Ref. Ares(2026)4593713 - 05/05/2026

HEALTH 4 EU kids

Your Kids' Health, Our Priority

Deliverable 6.2 Overview/applicative situation analyses of the implementation of Smart family

HEALTH4EUKids

Co-funded by the European Union

HaDEA Health and Digital Executive Agency

Project Acronym	HEALTH4EUKids
Dissemination Level	PU - Public
Nature of Document	D6.2 Report
Title of Document	R-Report
Reference Number	D6.2
Work Package	WP6
Version	
Expected Delivery Date	30/11/2024
Date	10/10/2025
Partner Responsible	**THL**
Authors (Name & Organization)	THL: Kuusipalo Heli, Koivurinta Emma, Mäki Päivi, Savolainen Nella Finnish Heart Association: Kati Kuisma, Taina Sainio

Executive Summary

EU Joint Action Health4EUkids aims to promote child health and prevent non-communicable diseases by strengthening healthy lifestyles among children and school-aged youth. Its focus is on preventing obesity by supporting physical activity and healthy eating within families and communities. Within this initiative, Work Package (WP) 6 is responsible for implementing the Smart Family (Neuvokas Perhe) lifestyle counselling method, developed in Finland, in six participating European Member States (MS); Croatia, Greece, Lithuania, Poland, Slovenia, and the Balearic Islands in Spain. The implementation is carried out through a structured knowledge-transfer process between the best practice Smart Family owners (Finnish Heart Association) and MS's, supported by coordinated activities, peer learning, joint meetings and ongoing technical assistance.

The general objective of WP6 is to support Member States in developing a sustainable, context-adapted lifestyle counselling system that aligns with national policy requirements. Its specific objective is to transfer the Smart Family best practice to professionals working with families in various settings, as well as directly to families in the participating countries.

This D6.2 deliverable report describes the implementation of the co-creative transfer training based on Smart Family modules in the six Member States during project months M12-M35. Cross-country implementation experiences indicate that the Smart Family method can be applied across diverse national contexts when a shared professional counselling approach is preserved.

Document History

Version	Date	Changes/Approval	Authors
V0.1	10/10/2025		
V0.2	30/03/2026	Revised according to the comments from the EU officer	Päivi Mäki, Kati Kuisma, Heli Kuusipalo

File Name:

This project has received funding from the European Union's ***EU4HEALTH*** *Programme under Grant Agreement no.* ***101082462***

Disclaimer:

Funded by the European Union.
This publication reflects only the author's view. It does not represent the view of the European Commission and the European Commission is not responsible for any use that may be made of the information it contains.

Table of Contents D6.2

1. Introduction **4**
2. Methodology **5**
2.1 Description of WP6 Tasks (T6.1–T6.4) 5
2.2 Implementation Strategy and Phased Approach 6
3. Applicative Situation Analyses **7**
3.1 Pre-Implementation Phases Analysis 7
3.2 Implementation Phase Analysis 12
3.3 Post-Implementation Phase Analysis 14
4. Implementation across the participating countries in diverse contexts **14**
4.1 Croatia 14
4.2 Greece 16
4.3 Lithuania 19
4.4 Poland 22
4.5 Slovenia 25
4.6 Spain (Balearic Islands) 28
5. Cross-Country Analysis **32**
5.1 Core components that must remain stable 32
5.2 Adaptable components and contextual modifications 32
5.3 Contextual enablers, barriers and implementation trade-offs 33
5.4 What works, for whom, and in which contexts 33
5.5 Implications for scaling and replication 34
6. Lessons Learned for Transferability and Scalability **35**

1. Introduction

According to the Grant Agreement, the general objective of WP6 is to support Member States (MS) in developing a lifestyle counselling system for childhood obesity that is adapted to national contexts, aligned with policy requirements, and sustainable over time. The main objective of this Work Package is to transfer the Smart Family best practice to professionals working with families in various settings, as well as directly to families in the participating MSs. The Smart Family method provides both professionals and families with practical information, guidance, and ready-to-use materials that promote healthy lifestyle habits. Professionals can integrate the method into their lifestyle counselling by offering tailored advice, motivation and support to families who are interested in making positive changes in their everyday routines.

The objective of this Deliverable 6.2 report (Overview/applicative situation analyses of the implementation of Smart Family) is to provide a comprehensive and structured situation analysis of how six European countries, Croatia, Greece, Lithuania, Poland, Slovenia, and the Balearic Islands in Spain, planned, prepared, and implemented the Finnish Smart Family method within the framework of WP6 during the period M12–M35.

More specifically, the report aims to:

- Describe the national implementation processes in each participating country, including the pre-implementation, implementation, and post-implementation phases, expanding on the plans presented in D6.1.
- Analyse the applicability of the Smart Family method in different health, education, and community settings across Member States.
- Identify contextual facilitators and barriers influencing local implementation activities, including organisational structures, professional practices, and available resources.
- Assess the extent to which the implementation actions were aligned with the WP6 objectives, including capacity-building, adaptation of tools, professional training, monitoring, and evaluation.
- Provide comparative insights to support the transferability and scalability of the Smart Family method across Europe.

In addition, this deliverable consolidates information gathered from national implementation teams through structured questionnaires, monitoring templates, qualitative feedback, and stakeholder reflections. The analysis therefore includes both quantitative summaries and qualitative insights into the real-world application of the Smart Family method . The findings presented here form an essential step between the planning phase reported in D6.1 and the framework for harmonised actions in D6.3.

To support these objectives, the implementation of Smart Family within WP6 follows a structured task framework (T6.1–T6.4), covering the preparatory work, implementation planning, capacity-building and evaluation for sustainability. These tasks form the operational basis for the national processes described in this report and build directly on the

preparatory analyses and plans already presented in Deliverable D6.1, where the pre-implementation phase was outlined in detail. A concise overview of the WP6 tasks and the phased implementation strategy is provided in the Methodology section (Chapters 2.1 and 2.2), which summarizes the sequence of actions guiding countries from initial planning toward long-term integration of the Smart Family method .

Timeline and scope clarification
According to the Grant Agreement, Deliverable D6.2 was originally scheduled for submission at M24. However, the deliverable was submitted at M35 (10 October 2025), together with a formal justification for the delay. As a result of this revised timeline, the report covers implementation activities up to M35, providing a more complete and up-to-date depiction of the implementation process than originally foreseen.

2. Methodology

2.1 Description of WP6 Tasks (T6.1–T6.4)

This chapter outlines the structure, purpose and operational workflow of WP6, which guides the preparatory, implementation, capacity-building and evaluation activities of the Smart Family best practice across participating MS. The WP6 task framework ensures that each country follows a coherent, phased and adaptable process for selecting, preparing and implementing modules, building capacity among professionals, and ensuring long-term sustainability.

Task 6.1 Preparatory Phase
The preparatory phase establishes the foundations for implementation by introducing the Smart Family ideology, supporting MS-level decision-making, and setting up collaboration structures.

Sub-task 6.1.1 Introduction of Smart Family ideology and contextual planning
Sub-task 6.1.2 Establishing a coordinated collaboration platform.

Task 6.2 Implementation Plan for Smart Family
This task involves the creation of a structured implementation plan, ensuring that operational responsibilities, timelines, training formats and evaluation principles are defined in advance.

