



# HEALTH4EU kids

Your Kids' Health, Our Priority

## D5.2 SWOT Analysis of Grünau Moves

**HEALTH4EUKids**

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Authors (Name & Organization)	Marta Garcia-Sierra (FISABIO), Rosana Peiró (DGSP-CV, FISABIO), All WP5 partners

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## Executive Summary

This document presents the results of the three sequential SWOT analyses (kick-off, pre-implementation, and post-implementation) conducted within WP5 of the Health4EUkids project. It synthesises the strengths, weaknesses, opportunities, and threats observed during the adaptation and implementation of the Grünau Moves best practice across 16 pilot sites in six European countries. The longitudinal approach adopted enables a process-oriented understanding of implementation, capturing how initial expectations evolved into operational realities and, ultimately, into consolidated lessons learned.

Across pilot sites, the SWOT analyses identify a consistent set of strengths, notably the effective use of schools as entry points to families, the mobilisation of community networks and local NGOs, and the application of participatory, community-based approaches. These elements proved instrumental in progressively strengthening engagement with children and families, including in vulnerable contexts. While implementation challenges were encountered—particularly in relation to sustaining participation over time and ensuring sufficient operational capacity—partners developed and applied practical, locally adapted strategies to address them. These included tailoring engagement approaches, working through trusted community actors, reinforcing intersectoral collaboration, and embedding actions within existing local structures, thereby enhancing feasibility and ownership across sites. External opportunities—such as existing policy frameworks, local assets, and collaboration platforms—further supported implementation, although their uptake varied depending on context, while broader structural factors—particularly the commercial determinants of health—remained beyond the full reach of local action.

Building on these findings, the report formulates key lessons learnt, presented as a practical decalogue to support the transferability and scalability of the intervention to other European contexts. The decalogue highlights key conditions for success, including: (1) early and continuous stakeholder engagement; (2) the use of participatory, community-based approaches; (3) sufficient time and resources to build trust and ownership; (4) strong intersectoral collaboration; (5) integration of actions within existing local structures and services; (6) capacity-building of local actors; (7) flexibility to adapt to context; (8) clear evaluation approaches from the outset; (9) sustained political commitment and institutional support; and (10) alignment with supportive policy frameworks to enhance sustainability and scalability. Taken together, these findings underline the need to combine locally driven action with supportive policy environments to maximise impact and ensure long-term sustainability.

# 1. Background and Introduction

## 1.1. Purpose and scope of the deliverable

This deliverable presents the results of the three sequential SWOT analyses conducted within WP5 of the Health4EUkids project, corresponding to the key phases of implementation: (i) kick-off (expectations), (ii) pre-implementation (initial adaptation and planning), and (iii) post-implementation (implementation experience and outcomes).

The analysis captures how the Grünau Moves best practice was adapted and implemented across 16 pilot sites in six European countries, identifying the main strengths, weaknesses, opportunities, and threats (SWOT) encountered throughout the process. Rather than providing a static assessment, the three-step SWOT approach allows for a process-oriented understanding of implementation, highlighting how expectations evolved into operational realities and, ultimately, into observed results.

Building on this longitudinal perspective, the report sets out key lessons learnt, presented as a practical decalogue to support the transferability and scalability of the intervention in other European contexts.

## 1.2. Pilot context and implications for SWOT interpretation

Given the diversity of implementation settings, the interpretation of SWOT findings requires a clear understanding of the local contexts in which the pilots were developed. The Grünau Moves intervention was implemented across 16 pilot sites in six European countries, all intentionally selected as areas experiencing socioeconomic vulnerability, in line with the project's focus on reducing health inequalities among children and families. At the same time, these sites encompass different living and socio-demographic conditions, governance structures, and scales of intervention, which required context-specific adaptations during implementation.

Differences population composition, and local capacities can significantly influence both the implementation process and the resulting strengths and challenges identified in each site. Providing a concise and comparable overview of these contextual factors is therefore essential to support a meaningful interpretation of the SWOT analyses and to understand how findings relate to different local realities.

All pilots followed the common methodological guidance of WP5, as described in deliverable [D5.1 Methodological Guide](#). However, variations in how this approach was operationalised at local level are reflected in differences in implementation approaches, stakeholder engagement, and delivery settings. In addition, the scale of intervention ranges from single-school pilots to neighbourhood, district, and municipality-level implementations, reflecting differences in governance arrangements and local capacity. All pilots were implemented within a common timeframe (2023–2025), corresponding to the main implementation phase of the project.

At the same time, despite these contextual differences and local adaptations, a number of common patterns emerge across the SWOT analyses. These shared elements are primarily linked to the core components of the Grünau Moves best practice and WP5 methodology, which have been consistently applied across pilot sites. In particular, recurring strengths and opportunities are associated with key local strategies such as community engagement,

intersectoral collaboration, and participatory approaches, which have proven effective across different contexts. These include securing political support, using schools as gateways to engage children and their families, and identifying and mobilising local NGOs and community associations as implementation partners, among others.

Table 1 provides a comparative overview of the 16 pilot sites, including key socio-demographic indicators, implementation approaches, scale of intervention, and timelines. To ensure comparability, only quantitative indicators related to social vulnerability (income, poverty, unemployment, educational attainment, and population composition) have been included. Where such data were not available, cells have been left blank to avoid the use of non-comparable qualitative information. Implementation approaches are summarised using short, harmonised descriptions derived from the WP5 methodological framework, capturing how the intervention model was operationalised in each site.

This overview provides the necessary context to interpret the SWOT findings presented in the following sections, while also supporting the identification of transferable elements that can inform future implementation in other settings.

**Table 1. comparative summary Grünau Moves 16 pilot sites.**

Country	Partner	Region / City	Pilot Area	Population (approx.)	Socio-demographic context	Implementation approach	Scale of intervention	Timeline
Greece	1. 6th HEALTH ADM (COO) / 1.1 UPAT (AE)	Prefecture of Achaia (Patras)	Patras, 2nd district (4 schools)	—	—	Structured school–community approach	4 schools	2023–2025
Belgium	2. Sciensano (BEN)	Flanders (Maasmechelen)	Maasmechelen municipality	39,914	€17,058 income p.p.; 23.8% children in poverty; 29.6% unemployment; 39.3% low education	Community-based, participatory approach, informal structure	Municipality-level	2023–2025
Belgium	2. Sciensano (BEN)	Flanders (Eeklo)	Eeklo municipality	22,140	€19,693 income p.p.; 23.4% children in poverty; 10.9% low work-intensity; 14% subjective poverty	Community-based, participatory approach, informal structure	Municipality-level	2023–2025
Hungary	3. NNGYK (BEN)	Budapest (District III)	Óbuda-Békásmegyer (1 school)	—	2,574 unemployed; 23,540 low education ( $\leq$ primary)	Structured school–community approach	One school	2023–2025
Hungary	3. NNGYK (BEN)	Pest county (Jászkarajenő)	Jászkarajenő municipality (1 school)	—	83 unemployed; 1,095 low education ( $\leq$ primary)	Structured school–community approach	One school	2023–2025
Malta	6. MFH (BEN)	Northern Harbour (Hamrun)	Hamrun municipality	—	—	Fully structured, WP5 methodology-based	Municipality-level	2023–2025
Spain	10. FISABIO (BEN)	Valencia (Cullera)	El Raval–St. Agustí (1 nbhd)	~1,500	~60% Roma; ~10% migrant; >50% low education; ~14% unemployment	Fully structured, WP5 methodology-based	Neighbourhood-level	2023–2025
Spain	10. FISABIO (BEN)	Valencia (Paterna)	La Coma (1 nbhd)	7,703	€24,147 income p.p.; 12.39% unemployment; 76.05% low education; 85% Roma / 15% migrant	Fully structured, WP5 methodology-based	Neighbourhood-level	2023–2025
Spain	10.1 SAS / 10.5 EASP / 10.9 FPS	Andalusia (Seville)	Polígono Sur (6 nbhd)	28,277	~60% unemployment; 45–50% low education; ~45% Roma; 8–10% migrant	Fully structured, WP5 methodology-based	District-level (6 nbhd)	2023–2025
Spain	10.2 IdISBa (AE)	Balearic Islands (Palma)	Llevant Sud (3 nbhd)	14,671	16.6% migrant; 40–48% low education	Fully structured, WP5 methodology-based	District-level (3 nbhd)	2023–2025

Country	Partner	Region / City	Pilot Area	Population (approx.)	Socio-demographic context	Implementation approach	Scale of intervention	Timeline
Spain	10.3 CSG (AE)	Galicia (Ponteareas)	Ponteareas municipality	23,049	€13,873 GDP p.c.; €13,098 income p.c.; 3.78% migrant	Fully structured, WP5 methodology-based	Municipality-level	2023–2025
Spain	10.4 IDIVAL (AE)	Cantabria (Torrelavega)	Covadonga nbhd	51,923	~9.6% migrant; ~50% low education	Structured school–community approach	Neighbourhood-level	2023–2025
Spain	10.4 IDIVAL (AE)	Cantabria (Torrelavega)	La Inmobiliaria nbhd	51,723	~19% migrant	Structured school–community approach	Neighbourhood-level	2023–2025
Spain	10.8 BIOSISTEMAK (AE)	Basque Country (Erandio)	Erandio municipality	24,2	~8.6% migrant; 0.31% low education	Fully structured, WP5 methodology-based	Municipality-level	2023–2025
Portugal	11. MS (BEN)	Alto Alentejo (Alter do Chão)	Alter do Chão municipality	—	—	Fully structured, WP5 methodology-based	Municipality-level	2023–2025
Portugal	11. MS (BEN)	Alto Alentejo (Portalegre)	Portalegre municipality	—	—	Fully structured, WP5 methodology-based	Municipality-level	2023–2025

*Note:* Quantitative socio-demographic indicators were not available for all pilot sites. In such cases, cells are left blank to ensure methodological consistency and avoid the use of non-comparable qualitative descriptions.

## 2. Aim and Objectives

The aim of this deliverable (D5.2 – SWOT analysis of Grünau Moves) is to provide a structured reflection on the implementation of the Grünau Moves best practice (BP) across 16 pilot sites in six countries (Spain, Portugal, Greece, Hungary, Belgium, and Malta). Implementation took place in both urban and rural contexts, with attention given to addressing the needs of deprived populations. By systematically analysing the strengths, weaknesses, opportunities and threats (SWOT) observed throughout the process, this report seeks to capture lessons learnt, identify key enablers and barriers, and inform future transferability of the intervention.

The specific objectives of the SWOT analysis are to:

1. **Assess the implementation process** of Grünau Moves by identifying success factors, barriers, and lost opportunities, with particular attention to the availability and limitations of data on obesogenic contexts, obesity, overweight, and other relevant indicators.
2. **Generate insights and lessons learnt from practice**, highlighting how local contexts, stakeholder engagement, and resources shaped outcomes.
3. **Support the transferability of best practices** by analysing how Grünau Moves can be adapted to different settings, in line with the overall objectives of the Joint Action.
4. **Inform future planning and sustainability** of community-based interventions for obesity prevention by drawing on the evidence collected, and experiences reported by pilot partners.

In this vein, the scope of the SWOT/SOAR analyses focuses on identifying barriers for the implementation, lost opportunities, success factors, and key performance drivers. The elements that define a SWOT analysis are as follow:

- **Strengths** are the positive attributes and resources that supported the intervention, providing a competitive advantage.
- **Weaknesses** are the negative aspects and gaps that limited performance or posed risks.
- **Opportunities** are the external factors and trends that created potential for added value or improvement.
- **Threats** are the external factors and challenges that could undermine success or sustainability.

Taken together, this framework provides the foundation for analysing the implementation of Grünau Moves BP across the pilot sites. The SWOT framework therefore serves as a structured approach to capture the conditions influencing implementation and to identify the factors most relevant for future planning.

### 3. Summary of Previous SWOT Analysis

Two rounds of SWOT analyses were conducted in the earlier phases of the project. The first round reflected expectations at the project kick-off, while the second captured the realities observed during the pre-implementation stage.

