Amsterdam will become the Healthiest City for Children!

Review 2012-2017

Part 2

Amsterdam Healthy Weight Programme
2018-2021 Multiannual Programme
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Document structure
In Part 2 of the multiannual programme we look back at the earlier years of the programme. The review is both quantitative and qualitative in nature. What has been done: the results/output that has been achieved (Chapter 2). Chapter 3 assesses whether the targets set have been achieved. Chapter 4 looks in detail at BMI trends in children by socio-economic status. And Chapter 5 highlights changes in behaviour over the programme period 2012-2017. Finally, we review and evaluate the qualitative targets that we set ourselves.

The AAGG implementation monitor – www.aagg.nl – is the source for Chapter 1. The latest AAGG outcome monitor (2017) is the main source of data for Chapters 2 and 3.
The Amsterdam Healthy Weight Programme (Amsterdamse Aanpak Gezond Gewicht, AAGG) has been running for around five years. In other words: the first five kilometres of this marathon are behind us. What has been done and achieved in this initial phase? That’s what this review is about.

Much of the work over the past five years has been about building the foundations. Initially, not everyone involved understood the urgency of the problem. The first challenge therefore was to establish a shared definition of the problem and a shared solution (healthy behaviour in a healthy environment). The first concrete action was the schools approach: a significant factor in a healthy environment for children. 120 of the 220 primary schools in Amsterdam are now participating in the initiative. The focus on this part of the programme is coming to an end. Healthy primary schools are gradually becoming the norm.

Network of partners
Building networks was a time-consuming business: contacting all the other players in the many domains of a child’s life took time. We then had to establish robust partnerships and provide partners with the knowledge and tools they needed to fulfil their role. The starting point and pace varies by field and by neighbourhood.

The last ‘Pact’ was signed in November 2017 in the neighbourhood of Slotervaart. In all eleven focus neighbourhoods agreements have now been signed between the healthcare and welfare professionals involved and relevant volunteer and community organisations around a whole-systems approach for families with overweight or obese children. So they are identified and treated for as long as is necessary. In addition, some five hundred professionals and volunteers learned about weight-related issues through an extensive training programme.

At the same time, the neighbourhood approach took shape: each of the five city districts involved in the programme now has its own neighbourhood manager who, depending on the context, options and opportunities in the neighbourhood, implements the programme in conjunction with local partners and local colleagues from the district, and coordinates the implementation of overarching AAGG components with implementation at neighbourhood level.

The building of a network of ‘healthy businesses’ started later and is therefore still in the process of being developed. Dozens of pioneers, from the supermarket chain Albert Heijn to a local snack bar, have already joined the Healthy Amsterdam Business Network. The First Thousand Days approach (from conception to the age of two) is still in the early stages. The establishment of a collaborative network with midwives, maternity care, youth healthcare and the Parent and Child teams (OKT) is still in full swing. The dedicated approach for teenagers did not start until 2017 and is still in the preparatory phase.

Trends
What are the trends in terms of healthy weight and healthy lifestyles amongst children in Amsterdam? In the spring of 2017 we were able to report that overweight and obesity had fallen by 12% (from 21% to 18.5% of all children). It is clear that children of all ages – with the exception of 14 and 16-year-olds— are more often found in the ‘healthy weight’ category than they were in 2012. Of the eleven ‘heaviest neighbourhoods’, nine are now lighter.
It is encouraging to see that the downward trend is particularly noticeable amongst children from families with a low or very low socio-economic status: the most difficult groups to get through to when it comes to a change in behaviour.

Even more important than the trends in terms of overweight and obesity is the fact that we are actually seeing changes in behaviour. More babies are being breastfed for longer, children are drinking sugary drinks less often and are exercising more.

Targets achieved?
Many of the targets for the first five years of the Amsterdam Healthy Weight Programme have been achieved. The programme focuses on both prevention and treatment for children who are already overweight. There is a specific policy for different neighbourhoods and different target groups. These are mainly accessed through the relevant partners, which we support in their role.