Sub-task 6.2.1 Activity planning and multidisciplinary structures
Sub-task 6.2.2 Recruitment of target agents and definition of key performance indicators
Sub-task 6.2.3 Selection of evaluation criteria

Task 6.3 Capacity-Building Oriented Implementation
This task focuses on strengthening the skills, awareness and motivation of agents involved in implementing the Smart Family modules.

Sub-task 6.3.1 Training of trainers
Sub-task 6.3.2 Transnational awareness-raising campaign
Sub-task 6.3.3 Participant recruitment
Sub-task 6.3.4 Practical implementation of modules
Sub-task 6.3.5 Continuous monitoring and corrective actions

Task 6.4 Evaluation and Sustainability
This task ensures that Smart Family modules become embedded in long-term structures and professional practices within participating countries.

Sub-task 6.4.1 Pathways towards continuous counselling
Sub-task 6.4.2 Collaboration with other WPs
Sub-task 6.4.3 Empowerment of agents and networks
Sub-task 6.4.4 Alignment with other initiatives and networks

2.2 Implementation Strategy and Phased Approach

To support the transfer and implementation of the Smart Family method across six participating MS, an adapted implementation strategy was applied. The strategy is based on the model originally developed within the JA CHRODIS-PLUS and was tailored for the JA Health4EUKIDS WP6 context. It is structured into three phases and defines clear responsibilities for national implementers as well as for JA WP6 leaders, who oversee and guide the implementation process (Figure 1).

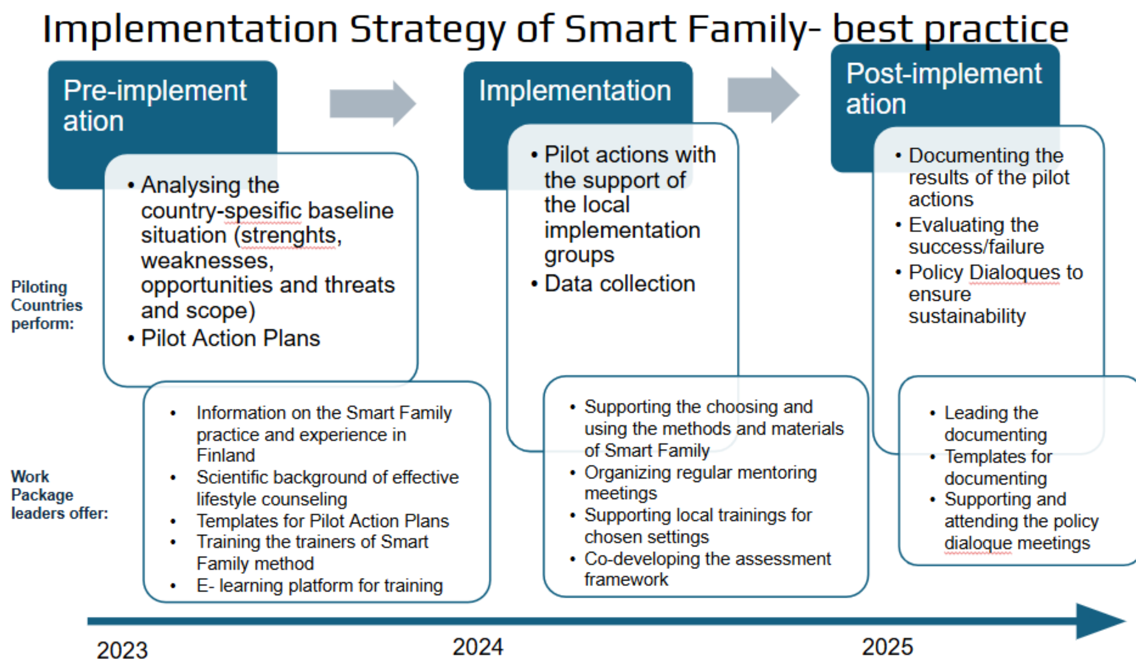

Figure 1. Implementation strategy of Smart Family in Health4EUKIDS

3.Applicative Situation Analyses

3.1 Pre-Implementation Phases Analysis

During the pre-implementation phase, each MS conducted a baseline assessment to determine the scope of their planned activities and to analyse contextual factors influencing the adoption of the Smart Family method. This work included a SWOT analysis to identify strengths, weaknesses, opportunities and threats relevant to implementation within each national setting (Table 1.

A more detailed description of the pre-implementation phase is provided in Deliverable 6.1.The SCOPE and SWOT analyses of the Member States can be found in the Google Drive: .https://drive.google.com/drive/folders/1dRpQ91ZplIGBkU0v9JNZEyWkMr-b_WL3

Table 1. SWOT Analysis of Smart Family Implementation Across Six Countries

Country	Strengths	Weaknesses	Opportunities	Threats
Croatia	Experience from previous Joint Actions; National “Healthy Living” programme; existing materials and HR resources; multidisciplinary team	Communication gaps; slow curriculum changes; staff shortages; difficulty engaging parents	Use of social media; non-invasive approach; education of young professionals	Family economic pressure; socio-economic access differences; risk of low perseverance
Greece	Strong national coordination structures; wide health network; authority to propose and monitor policies	Low cooperation from experts; lack of obesity data; regional disparities	Large-scale implementation potential; strong administrative channels; access to datasets; skilled personnel	Uneven regional implementation; poor data; lack of sustainability; competing health priorities
Lithuania	Public health specialists in schools; strong core team; real-time child health statistics; direct family contact	Limited autonomy; incomplete documentation; qualification challenges	Municipal support; digital systems; experience in prevention; direct engagement	Low family motivation; rising costs; barriers to sports; limited parental time
Poland	Motivated core team; Smart Family in education for students; validated materials; multidisciplinary approach	Reluctance in public health centers’ units and schools; parent/teacher overstimulation; dependence on family engagement	High public interest post-COVID; growing family-based prevention focus	Inflation impact; unstable cooperation; resistance to lifestyle change
Slovenia	Strong prevention system; national ZDAJ.net (https://zdaj.net/) platform; mental health screening; high trust in nurses	Understaffing; limited time; low awareness of ZDAJ.net; socioeconomic inequalities	Integration of Smart Family tools; early childhood focus; stigma reduction; stakeholder collaboration	Overworked staff; funding uncertainty; complexity of obesity
Spain (Balearic Islands)	Motivated team; strong nurse mobilisation; favourable outdoor environment; extensive health education work	Primary care challenges; low motivation; limited autonomy; sceptical paediatricians	Supportive health system leadership; community health strategy; Health Promoting Schools; EINASALUT platform	Political changes; rising healthy food prices; waiting lists; economic barriers for sports

Based on the SCOPE and SWOT analyses, all participating countries prepared pilot action plans using a common template. These plans, presented in Deliverable D6.1, outlined each country's key improvement areas, specific objectives and corresponding actions ("change packages") together with the intended key performance indicators. The plans served as the strategic framework for the implementation phase.

The selected actions were planned for implementation across a wide range of settings that each country identified during the pre-implementation phase, based on their contextual analyses, country-specific needs and the existing national structures for family-focused lifestyle counselling. These settings included healthcare services, maternity clinics, schools and daycare centres. A summary of the implementation settings, target groups, improvement areas and change packages for each country is presented in Table 2. These contextual differences illustrate how the Smart Family method was planned to adapt to varying organisational structures and national contexts while still maintaining the core principles of the method.

