Chapter 2

Systematic appraisal of integrated community-based approaches to prevent childhood obesity. Do we have the tools?

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Submitted
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Abstract

Traditional evaluation and monitoring methods are often unable to identify crucial elements of success or failure of integrated community-based approaches aiming to tackle childhood overweight and obesity, yet difficult to determine in complex programmes. Therefore, we aimed to systematically appraise strengths and weaknesses of such programmes and to assess the usefulness of the appraisal tools used. To identify strengths and weaknesses of the integrated community-based approaches two tools were used: the Good Practice Appraisal tool for obesity prevention programmes, projects, initiatives and intervention (GPAT), a self-administered questionnaire developed by the WHO; and the OPEN tool, a structured list of questions based on the EPODE theory, to assist face-to-face interviews with the principle programme coordinators. The strengths and weaknesses of these tools were assessed with regard to practicalities, quality of data acquired and the appraisal process, criteria and scoring. Several strengths and weaknesses were identified in all the assessed integrated community-based approaches, different for each of them. The GPAT provided information mostly on intervention elements whereas through the OPEN tool information on both the programme and intervention levels were acquired. Large variability between integrated community-based approaches preventing childhood obesity in the European region was identified and therefore each of them has different needs. Both tools in combination used seem to facilitate comprehensive assessment of integrated community-based approaches in a systematic manner, which is rarely conducted. Nonetheless, the tools should be improved in line to their limitations as recommended in this manuscript.
Appraisal of integrated community-based approaches

Introduction

Overweight and obesity are nowadays characterised as a major public health problem in Europe and are therefore highly prioritised on the European public health agenda [1]. The causal pathways that drive the increase of obesity prevalence are complex and predominately associated with lifestyle behaviours such as low levels of physical activity, sedentary lifestyles and unhealthy dietary habits. These lifestyles are influenced by societal, cultural, economic, organizational and environmental conditions [1-5]. This implies the need for integrating multiple sectors and targeting multiple levels of influence of unhealthy dietary and physical activity habits simultaneously [1, 5-7]. Therefore, a socio-ecological approach for interventions and programs has been proposed [5, 6, 8, 9] which involves a range of factors that affect individual behaviour, reflected at the interpersonal, organisational, community and policy levels [3, 6, 8, 9].

Based on a socio-ecological approach, integrated community-based approaches arise as considered to be the most promising in tackling overweight and obesity [1]. They are composed of a cluster of strategies performed in a community, designed for individual behavioural change towards a healthier lifestyle by means of involving various institutions, organizations and local stakeholders [10]. Although there is mounting evidence that such programmes are promising [8, 11, 12], it is still unclear what are the effective elements of such integrated community-based approaches and how implementation can be improved, as only a few process evaluations have been carried out to provide insight [9, 13].
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One of the few promising integrated community-based approaches that have provided some insights is based on the EPODE (‘Ensemble Prévènons l’Obésité Des Enfants’ or ‘Together let’s prevent childhood obesity’) approach, which depends on four main pillars: (i) political commitment, (ii) supporting services for design and implementation of interventions and campaigns (or social marketing), (iii) public and private partnerships (PPPs) and (iv) scientific monitoring, evaluation and dissemination of the programme [13, 14]. The strong political commitment refers to the official involvement of political representatives, who are in key positions for influencing local or national policies, as well as influencing relevant environmental factors that affect weight-related behaviours. Social marketing is comprised of applying marketing strategies, to achieve behavioural goals that promote health. Its messages are included into strategies, targeting the children, families and their local microenvironment, aiming at the same time to mobilise local stakeholders (teachers, catering services etc). The PPPs are established as collaboration between the academic world, the public sector-agencies and governmental institutions- and the for-profit sector, ensuring mutual respect, trust for each party and common goals. The scientific evaluation of the EPODE program includes four levels: the central organisation, the local organisation, the action at settings and the effect on the child. Consequently, the evaluation includes monitoring of process, as well as outcome indicators at all levels. The term dissemination refers to the use of evidence acquired from various sources to evaluate the implementation of EPODE and to facilitate the process evaluation. Detailed information about the EPODE philosophy and pillars can be found elsewhere [13, 14].
Appraisal of integrated community-based approaches

The OPEN project

As an innovative framework in the field of integrated community-based approaches for the prevention of childhood obesity, the EPODE approach has been widely adapted by integrated community-based programmes across Europe and elsewhere, adjusted to the country’s specificities and dynamics ([http://epode-international-network.com/members/programmes](http://epode-international-network.com/members/programmes)). In 2014 a European network of integrated community-based approaches targeting childhood obesity prevention-called the OPEN (Obesity Prevention through European Network) project- was initiated with financial support of the European Union. The purpose was to improve the methods of community-based approaches by building capacity through experience sharing and training according to the EPODE approach, besides learning from their own strengths and limitations. The many integrated community-based approaches aiming to tackle and/or prevent childhood overweight and obesity across Europe share obstacles challenging their effectiveness. The lack of effectiveness could also be attributed to unsuitable evaluation and monitoring methods, unable to identify crucial elements of success or failure, yet difficult to determine in complex programmes [7, 15, 16]. A systematic appraisal of the programmes’ strengths and weaknesses would potentially enhance understanding of important programme components to be improved or to be paradigmatic.

Therefore the aims of this study were:

1. To appraise the methods of the integrated community-based approaches in a systematic way.
2. To describe the strengths and weaknesses of the appraisal tools used to achieve the first aim.
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**Methods and materials**

For the first aim, two different tools were used to identify strengths and weaknesses of the integrated community-based approaches (referred as “programme-level”). The tools are the “Good Practice Appraisal tool for obesity prevention programmes, projects, initiatives and interventions” (GPAT; Appendix 1) (WHO, 2011), a self-administered questionnaire of the World Health Organization and the OPEN tool (Appendix 2), a structured list of questions based on the EPODE theory, aimed to assist face-to-face interviews with the principle programme coordinators and project managers. For the second aim, the strengths and weaknesses of these tools were assessed, based on the experience of the research team in using them to appraise integrated community-based approaches, with regard to:

i. The practicalities (time, cost and burden of data collection method).

ii. The quality of acquired data (complete, clear).

iii. The appraisal process, criteria and scoring.

**Recruitment of integrated community-based approaches**

We selected integrated community-based approaches programmes, initiatives and public organizations (the terms “programmes” and “integrated community-based/wide approaches” are used alternately further in this article), which implement integrated community-based interventions, in this case to prevent childhood obesity. Inclusion criteria for the current study were that they are based in the European Union and that they were on-going programmes at the time of data
collection. There was no intention to include all the existing on-going programmes of the European Union.

Two different networks of integrated community-based approaches (EPODE International Network and IDEFICS) were approached. Eight programmes that were members of the EPODE International Network and three from the IDEFICS network which fulfilled the inclusion criteria were approached and accepted to participate to the OPEN project. One of the IDEFICS sites (Delmenhorst) proved not to be on-going at the time of data collection (June-September 2014) and it was therefore excluded from this analysis. Two other appropriate programmes took the initiative to participate. Thus twelve programmes were finally included into this study.

We aimed to collect information by interviewing principal coordinators and/or project managers (at the national and/or local level). The programmes varied in type. Some were programmes that used a more integrated approach involving various stakeholders, networks and settings and running for longer term; whereas others were strategies or even initiatives implementing more simple interventions or campaigns. As illustrated in table 1, eight out of the twelve programmes were organized at the national level (i.e. in some, but not necessarily all, cities of the country), including central and local (city level) coordination with one exemption. Five were EPODE-like programmes. Another three were organized at the regional level and one of them included a central coordination team as well as a local team. One programme was organized at the local level. The programmes range from 1 to 62 communities and from school to whole-community approaches, resulting in a range of 7,000 to 300,000 children and families to be targeted/reached.
**Table 1.** Descriptive characteristics of the OPEN programmes.

<table>
<thead>
<tr>
<th>Programme, country</th>
<th>Programme range (region/city)</th>
<th>Year of initiation</th>
<th>Final target group(s)</th>
<th>Communities/schools reached</th>
<th>People reached/targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Programme, <em>Cyprus</em>&lt;sup&gt;¹&lt;/sup&gt;</td>
<td>Regional (Nicosia)</td>
<td>1995</td>
<td>Children and their families</td>
<td>8 communities</td>
<td>4,500 children and families</td>
</tr>
<tr>
<td>Salud Madrid, <em>Spain</em></td>
<td>Regional (Madrid)&lt;sup&gt;⁵&lt;/sup&gt;</td>
<td>N/A</td>
<td>0-17 year olds</td>
<td>179 communities</td>
<td>1,185,156 children and adolescents</td>
</tr>
<tr>
<td>EPODE Flandre Lys, <em>France</em>&lt;sup&gt;²&lt;/sup&gt;</td>
<td>Regional (Flanders - Lys)</td>
<td>2004</td>
<td>0-11 years olds</td>
<td>8 communities</td>
<td>34,000 people (7,000 children)</td>
</tr>
<tr>
<td>JOGG (Youngsters at a Healthy Weight), <em>The Netherlands</em>&lt;sup&gt;²&lt;/sup&gt;</td>
<td>National</td>
<td>2010</td>
<td>Families with 0-19 year olds</td>
<td>62 communities</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Keep fit, <em>Poland</em></td>
<td>National, School-based</td>
<td>2006</td>
<td>13-15 year olds</td>
<td>60% of the country’s 700,000 secondary schools</td>
<td>200,000 adolescents/year</td>
</tr>
</tbody>
</table>
Table 1. Descriptive characteristics of the OPEN programmes (continued).

<table>
<thead>
<tr>
<th>Programme, country</th>
<th>Programme range (region/city)</th>
<th>Year of initiation</th>
<th>Final target group (s)</th>
<th>Communities/ schools reached</th>
<th>People reached/targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>HELP (Healthy Eating Lifestyle Plan) initiative, Malta</td>
<td>National</td>
<td>2007</td>
<td>Families with 5-16 year olds</td>
<td>The whole country</td>
<td>Whole population and at-risk population</td>
</tr>
<tr>
<td>MUNSI, Portugal</td>
<td>National</td>
<td>2007</td>
<td>Children and teachers</td>
<td>1 community</td>
<td>1600 children</td>
</tr>
<tr>
<td>PAIDEIATROFI, Greece</td>
<td>National</td>
<td>2008</td>
<td>Families with 6-12 year olds</td>
<td>6 communities</td>
<td>N/A</td>
</tr>
<tr>
<td>Good Health Partille, Sweden</td>
<td>Local (Partille)</td>
<td>New</td>
<td>2-10 year olds</td>
<td>1 community</td>
<td>7.000 children</td>
</tr>
</tbody>
</table>
Table 1. Descriptive characteristics of the OPEN programmes (continued).

<table>
<thead>
<tr>
<th>Programme, country</th>
<th>Programme range (region/city)</th>
<th>Year of initiation</th>
<th>Final target group (s)</th>
<th>Communities/ schools reached</th>
<th>People reached/targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>SETS movement, <em>Romania</em> <em>²</em></td>
<td>National</td>
<td>2011</td>
<td>6-12 year olds</td>
<td>3 communities</td>
<td>190,000 children and families</td>
</tr>
<tr>
<td>Sporttube, <em>Slovakia</em></td>
<td>National <em>⁴</em></td>
<td>2009</td>
<td>6-19 year olds</td>
<td>200 schools</td>
<td>53,000 children</td>
</tr>
<tr>
<td>VIASANO, <em>Belgium</em> <em>²</em></td>
<td>National</td>
<td>2007</td>
<td>3-12 year olds</td>
<td>18 communities</td>
<td>700,000 inhabitants</td>
</tr>
</tbody>
</table>

1: Programmes included in the IDEFICS network and continues carrying out prevention activities independently.
2: Programmes using the EPODE approach for their realisation
3: HELP is a multi-level initiative running under the Health Promotion and Disease Directorate, Ministry of Energy and Health, Malta
4: The campaigns of the programme are implemented in different regions of Slovakia; no local coordination team involved.
5: Although the programme is regional, it is coordinated by a central team and the actual implementation is conducted by
Development and content of the tools

A. Good Practice Appraisal Tool

The tool was developed under a work package of the WHO/EC DG SANCO project “Monitoring progress on improving nutrition and physical activity and preventing obesity in the EU” (2008–2010). It is an open-ended questionnaire for the systematic assessment of the quality of programmes in order to identify good practices, which could be paradigmatic for future interventions targeting obesity prevention. The GPAT was developed on the basis of outcomes from a literature review regarding evaluation criteria and assessment tools that define an intervention as effective. For pilot testing, seven programmes completed the questionnaire and provided feedback and several experts pilot tested the appraisal form by assessing independently one of the programmes, while they provided additional feedback on the tool (Appendix 1).