At the same time, there is still much work to be done. Our approach in this field is already fairly tough but it could be even tougher. There is still plenty more to be done in the field of prevention. Council policy could be revised in a number of different ways to ensure that it contributes to the city’s health objectives. Successful parts of the programme have yet to be firmly embedded within the municipal organisation or one of the partners. All of these ambitions (and more) feature in the Programme Plan 2018-2021, Part 1.

What we are seeing, however, is a shift from ‘parents and children are responsible’ to ‘we are all responsible’ for a healthy social and physical environment for children. This shift contributes to the paradigm change in society that Amsterdam City Council is striving for through the AAGG: an unhealthy environment and unhealthy behaviour are increasingly on the agenda and are not the norm; a healthy environment and healthy behaviour increasingly become the norm.
2 REVIEW OF RESULTS (OUTPUT)

160 curative interventions involving more than 1,000 participants

60 children went on a holiday camp for obese children

11 neighbourhoods have a joint local Healthy Weight Pact

300 health ambassadors highlight the importance of a Healthy Lifestyle in the focus neighbourhoods

1 Healthy and cheap recipe book

130 paediatric nurses went on a course as part of the 1,000 days approach, which is aimed at 0 to 2-year-olds and their parents

1,734 healthy eating consultations for overweight children and their parents

1 Healthy and cheap recipe book

500 professionals in the city went on ‘learning expeditions’

1 Healthy and cheap recipe book

More than 150,000 neighbourhood residents reached

120 Jump-in schools

25 young people worked together to design a snappy core message

1 Amsterdam Standard of Care, which is adopted throughout the city

80 LEFF healthy lifestyle projects involving more than 800 participants

1,200 severely obese children identified and being treated

There is 1 Amsterdam Standard of Care, which is adopted throughout the city

500 professionals in the city went on ‘learning expeditions’

An average of 8 health markets a year

50 community initiatives a year

More than 150,000 neighbourhood residents reached

2 Neighbourhood Recipe Books

24,500 businesses reached through social media campaigns

1,200 severely obese children identified and being treated

25 young people worked together to design a snappy core message

60 children went on a holiday camp for obese children

11 neighbourhoods have a joint local Healthy Weight Pact

500 professionals in the city went on ‘learning expeditions’

2 Neighbourhood Recipe Books

50 community initiatives a year

120 Jump-in schools

24,500 businesses reached through social media campaigns

1,900 followers on Facebook; 1,400 on twitter

1,200 severely obese children identified and being treated

50 community initiatives a year

The product of 5 years of the AAGG – and the list is far from comprehensive –
In this chapter we review the targets that the council set itself at the outset and for the second AAGG Multiannual Programme (2015). Did we achieve these targets and, if so, to what extent? This includes not only quantitative data (statistics) but also qualitative data, such as long-term partnership agreements. Generally speaking, we believe that the majority of the targets for this initial period have been achieved. In some areas and in certain target groups in particular there are still major challenges, and these have informed the focus of the next programme period.

### 3.1 Progress on and achievement of ER targets

The mission for 2018 (the ‘5,000 metre mission’) was for children between the ages of 0 and 5 in Amsterdam to have a healthy weight. This mission was translated into the following ER targets:

- **More children are a healthy weight**
  - Sub-target: children between the ages of 0 and 5 in Amsterdam have a healthier weight than in 2013
- **Fewer children are overweight or obese**
  - Sub-target: children between the ages of 0 and 5 are no more than 5 percentage (%) points above the national average

It is clear from the latest AAGG outcome monitor 2017 that – with the exception of 14 and 16-year-olds – the ‘healthy weight’ category has increased for all ages.

A closer look at the 0 to 5-year-olds tells us that in Amsterdam:

- 5-year-olds have a healthier weight than in 2013
- There has been a significant reduction in the percentage of 5-year-olds who are overweight or obese:
  - the number of overweight 5-year-olds has fallen from 11.2% to 9.9%
  - the number of obese 5-year-olds has fallen from 4.3% to 3.1%

- There has also been a reduction in the number of overweight and obese 3-year-olds
- Amongst 2-year-olds on the other hand, there has been an increase. Since the 2-year-olds from 2014 are the 3-year-olds from 2015, an unclear picture is produced for which we don’t (as yet) have an explanation.