Table 2. Summary of Smart Family Pilot in six European Countries

Country	Implementation Setting	Target Group	Improvement Areas	Change Packages
Croatia	Kindergarten	Kindergarten nurses, professionals, and parents of children aged 1–7	1) Raise awareness of the importance of early adoption of healthy lifestyles for lifelong health and introduction to the Smart Family approach. 2) Empower children's and family's lifestyles and health literacy 3) Empower kindergarten and public health institute's nurses/staff's counselling skills	1) Organize a one-day lecture for kindergarten and county public health institute staff/nurses. 2) Use the national public health initiative The Week of Health in Kindergartens to introduce Smart Family activities. 3) Organize a workshop to introduce the Smart Family Card and its use in everyday counselling. Conduct follow-up and final evaluation of Smart Family implementation in Croatia.

Greece	Primary healthcare	Pregnant women (onsite in Patras and online nationwide); healthcare professionals	1) Increase incidence of exclusive breastfeeding from the first hour of birth by 20% among all pregnant women that delivered a healthy neonate. 2) Recruit and train health care professionals that work with children on Smart Family Methodology 3) Improve family lifestyle behaviour (dietary intake, sleep & physical activity)	1) Provide information based on WHO recommendations on infant feeding during the third follow-up. Apply the Smart Family counselling approach throughout, focusing on maternal responses to breastfeeding perception, barriers and benefits, Follow infant feeding intentions with questionnaires. 2) Recruit healthcare practitioners from Patras (6th Health ADM Region). Deliver two interactive training sessions (2 × 2 hours) emphasizing positive feedback and strength-based counselling and motivation and skill-building over treatment-based approaches. 3) Provide Smart Family materials on healthy snacking and serving sizes.Use visual materials (pictures, videos) showing meal and portion comparisons. Emphasize the Mediterranean diet and the importance of pulses and vegetables. Offer examples of child-friendly meal adaptations and balanced meal plans. Define and reduce non-productive screen time, replacing it with movement and active play. Publish an online, child-friendly book illustrating healthy daily routines.

Lithuania	School healthcare in Kaunas City	20–30 families with children aged 7–11; professionals working with them	1) Health literacy and knowledge about their lifestyle, nutrition, physical activity and stress management increased more than 15 percent after the intervention. 2) Physical activity increased more than 20 percent. BMI reduced. 3) Health-friendly nutrition education for the family and improvement of nutrition-related knowledge. 4) Parenting skills and stress management for families	1) Conduct pre- and post-intervention surveys on health behaviours. Provide nutritionist consultations, monthly family meetings for one year, psychological support, ongoing guidance and motivation from a case manager and relaxation and sleep hygiene lessons. Distribute all Smart Family materials from the Finnish team to families. 2) Offer twice-weekly family physical activity sessions for one year. Measure BMI before and after the project. Provide theoretical information on family exercise options. Use Smart Family materials from Finland. 3) Conduct practical cooking workshops with a chef. Provide nutritionist consultations. Conduct pre- and post-intervention nutrition surveys. Use Smart Family nutrition materials from Finland. 4) Offer psychologist consultations and relaxation/body image sessions for families and children. Use all relevant Smart Family materials from Finland.
Poland	Primary schools	Primary school pupils aged 6–12, their families, and	1) Train nursing and dietetics students to increase knowledge of overweight risk factors and	1) Prepare educational materials and training scripts.Train 100 first-level nursing students

		health/education professionals	enhance motivation and counselling skills for family lifestyle change. 2) Develop educational resources and methods to support lifestyle change in primary healthcare (PHC).	and 100 dietetics students. 2) Develop a repository of teaching materials for PHC teams. Prepare recommendations for training content and methods for nurses.Create e-learning training for PHC teams.Develop an online platform for families and educators with accessible materials.
Slovenia	Primary healthcare	Community nurses and parents	1) Train community nurses to use the Smart Family approach for lifestyle counselling during home visits in pregnancy, the perinatal period, and in the 2nd and 3rd year of the child's life. 2) Provide parents with information and tools to support lifestyle reflection and improvement.	1) Conduct six meetings with motivated community nurses from different regions: three online sessions (first half of the year) covering Smart Family ideology, behaviour change models, and tools.Two autumn workshops on motivational interviewing and strength-based approaches. A final focus group meeting for experience-sharing. Provide access to an e-platform with Smart Family presentations and materials. 2) Translate Smart Family articles on various topics for publication on the national parent website. Translate and upload Smart Family self-reflection tools to the same platform.
Spain (Balearic Islands)	Primary healthcare	Primary healthcare professionals and population of Evissa	1) Train a group of Primary Health Care professionals in the Smart Family model.	1) Complete Smart Family online training. Review all Smart Family materials and tools. Address questions with

			2) Design an intervention for the prevention and treatment of childhood overweight and obesity in Primary Health Care based on the Smart Family model, from the perspective of the social determinants of health. 3) Pilot the intervention for the treatment of childhood overweight and obesity in Primary Health Care.	the Finnish team. Agree on essential model elements and relevant materials for PHC use. Review existing local resources (EinaSalut). 2) Translate and adapt Smart Family materials to Spanish and Catalan, aligned with the Mediterranean diet. Integrate local elements (EinaSalut). Assess local assets for promoting healthy lifestyles in three participating health centres. Develop a comprehensive program document for prevention and treatment. Review and validate the program with the Smart Family team. 3) Design a data collection notebook. Identify participating families in paediatric offices. Conduct Smart Family interventions with families. Collect and review data periodically. Finalize the program based on pilot results.

To support shared monitoring across countries, the teams agreed to use a common process indicator focusing on professionals' motivation and perceived competence. For this purpose, an adapted Likert-scale version of the Encouraging Professional self-assessment tool was applied. The tool itself is derived from the validated Health Care Climate Questionnaire and provides a structured means for comparing baseline motivation levels between settings and tracking changes during implementation.

3.2 Implementation Phase Analysis

During the implementation phase, each country further refined their action plans developed during pre-implementation. This included clarifying the specific objectives, target groups and expected outcomes for each selected action. Based on these refined plans, the countries prepared detailed implementation schedules and step-by-step work plans outlining the tasks, responsibilities, required resources and anticipated milestones.

To support the practical roll-out of the selected actions, each country also established an implementation team or working group. These groups typically included representatives from relevant sectors and settings, such as healthcare, early childhood education, schools and municipal service, ensuring that the implementation could be embedded effectively within existing service structures. The working groups were responsible for coordinating the implementation process, monitoring progress, addressing emerging challenges and ensuring alignment with national and local priorities.

THL organized monthly meetings during the project period. The Finnish Heart Association (FHA) provided information expertise at monthly meetings, in the Helsinki meeting and in personal mentoring meetings for each participant in WP6. The experts of Smart Family developed an e-learning platform for training the trainers and all the materials and methods to assist the implementation of the Smart Family.

During co-creative mentoring meetings between FHA and MSs the practical implementation plans were chosen. FHA provided additional information and answered the MSs ' questions about training the professionals and provided demo training for MSs, pilot action plans and presented a wide variation of Smart family materials and tools which were adapted in local languages as well or modified culturally if needed.

The e-learning platform consists of six learning modules and theoretical background of the method, which can be used according to the MS´s chosen setting(s) to implement the Smart Family method. The modules are planned first to train the trainers/professionals but also include a wide selection of tools for families including self-assessment tools like Smart Family -card or Star tools. Each participating MS selected suitable modules and materials for their use during the pre-implementation phase and continued to implement.

