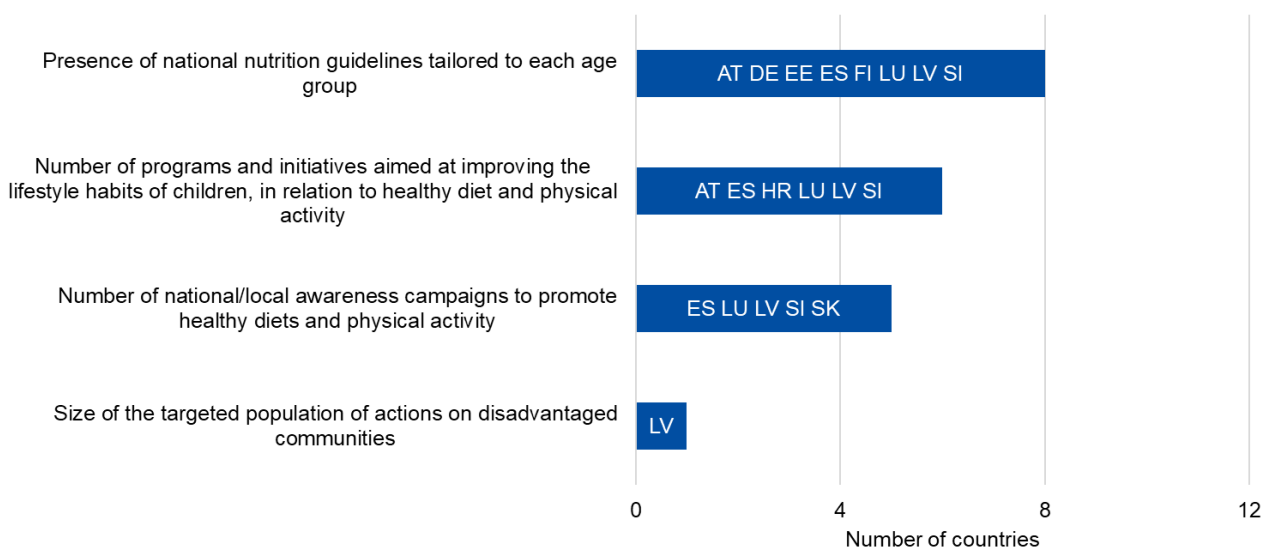
#### 4.5.5 Area 5 – Inform and empower families

A total of 10 country' representatives claimed that in their country at least one of the monitoring indicators listed in Figure 32 below is kept track of to monitor progress in the implementation of policies/actions under Area 5.<sup>478</sup> The table shows that a total of eight countries monitor the 'presence of national nutrition guidelines tailored to each age group'. Latvia reports monitoring all four suggested indicators under Area 5.

<sup>476</sup> 12 countries replied to this question and 15 countries did not provide an answer. Four countries (NL, SK, FR, LU) replied with 'I don't know', while Portugal marked the option 'none of the above'.

<sup>477</sup> Ministry of Health. (2018). Plan cadre national "Gesond iessen, méi beweegen" 2018– 2025. Available at: [Link](#).

<sup>478</sup> 13 countries replied to this question and 14 countries did not provide an answer. Two countries (FR, NL) replied with 'I don't know', while Italy marked the option 'other'.

**Figure 32 – Concerning Area 5, which of the following indicators does your country keep track of?**

Source: Authors' elaboration

Italy replied 'other' to the question and subsequently specified that the indicators presented are monitored in the context of the National Prevention Plan, implemented by Italian regions with their regional prevention plans. The survey respondent representing Slovakia added that the country also monitors the 'number of campaigns to raise awareness of the importance of nutrition labelling' as well as 'the number of people listening to the messages and acting on the campaigns'. Pursuant to the National Action Plan for the Promotion of Physical Activity,<sup>479</sup> Slovakian authorities also keep track of the number of kindergartens involved in projects related to physical activity, the number of children completing swimming, skiing, skating, or other training with a focus on physical activity, the number of schools with 3 hours of physical and sports training in primary school and the number of kindergartens and schools participating in the campaign "To Schools on Bicycles". Cypriot authorities reported that under the National Youth Strategy (NYS),<sup>480</sup> some indicators relevant to the monitoring of policies under Area 5 are collected, e.g. the number of children participating in the sports for all programmes (see CY country profile, Annex VI). Likewise, the Swedish "Towards a good and equitable health. A framework for implementing and monitoring the national public health policy"<sup>481</sup> indicates the collection of data on the number and quality of structured health dialogues in schools, focused on lifestyle factors and access to advice/counselling centres for young people through student health services (see SE country profile, Annex VI).

<sup>479</sup> SlovakLex. (2024). National action plan for the promotion of physical activity for the years 2024-2030. Available at: [Link](#).

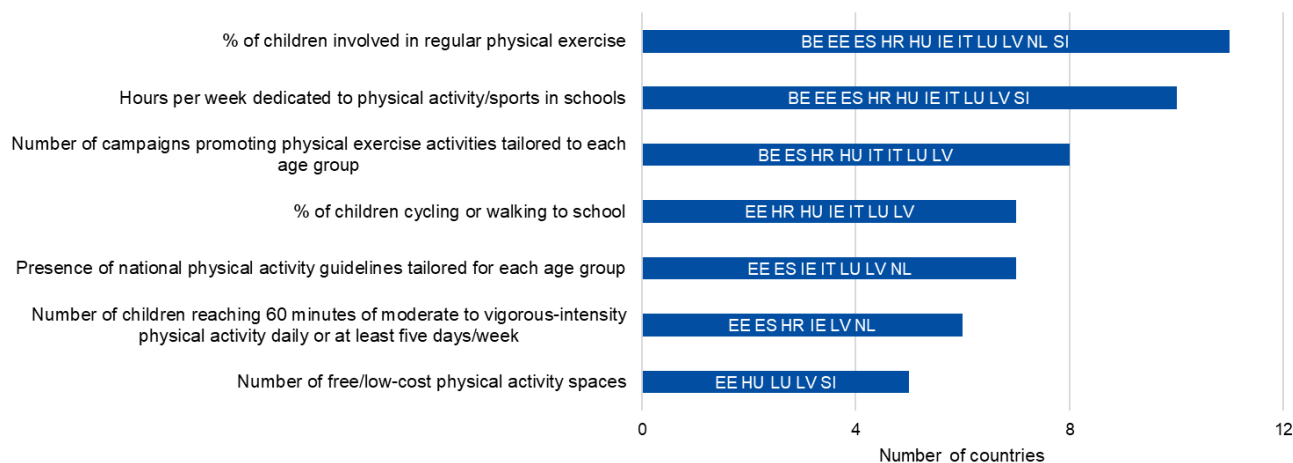
<sup>480</sup> Youth Board of Cyprus. (2017). National Youth Strategy description. Available at: [Link](#).

<sup>481</sup> Public Health Agency of Sweden. (2021). Towards a good and equitable health. A framework for implementing and monitoring the national public health policy. Available at: [Link](#).

#### 4.5.6 Area 6 – Encourage physical activity

A total of 10 country representatives claimed that in their country at least one of the monitoring indicators listed in Figure 33 below is kept track of to monitor progress in the implementation of policies/actions under Area 6.<sup>482</sup> The table below shows that all the responding 11 countries track the ‘% of children involved in regular physical exercise’. Lastly, Latvia reports monitoring all the seven suggested indicators under Area 6.

**Figure 33 – Concerning Area 6, which of the following indicators does your country keep track of?**



Source: Authors' elaboration

In the context of physical activity, Slovakia monitors the ‘number of schools implementing the EU Recommendation on the promotion of health-promoting physical activity in school curricula<sup>483</sup>’, the ‘number of supported civic associations in the field of sport’, the ‘number of children and adults involved’, the ‘number of schools and adults participating in the European Week of Sport’, and the ‘presence of playgrounds, free or reasonably priced sports facilities, infrastructure for walking and cycling in the community’. Czech Republic interviewed representatives reported that under the Action Plan for Promoting Physical Activity,<sup>484</sup> some indicators relevant to the monitoring of policies under Area 6 are collected, e.g. existence of physical activity support programmes for families with children (see CZ country profile, Annex VI). Likewise, Finnish authorities collect data regarding the implementation of programmes promoting physical activity among children through the National Obesity Programme,<sup>485</sup> in particular the monitoring of the number of hours of physical activity done by students, and through the number of registered municipalities and Early Childhood and Education Care units within the Joy in motion programme,<sup>486</sup> as well as the quality of the work in such units, and the amount of time spent doing physical activity in early childhood (see FI country profile, Annex VI). The Greek E.Y.Z.H.N –

<sup>482</sup> 13 countries replied to this question and 14 countries did not provide an answer. France replied with ‘I don’t know’, while Slovakia marked the option ‘other’.

<sup>483</sup> WHO (2018) Promoting Physical Activity in the Education Sector. Available at: [Link](#).

<sup>484</sup> Ministry of Health of the Czech Republic. (2015). Action Plan for Promoting Physical Activity. Available at: [Link](#).

<sup>485</sup> National Institute for Health and Welfare. (2018). Wellbeing through healthy nutrition and physical activity. Available at: [Link](#).

<sup>486</sup> Ministry of Education and Culture. (2016). Joy in motion programme – National physical activity and well-being programme. Available at: [Link](#).

National Action Plan for Children's Health<sup>487</sup> also prescribes the collection of data on children's physical condition and level of physical activity (see EL country profile, Annex VI). Under the Get Ireland Active! The National Physical Activity Plan for Ireland,<sup>488</sup> Irish authorities collect data on the proportion of children undertaking at least 60 minutes of moderate to vigorous physical activity every day and the proportion of children who do not take any weekly physical activity (see IE country profile, Annex VI). Further, the Latvian Health Promotion and Disease Prevention Plan,<sup>489</sup> commands the collection of data related to the proportion of the population (15 – 74 years) who spend at least 30 minutes, of their leisure time, 2 or more times a week, exercising with physical activity and the percentage of children (11, 13 and 15 years) being physically active (physical activity for at least 60 minutes per day) (see LV country profile, Annex VI). Lastly, under the National Sports Development Strategy,<sup>490</sup> Lithuanian authorities keep track of the share of students who participate in non-formal sports activities (see LT country profile, Annex VI).

---

<sup>487</sup> EYZHN. (2023). Description / Aims / Action of the project. Available at: [Link](#).

<sup>488</sup> Ministry of Health & Ministry of Transport, Tourism and Sport. (2016). Get Ireland Active. National Physical Activity Plan for Ireland. Available at: [Link](#).

<sup>489</sup> Ministry of Health. (2017). Health promotion and disease prevention plan. Available at: [Link](#).

<sup>490</sup> Database of the Parliament of the Republic of Lithuania. (2011). On the approval of the state sports development strategy. Available at: [Link](#).

## 5 Stakeholders' views on the EU Action Plan

This chapter presents the feedback collected through a survey with the national authorities, follow-up interviews as well as other relevant stakeholders (i.e. national and international NGOs, consumer organisations, academic experts and industry representatives) with respect to the impact of the EU Action Plan and recommendations for action.

### 5.1 Member States

This section presents both quantitative and qualitative results from the survey conducted with 40 national representatives and interviews with 42 representatives from ministries, national public health agencies, institutes of public health, and food safety agencies. It provides an overview of Member States' perspectives on the impact of the EU Action Plan, by examining the national authorities' familiarity with the plan and their views on its added value. Additionally, it explores the policymaking processes behind policies adopted since 2014 to address childhood obesity, assesses the national authorities' views on other EU initiatives accompanying the EU Action Plan, and summarises future actions that national authorities recommended.

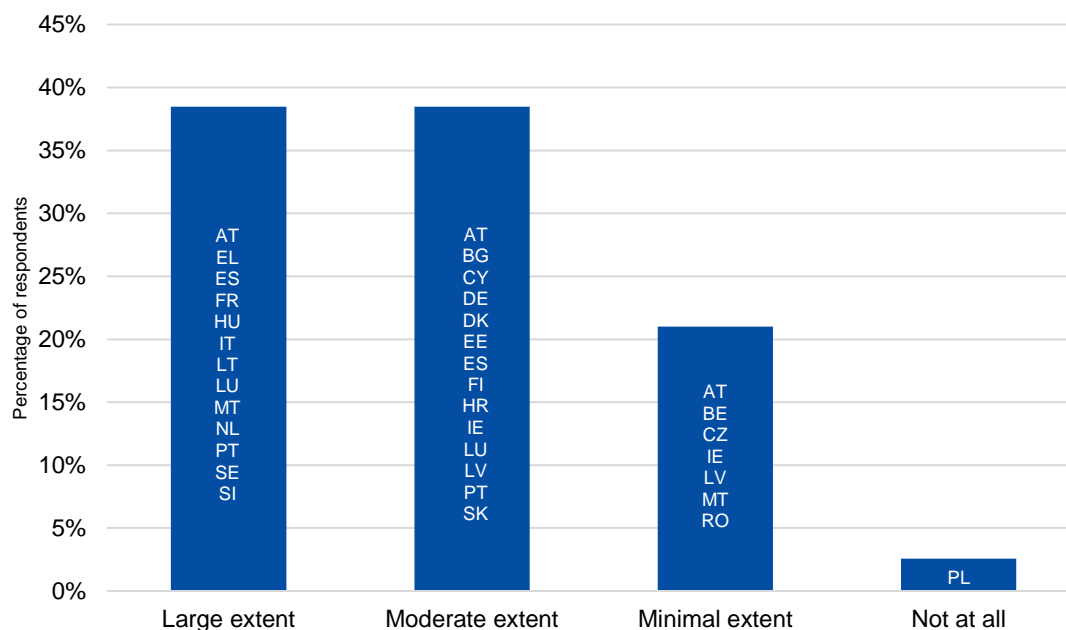
Survey and interview data have been divided into factual and subjective to enable in-depth qualitative analysis. Survey data have been grouped 'per country' when the reported statements are factual (e.g. policies in place and planned policies). In cases where multiple responses were received from the same country, these were integrated to provide a unified country-level response. For example, if one respondent indicated that Country A has nutritional labelling and another did not mention this but noted that Country A has taxes on unhealthy foods, we interpreted that Country A has both nutritional labelling and taxes on unhealthy foods. Conversely, when the information provided is primarily subjective (e.g. familiarity with the EU Action Plan), we refer to 'survey/interview respondents' as individuals. In this case, all the responses were reported, although sometimes contradictory (e.g. One representative of Country A claimed not to be familiar with the EU Action Plan while another representative of Country A claimed to be very familiar with it).

#### 5.1.1 Impact of the EU Action Plan

##### 5.1.1.1 Familiarity with the EU Action Plan

Overall, 38% of respondents (15 out of 40) claimed that they are familiar with the EU Action Plan 'to a large extent', 40% (16 out of 40) of respondents declared to be familiar with the EU Action Plan 'to a moderate extent' and 20% (8 out of 40) of respondents only 'to a minimal extent' (see Figure 34).

**Figure 34 – Extent to which national respondents are familiar with the EU Action Plan on Childhood Obesity 2014-2020**



Source: Authors' elaboration

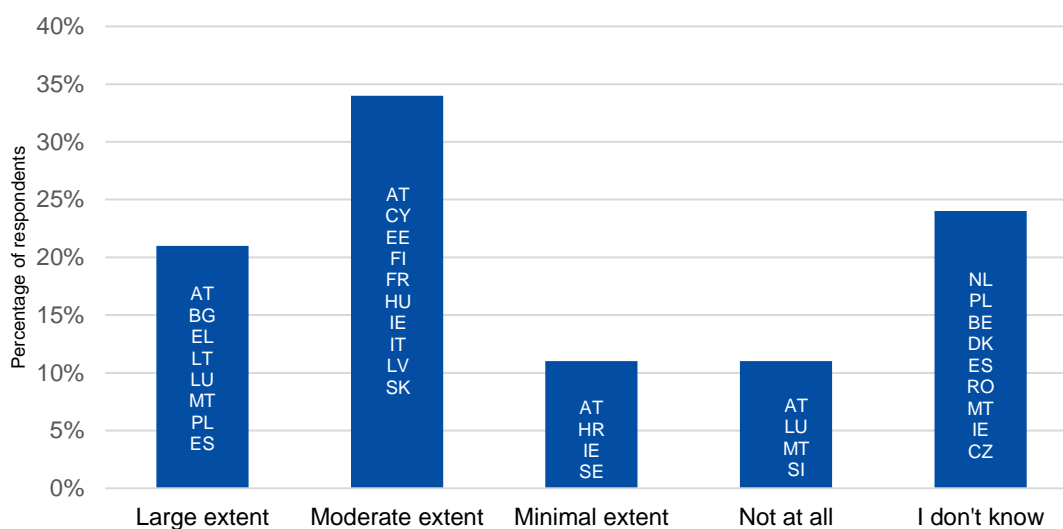
During the follow-up interviews, Member State representatives were asked to elaborate on their responses to the survey. Representatives from **Austria, Croatia, Denmark, Bulgaria** and **Slovenia** expressed confident familiarity with the EU Action Plan as it has been used as a guiding framework for national policy. Similarly, the representative from **Luxembourg** mentioned being familiar with the plan, mainly because they work in the preventive department of the Directorate. The **Cyprus** representative stated their familiarity with the Plan because they were involved in its drafting, in quality of a member of the former High-level Group for Nutrition and Physical Exercise. The representatives of **Slovakia, Greece, Latvia, Czech Republic, Finland, Lithuania** and the **United Kingdom** were also very familiar with the Plan and its objectives, which are aligned with the national political priorities in the respective countries. Czech authorities specified that the EU Action Plan on Childhood Obesity 2014-2020 was created at the same time as the Czech strategy "Health 2020 - Proper nutrition and eating habits - obesity prevention for the period 2015 – 2020" and has similar principles and goals. Conversely, the representative from the Public Health Agency from **Sweden** mentioned being to a minimal extent familiar with the EU Action Plan, indicating that it has not played a prominent role in shaping the country's approach to addressing overweight and obesity. Likewise, a **Belgian** respondent was not aware of the EU Action Plan but also stated that the department is working on a childhood obesity initiative which seems to be aligned with the objectives of the EU Action Plan.

#### 5.1.1.2 Added value of the EU Action Plan

In total, 38 out of 40 respondents replied to this question as respondents from Germany and Poland did not provide an answer. 21% of representatives (8 out of 38) believed that the EU Action Plan facilitated the introduction and/or the strengthening of national policies

in the field ‘to a large extent’. In contrast, 34% of stakeholders (13 out of 38) thought that the EU Action Plan did so ‘to a moderate extent; and 11% (4 out of 38) supported such a statement only ‘to a minimal extent’. Other 11% of respondents (4 out of 38), believed that the EU Action Plan did not help with the introduction or the enhancement of national measures combating childhood obesity in their respective countries. 24% of respondents (9 out of 38) did not know an answer to the question (see Figure 35).

**Figure 35 – To what extent the EU Action Plan on Childhood Obesity facilitated the introduction, or the strengthening of any policies implemented in your country?**



Source: Authors' elaboration

The follow-up interviews revealed that for most of the countries consulted (Austria, Spain, Ireland, Italy, Luxembourg, and Portugal), the EU Action Plan has been highly relevant in adopting or strengthening measures to tackle childhood obesity. However, Sweden and Belgium did not find it relevant.