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1 The term ER target refers to the social impact that we wish to achieve. ‘ER’ stands for bettER, highER, lowER, strongER etc.
2 Source: AAGG outcome monitor 2017; statistics for 2 and 3-year-olds from 2015, statistics for 5 years and older relate to school year 2015-16
The weight class a child falls into is determined by their BMI. Children are subject to international cut-off values on the basis of their age and gender that correspond to the BMI cut-off values for adults. Underweight is subdivided into moderately underweight (BMI 17-18.5 kg/m²) and seriously underweight (BMI < 17 kg/m²). Children who are moderately underweight are on the light side but are considered by youth healthcare professionals to have a healthy weight as long as there is no underlying clinical problem.

<table>
<thead>
<tr>
<th></th>
<th>2-year-olds</th>
<th></th>
<th>3-year-olds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2016</td>
<td>2012</td>
<td>2016</td>
</tr>
<tr>
<td>seriously underweight³</td>
<td>2.5</td>
<td>2.3</td>
<td>3.4</td>
<td>3.0</td>
</tr>
<tr>
<td>moderately underweight</td>
<td>11.5</td>
<td>11.3</td>
<td>12.6</td>
<td>12.1</td>
</tr>
<tr>
<td>healthy weight</td>
<td>77.5</td>
<td>77.6</td>
<td>74.7</td>
<td>76.9</td>
</tr>
<tr>
<td>overweight</td>
<td>7.3</td>
<td>7.5</td>
<td>7.8</td>
<td>6.9</td>
</tr>
<tr>
<td>obese</td>
<td>1.1</td>
<td>1.3</td>
<td>1.5</td>
<td>1.1</td>
</tr>
</tbody>
</table>
### 3.2 Progress on and achievement of sub-targets

The following sub-targets were set in the Multiannual Programmes for 2013-2014 and 2015-2018. An overview of the extent to which they have been achieved is set out below:

<table>
<thead>
<tr>
<th>Sub-target</th>
<th>Achieved?</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is clear evidence that health factors have been taken into account in urban design</td>
<td>This target has been achieved</td>
<td>Amongst others, far more water fountains, school playgrounds that encourage exercise and, under the Active City (Bewegende Stad) initiative, 'built-in exercise' is a starting point for new districts such as De Sluisbuurt.</td>
</tr>
<tr>
<td>2018: The heaviest neighbourhoods have gotten lighter</td>
<td>This target has been achieved</td>
<td>9 neighbourhoods have got lighter, 2 heavier (these are being investigated).</td>
</tr>
<tr>
<td>2018: Significant decrease in overweight and obesity amongst children in the neighbourhoods where the programme has been launched (Waterlandpleinbuurt, Indische Buurt, Slotermeer, Kolenkit, Bijlmer Centrum)</td>
<td>This target has been achieved</td>
<td>In 4 out of the 5 neighbourhoods overweight and obesity has decreased; in 1 neighbourhood it has remained the same.</td>
</tr>
<tr>
<td>Expansion of the neighbourhood approach to five other ‘overweight’ neighbourhoods</td>
<td>This target has been exceeded as the AAGG neighbourhood approach is being implemented in 7 rather than 5 neighbourhoods</td>
<td>From 5 to 11 neighbourhoods plus, since 2017, 1 voluntary neighbourhood in Amsterdam Zuid.</td>
</tr>
<tr>
<td>Fewer primary schools where 25% of pupils are overweight or obese</td>
<td>This target is proving extremely difficult to monitor. Schools merge or are closed down and, in practice, the fluctuation above or just under the threshold is significant. It was therefore decided to report here on the number of schools that have taken part and/or left the programme</td>
<td>120 schools are participating in the Jump-in schools programme.</td>
</tr>
<tr>
<td>All (severely) obese children are receiving matched care</td>
<td>This target has only been achieved in part</td>
<td>More than 1,200 children have been identified and receive matched care in 2017; this is not yet all severely obese children. The expectation is that the additional focus on children in special needs education from 2017 onwards and on teenagers (and therefore also secondary education) will mean that virtually all (severely) obese children will be identified and will then receive matched care. Only then will we know whether the educated guess of upwards of 2,000 children is correct; until then we will work on that assumption.</td>
</tr>
<tr>
<td>Demand-led services with scope for own responsibility and self efficacy</td>
<td>Mostly achieved</td>
<td>The majority of the commissioned services are demand-led; in many interventions, developing one's own responsibility and self efficacy is part of the methodology.</td>
</tr>
<tr>
<td>An chain of care without drop-out: the right type of care at the right time</td>
<td>Unknown whether this target has been achieved</td>
<td>Much progress has been made but we can't say this for sure. Evaluation and reporting in 2018.</td>
</tr>
</tbody>
</table>
The heaviest neighbourhoods have gotten lighter
The five neighbourhoods where the AAGG has been launched are highlighted in yellow. It is clear from the table below that four of the five neighbourhoods have got ‘lighter’ and one has remained at the same level. It is also clear from the table that the majority of the neighbourhoods are showing a positive trend but that the neighbourhoods Transvaal-Dapperbuurt, Noord West and Bijlmer Oost are showing an unexpectedly negative trend. During the new programme period we will therefore analyse these neighbourhoods in detail to find possible explanations for this.