Across all participating MSs, the implementation phase resulted in the successful development of the necessary training materials and delivery of professional training aimed at enabling the application of the Smart Family lifestyle counselling approach in practice. These training activities were a key prerequisite for ensuring that professionals had the required understanding, skills and tools to adopt the method in their daily work with families.

The scope and intensity of the training varied across countries, reflecting differences in professional cultures, existing counselling practices and institutional contexts. In some pilot countries, client-oriented and autonomy-supportive lifestyle counselling approaches were not yet well established in routine practice. In these contexts, such as Slovenia, several training sessions were organized to allow professionals time to practise, reflect on and internalise the Smart Family counselling approach. In other countries, such as Poland, a strategic decision was made to focus on training future professionals within educational settings, with the aim of strengthening competence and readiness for client-oriented lifestyle counselling in the longer term.

These context-specific training strategies demonstrate how the Smart Family method can be introduced and supported in different systems while maintaining a shared counselling logic. Together with continuous mentoring and access to common training materials, the training contributed to creating the practical conditions needed for the method to be implemented across diverse settings.

WP6 monthly meetings were organized by THL team lead regularly every month
and meeting agendas can be found in Google Drive:

https://drive.google.com/drive/folders/1-PpCIU8-THuO_zx2D23r3b_Anra0EguQ

WP6 Smart Family brand owner meetings were organized by the Finnish Heart Association team to support implementation and e-based learning networks. Mentoring Timetable in Google Drive:
https://drive.google.com/drive/folders/1AfyqfPRXG5k7RS2pqdKvH3UgMkCPJKtG

3.3 Post-Implementation Phase Analysis

The post-implementation phase focused on evaluating implementation activities and preparing for potential continuation. Approaches varied across MSs, reflecting differences in implementation models, scope and available resources.

Countries collected and analysed data using a combination of methods, including questionnaires, professional self-assessment tools, participation monitoring and qualitative feedback from stakeholders. These approaches provided insight into the feasibility of the method and its integration into practice.

Results were shared through policy dialogs, national reports, stakeholder meetings and exchanges between MSs. Cross-country dialogue supported mutual learning, particularly in comparing different implementation approaches and identifying context-specific solutions.

In several countries, the findings informed planning of next steps. These included further development of training activities, integration into existing services and exploration of opportunities for broader implementation. These were discussed in every MSs policy dialogues (that will be reported in D6.3. report). The extent of these plans depended on institutional capacity and alignment with national structures.

Overall, the post-implementation phase supported reflection on implementation experiences and created a basis for future development, while highlighting that pathways for continuation vary depending on national contexts. There are many paths to revise public health promotion and prevention policies, not just one option.

4. Implementation across the participating countries in diverse contexts

4.1 Croatia

Croatia implemented the Smart Family method in public kindergartens, building on the national Healthy Living health promotion programme. The implementation was carried out in collaboration with kindergarten staff and county public health institutes. The target groups included children aged 3–7, kindergarten educators and nurses, and staff from county public health institutes.

Table 3. Summary of Smart Family Piloting in Croatia

Category	Summary
Setting / Context	Public kindergartens; Healthy Living national programme; collaboration between kindergartens and county public health institutes.
Target group	Children 3–7 years; kindergarten educators, teachers, nurses; county public health institute staff.
Intervention design	Integration of Smart Family methods and materials into kindergarten activities and routine health promotion.
Timeline	Pre-implementation (M1–M13): Pilot plan completed Nov 2023. Implementation (M14–M36): Roll-out of improvement areas, workshops, activity bank, Smart Card. Post-implementation (M31–M36): Final evaluation and reporting.
Recruitment strategy / criteria	Voluntary participation through “Week of Health in Kindergartens”; invitations via national programme; family engagement via kindergarten communication channels.
Training format	One-day introductory workshop; additional training on Smart Family Card and counselling approach ; distribution of activity materials.
Adaptation process	Smart Family materials integrated into the Week of Health framework; activity bank adapted for local use; workshops tailored to national childhood obesity context.
Evaluation approach	Post-training feedback forms; quantitative and qualitative data; 6-month follow-up survey; indicators: participation numbers, satisfaction, extent of implementation, acceptance among children and families.

Implementation timetable

Croatia selected kindergartens as the main implementation setting. Professional training began in March 2024, with participation from all kindergarten professionals involved in the pilot. The aim was to reach families through health professionals working in early childhood education settings. Implementation activities started in April 2024, including the introduction of adapted Smart Family materials such as classroom group activities, educational tools, family-support materials, and assessment resources.

A second training session was organised in June 2024, with a focus on the Smart Family Card and its use in counselling, primarily targeting kindergarten nurses. A third training for health professionals in kindergarten settings was in November 2024. During the pilot phase, a total of 396 professionals were trained.

Across all sessions, materials distributed included:

- adapted Smart Family activity bank
- educational and communication materials
- counselling support tools
- family-oriented materials

A total of 117 participating kindergartens submitted reports describing the benefits and challenges experienced during implementation.

Reported benefits

- strong motivation to participate
- materials considered useful and supportive
- parental involvement observed
- enhanced professional networking

Implementation challenges

- tight implementation timelines
- lower-than-expected parental engagement
- need for additional practical guidance
- some uncertainty regarding methodology

4.2 Greece

Greece implemented the Smart Family method primarily within maternal and child health services in the city of Patras and surrounding areas. Two parallel intervention strands were developed:

1. Breastfeeding and maternal support: targeting pregnant women in the 32nd–35th week of gestation attending the two public maternity hospitals in Patras.
2. Healthy growth and lifestyle intervention: targeting all children aged 2–12 years living in Patras, irrespective of weight status.

The pilot was motivated by increasing childhood overweight and obesity rates in Greece, especially in the 6th Health ADM Region, where prevalence exceeds national averages. Low breastfeeding initiation and short breastfeeding duration further contributed to the need for early preventive actions. Dietary patterns in children have also shifted significantly toward ultra-processed foods, with estimates indicating that ~40% of daily energy intake comes from such products.

Table 4. Summary of Smart Family Piloting in Greece

Category	Summary
Setting / Context	Maternal and child health services; in-person activities in Patras maternity hospitals; online breastfeeding support.
Target group	Pregnant women (32nd–35th week); children aged 2–12 years; maternal and child health professionals.
Intervention design	Breastfeeding support (hands-on + online), lifestyle counselling for families, and multi-round training for health care professionals.
Timeline	Pre-implementation: Pilot planning. Implementation: Health care professional training Round 1 (Jan–Jul 2024), hands-on counselling for pregnant women (May 2024), online breastfeeding training (Jul 2024). Planned completion: Sept 2025.
Recruitment strategy / criteria	Recruitment through public maternity hospitals; community outreach; website-based information for families.
Training format	Multiple workshop rounds for professionals; hands-on sessions for pregnant women; online breastfeeding modules; distribution of Smart Family tools.
Adaptation process	Tailoring Smart Family content to maternal health workflows; adapting materials for breastfeeding promotion and early lifestyle guidance.
Evaluation approach	Professionals: Professional Motivation Questionnaire. Families: Health Care Climate Questionnaire & Perceived Competence Questionnaire. Monitoring engagement levels.