The questionnaire is comprised of 43 questions which cover three domains:

1. Main intervention characteristics,
2. Monitoring and evaluation of the interventions,
3. Implementation of the interventions.

An appraisal form is also included to calculate the score achieved for each of the items and domains assessed. Detailed information about the aim and development of the tool and the tool itself can be found elsewhere (Appendix 1).
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B. OPEN tool

For the interviews the OPEN tool was developed, a structured list of questions related to the EPODE pillars, flexible to additional information. The aims were:

1. To get insight into the way the programme was realised.
2. To identify barriers in implementation of the programmes.

The development of the OPEN tool was assisted by experts in the evaluation of integrated community-based programmes and experts from the EPODE International Network (JM and JMB). In line with their consultations, two semi-structured interview guides that have been previously used to describe the approach of EPODE-like programmes were used as a basis; the “EPODE Interview Guide” developed by Van Koperen et al [13] and the “Preliminary interview guide for the transfer of the EPODE approach”, developed by the EPODE International Network.

After thorough assessment of and discussion about the topics of the two interview guides, the expert group-comprised by health professionals/researchers in obesity prevention and management (JCS and CR), an expert in qualitative studies (MW), professionals in development and implementation of integrated community-based interventions (JMB and JM) and a researcher of community-based interventions (KM)- developed the OPEN tool (Appendix 2). The OPEN tool is composed of 56 questions (excluding sub-questions) exploring the four pillars of EPODE:

a. The involvement and commitment of political structures and political physical persons in the programme.
b. The type of public and private partnerships, if any, and their involvement in the programme.

c. The methods used to design and implement interventions— including the tools, means and expertise to reach the target groups.

d. The involvement of scientific expertise and methods to monitor and evaluate the programme.

Overall, the questions assess programme components either at the national and/or local level (Appendix 3). Moreover, questions regarding the interventions (n=10) are included, reflecting the methods used by the programme team.

Data collection

The principal programme coordinators and/or project managers were the main respondents to both the GPAT questionnaire and the in-person interviews. Their profession was either in disciplines of health or communication and marketing. Similarly, the profession of the other interviewees was either in health (e.g. public health specialist, clinical psychologist, paediatrician, nutritionist) or in marketing and communication.

A. Good Practice Appraisal Tool

The GPAT was disseminated to the principal programme coordinators through e-mail. The data collectors (i.e. the coordinators of the dissemination; KM and JM) indicated that when questions refer to interventions they should select only one in case they had multiple interventions. The completed questionnaires were reviewed on completeness and clarity. In order to ensure high quality data the data
collectors (KM and JM) discussed potential queries/misinterpretations of the questions from the GPAT face-to-face with the respondents, before the interviews through the OPEN tool were carried out. Additional information was asked (including programme documentation) and provided when necessary. Finally, verbal feedback was given from the respondents regarding the questionnaire.

B. OPEN tool

Face-to-face interviews with the principal programme coordinators and/or programme managers were conducted at the national or regional level (nine programmes), the local level (one programme) or both—the national and local level (two programmes). The number of the interviewees per interview ranged from 1 to 4. The same protocol was used for all programmes: the interviewers (JM and KM) visited the principal programme coordinators in their office, in English language and they audio-recorded the interviews. In one case the interviewee did not speak English, thus a colleague translated the information. In addition, all questions were asked following the OPEN tool in most of the cases, whereas otherwise, the interviewers assured that all the topics had been discussed by the end of the interview. In the cases of missing or unclear information, short-term, supplementary, face-to-face interviews were conducted (n=11) and additional information was asked via e-mail (n=4 out of the 11 supplementary interviews).
Data analysis

Appraisal of programmes’ methods by the GPAT and the OPEN tool

A. Good Practice Appraisal Tool

The GPAT questionnaires were appraised through the provided appraisal form (Appendix 1), which scores the items of each of the three domains of the questionnaire using a binary rating scale 0 (not included element) or 1 (included element). Given that it was often difficult to decide between extreme scores, we included an intermediate scale equal to 0.5 (partly included element). After calculating the score of each section, this was divided by the maximum section score, resulting in a score of 1 or less. The score refers to “good practice” if 0.8 or higher, to “acceptable practice” when it is 0.6-0.8, to “marginal practice” when it ranges between 0.4-0.6 and to “weak practice” when it is lower than 0.4. Finally, the average score of all three sections was calculated to appraise the programme as a whole. In line with the instructions of the Good Practice Appraisal Tool (Appendix 1), the data were appraised by two independent researchers. Firstly, KM made the initial appraisal. Secondly, equivocal information was thoroughly discussed with CR in order to agree on the final score of each item.

B. OPEN tool

The interviews were transcribed by one researcher (KM). Due to the lengthy interviews and limited time, the expert committee decided to transcribe only the answers to all questions of the structured question list instead of conducting verbatim transcription. This task was carefully undertaken in order to ensure transcription of all core information. In
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In order to appraise the realisation of each of the programmes, criteria for each of the four EPODE pillars were developed along with their scoring scales. The criteria were based on the logic model of EPODE [13] and the experience of the expert team on the critical elements of the EPODE pillars. During the appraisal process, the rating scales were adapted and criteria were added, depending on the information gathered by the programmes. This resulted in the OPEN tool analysis framework, composed by 101 items (Appendix 3). Thereafter, the information of each of the programmes was organised based on this framework, resulting in an overview of the programmes realisation (information matrix). The appraisal criteria of the analysis framework were assigned to a scoring scale from 0-2. A score of (0) stands for none existing element or poor quality. A score of 1 was given for existing element of moderate quality or a partly existing element and a score of 2 was given to existing elements of good quality. The reference criteria for the quality of the elements for each of the pillars, are derived by existing literature on the EPODE framework [13, 14, 17]. Three researchers (KM, CR and JM) reviewed and scored the information of each programme independently. Disagreements in the scoring of both tools were resolved by consensus of the expert group. Then a total score was calculated for each of the EPODE pillars. In many cases there were questions that did not apply to some of the programmes (labelled as “not applicable”), which were scored as 0.

During the appraisal of both sets of information, the evaluators encountered difficulties in scoring, due to essential differences in the integrated approach used by each of the programmes. Thus, interpretation of scores is dependent on the different contexts. An example is the scoring of the item about evaluation of the actions in the
setting (F4biii; Appendix 2); for a local programme the score depended on whether the majority of the actions have been evaluated, but for a national programme, if the majority of the communities evaluated their actions was considered.

Assessment of strengths and weaknesses of the appraisal tools

In order to clarify the strengths and weaknesses of the two tools to assess integrated community-based approaches, the expert team discussed thoroughly the experience of the data collectors and evaluators in using the tools. Specifically, practical aspects of the data collection were discussed, namely the burden of the data collection method, the time and the costs needed. In addition, considering the importance of acquiring high quality data, the information collected via both tools were compared in terms of being complete and clear. Moreover, the time needed for and ease of the appraisal process were discussed, along with the appraisal criteria and scoring.

Results

Appraisal of the programme’s methods

A. Good Practice Appraisal Tool

The assessment of the programmes through the GPAT showed that their practices, covering all three domains assessed, was characterized as acceptable for the 27% (3/11 programmes) of them, as “marginal” for 54.5% (6/11 programmes) and as “weak” for 18% (2/11 programme) (Table 2). The majority of the programmes (n=10) had scores below 0.60 in elements of “monitoring and evaluation” (Table 2). In the “implementation” domain most scores were between 0.18 and
Table 2. Scores of the programmes on the each of the GPAT’s domains.

| Programme, Country | Main Intervention Characteristics | Monitoring and evaluation | Implementation | Total 
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health Programme, Cyprus</td>
<td>0.66</td>
<td>0.31</td>
<td>0.41</td>
<td>0.45</td>
</tr>
<tr>
<td>Salud Madrid, Spain</td>
<td>0.76</td>
<td>0.54</td>
<td>0.59</td>
<td>0.63</td>
</tr>
<tr>
<td>EPODE Falndre Lys, France</td>
<td>0.41</td>
<td>0.31</td>
<td>0.45</td>
<td>0.41</td>
</tr>
<tr>
<td>JOGG, The Netherlands</td>
<td>0.95</td>
<td>0.61</td>
<td>0.41</td>
<td>0.66</td>
</tr>
<tr>
<td>Keep fit, Poland</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HELP initiative, Malta</td>
<td>0.75</td>
<td>0</td>
<td>0.45</td>
<td>0.40</td>
</tr>
<tr>
<td>MUNSI, Portugal</td>
<td>0.81</td>
<td>0.50</td>
<td>0.54</td>
<td>0.61</td>
</tr>
<tr>
<td>PAIDEIATROFI, Greece</td>
<td>0.71</td>
<td>0.38</td>
<td>0.45</td>
<td>0.51</td>
</tr>
<tr>
<td>Good Health Partille, Sweden</td>
<td>0.71</td>
<td>0</td>
<td>0.27</td>
<td>0.37</td>
</tr>
<tr>
<td>SETS movement, Romania</td>
<td>0.66</td>
<td>0.61</td>
<td>0.41</td>
<td>0.56</td>
</tr>
<tr>
<td>Sporttube, Slovakia</td>
<td>0.39</td>
<td>0</td>
<td>0.27</td>
<td>0.22</td>
</tr>
<tr>
<td>VIASANO, Belgium</td>
<td>0.6</td>
<td>0.54</td>
<td>0.18</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Max score | 1 | 1 | 1 | 1 |

Items scored (#) | 19 | 13 | 11 | 43 |

a: The domain assesses the following elements: targets, relevance, sustainability, target group, partners and cooperation and planning.

b: The domain assesses the following elements: indicators and monitoring, measurements, statistical methods, result assessment, stakeholders and communication.

c: The domain assesses the following elements: performance, partners and cooperation, communication and documentation, target group participation and achievement of intervention objectives.

d: Characterization of the programme practice according to the score achieved: >0.8 = "Good practice", 0.6-0.8 = "Acceptable practice", 0.4-0.6 = "Marginal practice", <0.4 = "Weak practice"
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Table 3. Scores of the on each of the four EPODE pillars.

<table>
<thead>
<tr>
<th>Programme, Country</th>
<th>Pillar</th>
<th>Political commitment Score (%)</th>
<th>PPPs Score (%)</th>
<th>Social Marketing Score (%)</th>
<th>Scientific evaluation and dissemination Score (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health Programme, Cyprus</td>
<td></td>
<td>16 (61.5)</td>
<td>2 (25)(^a)</td>
<td>35 (67)</td>
<td>27 (67.5)(^a)</td>
</tr>
<tr>
<td>Salud Madrid, Spain</td>
<td></td>
<td>11 (42)</td>
<td>7 (39)</td>
<td>31 (60)</td>
<td>22 (55)</td>
</tr>
<tr>
<td>EPODE Falndre Lys, France</td>
<td></td>
<td>24 (92)</td>
<td>12 (67)</td>
<td>35 (67)</td>
<td>16 (40)</td>
</tr>
<tr>
<td>JOGG, The Netherlands</td>
<td></td>
<td>22 (85)</td>
<td>17 (94)</td>
<td>42 (81)(^a)</td>
<td>26 (65)</td>
</tr>
<tr>
<td>Keep fit, Poland</td>
<td></td>
<td>20 (77)</td>
<td>14 (78)</td>
<td>27 (52)(^a)</td>
<td>23 (57.5)</td>
</tr>
<tr>
<td>HELP initiative, Malta</td>
<td></td>
<td>21 (81)</td>
<td>10 (55.5)</td>
<td>40 (77)</td>
<td>26 (65)</td>
</tr>
<tr>
<td>MUNSI, Portugal</td>
<td></td>
<td>17 (71)(^a)</td>
<td>5 (28)(^a)</td>
<td>25 (48)</td>
<td>28 (70)</td>
</tr>
<tr>
<td>PAIDEIATROFI, Greece</td>
<td></td>
<td>20 (77)</td>
<td>17 (94)</td>
<td>37 (71)</td>
<td>22 (55)(^a)</td>
</tr>
<tr>
<td>Good Health Partille, Sweden</td>
<td></td>
<td>26 (100)</td>
<td>8 (44)</td>
<td>33 (63)</td>
<td>6 (15)(^a)</td>
</tr>
<tr>
<td>SETS movement, Romania</td>
<td></td>
<td>15 (58)</td>
<td>16 (89)</td>
<td>38 (73)</td>
<td>21 (52.5)</td>
</tr>
<tr>
<td>Sporttube, Slovakia</td>
<td></td>
<td>3 (19)(^a)</td>
<td>5 (42)(^a)</td>
<td>21 (40)(^a)</td>
<td>1 (2.5)(^a)</td>
</tr>
<tr>
<td>VIASANO, Belgium</td>
<td></td>
<td>18 (69)</td>
<td>13 (78)</td>
<td>37 (71)</td>
<td>18 (45)</td>
</tr>
</tbody>
</table>

Maximum score (%) | 26 (100) | 18 (100) | 52 (100) | 40 (100) |

Number of items scored | 13 | 9 | 26 | 23 |

\(^a\): Not all items were scored; there were questions that could not be answered, because they did not apply to the programme during the appraisal.