#### SWOT 1: Kick-off (Expectations)

	<i>Helpful</i>	<i>Harmful</i>
<i>Internal</i>	<b>Strengths</b> <ul style="list-style-type: none"> <li>Schools and children as gateways to families</li> <li>Community networks, peer/family support, local NGOs</li> <li>Political will and municipal openness to “active living</li> </ul>	<b>Weaknesses</b> <ul style="list-style-type: none"> <li>Limited resources (staff, budget, cultural mediators)</li> <li>Evaluation challenges (defining indicators, measuring change)</li> <li>Communication challenges within diverse/multi-cultural communities</li> </ul>
<i>External</i>	<b>Opportunities</b> <ul style="list-style-type: none"> <li>Supportive regulations (school menus, advertising restrictions)</li> <li>Existing facilities: playgrounds, sports, gardens</li> <li>Alliances with NGOs, healthcare, community leaders, influencers</li> </ul>	<b>Threats</b> <ul style="list-style-type: none"> <li>Community acceptability, mistrust, and cultural barriers</li> <li>Structural inequalities: poverty, health literacy, lack of healthy environments</li> <li>Political turnover and commercial determinants (food industry)</li> </ul>

#### SWOT 2: Pre-implementation (Realities)

	<i>Helpful</i>	<i>Harmful</i>
<i>Internal</i>	<b>Strengths</b> <ul style="list-style-type: none"> <li>WP5 team committed, multidisciplinary, flexible, strong communication</li> <li>Training resources and shared understanding</li> <li>Some political will at local level and active community NGOs</li> </ul>	<b>Weaknesses</b> <ul style="list-style-type: none"> <li>Tight deadlines, lack of evaluation plan, few meetings, remote collaboration</li> <li>Challenges engaging families, low participation culture</li> <li>Data gaps: obesity indicators, indicators for comparisons, scientific communication complexity</li> </ul>
<i>External</i>	<b>Opportunities</b> <ul style="list-style-type: none"> <li>EU funding and awareness</li> </ul>	<b>Threats</b> <ul style="list-style-type: none"> <li>Economic: cost of living crisis, food</li> </ul>

	<p>campaigns already in place</p> <ul style="list-style-type: none"> <li>• Participatory structures at local level, school interest, celebrity/foundation initiatives</li> <li>• Cultural/environmental assets: Mediterranean diet, parks, bike lanes, sports trends, social media influence</li> </ul>	<p>prices, low investment in school meals</p> <ul style="list-style-type: none"> <li>• Behavioural/cultural: myths about healthy lifestyles, low parental participation</li> <li>• Systemic: commercial determinants (unhealthy foods), inequity, political shifts, multicultural segregation</li> </ul>
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In short, the following points summarize the main trends and developments observed across the two SWOT analyses, highlighting areas of continuity and change in the project's strengths, weaknesses, opportunities, and threats.

**Evolution of Strengths:** Community networks and schools as gateways to families remained important strengths. The project team's cohesion, multidisciplinary expertise, and flexibility also emerged as important internal strengths, reinforced by several factors: access to training resources and the establishment of a shared understanding of project methods and objectives (e.g., methodological guide, toolkit, pilot follow-up sessions, mid-term evaluation of the implementation process in MS5.4). Political support, however, remained limited and was present only in some local contexts.

**Persistent Weaknesses:** Engagement of families and caregivers remained challenging, though improvements were observed following adaptations and participatory strategies. Communication challenges within these diverse/multi-cultural communities persisted in some pilots, highlighting the need for targeted engagement strategies (e.g., the use of cultural mediators) to improve outreach and participation. Finally, limited resources (staff), tight deadlines, and gaps in evaluation capacity continued to constrain project activities, while data gaps—particularly the availability of health data on childhood overweight and obesity at the sub-local level—remained a critical area to address.

**Confirmed Opportunities:** Policy support and participatory governance structures at the local level were confirmed as relevant factors for facilitating project activities. Political support materialized in some municipalities but was inconsistent, and turnover slowed decision-making. Regulatory frameworks (school menus, advertising restrictions, and school facilities) were in place, and schools were generally receptive, though enforcement and uptake varied.



**Enduring Threats:** Systemic issues and socio-economic barriers—including poverty, inequalities, low health literacy, cultural habits, and low parental participation—remained significant, affecting engagement and access. Moreover, the commercial determinants added to the cost-of-living crisis (rising food prices, energy and housing costs, and limited household budgets), thereby reducing opportunities for healthy lifestyles. These challenges highlighted the need for structural policies to provide a supportive framework for local health promotion actions.

With this in mind, the following template was used for *SWOT 3: Post-implementation (Lessons Learned)*:

### SWOT 3: Post-implementation (Lessons Learned)

Work template (*in blank*):

Factor Type	Factor / Topic	Initial Expectation (SWOT 1)	What Happened in Practice (SWOT 2)	Status (utilised/overcomed/pending/not relevant)	Lessons Learned
 <b>Strength</b>	Schools & children	Schools as gateways to families; supportive of healthy habits	Schools engaged moderately; participation improved after adaptation		
 <b>Strength</b>	Community networks / NGOs	Close personal relationships; NGOs for health promotion; networked associations	Local NGOs active; WP5 team built strong communication; some networks underused		
 <b>Weakness</b>	Community engagement	Anticipated difficulties engaging families and caregivers	Engagement was low initially; improved after participatory adaptation		
 <b>Weakness</b>	Resources / Team	Limited resources (staff) and evaluation capacity	Tight deadlines, lack of evaluation plan, remote collaboration issues		
 <b>Opportunity</b>	Political support	Municipalities open to “active living”; elections as leverage	Some political support materialised; turnover slowed decisions		
 <b>Opportunity</b>	Regulatory / Policies	Laws on healthy menus, advertising restrictions, school facilities	Policies present, but enforcement limited; schools receptive		

 <b>Threat</b>	Socio-economic barriers	Poverty, inequalities, cultural habits, commercial determinants	Cost of living crisis, myths, low parental participation, food deserts		
 <b>Threat</b>	Sustainability / Commercial influence	Risk of low sustainability, commercial pressures	EU funding helped, but commercial determinants and inequity persist		

## 4. Results

### 4.1 Meeting Information SWOT 3: Post-implementation (Lessons Learned)

**Session name & time:**

12:00–13:00 | SWOT Analysis: Where We Are & Where We Aim to Go

**Date and Time:** 29 August, 2025

**Location:** Patra, Greece

*In-person meeting (venue):*

Achaia Beach Hotel, Kastellokambos Patra, 26500 Patra (Greece)

*Streaming:*

[Link to the SWOT Analysis 29 August, 2025 | 12:00–13:00](#)

Meeting ID: 334 959 893 545 4

clau d'accés: 7Qb2xs3L

**Attendees (20 people):**

Name of participant	Organisation	Country	Attendance
Eleni Papachatzi	UPAT	Greece	In-person
Péter Csizmadia	NNGYK	Hungary	In-person
Chiara Cattaneo	ISS	Italy	In-person
Sharon Vella	HPDP	Malta	In-person
Pauline Vassallo	HPDP	Malta	In-person
Leonor Quelhas Pinto	DGS	Portugal	In-person
Miguel Telo de Arriaga	DGS	Portugal	In-person
Xermán Bugallo Sanz	CSG	Spain	In-person
Rosana Peiró Pérez	CSGVA	Spain	In-person
Lilian Castro	Fisabio	Spain	In-person
Marta Garcia-Sierra	Fisabio	Spain	In-person
Maria Ramos	IDISBA	Spain	In-person



Javier Lera	IDIVAL	Spain	In-person
David Cantarero	IDIVAL	Spain	In-person
Marina Barreda	IDIVAL	Spain	In-person
Irati Erreguerena	Biosistemak	Spain	In-person
Amaia Menchaca Echevarria	Biosistemak	Spain	Online
Carolina Munoz Ibáñez	CSG	Spain	Online
Jaime Jiménez	EASP	Spain	Online
Rafael Rodríguez Acuña	FPS	Spain	Online
Alexandra Angelakopoulou	UPAT	Greece	Online

## 4.2 Results SWOT 3: Post-implementation (Lessons Learned)



The results of *SWOT 3: Post-implementation (Lessons Learned)* are presented using a structured template that combines insights from SWOT 1 and SWOT 2 with observations from the pilot implementation of Grünau Moves. For each factor—strength, weakness, opportunity, or threat—the initial expectations (from SWOT 1) and what occurred in practice (from SWOT 2) were synthesised, while WP5 partners reflected on and documented the status of the factor (utilised, overcome, pending, or not relevant) and the key lessons learned.



The analysis was conducted by three groups of five participants each (one online), providing a comprehensive overview of how the project adapted to local contexts and public administrations. Each group worked on the provided template for 45 minutes, followed by a plenary session in which they presented and discussed their findings. This session was recorded and transcribed, and the resulting material was used to complete the results in the written sheets.

**Group 1:** Results from the group formed by IDIVAL (Cantabria, Spain) (3 people) and HPDP (Malta) (5 people):



Factor Type	Factor / Topic	Initial Expectation (SWOT 1)	What Happened in Practice (SWOT 2)	Status (utilised/overcome/pending/not relevant)	Lessons Learned
 <b>Strength</b>	Schools & children	Schools as gateways to families; supportive of healthy habits	Schools engaged moderately; participation improved after adaptation	[IDIVAL] Utilised No problem with schools. All four schools engaged. [HPDP] Utilised Big school participated more than small school (change in head of school).	[IDIVAL] They needed the help of higher authorities to infiltrate in the schools. Felt powerless, yet still they managed to act (rely on local actors to do activities). [HPDP] They didn't have any problems contacting the head of school, who was approachable and supportive. They learned that they needed careful planning from the start due to school holidays.
 <b>Strength</b>	Community networks / NGOs	Close personal relationships; NGOs for health promotion; networked associations	Local NGOs active; WP5 team built strong communication; some networks underused	[IDIVAL] Utilised Community networks and NGOs participated. [HPDP] Pending Local council collaboration. Had a contact there which helped within their capacities.	[IDIVAL] They had no problem with establishing community networks. They relied on local actors to guarantee sustainability, integrating the activities as part of what the community was doing. [HPDP] Strong collaboration with the






					local council was key; providing professional support (e.g., healthcare staff) helped facilitate activities, while incentives could further increase participation of third sector.
<b>⚠ Weakness</b>	Community engagement	Anticipated difficulties engaging families and caregivers	Engagement was low initially; improved after participatory adaptation	<p>[IDIVAL] Overcome A small school with international students enabled engagement of both students and their parents.</p> <p>[HPDP] Overcome Through community outreaches organisation, work with schools who cares for different multicultural students.</p>	<p>[IDIVAL] Reached the community through a small, multicultural school; challenges included absenteeism in the Roman community and the need for trusted cultural mediators for non-native speakers (e.g., Arabic-speaking families).</p> <p>[HPDP] Point of access to vulnerable groups easier than we thought through school.</p> <p>[All] They needed a trusted, Arabic-speaking mediator to facilitate participation and help the community feel included</p>
<b>⚠ Weakness</b>	Resources / Team	Limited resources (staff) and evaluation capacity	Tight deadlines, lack of evaluation plan, remote collaboration issues	<p>[IDIVAL] Pending Staff capacity limited.</p> <p>[HPDP] Pending</p>	[IDIVAL] More resources, time, money, and appropriate training to


				Staff limited – you cannot be everywhere.	ensure a clear understanding of all project steps from the outset. [HPDP] More resources, time, money.
 <b>Opportunity</b>	Political support	Municipalities open to “active living”; elections as leverage	Some political support materialised; turnover slowed decisions	[IDIVAL] Pending [HPDP] Pending It’s difficult to engage the politicians. It requires persistent effort and follow-up.	[IDIVAL] Difficult to engage local authorities. They meet but don’t offer real support. [HPDP] Same. The Advisory Healthy Lifestyle Council is informed but follow-up is often limited. [All] It’s clear that persistent effort and learning are needed to involve politicians effectively.
 <b>Opportunity</b>	Regulatory / Policies	Laws on healthy menus, advertising restrictions, school facilities	Policies present, but enforcement limited; schools receptive	[IDIVAL] Utilised [HPDP] Utilised Policies in place, yet enforcement is limited.	[IDIVAL] In Spain, school food policies (e.g., healthy menu controls and subsidized meals for vulnerable students) are in place but not consistently enforced. [HPDP] In Malta, children bring their own lunches, and some still bring unhealthy food. Existing policies are mostly

					enforced but not fully adapted to the specific community.
 Threat	Socio-economic barriers	Poverty, inequalities, cultural habits, commercial determinants	Cost of living crisis, myths, low parental participation, food deserts	[IDIVAL] Pending [HPDP] Work in progress Vulnerable groups face high food costs and limited time to cook; addressing inequalities requires political support and funding.	[All] with no money and no time to cook, one cannot change healthy habits. Parents arriving late at night, no time to cook, and healthy eating is expensive. [HPDP] Need political support – no unhealthy food close to school.
 Threat	Sustainability / Commercial influence	Risk of low sustainability, commercial pressures	EU funding helped, but commercial determinants and inequity persist	[IDIVAL] Pending [HPDP] Pending Commercial influence remains strong, particularly marketing through social media.	[All] EU should enforce bans on marketing and advertising of unhealthy foods and beverages directed at children. EU should enforce the Child Guarantee. [HPDP] Cultural foods are generally accepted and often lack front-of-pack labels.