Results	Strong family engagement; low professional compliance in Round 1 (15 active out of 44 trained).
Lessons learned	Need for improved professional follow-up, clearer training structure, and additional engagement strategies.

Implementation timetable:

Pre-implementation phase

- Situation analysis conducted, showing elevated overweight/obesity prevalence in the 6th Health ADM Region and low breastfeeding initiation.
- Tailoring of intervention content for pregnancy, early childhood and family lifestyle changes.

Implementation phase

- May 2024: Hands-on lifestyle and breastfeeding support sessions for pregnant women at Patras maternity hospitals.
- July 2024: Online breastfeeding technique sessions delivered to families through the Greek Smart Family website.
- January–July 2024: First round of training for health care professionals, covering lifestyle counselling, breastfeeding promotion and Smart Family methods.
- The entire intervention is on track for completion in September 2025.

Trainings and materials

Health care professionals (midwives, nurses, physicians) received multiple rounds of training between January and July 2024. Training content included:

- strength-based family counselling
- breastfeeding support techniques
- applying Smart Family tools in maternal and child health settings
- using assessment tools and structured counselling workflows

Materials provided included:

- breastfeeding guidance tools
- Smart Family activity materials
- lifestyle and nutrition counselling handouts
- online resources for professional and family use

Family-facing materials

- Practical breastfeeding guidance
- Online training modules
- Printed nutrition and lifestyle materials for families
- Adapted counselling content for early childhood age groups

Strong interest was reported from families via the Greek Smart Family website, especially in the breastfeeding modules.

Preliminary results

- high engagement from families and pregnant women.
- strong online participation for breastfeeding content.
- low professional compliance during Round 1:
    - only 15 of 44 trained professionals actively implemented Smart Family methods.

Lessons learned

- additional support and follow-up are needed to maintain professional engagement.
- training design must include clearer expectations and supervision.
- breastfeeding and maternal support activities have strong potential for scale-up due to high demand.
- online modules are effective in reaching families.
- Round 2 of the "training the trainers" programme integrates these findings to strengthen uptake.

4.3 Lithuania

Lithuania implemented the Smart Family method in Kaunas city, combining in-person sessions (sports hall and kitchen studio) with a virtual learning environment (closed Facebook group and a Smart Family website). The target group consisted of families with 1st–4th grade children (7–11 years). A total of 20 families participated in the intensive programme, engaging in weekly physical activity sessions, cooking lessons, behavioural consultations and stress-management training.

The pilot addressed increasing overweight and obesity among primary school children in Kaunas, driven by low physical activity levels, unhealthy eating habits and limited family knowledge about basic public health principles. National survey data highlight insufficient exercise and limited participation in physical activity clubs among young schoolchildren, further underscoring the need for supportive family-based interventions.

Table 5. Summary of Smart Family piloting in Lithuania

Category	Summary

Setting / Context	Kaunas city; sports hall, kitchen studio and online learning environment (Facebook group + website).
Target group	Families with children aged 7–11 (grades 1–4).
Intervention design	Weekly sports sessions; cooking classes; dietitian consultations; behavioural coaching; stress-management sessions; online learning materials.
Timeline	Pre-implementation (M1–M13): Pilot plan completed Nov 2023. Implementation (M14–M30): Intensive programme delivered throughout 2024. Post-implementation (M31–M36): Final evaluation and reporting.
Recruitment strategy / criteria	Recruitment of 20–30 families from Kaunas; voluntary participation and outreach via municipal health bureau.
Training format	4 live sports sessions/month; 2 live cooking lessons; 2 online dietitian consultations; 4 online behavioural coach/psychologist group sessions; 1 live parenting/stress session.
Adaptation process	Local tailoring of Smart Family materials; integration with behavioural coaching; use of virtual platforms for continuous family support.
Evaluation approach	Adult oral interviews; self-reported body measurements; body composition tests; surveys before/after intervention.
Results	Improved family communication, physical activity, nutrition habits, stress management and body composition. Strong participant loyalty and team dedication.
Lessons learned	Challenges adopting recommendations; difficulty understanding positive parenting concepts; motivation barriers among some families.

Implementation timetable

Pre-implementation phase (M1–M13)

- situation analysis for Kaunas city.

- pilot action plan finalised by November 2023.
- identification of settings (sports, cooking, behavioural support).

Implementation phase (M14–M30)

- the one-year intensive programme ran throughout 2024, consisting of:
- 4 weekly in-person physical activity sessions
- 2 monthly cooking lessons
- 2 monthly online consultations with a dietitian
- 4 monthly online behavioural/psychological group consultations
- regular parenting & stress-management sessions
- continuous support through the Smart Family website and private Facebook group

Training was delivered by a multidisciplinary team including a nutritionist, chef, case manager, physical activity specialist and psychologist.

Post-implementation (M31–M36)

- Completion of evaluations (December 2024)
- Preparation of full report and national discussions on scaling

Trainings and materials

Families received hands-on and online training covering:

- Physical activity (weekly family-based exercise classes, theoretical information on home-based activity, baseline and final BMI measurements
- Nutrition (practical cooking sessions with a chef, individual consultations with a nutritionist, pre/post surveys on dietary habits)
- Family wellbeing & parenting (consultations with a psychologist, relaxation and stress-management classes, parenting support and body image sessions)

Materials provided

- All adapted Smart Family materials from Finland
- Locally developed lesson plans and materials
- Online educational resources via the website and Facebook group

Families particularly valued the supportive community atmosphere, flexible session scheduling, and the ability to interact with specialists directly.

Evaluation methods

- pre/post lifestyle and nutrition surveys
- self-reported monthly body measures
- on-site body composition testing
- qualitative interviews with adults
- monitoring of physical activity time

Early results

Participants reported notable improvements in:

- family communication and time spent together
- stress management among adults
- home cooking frequency and healthier food choices

- nutrition label literacy
- sleep quality
- physical activity levels in both adults and children
- body composition among adults

A strong sense of community and commitment developed, motivating parents and children to continue activities beyond the programme.

Implementation barriers
- some families struggled to apply recommendations consistently
- difficulties understanding positive parenting principles
- motivation challenges in certain households
- limited autonomy of the public health bureau for scheduling
- economic barriers (e.g., cost of sports subscriptions, rising food prices)

Lessons learned
- a supportive community increases adherence and motivation.
- combining live sessions with online resources improves accessibility.
- multidisciplinary teams can address highly diverse family needs.
- behaviour change requires continuous support and personalised guidance.
- structural challenges (motivation, economic barriers) must be addressed on a national scale-up.

Next steps and national relevance
In 2024, discussions began with the Lithuanian Ministry of Health on adapting Smart Family into a national policy model. Encouraging early results suggest feasibility for scaling to other Lithuanian cities.

4.4 Poland

Poland selected primary health care (PHC) and the broader health and education students and professionals as the main implementation setting. This approach reflects the urgent need to address rising childhood overweight and obesity, which affect up to 30% of school-aged children, with high regional variability and a strong socio-economic gradient. Early preventive action embedded in PHC, schools and family counselling is essential due to the long-term health risks and associated healthcare burden.

The Smart Family model was introduced as a way to strengthen lifestyle counselling in PHC, expand professional competencies and provide families with accessible tools for improving daily routines. The target groups were primary school children (6–12 years) and their families, reached through health and education workers.