Specifically, in **Spain**, the EU Action Plan influenced the adoption of national policies on the promotion of nutrition, physical activity, and surveillance of obesity, and contributed to the elaboration of initiatives in a combined action plan from the Ministry of Health. Additionally, according to Spanish representatives, the EU Action Plan set goals and standards for the entire EU, and they consider that such common goals and approaches are more effective than national individual approaches. **Portuguese** representatives deemed it important to have a set of actions on which national governments can take inspiration when adopting measures in this field. **Luxembourg** authorities explained that the EU Action Plan has provided a framework to follow for initiatives including physical activity, quality assurance for the sector, promotion of healthy activities for kids, and extensive offers for out-of-school care for children where healthy habits are promoted. Lastly, the EU Action Plan helped raise further awareness and interest among relevant stakeholders. According to an **Irish** representative, the EU Action Plan, together with the WHO Action Plan on Ending Childhood Obesity, support the implementation of policies that tackle childhood obesity. Around 2017, the Irish Health Service Executive (HSE) developed a national child health programme in which childhood obesity was included as a priority. During their work, they used the EU and WHO action plans as documents of support. The representative said that it helped to put a childhood lens on national policy.

Moreover, they noted that many of the themes of national obesity policy and the EU Action Plan are common, and there is nothing contradictory between the approaches.

The **Cypriot** authorities claimed that the country would probably not have adopted certain policies and achieved certain results if it were not for the existence of the Action Plan, which steered the national agenda and provided information and experiences from other countries. Likewise, the **Slovakian, Greek, Finnish, Croatian, Lithuanian, Danish and Slovenian** authorities reported that the EU Action Plan supported the adoption of many policies on the matter in the respective countries, which are indeed aligned with the objectives of the EU Action Plan. Specifically, **Croatian** authorities also reported that the EU Action Plan promoted the adoption of the Zagreb Declaration<sup>491</sup>, a result of the Summit of the Spouses of European Leaders. Within the Declaration, spouses of European leaders agreed to work together on a multi- and cross-sectoral level across relevant sectors and disciplines to find innovative solutions to promote breastfeeding, improve nutrition (a healthy and balanced diet), strengthen sustainable and secure food systems, reduce sedentary behaviours and increase physical activity for children from an early age. They also bring a set of policy recommendations to reduce childhood obesity.

**Austrian** authorities reported that the EU Action Plan has helped underline the need for policies tackling the childhood obesity problem and has helped guide national efforts within the separate areas of competency in the national administration. Lastly, **Bulgarian** authorities claimed that Bulgaria might have performed worse if the EU Action Plan on Childhood Obesity was not in place. The plan gives broad overview of all key areas that require action, it brings the agenda for fighting the childhood obesity epidemic higher on the governmental list of priorities and creates momentum among the countries in the EU to feel more accountable for not implementing efficient policies. In line with this, representatives from the **United Kingdom** support the EU Action Plan as an initiative that promotes the sharing of international best practices. Moreover, they believe that the implementation of the same initiatives across countries helps create a helpful and solid precedent to guide actions.

On the other hand, representatives of **Italy** claimed not to be aware of the influence of the EU Action Plan on national policymaking. However, they recall the EU Action Plan being useful for the Non-Communicable Diseases Department at the Ministry of Health since there is an alignment between the objectives of the Action Plan and measures adopted by the department (e.g. reduction of the pressure of marketing on buying HFSS food products, life course approach to obesity, and attention to the surrounding environment of consumers). The representative of **Sweden** reported that the EU Action Plan is not very well known among the Swedish authorities, hence it has not facilitated the adoption of any policies in the field of childhood obesity. The national authorities from **Belgium** and the **Netherlands** reported that the Action Plan did not result in specific actions at the national level. Among other reasons, these respondents considered an action plan as not the best 'legislative' tool to achieve the proposed objectives, yet they recognised that the Commission has limited competencies on the matter. The respondents further believed that the EU Action Plan was not as impactful because it was not 'advertised' among stakeholders, and the objectives were not accompanied by funding to support specific national actions.

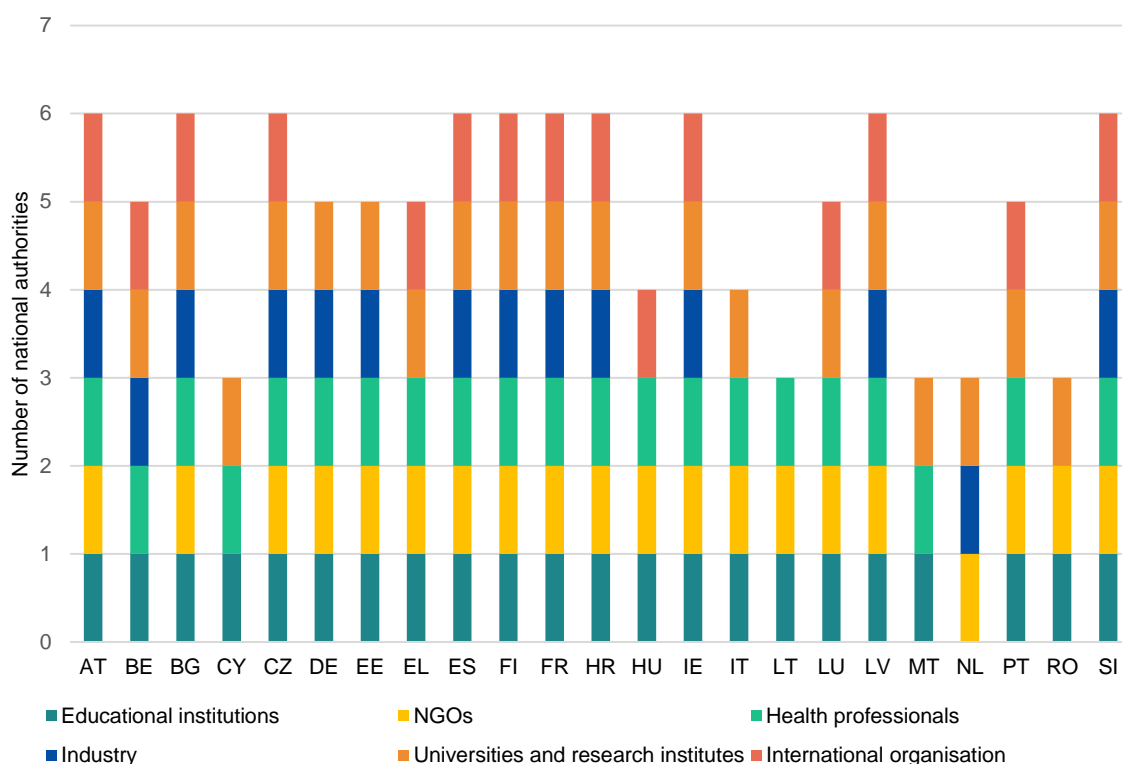
---

<sup>491</sup> Zagreb Declaration (2020). Available at: [Link](#).

### 5.1.2 Stakeholder involvement in policy-making process

National authorities responding to the survey were asked about the policy-making process for measures related to the Areas for Action of the EU Action Plan. In particular, the survey explored the involvement of different categories of stakeholders in policy-making, shown in Figure 36. All countries responded to the question. The graph displays responses from 23 countries that provided positive feedback.<sup>492</sup> Of these, 22 countries reported involving educational institutions, while 21 countries involved health professionals. NGOs and universities are also widely included in the policy-making process, with 20 and 21 countries, respectively, reporting their involvement. Notably, nine countries (CY, EL, HU, IT, LT, LU, MT, RT, RO) did not indicate 'industry' as being involved in the policy-making process.

**Figure 36 – Did your country include any stakeholders in the drafting and implementation of policies aimed at tackling childhood obesity?**



Source: Authors' elaboration

In addition, **Ireland's** representative responding to the survey added that the country involves children and youth as key stakeholders in policy-making while **Germany** specified that the involvement of the different stakeholder groups varied according to the specific policies concerned, without specifying which stakeholders.

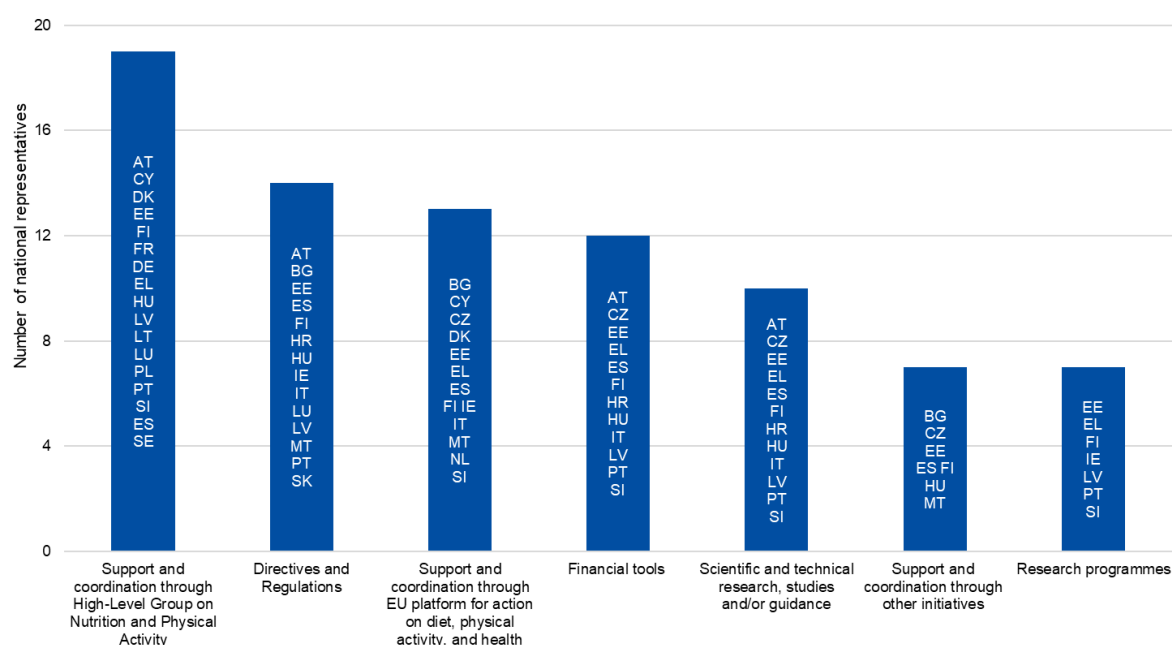
<sup>492</sup> Three countries (PT, SK, SE) replied with 'I don't know', while Denmark marked the option 'other'.

### 5.1.3 Perceptions of the EU Action Plan and other EU Actions

Consulted national authorities have been asked feedback on the actions of the European Commission concerning the implementation of the EU Action Plan. All countries except Poland replied to this question, due to the declared unfamiliarity with the EU Action Plan (under Question 2.1 of the survey).

Figure 37 displays the answers from 21 countries that provided a positive response.<sup>493</sup> Notably, the results show that support and coordination through the High-Level Group on Nutrition and Physical Activity was the most useful action of the Commission in this regard. Additionally, EU directives and regulations, financial tools and the support and coordination through the EU platform for action on diet, physical activity, and health are also deemed as very useful EU actions.

**Figure 37 – What have been, in your country’s experience, the most useful actions of the European Commission with respect to the implementation of the EU Action Plan on Childhood Obesity?**



Source: Authors' elaboration

During the interviews, national representatives from **Cyprus** and **Belgium** confirmed that the EU platform for action on diet, physical activity, and health and the High-Level Group on Nutrition and Physical Activity have been valuable initiatives, including offering coordination and a forum to exchange views among the Member States.

<sup>493</sup> Five countries (BE, DE, FR, RO and SE) replied that they did not know the answer to the question.

### 5.1.4 Member State Recommendations

As one of the final questions to the survey, and during interviews, Member State representatives were asked what kind of support they would like to receive at EU level to improve the state of childhood obesity in their country. Suggestions and recommendations for the future included:

- **Adopting multisectoral cooperation** focused on improving dietary behaviours, increasing physical activity and reducing sedentary behaviours, and reducing exposure to marketing of HFSS products (CY, FI, ES, and LT). To this purpose, Member States suggested strengthening actions at the EU level to reduce the marketing of unhealthy foods to children (AT, FI, IE, ES, LT, MT, SI) – as the Audiovisual Media Services Directive is deemed not to be as ambitious in this sense – as well as increasing awareness and attention to the level of access and influence that commercial actors and factors have on implementing regulations of food and marketing environments (IE).
- **Incentivise the industry** to produce "healthier" food products (SI). Alongside this, introducing a **front-of-pack nutrition labelling model for the EU** is deemed necessary to regulate the field (AT, BE, FI and LV).
- **Integrate sustainable diets** into other politics related to health (ES).
- Establishing a **formal forum** to share experiences and ideas concerning actions undertaken and related challenges of childhood obesity (AT, BE, CZ, ES, HU, LU, and PT) as well as **adopting guidance on the implementation of best practices** (BG and CZ).
- Providing **financial support through EU programmes** to achieve the Action Plan's objectives (CY, CZ, HU, LU, LV, MT, and PT), including joint actions (BE).
- **Increasing monitoring of actions adopted at the EU level** as national initiatives tend to be implemented without as much need for monitoring of actual results post-implementation (LU).
- **Financing for prevention actions**, including in pre-school phases, which solidly involves parents, who are the carers of children (BE).
- Launching a **new EU Action Plan on Childhood Obesity** (CY, ES, LT, PT and SI).

During the follow-up interviews, the **Austrian** representative argued for a revision of the EU Action Plan to establish mandatory restrictions on HFSS food marketing. An EU-wide approach combined with mandatory standards would allow greater comprehensiveness against the global nature of the advertisement and adherence to voluntary regulations. Moreover, the representative added that monitoring and evaluation standards for advertisements should be more rigorous. Additionally, they highlighted the economic costs of childhood obesity and the importance of promoting a sustainable food system. To achieve that, they pointed out that social and healthcare systems should ensure that healthy options are more frequently made default options so to facilitate consumers to make better choices for their health. Finally, the representative from Austria noted that current efforts to combat obesity are fragmented at the national level, leading to inefficient

use of resources and suboptimal outcomes. Therefore, they stressed that cooperation between EU Member States is essential and needs to be further encouraged. Authorities from **Luxembourg** suggested additional measures to be adopted at the EU level, including supporting systematic early obesity and overweight screenings. According to the Ministry of Education of Luxembourg, childhood obesity needs an enhanced whole of government approach, starting in the early childhood years. They advocated for a cross-sector collaboration to promote and enhance public awareness of health, children's physical, social and emotional development, and factors influencing obesity, through initiatives at the workplace, the health sector, and the social and private sphere, similar to the French "Mille premier jours" initiative<sup>494</sup>. They argued that a one-sector approach does not provide a holistic understanding of children's needs throughout their developmental stages. Similar final remarks were voiced by the **Italian** Ministry of Health representatives, who believed that an EU-wide approach could better integrate diverse perspectives and strengthen preventive measures in schools, including greater parental and family involvement. Additionally, they suggested more support in the earliest stages of life and stricter industry regulations to help reduce obesity.

The **Latvian** representatives emphasised the importance of strengthening policies that support families from the early stages of children's lives, especially regarding primary care. They pointed out that general practitioners are vital for health promotion and prevention, especially in detecting early signs of childhood obesity and informing parents about such issues. However, the Latvian representative believed that the engagement and commitment of primary care doctors in these tasks need to be enhanced, possibly through EU-level recommendations. Interviewed **Slovakian** authorities claimed that stronger inputs should come from the NGOs, which should pressure the Ministries of Health. Also, more focus on prevention would be needed to contrast childhood obesity. Representatives from **Ireland** expressed their support for the continuation of EU efforts in the field of childhood obesity. During the interview, they shared that they had the intention to raise this point at the EPSCO meeting (Employment, Social Policy, Health, and Consumer Affairs Council configuration) taking place on 23 and 2 April 2024.<sup>495</sup> In addition, Irish authorities would welcome a review of the EU Action Plan to strengthen efforts in this field. Lastly, the **Swedish** representative stressed that the link between obesity and mental health should take a more central role in preventive and treatment actions, as well as emphasising the broader impacts of obesity on both individuals and society, such as workforce losses and increased healthcare costs. Specifically, they highlight the need for a more comprehensive approach that involves schools, families, and the broader community towards the same goal. Finally, they shared that improving data collection mechanisms is essential, as they are the foundation of prevention actions and ensure that interventions are well-informed and targeted.

## 5.2 National and international NGOs

This section summarises the perspectives of stakeholders collected from 53 representatives of national and EU NGOs, consumer associations, the marketing and advertising industry, and food and beverage associations. It highlights stakeholders' views

---

<sup>494</sup> [First 1000 days](#).

<sup>495</sup> Council of the European Union. (2024). Informal meeting of health ministries. Available: [Link](#)

on the impact and added value of the EU Action Plan, their involvement in childhood obesity policy since 2014, and their input on recommendations for future actions.

### 5.2.1 Public Health NGOs

Some EU-level consulted stakeholders representing public health NGOs disclosed that they were involved in the High-level working group for Nutrition, Physical Activity, and Health during its mandate as well as aided in refining the action points of the EU Action Plan in the form of recommendations for EU and national-level policymakers on preventive measures for childhood obesity. The remaining three EU-level stakeholders and seven national-level stakeholders stated that they had not been directly involved in the drafting of the EU Action Plan, however, are active in the field of childhood obesity in various ways. Three EU-level stakeholders explained that their organisations are involved in the promotion of public health measures that impact obesity as well, namely related to Areas 2, 4 and 6 of the EU Action Plan. At the national level, stakeholders are active in the education of children about obesity and encourage various public health measures.

With regards to initiatives implemented in **schools**, stakeholders emphasised the need to strengthen actions for more nutritious food options in canteens and better nutritional education. While some schools offer programs promoting healthy habits, implementation is considered inconsistent, particularly concerning a lack of infrastructure for physical activity. Stakeholders suggested removing gender divides in sports, tailoring physical activity to different groups, and increasing time dedicated to physical exercise.

**Food reformulation** was seen as essential for reducing the fat, sugar, and salt content in foods, with many calling for stronger legislative action. Voluntary measures adopted or proposed were viewed as insufficient, and fiscal measures were suggested to be more effective in making healthier foods more affordable. **Taxation** on unhealthy products was generally supported, though stakeholders noted the need for complementary measures, such as subsidies on healthy foods, to avoid negatively impacting low-income families.

**Front-of-pack easy-to-understand nutritional labelling** was recognised as a useful tool for helping families make healthier choices, but stakeholders stressed the importance of educating the public on how to interpret these labels. Harmonized labelling schemes across regions were recommended to simplify and improve consumer understanding.

With regards to actions on **marketing restrictions** for unhealthy foods aimed at children, stakeholders called for more mandatory restrictions, including extending regulations to social media and prime-time television and banning advertising near schools and public spaces. Some also suggested prohibiting sports influencers from promoting unhealthy products.