**Group 2:** Results from the group formed by NNGYK (Hungary) (1 person), Biosistemak (Basque Country, Spain) (1 person), CSG (Galicia, Spain) (1 person), and Fisabio (Valencia, Spain) (1 person):





Factor Type	Factor / Topic	Initial Expectation (SWOT 1)	What Happened in Practice (SWOT 2)	Status (utilised/overcome/ending/not relevant)	Lessons Learned
 <b>Strength</b>	Schools & children	Schools as gateways to families; supportive of healthy habits	Schools engaged moderately; participation improved after adaptation	Utilised [All] The schools participated in the situational analysis and needs assessment, and form part of the Health Network (HN) and Core Group (CG).	[Biosistemak] to enhance the active participation in the HN it is important to offer incentives or gains, because they are overload (!!). [Fisabio], We engaged schools, but should have started with teachers' collaboration, as they facilitate all activities. [CSG] We would like to have more time for the evaluation, and we think that's
 <b>Strength</b>	Community networks / NGOs	Close personal relationships; NGOs for health promotion; networked associations	Local NGOs active; WP5 team built strong communication; some networks underused	Utilised [Biosistemak, CSG, Fisabio] Pending [NNGYK] NGOs are close to vulnerable people.	[Biosistemak] to guarantee the effectiveness and achievement of the process and project, NGOs participation is key, as they close to the vulnerable people. [NNGYK] There were no active NGO involvement in Hungary. [CSG] We'd like more possibilities to continue the calendar and deadlines. [Fisabio], We adapted to the large Health Network's schedule, learning to respect their times and existing work committees.

 <b>Weakness</b>	Community engagement	Anticipated difficulties engaging families and caregivers	Engagement was low initially; improved after participatory adaptation	[All] Utilised	[All] To have guidelines and validated methodology framework about how to implement participatory process is key to transform this weakness to strength. Thanks to that all pilots have followed and deployed a participatory process engaging all the community from the beginning.
 <b>Weakness</b>	Resources / Team	Limited resources (staff) and evaluation capacity	Tight deadlines, lack of evaluation plan, remote collaboration issues	[All] Overcome more or less.	[All] It is necessary to have more time to develop and create team building, implement community actions, to have the capacity to engage the community and mature it. Resources and experts in the field of community action are necessary for the real implementation of participatory processes. The evaluation plan should be defined and proposed from the beginning of the process.
 <b>Opportunity</b>	Political support	Municipalities open to “active living”; elections as leverage	Some political support materialised; turnover slowed decisions	[All] Utilised	[All] Political support is key, their commitment and agreement to support and boost the process is strategic for the real effectiveness and participation of the community.
 <b>Opportunity</b>	Regulatory / Policies	Laws on healthy menus, advertising restrictions, school facilities	Policies present, but enforcement limited; schools receptive	[All] Utilised OR overcome (enforcement limited)	[All] It is needed more cooperation with the schools, and healthcare professionals with different profile such as nutritionists, midwives, physical activity professionals, community nurses.
 <b>Threat</b>	Socio-economic barriers	Poverty, inequalities, cultural habits,	Cost of living crisis, myths, low parental	[All] Pending	[All] If you live in the peripheral area, it is difficult to implement changes if the

		commercial determinants	participation, food deserts		municipality and government do not support with money, social help policies and others. To have a good and in-depth situation analysis, economic situation, social determinants in all the places and areas is necessary to start defining the strategies and plan to overcome this threat and transform it into an opportunity or a strength.
 <b>Threat</b>	Sustainability / Commercial influence	Risk of low sustainability, commercial pressures	EU funding helped, but commercial determinants and inequity persist	[All] Pending	[All] EU funding is necessary to start the process, but the knowledge and common guidelines to define and interpret sustainability actions into the process is a weakness in some cases. Commercial determinants and inequities are challenges and barriers always for all these implementation processes and changes.

**Group 3 (online):** Results from the **online** group formed by FPS/EASP (Andalusia, Spain) (2 people), Biosistemak (Basque Country, Spain) (1 person), CSG (Galicia, Spain) (1 person), and UPAT (1 person):

Factor Type	Factor / Topic	Initial Expectation (SWOT 1)	What Happened in Practice (SWOT 2)	Status (utilised/overcome/pending/not relevant)	Lessons Learned
 <b>Strength</b>	Schools & children	Schools as gateways to families; supportive of healthy habits	Schools engaged moderately; participation improved after adaptation	[All] Utilised	[All] Schools proved to be key gateways to families, with higher engagement than initially expected.
 <b>Strength</b>	Community networks / NGOs	Close personal relationships; NGOs for health promotion; networked associations	Local NGOs active; WP5 team built strong communication; some networks underused	[All] Utilised	[All] NGO were active in the implementation but not used to be involved in this kind of participatory processes. NGO need to be empowered to be involved in future projects. They must be considered as equals to institutions.
 <b>Weakness</b>	Community engagement	Anticipated difficulties engaging families and caregivers	Engagement was low initially; improved after participatory adaptation	[All] Overcome Engagement was improved but not optimal	[All] Communication was fluid, finding new ways of work with the municipalities. They have an interest in networking to break the current “silos” way of functioning. Need to reinforce dissemination methods with them.
 <b>Weakness</b>	Resources / Team	Limited resources (staff) and evaluation capacity	Tight deadlines, lack of evaluation plan, remote collaboration issues	[All] Pending Problems still exist.	[All] We have improved tools to follow and implement actions. Plans could be shared in advance with other actors and countries. Resources are still a barrier to sustainability.

 <b>Opportunity</b>	<small>riority</small> Political support	Municipalities open to “active living”; elections as leverage	Some political support materialised; turnover slowed decisions	[All] Utilised	[All] Participation of politician. Good image for them too. Efforts for improvement and share healthy living.
 <b>Opportunity</b>	Regulatory / Policies	Laws on healthy menus, advertising restrictions, school facilities	Policies present, but enforcement limited; schools receptive	[All] Utilised	[All] Use this project to gain new role with health ministries for our municipal level, network coordination.
 <b>Threat</b>	Socio-economic barriers	Poverty, inequalities, cultural habits, commercial determinants	Cost of living crisis, myths, low parental participation, food deserts	[All] Overcome	[All] Make healthy living a priority. Choose cheap but healthy food options.
 <b>Threat</b>	Sustainability / Commercial influence	Risk of low sustainability, commercial pressures	EU funding helped, but commercial determinants and inequity persist	[All] Pending, still	[All] Still limited capacity to spread our messages within the population in cooperation with commercial companies.

## 5. Concluding Remarks—SWOT 3 Consolidated Results

In what follows, we highlight the consolidated results from *SWOT 3: Post-implementation (Lessons Learned)*. Where relevant, the SWOT findings are illustrated with concrete examples from pilot sites to support interpretation and enhance transferability to other contexts.

### Strengths

- **Schools and children:** All groups reported that schools remained a key entry point and actively participated in the pilots. Engagement improved compared to earlier phases, though differences were noted: while some contexts required support from higher authorities to gain access, others highlighted the importance of early teacher involvement. Schools were generally receptive, but incentives or workload considerations were identified as important factors for sustaining participation.

For example, in several pilots (e.g., Psaforai, Greece; Obuda-Bekasmegyér and Jászkarajenő, Hungary; Hamrur, Malta), schools hosted regular health promotion activities such as a summer school, workshops, sports events, and educational sessions integrated into school routines, facilitating continuous engagement with children and families.

- **Community networks and NGOs:** NGOs and community actors were utilised across most pilots and seen as essential to reaching vulnerable groups. However, their involvement varied: in some contexts, NGOs were very active; in others, their role was limited or pending. A common lesson was the need to empower NGOs and treat them as equal partners to institutions, while respecting their time constraints and offering adequate incentives.

For instance, in Polígono Sur (Spain), collaboration with community mediators and local associations was key to engaging hard-to-reach families, while in La Coma and Pontearreas, local health networks brought together NGOs, schools, and municipal actors to co-design and implement actions.

### Weaknesses

- **Community engagement:** Although engagement of families and caregivers was initially challenging, all groups reported improvements through participatory approaches, cultural mediators, and school-based outreach. Nevertheless, engagement was not always optimal, and pilots stressed the importance of guidelines and tested methodologies for community participation, as well as improved dissemination and communication strategies.

For example, in several pilots, initial low participation of families required the introduction of adapted strategies such as culturally sensitive outreach, the use of cultural mediators or the involvement of trusted community figures, as observed in Spain pilots such as Polígono Sur, Llevant Sud, La Coma or in Hamrur, Malta.

- **Resources and team capacity:** Resource limitations—staff, time, and evaluation capacity—remained a persistent challenge across groups. While some progress was made (e.g., improved tools for action planning, stronger collaboration), the need for more time, dedicated staff, and

expert support in community action was emphasised. Insufficient resources were seen as a barrier to both implementation and sustainability.

This was evident in multiple pilots where planned structural actions (i.e. improvements in the food environment or built environment interventions) were delayed or only partially implemented due to limited human and financial resources (e.g., Maasmechelen and Eeklo, Belgium; Covadonga, La Inmobiliaria, and El Raval de Cullera, Spain).

## Opportunities

- **Political support:** Political engagement was reported as utilised across most pilots, though uneven. Where present, political support provided visibility and legitimacy, but in other cases it remained limited or symbolic. A shared lesson was that sustained political commitment is strategic for effectiveness and long-term sustainability and community participation. For example, in municipalities such as Erandio, Pontareas, Alter do Chão and Portalegre, early involvement of local authorities and formal agreements contributed to stronger ownership and integration of actions into local planning processes. In contrast, in Torrelavega (Cantabria, Spain), where two neighbourhoods participated (Covadonga and La Inmobiliaria), political support was not effectively secured, resulting in the absence of structural actions and a stronger focus on school-based activities.
- **Regulatory frameworks and policies:** Policies (e.g., school food, advertising restrictions, facilities) were generally utilised and seen as an enabling factor. Still, enforcement varied widely, and pilots stressed the need for closer collaboration between schools, healthcare professionals, and competent authorities to translate policies into practice. In some contexts, this translated into concrete actions such as school food environment initiatives or alignment with existing municipal health and education strategies, although implementation depended on local enforcement capacity.

## Threats

- **Socio-economic barriers:** Poverty, inequalities, cultural habits, and commercial determinants continued to constrain project impact. While some groups reported partial progress (e.g., promoting affordable healthy food options), most highlighted the need for stronger structural policies and resources to mitigate these barriers. For instance, several pilots implemented mitigating actions such as cooking workshops and food literacy sessions (across most pilots), as well as initiatives to improve food access, including the creation of school gardens or weekly farmers' markets in underserved areas (e.g., La Coma and El Raval, respectively), aiming to address economic barriers to healthy eating.
- **Sustainability and commercial influence:** Sustainability remained pending in all groups but one. While EU funding enabled implementation, commercial determinants, inequities, and limited dissemination capacity were recurrent obstacles. All groups noted that, beyond funding, a lack of shared knowledge and common guidelines on defining and implementing sustainability actions hindered progress. Long-term sustainability requires clearer guidance, structural funding, and stronger regulation of unhealthy food marketing directed at children and adolescents.