\(^i\): The initiative consists mainly of sporadic physical activity events.

0.59 (Table 2), whereas the “main intervention characteristics” domain was of moderate quality in many of the programmes (n=7; table 2).
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B. OPEN tool

The appraisal based on the four EPODE pillars showed that achievement in “political commitment” ranged from 19% to 100%, from 25% to 89% in “public-private partnerships”, from 40% to 84% in “supporting services for implementation of interventions and campaigns” and from 2.5% to 70% in “scientific evaluation and dissemination” (Table 3). The results denoted several potential areas of improvement in the programmes’ approach in each of the pillars, however different for each one of them.

Strengths and weakness of the Good Practice Appraisal Tool

i. Practicalities in data collection

From the researchers’ viewpoint, the data collection through the GPAT was relatively inexpensive and time-effective, accounting for about eight man-hours (i.e. send all the questionnaires via e-mail, review their quality of information and ask clarifications). All respondents found the questionnaire too lengthy - the time to complete it ranged from 4 hours to a few days - and the formulation of some questions appeared to be unclear.

ii. Quality of data

Eleven out of the twelve programmes returned the completed questionnaire to the researchers. Five respondents mixed answers referring to the programme with those to the intervention level, whereas six responders focused on only one level (programme or intervention). In addition, seven respondents misinterpreted the terminology of items in the domain of “evaluation and monitoring” (21-23, 27-28; Appendix 1). Furthermore, the data collectors required the
programme documentation to get insight in the context, but this was often absent or not available in English for all the programmes.

iii. **Appraisal process, criteria and scoring**

The evaluators spent 1-2 hours for the data appraisal per programme and the process was difficult given the confusing information retrieved, as described above. One of the appraisal criteria did not correspond to the question asked (40). The criteria of five items (9, 13, 15, 16, 36) were vaguely defined (Appendix 1), leading to difficulties in scoring. Therefore, the evaluators appraised them often as “partly included element” (0.5). Another observation was that the appraisal of item 7 depended on the response of item 6, which in many cases was either replied inconsistently for the (intervention/programme) level (n=2) or not specified (n=2) or was missing/not conducted (n=1/n=3). Furthermore, the appraisal criteria were not formulated or suitable for the programme level.

**Strengths and weakness of the OPEN Tool**

i. **Practicalities of data collection**

Twelve face-to-face interviews were conducted. The data collection included considerable costs for the transportation/accommodation of the data collectors in twelve countries. Approximately 6-8 hours of transportation (with return) per visit, additionally to 1.5-4 hours for conducting the interviews were spent per data collector. The interviewees spent much of their time as well for the interview. Their burden decreased given the structured topic list, which facilitated clear questions and their immediate clarification by the interviewers when needed. The transcription lasted from 5-10 hours per interview.


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ii. *Quality of data*

We obtained clear and complete information on the programme and intervention level, especially after the complementary requested information (i.e. supplementary interviews, e-mails). The questions asked and responses given during the interviews were clarified when necessary, avoiding misinterpretation by the interviewees and allowing better understanding for the interviewers.

iii. *Appraisal process, criteria and scoring*

The average time of appraisal per programme was 8 hours. The appraising of the programme elements was difficult, due to the amount of information, large variability of the programmes in terms of complexity and the level of independence of the communities on their national coordination. The OPEN analysis framework was developed using criteria related to the EPODE pillars and scoring categories. These criteria and rating scales were being further specified during the analysis, resulting in a framework accounting for the programmes’ variability.

**Discussion**

*Appraisal of integrated community-based approaches’ methods*

Several strengths and weaknesses were found in all programmes, different for each of them. It is noteworthy that the quality of the programmes’ methods used differed per domain/pillar assessed, therefore a higher score does not imply that one programme was better than another one with a lower score. Nevertheless, the methods per domain are comparable between the programmes, when taking
into account their variable contexts; namely: a. the level of action (national, local, or both) and the actions themselves, b. the number of settings in which the EPODE approach was implemented within a community (one setting VS multiple settings targeted), c. the number of people targeted, d. the number of communities involved and e. the level of these communities’ dependence on the central coordination in order to be able to run their actions. It was very important to identify the strengths and weaknesses of the programme level in its specific context, in order to detect areas for improvement as regards the processes of the programme.

**Strengths and weaknesses of the appraisal tools**

The OPEN tool mainly enabled the identification of strengths and weaknesses of integrated community-based approaches. The OPEN tool detected key information on both programme and intervention levels of all study objects; and thus more insight was provided than with the GPAT which provided information regarding only the intervention level. In most cases the latter information set (from the GPAT) overlapped with or was complemented by the data yielded by the OPEN tool. The GPAT proved to be suitable to identify strengths and weaknesses of more simple interventions. It is well-known that traditional evaluation criteria of interventions examine its overall effectiveness, which is not suitable for complex community-based approaches [16]. Instead, evaluation methods should be sensitive in capturing the dynamics of complex approaches, which operate through multi-dimensional causal pathways, and account for the different roles that various people delivering interventions have and the choices they make [18-20].
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The pillar of “scientific monitoring, evaluation and dissemination” of the OPEN tool included the most objective assessment elements compared to the other pillars, questioning among others the (type of) monitoring of processes, as well as the evaluation of effects. Such assessment is supported by evidence indicating that, besides assessing the programme’s effectiveness, an insightful process evaluation is needed to answer questions for the conceptualisation, planning and performance of the programme [13, 16, 21, 22].

Strengths and limitations of the study

This is one of the few studies that appraised community-based approaches targeting obesity prevention, including the EPODE-like programmes, which have not been assessed before in a systematic way. Our innovative methodological framework combined two methods for conducting in-depth assessment of such approaches. On the one hand, face-to-face interviews, using a structured list and criteria related to the EPODE pillars, successfully provided insight into crucial elements of community-based approaches, reflecting the quality of involvement of community, political, private and scientific stakeholders and of social marketing principles. This method enhanced our understanding in how complex prevention programmes could be monitored and evaluated. On the other hand, this is the first documentation on the use of the GPAT, while its applicability in appraising integrated community-based approaches is described. Furthermore, two and three researchers were in charge of conducting the appraisal through the GPAT and the OPEN tool respectively, which decreased—but not eliminated—the subjectivity of the programme appraisal.
Nevertheless, the appraisal relied on self-reported information from the programmes. Therefore information bias is possible, as widely observed in survey research, attributed to the respondent’s comprehension, recalling ability from long-term memory, judgement of the retrieved information from his/her memory and selection of an answer [23]. Another limitation of our study was that the qualitative information was reduced to simple scores. This quantification proved to be inadequate as it led to loss of information and made it difficult for the evaluators to interpret the programmes’ processes without additional context information. For instance, in the cases of scoring into the category “partly included element”, this ranged from “almost not” to “almost yes”. Moreover, considering the weaknesses of the appraisal tools used in this study, all the crucial elements of an integrated community-based approach have not been assessed. Finally, the included integrated community-based approaches were selected through networking and therefore they are indicative rather than representative of such approaches in the European region.

Conclusions

There is large variability between integrated community-based approaches preventing childhood obesity in the European region—even if they follow a similar approach (i.e. EPODE-like programmes) and therefore each of them has different needs. Both tools we used seem to facilitate comprehensive assessment of integrated community-based approaches in a systematic manner, which is rarely conducted. Nevertheless, the tools should be improved in line to their limitations as presented in this manuscript.
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**Recommendations**

Based on our conclusions we suggest, firstly the creation of programme documentation, which shall be available also in English, in order to be communicated more easily among stakeholders, other programmes and experts in the field of evaluation from different countries. Secondly, improving the formulation of the GPAT’s questions will increase its applicability to the programme level. These two steps would give an overview of an integrated community-based approach. As a third step, in-person interviews through the OPEN tool shall complement unclear/missing information by the GPAT and the programme documentation, while they will enhance the assessment of the programme’s methods. Consequently, the programmes will potentially be improved, while public health practice and the involved stakeholders will be better informed.

**List of abbreviations**

EPODE: Together let’s prevent childhood obesity.

JOGG: Youngsters at a healthy weight.

HELP: Healthy eating lifestyle plan.

SETS: I live healthy too.

OPEN: Obesity Prevention through European Network.
Appraisal of integrated community-based approaches

References


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Chapter 2


Appraisal of integrated community-based approaches


Appendices
Appendix 1. Good practice appraisal tool for obesity prevention programmes, projects, initiatives and interventions (amended layout).

Good Practice Appraisal Tool

for obesity prevention programmes, projects, initiatives and interventions

WHO/EC Project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union
ABSTRACT

The World Health Organization Regional Office for Europe and the Directorate-General for Health and Consumers of the European Commission have established a joint three-year project to monitor progress in improving nutrition and physical activity and preventing obesity in the European Union.

As part of this project, a good practice appraisal tool was developed to assess good practice elements of design, monitoring, evaluation and implementation of preventive programmes, projects, initiatives and interventions that aim to counteract obesity and improve nutrition and physical activity. This report gives a description of the good practice tool for obesity prevention programmes and describes its development and use.

Keywords

BENCHMARKING
PRACTICE GUIDELINES
OBESITY - prevention and control
PROGRAM EVALUATION - methods
EUROPE

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List of abbreviations

The following abbreviations are used in this report.

Daly  disability-adjusted life years
Dg sanco  Directorate-General for Health and Consumers (EC)
Ec  European Commission
Eponde  Ensemble prévenons l’obésité des enfants (Together let’s prevent childhood obesity)
Eu  European Union
Nopa  Nutrition, Obesity and Physical Activity (database)
Qaly  quality-adjusted life years
Rivm  Dutch National Institute for Public Health and the Environment
Who  World Health Organization

Acknowledgements

This document is a deliverable of work package 3 of the three-year collaborative project between the World Health Organization (WHO) and the Directorate-General for Health and Consumers (DG SANCO) of the European Commission (EC), which began in January 2008 (2007WHO02) under the title “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union (EU).” A draft of the tool was discussed at a meeting on community initiatives to improve nutrition and physical activity, convened on 21–22 February 2008 in Berlin, Germany. WHO would like to express sincere appreciation to the participants of this workshop for their valuable contributions. WHO also wishes to thank the programmes’ stakeholders that took part in the pilot testing rounds of the tool. WHO is most grateful to the experts that pilot tested the appraisal component of the tool to evaluate the good practice elements of the programmes: Wanda Bemelmans, Roos Gun, Tim Lobstein, Susanne Legstrup, Alessandra Suglia and Joop van Raaij. Special thanks are due to the members of the project’s Advisory Group (Michele Cecchini, Barbara Legowski and Jean-Michel Oppert) for critically reviewing the tool and to the Dutch National Institute for Public Health and the Environment (RIVM) for its technical input throughout the development of the tool. Grateful thanks are extended to Katerina Vritaka, former intern at the WHO Regional Office for Europe, Copenhagen and Sonja Kahlemeier, Institute for Social and Preventive Medicine, Zurich for their technical input to the development of the tool; to Lideke Middelbeek, WHO Regional Office for Europe, Copenhagen for refinement of the tool and for writing this document; to Trudy Wijnhoven, WHO Regional Office for Europe, Copenhagen for her technical input and overall coordination; to Philippe Roux, DG SANCO, Luxembourg City for his feedback; and to Frank Theakston for the text editing.