**Campaigns and interventions to promote healthy living** were discussed, but stakeholders noted that the efforts that have been taken are often too short-term to have a lasting impact. Disadvantaged families, in particular, were seen as under-informed about available subsidies and support for healthier lifestyles.

Regarding **physical activity**, stakeholders agreed that improvements in public infrastructure, such as safe walking and cycling paths, are needed to encourage movement. Additionally, schools should offer after-school sports activities to bridge the gap between school hours and when parents finish work. Involving parents in physical

activity with their children, such as through household chores and outdoor activities, was also suggested.

**Monitoring and evaluation** of childhood obesity were seen as insufficiently addressed, with stakeholders calling for more comprehensive and systematic screening programs. Digitalising health records and improving follow-up after screenings were suggested to ensure children and families receive proper support beyond diagnosis.

Finally, **research and financial support** for childhood obesity prevention were deemed essential. Stakeholders discussed their involvement in various EU-funded projects, with some emphasising the need for greater collaboration between public and private sectors to access funding and support more effective prevention initiatives.

### 5.2.2 Education NGOs

The stakeholders representing educational NGOs which participated in the consultations stated that, whilst they were not actively involved in the drafting of the EU Action Plan, their organisations are involved in combating childhood obesity in their respective countries. One stakeholder explicitly stated that **the EU Action Plan had an impact on their organisation**, namely through encouraging the development of alliances (e.g. with educational institutions and municipalities) aimed at promoting a unified approach to tackling obesity as well as developing nutritional and physical activity guidelines.

Stakeholders discussed various factors influencing childhood obesity prevention, highlighting the need for better communication and support. While information on obesity risk factors is being disseminated, there is uncertainty about its effectiveness, and more education on healthy eating and the effects of obesity on child development was recommended. Stakeholders emphasised the importance of early intervention, combining clinical and educational support, and providing guidance to mothers during and after pregnancy, including breastfeeding.

**In schools**, the implementation of policies promoting healthier environments is inconsistent. While some schools emphasise healthy eating and physical activity, others allow unhealthy food options, and there is a need for improved physical activity facilities and healthier food in canteens. Limited resources, both human and financial, and academic demands are significant barriers to creating healthier school environments. Promoting healthier food choices faces challenges such as the promotion of unhealthy foods in shops and the perception that healthy foods are less appealing. Educational efforts are often insufficient, and there is a need for better training of school staff on nutrition.

**Front-of-pack labelling** can be useful, but stakeholders expressed concerns about its current effectiveness, suggesting more direct messaging, similar to tobacco warnings, might be necessary.

There is concern about the lack of strict **regulations on marketing** unhealthy foods to children, especially near schools. Stakeholders called for tighter controls on marketing practices to reduce children's exposure to unhealthy food advertising.

Stakeholders supported organising social campaigns and workshops to **promote nutrition and physical activity**, though limitations, such as language barriers and lack of hands-on

education in schools, were noted. Greater involvement from educational institutions, municipalities, and parent associations was recommended to enhance efforts. Supermarkets and government-level working groups were also identified as potential partners in spreading information and promoting healthier choices. However, it was noted that disadvantaged families may not be adequately informed about available subsidies, with suggestions to involve paediatricians and social workers in disseminating this information.

Lastly, none of the stakeholders had participated in European-funded projects related to childhood obesity, indicating a need for increased research and financial support in this area.

### 5.2.3 Sports NGOs

Among the participating representatives, no NGO representing the sport community has been actively involved in the drafting of the EU Action Plan. However, they reported that their respective organisations follow the EU Action Plan's guidelines, specifically in relation to Areas 2 and 6.

**In schools**, stakeholders noted that initiatives promoting healthier lifestyles are hindered by insufficient physical activity and the influence of technology. Schools often struggle to provide the right balance between academic learning and physical education. There is a lack of motivation among children, limited resources, and insufficient staff training to effectively encourage healthier habits. Recommendations included dedicating more time to physical activities, improving the integration of sports in education, and offering high-quality, balanced meals in schools. Regular awareness campaigns and better teacher training on childhood obesity prevention were also suggested.

**Regarding social campaigns**, stakeholders shared various initiatives aimed at promoting physical activity and healthy lifestyles, but they emphasised that informative campaigns alone are not enough to create lasting behaviour changes. Parallel initiatives are needed for a more sustainable impact.

**Public spaces and schools** were seen as inadequately equipped for free physical activity, with stakeholders pointing to a lack of policies to create green spaces and safe urban environments for children to exercise. While some cities are improving urban planning to encourage walking and cycling, many areas still lack the necessary **infrastructure**. Competitive sports are often prioritised, which can exclude children who are less athletic or from disadvantaged backgrounds. Stakeholders recommended promoting more inclusive, non-competitive physical activities that focus on enjoyment rather than performance.

**Monitoring and evaluation** efforts, such as COSI and national surveillance systems, are in place in several countries, but a lack of standardised data collection across regions hinders the comparability of obesity statistics. Stakeholders suggested that uniform markers for physical activity should be identified to better evaluate and address childhood obesity trends.

Finally, participation in European-funded projects was mentioned, with initiatives like DE-PASS<sup>496</sup> focusing on understanding the factors that influence physical activity behaviours across different populations and environments, helping policymakers promote healthier lifestyles effectively.

### 5.2.4 Parents associations

All the involved representatives from parent associations stated that they had not been involved in the drafting of the EU Action Plan. A few of them also remarked that they do not have a detailed knowledge of the EU Action Plan. Nonetheless, they believe that the EU Action Plan has had an impact on their organisation, to ensure an up-to-date awareness of various guidelines and recommendations and that projects meet both national, EU level and international standards.

Stakeholders shared **mixed impressions about the improvements under the EU plan**. One representative observed a positive impact, particularly in raising awareness about guidelines and best practices. However, concerns were raised about healthcare professionals' limited training and ability to address obesity, which was seen as a chronic disease. Another stakeholder added that while parents are often aware of healthy habits, systemic gaps such as doctors' insufficient training in nutrition and lack of consideration for family contexts hinder the effective management of childhood obesity.

It has also been observed that **schools play a crucial role in promoting healthier environments**, particularly through policies that encourage healthy eating and physical activity. Further, **taxation on unhealthy products is seen as potentially useful** if the revenue is used for awareness campaigns, though opinions differ on its overall effectiveness. Finally, stakeholders highlighted the importance of **research and funding** initiatives aimed at childhood obesity prevention, including educational projects and schemes promoting healthy food consumption in schools.

## 5.3 Consumer organisations

Consumer organisation representatives participating in the consultations have not been involved in the drafting of the EU Action Plan. Nonetheless, they recognised the EU Action Plan's efforts in tackling childhood obesity.

**Marketing and nutritional labelling were identified as significant influences on parents' choices**, particularly for infant formula. Stakeholders emphasised the need for harmonised labelling across countries and criticised the absence of provisions such as extended maternity leave to encourage breastfeeding, which they believed was overlooked in the Action Plan. Regarding the **promotion of healthier environments in schools**, stakeholders noted that while educating children about the dangers of unhealthy products is valuable, it is not sufficient. They advocated for concrete measures, such as banning unhealthy products and limiting beverage options in schools to milk and water, to create a more supportive environment for healthy choices. Indeed, some stakeholders observed that the systematic replacement of unhealthy foods with healthier options in

---

<sup>496</sup> DE-PASS. Available: [Link](#)

schools, restaurants, and shops is gaining traction but needs broader implementation. They also pointed out that while there is evidence of progress, the responsibility for healthier food choices is often disproportionately shifted to consumers rather than industries.

## 5.4 Food and beverage Industry

All the representatives of the food and beverage industry declared that they had not been consulted in the drafting of the EU Action Plan, however, one stakeholder stated that they had been consulted on the mid-term evaluation of the EU Action Plan conducted in 2017/2018. All stakeholders are involved in activities related to Area 2 of the EU Action Plan, primarily through the provision of healthy foods to children along with several other actions that encompass responsible advertising and raising consumer awareness, including to children (also through labelling initiatives).

Stakeholders discussed the various initiatives to **promote healthier environments in schools**, particularly regarding vending machines and food options. They generally agreed that vending machines should not be accessible to primary school children, and if used in secondary schools, they should only offer healthy, low-sugar, and low-fat options. Although some stakeholders did not support a total ban on vending machines, they emphasised the importance of restricting the products they dispense to healthier alternatives. A key issue highlighted was that schools often prioritise cost over health when choosing food providers, leading to less nutritious food being offered.

On **making healthier options more accessible**, stakeholders expressed their concerns regarding the implementation of food reformulation initiatives. These include potential consumer resistance to reformulated products, a lack of knowledge about safe ingredient substitutions, technological limitations, and difficulties in finding adequate suppliers. Collaboration across the supply chain was also seen as essential for success.

Regarding the implementation of **front-of-pack nutritional labelling**, stakeholders believed it could be effective in guiding consumers toward healthier choices but emphasised that it must be paired with education and awareness campaigns to create lasting lifestyle changes. One representative argued in favour of a harmonised EU labelling scheme, along with stricter regulation of health claims to ensure transparency and accuracy.

In relation to **taxation** measures for unhealthy foods, two industry stakeholders questioned their effectiveness, arguing that taxation alone does not lead to sustained behavioural changes and may simply pass costs on to consumers, disproportionately affecting lower-income households. Therefore, they suggested that taxation measures must go hand in hand with other measures like food reformulation, portion control, and education to encourage healthier lifestyle choices.

## 5.5 Marketing and advertisement industry associations

The invited participants declared that they had not been involved in the drafting of the EU Action Plan, however, their organisations are impacted by initiative under Area 4 of the EU

Action Plan, namely the **restriction of marketing** of unhealthy products to children. Regarding the effects of the EU Action Plan on the actors they represent, they both stated that their members are committed to the promotion of initiatives, particularly self-regulatory measures, to reduce the negative effects of advertisement of unhealthy foods on childhood obesity. Among the examples, stakeholders discussed the relevance of the EU Pledge,<sup>497</sup> which restricts marketing to children under 13 as part of its commitments, had been mentioned. The EU Pledge is considered as a good practice (see also Annex IX: Good practices). Lastly, they highlighted the need to balance advertisement and marketing restrictions with principles of proportionality and pluralism in the media.

## 5.6 Academic experts

All representatives consulted declared that whilst they were not actively involved in the drafting of the EU Action Plan, their organisations are involved in combating childhood obesity in their respective countries and the Plan guides their work. A stakeholder explained that, because of the EU Action Plan, a working group was set up to implement its recommendations, with some policies being actively based on the Plan.

The stakeholders discussed various issues related to initiatives on breastfeeding, childhood obesity prevention, and the promotion of healthy lifestyles. **Breastfeeding support** is generally strong, especially in countries with robust maternity leave policies, but challenges persist, particularly for women from lower socioeconomic backgrounds, due to limited access to resources and workplace facilities. Additionally, cultural barriers regarding public breastfeeding continue to be a problem in many areas.

For childhood obesity prevention, stakeholders emphasised the need for comprehensive, **long-term programs** that cover multiple areas such as healthy eating, physical activity, sleep, mental health, and access to healthcare. **Regular check-ups and evidence-based advice for parents**, particularly regarding nutrition and breastfeeding, were also recommended, along with the importance of addressing socioeconomic inequalities that limit access to healthy foods.

**Schools** play a crucial role in promoting healthier environments, with some offering healthy meals and banning unhealthy drinks. However, it is difficult to control the availability of unhealthy options outside school premises. Stakeholders suggested improving food offerings in schools and providing training to food providers, as well as ensuring that dietary requirements are considered.

In terms of **taxation measures**, stakeholders agreed that taxes on unhealthy products could be effective if designed well and used as part of a broader public health strategy. Education and simplified front-of-pack nutritional labelling were also seen as essential to help families make healthier choices. Stakeholders also stressed the importance of restricting the marketing of unhealthy foods to children, with calls for more stringent regulations across all media channels, including social media, and stricter penalties for non-compliance.

**Physical activity** remains a challenge for many families due to time, financial constraints, and a lack of infrastructure such as green spaces and cycle paths. Stakeholders

---

<sup>497</sup> EU Pledge. (2024). About the EU Pledge. Available at: [Link](#).

recommended urban redesign and policy support to encourage physical activity in schools and communities.

**Monitoring and evaluation** of childhood obesity were identified as key areas for improvement. While some countries have regular screening programs, there are often issues such as personnel shortages and a focus on BMI without sufficient follow-up care. Stakeholders suggested creating national obesity registers and improving health check-ups and data collection.

Lastly, there is a need for more **research and financial** support for childhood obesity prevention. While some countries have participated in European-funded projects, others struggle to attract funding for research in this area. Strengthening partnerships between researchers and policymakers was recommended to improve efforts to combat childhood obesity.

## 5.7 Summary of stakeholder recommendations

The table below summarises the recommendations made by consulted stakeholders in relation to the EU Action Plan on Childhood Obesity.

Table 26 – Stakeholder recommendations

Stakeholder Recommendation	Parent Associations	Academic experts	Education NGOs	Public Health NGOs	Sports NGOs	Food and beverage industry association	Consumer associations
<b>There is a need for a whole government approach to childhood obesity</b> , involving multiple stakeholders and transparent cooperation across government, healthcare, and society as a whole.	✓	✓	✓	✓	✓		
In general, <b>further action and policies that promote healthy eating and active living</b> were recommended, for example through educating children and parents on healthy living/nutrition, the provision of free healthy school meals, facilitating opportunities for active movement.	✓	✓	✓	✓	✓		
<b>There is a need for more government-led initiatives that are targeted and tailored to the needs of specific groups</b> such as vulnerable communities and age groups. E.g. in the case of the Netherlands where targeted treatment is focused on obesity prevention and care in children.		✓		✓	✓		
<b>Front-of-pack nutritional labelling is supported as a positive action</b> ; however, it was stressed that this must be instated <b>alongside consumer education</b> on how to interpret it.	✓	✓		✓		✓	
Actions should be taken with the aim of <b>changing food environments</b> as well as <b>improving nutrition education in schools</b> to empower children to make their own healthy choices.						✓	✓
<b>Social and commercial determinants of health</b> should be carefully considered in the design of policy and initiatives.		✓		✓			
<b>A cultural shift should be fostered</b> among parents, teachers, and sports coaches by formulating physical activity interventions that <b>recognise the importance of unstructured play</b> .			✓		✓		
In general, <b>greater policy action is needed against childhood obesity</b> . Moreover, <b>it is critical that policy is evidence-based and informed by scientific research</b> .						✓	✓
<b>More stringent regulations are broadly supported for restricting the marketing of unhealthy products to children</b> . However, considerations were raised by the Marketing and Advertising Associations that this should be balanced with principles of proportionality and pluralism of the media.		✓	✓	✓			

Stakeholder Recommendation	Parent Associations	Academic experts	Education NGOs	Public Health NGOs	Sports NGOs	Food and beverage industry association	Consumer associations
<p><b>Targeted support through subsidies should be provided for disadvantaged families</b> to enable them to easily make healthy choices. This should be complemented by <b>better information dissemination</b> related to the subsidies available as support for healthy lifestyles.</p>	✓	✓	✓	✓			

## 6 Conclusions

### 6.1 Summary of the main takeaways

The EU Action Plan on Childhood Obesity 2014-2020 provided a comprehensive framework for reducing childhood obesity in the EU. The evidence gathered in this study indicates that many Member States widely considered the EU Action Plan as a valuable tool in addressing childhood obesity. Overall, this study shows that **progress was made** compared to the period before 2014, and the EU Action Plan contributed positively to this progress.

The **prevalence of childhood overweight (including obesity) remains high** across the EU, with considerable differences between Member States. This study showed that, on average, childhood overweight and obesity rates have continued to rise from 2014 to 2022, indicating a need for broader and more comprehensive interventions. The latest results of the OECD Health at Glance report<sup>498</sup> shows that in 2022 one in five (21%) 15-years-old on average across the EU countries were classified as either overweight or obese. The data shows that across all age groups, boys consistently had higher rates of overweight and obesity than girls in both years. Additionally, the overall prevalence increased by approximately two percentage points across all age groups from 2018 to 2021, with the most significant rise observed among 13-year-old boys. Establishing a direct link between the EU Action Plan and changes in overweight and obesity rates is challenging. However, some examples of improvement are observed following the implementation of the Action Plan. Whilst Malta, Romania, Hungary, and Greece consistently ranked high for childhood overweight and obesity across all age groups in both 2014 and 2022, highlighting a persistent issue in these countries, Malta, Greece, and Italy also showed decreases in prevalence between 2014 and 2022.

This study showed that the **implementation of the EU Action Plan was in general 'moderately high'**, with EU Member States and the United Kingdom addressing, on average, 64% of the key topics outlined in the EU Action Plan. Actions on approximately 48% of these topics were newly launched or updated after the Action Plan's adoption. Several countries demonstrated increased commitment to addressing childhood obesity by adopting new national plans. For instance, Greece, Spain, and the United Kingdom introduced new Childhood Obesity Plans after 2014 in line with the EU Action Plan's objectives. Additionally, seven countries explicitly cited the EU Action Plan in their policy documents, further reflecting its influence on national planning and action. Various actions related to childhood obesity were also launched by the European Commission, such as Joint Actions and research studies.

Familiarity of national representatives with the EU Action Plan varied, with **38% of respondents indicating they were familiar 'to a large extent'**, while 40% claimed to be familiar 'to a moderate extent'. Additionally, 21% of respondents believed the Action Plan significantly facilitated the introduction or strengthening of national policies, while 34% felt

---

<sup>498</sup> OECD/European Commission (2024), Health at a Glance: Europe 2024: State of Health in the EU Cycle, OECD Publishing, Paris. Available at: [Link](#)

it did so to a moderate extent.<sup>499</sup> During interviews, several national authorities agreed that the country would probably not have adopted certain policies and achieved certain results if the absence of the EU Action Plan, which steered the national agenda and provided information and experiences from other countries.

Nonetheless, the Action Plan's impact was subjected to Article 168 TFEU prescribing a complementary legislative role of the EU to the Member States' competence when adopting policies in the area of health. Thus, Member States adopted measures on a voluntary basis, and often, their action was dependent on the political priorities and capacity of the individual countries. This resulted in fragmented implementation across Member States, where some countries implemented actions on many new key topics, while others implemented only a few and in limited areas. The inconsistency hindered a cohesive approach, as varying levels of commitment and resources among countries led to uneven progress and gaps in addressing obesity policy effectively across the region. The analysis of implementation showed that Finland, Lithuania and France were the countries that adopted or updated the most key topics since 2014, while the Czech Republic, Cyprus and Slovakia were the least. Nonetheless, no country adopted all key topics outlined in the EU Action Plan. Across countries, efforts to combat childhood obesity largely focused on improving school environments by enhancing school meals, banning vending machines, and updating dietary guidelines (Area 2), as well as on promoting breastfeeding (Area 1). Moreover, all countries participated in at least one Joint Action related to childhood obesity, and most engaged in international and national surveys to monitor overweight and obesity, as well as lifestyle and dietary patterns. However, implementation in policy areas related to facilitating healthy choices by improving food environments (Areas 3 and 4) remained limited, with many relying on voluntary agreements with the food industry and private actors in topics regarding food reformulation and restrictions on marketing and advertisement.