While many pilots successfully implemented Local Action Plans (LAPs) during the project period, continuation beyond project funding often depended on securing institutional commitment or integration into existing services, which was not consistently achieved across all sites. Notably, good practices emerged in contexts where municipal governments were involved early on, sometimes formalised through agreements or protocols with health authorities (e.g. Erandio, Pontareas, Alter do Chão, Portalegre), which contributed to stronger long-term commitment and sustainability.

Finally, the influence of commercial determinants (e.g. marketing and availability of unhealthy food) was consistently identified as a structural barrier that cannot be effectively addressed through local action alone. In this regard, pilots consistently highlighted the need of upstream, structural policies at EU and national levels.

Overall, the consolidated results from SWOT 3 highlight both the progress achieved and the persistent challenges faced during implementation. Importantly, beyond the challenges identified, the SWOT 3—Consolidated results highlight several consistent implementation strengths across pilots. Schools proved to be effective and reliable entry points to reach children and families; participatory approaches significantly improved community engagement; NGOs and community actors played a key role in reaching vulnerable populations; and political support, when secured, enhanced legitimacy, visibility, and integration into local systems. These elements represent core success factors for the transferability of the Grünau Moves approach.

These insights provide the basis for the next sections, which present locally generated solutions, evaluation indicators, and the key lessons learned across pilots.

## **6. From identified challenges to locally generated solutions**

Building on the SWOT findings presented in Section 5, this section illustrates how the challenges identified were addressed in practice across pilot sites. While the SWOT analyses primarily aimed to identify strengths, weaknesses, opportunities, and threats related to the implementation of the Grünau Moves best practice, these discussions with WP5 implementers also generated a range of practical responses. Although these exchanges were not structured as a formal cross-site compilation of solutions, several common strategies emerged across pilot sites, often reflecting shared implementation challenges across different contexts.

These findings should be interpreted in light of the methodological approach applied in WP5. The Grünau Moves implementation does not rely on predefined or standardised solutions; instead, it is based on a participatory, action-oriented process through which context-specific responses are generated at local level.

Across all pilot sites, implementation followed a common sequence of key steps: participatory needs assessment, health assets mapping, co-design and prioritisation of actions, implementation through Local Action Plans (LAPs), and evaluation. These steps were carried out through intersectoral structures, including Core Groups and Local Health Networks, bringing together schools, children, families, local authorities, health professionals, and community organisations.

Within this framework, solutions to identified challenges—such as limited political support or socio-economic barriers—were not addressed through externally defined measures, but through locally co-designed actions. Needs and priorities were identified directly by community members and stakeholders, ensuring that proposed actions were closely aligned with the lived realities of target populations.

In addition, the use of health assets mapping further introduced a salutogenic perspective, shifting the focus from deficits to existing local resources and capacities. This approach facilitated the identification and mobilisation of community assets, including natural community leaders, local NGOs, social networks, municipal actors and services, as well as physical spaces such as schools, playgrounds, and other public spaces.

In practice, several clusters of strategies emerged across pilots:

**1. Strengthening participative governance and political engagement.** Pilots reported efforts to secure and maintain engagement from local authorities through continuous communication, involvement of municipal representatives in Core Groups and Local Health Networks, and alignment of project actions with existing local health and social policies. In some cases, this translated into active participation of municipal councils or technical staff in planning and implementation processes, contributing to local ownership of the intervention. Examples of good practices include the early involvement of municipal governments, sometimes formalised through agreements or protocols between municipalities and health authorities (e.g. Erandio, Pontareas, Alter do Chão, Portalegre), helping to ensure long-term commitment, sustainability, and scalability. In addition, existing regional networks of municipalities for health—such as RELAS in Andalusia, REGAPS in Galicia, and XarxaSalut in the Valencian Region—provide supportive frameworks that facilitate coordination, knowledge exchange, and the integration of health promotion actions at local level. Importantly, adherence to these networks usually requires formal approval by the municipal council. More broadly, the integration of co-designed actions into local services—health, education, and municipal structures—combined with stakeholder engagement, training, and governance mechanisms, supports the continuation of the model beyond the project duration.

**2. Addressing socio-economic barriers through community-based actions.** To address to constraints related to income, time, and access to healthy food, several pilots implemented practical, community-oriented interventions. These included cooking workshops and food literacy sessions in schools (across most pilots), activities in community settings and supermarkets, and the development of simple educational materials adapted to local contexts. Additional strategies focused on capacity building, such as train-the-trainers approaches (e.g. Polígono Sur, Alter do Chão, Portalegre), aimed at empowering teachers and community agents. Interventions in the physical and social environment included school gardens and weekly farmers' markets in underserved areas (e.g. La Coma, El Raval in Cullera), as well as initiatives promoting active lifestyles, such as safe routes to school, active breaks, sports activities, active schoolyards, and traditional games in public spaces (e.g. Psarofai district, Óbuda-Békásmegyer, Jászkarajenő, Llevant Sud, Pontareas, Alter do Chão, Portalegre).

**3. Addressing the commercial determinants of health.** Regarding this external and persistent threats identified, pilots recognised that some challenges—particularly those related to structural and commercial determinants of health—could not be fully addressed through local action alone. In particular, WP5 implementers call for consistent upstream action through legislation and enforcement of structural policies that address the commercial determinants of health—such as stronger regulation of unhealthy food marketing aimed at children and adolescents; provision of free school meals for children in vulnerable situations; mandatory evaluation of school-meal programs; setting limits on

added sugars, salt, and saturated fats; and capping prices of fresh fruits and vegetables—to reinforce and back up local, bottom-up initiatives.

**3. Leveraging core implementation strategies of the Grünau Moves approach.** Many of these responses were embedded in the core features of the Grünau Moves model, including the use of schools as entry points to families, the mobilisation of local NGOs and community organisations, and the establishment of Core Groups and Local Health Networks to support co-design and implementation. These strategies were applied consistently across pilot sites and contributed to improved engagement, coordination, and local relevance of interventions.

Overall, while the SWOT process did not systematically document or compare solutions across sites, the experiences reported by partners indicate that practical, context-adapted strategies to address identified barriers were developed and tested within the pilots. These experiences are further detailed in Deliverable D5.3, including a more detailed description of the Local Action Plans (LAPs).

Finally, the experience across pilots suggests that sustainability of the Grünau Moves approach depends on three key conditions: (i) early institutional anchoring, particularly through engagement of local authorities and integration into existing services; (ii) sustained community engagement through participatory approaches and local networks; and (iii) supportive policy environments addressing structural and commercial determinants of health. While not all pilots achieved these conditions to the same extent, the lessons learned provide a clear pathway for strengthening long-term sustainability beyond EU funding.

## 7. Evaluation Indicators Operationalised Across Pilots

In the post-implementation phase, Grünau Moves pilots operationalised a set of evaluation and process indicators initially identified during the first SWOT round (Expectations) and further refined in Milestone 23 report, incorporating OECD-informed guidance on evaluating public health best practices, particularly in relation to healthy eating and active lifestyles.

While a common evaluation framework was proposed, the actual operationalisation of indicators varied across pilots depending on local context, data availability, and methodological choices. A detailed, pilot-specific description of indicators, data sources, and results is provided in Deliverable D5.3 (Post indicators report—Evaluation of Grünau Moves best practice).

These indicators, spanning behavioural, environmental, participation, policy, and qualitative domains, were adapted to local contexts and data availability.

### 1. Health & Behaviour Indicators

- **Suggested indicators:** Fruit and vegetable consumption, physical activity levels, sugary drink intake. However, these were not systematically operationalised across pilots; individual-level indicators are not always available at the level of the small areas (municipality or neighbourhood), and so it was not a core requirement for WP5 partners to measure them.
- **Feasibility lessons:** Surveys, health records, school-based reporting, as well as participatory and non-standardised methods (e.g. needs assessment tools like the Living Healthy Tool, community activities) were effective for capturing behaviour changes. Examples: in Polígono

Sur (Spain), data from clinical records was extracted, while in Alter do chão and Portalegre (Portugal) an anthropometric and lifestyle evaluation study was conducted. Finally, in the Valencian Region, this Joint Action led to the establishment of a Regional Child Obesity Observatory, designed to monitor and analyse data at local level. Overall, individual-level behavioural indicators were only partially operationalised, relying primarily on proxy or community-based data sources rather than standardised measurement across pilots.

## 2. Environmental / Structural Indicators

- **Suggested indicators:** Availability of sports facilities, green spaces, food environment (fast-food access, health labels), school meal guidelines, soft drink bans.
- **Feasibility lessons:** Objective assessments via mapping, Photovoice, walk-along activities, and use of the Living Healthy Tool proved reliable, and were among the most consistently operationalised across pilots (e.g., Maasmechelen and Eeklo, Belgium; Hamrun, Malta; Spain pilots). These indicators were operationalised in most pilots through both desk-based data (e.g., municipal/administrative registers) and participatory assessment methods, making them the most comparable domain across sites.

## 3. Participation / Process Indicators

- **Suggested indicators:** Number of participating schools, children, families; workshops and community sessions held; stakeholder involvement.
- **Feasibility lessons:** Participation data were easily tracked through Core Groups, Local Health Networks and activity-participation records, and registered in the Action Factsheets. Strong engagement depended on early community leaders and stakeholders involvement and use of cultural mediators in multiethnic settings (e.g., Polígono Sur, Hamrun). These indicators were systematically operationalised across all pilots and constituted the most consistently available dataset for monitoring implementation processes and reach.

## 4. Policy / Structural Indicators

- **Suggested indicators:** Municipal support, regulatory frameworks, existence of school nutrition policies, adoption of healthy food and activity guidelines.
- **Feasibility lessons:** Policy presence did not always translate to consistent enforcement (e.g., Hamrun, Malta; Spain pilots); pilots highlighted the need for ongoing monitoring and engagement with competent authorities, which often fall within national/regional authorities, and thus out of the scope of this project aimed at local-level interventions. As a result, these indicators were operationalised mainly through qualitative and documentary review (e.g., policy mapping, stakeholder input), rather than through measurable enforcement or outcome indicators.

## 5. Qualitative Indicators

- **Suggested indicators:** Stakeholder perceptions, community feedback, perceived barriers, facilitators, and attitudes towards healthy lifestyles were extensively used across all pilots.
- **Feasibility lessons:** Participatory methods, interviews, and focus groups, using or not specific tools to structure conversations (e.g., the Living Healthy Tool or Group Model Building methodology), effectively captured qualitative insights and complemented quantitative data (all pilots). These indicators were universally operationalised and played a central role in assessing perceived effectiveness, contextual change, and implementation process quality.

## Summary Indicators Feasibility of Measurement

- Individual-level quantitative data (e.g. BMI, detailed dietary intake) were difficult to collect and apply at such micro-scales, as they are often not available. However, community-level proxy indicators provided meaningful insights.
- Participatory approaches enhanced feasibility and data quality for qualitative indicators on behavioural, environmental and social contexts, as well as process evaluation. Thus, participatory methods proved particularly effective both for data collection and for engaging communities in the evaluation process.
- Environmental, process, and qualitative indicators were the most feasible and consistently applied across pilots.
- Structural and policy indicators were more reliably assessed using objective measures and local administrative data, although gaps remained.
- Data availability and comparability across sites remained uneven, confirming the challenges already identified in SWOT 2 regarding evaluation capacity and data gaps.

All in all, the evaluation approach evolved from an initially comprehensive and indicator-driven framework towards a more pragmatic and context-sensitive model, combining available quantitative data with participatory and qualitative evidence. This shift is better aligned with the core principles of the Grünau Moves community-based health promotion approach, as well as with the realities of a six-country Joint Action, in which health authorities contextualised and transferred this best practice in real-life, non-controlled settings.

### Overview of the availability and limitations of data related to the obesogenic context, obesity, overweight, and other key indicators

Finding health data at the local level (e.g., for a municipality or neighbourhood) presents several important challenges that affect researchers, policymakers, and citizens alike. In fact, there is a lack of availability of detailed data, as most information is provided at the national or regional level, but not disaggregated locally.