Introduction

A three-year joint WHO/EC DG SANCO project covering the period 2008–2010, entitled “Monitoring progress on improving nutrition and physical activity and preventing obesity in the EU” was established to evaluate the status of country development and implementation of policies and actions in the area of nutrition, physical activity and obesity prevention. The main outcome of the project is a database on these areas (the NOPA database), which includes surveillance data, country policy documents, policy implementation tools and information on good practices. Work package of this project concerns the collection of existing public health programmes, projects, initiatives and interventions designed to improve nutrition and physical activity or prevent obesity of the general population. Another important component is the development of a good practice appraisal tool to review and assess the quality of the identified programmes by independent experts. Both a summary of the programmes and an indication of good practice will be made available through the NOPA database.

This report describes the development of the appraisal tool, presents its three components and gives instructions on how the Regional Office will use it.

Background

Overweight and obesity are serious public health challenges in the WHO European Region (1). Many local and national programmes aim at counteracting the increasing obesity levels by promoting healthy eating and physical activity (2). Some of these programmes have shown to be more successful than others in preventing obesity and thus can serve as good examples for programme planners and decision-makers in order to facilitate their choice of interventions to adopt. To identify good practice, a tool has been developed to evaluate good practice elements of the planning, monitoring, evaluation and implementation of programmes that can target children, adolescents or adults as well as be nationally, regionally or locally initiated in community, school or workplace settings.

---

1 Hereinafter, the term programmes refers to programmes, projects, initiatives and interventions.
Aim of the tool

The purpose of the tool is to systematically assess the quality of programmes. Using a set of predefined criteria, the tool aims to identify programmes that can be considered good practice and can serve as an example for future initiatives that aim to improve nutrition and physical activity or prevent obesity. The tool can be used to monitor and document the aspects of the programmes that are known to contribute to the effectiveness of an intervention and to identify points for improvement. The tool generates a good practice score for three different programme components (planning, monitoring and evaluation, and implementation) as well as for the intervention as a whole.

Development of the tool

The following methods were employed in developing the tool.

1. A literature review was carried out on evaluation criteria for determining the effectiveness of interventions, assessment tools for obesity and public health interventions and scoring systems (3-15). The outcome of this review resulted in a first set of quality criteria that may be regarded as predictors of good practice and in a first draft of the tool.

2. In February 2008, the Regional Office organized a meeting on community interventions to improve nutrition and physical activity, which was hosted by the German Federal Ministry of Health (2). During the meeting, a consultation round was organized to discuss different elements of community interventions and to get feedback on the first draft of the tool. The received comments were used to further refine the tool. In addition, some experts were consulted individually.

3. To identify gaps and to review feasibility, user friendliness and relevance, the tool was pilot tested through three pilot rounds between 2007 and 2009. Eleven programmes were approached to complete the questionnaire (first component of the tool), provide relevant reference material and give feedback on the questions included. Feedback was received from seven:
   - “Alitie in forma – a project promoting a healthier lifestyle and habits” from Italy (http://www.piedibus.it/uni/biblioteca/1152783714_ALBITAE%20IN%20FORMA.pdf, accessed 21 December 2010);
   - “Bike It – a school cycling project” from the United Kingdom (http://www.sustrans.org.uk/what-we-do/bike-it, accessed 21 December 2010);
   - “Community Food Cooperatives – a project to supply fruit and vegetables from locally produced sources” from Wales, United Kingdom (http://www.physicalactivityandnutritionwales.org.uk/page.cfm?orgid=740&pid=29570, accessed 21 December 2010);
   - “EPODE France – Together let’s prevent childhood obesity – a community-based intervention to prevent childhood obesity with local stakeholders” implemented in various European countries (http://www.epode.org/, accessed 21 December 2010);
   - “Happy Body – a project to enhance fitness of the Belgian population via the promotion of healthy nutrition and physical activity” from Belgium (http://www.happybodytouyou.be/, accessed 21 December 2010);
   - “Healthy School Canteen – a programme to establish healthy school canteens in secondary schools” from the Netherlands (http://www.degezondeschoolkantine.nl, accessed 21 December 2010); and
   - “Programme on nutrition prevention and health of children adolescents in Aquitaine – a programme that was initiated to stabilize the prevalence of childhood obesity” (http://www.nutritionenfantaquitaire.fr/, accessed 21 December 2010).

4. The appraisal form (second component of the tool) was pilot tested by various experts, who were asked to independently appraise one of the seven programmes and to make comments on the tool.

The tool components

The tool consists of three parts.

1. The questionnaire serves as the information-gathering form for the tool. Programme managers are asked to answer 43 questions and provide relevant reference materials, such as a programme description, internet links, evaluation report, overview of budget and time-line. The questionnaire comprises the following three sections.

   - Main intervention characteristics. This consists of questions related to the general design and planning of a programme, such as the main objectives, planned activities, target group and involved stakeholders.
   - Monitoring and evaluation. This consists of questions related to the monitoring and evaluation process and thus addresses indicators, statistics and measurements.
   - Implementation. This consists of questions related to the implementation stage of the intervention and refers to performance, programme management and target group participation.
2. **The appraisal form**, with 43 criteria statements, serves as a check list for reviewers to assess the information gathered in the questionnaire.

3. **A scoring sheet** allows one to calculate a good practice score for each of the three sections as well as for the programme as a whole.

**Scoring of good practice**

An indication of good practice is obtained for each section as well as for the intervention as a whole. This makes it possible to highlight programmes that may, for example, have a very good design but poor evaluation and implementation, or programmes that are well-evaluated but struggle with design and implementation, or programmes that are not well-designed and evaluated but nevertheless have an excellent implementation. For ongoing programmes, only the first section of the questionnaire and appraisal form can be completed.

First, a total score is obtained for each section. This is divided by the maximum section score, leading to section scores less than or equal to unity. A score of 0.8 or higher in a section certifies a programme as “good practice” in the respective section, a score of 0.6–0.8 refers to acceptable practice, a score of 0.4–0.6 indicates marginal practice and a score below 0.4 refers to weak practice. Then, based on the outcome of the three section scores, an average good practice score for the programme is calculated.

For the calculation of the scores, a distinction is made between core questions and general questions. A higher weighting is given to core questions than to general questions, as these are considered to be more crucial in quality assessment. Core questions are therefore multiplied by a factor of 3 and general questions are given one mark.

**Assessment of programmes**

The Regional Office will apply the following steps for the assessment of good practice elements of public health programmes that aim to improve nutrition and physical activity or prevent obesity in the general population.

**Step 1. Completion of questionnaire by coordinator.** The programme coordinator is asked to answer the 43 questions of the questionnaire and provide relevant reference materials, such as a programme description, internet links, evaluation report, overview of budget and time-line. After completion, the coordinator is requested to send the questionnaire back to the Regional Office.

**Step 2. Assessment of good practice using the appraisal form.** The Regional Office has established a roster of experts to assist in the appraisal of programmes. Each programme will be reviewed independently by two of these experts. For each programme, experts will be asked to complete the appraisal form, depending on their expertise or area of work within the programme to be appraised.

**Step 3. Scoring.** On the basis of the two completed appraisal forms, a good practice score is calculated for each section as well as for the whole programme.

**Step 4. Inclusion in database.** A description of the programme and the obtained score are incorporated into the NOPA database (http://data.euro.who.int/nopa, accessed 19 May 2011).
Questionnaire to gather information on obesity prevention programmes

Instructions

We kindly ask the coordinator to complete the questionnaire and provide any relevant reference material/programme documentation, e.g. general programme description, report on the outcomes, programme evaluation, scientific publications, links to web sites, etc.

The information provided will be treated confidentially. Only final scores from each section, the programme description provided by you and information from marked areas will be included in the database.

You may need to consult your colleagues before completing certain questions.

General programme information

 ✓ Name of the programme:

 ✓ Country and region (if applicable) where the programme is based:

 ✓ Web site (if existing):

 ✓ Time and period (start and end dates):

 ✓ Funding sources:

 ✓ Time period covered by the funding:

 ✓ Number of staff (both paid and unpaid) involved:

 ✓ Give a short description of the programme (maximum of about 300 words)

Contact details of programme

 ✓ Name and job title:

 ✓ Organization:

 ✓ E-mail address:

 ✓ Postal address and telephone number:

I. Main intervention characteristics

1. Describe the overall aim(s) of the intervention.

2. Indicate which of the following components are addressed by the intervention.

   - Healthy eating
   - Physical activity
   - Other

   Please specify:

3. List the objective of the intervention.
4. Is the intervention based on current scientific knowledge and/or theoretical models and/or previous experience from other projects?
   - Yes, current scientific knowledge
   - Yes, current theoretical models
   - Yes, previous experience
   - No

   *Please provide further details about your answer option:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

5. Were existing (inter)national diet and physical activity guidelines taken into account during the development of the intervention?
   - Yes

   *Please specify the guidelines, the publisher and the publication date:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   - No

   *Please explain why not:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

6. Has a needs assessment been carried out?
   - Yes

   *Please specify the results of the needs assessment:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   - No

   *Please explain why not:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

7. Describe the planned key activities.

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

8. Does the intervention also address environmental factors (i.e. factors beyond individual control)?
   - Yes

   *Please specify which factors are addressed and how:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   - No

   *Please explain why not:*

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
9. Is the approach of the intervention designed to have a lasting effect on the risk factors?

☐ Yes

*Please provide further details:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☐ No

*Please explain why not:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10. Describe the structures within which the intervention was carried out.

☐ Existing structures (e.g., part of the administration, nongovernmental organization, etc.)

☐ Newly created structure that will continue to exist after the intervention is concluded

☐ Newly created structure that will not continue to exist after the intervention is concluded

☐ No specific structure (e.g., project team)

*Please provide further details about the indicated answer option:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

12. Does the intervention have a special focus on vulnerable groups (socioeconomically disadvantaged people, ethnic minorities, children, elderly people, etc.)?

☐ Yes

*Please specify the vulnerable groups:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☐ No

*Please explain why not:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

13. Does the intervention aim to empower the target group(s)?

☐ Yes

*Please specify:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☐ No

*Please explain why not:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11. Describe the target group(s) of the intervention.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
14. Was/were the target group(s) involved in setting the objectives and designing the intervention?

☐ Yes

*Please specify:*

---------------------------------------------------------------------------------------------

☐ No

*Please explain why not:*

---------------------------------------------------------------------------------------------

15. Have possible adverse effects of the intervention on the target group(s) been considered and minimized?

*Explanation: An adverse effect is a harmful and undesired effect resulting from an intervention.*

☐ Yes

*Please specify:*

---------------------------------------------------------------------------------------------

☐ No

*Please explain why not:*

---------------------------------------------------------------------------------------------

16. Describe the involvement of stakeholders in the planning phase of the intervention and specify the stakeholders.

*Explanation: A stakeholder is a person, group or organization that affects or can be affected by the intervention.*

---------------------------------------------------------------------------------------------

17. Specify the sectors represented by the professionals that were involved in the intervention (e.g. health, transport, environment, education, etc.) and describe their role in the intervention.

---------------------------------------------------------------------------------------------

18. How much of the total budget was allocated to the evaluation of the programme (as a percentage of the total budget)?

---------------------------------------------------------------------------------------------

19. How was the programme management carried out?

☐ A timetable in which tasks, activities and responsibilities were clearly described

☐ Day-to-day-planning with programme team

☐ Other technique, namely: ______________________________________________________________

☐ No specific programme management technique was applied

*Please provide further details about your answer option:*

---------------------------------------------------------------------------------------------
II. Monitoring and Evaluation

20. Has resource utilization (funds, human resources, materials) for the intervention been monitored?

☐ Yes

Please specify the indicators and their frequency of measurement:

☐ No

Please explain why not:

☐ Summary evaluation was carried out at the end of the intervention

☐ No specific monitoring or evaluation was carried out

21. Describe how the process of the intervention was measured.

☐ Specific indicators were used

Please specify the indicators and the frequency of measurement for each indicator:

☐ Summary evaluation was carried out at the end of the intervention

☐ No specific monitoring or evaluation was carried out

Process indicators are used to measure progress in the processes of change and to investigate how something has been done, rather than what has happened as a result. An example is the setting up of an expert advisory committee with active responsibility for quality assurance of the intervention or adherence to the time plan of the programme. Process indicators should be measurable (use at least qualitative dimensions), factual (mean the same to everyone), valid (measure what they claim to measure), verifiable (be able to be checked) and sensitive (reflect changes in the situation).