Despite the considerable number of initiatives introduced after 2014, it is important to recognise that not all measures can be linked to the EU Action Plan. First, all countries had adopted initiatives before the EU Action Plan. Second, initiatives from other international bodies, such as the WHO Commission on Ending Childhood Obesity (ECHO)<sup>500</sup> and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases, might have also influenced the adoption of national policies (2013-2020).<sup>501</sup>

This study revealed that several challenges persist in addressing childhood obesity from 2014. The main challenges that span across the eight Areas for Action included lack of formal recognition of obesity as a disease, financial constraints, and institutional barriers related to policy implementation such as poor intersectoral collaboration and weaknesses in healthcare systems coordination. Although several countries had policies planned, particularly in the areas of marketing restriction, front-of-pack nutritional labelling and taxation, according to national authorities and other consulted stakeholders many of these initiatives failed during the policy-making process due to lack of scientific evidence and/or lack of political prioritisation. Some national authorities mentioned that an EU-wide

---

<sup>499</sup> As explained in section 5.1, consultation data have been divided into factual and subjective to enable in-depth qualitative analysis. In this case, since the information provided is primarily subjective, 'survey respondents' are referred as individuals. In the survey, multiple representatives from some countries participated. In some instances, contradictory responses were provided by different representatives from the same country.

<sup>500</sup> WHO. (2016). Report of the commission on ending childhood obesity. Available at: [Link](#)

<sup>501</sup> WHO. (2013). Global action plan for the prevention and control of NCDs. Available at: [Link](#)

approach combined with mandatory standards would better reflect the complexity of the issue and be in line with the single market.

**Views among stakeholders on the policies addressing the eight Areas for Action of the EU Action Plan were divided.** Notably, industry actors showed different views on how to address childhood obesity compared to representatives from NGOs, academic experts and consumer organisations. One of the main topics of discussion revolved around whether the voluntary nature of certain measures under Area 3 and Area 4 were sufficient to curb the rise in childhood obesity. These include front-of-pack nutritional labelling, taxation, food reformulation and marketing and advertisement restrictions. Industry actors agreed that voluntary measures are sufficient, while NGOs and consumer organisations disagreed. Yet, the introduction of HFSS food taxation and food reformulation policies has **resistance from consumers for fear of food product price increases**. Further, most stakeholders agreed that schools play a crucial role to address childhood obesity, and that more should be done particularly to improve school lunch menus and incorporating more physical activity throughout the school day. Public Health NGOs and parent associations highlight that low-income families often lack adequate support to create healthy environments for their children. Families are not always informed about subsidies for healthy lifestyles, and application barriers persist. Access to physical activity is also unequal, with financial limitations and limited public amenities impacting children's activity levels.

In conclusion, the EU Action Plan successfully demonstrates a shared commitment among Member States to tackle childhood obesity. Moreover, it established clear priority areas and provided a toolbox of potential measures. However, despite these achievements, the EU Action Plan only partially achieved its goal of halting the rise in childhood overweight and obesity by 2020. **All countries still fall short of the optimal policy environment**, as no country fully implemented all the key topics, and the interviewed national representatives agreed significant work remains to be done. The findings highlight the need for continued measures that address the rise in childhood obesity across the EU. Addressing this issue is critical, given the long-term health implications over the life course and the strong links between childhood obesity and other non-communicable diseases (NCDs), including cardiovascular diseases (CVD), cancer, diabetes, neurodegenerative conditions, and respiratory disorders. The study **identified 63 best practices** from over 1,500 obesity policies, with 58 identified in the EU and the UK. The selected interventions reflect key policies that can serve as examples to other countries who are considering adopting similar approaches. The selection of best practices shows a wide repartition of policy interventions, particularly in school settings (Area 2: Promote healthier environments), in community-based interventions (Area 5: Inform and empower families) and in physical activity promotion for children (Area 6: Encourage Physical Activity). Small-scale best practices prevail, with only a few large-scale best practices identified.

## 7 Bibliography

Buoncristiano, M. et al. (2021). Childhood overweight and obesity in Europe: Changes from 2007 to 2017. *Obesity Reviews*, 22, e13226. Available at: [Link](#)

Directorate-General for Health and Food Safety (2017). Tartu call for a healthy lifestyle: Joint actions to promote healthy lifestyles. Available at: [Link](#)

Directorate-General for Health and Food Safety (European Commission), Joint Research Centre (European Commission), Maltese EU Presidency team (2017). Public procurement of food for health. Available at: [Link](#)

European Association for the Study of Obesity. (2021). EASO reacts to European Commission Update on Obesity Prevention Brief. Available at: [Link](#)

European Association for the Study of Obesity. (2023). Flash Report: Overcoming policy barriers to improve care for people living with obesity: EU added value. Available at: [Link](#).

European Commission – Directorate-General for Health & Food Safety. (2017). Criteria to Select Best Practices in Health Promotion and Disease Prevention and Management in Europe. Available at: [Link](#).

European Commission (n.d.). Health Promotion and Disease Prevention Knowledge Gateway. Available at: [Link](#)

European Commission, Directorate-General for Health and Food Safety, Pushkarev, N., Hansen, J., Driesenaar, J. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: the childhood obesity study, Publications Office. Available at: [Link](#)

European Commission, European Health and Digital Executive Agency. (2022). EU REformulation Monitoring (EUREMO): feasibility study for a monitoring system on reformulation initiatives for salt, sugars and fat: final report. Available at: [Link](#)

European Commission. (2014). EU Action Plan on Childhood Obesity 2014-2020. Available at: [Link](#)

European Commission. (n.d.). Best Practice Portal. Available at: [Link](#)

European Commission. (n.d.). EU platform for diet, physical activity, and health. Available at: [Link](#)

European Commission. (n.d.). YouthWiki. Available at: [Link](#).

Farpour-Lambert NJ, Baker JL, Hassapidou M, Holm JC, Nowicka P, O'Malley G, et al. Childhood Obesity Is a Chronic Disease Demanding Specific Health Care--a Position Statement from the Childhood Obesity Task Force (COTF) of the European Association for the Study of Obesity (EASO). *Obes Facts*. 2015;8(5):342-9. Available at: [Link](#)

Global Obesity Observatory. Available at: [Link](#)

Grammatikaki, E., et al., Marketing of food, non-alcoholic, and alcoholic beverages. A toolkit to support the development and update of codes of conduct. Available at: [Link](#)

Jackson-Leach, R., Montague, F., & Lobstein, T. (2016). *Obesity Atlas for the European Union: 2017*. London, UK: World Obesity Federation. Available at: [Link](#)

Joint Action on Implementation of Validated Best Practices in Nutrition (Best-ReMap). Available at: [Link](#)

Joint Action on Nutrition and Physical Activity (JANPA). (2015-2017). Available at: [Link](#)

Joint Research Centre, Institute for Health and Consumer Protection, Kardakis, T., Storcksdieck genannt Bonsmann, S., Nelson, M. et al., Mapping of national school food policies across the EU28 plus Norway and Switzerland. Available at: [Link](#)

Joint Research Centre. (2016) How to promote water intake in schools. A toolkit. Available at: [Link](#)

Joint Research Centre. (2016). How to promote fruit and vegetable consumption in schools. A toolkit. Available at: [Link](#)

Jurić, P., et al. (2022). Effectiveness of a population-scaled, school-based physical activity intervention for the prevention of childhood obesity. Available at: [Link](#)

Loring B., Robertson, A. (2014). *Obesity and inequities: guidance for addressing inequities in overweight and obesity*. World Health Organization. Regional Office for Europe. Available at: [Link](#)

Luli et al. (2023). The Implications of defining obesity as a disease: a report from the Association for the Study of Obesity 201 annual conference. Available at: [Link](#).

OECD. (2019). *The Heavy Burden of Obesity: The Economics of Prevention*, OECD Health Policy Studies, OECD Publishing, Paris. Available at: [Link](#).

OECD. (2020). OECD Reviews of Public Health: Latvia: A Healthier Tomorrow, OECD Reviews of Public Health, OECD Publishing, Paris. Available at: [Link](#)

OECD. (2022), Healthy Eating and Active Lifestyles: Best Practices in Public Health, OECD Publishing, Paris. Available at: [Link](#).

OECD. (2022). Guidebook on Best Practices in Public Health, OECD Publishing, Paris. Available at: [Link](#)

OECD. (2022). Healthy Eating and Active Lifestyles Best Practices in Public Health, , OECD Publishing, Paris Available at: [Link](#)

OECD. (2023). Personalised Approach to Obesity Management in Children. Available at: [Link](#)

OECD. (2024). Beating Cancer Inequalities in the EU: Spotlight on Cancer Prevention and Early Detection, OECD Health Policy Studies, OECD Publishing, Paris. Available at: [Link](#)

OECD. (2024). OECD Reviews of Health Systems. Available at: [Link](#)

OECD. (2017). Obesity Update 2017. Available at: [Link](#)

OECD/European Union. (2022). Health at a Glance: Europe 2022: State of Health in the EU Cycle, OECD Publishing, Paris. Available at: [Link](#).

OECD/European Commission (2024), Health at a Glance: Europe 2024: State of Health in the EU Cycle, OECD Publishing, Paris. Available at: [Link](#)

Science and Technology in Childhood Obesity Policy (STOP) project. Available at: [Link](#).

UNICEF, City of Amsterdam, EAT. (2020). The Amsterdam Healthy Weight Approach: Investing in healthy urban childhoods: A case study on healthy diets for children. Available at: [Link](#)

WCRFI. (2021). Nutrition policy index. Available at: [Link](#)

WCRFI. (2021). Physical activity policy index. Available at: [Link](#)

WHO. (2014). Obesity and overweight. Available at: [Link](#)

WHO & UNICEF. (2021). Compendium of Skilled Breastfeeding counselling case studies. Available at: [Link](#)

WHO. (2004). Global Strategy on Diet, Physical Activity and Health. Available at: [Link](#)

WHO. (2012). Population-based approaches to childhood obesity prevention. Available at: [Link](#).

WHO. (2013). Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health. Available at: [Link](#)

WHO. (2015). European Food and Nutrition Action Plan (2015-2020). Available at: [Link](#)

WHO. (2016). Report of the commission on ending childhood obesity. Available at: [Link](#).

WHO. (2016). Report of the commission on ending childhood obesity. Available at: [Link](#)

WHO. (2016). Tackling food marketing to children in a digital world: trans-disciplinary perspectives. Available at: [Link](#)

WHO. (2017). Report of the Commission on Ending Childhood Obesity: implementation plan. Available at: [Link](#)

WHO. (2017). Tackling NCD: 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Available at: [Link](#)

WHO. (2018). Global nutrition policy review 2016-2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition. Available at: [Link](#).

WHO. (2018). Health systems respond to noncommunicable diseases. Compendium of good practices. Available at: [Link](#).

WHO. (2019). Mapping the health system response to childhood obesity in the WHO European Region: an overview and country perspectives. Available at: [Link](#).

WHO. (2019). Mapping the health system response to childhood obesity in the WHO European Region: an overview and country perspectives. Available at: [Link](#).

WHO. (2021). Physical Activity Factsheets. Available at: [Link](#).

WHO. (2021). WHO guidelines on physical activity and sedentary behaviour: at a glance. Available at: [Link](#)

WHO. (2022). Report on the fifth round of data collection, 2018–2020: WHO European Childhood Obesity Surveillance Initiative (COSI). Available at: [Link](#)

WHO. (2023). WHO Region Office for Europe Nutrient Profile Model: Second Edition. Available at: [Link](#)

WHO. (2024). Commercial Determinants of Noncommunicable Diseases in the WHO European Region. Available at: [Link](#).

WHO. (n.d.). Global Database on the Implementation of Nutrition Action. Available at: [Link](#)

WHO. (n.d.). Health system reviews (HiT series). Available at: [Link](#)

World Obesity Federation. (2016). World Obesity Action Initiative. Available at: [Link](#)

World Obesity Federation. (2021). Health Systems. Available at: [Link](#)

## 8 Annexes

### 8.1 Annex I: Description Areas for Action

<i>Areas and key topics</i>	<i>Definitions</i>	<i>Source</i>
<b>AREA 1: Supporting a healthy start in life</b>		
1.1 Guidance before and during pregnancy on maternal nutrition and physical activity	Policies, strategies, or guidelines to ensure that women receive guidance on nutrition and physical activity before, during and immediately after pregnancy. This includes increasing awareness of maternal nutrition (e.g. folic acid), maintaining a healthy weight during pregnancy, as well as providing clear messages on physical activity promotion and sedentary behaviours.	Mid-term evaluation
1.2 Promote and protect breastfeeding	Policies, strategies, or guidelines that empower women to breastfeed (e.g. participation in WHO Baby Friendly Hospital initiative).	Mid-term evaluation
1.3 Guidance on complementary feeding	Policies or guidelines or informational material on complementary feeding of infants.	Mid-term evaluation
1.4 Training for healthcare and childcare professionals	Policies, strategies, and initiatives to update the knowledge of healthcare and childcare professionals on the risk factors of overweight and obesity, as well as obesity management practices.	New (based on EU Plan)
1.5 Improvement of childhood obesity management	Strategies, initiatives, guidelines, or actions to improve management services (e.g. interventions or weight loss programmes) for overweight and obese children.	New (based on EU Plan)
1.6 Promotion of healthy habits among vulnerable pregnant women and infants	Targeted policies, strategies or initiatives implemented to encourage healthier food habits and physical activity among pregnant women and infants from vulnerable groups, such as ethnic minorities or people with low socioeconomic status.	New (based on EU Plan)
<b>AREA 2: Promote healthier environments</b>		
2.1 Physically active school environments	Policies on improving the children's active school environment (e.g. having active breaks or active commuting to and from school), beyond Physical Education class.	Mid-term evaluation (Rephrased)
2.2 Policies on vending machines (healthy snacks)	Policies, strategies, or initiatives that increase the availability of healthy food/drinks and/or limit the accessibility of unhealthy options in vending machines located within school grounds and other spaces for children, such as sports clubs and recreational areas. This includes specific bans to vending machines in schools.	Mid-term evaluation
2.3 Policies on sweetened beverages & energy drinks	Policies, strategies, and initiatives to reduce consumption of sweetened beverages and energy drinks for children in school facilities. Such policies can include installing water fountains to increase freshwater consumption at schools or policies that determine which foods can be offered in school facilities.	Mid-term evaluation (Rephrased)
2.4 Integration nutrition education	Integration of nutrition education aspects as part of the school curriculum (social science, health education) in primary and secondary schools.	Mid-term evaluation
2.5 Integration physical activity education	Integration of physical activity education in school curricula in primary and secondary schools.	Mid-term evaluation
2.6 Healthy lunches at school canteens	Public procurement policies, strategies, and initiatives to promote healthy eating in school canteens and make schools attractive to eat in (e.g. policies on school food standards, nutritional guidelines for school canteens).	New (based on EU Plan)
<b>AREA 3: Make the healthy option the easier option</b>		

<i>Areas and key topics</i>	<i>Definitions</i>	<i>Source</i>
3.1 a) Food reformulation: salt	Policies or initiatives on food reformulation/food product improvements for limiting salt.	Mid-term evaluation
3.1 b) Food reformulation: total and/or saturated fats	Policies or initiatives on food reformulation/food product improvements for limiting total fat and/or saturated fat.	Mid-term evaluation
3.1 c) Food reformulation: sugar	Policies or initiatives on food & drinks reformulation/food & drinks product improvements for limiting sugar.	Mid-term evaluation
3.1 d) Food reformulation: calories; or portion sizes	Policies or initiatives on food reformulation/food product improvements for calories or policies or initiatives on portion sizes.	Mid-term evaluation
3.2 Monitoring food reformulation	System to monitor the level of nutrients (and thus the effect of strategies for food reformulation/food product improvement	Mid-term evaluation
3.3 Mandatory or voluntary easy to understand nutrition labelling	Easy to understand labelling, such as front of pack nutrition labelling on pre– packed foods or menu labelling, to help consumers make healthier choices.	Mid-term evaluation
3.4 Taxation	Policies on food taxation for products/nutrients that are high in fat (particularly high in saturated fat), sugar or salt or do otherwise not fit nutritional guidelines ('unhealthy' foods).	Mid-term evaluation
3.5 Subsidies and affordability initiatives	Policies on subsidies for healthier options ('healthy' foods) and other initiatives to make food more affordable to families, other than school meals, the EU School Fruit and Vegetable Scheme and the EU School Milk Scheme.	Mid-term evaluation
3.6 Promotion of freshwater intake	Policies, strategies, or actions to facilitate the promotion of freshwater intake in public spaces such as hospitals or administration (e.g. installation of water fountains)	New (based on EU Plan)
3.7 Nutritional training for food providers and producers	Policies, strategies, or actions that encourage nutritional training for staff working in restaurants and cafes, as well as food producers, particularly in suitable portion sizes for children and avoiding less healthy products and recipes (this includes private and public sector services).	New (based on EU Plan)
<b>AREA 4: Restrict marketing and advertising to children</b>		
4.1 Mandatory restrictions on marketing	Legally binding legislation to limit marketing to children marketing of HFSS foods and drinks to children. This can include TV, internet, and social media marketing.	Mid-term evaluation (already present but split in 2 topics now)
4.2 Voluntary restrictions to restrict marketing	Voluntary government agreements or industry agreements to limit marketing of HFSS foods and drinks to children. This includes TV, internet, and social media marketing.	Mid-term evaluation (already present but split in two topics now)
4.3 Nutrient criteria to reduce marketing	Established nutrition criteria to enable the classification of food and drink product and to determine if they are unhealthy enough to be restricted from being advertised to children.	Mid-term evaluation
4.4 Marketing activities in schools	Strategies, initiatives, and guidelines to forbid marketing of HFSS foods and drinks at preschools, schools, and other places for children (e.g. sports clubs, recreational space).	New (based on EU Plan)
<b>AREA 5: Inform and empower families</b>		
5.1 Campaigns on diet & physical activity targeting children and their families	National campaigns to educate and support families make healthy choices and promote physical activity, as well as to promote changes in social norms to encourage healthy lifestyles.	Mid-term evaluation (rephrase)
5.2 Implementation community– based interventions	Policies or initiatives to support community– based interventions (i.e. inclusion of different stakeholders to target obesity, such as supermarkets, schools, families).	Mid-term evaluation
5.3 Targeted support for disadvantaged families	Policies, strategies, and initiatives to support disadvantaged families by making healthy foods more easily available, accessible, and affordable (e.g. reduction of food poverty initiative).	New (based on EU Plan)
5.4 National nutritional guidelines	Existence of national nutritional guidelines tailored for each age group, combined with strategies to ensure that such information is clear, easy to understand, accessible and effectively delivered to the target groups.	New (based on EU Plan)