Even when some data exists, it is often scattered across different institutions—hospitals, health centres, city councils, regional authorities. This makes data collection and comparison difficult, especially because different administrations may use varying methodologies, indicators, or formats, which complicates combining data and conducting consistent analyses. In some cases, the data does exist but is not public or requires special permissions, limiting its use for research and, more importantly, for communities.

Large municipalities may have the capacity to manage these systems, and in many cases, they do, making such data available. However, most municipalities in Europe are small and typically lack sufficient technical staff or budget to organize these information systems, which require coordinating multiple administrations with access to local data, as well as systematically collecting, analysing, and publishing health data. This challenge is compounded by the need to establish a unified methodology across all municipalities.

There is an additional issue specific to health data related to privacy and confidentiality. Health data is highly sensitive, and for low-prevalence diseases, local-level disaggregation in small areas increases the risk of identifying individuals. As a result, the publication of detailed information is often restricted.

Overall, these challenges make it difficult to accurately understand health conditions in specific communities and to design effective interventions, as well as to analyse and evaluate the impacts of local policies and actions, identifying inequalities between neighbourhoods or specific communities.

To obtain health data at the municipal level in a way that is useful, comparable, and sustainable, it would be necessary to establish a system that addresses some of the challenges described. Common standards and methodologies would need to be defined so that data can be compared across different local settings.

A useful strategy could be to define a “minimum dataset of health indicators” at the local level, similar to the “minimum basic dataset at hospital discharge,” which enables comparison because the same methodology is used across all hospitals. It would be important to select certain health indicators that can act as tracers of both child and adult health. For example, childhood overweight and obesity would be a good proxy indicator, as there is extensive data available and of quality for this population. Children are routinely weighed and measured at specific ages in most European countries, and this is also known to be a predictor of morbidity and mortality in the adult population of a given neighbourhood or municipality.

To overcome limitations related to small areas in health data, “minimum thresholds” can also be applied—that is, not publishing data when the number of cases falls below a certain threshold, as is already done, for example, with mortality data.

Achieving this would require strengthening multilevel governance by coordinating local, regional, and national administrations to share data in a structured way. As mentioned earlier, this process would need to be led by a central body to ensure that data, as well as data collection and analysis methodologies, are comparable, while also providing technical and methodological support—including specific support for smaller towns and cities.

Developing open data portals with simple visualizations and downloadable datasets would be a key objective. This would facilitate use by professionals, researchers, technical staff, and citizens. Most importantly, it would help evaluate the impact of health promotion policies, empowering the population to observe these changes and contribute additional information through participatory governance structures, such as those used in this project.

## Operationalisation in D5.3 Post indicators report—Evaluation of Grünau Moves best practice

Templates for collecting the data from the partners and pilot sites:

<b>A. Population &amp; Sociopolitical Context</b>			
<b>Criteria Category</b>	<b>Indicator / Description</b>	<b>Available Data / Evidence</b>	<b>Source / Reference</b>
Socioeconomic Status (SES)	Education level, employment, income, deprivation indices	Yes / No + data excerpt or summary	Source name + year
Opportunity Indicators	Institutional support, prior projects, community engagement, institutional support, etc.	Narrative description	Project reports / local gov.

B. Structural Indicators of the Obesogenic Environment			
Indicator	Data / Description	Source	Measurement Unit
Availability of sports facilities	e.g., number of public sports facilities per 10,000 people	e.g., Municipal data	Facilities per 10,000 people
Availability of green spaces	e.g., total m <sup>2</sup> of green space per capita	e.g., Urban planning records	m <sup>2</sup> per capita
Access to fast-food restaurants	e.g., number within 500m of schools	e.g., Local mapping	Count / Density
Share of foods with recognised health symbol (e.g., Nutri-Score, Keyhole)	e.g., % of labelled products in school canteens	e.g., Food audits	%
Nutrition quality of meals in restaurants and schools	e.g., average meal score using a quality index	e.g., School meal assessments	Qualitative/score
Share of schools with a ban on the sale of soft drinks	e.g., % of schools implementing this policy	e.g., School admin records	%
Nutrition guidelines in schools & compliance	e.g., % of schools following official nutrition guidelines	e.g., Ministry of Education	%

**Reference to Detailed Pilot Data:** For a comprehensive overview of the operationalised indicators per pilot, including measurement methods and results, see Deliverable D5.3 (Post indicators report—Evaluation of Grünau Moves best practice).

## 8. Lessons Learnt for Transferability and Scalability

Finally, we formulated the lessons learnt as a practical decalogue, highlighting the key ingredients that other countries or regions would need to transfer, adapt, and scale up the Grünau Moves best practice.

- 1. Allocate sufficient resources:** Community-based health promotion and prevention interventions take time. Fieldwork, stakeholder involvement, and co-creation processes require adequate staff and budget; this is a low-cost intervention.
- 2. Follow a methodological guide:** A clear reference framework helps align partners, standardise processes, and support adaptation across contexts.
- 3. Use participatory toolkits:** Practical, ready-to-use instruments are essential. In this project, an ad-hoc tool was created and shared to guide participatory work.
- 4. Invest in capacity building:** Short training sessions (“training pills”) provided by best practice owners proved highly valuable to strengthen local teams.
- 5. Adapt strategies to vulnerable populations:** Working with culturally diverse, often segregated or unstable groups (e.g., migrant population) requires creativity and tailored approaches to build trust and ensure ongoing engagement.
- 6. Secure municipal political support:** Sustainable implementation depends on explicit commitment and backing from local authorities.
- 7. Rely on schools as gateways to families:** Schools provide direct access to families and are natural allies in promoting healthier habits.
- 8. Engage community networks and NGOs:** These actors are essential to reach vulnerable groups and to ensure activities resonate locally.

9. **Design from the bottom up:** Effective local actions must be co-designed with communities, and tailored to their needs as perceived by them. Applying top-down solutions after the fact undermines both relevance and sustainability.
10. **Back local action with upstream policies:** Local interventions must be supported by broader structural measures (e.g., restrictions on food marketing to children, enforcement of the EU Child Guarantee) to maximise and sustain impact.

These lessons summarize the practical knowledge gained for adapting and implementing Grünau Moves in diverse contexts. They serve as guidance for reinforcing local action and ensuring lasting impact through supportive policies.

## Annexes

# A1 SWOT 1: Kick-off Meeting (Expectations)

[Athens, Greece], [8<sup>th</sup> and 9<sup>th</sup> February 2023]

FISABIO  
Àrea de Gestió i Promoció Científica

# SWOT Analysis – WP5 project partners

WP 5 Grunau Moves

Health4EUkids Kick off Meeting — WP5 SWOT Analysis Session, Athens (Greece), February 8-9, 2023

## Authors

Marta Garcia-Sierra (FISABIO)  
Ana Boned-Ombuena (FISABIO)  
Joan Quiles (FISABIO)  
Cintia Sancanuto Chardi (FISABIO)  
Rosana Peiró (FISABIO)

## Contributors

WP5 Project Partners and Affiliated Entities

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## Meeting Details

Participants and minutes from the session:

**Thursday 9, February, 11.00-13.00**

**WP5: All partners working on Grünau moves**

*Lead: Fisabio, 120-minute teamwork*

Mrs. Cintia Sancanuto (FISABIO - Fundacion Para el Fomento de la Investigacion Sanitaria y Biomedica de la Comunitat Valenciana - GD Public Health Valencia/FISABIO Research Foundation, Spain) presented the Best practice of Grünau Moves with a reference to Xarxasalut, the criteria to choose the deprived place, the alliances and the sources of Spain.

Mrs. Maria Ramos Monserrat (IdISBa - Fundacio Institut d'Investigacio Sanitaria Illes Balears - Health Promotion Department of Balearic Islands, Spain) referred to Health4EUkids area selection criteria (quantitative, qualitative).

Mrs. Paloma Lanza León and Mr. Javier Isaac Lera Torres (IDIVAL - Fundacion Instituto de Investigacion Marques de Valdecilla - Valdecilla Biomedical Research Institute, Spain) referred to the criteria for choosing the interventional place and the next steps.

Mr. Jaime Jiménez Pernet (EASP - Escuela Andaluza de Salud Publica SA - Andalusian School of Public Health, Spain) presented the choice of implementation neighborhood for the good practice Grünau Moves in Andalusia with a reference to the “Poligono sur”, Seville South District, some problems identified in the district and the main stakeholders: Commissioner’s office Poligono Sur.

Mrs. Carolina Muñoz Ibáñez (CSG - Consellería de Sanidade de Galicia, Spain) referred to the place of the intervention (Galicia – Northwest of Spain) and the criteria identified. Also referred to information resources.

Mrs. Amaia Mentxaka (DSP - Public Health Dept. Basque Country, Spain) presented to the proposal of Basque Country with a reference to the place, the information resources and the alliances.

Mr. Péter Csizmadia (NNK - Nemzeti Nepegeszsegugyi Kozpont - National Public Health Institute, Hungary) presented the Hungarian participation in the Grünau Moves project with a reference to the administrative areas and the underprivileged areas of Hungary, the beneficiary settlements and how to define them, the comprehensive catch up program in Hungary and the Hungarian plan.

Finally, a discussion with the following topics took place, chaired by Mrs. Ana Boned:

1. What could be the positive aspects opportunities/facilities that we could identified in a vulnerable neighborhood that helps us to develop and improve the intervention? How can we take advantage of them?
2. What could be the negative aspects weaknesses/barriers/limitations that can reduce the positive impact of our intervention? How can we overcome them, or limit their impact or even take advantage of them?
3. What aspects/indicators/information do you think could be useful and easy to obtain for monitoring the process?

4. Our final outcomes “reducing the obesity” could be difficult to achieve. Do you have any suggestions to other partial or other outcomes? What would they be? Could you provide some examples?

Representatives result speech:

- Mrs. Mariella Borg Buontempo (MFH - Health Promotion and Disease Prevention Directorate - Ministry for Health, Malta)
- Mr. Péter Csizmadia (NNK - Nemzeti Nepegeszsegugyi Kozpont - National Public Health Institute, Hungary)
- Mr. Chiara Cattaneo (ISS - Istituto Superiore di Sanità - Italian National Institute of Health, Italy)
- Mrs. Ines Urieta (DSP+Kronikgune - Public Health Dept. Basque Country – Kronikgune, Spain)

## Aim and objectives

On the occasion of Health4EUKids’ kick off meeting held on 8–9 February 2023, Hotel Stanley, Athens, Greece, a 120-minute teamwork was held on Thursday 9, 11:00–13:00, where all partners involved in WP5 Grünau Moves had the opportunity to discuss relevant issues for the planning of the tasks within this WP through a participatory SWOT analysis activity conducted using the World Café methodology. A World café is a participatory method designed to foster dialogue and make connections to the ideas of others.

## Methodology

The World Café was organised with four tables, each dedicated to one of the above questions. Participants rotated between the tables in successive rounds, ensuring that each group contributed to all four questions. Following World Café principles, one participant remained at each table as “host,” sharing the insights gathered from previous rounds and ensuring continuity so that conversations were built collectively rather than repeated. This format allowed ideas to evolve through successive contributions, fostering connections across groups and generating a rich, shared understanding of the factors relevant to the SWOT analysis.

The 4 questions presented at the In-person participatory teamwork session, namely the World café activity for conducting the initial SWOT Analysis are as follow:

1. What could be the opportunities/strengths in a vulnerable neighbourhood that help us to develop the intervention? How can we take advantage of them?
2. What could be the threats/weaknesses/difficulties/barriers that can reduce the positive impact of our intervention? How can we overcome them, or limit their impact or even take advantage of them?
3. What aspects/indicators/dimensions do you think could be useful and easy to obtain for monitoring the process?
4. Our final outcomes “reducing obesity” could be difficult to achieve. Do you have any suggestions of other partial outcomes? What would they be? Could you provide some examples?

## Results

In what follows, we outline the results obtained and comment on the key strategies to put forward for the topics and issues assessed collectively.