Table 6. Summary of Smart Family piloting in Poland

Category	Summary

Setting / Context	Primary health care (PHC) teams; health and education professionals; university students; multi-sector local group.
Target group	Children aged 6–12 and their families; PHC staff; school nurses/educators; nursing and dietetics students.
Intervention design	Two-phase training model: (I) student training; (II) development of PHC learning materials, e-learning and family platform.
Timeline	Pre-implementation (M1–M13): Context analysis; plan finalised Nov 2023. Implementation (M14–M30): Two training phases delivered Mar–Sep 2024; e-learning development ongoing. Post-implementation (M31–M36): Evaluation.
Recruitment strategy / criteria	Collaboration with universities, PHC units, local municipalities, professional associations, and educators.
Training format	In-person training sessions for students and professionals; development of scripts and materials; online learning modules under preparation.
Adaptation process	Creation of national learning repository and family platform; tailoring Smart Family materials to Polish PHC structures.
Evaluation approach	Pre/post satisfaction surveys for PHC teams; monitoring completion of e-learning; assessment of training materials.
Results	230 students trained; training materials welcomed; phase II development ongoing.
Lessons learned	Structural gaps in paediatric dietetics; limited training in positive psychology; cultural norms challenging non-judgmental approaches; time constraints.

Implementation timetable

Pre-implementation phase (M1–M13)

- National and regional context analysis
- Mapping PHC capacity, workforce gaps and needs

- Pilot action plan completed November 2023

Implementation phase (M14–M30) consisted of two structured phases:

- phase I (March–September 2024): Training nursing and dietetics students. A total of 230 students completed Smart Family training. Focus areas:risk factors and determinants of overweight, motivational counselling, Smart Family lifestyle counseling methodology and working with families using a non-judgmental and supportive approach

Training sessions and participation:

Date	Target group	Participants
20.03.2024	Dietitians	20
21.03.2024	Dietitians	30
13.04.2024	Dietitians	9
09.04.2024	School nurses, psychologists, educators	38
23.05.2024	Nurses	49
06.06.2024	Nurses	54
06.06.2024	Dietitians	30

Phase II (2024): Development of learning materials and e-learning
Activities included: development of teaching materials and scripts, creation of a national repository for PHC teams, preparation of an e-learning training package, creation of a digital platform for families and educators, storing all resources, drafting recommendations for future nurse training in lifestyle counselling and E-learning development continued until end of 2024.

Post-implementation (M31–M36)

- Evaluation of training and tools
- Satisfaction assessment among PHC teams
- Integration of findings into national recommendations

Training formats
- in-person training sessions for students and PHC professionals

- interactive lectures and group work
- workshops on motivational counselling
- preparation of digital and printed educational materials
- planning of e-learning modules for PHC use

Materials developed

- training scripts and slides
- repository of PHC teaching resources
- digital platform with family-accessible materials
- recommendations for nurse education content
- smart Family materials adapted to Polish context

Evaluation methods

- satisfaction surveys among PHC teams
- pre/post evaluation of e-learning (once launched)
- assessment of training materials
- optional case studies in pilot PHC units

Early results

- high enthusiasm among participants
- training materials considered useful and relevant
- strong engagement from nursing and dietetics students
- increased interest among PHC teams

Challenges identified

- lack of established career pathways for paediatric dietitians
- insufficient training in positive psychology and non-judgmental counselling
- cultural norms: difficulty shifting toward supportive, non-blaming dialogue
- limited time in PHC workflows to implement new methods

Lessons learned

- Smart Family aligns well with PHC needs, but structural constraints remain.
- broader training in motivational and positive psychology methods is required.
- family-wide approaches are essential for sustainable change.
- multisector cooperation (health, education, local government) is crucial.
- the student training model is a promising long-term investment.

Next steps and national potential

- completion of PHC e-learning by end of 2024
- development of further training sessions for members of the Polish Association of Dietitians (PTD)
- potential expansion to selected PHC units for practical piloting
- use of developed materials to inform national policy and future preventive programmes

4.5 Slovenia

Table 7. Summary of Smart Family piloting in Slovenia

Category	Summary
Setting / Context	Community nursing; national health website ZDAJ.net; home visits from pregnancy to child age 3.
Target group	Community nurses (pilot group); expectant and new parents (via national webpage).
Intervention design	Online training (Smart Family approach, behavioural change models, tools); in-person workshops; articles and tools for families on ZDAJ.net.
Timeline	Pre-implementation (M1–M13): Pilot plan finalised Nov 2023. Implementation (M14–M30): Training meetings, workshops, publication of translated tools. Post-implementation (M31–M36): Evaluation and reporting.
Recruitment strategy	10 motivated community nurses + 4 regional coordinators; JA NIJZ team.
Training format	Three online meetings; two in-person workshops (motivational interviewing, strength-based approach); final focus group session.
Adaptation process	Translation, design and publication of Smart Family articles and tools on ZDAJ.net; tailoring content to Slovenian perinatal care.
Evaluation approach	Motivation questionnaires; Satisfaction questionnaires; assessment of practice change; qualitative focus group.
Results	Nurses highly motivated; confidence growing; many SF principles already used; time constraints noted.
Lessons learned	Need for more time and staffing; strong parental contact enables SF integration; digital resources essential.

Implementation timetable

Pre-implementation phase (M1–M13)

- Situation analysis of maternal/child health needs

- Review of early childhood diet, breastfeeding indicators and ACEs
- Preparation of Smart Family pilot plan (completed November 2023)

Implementation phase (M14–M30)

- Implementation included structured training for community nurses and development of digital content for families.

Training community nurses (Improvement Area I)

Pilot group: 10 community nurses and 4 regional coordinators

Training activities:

- three online meetings (spring):
    - Smart Family ideology
    - behavioural change models
    - Smart Family tools and counselling logic
- two in-person workshops (autumn):
    - motivational interviewing practice
    - strength-based approach
    - practical counselling techniques
- final meeting:
    - Focus group to discuss early implementation experiences

Nurses also received access to an E-platform containing Smart Family materials, presentations and tools.

Providing materials for families (Improvement Area II)

Activities included:

- translating Smart Family articles for the national webpage
- adapting tools for parental self-reflection on lifestyle, routines and wellbeing
- graphic design, layout and publication
- promotion via NIJZ social media channels

Parents were offered materials on topics such as:

- building a positive family environment
- healthy introduction of solid foods
- maternal/paternal lifestyle and activity
- stress regulation and wellbeing

Post-implementation (M31–M36)

- analysis of training impact
- review of nurse adoption of Smart Family tools
- usage statistics from ZDAJ.net

- focus group synthesis and final reporting

Training components

- online theoretical sessions
- practical workshops (motivational interviewing, strength-based communication)
- case-based exercises
- peer exchange and reflective discussions
- access to online resource library

Digital and printed materials

- translated Smart Family tools (self-reflection forms, parent guidance, lifestyle tools)
- digital articles published on ZDAJ.net
- child-friendly materials and worksheets
- presentations and counselling scripts for nurses

Evaluation methods

- Motivation for Implementation Questionnaire pre-/post-training
- Satisfaction with Meetings Questionnaire after each session
- Assessment of practice changes (tool use, counselling behaviour)
- Qualitative focus group on implementation experiences

Early results

- High motivation: Nurses showed strong willingness to adopt Smart Family methods.
- Existing strengths: Many already applied SF principles (non-judgment, asking questions, noticing strengths, showing genuine interest).
- High satisfaction:
  - Online meeting satisfaction: 4.4/5 and 4.1/5
- Main barrier: Lack of time in current workload to fully integrate new approaches.
- Confidence gap: Nurses valued the approach but were uncertain about consistent implementation while understaffed.