<i>Areas and key topics</i>	<i>Definitions</i>	<i>Source</i>
<b>AREA 6: Encourage physical activity</b>		
6.1 Physical activity promotion for children	Policies, strategies, and initiatives on physical activity promotion tailored for each age group. This includes campaigns to increase awareness and knowledge about benefits of physical activity as well as changing social norms.	Mid-term evaluation
6.2 National physical activity guidelines	Existence of national physical activity guidelines tailored for each age group, combined with strategies to ensure that such information is clear, easy to understand, accessible and effectively delivered to the target groups.	Mid-term evaluation
6.3 Infrastructure for physical activity	Policies, strategies, and initiatives that promote access to free/low– cost physical activity spaces (e.g. increase accessibility to save green spaces for children to do sports).	New (based on EU Plan)
6.4 Safe and easy active mobility	Policies, strategies, and actions to improve the layout of urban areas to facilitate active mobility (e.g. provision of cycle lanes, pavements and pedestrianised zones, adequate lighting).	New (based on EU Plan)
<b>AREA 7: Monitoring and evaluation</b>		
7.1 National diet and nutrition survey	National representative diet/nutrition survey.	Mid-term evaluation
7.2 National physical activity and sports survey	National representative survey on physical activity and sports.	Mid-term evaluation
7.3 a) Participation international survey: COSI	Participation in the WHO European Childhood Obesity Surveillance Initiative (COSI) survey.	Mid-term evaluation
b) Participation international survey: HBSC	Participation in WHO Healthy Behaviour among Schoolchildren and for Health– Promotion Schools (HBSC) survey.	New (based on EU Plan)
7.4 Screening for childhood overweight and obesity	Routine screening programmes for childhood overweight and obesity in primary care. Paediatricians routinely calculate children's BMI (based on weight and height information) and measure fat fold.	Mid-term evaluation (already present, but under different Area)
<b>AREA 8: Increase research and financial support</b>		
8.1 Participation in European Joint research actions	Participation in Joint actions and research activities to coordinate research programmes, ensure quality and conformity, at the EU level (e.g. CHORDIS, JANPA).	New (based on EU Plan)
8.2 Financial support for obesity programmes	Actions to further improve national financing possibilities and well as financial support to obesity programmes.	New (based on EU Plan)

## 8.2 Annex II: Colour-code criteria for Area for Action

Areas and key topics	Criteria for colour-code system
1.1 Guidance before and during pregnancy on maternal nutrition and physical activity.	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Guidance in both physical activity and nutrition and provided during all stages of pregnancy – before, during, and after. Key topic considered “fully implemented” if a country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and this guidance has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially implemented:</b> There is guidance available, but not comprehensive. It could either focus on only one aspect (nutrition or physical activity) or be provided only during certain stages of pregnancy, rather than throughout.</li> <li>• <b>Planned:</b> Policy documents confirm that measures on maternal nutrition and physical activity are expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that there is no implementation of guidance for maternal nutrition and physical activity. If guidance is provided solely on daily oral iron and folic acid supplementation and not on other aspects, it would not qualify within this classification, the policy should be considered not implemented.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of guidance or policies on nutrition and physical activity during pregnancy.</li> </ul>
1.2 Promote and protect breastfeeding	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Comprehensive policies, strategies, or guidelines are in place to empower women to breastfeed. This includes initiatives like participation in the WHO Baby Friendly Hospital initiative, ensuring support for breastfeeding practices is available and accessible to women. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and this guidance has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> Policies, strategies, or guidelines exist, but they may not be comprehensive or universally accessible. This could also mean that only certain aspects of breastfeeding empowerment are addressed or that support is available only for some population groups (e.g. disadvantaged communities) or in some settings but not others (e.g. only in certain regions or hospitals).</li> <li>• <b>Planned:</b> Policy documents confirm that measures to empower women to breastfeed, such as participation in initiatives like the WHO Baby Friendly Hospital initiative, are expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is no implementation of policies, strategies, or guidelines to empower women to breastfeed.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies, strategies, or guidelines aimed at empowering women to breastfeed.</li> </ul>

Areas and key topics	Criteria for colour-code system
1.3 Guidance on complementary feeding	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Comprehensive policies, guidelines, or informational material are available on complementary feeding of infants. This includes clear guidance on introducing solid foods alongside continued breastfeeding or formula feeding, ensuring proper nutrition and dietary diversity for infants from 6 months of age up to 24 months or beyond<sup>502</sup>.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and this guidance has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> Policies, guidelines, or informational material exist, but they may not cover all aspects of complementary feeding comprehensively. This could also mean that only certain aspects of complementary feeding are addressed or that support is available only for some population groups (e.g. disadvantaged communities) or in some settings but not others (e.g. only in certain regions or hospitals).</li> <li>• <b>Planned:</b> Policy documents confirm that measures related to complementary feeding of infants are expected to be put into place at a future date but have not yet been fully implemented.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is no implementation of policies, guidelines, or informational material on complementary feeding of infants.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies, guidelines, or informational material on complementary feeding of infants.</li> </ul>
1.4 Training for healthcare and childcare professionals	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, and initiatives are in place to comprehensively update the knowledge of healthcare and childcare professionals on the risk factors of overweight and obesity, as well as effective obesity management practices. This includes ongoing education and training programs, workshops, seminars, and access to informational resources covering a broad spectrum of factors contributing to overweight and obesity, and evidence– based practices for prevention, intervention, and management. Key topic considered “fully implemented” if country has implemented at least one national measure either for healthcare professionals or childcare professionals.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and this guidance has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies, strategies, or initiatives exist, they may not cover all aspects comprehensively. This could mean that only certain aspects of overweight and obesity risk factors or management practices are addressed, or that support is available only for specific population groups (e.g. healthcare professionals in certain specialties or settings). There may be also limitations in accessibility, resources, or coverage, resulting in disparities in knowledge update efforts.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at updating the knowledge of healthcare and childcare professionals on the risk factors of overweight and obesity, as well as obesity management practices, are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of policies, strategies, or initiatives aimed at updating the knowledge of healthcare and childcare professionals on the risk factors of overweight and obesity, as well as obesity management practices.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies, strategies, or initiatives aimed at updating the knowledge of healthcare and childcare professionals on the risk factors of overweight and obesity, as well as obesity management practices.</li> </ul>

<sup>502</sup> With is in alignment with [WHO definition](#).

Areas and key topics	Criteria for colour-code system
1.5 Improvement of childhood obesity management	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Strategies, initiatives, guidelines, or actions are in place to comprehensively improve management services for overweight and obese children. This includes the implementation of evidence-based interventions or weight loss programs tailored specifically for children, covering aspects such as dietary interventions, physical activity promotion, behavioural counselling, and support services. These programs should be accessible, effective, and inclusive, addressing the diverse needs of overweight and obese children across different settings. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and this guidance has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While strategies, initiatives, guidelines, or actions exist, they may not cover all aspects comprehensively (only dietary interventions, or physical activity promotion, or behavioural counselling, or support services are provided). This could also mean that support is available only for some population groups (e.g. disadvantaged communities) or in some settings but not others (e.g. only in certain regions or hospitals).</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at improving management services for overweight and obese children are expected to be implemented at a future date but have not yet been fully realized.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of strategies, initiatives, guidelines, or actions aimed at improving management services for overweight and obese children.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of strategies, initiatives, guidelines, or actions aimed at improving management services for overweight and obese children.</li> </ul>
1.6 Promotion of healthy habits among vulnerable pregnant women and infants	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, or initiatives are in place and actively encourage healthier food habits and physical activity among pregnant women and infants from vulnerable groups, such as ethnic minorities or people with low socioeconomic status (i.e. targeted policy<sup>503</sup>). These initiatives are comprehensive, addressing the specific needs and challenges faced by these groups, and are accessible and culturally sensitive in promoting behaviour change. Examples can include: antenatal programmes for women with social complexities or women living in deprived areas. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While targeted policies, strategies, or initiatives exist, they may not cover all aspects comprehensively. This could mean that only certain interventions are available but only cover certain aspects (only nutrition or physical activity) or that there are limitations in accessibility, coverage, or effectiveness. Additionally, the intervention might have only been implemented in some settings but not others (e.g. only in certain regions or hospitals).</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at encouraging healthier food habits and physical activity among pregnant women and infants from vulnerable groups are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of targeted policies, strategies, or initiatives aimed at encouraging healthier food habits and physical activity among pregnant women and infants from vulnerable groups.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of targeted policies, strategies, or initiatives aimed at encouraging healthier food habits and physical activity among pregnant women and infants from vulnerable groups.</li> </ul>

<sup>503</sup> “Universal interventions, targeting whole populations, are not ideal for addressing specific health inequalities and have also been shown to widen inequalities” ([Yuan et al, 2014](#)).

Areas and key topics	Criteria for colour-code system
2.1 Physically active school environments	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies are in place to comprehensively promote an active school environment for children and adolescents. These policies include initiatives such as active breaks, active commuting to and from school, and other opportunities for physical activity throughout the school day. They are implemented across all schools nationally and are supported by resources, training, and infrastructure to ensure their effectiveness. This excludes any efforts made in relation to improving Physical Education class. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives exist, they may not cover all aspects comprehensively. This could mean that only certain interventions are available, or that there are limitations in accessibility, coverage, or effectiveness. For example, active breaks may be encouraged in some schools but not others, or infrastructure for active commuting may be lacking in certain areas. This could also include geographical variations in policies implementation.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at improving the children's active school environment beyond Physical Education class are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of policies aimed at improving the children's active school environment.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies aimed at improving the children's active school environment.</li> </ul>
2.2 Policies on vending machines (healthy snacks)	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, or initiatives are in place to comprehensively limiting access to unhealthy options in vending machines within school grounds and other children's spaces, such as sports clubs and recreational areas (this can include total bans on vending machines, or restrictions on unhealthy food options). The policy can be considered fully implemented regardless of whether there are additional actions to increase the availability of healthy foods/drinks in schools. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not cover all aspects comprehensively. This could include geographical variations in restrictions or bans on vending machines or policies implemented for only some school grades (i.e. only banned in primary schools but not secondary schools).</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at limiting access to unhealthy options in vending machines may be planned for implementation in the future.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of policies aimed limiting access to unhealthy options in vending machines.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies aimed at limiting access to unhealthy options in vending machines.</li> </ul>

Areas and key topics	Criteria for colour-code system
2.3 Policies on sweetened beverages & energy drinks	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, and initiatives are in place to reduce consumption or ban provision of sugary drinks<sup>504</sup>, or energy drinks for children in school facilities. These measures may include installing water fountains to increase freshwater consumption, or policies that restrict/ban the availability of certain foods/drinks in school facilities (including school cafeterias). If ban only applies to energy drinks, the policy cannot be considered fully implemented.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not cover all aspects comprehensively. This could include geographical variations in restrictions or bans on sugary drinks or policies implemented for only some school grades (i.e. only banned in primary schools but not secondary schools). This could also include bans for energy drinks only, but not for other sugary drinks.</li> <li>• <b>Planned:</b> Policies aimed at reducing consumption or banning provision of sugary drinks or energy drinks for children in school facilities may be planned for implementation in the future.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of policies aimed reducing consumption or banning provision of sugary drinks or energy drinks for children in school facilities.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies aimed reducing consumption or banning provision of sweetened beverages/soft drinks or energy drinks for children in school facilities.</li> </ul>
2.4 Integration nutrition education	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Nutrition education aspects are integrated within the subjects such as social science, biology and health education or there is a nutrition education subject in both primary and secondary schools nationally. The curriculum covers a wide range of topics related to nutrition, including healthy eating habits, food choices, meal planning, and the importance of balanced diets. Teaching materials, lesson plans, and resources are readily available to support educators in delivering effective nutrition education to students. This excludes extracurricular/voluntary activities on nutrition.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014 (e.g. changes to school curriculum/ school reforms).</li> <li>• <b>Partially Implemented:</b> While efforts may be made to integrate nutrition education into the curriculum, there may be limitations or gaps in coverage. This could include inconsistencies in the implementation across different schools or regions, or inadequate resources and training for educators. Additionally, the integration of nutrition education may be more prominent in certain subjects or grade levels than others.</li> <li>• <b>Planned:</b> Policy documents confirm that integration of nutritional aspects into school curriculum is expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no integration of nutritional aspects into school curriculum.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding integration of nutritional aspects into school curriculum.</li> </ul>

<sup>504</sup> Sugary drinks (also categorised as sugar-sweetened beverages or “soft” drinks) refer to any beverage with added sugar or other sweeteners (high fructose corn syrup, sucrose, fruit juice concentrates, and more). This includes soda, pop, cola, tonic, fruit punch, lemonade (and other “ades”), sweetened powdered drinks, as well as sports and energy drinks. (Harvard C.H. CHAN. [The Nutrition Source](#)).

Areas and key topics	Criteria for colour-code system
2.5 Integration physical activity education	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Physical activity education is integrated into the school curricula of both primary and secondary schools nationally. The curriculum includes structured lessons and activities aimed at promoting physical activity, covering various aspects such as exercise physiology, sports skills, fitness training, and the importance of an active lifestyle. Teachers receive adequate training and support to effectively deliver physical activity education, and resources such as equipment and facilities are readily available to facilitate engagement in physical activities. No minimum number of hours applies.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014 (e.g. changes to school curriculum/ school reforms).</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not cover all aspects comprehensively. This could include inconsistencies in implementation across different schools or regions, or insufficient resources and training for educators. Additionally, the integration of physical activity education may be more prominent in certain subjects or grade levels than others.</li> <li>• <b>Planned:</b> Policy documents confirm that integration of physical activity aspects into school curriculum is expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no integration of physical activity aspects into school curriculum.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding integration of physical activity aspects into school curriculum.</li> </ul>
2.6 Healthy lunches at school canteens	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, and initiatives are in place to comprehensively promote healthy eating in school canteens and create appealing dining environments within schools. These measures may include food procurement policies, well– defined school food standards and nutritional guidelines for school canteens. The policy can be considered fully implemented there is at least one national initiative implemented.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and policies, strategies or initiatives have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not cover all aspects comprehensively. This could include inconsistencies in the implementation of policies, strategies, and initiatives across different schools or regions, or challenges in enforcing compliance with procurement policies. Additionally, partial implementation might involve guidance for specific food categories.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at promoting healthy eating in school canteens are expected to be implemented at a future date but have not yet been fully realized.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of measures aimed at promoting healthy eating in school canteen.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures aimed at promoting healthy eating in school canteen.</li> </ul>

Areas and key topics	Criteria for colour-code system
3.1 a) Food reformulation: salt	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Nationally established guidelines or regulations for reformulating or reducing salt content in food products across various food categories or formal agreements between the government and industry (with formal targets and timeline). This includes voluntary and mandatory salt limits. It excludes participation in international partnerships, like EU Salt Initiative.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and food reformulation approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not cover all aspects comprehensively. This could include unequal implementation of reformulation targets across different food categories (e.g. reformulation only applies to bread products) or regions. Additionally, implementation is considered partial if there are some food manufacturers making significant progress while others lag behind.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at reformulating/improving salt content on food products are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of measures aimed at reformulating/improving salt content on food products.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures aimed at reformulating/improving salt content on food products.</li> </ul>
3.1 b) Food reformulation: total and/or saturated fats	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Nationally established guidelines or regulations are in place for reformulating or improving food products to limit total fat and/or saturated fats or formal agreements between the government and industry (with formal targets and timeline).. These guidelines encompass both voluntary and mandatory limits on fat content in various food categories. This excludes any policy related to limiting trans fats only<sup>505</sup>.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and food reformulation approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not comprehensively cover all aspects. This could involve unequal implementation of reformulation targets across different food categories (e.g. reformulation only applies to baked products) or regions. Additionally, partial implementation may occur if some food manufacturers make significant progress in reducing total fat and/or saturated fats while others lag behind.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at reformulating/improving total and/or saturated fats content on food products are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of measures aimed at reformulating/improving total and/or saturated fats content on food products.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures aimed at reformulating/improving total and/or saturated fats content on food products.</li> </ul>

<sup>505</sup> There is an [EU regulation](#) establishing a maximum limit of trans fat, that Member States must comply with.

Areas and key topics	Criteria for colour-code system
3.1 c) Food reformulation: sugar	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Nationally established guidelines or regulations are in place for reformulating or improving food products to limit sugar or formal agreements between the government and industry (with formal targets and timeline). These guidelines encompass both voluntary and mandatory limits on sugar content in various food categories.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and food reformulation approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies or initiatives may exist, they may not comprehensively cover all aspects. This could involve unequal implementation of reformulation targets across different food categories (e.g. reformulation only applies to baked products) or regions. Additionally, partial implementation may occur if some food manufacturers make significant progress in reducing sugar content while others lag behind.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at reformulating/improving sugar content on food products are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no implementation of measures aimed at reformulating/improving sugar content on food products.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures aimed at reformulating/improving sugar content on food products.</li> </ul>
3.1 d) Food reformulation: calories or initiatives on portion sizes	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Nationally established guidelines or regulations are in place for reformulating or improving food products to reduce calories, or formal agreements between the government and industry (with formal targets and timeline), or for reducing portion sizes<sup>506</sup>. The policy can be considered fully implemented regardless of whether efforts are made to reduce calorie content or portion sizes.</li> <li>• <b>Updated:</b> Policy is considered “fully implemented” and food reformulation approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While public policies or initiatives may exist, they may not comprehensively cover all aspects. This could involve unequal implementation of reformulation targets across different food categories (e.g. reformulation only applies to baked products) or regions.</li> <li>• <b>Planned:</b> Policy documents confirm that measures aimed at reformulating or improving food products for reducing calories or portion sizes are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there are currently no public measures aimed at reformulating or improving food products for reducing calories or portion sizes.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding public measures aimed at reformulating or improving food products for reducing calories or aimed at reducing portion sizes.</li> </ul>

<sup>506</sup> Changes to portion sizes is not a form of food reformulation. Changing portion sizes involves adjusting the amount of food served or packaged, but it does not alter the actual content or ingredients of the food itself. Nonetheless, adjusting portion sizes can be a strategy to help consumers manage their calorie intake and promote healthier eating habits.

Areas and key topics	Criteria for colour-code system
3.2 Monitoring food reformulation	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> A comprehensive national system is in place to monitor the level of nutrients in food products, allowing for the effective evaluation of strategies for food reformulation and product improvement. This system encompasses regular monitoring and analysis of nutrient levels in various food categories, providing valuable data to assess the impact of reformulation efforts on the nutritional composition of foods.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and measures been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While a monitoring system may exist, it may not comprehensively cover all aspects or food categories (e.g. only salt content is monitored). This could also involve limitations in frequency of monitoring, as well as challenges in data collection and analysis.</li> <li>• <b>Planned:</b> Policy documents confirm that a national monitoring system for assessing the level of nutrients in food products is expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no national monitoring system for assessing the level of nutrients in food products.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of monitoring system for assessing the level of nutrients in food products.</li> </ul>
3.3 Mandatory or voluntary easy-to-understand nutrition labelling	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> A national policy is in place to adopt easy to understand Front of pack nutrition labelling (FOPNL). To meet this criterion, FOPNL should be recommended by the government (thus not driven by private industry initiatives). The policy can be considered fully implemented regardless of whether a national policy is in place for menu labelling in restaurants or food outlets to provide information on the nutritional content of menu items in a clear and concise manner<sup>507</sup>.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and nutritional labelling been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> If a public policy is recommending FOPNL only in certain regions or food categories, or if only menu labelling is available without complementary easy-to-understand FOPNL on pre- packed foods.</li> <li>• <b>Planned:</b> Efforts to implement an easy- to- understand labelling on pre-packaged foods or menus are expected to be put into place at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm is currently no implementation of easy- to- understand labelling on pre-packaged foods or menus to help consumers make healthier choices, or such implementation is only implemented by industry without government recommendation.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of easy- to- understand labelling on pre-packaged foods or menus.</li> </ul>

<sup>507</sup> Rationale: FOPNL on prepacked foods has a broader impact / is more visible than only menu labelling; therefore, only menu labelling should not be indicated as ‘fully implemented’.