22. Describe how the output of the intervention was measured.

☐ Specific indicators were used

Please specify the indicators and the frequency of measurement for each indicator:

Output indicators are used to quantify conducted activities, for example the total number of participants. They are also used to measure the outputs or products that result from processes, such as the publication of a booklet on healthy diets. Output indicators can also include improving the social and physical environments of various settings to support the adoption of healthier types of behaviour, such as improved access to fruit and vegetables or safe cycling routes. They should be linked to the objectives and be measurable, factual, valid, verifiable and sensitive.
23. Describe how the outcome of the intervention was measured.

☐ Specific indicators were used

*Please specify the indicators and the frequency of measurement for each indicator:*

☐ Summary evaluation was carried out at the end of the intervention
☐ No specific monitoring or evaluation was carried out

*Outcome indicators are used to measure the ultimate outcomes of an action. Depending on the specified objectives, these might be short-term (such as increased knowledge), intermediate (such as change in behaviour) or long-term (such as reduction in incidence of cardiovascular disease). An example is the reduction of the percentage of primary school children in the community of Sandes not reaching the minimum recommended amount of physical activity by 5%. They should be related to the targets as well as quantifiable, factual, valid and verifiable.*

24. Indicate the demographic and socioeconomic factors of the target population that have been measured.

☐ Age
☐ Gender
☐ Income/socioeconomic status
☐ Education
☐ Occupation
☐ Ethnicity
☐ Geographical location
☐ Other, namely:

25. Was a long-term follow-up carried out after the end of the intervention?

☐ Yes

*Please specify how many months after the end of the intervention:*

☐ No

*Please explain why and continue with question 27:*

26. Describe the sample of the study population that was monitored as part of the follow up *(please give a percentage)*.

☐ Yes

*Please specify:*

☐ No

*Please explain why not:*

---

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28. Were confounding factors taken into consideration?

Explanation: A confounding factor is a variable that can cause or prevent the outcome of interest, is not an intermediate variable, and is associated with the factor under investigation. A confounding factor may be due to chance or bias. Unless it is possible to adjust for confounding variables, their effects cannot be distinguished from those of factor(s) being studied.

☐ Yes

Please specify:

_____________________________________________________________________

_____________________________________________________________________

☐ No

Please explain why not:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

29. Have cost–effectiveness calculations been made?

Explanation: Cost–effectiveness compares the relative expenditure (costs) and outcomes (effects) of two or more courses of action. Typically cost–effectiveness is expressed in terms of a ratio, where the denominator is a gain in health from a measure (e.g. years of life, sight-years gained) and the numerator is the cost of the health gain. A special case is cost–utility analysis, where the effects are measured in terms of years of healthy life lived, using a measure such as quality-adjusted life years (QALY) or disability-adjusted life years (DALY).

☐ Yes

Please provide further details about how the calculations were made:

_____________________________________________________________________

_____________________________________________________________________

☐ No

Please explain why not:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

30. Has an evaluation of the intervention been carried out?

☐ Yes, an external evaluation
☐ Yes, an internal evaluation
☐ Yes, both internal and external evaluations
☐ No (please go to part III)

Please provide further details about the evaluation that has been carried out:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

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31. Are stakeholders’ opinions assessed in monitoring and evaluation?

☐ Yes

*Please specify and indicate the respective stakeholders:*

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

☐ No

*Please explain why not:*

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

III. Implementation

33. Has a pilot study been performed?

☐ Yes

*Please provide details of the pilot study:*

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

☐ No

*Please explain why not:*

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

32. Is the monitoring and evaluation process described in the main programme documentation?

☐ Yes

*Please give an overview and provide a reference:*

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

☐ No

*Please explain why not:*

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

34. Describe the activities that have been carried out.

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

35. Describe the performance of the intervention in terms of time management and the activities that were undertaken to ensure high-quality delivery.

____________________________________________________________________________________________________________________________________________________________________________________________________________________________

36. Describe which stakeholders were involved in the implementation and describe their roles.

____________________________________________________________________________________________________________________________________________________________________________________________________________________________
37. Is the initiative coordinated or linked with other relevant interventions?

☐ Yes

Please specify the intervention(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ No

Please explain why not:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

38. Provide an overview of the resources that were invested and indicate where more information can be found.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

39. Is the implementation process described in the main programme documentation?

☐ Yes

Please give an overview and provide a reference:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ No

Please explain why not:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

40. Has actual outcome performance been measured against a control group?

☐ Yes

Please specify where further documentation on the outcome performance can be found:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ No

Please explain why not:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

41. Has the planned target group participation been reached?

☐ Yes

Please specify:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ No

Please explain why not:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

XV
42. To what extent have the planned key activities indicated in section 1 (question 7) been carried out? 
   \textit{(Please give a percentage)}:

\vspace{1cm}

43. To what extent have the objectives indicated in section 1 (question 3) been achieved? \textit{(Please give a percentage)}:

\vspace{1cm}
Appraisal form – a checklist for reviewers

I. Main intervention characteristics

Targets

1. The aims of the intervention are clearly described.
   - Yes
   - No

2. The intervention combines healthy eating and physical activity.
   - Yes
   - No

3. SMART objectives are provided.
   - Yes, at least 3 of the 5
   - No, or not specified

Explanation: SMART objectives are:
1. Specific: objectives should clearly specify what is to be achieved
2. Measurable: objectives should be phrased in a way that achievement can be measured
3. Achievable: objectives should refer to something that the intervention can actually influence and change
4. Realistic: objectives should be realistically attainable within the given time frame and with the available resources (human and financial resources and capacity)
5. Time-bound: objectives should relate to a clearly stated time frame.

Relevance

4. The intervention is based on current scientific knowledge and/or theoretical models and/or previous experience.
   - Yes, current scientific knowledge
   - Yes, theoretical models
   - Yes, previous experience
   - No, or not specified

5. The intervention acts in coherence with existing diet and/or physical activity guidelines.
   - Yes, the intervention acts in coherence with national or international guidelines
   - No, or other guidelines, or not specified

6. A needs assessment has been performed.
   - Yes
   - No, or not specified

7. Planned key activities are relevant to the needs of the target group.
   - Yes
   - No, or not specified

8. The activities also address environmental factors (i.e. factors beyond individual control).
   - Yes
   - No, or not specified

Examples
School: provision of healthy meals in the canteen, school fruit and vegetable schemes, removal or change of contents of vending machines, provision of cheap or free water supply.
Workplace: promotion of stair use, availability of facilities for physical activity and showers for staff coming by bicycle, provision of healthy meals in the canteen, promotion of participation in sports, such as a company marathon team.
Community: improved information and access to a choice of healthier foods and to sport and recreational facilities and green spaces for physical activity, availability and accessibility of a safe transport infrastructure and of institutional or organizational incentives for non-motorized means of transportation, presence of aesthetic attractions and comforts as well as absence of physical disorder.
Media: improved image of healthy eating and living through in television, video games and billboards.
Sustainability

9. The intervention is designed to have a lasting effect on the risk factors.
   - Yes
   - No, or not specified

10. The activities are taking place within structures that can carry on the intervention.
    - Yes
    - No, or not specified

Examples
School: inclusion of nutrition education in the curriculum, teacher training in the promotion of healthy nutrition and/or physical activity.
Workplace: presence of staff canteens serving quality meals, provision of facilities for physical activity in the workplace (e.g. gym, basketball court).
Transport: improved provision of walking and cycling routes, promotion of stair use in public buildings.
Community: provision of information on nutrition in local stores, improvement of the aesthetics of the environment.
Media: popular soap operas promote healthy choices and active living.

Target group

11. The target group(s) is/are clearly stated.
    - Yes
    - No, or not specified

12. There is a special focus on vulnerable groups (socioeconomically disadvantaged people, ethnic minorities, children, elderly people, etc.).
    - Yes
    - No, or not specified

13. The intervention aims to empower the target group(s).
    - Yes
    - No, or not specified

Explanation: The intervention increases the capacity of individuals or groups to make choices about their health and to transform those choices into desired actions and outcomes by strengthening personal abilities such as self control, confidence and autonomy.

14. The target group(s) has/have been involved in setting the objectives and designing the intervention.
    - Yes
    - No, or not specified

15. Possible adverse effects of the intervention were considered and minimized.
    - Yes
    - No, or not specified

Partners and cooperation

16. The main stakeholders were involved in the planning phase of the intervention.
    - Yes, all
    - Yes, at least one
    - No, or not specified

Examples of stakeholders
Family and preschool: parents, social workers, kindergarten or nursery teachers, children.
School: children, parents, teachers, school board members, food providers.
Workplace: employees, company board members, staff association, food providers.
Community: community members, community board members, social workers of ongoing projects or established institutions.
Media: target group members, advocacy groups of the target group (such as representing youth, ethnic groups, women, socioeconomically disadvantaged people), experts in this field of action, governing health policy department.

17. The intervention involves professionals from different sectors.
    - Yes
    - No, or not specified

Planning

18. A proportion of the budget is allocated to monitoring and evaluation.
    - Yes, 5% or more
    - Yes, less than 5%
    - No, or not specified
19. A timetable has been set in which tasks, activities and responsibilities are clearly described.

[□] Yes
[□] No, or not specified

II. Monitoring and evaluation

Indicators and monitoring

20. Resource utilization (funds, human resources, materials) have been monitored.

[□] Yes
[□] No, or not specified

21. Process indicators are measured regularly.

[□] Yes
[□] No, or not specified

Explanation: Process indicators are used to measure progress in the processes of change and to investigate how something has been done, rather than what has happened as a result. An example is the setting up of an expert advisory committee with active responsibility for quality assurance of the intervention or adherence to the time plan of the programme. Process indicators should be measurable (use at least qualitative dimensions), factual (mean the same to everyone), valid (measure what they claim to measure), verifiable (be able to be checked) and sensitive (reflect changes in the situation).

22. Output indicators are measured regularly.

[□] Yes
[□] No, or not specified

Explanation: Output indicators are used to quantify conducted activities such as the total number of participants. They are also used to measure the outputs or products that come about as the result of processes, for example the publication of a booklet on healthy diets. Output indicators can also include improving the social and physical environments of various settings to support the adoption of healthier types of behaviour, such as improved access to fruit and vegetables or safe cycling routes. They should be linked to the objectives and be measurable, factual, valid, verifiable and sensitive.

23. Outcome indicators are measured regularly.

[□] Yes
[□] No, or not specified

Explanation: Outcome indicators are used to measure the ultimate outcomes of an action. Depending on the specified objectives, these might be short-term (such as increased knowledge), intermediate (such as change in behaviour) or long-term (such as reduction in incidence of cardiovascular disease). An example is the reduction of the percentage of primary school children in the community of Sandes not reaching the minimum recommended amount of physical activity by 5%. They should be related to the targets as well as quantifiable, factual, valid and verifiable.

Measurements

24. Demographic and socioeconomic factors of the target population are measured (age, gender, income/socioeconomic status/education, occupation, ethnicity and geographical location).

[□] Yes, at least one of the above-mentioned factors
[□] No

25. A long-term follow-up was performed at least 6–12 months after the intervention.

[□] Yes
[□] No, or not specified

26. The follow-up is performed in a representative sample of the target group and includes more than 80% of the evaluation sample.

[□] Yes
[□] No, or not specified

Statistical methods

27. The statistical methods are described.

[□] Yes
[□] No, or not specified
28. Confounding factors are taken into consideration.

[ ] Yes
[ ] No, or not specified

*Explanation: The theme of confounding is mentioned and existing confounding factors are explained (if reported) and the extent of confounding is discussed.*

**Result assessment**

29. Cost–effectiveness calculations are made.

[ ] Yes
[ ] No, or not specified

*Explanation: Cost–effectiveness compares the relative expenditure (costs) and outcomes (effects) of two or more courses of action. Typically cost–effectiveness is expressed in terms of a ratio, where the denominator is a gain in health from a measure (e.g. years of life, sight-years gained) and the numerator is the cost of the health gain. A special case is cost–utility analysis, where the effects are measured in terms of years of healthy life lived, using a measure such as quality-adjusted life years (QALY) or disability-adjusted life years (DALY).*

30. External and/or internal evaluations have been performed.

[ ] Yes, both
[ ] Yes, an external evaluation
[ ] Yes, an internal evaluation
[ ] No, or not specified

**Stakeholders**

31. Stakeholders' opinions are assessed in monitoring and evaluation.

[ ] Yes
[ ] No, or not specified

**Communication**

32. The monitoring and evaluation process is described in the main intervention documentation.

[ ] Yes
[ ] No, or not specified

---

**III. Implementation**

**Performance**

33. A pilot study has been performed.

[ ] Yes
[ ] No, or not specified

34. The activities that are carried out are relevant to the objectives of the intervention (compare with question 3 under main intervention characteristics).