Lessons learned

- Community nurses' long-term contact with families creates ideal conditions for Smart Family integration.
- Digital tools on a national platform significantly expand reach.
- More training time and ongoing support are needed for sustainable adoption.
- Behaviour change counselling is feasible and welcomed, but structural constraints (staffing, time) limit full application.

Next steps and national potential

Slovenia's approach shows strong potential for scaling Smart Family within its universal home-visit community nursing model.

Planned next steps include:

- expanding access to Smart Family tools on the national webpage
- supporting community nurses with continued training and mentoring
- integrating Smart Family content into regular perinatal and early childhood counselling
- evaluating digital engagement and family usage patterns

4.6 Spain (Balearic Islands)

Spain piloted the Smart Family method in Primary Health Care (PHC) in the Balearic Islands, with a strong community-health orientation. The Balearic Islands face a significant childhood overweight and obesity burden. Earlier EPOIB studies (2005, 2017) showed that over 30% of boys and girls in Eivissa were living with overweight, with higher prevalence in disadvantaged families and neighbourhoods.

Obesity in Spain is recognised as the result of an obesogenic environment influenced by socioeconomic factors, family context, neighbourhood resources, food systems, digital environment, and access to sports and recreation. Spain's approach therefore integrates Smart Family into PHC while simultaneously addressing social determinants of health through community partnerships. The target groups include families with children up to 14 years old, families expecting a baby, and PHC professionals, with a special focus on socioeconomically disadvantaged families.

Table 8. Summary of Smart Family piloting in Spain (Balearic Islands)

Category	Summary
Setting / Context	Primary Health Care centres in Eivissa; community health strategy; municipal partnerships; schools and neighbourhood associations.
Target group	PHC paediatric nurses & paediatricians; families with children 0–14 years (treatment arm); families expecting a baby or with children 0–14 where the mother has obesity/low education (prevention arm).
Intervention design	Training PHC professionals; designing an obesity prevention & treatment programme based on Smart Family; piloting two interventions (treatment + prevention) with families.

Timeline	Pre-implementation (M1–M13): Training PHC, design of programme (Nov 2023–Jan 2024). Implementation (M14–M30): Piloting interventions (Jan–Dec 2024). Post-implementation (M31–M36): Evaluation and reporting (2024–2025).
Recruitment strategy	Equity-based prioritisation; families selected via PHC paediatric nurses; involvement of schools and community networks.
Training format	Online training sessions; review of Smart Family materials; adaptation to Mediterranean diet; co-design sessions with the Finish Smart Family team.
Adaptation process	Translation (Spanish/Catalan); contextualisation to Balearic Islands; integration with local resources (EinaSalut).
Evaluation approach	Mixed methods: self-efficacy questionnaires, material audits, quantitative family indicators, focus groups.
Results	Training completed; programme draft developed; early family recruitment initiated.
Lessons learned	Need for strong community collaboration; structural barriers in access to sports; PHC motivation to renew its role via Smart Family.

Implementation timetable

Pre-implementation phase (M1–M13)
- Smart Family study visit to Finland (Sept 2023)
- action plan finalised (Nov 2023)
- initial meetings with Eivissa City Council (since July 2023)
- objective 1: Training PHC professionals (Sept–Dec 2023)
- objective 2: Intervention design (Nov 2023–Jan 2024)

Implementation phase (M14–M30)
- piloting treatment intervention with 12 families (child BMI ≥90th percentile)
- piloting prevention intervention with 12 families (maternal obesity & low education level)
- regular data collection, home-based and PHC appointments
- monitoring family-level behaviour change and use of community assets

Post-implementation (M31–M36)

- evaluation of training (Dec 2023)
- evaluation of programme design (Feb 2024)
- evaluation of pilots (Mar–May 2024)
- final report (May–June 2025)
- scientific publication (Jul–Aug 2025)
- presentation of results (Sept 2025)
- review of programme for scale-up (Sept 2025)

Training formats and materials for PHC professionals (Objective 1)

- online Smart Family training
- review of practical tools and counselling approach
- co-creation discussions with the Finnish Smart Family team
- agreement on essential elements for PHC use
- review of local Balearic resources (EinaSalut)

Materials used

- Smart Family tools (translated into Spanish & Catalan)
- lifestyle reflection worksheets
- maternal and child health guidance
- mediterranean diet–adapted materials
- tools to explore social determinants of health
- community asset maps from health centres

Intervention design (Objective 2)

A full programme for preventing and treating childhood overweight and obesity in PHC was developed, incorporating:

- Smart Family ideology
- social determinants of health framework
- mediterranean dietary patterns
- local community assets (sports facilities, school networks, free physical activity routes)
- tailored parenting and home-environment components

Evaluation methods

- self-efficacy questionnaires for PHC professionals (pre/post)
    - The Motivating and Encouraging Professional
    - Implementation Motivation Questionnaire at Training
- narrative reflection ("story-writing") by paediatric nurses
- review of the number of materials and assets integrated
- family-level quantitative indicators collected throughout the pilot
- focus groups with families after the intervention

It was initially planned to repeat both questionnaires at the end of the intervention. However, results obtained in the first round showed that the professionals participating in the pilot were highly motivated from the outset and had clearly understood and integrated the Smart Family methodology. Therefore open interviews with the three paediatric nurses involved in the

intervention were conducted. An intermediate interview was already conducted in April 2025. A final interview was carried out in July 2025, once the intervention had concluded.

Key quantitative indicators (Examples)
For families:
- physical activity (IPAQ for parents, Childhood IPAQ for children)
- diet quality (PREDIMED; Childhood PREDIMED)
- emotional wellbeing (Warwick–Edinburgh)
- sleep, screen time, use of community health assets
- BMI (reduction for treatment group; maintenance for prevention group)

For PHC system:
- number of translated/adapted materials
- number of assets included
- PHC self-efficacy change
- adherence rate to family interventions

Early results
- strong enthusiasm among PHC paediatric nurses
- identification of significant community-level barriers (limited access to sport facilities, cost issues, long waiting lists)
- excellent collaboration from Eivissa municipal authorities
- recognition that Smart Family can revitalise PHC motivation and focus

Lessons learned
- equity perspective is essential for family selection
- community health strategy enhances reach to disadvantaged families
- combining PHC + school + neighbourhood action makes the model feasible
- structural limitations in municipal sports access need policy solutions
- families respond positively when interventions address whole-family wellbeing

Next steps and national potential
- refinement of programme for Balearic Islands implementation
- development of a scientific article
- potential integration into regional PHC strategies
- strengthening community partnerships to enable scale-up
- advocacy for municipal action on sports accessibility, safe routes and school facilities safety

5. Cross-Country Analysis

The comparative analysis demonstrates that, despite differences in health or education system structures, target populations and delivery contexts, the implementation of the Smart Family method across participating Member States followed a set of shared patterns. At the same time, the findings highlight how the method can be adapted to diverse institutional and cultural contexts without compromising its underlying approach.