<table>
<thead>
<tr>
<th>AAGG neighbourhood</th>
<th>Overweight including obesity in 2012</th>
<th>Overweight including obesity in 2016</th>
<th>Difference at neighbourhood level between 2012-2016, by percentage point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kolenkit (1)</td>
<td>26%</td>
<td>24.3%</td>
<td>-1.7</td>
</tr>
<tr>
<td>Bos en Lommer (1)</td>
<td>23%</td>
<td>20.6%</td>
<td>-2.4</td>
</tr>
<tr>
<td>Slotermeer (2)</td>
<td>25.5%</td>
<td>24.4%</td>
<td>-1.1</td>
</tr>
<tr>
<td>Geuzenveld (2)</td>
<td>26%</td>
<td>21.4%</td>
<td>-4.6</td>
</tr>
<tr>
<td>Osdorp (3)</td>
<td>22%</td>
<td>18.7%</td>
<td>-3.3</td>
</tr>
<tr>
<td>Slotervaart (4)</td>
<td>21%</td>
<td>18.2%</td>
<td>-2.8</td>
</tr>
<tr>
<td>Dapperbuurt (5)</td>
<td>15.5%</td>
<td>20.6%</td>
<td>+5.1</td>
</tr>
<tr>
<td>Transvaalbuurt (5)</td>
<td>16%</td>
<td>17%</td>
<td>+1</td>
</tr>
<tr>
<td>Indische Buurt (6)</td>
<td>23.5%</td>
<td>18.7%</td>
<td>-4.8</td>
</tr>
<tr>
<td>Noord Oost (7)</td>
<td>23%</td>
<td>21.3%</td>
<td>-1.7</td>
</tr>
<tr>
<td>Waterlandpleinbuurt(7)</td>
<td>25.5%</td>
<td>24.8%</td>
<td>-0.7</td>
</tr>
<tr>
<td>Oud Noord (8)</td>
<td>21%</td>
<td>18.3%</td>
<td>-2.7</td>
</tr>
<tr>
<td>Noord West (9)</td>
<td>16%</td>
<td>17%</td>
<td>+1</td>
</tr>
<tr>
<td>Bijlmer Centrum (10)</td>
<td>19.7%</td>
<td>19.7%</td>
<td>0</td>
</tr>
<tr>
<td>Bijlmer Oost (11)</td>
<td>21%</td>
<td>21.3%</td>
<td>+0.3</td>
</tr>
</tbody>
</table>