[ ] Yes, all
[ ] Yes, partially
[ ] No, or not specified

35. The intervention was implemented according to the timetable, and activities to ensure high-quality delivery were carried out.

[ ] Yes
[ ] No, or not specified

**Partners and cooperation**

36. Relevant stakeholders are involved in the implementation.

[ ] Yes, all
[ ] Yes, at least one
[ ] No, or not specified

**Examples**

*Family and preschool:* parents, social workers, kindergarten or nursery teachers, children.

*School:* children, parents, teachers, school board members, food providers.

*Workplace:* employees, company board members, staff association, food providers.

*Community:* community members, community board members, social workers of ongoing projects or established institutions.

*Media:* target group members, advocacy groups of the target group (such as representing youth, ethnic groups, women, socioeconomically disadvantaged people), experts in this field of action, governing health policy department.
37. The initiative is coordinated and linked with other relevant interventions.
   - Yes
   - No, or not specified

*Explanation:* Networking can strengthen the sustainability of the programme and is an indicator of transparency and willingness to learn from others.

### Communication and documentation

38. Resource information (funds, human resources, materials) is described in the main programme documentation.
   - Yes
   - No, or not specified

39. The implementation process (activities, staff affiliations, timetable, monitoring and evaluation) is described in the main programme documentation.
   - Yes
   - No, or not specified

40. The main programme documentation is publicly accessible (a web link is provided).
   - Yes
   - No, or not specified

### Target group participation

41. The planned target group participation has been reached.
   - Yes
   - No, or not specified

### Achievement of intervention objectives

42. A minimum of 70% of planned activities have been performed.
   - Yes
   - No, or not specified

43. At least 90% of the objectives have been achieved.
   - Yes
   - No, or not specified
References


For further information please contact:

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2100 Copenhagen Ø, Denmark Tel.: +45 39 17 17
17. Fax: +45 39 17 18 18.
E-mail: postmaster@euro.who.int
Web site: www.euro.who.int
Appendix 2. OPEN tool question list.

Name:
Position:
Name of the programme:
City-Country:

Questions for the main programme coordinator

The aim of this interview is to better understand your organization and your childhood obesity prevention activities in order to provide you with practical advice, based on the experience we have in implementing community-based programmes. We ask you to give your point of view on the following themes: general organization, political involvement, public & private partnership, campaigns & interventions, communication, scientific aspects and budget.

A. General – How is the programme organised

1. What organization (government, company, NGO…) and what department are you part of?
2. What is your background?
   a. Have you followed any extra training for this programme? Please describe.
3. How long have you been working on the XXX programme?
4. How many days/hours per week do you work on the XXX programme?
5. Has a team been organised as a result of the xxxx programme?
   a. How is this team organized?
      i. How many members working for the programme
      ii. Their expertise
      iii. Their task/duties (in the programme)?
6a. Are there on-going programmes / campaigns as part of a National Plan on obesity prevention / promotion of healthy lifestyle?

6b. Does your programme fit in that plan?
   - How?

7. Please describe the communities reached and target groups approached
   a. Number of communities
   b. Number of people
   c. Age groups

### B. Political involvement at National/Regional level

1. Is there a formal agreement to the programme at National/regional level with political structure?
   - If yes,
     a. What does it include?
        - Tasks/responsibilities of the parties?
          What do(es) political partner(s) provide to the XXX programme (e.g. Financial ? / Expertise? / Benefits in kind: physical space, communication materials, manpower, evaluation, data use?)?
        - How do they contribute?
     b. Who is responsible in your programme /team for ensuring political commitment at national/local level?

2a. Is the programme supported within the municipality?

2b. How does this translate in practice (structures, organisations, human resources, advocacy, funds)

3. Do political partners actively advocate the programme? How?

4. What do the National/Regional political representatives think about the programme? (supporters, neutral, against)

5. Are you working directly with a political representative representing the programme?
a. Who

6. Do the other sectors of the municipality contribute to the XXX programme?
   a. How? Is there cooperation between these sectors (inter-sectoral cooperation)?
   b. Which ones?
   c. Do elected representatives of the municipality contribute to the programme?

7. How do you communicate the progress of the programme to your political partners? Telephone calls – frequency; Emails – frequency; Reports – frequency
   a. Meetings – frequency

8. When are the next National/Regional elections?

9a. Are you satisfied with the established political commitment?
9b. What is needed to progress?

C. Public-private partnership

1. Are there public/private partnerships involved?
   -If yes,
     a. Who is responsible for creating/handling the PPPs in your team? What are his/her tasks regarding it?
     b. How PPP is being applied in the national/regional level? What does it mean for the programme (parties involved in the agreement – NGO and communication agency, national/local authorities and private partners, government and NGO/for-profit organisation-, how important is it for the programme to have an agreement between these parties?
     c. How is this activity (e.g. time/materials/personnel spent for recruitment and management) financed?
     d. Helping factors/barriers for the development of PPP?
   -If no,
     • Why not?
• Do you plan to involve a partnership like this in xxxx? In what way?
• Who, why, when?

2. Has knowledge been acquired for the development and management of PPP, and if so how?
• Existed expertise or training(s)? Could you explain?
• If training, by whom? Was it helpful?
• Do you use it in your work? If yes, how?

3. What is the position of the National/Regional government regarding PPP?

4. What is the
   a. Society’s
   b. Scientific community’s view on PPP?

5. Who are your actual partners?
   a. public
   b. private
   c. Are there any potential partners?
      i. Public
      ii. private

List to ask:

<table>
<thead>
<tr>
<th>Government:</th>
<th>Media</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universities:</td>
<td>Companies:</td>
</tr>
<tr>
<td>Hospitals:</td>
<td>Foundations:</td>
</tr>
<tr>
<td>Health-others:</td>
<td>Religious bodies:</td>
</tr>
<tr>
<td>Associations:</td>
<td>Political bodies:</td>
</tr>
</tbody>
</table>

6. Do you have a PPP charter?
   • Is it programme-specific or a pre-existing document? Which one?
   • Have you undergone conflict of interest issues? How did you solve the problem?
7. How do these parties contribute to the programme?
   - Financial? / Expertise? / Benefits in kind: physical space, communication materials, manpower, evaluation, data use?
     a. Public partners
     b. Private partners
       - How is this agreed? (price + period)

8. Why did these partners join the programme?
   a. How did you convince them?
   b. What is the advantage for them to join the programme? / Good reputation? / Health of employees? / corporate social responsibility / other)?
   c. How do you keep them motivated (regular meetings, annual reviews, media coverage reports, evaluation reports, etc.)?

9. How often do you meet your private partners and on what occasions (single meetings, events etc.)

10. Are you satisfied with the established PPP?
    i. What is needed to progress?

D. Development of interventions and campaigns at National/Regional level

1. Do you develop and implement interventions and/or campaigns?
   Specify
   a. At what level?

2. Has knowledge been acquired regarding the design and deployment of interventions and/or campaigns? specify
   -if so
     a. Existed expertise or training(s)? Could you explain?
     b. If training, by who and was it helpful?
     c. Do you use it in your work and how?

3. Which are the target groups of your interventions / campaigns?
   Specify
   a. Final target group(s)
b. Parent as target group
c. Other intermediate target group(s) (e.g. local managers)
d. Do you consider the local stakeholders participating in the interventions and campaigns as target groups?

4. Has a target group analysis been done? If yes, how did you use it?

5. Could you please describe the process of the planning of an intervention?
   a. Who is responsible for this? What are his/her tasks?
   b. How is the theme decided? On what basis (needs analysis, focus groups, ITVs, feedback from local project managers). Please give details of the process.
   c. Who else is involved and what are the specific tasks?
      i. Is the final target group involved in the planning phase?
      ii. Any private partners?
   d. Are you satisfied with the overall process for planning the interventions and campaigns?
      i. What is needed to progress?

6. Could you please describe the process of the implementation of an intervention?
   a. Who is responsible for this? What are his/her tasks?
   b. Who is developing the tools? Form contents to graphic design and printing.
   c. Is there anyone validating the contents of the tools/intervention? Please give details
   d. Who else is involved and what are the specific tasks.
   e. Is there any training of the people involved in the field (form LPM to volunteers)?
   f. Are you satisfied with the overall process for implementing the interventions and campaigns?
      i. What is needed to progress?
7. What tools do you develop for your target groups? (e.g. intervention guide, poster, leaflet, book, recipe sheet)

8. If there are on-going programmes / campaigns on childhood obesity prevention or on other related public health issues, do you make use of their tools? How?

9. Do you use the experience of the local coordination teams/ actors directly involved for the design of future interventions/campaigns?
   - If yes, how (the actions they have implemented, their methodology, the tools they have developed, their feedback on the tools etc)?
   - If not, why?

10. What do your interventions/ campaigns (specify) include in terms of:
     a. Themes: Food habits/physical activity/ other
        i. (micro/macro)environmental change/
     b. Activities: organization of events, workshops, PR/ other

11. Can you describe the last intervention/campaign (specify) you have led?
    - Duration
    - When was it
    - Theme
    - Methodological tools
    - Communication tools
    - Intervention tools
    - Was it was a success/not a success? Why

Can you provide us with some materials?

Local level:
- Do you include other existing actions in the town in the XXX programme? Which are they?
- To what extend do you use the materials (methodological, communication, intervention tools) provided by the national coordination? Why?
E. Communication on the programme at National/Regional level

1. Has knowledge been acquired on communication / PR activities?
   a. Existing expertise or training(s)? Could you explain?
   b. If trainings, from where? was it helpful?
   a. Do you use it in your work and how?

2. What communication materials and channels do you use*?
   *Website, Newsletter, Press releases, Press events, One-to-one
direct communication (journalists, political, scientific,
private partners), Newspapers, TV, social media, Web TV,
Radio, Facebook, Twitter, Google +, Google groups

3. Who is responsible for the communication of the programme?
   • Internal/external?
   • Why is it organized like this? (if not answered previously)
   • Does it work well?
   • Helping factors/barriers?

4. Are your PPP partners involved in the PR communication activities?
   - If yes, how?
     • Advantages – disadvantages of this involvement?

5. Is there a communication plan?
   • If yes, how often is it being set-up?

6. Do you evaluate your PR communication?
   a. What are your results in terms of media coverage/visibility?
   b. Are you satisfied with these results? Why?

F. Scientific aspects at National/Regional level

1. Is scientific support used within the programme?
   a. Did you create a scientific advisory board or individual experts
      are collaborating occasionally, or both? Please explain.
   b. Who is part of it? What are their areas of expertise?
c. What are their responsibilities within the programme? (tools contents, validation, evaluation, publication, spokesperson)

d. Do you have scientific spokespersons?
   • Who?

e. How often do you meet the scientific experts and for what purpose?

f. How is it financed?

g. How do you feel about this collaboration?
   • Does it work well?
   • Why?

2. Have knowledge been acquired on the scientific aspects of the programme (understanding obesity, intervention protocol, evaluation) and if so how?
   • Do you use it in your work? How?

3. Does an evaluation take place?
   a. Is there an evaluation framework?
      i. If yes, Who developed it? Does it follow a specific methodology (e.g. a logic model, definition of SMART objectives)?
   
   b. Who is responsible for the evaluation?

4. What is evaluated?
   c. Processes:
      i. Central coordination
      ii. Local coordination
      iii. Setting/actions
   
   d. Effects:
      i. Behavioral change of children/families
      ii. BMI

If the interviewee explains in detail, make sure the elements in q5 are mentioned.

5. At what points does evaluation take place?
   • Why is it organised like this?
   • How is this financed?
   • Does it work well? Why?
6. Are you satisfied with the evaluation process of your programme (what is evaluated, funding, feasibility)?
   i. What is needed to progress?