Across all countries, implementation focused on three interconnected elements: strengthening professional competencies, adapting and disseminating Smart Family materials, and embedding the approach within existing service structures. While these elements were consistently present, their practical application varied depending on national priorities, available resources and organisational settings. The synthesis below distils the core and adaptable components of the programme, as well as key enabling factors, barriers and implications for scaling and replication.

5.1 Core components that must remain stable

The analysis shows that the transferability of the Smart Family method depends primarily on how professionals work with families, rather than on specific materials or setting. .

Across all participating countries, the core component that remained stable was the professional counselling approach, which is family-centred, solution-focused and based on motivational interviewing. In practice, this involved a shift from directive, advice-giving practices towards dialogical interaction emphasising active listening, open questions, recognition of families' strengths and support for self-efficacy.

This interactional approach was applied across diverse settings, including primary health care, community nursing, early childhood education, and family-based programmes. It was treated as a non-negotiable element of the method and consistently supported through structured training like scientific strand for MSs, mentoring from FHA and peer experience exchange between MSs.

To support reflection on counselling practices, a common self-assessment measure (the Encouraging Professional self assessment tool) focusing on autonomy-supportive and motivating interaction was introduced for MSs. While its systematic use varied across countries, it contributed to strengthening awareness of the counselling approach.

The findings indicate that when this core counselling approach was clearly defined and reinforced through training and continuous support, the Smart Family method could be implemented flexibly across contexts without compromising its methodological integrity.

5.2 Adaptable components and contextual modifications

In contrast to the stable counselling core, materials, tools and delivery formats were intentionally designed to be adaptable to different contexts and countries.

All participating MSs translated, culturally adapted and disseminated Smart Family materials for families, and selected tools according to their specific implementation settings and target groups. The availability of a modular material package enabled countries to tailor content to national dietary patterns, service structures and professional roles.

Adaptations were also visible in delivery formats. Some countries prioritised face-to-face workshops and hands-on training, while others focused on developing e-learning modules and large-scale training packages. Implementation settings varied widely, including community nurses' home visits, pregnancy and breastfeeding services, kindergarten environments, school-based programmes, and primary health care systems.

Digital solutions played an important role in several countries, with the development of online platforms, e-learning environments and digital materials for both professionals and families. These context-specific adaptations strengthened relevance and feasibility while maintaining a shared counselling logic and communication concepts across all pilots.

5.3 Contextual enablers, barriers and implementation trade-offs

Several common enabling factors were identified across MSss. These included alignment with existing prevention strategies and service structures, professionals' interest in strength-based and non-directive counselling approaches, and the availability of structured training materials and continuous mentoring support.

A key enabling factor was the comprehensive provision of training materials and tools by the Smart Family developers. This included a structured e-learning platform, modular training content for professionals, and a wide range of adaptable materials for families. These resources ensured a shared methodological foundation while allowing flexible implementation across national contexts.

At the same time, common barriers were identified, primarily related to structural constraints such as limited time for counselling, competing professional responsibilities, and restricted resources for sustained implementation. Across countries, it was observed that adopting a new counselling approach requires time, repeated practice, support and opportunities for reflection.

An important cross-country trade-off concerned reach versus intensity. Integration into routine services enabled broader population reach but limited the depth of support per family, whereas more intensive, programme-based approaches allowed deeper engagement with fewer families. These trade-offs have direct implications for implementation choices and scalability.

5.4 What works, for whom, and in which contexts

The cross-country comparison highlights that different implementation approaches are effective under different conditions, depending on institutional capacity, professional culture and available resources.

High-intensity, family-based interventions were particularly effective for motivated families requiring comprehensive lifestyle support (e.g. Lithuania). These approaches enabled deeper engagement and behavioural change but required substantial professional input, limiting their scalability.

In contrast, integration into routine services, such as community nursing, primary health care or early childhood education settings, enabled broader reach with lower intensity per family. These models are more feasible for large-scale implementation but may provide less personalised support for families.

Workforce-oriented approaches, focusing on training current and future professionals, proved effective in strengthening long-term system capacity. These approaches are particularly suitable in contexts where sustainable structural change is prioritised over immediate individual-level impact.

The analysis indicates that no single implementation model is universally optimal. Instead, the choice of approach should be guided by the intended level of impact, available resources, institutional capacity and the specific needs of the target population.

5.5 Implications for scaling and replication

The cross-country analysis demonstrates that the Smart Family method is both adaptable and scalable across different health and social systems. This was also clearly reflected in the policy dialogues organised within the pilots, as reported in Deliverable D6.3.

For successful scaling and replication, the findings suggest that:

- the core counselling approach must remain stable and be supported through structured training and continuous learning,
- materials and tools should remain adaptable to local contexts,
- implementation should build on existing service structures to ensure feasibility and sustainability,
- and strategic choices need to be made between reach and intensity based on available resources and target population needs.

Overall, maintaining a clear distinction between stable and adaptable components enables both fidelity and flexibility. This allows the Smart Family method to support a wide range of implementation models, from system-level capacity building to intensive family-based interventions, depending on national priorities and implementation capacities.

6. Lessons Learned for Transferability and Scalability

The cross-country implementation of the Smart Family method highlights several practical lessons for transferring and scaling lifestyle counselling approaches across different national contexts. Rather than a single implementation setting, the findings emphasise the importance of aligning the approach with existing systems, resources and policy priorities.

A key lesson is that embedding the method within existing service structures increases feasibility and sustainability. For example, integration into community nursing in Slovenia and primary health care in Spain enabled the approach to be applied within routine services, supporting broader reach without requiring the creation of new structures. In contrast, Lithuania demonstrated that intensive, programme-based implementation can achieve deeper engagement with families, although with higher resource requirements. Entry points linked to existing family contact points, such as maternal and early childhood services, also showed strong potential for engagement and future scale-up.

Another important insight is that professional training alone is not sufficient for practice change. Countries that combined training with continuous support to professionals, supervision and opportunities for practical application were more successful in integrating the counselling approach into everyday work. The availability of structured training materials, including e-learning platforms and adaptable tools, supported a shared methodological foundation and enabled flexible delivery across contexts.

The analysis also highlights the importance of contextual relevance and collaboration. Multidisciplinary and multisector cooperation, involving health, education and community actors, strengthened implementation and supported addressing families' diverse needs. In addition, approaches that considered equity and community context, such as targeting disadvantaged families or integrating services at community level, improved reach and responsiveness.

From a scalability perspective, a central consideration is the balance between reach and intensity. Approaches embedded in routine services are more easily scalable, whereas intensive interventions require more resources but may produce stronger engagement at the family level. Poland's focus on training future professionals illustrates an additional pathway to scalability by strengthening long-term system capacity. At the same time, structural constraints, such as limited time, staffing and access to supportive environments, need to be addressed to enable wider implementation.

Overall, the findings suggest that successful transfer and scaling depend on three key factors: integration into existing systems, sustained investment in professional competence, and the ability to adapt implementation models to local contexts while maintaining a shared core approach.

The experiences generated within this Joint Action, together with the harmonized framework, policy dialogues (as reported in Deliverable 6.3) and the implementation strategy, provide a practical and transferable foundation for future use. Collectively, these elements form a coherent pathway for the continued implementation of the Smart Family method and support

its uptake in other EU Member States seeking to adopt and adapt this best practice within their own national contexts.