There are 11 AAGG neighbourhoods. From the table below there appear to be more, but this is because a number of neighbourhoods where efforts have been intensified at neighbourhood level and/or which are different from the rest of the area have been shown separately. For example, the Waterlandpleinbuurt neighbourhood in Noord is shown separately from Noord-Oost (NB: the statistics for Waterlandpleinbuurt are not included in those for Noord-Oost); since 2015 Slotermeer and Geuzenveld have constituted 1 AAGG neighbourhood whereas, until 2015, it was only Slotermeer; in the Dapperbuurt and Transvaalbuurt neighbourhoods there is 1 joint programme; and Kolenkit is part of Bos en Lommer (NB: here too the statistics for Kolenkit are separate from those of Bos en Lommer).
One of the biggest challenges in tackling wicked problems in the social domain is influencing the least accessible groups. At the same time, those who are least able to help themselves often have the most problems. This is certainly the case with overweight and obesity amongst children. Consequently, the Amsterdam Healthy Weight Programme focused on these groups in particular from the outset. What developments have we seen since then? In all SES categories, the proportion of children who are overweight or obese is decreasing. This decrease is also evident in the low and very low SES groups, which, in a national and international context, is extremely unusual.

**BMI-SES development by district**

The following graphs show the trend in overweight and obesity by socio-economic status group for each district. The trend in Amsterdam is reflected in the trend in the BMI by SES at district level. To provide a complete overview, we have also included the districts of Centrum and Zuid, although they are not ‘AAGG districts’. In several districts, some categories of SES do not feature. This is due to the small number of children that belong to that particular SES category in the district concerned. For example, in the Noord district, the SES category ‘high’ is missing, in West ‘low’ and ‘very high’ are missing, in Zuidoost ‘very high’, and in Zuid and Centrum ‘low’ and ‘very low’.

The statistics indicate prevalences for all age groups together. In other words, 2, 3, 5 and 10-year-olds, plus secondary school, years 2 and 4 (excl. special needs (primary) education).

NB: The percentage distribution on the vertical axes may vary by district. For example, the vertical axis for Noord goes from 0 to 30%, while that of Centrum goes from 0 to 12%.
District West: overweight and obesity amongst children in Amsterdam by socio-economic status

District Oost: overweight and obesity amongst children in Amsterdam by socio-economic status

District Nieuw-West: overweight and obesity amongst children in Amsterdam by socio-economic status

District Zuidoost: overweight and obesity amongst children in Amsterdam by socio-economic status

District Centrum: overweight and obesity amongst children in Amsterdam by socio-economic status

Stadsdeel Zuid: overgewicht en obesitas van Amsterdamse kinderen naar sociaaleconomische status
4.1 BMI-SES trend for 5 and 10-year-olds

If we look at the BMI-SES trend for 5 and 10-year-olds, we see a decrease in overweight and obesity for the categories very low, low and average SES. The decrease for very low and average SES is significant.

Trend in prevalence of obesity by SES for 5 and 10-year-olds (2012-2015 period)

4.2 BMI-SES trend for specific target groups

Overweight and obesity are more common in children with a migration background. Between 2012 and 2015 in Amsterdam, we see a reduction in overweight amongst children of Dutch ethnicity and Moroccan ethnicity. We also see a reduction in obesity amongst children of Dutch, Moroccan, Surinamese or Turkish ethnicity.

Overweight in 2 to 18-year-olds by ethnic background

Obesity in 2 to 18-year-olds by ethnic background
Healthy eating, healthy exercise and a good night’s sleep help maintain a healthy weight. This must start at the very beginning of a child’s life. Changes in behaviour may be more indicative than a change in BMI as to whether children’s lifestyles are changing for the better. After all, weight loss may be the result of dieting, occasional severe efforts, but is only sustainable if it goes hand in hand with permanent behavioural changes. Breaking away permanently from unhealthy, ingrained behaviour is extremely difficult to do. That’s why it’s so important that children learn to adopt a healthy lifestyle, thus healthy behaviours, from an early age, and that an unhealthy lifestyle and unhealthy behaviours are avoided wherever possible. This review of behavioural changes is not so much about the highness or lowness of the individual figures in the boxes. It’s more about establishing whether there has been a change in the trend and, of course, ideally a change for the better. And this change for the good is clear to see and, for many aspects, it is significant. This is a clear indication that Amsterdam is on the right road.

An asterisk* after a figure indicates that the change is significant.
All the figures in the tables are percentages

Results on behaviour: Infant feeding
Scientific research indicates that overweight is less common in children who have been breastfed.