Areas and key topics	Criteria for colour-code system
3.4 Taxation	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Food taxation is adopted nationally for products contributing significantly to population intakes of added/free sugars, saturated fat (excluding trans– fat) and/or salt, or those not adhering to nutritional guidelines, and they have been implemented with the goal of discouraging the consumption of such foods,</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and food taxation approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies may exist, they may not comprehensively cover all nutrient (i.e. taxes adopted only for fat, or sugar or salt). Additionally, partially implemented might involve unequal implementation across regions.</li> <li>• <b>Planned:</b> Policy documents confirm that food taxation policy on all or some products high in fat, sugar, and salt are expected to be put into place at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no food taxation policy on all or some products high in fat, sugar, and salt.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status food taxation policy on all or some products high in fat, sugar, and salt.</li> </ul>
3.5 Subsidies and affordability initiatives	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Comprehensive national policies to make healthy foods more affordable to families. These policies encompass various measures such as: vouchers, coupons or reductions to Value Added Tax (VAT) for fruits, vegetables, whole grains, lean proteins, and other healthy options (foods low in fat, sugar and salt). EU School Fruit and Vegetable Scheme and the EU School Milk Scheme are excluded from this definition.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and food affordability measures have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While policies may exist, they may not comprehensively cover all food categories or population groups. This could involve limitations in the scope or extent of subsidies (i.e. subsidies only apply to fruits), as well as variation in reaching all segments of the population in need of support. Additionally, partial implementation may occur if there are variations in the availability or affordability of healthy foods across different regions.</li> <li>• <b>Planned:</b> Policy documents confirm that subsidies and affordability initiatives are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is currently no subsidies and affordability initiatives.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of subsidies and affordability initiatives.</li> </ul>

Areas and key topics	Criteria for colour-code system
3.6 Promotion of freshwater intake	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, or actions adopted nationally to facilitate the promotion of freshwater intake in public spaces (e.g. hospitals, administration buildings or schools). These efforts encompass the installation of water fountains, making freshwater readily accessible to staff, visitors and/or students. Additionally, campaigns may accompany these installations to promote the importance of staying hydrated and encourage individuals to choose water as their beverage of choice, but these are not necessary to consider the key topic as “fully implemented”. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and promotion of fresh drinking water has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While efforts may be made to promote freshwater intake in public spaces, they may not comprehensively cover all areas or facilities. This could involve limitations in the number or accessibility of water fountains, as well as adoption gaps across different regions or types of public spaces. Additionally, partial implementation might also involve if there is a national/regional campaign to promote freshwater intake, without an accompanying improvement of drinking areas/facilities.</li> <li>• <b>Planned:</b> Policy documents confirm that measures that promote fresh water intake are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there are currently no measures that promote fresh water intake.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures that promote fresh water intake.</li> </ul>
3.7 Nutritional training for food providers and producers	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies, strategies, or actions are nationally adopted to encourage nutritional training for staff working in restaurants and cafes, as well as food producers. These efforts focus particularly on appropriate portion sizes for children and promoting healthier products and recipes, encompassing both private and public sector services. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and nutritional training initiatives have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While efforts may exist to encourage nutritional training, they may not comprehensively cover all areas or sectors. This could involve limitations in the scope or extent of training, as well as disparities in implementation across different types of food establishments or regions.</li> <li>• <b>Planned:</b> Policy documents confirms that measures to encourage nutritional training are expected to be implemented at a future date but have not yet been fully realised.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there are currently no measures in place to encourage nutritional training for staff working in restaurants and cafes, as well as food producers.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures to encourage nutritional training.</li> </ul>

Areas and key topics	Criteria for colour-code system
4.1 Mandatory restrictions on marketing	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> National legislation is in place that legally restricts the marketing of HFSS foods and drinks to children in television. These restrictions are legally binding and actively enforced, effectively reducing children's exposure to unhealthy food and drink marketing. The policy can be considered "fully implemented" regardless of whether legislation consider internet and social media restrictions.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered "fully implemented" and legislation has been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> Efforts have been made to introduce legislation limiting marketing of HFSS foods and drinks to children, but there may be gaps in enforcement or coverage. For example, restrictions might exist for only for schools, online platforms or social media, but not for TV. Additionally, if implementation varies across regions or implementation only applies to certain product categories (i.e. sugary drinks only).</li> <li>• <b>Planned:</b> There are plans or proposals to introduce legislation to limit marketing of HFSS foods and drinks to children, but it has not yet been fully enacted.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there are no legal measures in place to restrict marketing of HFSS foods and drinks to children.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of legislation aimed at limiting marketing of HFSS foods and drinks to children.</li> </ul>
4.2 Voluntary restrictions to restrict marketing	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Voluntary agreements between the government and relevant industries,, have been established and are effectively limiting the marketing of HFSS foods and drinks to children in television. These agreements are comprehensive (i.e. they consider a wide range of HFSS foods), and companies are actively monitored for compliance. The policy can be considered "fully implemented" regardless of whether agreement consider internet and social media restrictions.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered "fully implemented" and agreements have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> Efforts have been made to introduce industry agreements on the marketing of HFSS foods and drinks to children, but there may be gaps in enforcement or coverage. For example, restrictions might exist for only for online platforms or social media, but not for TV. Additionally, if implementation varies across regions or implementation only applies to certain product categories (i.e. sugary drinks only).</li> <li>• <b>Planned:</b> There are plans or proposals to introduce legislation to limit marketing of HFSS foods and drinks to children, but it has not yet been fully enacted.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there are no legal measures in place to restrict marketing of HFSS foods and drinks to children.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of legislation aimed at limiting marketing of HFSS foods and drinks to children.</li> </ul>

Areas and key topics	Criteria for colour-code system
4.3 Nutrient criteria to reduce marketing	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Established nutrition criteria have been developed together with national public health authorities to classify food and drink products and determine if they are unhealthy enough to be restricted from being advertised to children. These criteria are widely recognised, consistently applied, and effectively used to regulate advertising practices. The use of the WHO nutrition criteria<sup>508</sup> is excluded, as it is not a nationally established criteria.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” nutrition criteria have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While some national nutrition criteria exist, there may be inconsistencies in their application or gaps in coverage. Different regions or industries might use different criteria, leading to variations in which products are deemed unhealthy for advertising to children.</li> <li>• <b>Planned:</b> There are plans or proposals to introduce nutrition criteria that enables the classification of food products to determine whether they are healthy enough to be advertised to children.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is no national criteria that enables the classification of food products to determine whether they are healthy enough to be advertised to children.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of nutrition criteria that enables the classification of food products to determine whether they are healthy enough to be advertised to children.</li> </ul>
4.4 Marketing activities in schools	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Policies have been implemented to prohibit the marketing of foods and drinks that do not meet marketing nutritional criteria at preschools, schools, and other children’s locations such as sports clubs and recreational spaces. These measures include prohibition on school sports sponsoring. The policy can be considered “fully implemented” regardless of whether it considers environments near school.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and marketing restrictions in schools been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> Efforts have been made to restrict marketing of marketing of foods and drinks that do not meet marketing nutritional criteria, there are gaps in coverage and enforcement. For example, implementation varies across regions or implementation only applies to certain product categories (i.e. sugary drinks only).</li> <li>• <b>Planned:</b> There are plans or proposals to forbid marketing of HFSS foods and drinks at preschools, schools, and other children's locations, but they have not yet been fully implemented.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there are no measures in place to restrict the marketing of HFSS foods and drinks at preschools, schools, and other places for children.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of measures in place to restrict the marketing of HFSS foods and drinks at preschools, schools, and other places for children.</li> </ul>

<sup>508</sup> WHO (2023). New WHO tool aim to protect children from unhealthy food marketing. Available at: [Link](#)

Areas and key topics	Criteria for colour-code system
5.1 Campaigns on diet & physical activity targeting children and their families	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Campaign has been successfully implemented nation– wide to educate and support families in making healthy choices and promoting physical activity. The campaign provides practical guidance and resources to families and actively promote changes in social norms to encourage healthy lifestyles. Key topic considered “fully implemented” if country has implemented at least one national campaign.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While health promoting campaigns might exist, they may not cover all aspects comprehensively. This could mean that campaign only cover certain aspects of childhood obesity (only nutrition or physical activity) or that campaigns might have only been implemented in some settings but not others (e.g. only in certain regions).</li> <li>• <b>Planned:</b> There are plans or proposals to introduce national campaigns to educate and support families.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is no national campaign to educate and support families.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of national campaigns to educate and support families.</li> </ul>
5.2 Implementation community– based interventions	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Initiatives have been established to support community– based interventions targeting overweight and obesity. These policies involve the collaboration of various stakeholders, including supermarkets, schools, families, and other community organisations. They provide useful and accessible resources, guidelines, and incentives to encourage these stakeholders to actively participate in obesity prevention efforts. Additionally, there are mechanisms in place to coordinate and monitor the implementation of these interventions at the community level. Key topic considered “fully implemented” if country has implemented at least one successful community– based intervention.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> Efforts have been made to implement initiatives supporting community– based interventions targeting overweight and obesity, but there are limitations in coverage or effectiveness. For example, certain stakeholders are fully engaged, resources allocated for intervention implementation are insufficient, or coordination among stakeholders may be lacking.</li> <li>• <b>Planned:</b> There are plans or proposals to introduce national campaigns to educate and support families.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is no national campaign to educate and support families.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of national campaigns to educate and support families.</li> </ul>

Areas and key topics	Criteria for colour-code system
5.3 Targeted support for disadvantaged families	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Targeted policies, strategies or initiatives that promote healthy living have been implemented with the goal of supporting disadvantaged families. These initiatives are comprehensive, addressing the specific needs and challenges faced by these groups, and are accessible and culturally sensitive in promoting behaviour change. The strategies might include comprehensive efforts to address food poverty and ensure that nutritious foods are accessible and affordable for disadvantaged families, other tailored policies advocating healthy living also meet the criteria for being deemed "fully implemented." Key topic considered "fully implemented" if country has implemented at least one successful national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered "fully implemented" and health promotion approaches have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially implemented:</b> Certain strategies for disadvantaged families may be in place, but there could be limitations in terms of coverage, effectiveness, or sustainability. Additionally, regional disparities in program implementation might exist.</li> <li>• <b>Planned:</b> Policy documents confirm plans to further enhance support for disadvantaged families by making healthy foods more available, accessible, and affordable. However, these plans have not yet been fully realized, and implementation is pending.</li> <li>• <b>No implementation:</b> Policy documents confirm the absence of implemented policies, strategies, or initiatives aimed at supporting disadvantaged families.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of policies, strategies, or initiatives aimed at supporting disadvantaged families.</li> </ul>
5.4 National nutritional guidelines	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> National nutritional guidelines have been adopted that differentiate between population groups (adults and children). Key topic can be considered "fully implemented" whether nutritional guidelines are accompanied or not by comprehensive strategies to ensure that the information is clear, easy to understand, accessible, and effectively delivered to the target groups. Additionally, nutritional guidelines that are specific to toddlers, children or adolescents are not necessary to consider these key topic as "fully implemented".</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered "fully implemented" and guidelines have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially implemented:</b> There is guidance available, but not comprehensive. It could be provided only in a specific region.</li> <li>• <b>Planned:</b> Policy documents confirm that national nutritional guidelines are expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that there are no national nutritional guidelines.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of national nutritional guidelines.</li> </ul>
6.1 Physical activity promotion for children	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Campaign has been successfully implemented nation– wide to educate and support children in doing physical activity. The campaign provides practical guidance and resources to children and actively promote changes in social norms to encourage healthy lifestyles. Key topic considered "fully implemented" if country has implemented at least one national physical activity promotion initiative.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered "fully implemented" and health promotion approach been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While health promoting campaigns might exist, they may not cover all aspects comprehensively. This could mean that campaigns might have only been implemented in some settings but not others (e.g. only in certain regions).</li> <li>• <b>Planned:</b> There are plans or proposals to introduce national initiative to educate and support children in making physical activity.</li> <li>• <b>No Implementation:</b> Policy documents confirm that there is no national initiative to educate and support children in making physical activity.</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of national initiative to educate and support children in making physical activity.</li> </ul>

Areas and key topics	Criteria for colour-code system
6.2 National physical activity guidelines	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> National physical activity guidelines have been adopted that differentiate between population groups (adults and children). Key topic can be considered “fully implemented” whether physical activity guidelines are accompanied or not by comprehensive strategies to ensure that the information is clear, easy to understand, accessible, and effectively delivered to the target groups. Additionally, physical activity guidelines that are specific to toddlers, children or adolescents are not necessary to consider these key topic as “fully implemented”.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and guidelines have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially implemented:</b> There is guidance available, but not comprehensive. It could be provided only in a specific region.</li> <li>• <b>Planned:</b> Policy documents confirm that national physical activity guidelines are expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy document confirms that there are no national physical activity guidelines.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of national physical activity guidelines.</li> </ul>
6.3 Infrastructure for physical activity	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> At least one policy, strategy, and initiative promoting access to free or low-cost physical activity spaces have been successfully implemented. These efforts include measures to increase accessibility to safe green spaces for children to engage in sports and other physical activities or increasing the number of facilities to practice sports (e.g. sports hall, swimming pools). Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and infrastructure for physical activity have been updated or newly built after 2014.</li> <li>• <b>Partially implemented:</b> While initiatives promoting access to physical activity spaces may exist, they may not cover all aspects comprehensively. This could include partial coverage of certain geographical areas or limited implementation of measures to improve accessibility. There may also be disparities in access among different population groups</li> <li>• <b>Planned:</b> Policy documents confirm that plans or proposals to introduce policies, strategies, and initiatives to promote access to free or low-cost physical activity spaces are expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that there are no policies, strategies, and initiatives to promote access to free or low-cost physical activity spaces.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of policies, strategies, and initiatives to promote access to free or low-cost physical activity spaces.</li> </ul>
6.4 Safe and easy active mobility	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> At least one national policy, initiative or action has been successfully implemented at national level to enhance active mobility (in urban areas) among children and adolescents. This might include the provision of cycle lanes, pavements, pedestrianised zones, and adequate lighting throughout the city. Key topic considered “fully implemented” if country has implemented at least one national measure.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and initiatives been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially Implemented:</b> While there are policies and actions in place, they may not cover all aspects comprehensively. Only certain cities may have improved their infrastructure for active mobility or there might be disparities in accessibility or quality of infrastructure across different neighbourhoods.</li> <li>• <b>Planned:</b> Policy documents indicate intentions to implement measures to improve the layout of urban areas for active mobility in the future. However, these plans have not yet been fully realized, and implementation is pending.</li> <li>• <b>No Implementation:</b> Policy documents confirm the absence of implemented policies, strategies, or actions aimed at improving the layout of urban areas for active mobility</li> <li>• <b>Unavailable Information:</b> Desk research did not yield any information regarding the status of policies, strategies, or actions aimed at improving the layout of urban areas for active mobility.</li> </ul>

Areas and key topics	Criteria for colour-code system
7.1 National diet and nutrition survey	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> The country has successfully conducted at least one round of national diet and nutrition survey for the general population (where children are included) or to children only, ensuring that data collection is representative of the entire populations.</li> <li>• <b>Newly implemented/Updated:</b> The country initiated its national diet and nutrition survey after 2014, or has conducted new rounds of existing survey.</li> <li>• <b>Partially implemented:</b> While a national diet and nutrition survey exists, it may only cover certain regions or demographics, leading to a non– representative sample.</li> <li>• <b>Planned:</b> Policy documents confirm that national diet and nutrition survey is expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that the country has not conducted a national diet and nutrition survey, indicating a lack of comprehensive data collection on physical activity and sports participation nationwide.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of a national diet and nutrition survey in the country.</li> </ul>
7.2 National physical activity and sports survey	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> The country has successfully conducted at least one round of national physical activity and sports survey for the general population (where children are included) or to children only, ensuring that data collection is representative of the entire populations.</li> <li>• <b>Newly implemented/Updated:</b> The country initiated its national physical activity and sports survey after 2014.</li> <li>• <b>Partially implemented:</b> While a national physical activity and sports survey exists, it may only cover certain regions or demographics, leading to a non– representative sample or if there have been surveys but no recent data collection since 2014</li> <li>• <b>Planned:</b> Policy documents confirm that national physical activity survey is expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that the country has not conducted a national physical activity and sports survey, indicating a lack of comprehensive data collection on physical activity and sports participation nationwide.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of a national physical activity and sports survey in the country.</li> </ul>
7.3 a) Participation international survey:  COSI	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> The country has actively participated in at least one round of the WHO European Childhood Obesity Surveillance Initiative (COSI) survey.</li> <li>• <b>Newly implemented/Updated:</b> The country started to participate in COSI survey after 2014.</li> <li>• <b>Partially implemented:</b> Only some regions participate in COSI survey; therefore, sample is not representative of all the country’s status on childhood obesity.</li> <li>• <b>Planned:</b> Policy documents confirm that participation in COSI survey expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that the country does not participate in COSI survey.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of participation in COSI survey.</li> </ul>
7.3 b) Participation international survey:  HBSC	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> The country has participated in at least one round of the Healthy Behaviour among School– aged Children (HBSC) survey.</li> <li>• <b>Newly implemented/Updated:</b> The country started to participate in HBSC survey after 2014.</li> <li>• <b>Partially implemented:</b> Only some regions participate in HBSC survey; therefore, sample is not representative of all the country’s status on childhood obesity.</li> <li>• <b>Planned:</b> Policy documents confirm that participation in HBSC survey expected to be put into place at a future date but have not yet been implemented.</li> <li>• <b>No implementation:</b> Policy documents confirm that the country does not participate in HBSC survey.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of participation in HBSC survey.</li> </ul>