7. Do you have implementation and evaluation results?
   a. How do you use them (scientific publication, dissemination, other use)
   b. Do you have scientific publications?
      COLLECT PUBLICATIONS

8. What scientific events do you participate in and how (poster, presentation, workshop...)?
9. What scientific events do you attend?
10. Budget (% or €) for evaluation activities

Footnotes
^: Questions addressed to the intervention level.
Appendix 3. Template of the analysis grid of the OPEN tool.

<table>
<thead>
<tr>
<th>CODE</th>
<th>ELEMENT</th>
<th>INTERVIEW QUESTION</th>
<th>ANSWER</th>
<th>SCORING CATEGORIES</th>
<th>RESEARCHERS’ COMMENT</th>
<th>SCORE</th>
<th>MAX SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Structure</td>
<td>What organization (government, company, NGO...) and what department are you part of?</td>
<td></td>
<td>Descriptive</td>
<td>NOT SCORED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Background</td>
<td>What is your background? a. Have you followed any extra training for this programme? Please describe.</td>
<td></td>
<td></td>
<td>NOT SCORED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>How long working for the programme</td>
<td></td>
<td></td>
<td></td>
<td>NOT SCORED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A4i</td>
<td>Principal programme Coordinator Commitment</td>
<td>How many days/hours per week do you work on the XXX programme?</td>
<td>1. Part time, some full time 2. Full time</td>
<td>The ones operating at the same level and share the tasks are combined.</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| A4ii | Project Coordinator Commitment (local level) | 1. Part time, some full time  
2. Full time | The ones operating at the same level and share the tasks are combined. | 2 |
| A5i | Programme team | Has a team been organised as a result of the programme? ai. How many members working for the programme  
0. 1 person  
1. 2-3 people  
2. more than 3 | 2 |
| A5ii | Programme team expertise | aii. Their expertise  
0. One expertise  
1. Two expertise  
2. 3 or more expertise | 2 |
| A6a | National plan on obesity prevention/promotion of healthy lifestyle | a. Are there on-going programmes / campaigns as part of a National Plan on obesity prevention / promotion of healthy lifestyle?  
0. No/Don't know -> skip the next question  
1. Yes -> go to the next question | 0 |
| A6b | Collaboration with existing programmes of National plan | b. Does your programme fit in that plan?  
0. We do not fit in the plan  
2. we are part/fit in the plan | 2 |
| A7a | Communities reached | | Descriptive | NOT SCORED |
| A7b  | People reached | Descriptive | NOT SCORED |
| A7c  | Target groups  | Descriptive | NOT SCORED |

### B. POLITICAL INVOLVEMENT

<table>
<thead>
<tr>
<th>CODE</th>
<th>ELEMENT</th>
<th>INTERVIEW QUESTION</th>
<th>ANSWER</th>
<th>SCORING CATEGORIES</th>
<th>RESEARCHERS’ COMMENT</th>
<th>POINTS SCORE</th>
<th>MAX POINT</th>
</tr>
</thead>
</table>
| B1   | Formal agreement    | Is there a formal agreement to the programme at National/regional level with political structure? | 0. No  
2. Yes | 0. No  
2. Yes | 0. No  
2. Yes | 0. No  
2. Yes | 2         |
| B1a  | Type of contribution| What do(es) political partner(s) provide to the XXX programme?                     | 0. No contribution  
1. Financial/expertise/in kind contribution/ networking advocacy-visibility/institutional support  
2. three or more of 1 (incl. financial/expertise/in kind) | 0. No contribution  
1. Financial/expertise/in kind contribution/ networking advocacy-visibility/institutional support  
2. three or more of 1 (incl. financial/expertise/in kind) | 0. No contribution  
1. Financial/expertise/in kind contribution/ networking advocacy-visibility/institutional support  
2. three or more of 1 (incl. financial/expertise/in kind) | 0. No contribution  
1. Financial/expertise/in kind contribution/ networking advocacy-visibility/institutional support  
2. three or more of 1 (incl. financial/expertise/in kind) | 2         |
| B1b | Person in charge of Political partnerships establishment and management | Who is responsible for creating/handling the political commitment in your team? What are his/her tasks regarding it? | 0. Nobody  
1. someone but not a specific person of the team  
2. one or more clearly identified people | 2 |
|---|---|---|---|
| B2a | Municipal support | Is the programme supported within the municipality? | 0. No  
1. sometimes  
2. yes always | 2 |
| B2b | Type of municipal contribution | *How does this translate in practice (structures, organisations, human resources, funds)* | 0. No contribution  
1. Financial/expertise/in kind contribution/structures/organisations/human resources  
2. More than two of 1. | 2 |
| B3 | Advocacy of political partners NATIONAL LEVEL | Do political partners actively advocate the programme? How? | 0. No  
1. A little (involved but passive)  
2. Yes (pro-active) | 2 |
| Add: Advocacy of political partners LOCAL LEVEL | | | 0. No  
1. A little (involved but passive)/some pro-active, some not  
2. Yes (pro-active) | 2 |
| B4 | Programme reputation within political structures  
NATIONAL LEVEL | What do the National/Regional political representatives think about the programme? (supporters, neutral, against) | a. Against  
b. Neutral  
c. Positive | NOT SCORED |
|---|---|---|---|---|
| ADDITIONAL | Opinion of political representative on programme  
LOCAL LEVEL | Opinion of political representative on programme | a. Against  
b. Neutral  
c. Positive | NOT SCORED |
| B5 | Political representative | Are you working directly with a political representative representing the programme? | 0. No  
2. Yes | 2 |
| B5a | Who? | Who? | | NOT SCORED |
| B6 | Intersectoral contribution  
Do the other sectors of the municipality contribute to the XXX programme? | Do the other sectors of the municipality contribute to the XXX programme? | 0. Not at all (or barely)  
1. contribution in some of the communities  
2. contribution in the majority of the communities | 2 |
<p>| B6a | <strong>Intersectoral collaboration</strong> | How? Is there cooperation between these sectors (Intersectoral cooperation)? | 0. Not at all (or barely) 1. Intersectoral in some of the communities 2. Intersectoral in the majority of the communities | Depends on the municipality rather than on the programme | NOT SCORED |
| B6b | <strong>Which sectors?</strong> | Which ones? | 0. 1 sector 1. 2-3 sectors 2. More than 3 sectors | | |
| B6c | <strong>Elected representatives (aldermen/decision makers) contribution</strong> | Do elected representatives of the municipality contribute to the programme? | 0. No 1. Sometimes 2. Yes always | | |
| B7a | <strong>Type of communication with Political partners</strong> | How* do you communicate the progress of the programme to your political partners? | 0. No communication 1. Some of the list excl. face-to-face communication 2. Some of the list incl. face-to-face communication | *List face-to-face meeting, telephone, skype, email, letter | |
| B7b | <strong>Frequency of Communication with Political partners</strong> | | 0. 1 time / year or less 1. 2-3/year 2. more than 3/year | | |
| B9a | <strong>Satisfaction</strong> | Are you satisfied with the established political commitment? | a. No b. It could be better c. Yes, satisfied | | NOT SCORED |</p>
<table>
<thead>
<tr>
<th>CODE</th>
<th>ELEMENT</th>
<th>INTERVIEW QUESTION</th>
<th>ANSWER</th>
<th>SCORING CATEGORIES</th>
<th>RESEARCHERS' COMMENT</th>
<th>POINTS SCORED</th>
<th>MAX POINTS</th>
</tr>
</thead>
</table>
| C1   | Involvement of private partnerships | Are any there PPPs involved? | 0.No  
1. Yes, occasionally  
2. Yes, constantly | | | 2 | |
| C1a  | PPP management in the team | Who is responsible for creating/handling the PPPs in your team? What are his/her tasks regarding it? | 0. Nobody  
1. Someone but not a specific person of the team  
2. One or more clearly identified people | | | 2 | |
<p>| C1b  | Type of involvement | How PPP is being applied in the national/regional level? What does it mean for the programme (parties involved in the agreement – NGO and communication agency, | | | NOT SCORED | |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>C1c</th>
<th>C1d</th>
<th>C2</th>
<th>C3</th>
<th>C5a</th>
<th>C5b</th>
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<tbody>
<tr>
<td>National/local authorities and private partners, government and NGO/for-profit organisation?</td>
<td></td>
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<tr>
<td>Financing PPP activities</td>
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<td>Facilitators and Barriers</td>
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<td>Knowledge on PPPs</td>
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<tr>
<td>Government opinion on PPP</td>
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<tr>
<td>National Level - Private</td>
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<tr>
<td>National Level - Public/Non-profit</td>
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<tr>
<td>How is this activity (e.g. time/materials/personnel spent for recruitment and management) financed?</td>
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<tr>
<td>Has knowledge been acquired for the development and management of PPP, and if so how?</td>
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<tr>
<td>What is the position of the National/Regional government regarding PPP?</td>
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<tr>
<td>Which are your actual partners?</td>
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<tr>
<td>Which are your actual partners?</td>
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</table>

- 0. No
- 1. Short training
- 2. Existing expertise or experience
- 3. More than 3

- a. Negative/reluctant
- b. Neutral
- c. Positive

- 0. 0
- 1. 1-3
- 2. More than 3
<p>| | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>C5ci</td>
<td>Potential Private Partners</td>
<td></td>
<td></td>
<td></td>
<td>NOT SCORED</td>
</tr>
<tr>
<td>C5cii</td>
<td>Potential Public Partners</td>
<td></td>
<td></td>
<td></td>
<td>NOT SCORED</td>
</tr>
<tr>
<td>C6</td>
<td>PPP CHARTER</td>
<td></td>
<td>0. No charter</td>
<td>1. Some conditions / partner</td>
<td>2. Charter</td>
</tr>
<tr>
<td>C7a</td>
<td>Contribution of private partners</td>
<td>How do these parties contribute to the programme?</td>
<td>0. No contribution</td>
<td>1. Financial/expertise/in kind contribution/ networking advocacy-visibility/institutional support / human resources</td>
<td>2. 3 or more of 1st category (incl. financial/expertise/in kind)</td>
</tr>
<tr>
<td>C7b</td>
<td>Contribution of public partners</td>
<td>How do these parties contribute to the programme?</td>
<td>0. No contribution</td>
<td>1. Financial/expertise/in kind contribution/ networking advocacy-visibility/institutional</td>
<td>Within advocacy visibility is considered</td>
</tr>
<tr>
<td></td>
<td>Motive for partnership</td>
<td>Why did these partners join the programme? a. How did you convince them? b. What is the advantage for them to join the programme? / Good reputation? / Health of employees? / corporate social responsibility / other)?</td>
<td></td>
<td>NOT SCORED</td>
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<tr>
<td>C9</td>
<td>Communication with Private partners (frequency of contacts)</td>
<td>How often do you meet your private partners and on what occasions*</td>
<td>0. 1 time / year or less (no face to face contact)</td>
<td>* List: face-to-face meeting, events</td>
<td></td>
</tr>
<tr>
<td>C10</td>
<td>Satisfaction</td>
<td>Are you satisfied with the established PPPs? a. No b. It could be better c. Yes, satisfied</td>
<td>NOT SCORED</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>C10i.</td>
<td>Needs assessment</td>
<td>What is needed to progress?</td>
<td></td>
<td>NOT SCORED</td>
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### C. TOTAL 16