### 1. Opportunities, strengths, alliances...:

- Schools (to engage the patient via the school; schools will be supportive because they work on healthy eating habits, physical education,..)
- To promote psychosocial skills through the use of the playground (Italy experience)
- Local formal authorities (the implementation of the intervention will start after local and national elections, and so to contact the new elected representatives could be important to put the obesity prevention in the new political agenda; municipality willing to participate and sustain any interventions; municipalities which support “active living” and participating in “healthy cities”)
- Existing facilities/places (need to create safe places for mothers from different cultures to discuss, meet, etc.; make maximum use of existing facilities [e.g. sport, gardens,...])
- Close personal relationships (family bonds, peer support)
- Regulation and laws (in Spain they are preparing a law on healthy menus at schools; the advertisement regulation laws of sugary drinks and unhealthy foods; to restrict vending machines in schools)
- Networking (associations working on childhood obesity; presence of non-profit associations in the community dealing with health and wellbeing issues; NGOs working with social issues; Primary Healthcare implication; to take advantage of and connect with local community leaders to bond earlier with the communities; to create/strengthen a health promotion network in the community; collaboration between different services, entities, schools, etc.; other municipalities nearby that have a community process could push the new area to get involved in community engagement; deprived areas due to their characteristics and kind of population/incomes have already many associations/NGOs working on the area: knowledge, experience, network; networking between societies-NGOs working with children; sports associations with children; use strong-opinion leaders/influencers specially from different cultures [even if unexpected])

The analysis of opportunities and strengths revealed, among other the following key issues. The project is seen as an opportunity to engage local authorities and develop supportive regulations to create a conducive environment for obesity prevention. Examples include regulating public procurement, introducing healthy and sustainable school menus, taxing sugar-sweetened beverages (SSB), regulating food advertisement, or banning vending machines in schools. However, the new scenario post-elections might complicate matters in this sense. Schools, though, are viewed as an asset and an ally. Engaging schools can be a crucial aspect of tackling childhood obesity as they play a significant role in children's lives. Schools can promote healthy eating habits and physical education, making them supportive partners in obesity prevention efforts.

## 2. Weaknesses/barriers/limitations/threats...:

- Acceptability of the community/parents
- Cars and car industry
- It is challenging and difficult to change behaviour
- Commercial determinants
- Commitment to sustainability, adequate staff provision, cultural mediators
- Communication skills (isolation, lack of interaction within the community)
- Different minorities stay in different isolations; how to get them out of it?
- Denial of big companies selling "dirty" foods
- Dysfunctional families (lack of time, etc.)
- Elections and possible change of political party in power, less favourable to community action
- Existing perception and knowledge about child obesity
- Habits or cultural ideologies that lead to specific food habits
- Health inequalities in the communities and determinants of health
- Intergenerational transmission of SES - it is difficult to break the circle of poverty
- Lack of available health professionals in changing approach to health promotion
- Lack of computer skills
- Lack of employment opportunities for new migrants
- Lack of healthy living environment
- Lack of political commitment in the long term (politicians not supporting these actions)
- Less facilities in the neighbourhood
- Lack of time or low cooperation of local people because they have other priorities
- Low level of facilities, sport, resources, budget
- Low levels of literacy and health literacy (education)
- Poverty/stigma/cultural behaviour as a barrier
- Misbeliefs of the community they think engaging and will not work or produce anything: "hard to reach"
- Negative beliefs towards institution and this intervention
- Power dynamics among community organisations and stakeholders could be a barrier to implementation; to acknowledge this in the mapping is important
- Price of healthier options
- Resources, human and economic
- To measure the changes and define meaningful indicators

The analysis of weaknesses and threats to the intervention has revealed initial concerns about limited resources for health promotion, on the one hand, and poverty and responsiveness, on the other. The weaknesses and limitations identified include a lack of a healthy living environment, insufficient physical activity or sport facilities, insufficient health professionals, and population's time constraints hampering participation, among other. On the other hand, the threats and barriers are related to the difficulty of changing behaviour, isolation, complicated family environments, low literacy levels, unemployment, poverty perpetuation, stigma, cultural norms, negative beliefs generating distrust, lack of acceptability, and little political commitment or willingness to bring about change in disadvantaged communities.

### 3. Evaluation of results: aspects, indicators...

- Availability of free or almost free bikes for the neighbourhood
- Availability of paediatricians and number of accesses to paediatrician first aid
- Comparing results with other countries or areas
- Changes in urban planning: bike lanes, walkable paths, green spaces
- Mapping environmental resources, measuring before-after the number of sports activities, playgrounds, social work resources, etc.
- Methodology, indicators of results: set minimum standards or success, namely to define X indicators; not to use result indicators, but just process indicators; use qualitative evaluation, namely focal interviews on X interventions; survey (validated) on physical activity and dietary habits at t=0 and at the end of process; environmental resources mapping at t=0 and after (sports, playgrounds, joint work...)
- Survey on physical activity and dietary habits at t=0 and at the end, according to validated scales
- Free fitness centres/physical activity facilities available for children
- Increase in fruit and vegetables consumption or healthy foods
- Increase in the use of the playground
- Increase of the level of physical activity - quantitative measures on individual changes in PA habits
- Increase the opportunities in daily physical activities
- km of bike lanes in the neighbourhood
- km of walkable paths in the neighbourhood
- Number of actions for diet or sports in school
- Number of dissemination actions about obesity in the community
- Number of new actions for child obesity in the community
- Number of new partners interested in implementing the best practice in the future
- Number of promotion initiatives at the beginning and end in the area
- Number of sporting events in the community
- Participation of families in collective activities as courses, walks, parties...
- Policy changes to sustain the interventions (e.g., increase funding for health promotion, provide free access to physical activity facilities, number of activities on promotion before/after, availability to paediatrics access)
- Qualitative evaluation of the intervention by the school personnel
- Reduction in consumption of "dirty foods"
- Set minimum standards for success
- To overcome a deterministic perspective, we could focus on evaluation of implementation, analysing the role of contexts on the differences in results of intervention implementation; the number of cases (Spain, Hungary, Malta) is adequate for this approach
- Number of calls to the police (no dimension)

Concerning the indicators for evaluating the outputs of the intervention, the general opinion revolves around obtaining quantitative indicators on individuals' health behaviours, the local built environment, healthcare resources, actions implemented, stakeholders' engagement, and policy and planning measures allowing sustainable change. First, it is proposed to conduct a survey on individuals' physical activity and dietary habits at t=0 and at the end of the intervention to register any changes. Second, carry out a before-after mapping of environmental resources, namely bike lanes, walkable paths, playgrounds, physical activity facilities, sports activities, etc., to capture indicators of availability and

usage. In addition, monitor the integration of childhood obesity prevention measures into local policies and planning. Finally, assess the availability and accessibility of medical facilities, equipment, and personnel (e.g., paediatricians, social workers).

#### 4. Monitoring of process: aspects, indicators...

- Accomplish the timeline/milestones of the project
- Adherence to activity which was planned (time/quantity)
- Adherence to the timeline/milestones of the project
- Baseline of BMI individuals in the community and reduction of BMI in the community
- Budget or new funding assigned to the process or to health promotion in general in that municipality/community? [yes/no]
- Commitment of the major signed and approved by the municipal assembly
- Structures: 1) identify “right” people, 2) who is responsible, 3) what working multi-sectoral groups already exist
- Identify the stakeholders
- If press speaks about the project
- Include the unexpected (e.g., hairdressers/beauticians)
- [Total number of] involved people in the program/intervention
- Involvement of the community and stakeholders, internal and external to the project (i.e. monitoring the process)
- Number of actions undertaken - How many education/courses have been organized and how many people attended
- Number of agents of the different small regions or communities (Roman, migrants...) participating in the process/interventions
- Number of communication activity; i.e. people reach to the messages
- Number of complaints (negative) or press news (positive) related with the intervention evolution/progress. This implies clear processes for communication with community participants (people and organisations)
- Number of decision makers in the municipality (in a period) taking into account HiAP, Equity, obesity...
- Number of decision makers who are actively involved and willing to listen and act
- Number of different regions participating by their agents
- Number of new (free) facilities for physical activity in the neighbourhood
- Number of participatory workshops
- Number of professionals participating
- Number of schools participating in the initiatives
- Number of stakeholders
- Number of training activities done with kids, at school
- Number of target population reached; i.e. vulnerable people reached (migrants, ethnic minorities [Roman]...). (*What is the percentage of community members getting the message?*)
- Percentage of kids participating in the process
- Periodically meetings with local stakeholders/actors (i.e. ask their opinion and aspects to improve)

The process indicators proposed by the attending partners focus on three main sets of indicators, namely performance indicators, engagement and participation, and actions launched. The first set of performance indicators includes measuring the adherence to the calendar and timely completion of the

scheduled activities. The second set of indicators focuses on engagement and participation of relevant stakeholders, including target population reached community leaders, policy makers, health practitioners, schools and school community members, with a more or less stable degree of participation in the project. This set of indicators also involve the number of participatory activities held and participants at each stage of development of the community intervention (identification, co-design, deployment, action), as well as the communication/dissemination actions carried out. This might be the main set of process indicators, provided the input received. Finally, a third set of indicators involves quantifying the number of actions co-designed for their implementation within the case study areas.

## Concluding Remarks & Takeaway Messages

### Opportunities & Strengths (Helpful)

- **Schools & Children:** Schools were seen as natural allies (already working on nutrition/physical activity) and a strong gateway to families.
- **Local Authorities & Political Will:** Municipalities open to supporting “active living” agendas; chance to engage newly elected representatives and put obesity prevention on political agendas.
- **Community & Networks:** Close family bonds, peer support, and existing NGOs/associations dealing with health/social issues offered opportunities for collaboration. Community leaders and influencers (including from minority groups) could help build trust.
- **Regulatory Environment:** New laws emerging on healthy school meals, advertising restrictions on sugary/unhealthy foods, and limits on vending machines in schools.
- **Facilities & Environments:** Sports facilities, playgrounds, gardens, and safe spaces for intercultural dialogue could be maximised.
- **Alliances & Partnerships:** Potential to strengthen a local health promotion network by linking schools, NGOs, primary healthcare, municipalities, and neighbouring community processes.

**Takeaway:** At the start, schools, political will, and dense community networks were recognised as the key assets for building intervention capacity.

### Weaknesses, Barriers & Threats (Harmful)

- **Community-Level Barriers:** Acceptability among parents, lack of trust in institutions, cultural/language isolations, dysfunctional families, stigma, and negative beliefs toward interventions.
- **Structural & Environmental Constraints:** Poverty, food prices, unhealthy food environments, lack of facilities, health inequalities, and intergenerational transmission of low SES.
- **Behavioural & Cultural Barriers:** Difficulty of behaviour change, unhealthy habits, cultural ideologies around food, myths, and lack of health literacy.

- **Systemic Challenges:** Limited resources (financial/human), insufficient staff or cultural mediators, power dynamics among organisations, and lack of political long-term commitment.
- **External Risks:** Elections and political turnover, commercial determinants of health, and the car/transport system as a barrier to active mobility.
- **Evaluation Barriers:** Difficulty measuring change, lack of indicators, and challenges in defining meaningful success metrics.

**Takeaway:** Major anticipated barriers were rooted in socio-economic inequalities, community mistrust, and systemic resource gaps, combined with threats from political and commercial interests.

### Evaluation of Results (Suggested Indicators)

- **Health & Behaviour Indicators:** BMI baseline and follow-up, fruit/veg consumption, PA levels, dietary surveys, reduction in “dirty foods.”
- **Environmental Indicators:** Bike lanes, walkable paths, playgrounds, green spaces, access to paediatricians, mapping of sports/social facilities.
- **Participation Indicators:** Family involvement, school activities, sporting events, workshops, community courses, % of target population reached.
- **Policy/Structural Indicators:** Policy changes, municipal commitments, new facilities, budget allocation.
- **Process Indicators:** Timeline adherence, number of actions, community/stakeholder involvement, communication activities, media coverage, feedback from schools and families.
- **Qualitative Indicators:** Perceptions of school personnel, stakeholder interviews, qualitative evaluation of implementation and context.