Areas and key topics	Criteria for colour-code system
7.4 Screening for childhood overweight and obesity	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Routine screening programs for childhood overweight and obesity are in place in primary care (or in school clinics). a</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and program protocols have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially implemented:</b> While routine screening programs exist, they may not cover all aspects comprehensively. For instance, there might be variations in the consistency of screening across different primary care practices and regions, or certain aspects of childhood overweight and obesity monitoring may be addressed more thoroughly than others (e.g. screening for obesity, but not for overweight).</li> <li>• <b>Planned:</b> Policy documents confirm there are plans to further enhance routine screening programs for childhood overweight and obesity in primary care settings. However, these enhancements have not yet been fully realised.</li> <li>• <b>No implementation:</b> Policy documents confirm the absence of implemented routine screening programs for childhood overweight and obesity in primary care. Paediatricians do not routinely calculate BMI or measure fat fold as part of standard practice for assessing children's health and development.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of routine screening programs for childhood overweight and obesity in primary care.</li> </ul>
8.1 Participation in European Joint research actions	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> The country has participated in at least one Joint Action related to childhood obesity.</li> <li>• <b>Newly implemented/Updated:</b> The country started to participate in a Joint Action related to childhood obesity after 2014.</li> <li>• <b>Partially implemented:</b> Not applicable.</li> <li>• <b>Planned:</b> Policy documents confirm that there are plans to participate in Joint Action related to childhood obesity, and the country has not participated in any Joint Action previously.</li> <li>• <b>No implementation:</b> Policy documents confirm that the country has never participated in any Joint Action related to childhood obesity</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of participation in Joint Action related to childhood obesity.</li> </ul>
8.2 Financial support for obesity programmes	<ul style="list-style-type: none"> <li>• <b>Fully Implemented:</b> Actions to improve national financing possibilities and financial support for obesity programs have been successfully implemented. This includes comprehensive strategies to enhance funding opportunities and provide financial support to obesity programs at the national level. Efforts may include increasing budget allocations, establishing dedicated funding mechanisms, and implementing policies to ensure sustainable financial support for obesity prevention and management initiatives.</li> <li>• <b>Newly implemented/Updated:</b> Policy is considered “fully implemented” and funding possibilities have been updated with revisions or newly implemented after 2014.</li> <li>• <b>Partially implemented:</b> Certain funding mechanisms or support programs might be in place, but there could be limitations in terms of funding availability, coverage, or accessibility. Additionally, disparities in financial support across different regions or populations may still exist.</li> <li>• <b>Planned:</b> Policy documents confirm plans to further enhance national financing possibilities and financial support for obesity programs. However, these plans have not yet been fully realised, and implementation is pending.</li> <li>• <b>No implementation:</b> Policy documents confirm the absence of implemented actions to improve national financing possibilities and financial support for obesity programs.</li> <li>• <b>Unavailable information:</b> Desk research conducted did not yield any information regarding the status of actions to improve national financing possibilities and financial support for obesity programs.</li> </ul>

### 8.3 Annex III: Summary colour-code system

Figure 38 – Overview status of implementation per key topic and country

	AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IE	IT	LV	LT	LU	MT	NL	PL	PT	RO	SK	SI	ES	SE	UK
<b>AREA 1: Supporting a healthy start in life</b>																												
1.1 Guidance before and during pregnancy on maternal nutrition and physical activity	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
1.2 Promote and protect breastfeeding	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
1.3 Guidance on complementary feeding	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
1.4 Training for healthcare and childcare professionals	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
1.5 Improvement of childhood obesity management	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
1.6 Promotion of healthy habits among vulnerable pregnant women and infants	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 2: Promote healthier environments</b>																												
2.1 Physically active school environments	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.2 Policies on vending machines (healthy snacks)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.3 Policies on sweetened beverages and energy drinks	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.4 Integration nutrition education	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.5 Integration physical activity education	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.6 Healthy lunches at school canteens	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 3: Make the healthy option the easier option</b>																												
3.1 a) Food reformulation: salt	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
b) Food reformulation: saturated fat	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
c) Food reformulation: sugar	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
d) Food reformulation: calories & portion sizes	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3.2 Monitoring food reformulation	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3.3 Mandatory or voluntary easy to understand nutrition labelling	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3.4 Taxation	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3.5 Subsidies and affordability initiatives	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3.6 Promotion of freshwater intake	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3.7 Nutritional training for food providers and producers	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 4: Restrict marketing and advertising to children</b>																												
4.1 Mandatory restrictions on marketing	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
4.2 Voluntary restrictions on marketing	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
4.3 Nutrient criteria to reduce marketing	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
4.4 Marketing activities in schools	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 5: Inform and empower families</b>																												
5.1 Campaigns on diet & physical activity targeting children and their families	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
5.2 Implementation of community-based interventions	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
5.3 Targeted support for disadvantaged families	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
5.4 National nutrition guidelines	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 6: Encourage physical activity</b>																												
6.1 Physical activity promotion for children	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
6.2 National physical activity guidelines	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
6.3 Infrastructure for physical activity	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
6.4 Safe and easy active mobility	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 7: Monitoring and evaluation</b>																												
7.1 National diet and nutrition survey	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
7.2 National physical activity and sports survey	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
7.3 Participation international survey: COSI	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
7.4 Participation international survey: HBSC	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
7.5 Screening for obesity	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
<b>AREA 8: Increase research and financial support</b>																												
8.1 Participation in European Joint Actions	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
8.2 Financial support for obesity programmes	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

**Note: Light blue – Fully Implemented:** National measure already implemented before the adoption of the EU Action Plan in 2014; or policy document confirms the existence of relevant measure, but original policy, as well as the date of implementation, has not been identified. **Dark green – Partially implemented:** Measure is available, but implementation is not comprehensive (only covers certain products, social groups, or regions). Partially implemented status is also awarded if National authorities self-reported that existing measures are insufficient to award fully implemented status. **Light green – Newly implemented/updated:** Measure is considered “fully implemented” and this measure has been updated/revised or newly implemented after 2014. This does not necessarily mean that the action is undertaken as a result of the EU Action Plan. **Amber–Planned:** Policy documents confirm that measures expected to be put into place at a future date but have not yet been implemented. Adoption may still be contingent on policy process. Planned status is assigned to key topics where there is no other fully implemented policies. **Red – No implementation:** policy documents confirm that there is no implementation of policies. However, actions may be undertaken on initiative from local authorities, NGOs, or private parties. **Grey – Unavailable information:** Desk research and consultation activities did not yield any information regarding the status of measures in the country.

## 8.4 Annex IV: Description of efforts by the European Commission and international organisations after 2014

**Table 27 – Efforts by the European Commission**

Areas for action	Coordination and Support	Scientific and Technical Guidance	Financial Tools
All areas	<p><b>Join Actions on Chronic Disease (CHRODIS) (2014– 2017)<sup>509</sup> and CHRODIS+ (2017– 2020)<sup>510</sup></b></p> <p><b>Steering Group on Health Promotion, Disease Prevention and Management of Non– Communicable Diseases (SGPP)<sup>511</sup> (2016)</b></p> <p><b>Joint Action on Health Equity Europe (JAHEE)<sup>512</sup> (2018– 2021)</b></p> <p><b>“Healthier Together”– The EU initiative on non– communicable diseases (NCDs)<sup>513</sup> (2021)</b></p> <p><b>Expert Group on Public Health<sup>514</sup> (2022)</b></p> <p><b>Joint Action PreventNCD (2024-2027)<sup>515</sup></b></p>	<p><b>Mapping and zooming in on childhood obesity<sup>516</sup> (2018)</b></p> <p><b>Science and Technology in childhood Obesity Policy (STOP)<sup>517</sup> (EU– funded Project) (2018– 2022)</b></p> <p><b>Confronting Obesity: Co– creating policy with youth (CO– CREATE)<sup>518</sup> (EU– funded Project) (2018– 2023)</b></p>	<p><b>Horizon 2020<sup>519</sup> (2014– 2020)</b></p> <p><b>Third Health Programme<sup>520</sup> (2014– 2020)</b></p> <p><b>EU4Health Programme<sup>521</sup> (2021– 2027)</b></p>

<sup>509</sup> Join Actions on Chronic Disease (CHRODIS). Available at: [Link](#).

<sup>519</sup> European Commission. Horizon 2020. Available at: [Link](#)

Areas for action	Coordination and Support	Scientific and Technical Guidance	Financial Tools
Area 1: Supporting a healthy start in life	n.a.	<p><b>Genetics of metabolically healthy obesity unhealthy normal weight in children (Child– MHO)<sup>522</sup></b> (EU– Funded Project) (2018– 2019)</p> <p><b>Smart Nursing Bra – Presque project<sup>523</sup></b> (EU– Funded Project) (2019)</p> <p><b>OBesity Training and INformation Services for Europe (OBTAINS– E)<sup>524</sup></b> (EU– Funded Project) (2022)</p>	n.a.

<sup>511</sup> European Commission. (n.d.). The Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP). Available at: (Link no longer available)

<sup>512</sup> Joint Action on Health Equity Europe. Available at: [Link](#).

<sup>513</sup> European Commission. (n.d.). Healthier Together – EU non-communicable diseases initiative. Available at: [Link](#).

<sup>514</sup> European Commission. (n.d.). Expert Group on Public Health. Available at: [Link](#).

<sup>515</sup> PreventNCD. Available at: [Link](#)

<sup>516</sup> European Commission, Joint Research Centre, Storcksdieck genannt Bonsmann, S., Carvalho, R., Safkan, S. (2018). Mapping and zooming in on childhood obesity. Available at: [Link](#)

<sup>517</sup> Science and Technology in childhood Obesity Policy (STOP). Available at: [Link](#).

<sup>518</sup> Confronting Obesity: Co-creating policy with youth (CO-CREATE). Available at: [Link](#).

<sup>519</sup> European Commission. Horizon 2020. Available at: [Link](#)

<sup>520</sup> Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing Decision No 1350/2007/EC. Available at: [Link](#)

<sup>521</sup> Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, and repealing Regulation (EU) No 282/2014. Available at: [Link](#)

<sup>522</sup> Child-MHO (Genetics of metabolically healthy obesity (MHO) and metabolically unhealthy normal weight (MUNW) in children. Available at: [Link](#).

<sup>523</sup> Presque project. Available at: [Link](#)

<sup>524</sup> OBTAINS. Available at: [Link](#)

Areas for action	Coordination and Support	Scientific and Technical Guidance	Financial Tools
<p><b>Area 2:</b> Promote healthier environments</p>	<p><b>Fruit, Vegetables and Milk Scheme</b><sup>525</sup> (2017)</p> <p><b>Guidelines on public procurement of food for health</b><sup>526</sup> (2017)</p>	<p><b>Report on school food and nutrition in Europe</b><sup>527</sup> (2014)</p> <p><b>Toolkit for promoting water in schools</b><sup>528</sup> (2016)</p> <p><b>Toolkit for promoting fruits and vegetables</b><sup>529</sup> (2016)</p> <p><b>Schools for Health in Europe</b> (SHE–network)<sup>530</sup> (EU– Funded Project) (2021)</p> <p><b>Schools4Health</b><sup>531</sup> (EU– Funded Project) (2023– 2025)</p>	<p>n.a.</p>

<sup>525</sup> European Commission. (n.d.). School fruit, vegetables, and milk scheme. Available at: [Link](#)

<sup>526</sup> Directorate-General for Health and Food Safety (European Commission), Joint Research Centre (European Commission), Maltese EU Presidency team (2017). Public procurement of food for health. Available at: [Link](#)

<sup>527</sup> Joint Research Centre, Institute for Health and Consumer Protection, Kardakis, T., Storcksdieck genannt Bonsmann, S., Nelson, M. et al., Mapping of national school food policies across the EU28 plus Norway and Switzerland. Available at: [Link](#)

<sup>528</sup> Joint Research Centre. (2016) How to promote water intake in schools. A toolkit. Available at: [Link](#)

<sup>529</sup> Joint Research Centre. (2016). How to promote fruit and vegetable consumption in schools. A toolkit. Available at: [Link](#)

<sup>530</sup> SHE-network. Available at: [Link](#)

<sup>531</sup> Schools4Health. Available at: [Link](#)

Areas for action	Coordination and Support	Scientific and Technical Guidance	Financial Tools
<b>Area 3:</b> Make the healthy option the easier option	<p><b>Added Sugars Annex – EU Framework for National Initiatives on Selected Nutrients</b><sup>532</sup> (2015)</p> <p><b>Added Saturated Fat Annex – EU Framework for National Initiatives on Selected Nutrients</b><sup>533</sup> (2016)</p> <p><b>Regulation (EU) 2019/649 on trans– fat, other than trans– fat naturally occurring in fat of animal origin</b> (2019)<sup>534</sup></p> <p><b>Food 2030</b><sup>535</sup> (2023)</p>	<p><b>Food composition database for nutrient intake: selected vitamins and minerals in selected European countries</b><sup>536</sup> (2017)</p> <p><b>WhoEUGrain project</b><sup>537</sup> (EU– funded Project) (2019)</p> <p><b>EU REformulation Monitoring (EUREMO)</b><sup>538</sup> (2022)</p> <p><b>FABLE - Food and Beverages Labels Explorer</b> (2023)<sup>539</sup></p>	n.a.
<b>Area 4:</b> Restrict marketing and advertising to children	<p><b>Directive (EU) 2018/1808 amending Directive 2010/13/EU (Audiovisual Media Services Directive) in view of changing market realities</b> (2018)<sup>540</sup></p>	<p><b>Marketing of food, non– alcoholic, and alcoholic beverages. A toolkit to support the development and update of codes of conduct</b><sup>541</sup> (2019)</p>	n.a.

<sup>532</sup> Directorate-General for Health and Food Safety. (2015). Added Sugars Annex – EU Framework for National Initiatives on Selected Nutrients. Available at: [Link](#)

<sup>533</sup> Ibid.

<sup>534</sup> Commission Regulation (EU) 2019/649 of 24 April 2019 amending Annex III to Regulation (EC) No 1925/2006 of the European Parliament and of the Council as regards trans-fat, other than trans-trans-fat naturally occurring in fat of animal origin. Available at: [Link](#)

<sup>535</sup> European Commission. (n.d.). Food 2030. Available at: [Link](#)

<sup>536</sup> European Food Safety Authority. (2017). Food composition database for nutrient intake: selected vitamins and minerals in selected European countries. Available at: [Link](#)

<sup>537</sup> WhoEUGrain Project. Available at: [Link](#)

<sup>538</sup> European Commission, European Health and Digital Executive Agency. (2022). EU REformulation MOnitoring (EUREMO): feasibility study for a monitoring system on reformulation initiatives for salt, sugars and fat: final report. Available at: [Link](#)

<sup>539</sup> European Commission. (2023). FABLE - Food and Beverages Labels Explorer. Available at: [Link](#)

<sup>540</sup> Directive (EU) 2018/1808 of the European Parliament and of the Council of 14 November 2018 amending Directive 2010/13/EU on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Audiovisual Media Services Directive) in view of changing market realities. Available at: [Link](#).

<sup>541</sup> Grammatikaki, E., et al., Marketing of food, non-alcoholic, and alcoholic beverages. A toolkit to support the development and update of codes of conduct. Available at: [Link](#)

Areas for action	Coordination and Support	Scientific and Technical Guidance	Financial Tools
<b>Area 5:</b> Inform and empower families	<p><b>Joint Action on Nutrition and Physical Activity (JANPA)</b><sup>542</sup> (2015– 2017)</p> <p><b>Tartu Call for Healthy Lifestyles</b> (2017)<sup>543</sup></p> <p><b>Health Promotion and Disease Prevention Knowledge Gateway</b><sup>544</sup> (2017)</p> <p><b>Joint Action on Implementation of Validated Best Practices in Nutrition (Best– ReMap)</b><sup>545</sup> (2019– 2023)</p> <p><b>HealthyLifestyle4All Campaign</b><sup>546</sup> (2021– 2023)</p>	<p><b>Feel4Diabetes study</b><sup>547</sup> (EU–funded project) (2015– 2019)</p> <p><b>A Healthy Diet for a Healthy Life 2.0</b><sup>548</sup> (Joint Programming Initiative) (2016– 2021)</p>	n.a.

<sup>542</sup> Joint Action on Nutrition and Physical Activity (JANPA) (2015-2017). Available at: [Link](#)

<sup>543</sup> Directorate-General for Health and Food Safety (2017). Tartu call for a healthy lifestyle: Joint actions to promote healthy lifestyles. Available at: [Link](#).

<sup>544</sup> European Commission (n.d.). Health Promotion and Disease Prevention Knowledge Gateway. Available at: [Link](#)

<sup>545</sup> Joint Action on Implementation of Validated Best Practices in Nutrition (Best-ReMap). Available at: [Link](#).

<sup>546</sup> European Commission (n.d.). HealthyLifestyle4All initiative (2021-2023). Available at: [Link](#).

