# Executive Summary of the Project: a summary of the Policy recommendations

The HOPE project consisted of ten work packages. There were two co-ordinating centres: the Department of Public Health of the Erasmus MC Rotterdam and the IOTF/IASO (London). Erasmus MC was responsible for the overall coordination of research activities, while IOTF/IASO coordinated the networking actions and the translation of the HOPE results into policy recommendations (IOTF/IASO). The table below provides an overview of the work packages, the work package leaders and their institutes.

| Nr | Title | Work Package Leader | Site |
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| 1 | Co-ordination of project | Frank J. van Lenthe & Johannes Brug | Erasmus MC – Rotterdam |
| 2 | Integrating obesity research in Europe: A network of networks | Tim Lobstein & Philip James | IOTF/IASO –London |
| 3 | Early childhood obesity prevention | Adriano Cattaneo | IRCCS Burlo – Trieste |
| 4 | Obesity prevention among children and adolescents (10-18 years) | Knut-Inge Klepp & Nanna Lien | University of Oslo – Oslo |
| 5 | Obesity prevention among young adults | Frank J. van Lenthe | Erasmus MC– Rotterdam |
| 6 | National policy obesity prevention interventions | Agneta Yngve | Karolinska Institute |
| 7 | Policy on socio-economic inequalities in overweight and obesity and their determinants across Europe | Anton Kunst | Erasmus MC – Rotterdam |
| 8 | The effectiveness of physical activity interventions and policies for curbing the obesity epidemic | Jean-Michel Oppert | Institut National de la Santé et de la Recherche Médicale – Paris |
| 9 | The effectiveness of nutrition interventions and policies for curbing the obesity epidemic | Ilse De Bourdeaudhuij & Lea Maes | Ghent University – Ghent |
| 10 | Scenarios for the impact of obesity on the health of European populations | Anton Kunst & Johan Mackenbach | Erasmus MC – Rotterdam |

HOPE (Health promotion through obesity prevention across Europe: an integrated analysis to support European health policy) is Europe's largest project to study the role of behavioural and environmental drivers causing the rapid rise in obesity prevalence in Europe. The project undertook systematic literature reviews and brought together a network of experts involved in research and policy around Europe, and has produced a comprehensive summary of the key findings and policy implications based on these findings (see Appendix 1 *The HOPE project: a review of the policy implications* for a full overview*).*The matrix below provides a brief summary of the main findings and recommendations for policy.

| **Policy issue** | **Key findings and recommendations** | **Further comments** |
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| **Cross-departmental policy issues** | Member states show different levels of documentation, different range of issues addressed and their policies are not consistently linked to actions, and may be inadequately evaluated.<br>Health behaviour is influenced by social, financial and physical environments. Multi-sectoral approaches are more likely to change these environments, and are needed at local and national level.<br>There is a strong association between low socio-economic status (SES) and a higher risk of obesity in women in most countries, and in men and older children in some countries. Some ethnic groups are at lower risk, some higher. Some ethnic groups are at particularly high risk of obesity-related diseases for a given level of BMI. Modelling indicates that up to 7% of the national health burden can be attributed to SES inequalities. The current trends show that inequalities in health are increasing.<br>Not all member states are aware of the costs of obesity to health services and to their economy. Scenario modelling can | Guidelines are needed on removing barriers so that 'healthy choices are easy choices' and on policy assessment so that there is 'health in all policies'.<br>Those member states with independent councils to review and evaluate policy implementation are more likely to have effective policies.<br>There is a need for national and EU guidelines on reducing health inequalities within a framework for maximising total population health. More evidence is needed to assess how different groups (SES, ethnic etc) respond to different forms of intervention.<br>Attractive policies are 'no regret' policies – i.e. worth promoting even if no effect on obesity (e.g. physical activity promotion, breastfeeding promotion).<br>Obesity policies can be linked to global warming, reduced carbon footprints and reduced mental |