What are the trends in Amsterdam?

- 2 weeks: bottle feeding is less common and a combination of breastfeeding and bottlefeeding is more common
- 3 months: breastfeeding is more common, bottlefeeding is less common
- 6 months: breastfeeding is more common and bottlefeeding or a combination of breastfeeding and bottlefeeding is less common

<table>
<thead>
<tr>
<th></th>
<th>2 weeks</th>
<th></th>
<th>3 months</th>
<th></th>
<th>6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Bottlefeeding</td>
<td>13</td>
<td>11*</td>
<td>40</td>
<td>36*</td>
<td>61</td>
</tr>
<tr>
<td>Combination of breastfeeding and bottlefeeding</td>
<td>18</td>
<td>20*</td>
<td>20</td>
<td>20</td>
<td>19</td>
</tr>
</tbody>
</table>
Results on behaviour: Food in primary schools
Most significant improvement: more children drink a maximum of two glasses of sugary drinks a day.

<table>
<thead>
<tr>
<th></th>
<th>5-year-olds</th>
<th>10-year-olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast every day</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Vegetables every day</td>
<td>96</td>
<td>97*</td>
</tr>
<tr>
<td>Fruit every day</td>
<td>86</td>
<td>87</td>
</tr>
<tr>
<td>Max. of 3 snacks a day</td>
<td>94</td>
<td>95*</td>
</tr>
<tr>
<td>Max. of 2 glasses of sugary drinks a day</td>
<td>65</td>
<td>75</td>
</tr>
</tbody>
</table>

Results on behaviour: Exercise in primary schools
Most significant improvement: amongst 5 and 10-year-olds, more children exercise for at least 1 hour a day.

<table>
<thead>
<tr>
<th></th>
<th>5-year-olds</th>
<th>10-year-olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise for an average of 1 hour or more a day</td>
<td>41</td>
<td>47*</td>
</tr>
<tr>
<td>Member of a sports club</td>
<td>53</td>
<td>56*</td>
</tr>
<tr>
<td>Spend an average of 2 hours or less a day watching TV or at a computer (outside school)</td>
<td>94</td>
<td>95*</td>
</tr>
</tbody>
</table>

Results on behaviour: Girls still exercise less than boys
Girls differ from boys on exactly the same aspects in 2012-2013 as they do in 2015-2016, i.e.:
- 5-year-olds: fewer girls meet the requirement of exercising for an average of 1 hour or more a day.
- 10-year-olds: girls score lower for 1 hour or more of exercise and membership of a sports club.
  In terms of screen time, girls do better than boys in both years.

<table>
<thead>
<tr>
<th></th>
<th>5-year-olds</th>
<th>10-year-olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise for an average of 1 hour or more a day</td>
<td>44</td>
<td>37*</td>
</tr>
<tr>
<td>Member of a sports club</td>
<td>53</td>
<td>52</td>
</tr>
<tr>
<td>Spend an average of 2 hours or less a day watching TV or at a computer (outside school)</td>
<td>94</td>
<td>94</td>
</tr>
</tbody>
</table>
6 REVIEW OF QUALITATIVE TARGETS

As well as quantitative targets, qualitative targets were also set for the AAGG in 2012 and 2015. What can be reported in relation to these targets?

Paradigm shift
It is clear that there has been a social and ideological change in terms of healthy behaviour being the norm. This cannot be directly traced back to one cause, let alone our programme. But there is a societal movement going on that the AHWP unmistakably fits into and is part of. For example, drinking water (at home and at school) is becoming increasingly common, for more and more families getting enough exercise is the norm, and the importance of sleep is also gradually attracting more attention. In addition, public opinion around the issue of responsibility is changing: more and more people agree with us that the environment in which children grow up must be a healthy one. Reason enough to continue on the set course.

Normative approach & time to get tough
Led by the alderperson, unanimously supported by the College of Mayor and Alderpersons and municipal council, Amsterdam sets the healthy norm and communicates this broadly. Take, for example, Amsterdam’s membership of the ‘Stop Unhealthy Food Marketing to Kids Coalition’ (Alliantie Stop Kindermarketing ongezonde voeding), which aims to ban the marketing of unhealthy foods to children, and the associated changes in its policy around sports events. We also make our views known in areas in which we have no formal involvement, such as choices made by businesses and national regulations. But... the approach can be even tougher: see Part 1 of the new Multiannual Programme (2018-2021).

Prevention and reversal
The programme focuses on prevention for the entire population - with additional focus on the target groups that need it – and on care, help and support for families with children who are already overweight or obese.

Prioritising target groups
In all parts of the programme the AHWP focuses on the prioritised target groups. For example, the focus of the schools approach is on the ‘heaviest’ schools, and the focus of the neighbourhood approach is on the ‘heaviest’ neighbourhoods. The choice of domains and themes – children in special needs education, poverty – also holds a prioritisation of target groups on the basis of: with whom is the need (or the risk) greatest?

Accessing target groups through professionals
Children and their parents are mainly reached through healthcare, welfare and education professionals. In addition, we are increasingly reaching target groups through our voluntary partners, who, in their own way, make an equally valuable contribution to the programme’s objectives.

Embedding the programme where possible and expedient
The instruction is to embed the programme in municipal organisations, but the instruction is also to transfer responsibility only when there is certainty that the part of AAGG to be transferred to the new ‘owner’ is and will remain in good hands. In fact, this assignment has been changed to: remain alert and only transfer (embed) where stringent conditions are met. Two components have already been transferred: the objective and activities of ‘healthier urban design’ (Gezonder ingerichte omgeving) have been embedded through the Active City programme (Bewegende Stad) and by the City...
Planning and Sustainability unit. The component ‘Digital Approach’ (Digitale Aanpak) has been embedded through the Public Health Service (GGD) under Healthcare Innovation (Zorginnovatie). The component ‘Schools Approach’ (Scholenaanpak) is well on its way to being embedded in Amsterdam’s primary schools.

Alignment with existing policy
The AAGG aspires wherever possible to align and coordinate with existing policy, both within the municipal organisation and outside it. So far this has primarily been through collaboration and a soft approach. Especially within the municipal organisation this can certainly be done more firmly and effectively: see Part 1 of the new Multiannual Programme (2018-2021).

Collaboration with care partners
This objective is achieved through local implementation of the Healthy Weight Pact in the AAGG neighbourhoods and in the local social youth teams (Parent and Child Teams). In the forthcoming programme period we will review progress with the Parent and Child teams and determine whether improvements are required.

Use of digital services
Wherever we can, we take advantage of what is already being done in the Public Health Service (GGD), e.g. via the successful YourPHS (JouwGGD) – a chat service that offers advice on health issues for teenagers. We are also developing our own specific services, such as the e-tool Conversation skills for excellent professionals (Gesprekstechnieken voor excellente professionals).

Accountable and transparent
By using programmatic methods there are fixed accountability moments. With the annual implementation plans (based on the Multiannual Programme), annual reports, an annual outcome monitor and a quarterly output monitor, we meet stringent requirements in terms of accountability and transparency.
Amsterdam children are getting healthier

12% fall in the total number of children who are overweight or obese

Declining trend
Between 2012 and 2015, the percentage of overweight children (aged 2 to 18) fell from 21% to 18.5%.

Absolute decrease in the number of overweight children
- 2,500
From more than 27,000 to 24,500.*

* Despite an additional 5,000 children in Amsterdam since 2012.

Socio-economic status (SES)
There has been a decline in the percentage of overweight and obese children among those with a low or very low SES.
There has been a slight decline in the percentage of overweight and obese children among those aged 2, 3, 5, 10, and 14.

In relative terms, the most overweight and obese children in Amsterdam are of Turkish ethnicity. As Dutch children form the largest group in Amsterdam, however, there are a large number of Dutch children who are overweight or obese.

Girls tend to be overweight slightly more often than boys. The percentage of overweight and obese children has fallen among both boys and girls.

More and more babies are being breastfed

Primary school children are drinking sugary drinks less often

Primary school children are getting more exercise