<sup>547</sup> Feel4Diabetes study. Available at: [Link](#)

<sup>548</sup> Initiative Healthy Diet, Healthy Life (HDHL). Available at: [Link](#)

Areas for action	Coordination and Support	Scientific and Technical Guidance	Financial Tools
<b>Area 6:</b> Encourage physical activity	<p><b>European Sports Forum</b><sup>549</sup> (2014)</p> <p><b>EU Work Plan for Sport</b> (2014– 2017,<sup>550</sup> 2021– 2024<sup>551</sup>)</p> <p><b>#BeActive Education Award</b><sup>552</sup> (2015)</p> <p><b>#BeInclusive EU Sport Awards</b><sup>553</sup> (2017)</p> <p><b>SHARE initiative</b><sup>554</sup> (2018– 2023)</p> <p><b>European Week of Sports</b><sup>555</sup> (2021)</p>	<p><b>Social Biking' Challenge</b><sup>556</sup> (EU– funded Project) (2018)</p> <p><b>European Physical Activity on Prescription model project (EUPAP)</b><sup>557</sup> (2019– 2023)</p>	<p><b>Erasmus+ programme</b><sup>558</sup> (2014– 2020) (2021– 2027)</p>
<b>Area 7:</b> Monitoring and evaluation	n.a.	<p><b>Big Data Against Childhood Obesity (BigO)</b><sup>559</sup> (EU– funded Project) (2016– 2021)</p>	n.a.
<b>AREA 8:</b> Increase research and financial support	<p><i>Area 8 is not represented in the table because it focuses on the adoption of Joint Actions and financial support for obesity programs, which are key topics intersecting with other Areas for Action.</i></p>		

<sup>549</sup> European Commission (n.d.). EU Sport Forum. Available at: [Link](#)

<sup>550</sup> Resolution of the Council and of the Representatives of the Governments of the Member States, meeting within the Council, of 21 May 2014 on the European Union Work Plan for Sport (2014-2017). Available at: [Link](#)

<sup>551</sup> Resolution of the Council and of the Representatives of the Governments of the Member States meeting within the Council on the European Union Work Plan for Sport (2021-2024) 2020/C 419/01. Available at: [Link](#)

<sup>552</sup> European Commission (n.d.). #BeActive Awards. Available at: [Link](#)

<sup>553</sup> European Commission (n.d.). #BeInclusive EU Sport Awards. Available at: [Link](#)

<sup>554</sup> European Commission (n.d.). SHARE initiative (2018-2023). Available at: [Link](#)

<sup>555</sup> European Commission (n.d.). European Week of Sport. Available at: [Link](#)

<sup>556</sup> Social Biking Challenge. Available at: [Link](#)

<sup>557</sup> European Physical Activity on Prescription model (EUPAP). Available at: [Link](#)

<sup>558</sup> European Commission. What is Erasmus+?. Available at: [Link](#)

<sup>559</sup> Big Data Against Childhood Obesity (BigO). Available at: [Link](#)

Table 28 – Efforts by other international organisations

Areas for Action	WHO	OECD	WOF	EASO
All Areas	<p><b>Global Strategy on Diet, Physical Activity and Health</b><sup>560</sup> (2004)</p> <p><b>WHO Global Action Plan for the Prevention and Control of NCDs</b><sup>561</sup> (2013–2020)</p> <p><b>Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020</b><sup>562</sup> (2013)</p> <p><b>WHO report on the Commission on ending childhood obesity</b><sup>563</sup> (2016)</p> <p><b>Report of the Commission on Ending Childhood Obesity: implementation plan</b><sup>564</sup> (2017)</p> <p><b>WHO Acceleration Plan to Stop Obesity</b><sup>565</sup> (2020)</p>	<p><b>Promoting Health, Preventing Disease. The economic case</b><sup>566</sup> (2015)</p> <p><b>The Heavy Burden of Obesity. The Economics of Prevention</b><sup>567</sup> (2019)</p> <p><b>OECD Reviews of Public Health: Latvia. A Healthier Tomorrow</b><sup>568</sup> (2020)</p> <p><b>Healthy Eating and Active Lifestyles Best Practices in Public Health</b><sup>569</sup> (2022)</p> <p><b>Guidebook on Best Practices in Public Health</b><sup>570</sup> (2022)</p>	<p><b>World Obesity Action Initiative</b><sup>571</sup> (2015)</p> <p><b>Science and Technology in childhood Obesity Policy (STOP)</b><sup>572</sup> (EU– funded Project) (2018– 2022)</p> <p><b>Confronting Obesity: Co– creating policy with youth (CO– CREATE)</b><sup>573</sup> (EU– funded Project) (2018– 2023)</p>	<p><b>Childhood Obesity Taskforce</b><sup>574</sup> (2015)</p> <p><b>Obesity Policy Engagement Network– EU (OPEN)</b><sup>575</sup> (2020)</p>

<sup>560</sup> WHO. (2004). Global Strategy on Diet, Physical Activity and Health. Available at: [Link](#)

<sup>566</sup> McDaid D, Sassi F, Merkus SE. (2015) Promoting Health, Preventing Disease. The economic case. Berkshire: Open University Press. Available at: [Link](#)

<sup>571</sup> World Obesity Federation. (2016). World Obesity Action Initiative. Available at: [Link](#)

<sup>574</sup> Farpour-Lambert NJ, Baker JL, Hassapidou M, Holm JC, Nowicka P, O'Malley G, et al. Childhood Obesity Is a Chronic Disease Demanding Specific Health Care--a Position Statement from the Childhood Obesity Task Force (COTF) of the European Association for the Study of Obesity (EASO). *Obes Facts*. 2015;8(5):342-9. Available at: [Link](#)

<sup>575</sup> OPEN-EU. Available at: [Link](#)

Areas for Action	WHO	OECD	WOF	EASO
<b>Area 1:</b> Supporting a healthy start in life	<b>International Code of Marketing of Breast– milk Substitutes</b> <sup>576</sup> (1974)  <b>Baby–Friendly Hospital Initiative</b> <sup>577</sup> (1991)  <b>Plan on Maternal, Infant and Young Child Nutrition</b> <sup>578</sup> (2014)	n.a.	<b>Management &amp; Advocacy for Providers, Patients and Systems</b> (MAPPS) <sup>579</sup> (2018)  <b>OBesity Training and INformation Services for Europe</b> (OBTAINS– E) <sup>580</sup> (EU–funded Project) (2022)  <b>Specialist Certification in Obesity Professional Education</b> (SCOPE) <sup>581</sup> (n.d.)	<b>MEP Interest Group on Obesity and Resilient Health Systems</b> <sup>582</sup> (2020)
<b>Area 2:</b> Promote healthier environments	<b>Making Every School a Health Promoting School</b> <sup>583</sup> (1992)	n.a.	n.a.	n.a.

<sup>565</sup> WHO. (2022). WHO acceleration plan to stop obesity. Available at: [Link](#)

<sup>566</sup> McDaid D, Sassi F, Merkus SE. (2015) Promoting Health, Preventing Disease. The economic case. Berkshire: Open University Press. Available at: [Link](#)

<sup>567</sup> OECD. (2019). The Heavy Burden of Obesity: The Economics of Prevention, OECD Health Policy Studies, OECD Publishing, Paris. Available at: [Link](#)

<sup>568</sup> OECD. (2020). OECD Reviews of Public Health: Latvia: A Healthier Tomorrow, OECD Reviews of Public Health, OECD Publishing, Paris. Available at: [Link](#)

<sup>569</sup> OECD. (2022). Healthy Eating and Active Lifestyles Best Practices in Public Health, , OECD Publishing, Paris Available at: [Link](#)

<sup>570</sup> OECD. (2022). Guidebook on Best Practices in Public Health, OECD Publishing, Paris. Available at: [Link](#)

<sup>571</sup> World Obesity Federation. (2016). World Obesity Action Initiative. Available at: [Link](#)

<sup>572</sup> Science and Technology in childhood Obesity Policy (STOP). Available at: [Link](#)

<sup>573</sup> Confronting Obesity: Co-creating policy with youth (CO-CREATE). Available at: [Link](#)

<sup>574</sup> Farpour-Lambert NJ, Baker JL, Hassapidou M, Holm JC, Nowicka P, O'Malley G, et al. Childhood Obesity Is a Chronic Disease Demanding Specific Health Care--a Position Statement from the Childhood Obesity Task Force (COTF) of the European Association for the Study of Obesity (EASO). *Obes Facts*. 2015;8(5):342-9. Available at: [Link](#)

<sup>575</sup> OPEN-EU. Available at: [Link](#)

<sup>576</sup> WHO. (n.d.). International Code of Marketing of Breast-Milk Substitutes. Available at: [Link](#)

<sup>577</sup> WHO. (n.d.). Baby-Friendly Hospital Initiative. Available at: [Link](#)

<sup>578</sup> WHO. (2014). Comprehensive implementation plan on maternal, infant, and young child nutrition. Available at: [Link](#)

<sup>579</sup> World Obesity Federation. (n.d.). MAPPS. Available at: [Link](#)

<sup>580</sup> OBTAINS. Available at: [Link](#)

<sup>581</sup> World Obesity Federation. (n.d.). SCOPE. Available at: [Link](#)

<sup>582</sup> MEP Obesity Interest Group. Available at: [Link](#)

<sup>583</sup> WHO. (2021). Making every school a health-promoting school – Implementation Guidance. Available at: [Link](#)

Areas for Action	WHO	OECD	WOF	EASO
<b>Area 3:</b> Make the healthy option the easier option	<b>European Salt Action Network (ESAN)</b> <sup>584</sup> (2014)	<b>The role of fiscal policies in health promotion</b> <sup>585</sup> (2013) <b>Obesity Update 2017</b> <sup>586</sup> (2017)	n.a.	n.a.
<b>Area 4:</b> Restrict marketing and advertising to children	<b>European Nutrient profile model</b> <sup>587</sup> (2015) <b>Report “tackling food marketing to children in a digital world: trans-disciplinary perspectives”</b> <sup>588</sup> (2016)	n.a.	n.a.	n.a.
<b>Area 5:</b> Inform and empower families	<b>European Food and Nutrition Action Plan</b> <sup>589</sup> (2015– 2020)	n.a.	n.a.	n.a.

<sup>584</sup> WHO. (n.d.). European Salt Action Network (ESAN). Available at: [Link](#)

<sup>585</sup> Sassi F., Belloni A., Capobianco C. (2013) The Role of Fiscal Policies in Health Promotion. OECD Health Working Papers, No. 66., Paris: OECD Publishing. Available at: [Link](#)

<sup>586</sup> OECD. (2017). Obesity Update 2017. Available at: [Link](#)

<sup>587</sup> WHO. (2023). WHO Region Office for Europe Nutrient Profile Model: Second Edition. Available at: [Link](#)

<sup>588</sup> WHO. (2016). Tackling food marketing to children in a digital world: trans-disciplinary perspectives. Available at: [Link](#)

<sup>589</sup> WHO. (2015). European Food and Nutrition Action Plan (2015-2020). Available at: [Link](#)

Areas for Action	WHO	OECD	WOF	EASO
<b>Area 6:</b> Encourage physical activity	<p><b>WHO European Healthy Cities Network</b><sup>590</sup> (1988)</p> <p><b>Global Action Plan on Physical Activity</b><sup>591</sup> (2018–2030)</p> <p><b>Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age</b><sup>592</sup> (2019)</p> <p><b>WHO guidelines on physical activity and sedentary behaviour</b><sup>593</sup> (2020)</p>	<p><b>Step Up! Tackling the Burden of Insufficient Physical Activity in Europe</b><sup>594</sup>(2023)</p>	n.a.	n.a.
<b>Area 7:</b> Monitoring and evaluation	<p><b>Childhood Obesity Surveillance Initiative (COSI)</b><sup>595</sup> (2007)</p>	<p><b>OECD Health Statistics 2023</b><sup>596</sup> (2023)</p> <p><b>Health at a Glance 2021</b><sup>597</sup> (2021)</p>	<p><b>Global Obesity Observatory</b><sup>598</sup> (1988)</p>	n.a.
<b>AREA 8:</b> Increase research and financial support	<p><i>Area 8 is not represented in the table because it focuses on the adoption of Joint Actions and financial support for obesity programs, which are key topics intersecting with other Areas for Action.</i></p>			

<sup>590</sup> WHO. (n.d.). WHO European Healthy Cities Network. Available at: [Link](#)

<sup>591</sup> WHO. (2018). Global action plan on physical activity 2018–2030: more active people for a healthier world. Available at: [Link](#)

<sup>592</sup> WHO. (2019). Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age. Available at: [Link](#)

<sup>593</sup> WHO. (2020). Guidelines on physical activity and sedentary behaviour. Available at: [Link](#).

<sup>594</sup> OECD/WHO. (2023). Step Up! Tackling the Burden of Insufficient Physical Activity in Europe, OECD Publishing, Paris. Available at: [Link](#)

<sup>595</sup> WHO. (n.d.). WHO European Childhood Obesity Surveillance Initiative (COSI). Available at: [Link](#)

<sup>596</sup> OECD. (2023). OECD Health Statistics 2023. Available at: [Link](#)

<sup>597</sup> OECD. (2021). Health at a Glance 2021. Available at: [Link](#)

<sup>598</sup> World Obesity Federation. (n.d.). Global Obesity Observatory. Available at: [Link](#)

## 8.5 Annex V: Country profiles with colour-code

[See separate document]

## 8.6 Annex VI: Country profiles

[See separate document]

## 8.7 Annex VII: Obstacles and Challenges

[See separate document]

## 8.8 Annex VIII: Best Practices

[See separate document]

## 8.9 Annex IX: Good Practices

A total of 24 good practices have been identified in the Member States and the UK. These mostly concern Area 2 (Promote healthier environments) and Area 3 (Make the healthy option the easier option). The good practices identified per country are listed in the Table below. Moreover, industry representatives consulted during the study reported the following good practices as been successful:

- **EU Pledge**,<sup>599</sup> a voluntary initiative led by food and beverage companies in Europe aimed at limiting advertising of foods and drinks to children under 13 years old. Launched in 2007, it seeks to address concerns about childhood obesity by ensuring that advertising for products high in sugar, salt, or fat is not targeted toward young audiences, unless the product meets specific nutritional criteria. Companies participating in the EU Pledge commit to responsible marketing practices across various media, including TV, print, and digital platforms. The initiative is regularly monitored and updated to reflect new trends and regulatory requirements.

---

<sup>599</sup> EU Pledge. (2024). About the EU Pledge. Available at: [Link](#).

- **Horizon project BIO-STREAMS**,<sup>600</sup> a multi-pillar framework to address childhood obesity by building on an EU biobank, micro-moments (critical moments that have a significant impact on children's daily decisions related to diet, physical activity, and overall lifestyle) and mobile recommendation systems. They are also involved in a healthy schools' and healthy food and lifestyle, regional action and research projects in Limburg as well as the 'vegetable coalition' started by some corporate companies.
- **SPARK PE programme**<sup>601</sup> (originating in the US but used worldwide) which is an evidence-based Physical Education curriculum that aims to increase children's moderate-to-vigorous physical activity (MVPA) levels in school PE lessons.

---

<sup>600</sup> BIO-STREAMS (n.d). BIO-STREAMS. Available at: [Link](#).

<sup>601</sup> Spark (n.d). Spark: The World's Most Evidence-Based Physical Education & Physical Activity Programs. Available at: [Link](#).

**Table 29 – Identified good practices across the EU and the UK**

Country	Practice	EU Action Plan Areas								Source
		1	2	3	4	5	6	7	8	
Austria	"Richtig essen von Anfang an!" - REVAN <sup>602</sup>									Survey
Belgium	Eyes for Treats project (2018) <sup>603</sup>									Interview
Bulgaria	Regulation issued by the Minister of Agriculture, Food and Forestry No. 2 from January 20, 2021 on the Specific safety and quality requirements of the food offered at children's establishments, school canteens and the retail facilities at the territory of schools and children's establishments, as well as food offered at organized events for children and students (2021) <sup>604</sup>									Interview
Bulgaria	Voluntary reformulation targets to reduce the content of salt, fat, saturated fatty acids and sugars in priority food groups for the country, guided by the Ministry of Health Nutrition Council <sup>605</sup>									Interview
Cyprus	Health Advocacy Ambassador programme in Educational Institutions <sup>606</sup>									Interview
Cyprus	Sport for all program (1985-ongoing) <sup>607</sup>									Interview
Czech Republic	"Exercise and nutrition in the prevention of obesity" - focused on a healthy lifestyle and physical activity (obesity prevention) <sup>608</sup>									Survey/ Interview
Czech Republic	"Mosaic of health" - focused on a healthy lifestyle (2016) <sup>609</sup>									Survey/ interview
Czech Republic	"It's on our plate and we care" - part of the Healthy School canteen project <sup>610</sup>									Survey/ Interview

<sup>602</sup> Richtig essen von Anfang an. (n.d.). About us. Available at: [Link](#).

<sup>603</sup> [Do you have an eye for goodies? | Eye Treats \(oogvoorlekkers.be\)](#).

<sup>604</sup> Available at: [Link](#) and [Link](#).

<sup>605</sup> Available at: [Link](#).

<sup>606</sup> Press and Information Office (2022). Press Conference release for the National Program Aristotle. Available at: [Link](#).

<sup>607</sup> Cyprus Sport Organisation (2023). Sports for all. Available at: [Link](#).

<sup>608</sup> Reported by Department of Public Health Protection within the Health Ministry of Czech Republic. No links provided.

<sup>609</sup> Mosaic of Health. Available at: [link](#).

<sup>610</sup> It's on our plate and we care. Available at: [link](#) and [link](#).

Study on the evaluation of the EU Action Plan on Childhood Obesity: Final report

Country	Practice	EU Action Plan Areas								Source
		1	2	3	4	5	6	7	8	
Greece	Nutrition standards for foods provided in public and private preschool premises									Interview
Ireland	Food reformulation task force <sup>611</sup>									Survey/ Interview
Latvia	Nutrition standards in educational, social care and rehabilitation institutions (2012) <sup>612</sup>									Survey/ Interview
Latvia	Law on the Circulation of Energy Drinks (2016) <sup>613</sup>									Survey
Latvia	Memorandum of Cooperation on changes to child– friendly non– alcoholic beverages advertising (2011) <sup>614</sup>									Interview
Lithuania	Ban the sale of energy drinks to minors (2014) <sup>615</sup>									Interview
Lithuania	Procedures for the Organization of Food In Pre-School Education, General Education Schools And Children's Social Care Institutions (2018) <sup>616</sup>									Interview
Luxembourg	Pedagogic guide – Children on the move: how can movement take place in non-formal education? <sup>617</sup>									Survey
Luxembourg	Bewegte Schule (moving schools) <sup>618</sup>									Interview
Luxembourg	Luxembourg lives Sport (LTAD) mind map (2023) <sup>619</sup>									Desk research

<sup>611</sup> Available at: [link](#).

<sup>612</sup> Ministry of Health (2012). Nutrition standards in educational, social care and rehabilitation institutions. Available at: [Link](#).

<sup>613</sup> Available at: [link](#).

<sup>614</sup> Ministry of Health (2011). Memorandum of Cooperation on changes to child– friendly non– alcoholic beverages advertising. Available at: [Link](#)

<sup>615</sup> Database of the Parliament of the Republic of Lithuania. (2014). Lietuvos Respublikos maisto įstatymo Nr. VIII-1608 2 straipsnio pakeitimo ir įstatymo papildymo 6-1 straipsniu įstatymas. Available at: [Link](#).

<sup>616</sup> Database of the Parliament of the Republic of Lithuania. (2018). Dėl Lietuvos Respublikos sveikatos apsaugos ministro 2011 m. Lapkričio 11 d. Įsakymo nr. V-964 „dėl maitinimo organizavimo ikimokyklinio ugdymo, bendrojo ugdymo mokyklose ir vaikų socialinės globos įstaigose tvarkos aprašo patvirtinimo pakeitimo. Available at: [Link](#).

<sup>617</sup> Available at: [Link](#).

<sup>618</sup> Bewegte Schule. Available at: [link](#).

<sup>619</sup> Official Website of the Government of Luxembourg (2023). Präsentation der "Lëtzebuerg leeft Sport – Mindmap": 50 konkrete Ideen zur Förderung von Sport und körperlicher Aktivität auf kommunaler Ebene. Available at: [Link](#)

Study on the evaluation of the EU Action Plan on Childhood Obesity: Final report

Country	Practice	EU Action Plan Areas								Source
		1	2	3	4	5	6	7	8	
Luxembourg	Active School/Clever Move project (2014) <sup>620</sup>									Desk research
The Netherlands	National Model of Integrated Care for Childhood Overweight and Obesity <sup>621</sup>									Workshop
Portugal	Law No. 30/2019 to Restrict marketing to children (2019) <sup>622</sup>									Survey
Slovakia	Really Healthy Schools in Slovak schools (2021-ongoing)									Desk research
Slovenia	Practise Cooking Kids (2018) <sup>623</sup>									Interview

Source: Authors' elaboration

<sup>620</sup> GIMB (2024). Clever Move. Available at: [Link](#)

<sup>621</sup> Halberstadt, J., Koetsier, L.W., Sijben, M., Stroo, J., van der Velde, M., van Mil, E.G.AH., Seidell, J.C., (2023). The development of the Dutch "National model integrated care for childhood overweight and obesity". Available at: [Link](#).

<sup>622</sup> PGD Lisboa (2019). Lei n.º 30/2019, de 23 de Abril. Available at: [Link](#).

<sup>623</sup> [Kuhnapato | SPAR SI](#); [Kuhnapato | OŠ Bovec \(solabovec.si\)](#).

## 8.10 Annex X: Consultation Materials

[See separate document]

## 8.11 Annex XI: Synopsis Report

[See separate document]