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| | show the cost impacts of obesity and cost-effectiveness of interventions. | stress. |
| **National surveillance** | Member states have differing levels of surveillance for obesity, dietary intake and physical activity. There is a need for improved research tools to aid data collection. These factors seriously hamper the ability to predict service needs and assess policy interventions. | Need for EU-wide guidelines on surveillance and targets for data reporting. |
| **Maternal health** | Gestational diabetes is more common among obese pregnant women, and it is a high risk factor for child obesity. Obesity in pregnancy is more common in lower SES women, and raises risk of birth complications. Obesity in parents strongly raises the risk of obesity in children. | National and EU guidelines are needed. |
| **Pre-school and family settings** | More rapid weight gain, and weight gain at an earlier stage, raise the risk of child obesity. Breastfeeding, especially if exclusive in the first 6 months, helps prevent subsequent child obesity. Early weaning may increase risk.<br>Meal patterns affects food intake. TV watching is a risk factor for child obesity. | National and EU guidelines needed for infant feeding practices. Baby Friendly initiatives in hospitals and community services need wider support. Guidance is needed on nutrition and physical activity standards for child care facilities – good standards are a 'no regret' policy. |
| **Education/school settings** | Multi-component (involving teaching and practice, diet and physical activity) and 'whole-of-school' policies (including staff, children and parents, food services, classroom teaching, physical education, after-school activities and parental involvement) can improve health behaviour. School food practices can influence home practices. Lack of evidence on whether they work equally well across SES groups.<br>Some evidence that targeting soft drink consumption and | Guidance on 'Nutrition -Friendly Schools' and 'Health-Promoting Schools' is available from WHO. Health promotion in schools is a 'no regret' policy. Targeting overweight children may stigmatise the child. Weight-loss interventions may reduced a child's self-esteem if the intervention is not effective.<br>Use of social marketing techniques which demonise |

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| | promoting physical activity can be beneficial.<br>Child obesity is linked to lower educational achievement. Adults who were low-achievers are more likely to have children that become obese. | 'junk' food and inactivity may be effective: e.g. *Sportacus* and *Food Dudes.* These programmes need further evaluation. |
| **Work and care environments** | Workplace interventions may help more motivated individuals, but less likely to have an effect on low SES individuals. Unknown gender differences. Workplace support for breastfeeding and maternity leave policies should be encouraged. | Large sections of the population do not benefit from workplace interventions. EU guidance is needed on standards for workplace child care, breastfeeding-friendly workplaces and maternity leave. |
| **Neighbourhood environment, transport** | Planning regulations can influence food availability; transport policies to encourage walking and cycling; building regulations to encourage walking and use of stairs parks, play areas and residential streets. | Policies need to be sensitive to inequalities. 'Health-in-all-policies' methodology is needed. NB: it is difficult to prove the health benefits of environmental interventions. |
| **Trade and industry** | Pricing interventions can change consumption patterns. Improving price and availability (e.g. subsidised fruit and vegetable distribution) can raise intake. Front-of-pack labelling can influence choice of products, and can encourage better product formulation. | Price is a key influence on food choice. Nutrition labelling with traffic light or keyhole interpretation is likely to be easier for non-numerate and lower SES consumers. |
| **Media and culture** | Restrictions on marketing breast milk substitutes need to be maintained, and controls on promotional marketing of fatty, sugary food to children need to be strengthened. Social marketing campaigns can change behaviour, especially if combined with other changes (e.g. price and availability of products). Greatest impact among motivated and higher SES groups. | Commercial self-regulation of marketing has been criticised as inadequate.<br>Social marketing serves other purposes: e.g. encouraging industry compliance and generating public support for legislation. |
| **Agricultural** | Supply policies influence consumption through price and | Agricultural support and trade barriers affect local |

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| **policy** | availability. EU interventions (e.g. subsidised fruit for schools) are assumed to have health effects. Policies which reduce meat consumption and increase fruit and vegetable consumption will improve dietary health. Policies which switch from meat to plant oils and sugar may worsen dietary health. | supply and consumer prices. Research on their effect on health is just emerging. Public sector purchasing contracts can be used to influence supply chain economics. |
| **Research** | Public health interventions are not easily tested with controlled trials. Other approaches are needed.<br>Research is needed on influences on food choices (especially non-rational influences) and on the use of fiscal measures to influence choice. | More research needs are identified above. |