**Takeaway:** The group favoured a **broad monitoring framework**, mixing environmental, behavioural, and process indicators, and emphasised both quantitative and qualitative evaluation.

### Monitoring of Process (Suggested Aspects)

- **Governance & Structures:** Identify responsible actors, ensure mayoral/municipal commitment, regular meetings with stakeholders.
- **Participation:** Number of schools, professionals, children, families, and vulnerable groups involved.
- **Activities & Communication:** Number of training sessions, participatory workshops, education courses, communication events, media presence.
- **Outcomes Tracking:** New facilities for physical activity, stakeholder engagement, percentage of community reached, complaints/feedback, policy uptake.

**Takeaway:** Early monitoring recommendations stressed participatory processes (community and stakeholder involvement), strong political buy-in, and tracking both outputs (activities) and early outcomes (policy, facilities, participation).

### Overall Insight

At Kick-off, the consortium identified a **rich landscape of opportunities** (schools, political momentum, NGOs, regulations) but also anticipated **serious community and structural barriers** (poverty, mistrust, cultural divides, commercial forces). Evaluation and monitoring were designed to be broad and multi-level, acknowledging that “reducing obesity” directly would be hard, and focusing instead on **process, environment, and participation outcomes**.



## Health4EUKids - Kick off meeting

8-9 February 2023, Hotel Stanley, Athens, Greece



Wednesday 8, February from 09:00 a.m. to 17:00 p.m.	
09:00-09:30	Registration
	<b>Session 1: Project overview</b> <i>Chairs: Apostolos Vantarakis, University of Patras, Greece</i>
09.30-09.40	<b>Welcome,</b> <i>Mina Gaga, Deputy Minister of Health, Greece</i> <i>John Karvelis, Director of 6th DYPEDE, Greece</i>
09.40-10.00	<b>Welcome speech: "Child Obesity Facts. Is it all about Diet?"</b> (consequences of obesity across life course, overall nutrition risk factors, and emphasise on lifestyle-behaviour and environmental settings) <i>Emmanuela Magripli, Ass. Professor in Nutritional Epidemiology &amp; Public Health</i> <i>Laboratory of Dietetics and Quality of Life; Department of Food Science and Human Nutrition</i> <i>School of Food and Nutritional Sciences; Agricultural University of Athens,</i> <i>Research Associate, Harokopio University, Visiting Faculty, United Arab Emirates University</i>
10:00-10:30	<b>Introducing Health4EUKids</b> <i>Apostolos Vantarakis, University of Patras, Greece</i>
10:30-10:50	<b>Grant management, Reporting and Amendments (online)</b> <i>Alessandro Chiodini, Scientific project Officer, Health, and Food Safety Unit, HADEA</i>
10:50-11:00	<b>Financial Questions</b>
11:00-11:30	<b>Coffee Break</b>
11:30-12:30	<b>WP1 (Coordination): Joint Action Management Plan</b> <i>George Karidas (6th DYPEDE, Greece)</i> <b>Partners presentations:</b> Each partner will present in 3 slides their institute/research team
12:30-13:00	<b>WP2 (Dissemination): Communication and dissemination plan</b> <i>George Karidas (6th DYPEDE, Greece)</i>
13:00-14:00	<b>Lunch</b>
14:00-16:00	<b>Visit to Acropolis museum (offered by DYPEDE)</b>
	<b>Session 2: Starting to be operative (I)</b> <i>Chairs: Angela Giusti (ISS Italy), Rosana Peiro Pérez (Fisabio, Spain), Heli Kuusipalo (THL Finland)</i>
16:45-17:15	<b>WP3 (Evaluation): Monitoring and Evaluation framework</b> <i>Lead: Péter Csizmadia (NNK, Hungary)</i>
17:15-17:30	<b>WP4: Sustainability (overview)</b> <i>Lead: Angela Giusti, Chiara Cattaneo (ISS, Italy)</i>
17:30-17:45	<b>WP5: Grünau Moves (overview)</b> <i>Lead: Rosana Peiro Pérez (FISABIO, Spain)</i>
18:00-18:15	<b>WP6: Smart life (overview)</b> <i>Lead: Heli Kuusipalo (THL Finland)</i>
18:15-18.30	<b>Final considerations of 1<sup>st</sup> day</b> <i>Apostolos Vantarakis, University of Patras, Greece</i>
21.00	<b>Official dinner (offered by DYPEDE)</b>
Thursday 9, February from 08:30 a.m. to 17:00 p.m.	
	<b>Session 3: Starting to be operative (Part II)</b> <i>Chairs: Péter Csizmadia (NNK, Hungary)</i>
08:30-10.30	<b>WP6: All partners working on Smart life</b> <i>Lead: THL, 120-minute teamwork</i>
10:30-11:00	<b>Coffee break</b>
11.00-13.00	<b>WP5: All partners working on Grünau moves</b> <i>Lead: Fisabio, 120-minute teamwork</i>
13:00-14:00	<b>Lunch</b>
14.00-16.00	<b>WP4: All partners working on Sustainability</b> <i>Lead: ISS, 90-minute teamwork</i>
16:00-17:00	<b>Final remarks</b> <i>Apostolos Vantarakis, University of Patras (Greece)</i>

Zoom link: <https://upatras-gr.zoom.us/j/93029921226?pwd=RmgvYVB1aUZ2cUhPaDJJcnpJWm9lQT09>

Meeting ID: 930 2992 1226 Passcode: 309575

## **A2 SWOT 2: Pre-implementation (Realities)**

[Santiago de Compostela], [5<sup>th</sup> and 6<sup>th</sup> October 2023]

FISABIO  
Àrea de Gestió i Promoció Científica

# **SWOT Analysis – WP5 project partners**

**WP 5 Grunau Moves**

**WP5 in-person meeting Santiago de Compostela,  
Galicia (Spain), October 5-6, 2023**

## Authors

Marta Garcia-Sierra (FISABIO)  
Rosana Peiró (FISABIO)  
Ana Boned (FISABIO)  
Joan Quiles (FISABIO)

## Contributors

WP5 Project Partners and Affiliated Entities

### **Disclaimer:**

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## Meeting Information

### Session name & time:

11:30-13:30 | Session 4: Planning the SWOT Analysis

**Date and Time:** 6 October, 2023

**Location:** Santiago de Compostela, Galicia, Spain

### In-person meeting (venue):

Conselleria de Sanidade, Rúa de Ceuta, s/n, 15703 Santiago de Compostela, A Coruña  
Edificio Administrativo San Lázaro s/n  
15703 Santiago de Compostela

### Streaming:

Link to the 5th of October meeting

<https://call.lifesizecloud.com/19457009>

Access code: 3245#

Link to the 6th of October meeting

<https://call.lifesizecloud.com/19457033>

Access code: 90545#

### **Attendees:**

In-person attendees: Germán Molina Romera (Conselleria de Sanidade, Galicia), Alba Regueira Castro (Conselleria de Sanidade, Galicia), Xerman Bugallo Sanz (Conselleria de Sanidade, Galicia), Uxía Rodríguez Lavandeira (Conselleria de Sanidade, Galicia), Carolina Muñoz Ibáñez (Conselleria de Sanidade, Galicia), Silvia Suárez Luque (Conselleria de Sanidade, Galicia), Iria Martínez Costas (Conselleria de Sanidade, Galicia), Marta Pérez Álvarez (Conselleria de Sanidade, Galicia), María Elena López González (Xefatura Pontevedra, Galicia), Natalia Botana Rey (Xefatura Pontevedra), Raquel Plana Pinto (Concello de Pontearreas, Galicia), Luz Iranzo Pérez (Fisabio & CSP-Alzira, Valencia), Rosa María Casalilla Chica (IDIVAL, Cantabria), Paloma Lanza León (IDIVAL, Cantabria), Jessie van Kerckhove (Sciensano, Belgium), Cintia Sancanuto (Fisabio & CSP-Valencia, Valencia), Trinidad Planas (IDISBA, Baleares), Peter Csizmadia (NCPHP, Hungary), Marta Garcia-Sierra (Fisabio, Valencia), Inés Urieta Guijarro (DSPV, Basque Country), Amaia Mentxaka Etxebarria (DSPV, Basque Country), Kyriaki Premtou (6th Health ADM, Greece), Lamprini Lachanioti (6th Health ADM, Greece), Maria Brouma (UPAT, Greece), Catalina Núñez Jniménez (IDISBA, Baleares), Rosana Peiró Pérez (Fisabio, Valencia), Stefanie Vandevijvere (Sciensano, Belgium).

On-line attendees: Eleni Papachatzi (UPAT, Greece) ([elepapach@upatras.gr](mailto:elepapach@upatras.gr)), Ana Boned-Ombuena (Fisabio, Valencia) ([boned\\_ana@gva.es](mailto:boned_ana@gva.es)), Guadalupe Longo Abril (SAS, Andalusia) ([guadalupe.longo@juntadeandalucia.es](mailto:guadalupe.longo@juntadeandalucia.es)), Pablo García Cubillana (SAS, Andalusia) ([pablo.garcia-cubillana.sspa@juntadeandalucia.es](mailto:pablo.garcia-cubillana.sspa@juntadeandalucia.es)), Rafael Rodríguez Acuña (SAS, Andalusia) ([rafael.rodriguez.acuna@juntadeandalucia.es](mailto:rafael.rodriguez.acuna@juntadeandalucia.es)), Jaime Jiménez Pernet (EASP, Andalusia) ([jaime.jimenez.easp@juntadeandalucia.es](mailto:jaime.jimenez.easp@juntadeandalucia.es)), Amparo Lupianez (EASP, Andalusia) ([amparo.lupianez.easp@juntadeandalucia.es](mailto:amparo.lupianez.easp@juntadeandalucia.es)), Zsófia Kimmel ([kimmel.zsofia@nnk.gov.hu](mailto:kimmel.zsofia@nnk.gov.hu)) (NCPHP, Hungary), Vittorio Palermo (ISS, Italy) ([vittorio.palermo@iss.it](mailto:vittorio.palermo@iss.it)).

## Methodology

SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) is a strategic planning tool used to assess the project's internal and external factors that facilitate or hamper the implementation and context-adaptation of the best practice (BP) being transferred to a new setting. The primary aim of strategic planning, with SWOT analysis as an initial step, is to create and implement a strategy that effectively incorporates internal and external factors. SWOT analysis also proves useful when unexpected strategic options emerge, requiring a re-evaluation of the decision-making context.

Within the scope of WP5 on the transferring and pilot implementation of the BP Grünau Moves (Germany), several outputs are planned involving the performance of SWOT analysis, namely:

- **D5.2 – SWOT analysis of Grünau moves (due in M33 – Aug. 2025).** Description: Report on the main opportunities, weaknesses and strengths and threats in the implementation process, including a description of the availability and limitations of data of the obesogenic context, obesity and overweight other and other key data. Means of Verification/Type: R – Document, report / PU – Public.
- **Objective of the SWOT Analysis:** to derive insights and lessons learnt from practice in correspondence with the main aim of Joint Actions (JA). “Joint Actions” are aimed at analysing how best practices can be adapted to context-specific conditions (i.e., transferability).

When preparing D5.2 and maximizing the benefits of applying SWOT analysis, several decisions were made, including:

- Each project partner would conduct the analysis for their pilot setting.
- A common space would be created to share results and reflect on commonalities and specificities.
- The analysis would follow a three-stage calendar: initial (with the Core Group and Health Network), during implementation (with stakeholders such as schools, PHC, youth associations, sports clubs, traders' associations, local police), and final (with the Core Group and Health Network).

These decisions were confirmed during the WP5 in-person meeting in Santiago de Compostela, October 5–6, 2023. In this context, and as part of Session 4 – SWOT Analysis. Preparing for “D5.2 – SWOT analysis of Grünau Moves (M33 – Aug. 2025)”, WP5 partners conducted their SWOT analysis as relevant stakeholders for transferring and adapting the best practice in their territories. Online participants completed the task using the tool available at <https://dafo.ipyme.org/Home>. The following sections present the results.

## Results

Here is presented the matrix of SWOT factors highlighted by WP5 project partners regarding the pilot implementation and context-adaptation of BP Grünau Moves to their territories and public administrations.