### D. DEVELOPMENT OF INTERVENTIONS AND CAMPAIGNS

<table>
<thead>
<tr>
<th>CODE</th>
<th>ELEMENT</th>
<th>INTERVIEW QUESTION</th>
<th>ANSWER</th>
<th>SCORING CATEGORIES</th>
<th>RESEARCHERS' COMMENT</th>
<th>POINTS SCORED</th>
<th>MAX POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>Are there interventions/campaigns</td>
<td>Do you develop and implement interventions and/or campaigns? Specify</td>
<td>0. No</td>
<td>1. Occasionally 2. Systematically</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>D1a</td>
<td>Level of implementation of intervention</td>
<td>At what level?</td>
<td>Descriptive</td>
<td></td>
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<tr>
<td>D2</td>
<td>Knowledge for developing interventions/campaigns</td>
<td>Has knowledge been acquired regarding the design and deployment of interventions and/or campaigns? Specify. a. Existed expertise or training(s)? Could you explain?</td>
<td>0. No</td>
<td>1. Short training/short-term experience (less than 4 years and developed few interventions) 2. Expertize-appointed experts /long term experience (more than 4 years and developed</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>D3a</strong> Age groups of interventions / campaigns</td>
<td><strong>D3b</strong> Parents as target groups</td>
<td><strong>D3c</strong> Intermediate target groups</td>
<td><strong>D3d</strong> Local stakeholders considered as target groups</td>
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<tr>
<td></td>
<td>Which are the target groups of your interventions / campaigns? specify</td>
<td>0. No 1. Occasionally 2. Constantly (each campaign)</td>
<td>0. None 1. Occasionally 2. Constantly</td>
<td>Do you consider the local stakeholders participating in the interventions and campaigns as target groups?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>0. One of the list 1. 2 target groups of the list 2. All 3 target groups of the list</td>
<td>We need to know if there are specific interventions/actions towards parents-Account for it for 2nd appraisal</td>
<td></td>
<td>0. No 1. Occasionally 2. Constantly (each campaign)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>List: Children 0-3, children 4-12, adolescents 13-18</td>
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</tbody>
</table>
| D4 | Target group analysis | Has a target group analysis been done? If yes, how did you use it? | 0. No  
1. Occasionally/partly  
2. Constantly (each campaign) | Here analysis of the final target group assessed; social marketing in the field | 2 |
| D5a | Multi-disciplinary team for the planning phase | Could you please describe the process of the planning of an intervention?  
a. Who is responsible for this? | 0. One expertise  
1. Two expertise  
2. 3 or more expertise | 2 |
| D5b | Following a process to select a theme | How is the theme decided? On what basis (needs analysis, focus groups, ITVs, feedback from local project managers). Please give details of the process. | 0. No specific basis  
1. Based on scientific knowledge or assessments on the local level  
2. Based on scientific knowledge and assessments on the local level | 2 |
| D5c | Multi-stakeholder involvement in the | Who else is involved and what are the specific | 0. No  
1. Yes occasionally | 2 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>planning phase tasks?</th>
<th>2. Yes constantly</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D5ci</td>
<td>Final target group involvement in the planning phase</td>
<td>Who else is involved and what are the specific tasks?</td>
<td>0. No</td>
<td>1. Yes occasionally</td>
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<td>2. Yes constantly</td>
<td></td>
</tr>
<tr>
<td>D5cii</td>
<td>Can Private partners intervene in the contents?</td>
<td>Any private partners?</td>
<td>0. Yes</td>
<td>1. No</td>
</tr>
<tr>
<td>D5d</td>
<td>Satisfaction regarding the planning</td>
<td>Are you satisfied with the overall process for planning the interventions and campaigns? What is needed to progress?</td>
<td>a. No</td>
<td>b. It could be better</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>c. Yes, satisfied</td>
<td></td>
</tr>
<tr>
<td>D5di</td>
<td>Need assessment</td>
<td>What is needed to progress?</td>
<td></td>
<td>NOT SCORED</td>
</tr>
<tr>
<td>D6b</td>
<td>Existence of a social marketing team OR Expert</td>
<td>Who is developing the tools? Form contents to graphic design and printing</td>
<td>0. No</td>
<td>1. Yes, one person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Yes, a team</td>
<td></td>
</tr>
<tr>
<td>D6c</td>
<td>Validation of the campaigns contents</td>
<td>Is there anyone validating the contents of the tools/intervention? Please give details</td>
<td>0. No</td>
<td>1. Yes, by one expert (e.g. dietician)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Yes, by the SAB or more experts</td>
<td></td>
</tr>
<tr>
<td>D6e</td>
<td>Training of the Local Manager</td>
<td>Is there any training of the people involved in the field (form LPM to volunteers)?</td>
<td>0. No</td>
<td>1. For some activities/campaigns</td>
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<td>2. Yes, systematically</td>
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<tr>
<td><strong>D5f</strong></td>
<td><strong>Satisfaction regarding the implementation</strong></td>
<td>Are you satisfied with the overall process for implementing the interventions and campaigns?</td>
<td>a. No &lt;br&gt;b. It could be better &lt;br&gt;c. Yes, satisfied</td>
<td>NOT SCORED</td>
</tr>
<tr>
<td><strong>D5fi</strong></td>
<td><strong>Programme Need assessment</strong></td>
<td>What is needed to progress?</td>
<td>NOT SCORED</td>
<td></td>
</tr>
<tr>
<td><strong>D7</strong></td>
<td><strong>Tools developed/used</strong></td>
<td>What tools do you develop for your target groups? (e.g. intervention guide, poster, leaflet, book, recipe sheet) -</td>
<td>0. None &lt;br&gt;1. Methodological or communication tools &lt;br&gt;2. methodological and communication tools</td>
<td>2</td>
</tr>
<tr>
<td><strong>D8</strong></td>
<td><strong>Use of tools from other programmes</strong></td>
<td>If there are on-going programmes / campaigns on childhood obesity prevention or on other related public health issues, do you make use of their tools? How?</td>
<td>Not a Social Marketing element</td>
<td>NOT SCORED</td>
</tr>
<tr>
<td>D9</td>
<td>Use of experience of local actors</td>
<td>Do you use the experience of the local coordination teams/actors directly involved for the design of future interventions/campaigns? A. If yes, how (the actions they have implemented, their methodology, the tools they have developed, their feedback on the tools etc)?</td>
<td>0. Never 1. Sometimes 2. Constantly</td>
<td>2</td>
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<tr>
<td>D10a</td>
<td>Diversity of the themes</td>
<td>What do your interventions/campaigns (specify) include in terms of: a. Themes: Food habits/physical activity/other</td>
<td>0. 1 theme (e.g. only PA) 1. 2 themes (e.g. PA and food habits) 2. More than 2 themes</td>
<td>2</td>
</tr>
<tr>
<td>D10ai</td>
<td>Changing of the environment</td>
<td></td>
<td>0. None 1. one macro/micro-environmental change 2. both macro/micro-environmental change or more on than one in any level</td>
<td>micro- (e.g. family, culture) and macro-level considered equally important; though more</td>
</tr>
<tr>
<td>Code</td>
<td>Element</td>
<td>Interview Question</td>
<td>Answer</td>
<td>Scoring Categories</td>
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| D10b  | Diversity of the activities          | What do your interventions/ campaigns (specify) include in terms of:  
|       | b. Activities: organization of events, workshops, PR/ other | 0. Single method/approach for short term  
|       |                                       | 1. Single method/approach for long term  
|       |                                       | 2. Synergy of methods with interventions |                           |                      |               |            |
| ADDITIONAL | Number of activities implemented / month | 0. Less than 3  
|       |                                       | 1. 2 to 5  
|       |                                       | 2. More than 5 |                           |                      |               |            |
|       |                                       | **D. TOTAL** 43                                        |                            |                                      |                      |               |            |
| E1    | Training of the coordination Team    | Has knowledge been acquired on communication / PR       | 0. No  
|       |                                       | 1. Short training  
|       |                                       | 2. Expertize/assigned to |                           |                      | 2             |
| E2 | Communication materials and channels | What communication materials and channels* do you use? | 0. none  
1. 1 to 4 channels  
2. More than 4 | *Website, Newsletter, Press releases, Press events, One-to-one direct communication (journalists, political, scientific, private partners), Newspapers, TV, social media, Web TV, Radio, Facebook, Twitter, Google +, Google groups, other | 2 |
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<tbody>
<tr>
<td>E3</td>
<td>Communication responsibility</td>
<td>Who is responsible for the communication on the programme</td>
<td>For information</td>
<td>NOT SCORED</td>
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<tr>
<td>E4</td>
<td>Involvement of PPP</td>
<td>There can be</td>
<td>NOT SCORED</td>
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</table>
### F. SCIENTIFIC ASPECTS

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<tr>
<th>CODE</th>
<th>ELEMENT</th>
<th>INTERVIEW QUESTION</th>
<th>ANSWER</th>
<th>SCORING CATEGORIES</th>
<th>COMMENT</th>
<th>POINTS SCORED</th>
<th>MAX POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1a</td>
<td>Existence of scientific support</td>
<td>Did you create a scientific advisory board or</td>
<td>0. None 1. Expert consultation</td>
<td>2</td>
<td>2</td>
<td></td>
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</tbody>
</table>
individual experts are collaborating occasionally, or both? Please explain.

| F1b | Fields of expertise | Who is part of it? What are their areas of expertise? | 0. One expertise  
|     |                    |                                                      | 1. Two expertise  
|     |                    |                                                      | 2. 3 or more expertise |

| F1c | Role of SAB / experts | What are their responsibilities* within the programme? | 0. Less than 2 (from list)  
|     |                      |                                                      | 1. 2 to 3 (from list)  
|     |                      |                                                      | 2. More than 3 (from list)  

*List: Tools’ contents, Tools’ validation, Evaluation, publication, data collection, data analyses, programme design and implementation, applications for funds

| F1d | Scientific Spokesperson | Do you have scientific spokes persons? Who? | 0. No  
|     |                        |                                                      | 1. Yes, but not a specific person  
|     |                        |                                                      | 2. Yes, one or more clearly identified spokesperson |

|       | 2                      | 2                      | 2                     |
| F1e | Meeting frequency with scientific experts | How often do you meet the scientific experts | 0. 1 per year or less  
1. 2 to 3 per year  
2. More than 3 per year | 2 |
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</thead>
<tbody>
<tr>
<td>F1f</td>
<td>How is scientific support financed</td>
<td></td>
<td>NOT SCORED</td>
<td></td>
</tr>
</tbody>
</table>
| F1g | Satisfaction | How do you feel about this collaboration? | a. No  
b. It could be better  
c. Yes, satisfied | NOT SCORED |
| F2 | Training of the coordination team on sc. Aspects | Have knowledge been acquired on the scientific aspects of the programme (understanding obesity, intervention protocol, evaluation) and if so how? | | NOT SCORED |
| F3 | Systematic evaluation approach | Does an evaluation take place? | 0. No  
1. Yes, but not in representative sample/insufficient/sometimes  
2. Yes, in a representative sample/sufficient/always | 2 |
| F3a | Evaluation framework | Is there an evaluation framework? | 0. No  
2. Yes | 2 |
| F3ai | Evaluation methodology | Does it follow a specific methodology (e.g. a logic) | 0. No  
2. Yes | 2 |
<table>
<thead>
<tr>
<th>F3b</th>
<th>Who responsible for the evaluation</th>
<th>d. Who is responsible for the evaluation?</th>
<th>0. Nobody 1. No scientific discipline responsible 2. Scientific discipline(s) responsible</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>F4ai</td>
<td>Is the central coordination level evaluated</td>
<td>Are processes evaluated?</td>
<td>0. No 1. Yes, Sometimes/partly 2. Yes, Systematically</td>
<td>2</td>
</tr>
<tr>
<td>F4a ii</td>
<td>Is the local coordination level evaluated</td>
<td>Are processes evaluated?</td>
<td>0. No 1. Yes, Sometimes/partly 2. Yes, Systematically</td>
<td>2</td>
</tr>
<tr>
<td>F4a iii</td>
<td>Is the setting (actions) evaluated</td>
<td>Are processes evaluated?</td>
<td>0. No 1. Yes, Sometimes/partly 2. Yes, Systematically</td>
<td>2</td>
</tr>
<tr>
<td>F4b i</td>
<td>Are the children/families behaviour change evaluated</td>
<td>Are effects evaluated?</td>
<td>0. No 1. Only once 2. Yes</td>
<td>2</td>
</tr>
<tr>
<td>F4b ii</td>
<td>BMI evaluation</td>
<td>Are effects evaluated?</td>
<td>0. No 1. Only once 2. Yes</td>
<td>2</td>
</tr>
</tbody>
</table>
| F5 | Frequency of evaluation | At what points does evaluation take place? | 0. No evaluation  
1. After/one measurement  
2. Before and after/More regularly | 2 |
|---|---|---|---|---|
| ADD | Against a control group? | | 0. No control group  
2. Yes | 2 |
| F6 | Satisfaction | Are you satisfied with the evaluation process of your programme (what is evaluated, funding, feasibility)? | a. No  
b. It could be better  
c. Yes, satisfied | NOT SCORED |
| F6i | Need assessment | What is needed to progress? | | NOT SCORED |
| F7 | Results | Do you have implementation and evaluation results? | 0. No  
1. In process  
2. Yes | Judging for the overall programme-existence of results | 2 |
| F7a | Dissemination in communities and stakeholders | How do you use them (scientific publication, dissemination, other use) | 0. Not at all  
1. Yes to the communities or stakeholders  
3. Yes to communities and stakeholders | 2 |