	<b>Helpful</b>	<b>Harmful</b>
<b>Internal</b>	<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• [WP5] Team commitment</li> <li>• [WP5] Multidisciplinary team</li> <li>• [WP5] Flexibility and acceptability</li> <li>• [WP5] Previous experience in JA</li> <li>• [WP5] Excellent communication and relations</li> <li>• [WP5] Training pills taught by social experts and online tools provided</li> <li>• [WP5] Shared understanding</li>   <li>• [PILOT] Political will and capacity to intervene at the local scale</li> <li>• [PILOT] Children are a good gateway to families</li> <li>• [PILOT] Schools as stakeholders have great interest</li> <li>• [PILOT] Ongoing projects by local NGOs, etc.)</li> <li>• [PILOT] Social fabric and networks</li> <li>• [PILOT] Community project in progress</li> <li>• [PILOT] New regulations on healthy food at the schools</li> <li>• [PILOT] In certain countries, the local government has the competencies on authorising new food outlets</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• [WP5] Tight deadlines</li> <li>• [WP5] Lack of Evaluation Plan (D3.1)</li> <li>• [WP5] Distance between partners (remote)</li> <li>• [WP5] Few meetings (increase frequency)</li> <li>• [WP5] Limited diversity of professional profiles in the team</li>   <li>• [PILOT] Engage families (focus on 'caregivers')</li> <li>• [PILOT] Lack of trust and lack of participation culture</li> <li>• [PILOT] Lack of basic services</li> <li>• [PILOT] Food desert, food swamps</li> <li>• [PILOT] Geographic isolation</li> <li>• [PILOT] Obesity not a priority for them</li> <li>• [PILOT] Food prices, low incomes</li> <li>• [PILOT] Lack of jurisdiction at the local level</li> <li>• [PILOT] Lack of time to approach the project</li> <li>• [PILOT] Lack of capability to transfer the information to our team</li> <li>• [PILOT] Few resources in the project</li> <li>• [PILOT] Too little time in advance to understand plan + project too short</li> <li>• [PILOT] Extraction of obesity data</li> <li>• [PILOT] We are too scientific which complicates communication to stakeholders</li> <li>• [PILOT] Methodology still unknown</li> <li>• [PILOT] Indicators and difficulties to establish comparisons</li> <li>• [PILOT] The difficulty of extrapolating some practices</li> </ul>

<b>External</b>	<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• European funding</li> <li>• Pre-existent participatory structures at the local level (internal?)</li> <li>• Previous scientific evidence, literature, and data on obesity</li> <li>• Having Grünau Moves best practice to rely on</li> <li>• Political will at local, regional, and national levels</li> <li>• Awareness of stakeholders (local government, schools, paediatricians) and awareness campaigns that are already being done</li> <li>• Searching for alliances with key stakeholders like Fundación Pau Gasol or Fundación Rafa Nadal</li> <li>• Famous cooks in the region organise activities (e.g. school orchards)</li> <li>• Mediterranean and Atlantic diets</li> <li>• Several natural resources like parks and open-air spaces at schools</li> <li>• Data from the public health system</li> <li>• Universal health system</li> <li>• Weekly markets for groceries</li> <li>• Tournaments, hiking groups, healthy routes</li> <li>• Body image and sports trends</li> <li>• Social media and imitation behaviours</li> <li>• Bike lanes and routes and walking paths</li> <li>• Involvement of diverse organisations</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Absence of political will</li> <li>• Unsustainable interventions</li> <li>• Reaching vulnerable groups</li> <li>• Food prices, inflation, and cost of living crisis</li> <li>• Preservation of perishable food items (fresh foods) can be challenging</li> <li>• Economic interests prevail</li> <li>• Low investment in school meals</li> <li>• Effectiveness of interventions (data, indicators, measuring, literature)</li> <li>• Low participation of parents and children</li> <li>• Commercial determinants of food(ing)</li> <li>• Unethical commercial strategies using paediatric association names: 'Industrial Epidemic'</li> <li>• Unawareness of the community perspective of the problem by paediatricians, PHC professionals.</li> <li>• Few connections between GPs and the community</li> <li>• Socio-economic determinants</li> <li>• Willpower &amp; the 'American-dream culture'</li> <li>• Maintenance of inequity and poverty</li> <li>• Lack of visibility of the problem from community perspective (DSS)</li> <li>• Few knowledge of mass media (IG influencers, tiktokers, ...) promotion of healthy alternatives</li> <li>• Myths: 'eating healthy is expensive', 'fat babies are normal', 'exercising takes much time'</li> <li>• Lack of awareness of the project in the community</li> <li>• Pressure from multinational food companies</li> <li>• Influence of (recent) political changes</li> <li>• Multicultural and segregated population groups (language barriers, religion, ethnicity, racism...)</li> <li>• Not long-term view in planning</li> </ul>
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## Concluding Remarks & Takeaway Messages

### Strengths (Internal, Helpful)

- **WP5 Team Factors:** Strong commitment, multidisciplinary skills, flexibility, prior experience in Joint Actions, excellent communication, and shared understanding. Training resources (e.g., online tools, expert-led sessions) strengthened collaboration despite distance.
- **Contextual Factors (at pilot level):** Political will at the local level, schools and children acting as gateways to families, and active local NGOs and networks. Existing regulations (e.g., healthier school food policies) and community projects provided fertile ground for intervention.

**Takeaway:** Both team-level and community-level assets created a supportive base for implementation, especially through political engagement, schools, and NGOs.

### Weaknesses (Internal, Harmful)

- **WP5 Team Factors:** Tight deadlines, lack of a formal evaluation plan, limited diversity in professional profiles, few meetings, and distance between partners.
- **Contextual Factors (at pilot level):** Difficulties engaging families and caregivers, low participation culture, lack of trust, insufficient basic services, food deserts/swamps, low incomes, and obesity not being a perceived priority. Barriers also included limited jurisdiction at local level, scarce resources, difficulty communicating complex/scientific content, short project duration, and gaps in obesity data and indicators.

**Takeaway:** Weaknesses highlighted structural barriers (poverty, food environments, service gaps), alongside process challenges (data collection, evaluation, scientific communication, short timelines).

### Opportunities (External, Helpful)

- **Structural Opportunities:** European funding, supportive political frameworks at multiple levels, and universal health system infrastructure.
- **Community Assets:** Existing participatory structures, social networks, and health awareness campaigns. Schools, paediatricians, NGOs, and even celebrity chefs or foundations offered collaboration potential.
- **Environmental & Cultural Factors:** Access to Mediterranean/Atlantic diets, natural resources (parks, bike lanes), markets, and cultural trends around body image, sports, and social media.

**Takeaway:** A rich ecosystem of potential allies, cultural assets, and natural resources could be mobilised to strengthen interventions.

## Threats (External, Harmful)

- **Structural Threats:** Inflation, cost of living crisis, low investment in school meals, and broader socio-economic inequalities.
- **Behavioural & Cultural Threats:** Myths about healthy lifestyles (e.g., “healthy eating is expensive”), low awareness in the community, limited parental engagement, and competing cultural attitudes (e.g., “fat babies are normal”).
- **Systemic Threats:** Commercial determinants of health, unethical marketing by food industry, weak community connections among health professionals, and lack of long-term planning.
- **Contextual Threats:** Political instability, multicultural and segregated populations with language/religion barriers, and lack of visibility for obesity as a public health problem.

**Takeaway:** External threats were significant and multifaceted, spanning economic, cultural, systemic, and political domains, with particular challenges in reaching vulnerable groups.

## Overall Insight

This SWOT exercise showed that while the project benefitted from strong internal cohesion and a supportive local ecosystem (schools, NGOs, political will), its implementation was challenged by deep structural weaknesses (poverty, food deserts, low trust) and powerful external threats (economic crisis, commercial determinants, socio-cultural myths). Opportunities were abundant but required sustained engagement and adaptation to local realities.



# Health4EUKids – WP5 In-person Meeting

5-6 October 2023, Santiago de Compostela, Spain



HEALTH 4 EU kids  
Your Kids' Health, Our Priority

Thursday 5 October, from 12:00 p.m. to 17:40 p.m.	
12:00-13:00	Registration and welcome appetizer at Conselleria de Sanidade
	<b>Session 1: WP5 overview – Current status and upcoming steps</b> <i>Chairs: Rosana Peiró, Fisabio &amp; General Directorate of Public Health, Valencia, Spain</i>
13:00-13:10	<b>Welcome on behalf of the General Directorate of Public Health, Generalitat Valenciana, Spain &amp; General Directorate of Public Health, Consellería de Sanidade, Galicia, Spain</b>
13:10-13:20	<b>Presentation of the Plan Obesidade Zero en Galicia</b> <i>Carolina Muñoz Ibáñez, Xefa de Servizo de Estilos de Vida Saudables e Educación para a Saúde, D.X. De Saúde Pública, Consellería de Sanidade, Galicia, Spain</i>
13:20-13:40	<b>WP5 current status and agenda for achieving our objectives</b> <i>Rosana Peiró, Fisabio &amp; General Directorate of Public Health, Valencia, Spain</i> <i>García-Sierra, Marta, Fisabio, Valencia, Spain</i>
13:40-14:00	<b>Preparing for D5.1 Implementation guide (due in M13)</b> <i>Rosana Peiró, Fisabio &amp; General Directorate of Public Health, Valencia, Spain</i> <i>García-Sierra, Marta, Fisabio, Valencia, Spain</i>
	<b>Session 2: Presentation of case studies</b> <i>Chairs: Rosana Peiró (Fisabio &amp; GDPH Valencia, Spain), Marta Garcia-Sierra (Fisabio, Spain)</i>
14:00-15:00	<b>Presentation of case studies (I)</b> <i>All partners working on Grunau moves</i> <i>Lead: Fisabio, 60-minute presentation (3 case studies)</i>
15:00-15:30	<b>Coffee Break</b>
15:30-17:40	<b>Presentation of case studies (II)</b> <i>All partners working on Grunau moves</i> <i>Lead: Fisabio, 130-minute presentation (8 case studies)</i>
18:15-20:00	<b>Cultural Visit (Cathedral of Santiago de Compostela_Museum. Decks and Carraca's Tower)</b> <i>(offered by Consellería de Sanidade de Galicia)</i>
21:00	<b>Dinner at local restaurant</b>
Friday 6 October, from 09:00 a.m. to 17:30 p.m.	
	<b>Session 3: Monitoring and evaluating the case study interventions</b> <i>Chairs: Rosana Peiró (Fisabio &amp; GDPH Valencia, Spain), Marta Garcia-Sierra (Fisabio, Spain)</i>
09:00-11:00	<b>Monitoring and evaluating the interventions</b> <i>All partners working on Grunau moves</i> <i>Lead: Fisabio &amp; Ulrike Igel, 120-minute teamwork</i>
11:00-11:30	<b>Coffee Break</b>
	<b>Session 4: Planning the SWOT Analysis</b> <i>Chairs: Rosana Peiró (Fisabio &amp; GDPH Valencia, Spain), Marta Garcia-Sierra (Fisabio, Spain), Zsofia Kimmel (NNGYK, Hungary), Peter Csizmadia (NNGYK, Hungary)</i>
11:30-13:30	<b>SWOT Analysis</b> <i>All partners working on Grunau moves</i> <i>Lead: Fisabio &amp; NNGYK, 120-minute teamwork</i>
13:30-14:30	<b>Lunch Break</b>
	<b>Session 5: Living Healthy tool – Pilot experiences</b> <i>Chairs: Rosana Peiró (Fisabio &amp; GDPH Valencia, Spain), Marta Garcia-Sierra (Fisabio, Spain)</i>
14:30-16:00	<b>Living Healthy tool – Pilot experiences</b> <i>All partners working on Grunau moves</i> <i>Lead: Fisabio, 120-minute teamwork</i>
16:00-16:30	<b>Coffee Break</b>
16:30-17:30	<b>Final Remarks</b> <i>Rosana Peiró, Fisabio &amp; General Directorate of Public Health, Valencia, Spain</i>

Zoom link:  
Meeting ID:  
Passcode:

