HEALTH 4 EU kids

Your Kids' Health, Our Priority

Deliverable 6.3 Framework for Harmonized Actions

HEALTH4EUKids

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Authors (Name & Organization)	THL: Kuusipalo Heli, Koivurinta Emma, Mäki Päivi, Savolainen Nella Finnish Heart Association: Kati Kuisma, Taina Sainio

Executive Summary

This report presents the developed framework for harmonized actions to implement Smart Family best practice based on experiences in six European countries—Croatia, Greece, Lithuania, Poland, Slovenia, and the Balearic Islands of Spain with financial support from the European Commission. The framework for harmonized actions is a Smart Family -specific practical application of the more general implementation strategy utilized in the project and originally developed in the CHRODIS PLUS Joint Action and presented in D6.2 deliverable report. This framework was co-created with the implementing countries in this project and can be utilized when implementing Smart Family -method in other countries. In this report, the framework for harmonized actions is referred to as the *Smart Family Implementation Framework*.

This report also supplements the D6.2 deliverable report that describes the implementation of the co-creative transfer training based on Smart Family modules in the six Member States during project months M12-M35 and the experiences and preliminary results from the implementing countries. Supplementary information is given on the results of the implementation in each country based on questionnaire data from the professionals in different countries and policy dialogue reports from each country.

This report also highlights the actions done under the transnational awareness-raising campaign related to the Smart Family method and childhood obesity. It was implemented through decentralized and context-specific communication activities rather than through a single, centrally coordinated transnational campaign. Communication was embedded in

national pilot actions and aligned with each country's implementation strategy, target groups and service structures.

Document History

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1. Introduction

EU Joint Action Health4EUkids aimed to promote child health and prevent non-communicable diseases by strengthening healthy lifestyles among children and school-aged youth. Its focus was on preventing obesity by supporting healthy environments, physical activity and healthy eating within families and communities by implementing two best practices, Grunau Moves and Smart Family. Preventing childhood obesity requires actions that target both the individual and the family—providing information, support, and professional guidance. In addition, structural measures at society level are needed to shape living environments so that it is easier for families to make health-promoting choices. Although the practices differed from each other, the challenges of implementation affected both. Implementing effective practices requires an implementation strategy, engagement of stakeholders, and practical tools. The challenge of embedding these practices further in the systems of implementing countries applies to both.

Within this initiative, Work Package (WP) 6 was 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 was 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 was to support Member States in developing a sustainable, context-adapted lifestyle counselling system that aligns with national policy requirements. Its specific objective was 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.

Deliverable report 6.2 provided 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.

This deliverable report 6.3 presents the harmonized framework for actions implemented under WP6 of the Health4EUkids Joint Action. This report also supplements the D6.2 deliverable report during project months M12-M35 and the experiences and preliminary results from the implementing countries. Supplementary information is given on the results of the implementation in each country based on the questionnaire data from professionals in different countries and policy dialogue reports from each country and the actions done under the transnational awareness-raising campaign related to the Smart Family method and childhood obesity.

2.Framework for harmonized actions - the Smart Family Implementation Framework

2.1 Implementation Strategy of CHRODIS Plus - Basis for the Framework

The implementation strategy developed in the CHRODIS Plus Joint Action served as the basis for the Framework for Harmonized Actions in WP6 (Figure 1). The implementation strategy consisted of three phases—pre-implementation, implementation, and post-implementation—each with specific tasks and designated tools. This strategy guided the coordinated implementation of the Smart Family practice across participating Member States, providing a structured approach for planning, implementation and preparation for sustainability. This alignment ensured that the methodology built on proven practices while being tailored to the specific context of WP6 and the Health4EUkids objectives.

The implementation strategy's primary purpose was to provide a clear structure, tools and practical guidance for all three implementation phases of the process. By outlining well-defined steps, the implementation strategy supported Member States in organizing resources, aligning methodologies, and maintaining quality standards throughout implementation.

In addition to guiding the pilot implementation, the framework played a critical role in enabling continuity and institutionalization of the SmartFamily approach. This ensures that the method can be scaled effectively and integrated into national health promotion strategies, contributing to long-term impact and sustainability.

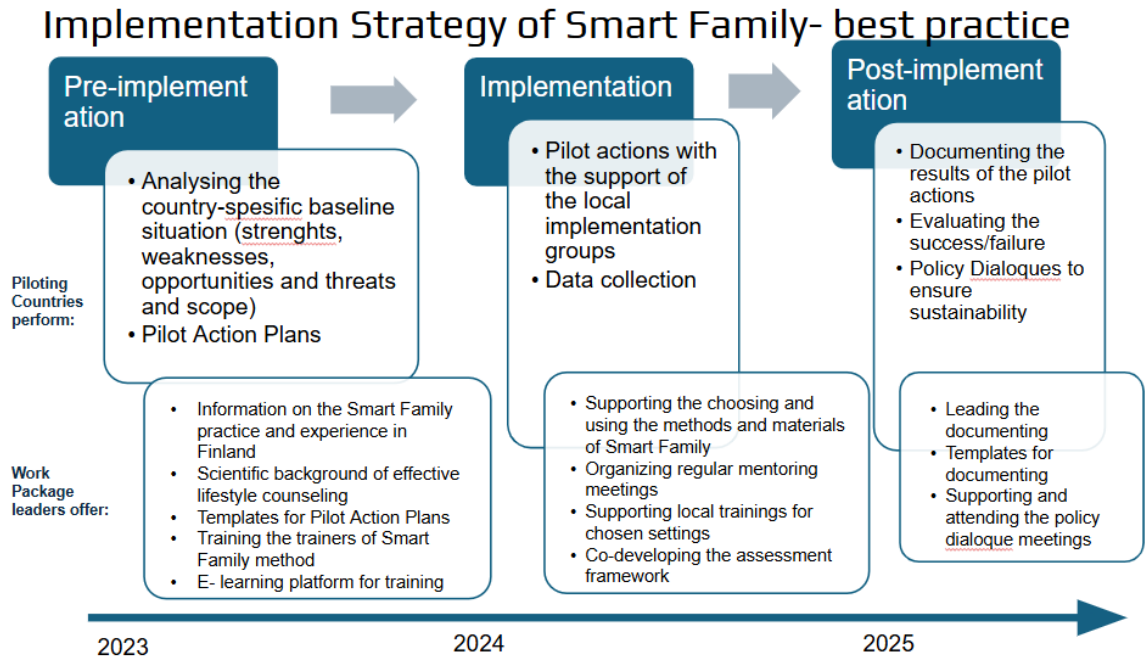

Figure 1. Implementation strategy of Smart Family in Health4EUKIDS.

Figure 1 describes the general plan of WP6, adapted and modified from CHRODIS Plus tools. As shown in Figure 2, the implementation and post-implementation phases were planned to overlap, allowing the Member States for flexible transition to the post-implementation phase, in accordance with their individual timelines.

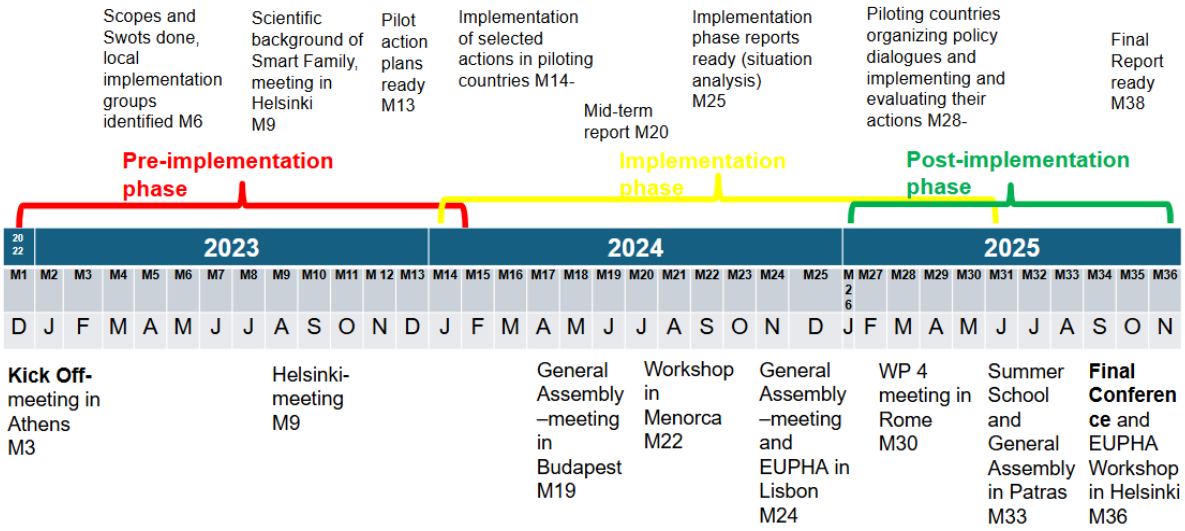

Figure 2. The timeline for WP6 of JA Health4EUKids.

2.2. Development of The Smart Family Implementation Framework

Building on the implementation strategy developed in the CHRODIS Plus Joint Action, the aim of The Smart Family Assessment Framework was to further develop and tailor this model into a practical and context-sensitive tool specifically suited for the implementation of the Smart Family method.

The development of the framework was based on a collaborative and iterative co-creation process led by the Finnish Heart Association and involving European partner countries. The Smart Family method, while grounded in a strong core model, requires adaptation to different health systems, professional roles, and cultural contexts. The goal of this project was to develop an implementation framework to support the successful implementation and integration of the method across different European countries during the H4EUK Joint Action and in the future. The framework was designed to assist implementing countries in assessing their readiness, guiding the implementation process, and supporting long-term sustainability and scale-up (Figure 3.).

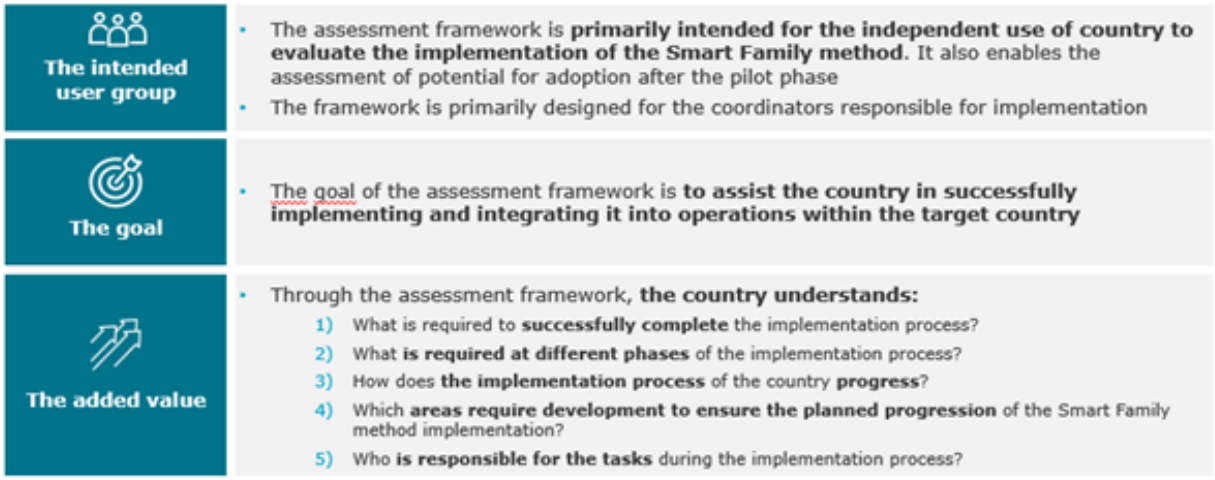

Figure 3. The goal of the Implementation framework is to assist the country in successful implementation and integration of the method

2.2.1 The Smart family Implementation framework development process

The framework was developed using a multi-method approach combining qualitative data collection (interviews of Member States), stakeholder engagement, and iterative validation. A total of nine professionals from Member States that participated in piloting the Smart Family method in WP6, were interviewed. The professionals were selected based on their involvement in the implementation of the Smart Family method and their knowledge of national systems. This ensured that the framework reflects diverse implementation environments, including countries at different stages of implementation.

The framework aims to consider commonly identified potential challenges. The interviews and country-level pilot experiences provided practice-based insights into implementation processes, identifying key barriers and facilitators across diverse contexts. The findings highlighted four main domains of implementation challenges: (1) system-level and contextual factors, (2) organizational capacity, (3) professional engagement, and (4) family-level dynamics (Figure 4). These included variations in operating environments, limited resources and managerial support, challenges in professional adoption, and difficulties in engaging and retaining families. Equity-related challenges were also identified, particularly regarding the unequal reach of interventions across population groups.

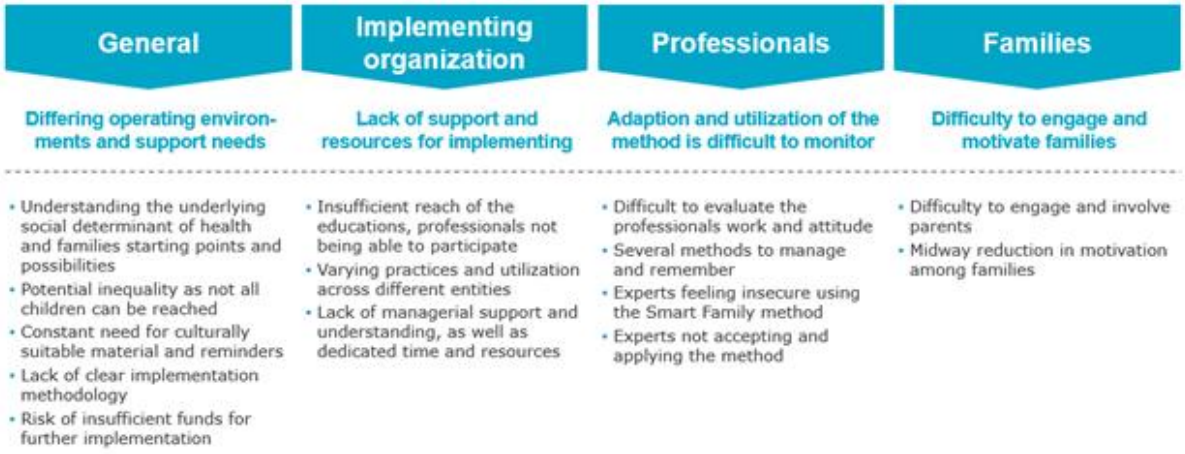

Figure 4. Summary of the interview findings of identified potential challenges

These findings directly informed the development of the Smart Family Implementation framework, ensuring alignment between identified implementation challenges and proposed actions.

2.2.2 The Smart Family Implementation framework

The Implementation framework is based on a three-phase model—pre-implementation, implementation, and maintenance—derived from the JA-CHRODIS Plus implementation strategy and adapted to the context of JA Health4EUkids. The framework thus operationalizes CHRODIS Plus implementation strategy into a structured and practical tool for Smart Family method.

The phases from pre-implementation and implementation to maintenance phase, form a continuum from readiness to implementation and long-term sustainability, with flexibility for overlapping stages depending on country-specific contexts. (Figure 5)

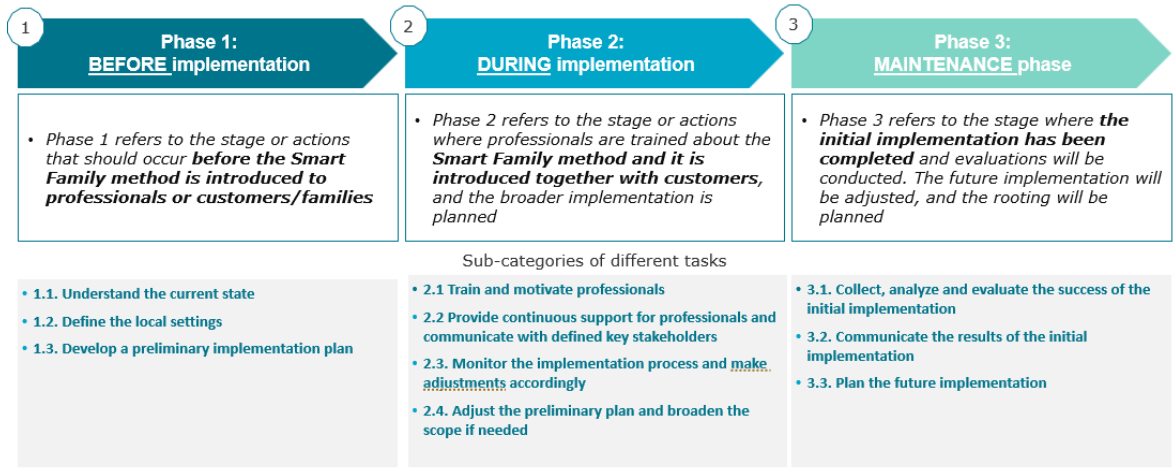

Figure 5. The Smart Family Implementation framework is structured into three phases and sub-categories under each phase

The pre-implementation phase focuses on assessing the current state, defining local implementation settings, engaging stakeholders, and developing a context-specific implementation plan. The implementation phase emphasizes capacity building, including training and supporting professionals, stakeholder engagement, and continuous monitoring and feedback. The maintenance phase focuses on evaluation, communication of results, and planning for scale-up and institutionalization of the method.

Across all phases, the framework incorporates continuous monitoring and evaluation, supports adaptive implementation through feedback loops, and enables both standardization and local adaptation while maintaining fidelity to the core elements of the method as described in figure 6.

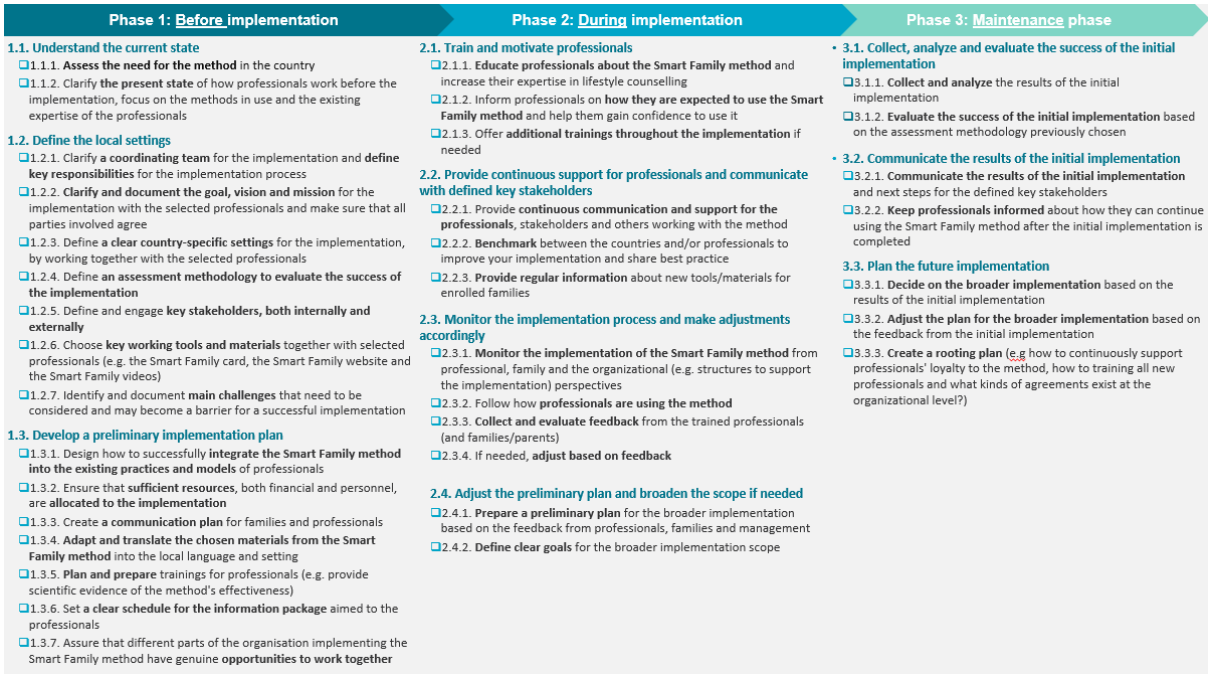

Figure 6. Subtasks of sub-categories under each phase

3.Evaluation of the Smart Family Implementation Framework

Representatives from the countries that had implemented the Smart Family best practice were asked (October/November 2025), via an electronic Webropol survey (Annex 1) how well the piloting/implementation had succeeded at different stages, what they would do differently now, and whether they had received sufficient support. The Webropol evaluation used a five-point Likert scale (1 = very poorly to 5 = very well). The scale enabled structured comparison of implementation performance across countries and phases, while also identifying strengths and areas for improvement. It additionally served as a validation tool for the Implementation framework by linking planned implementation steps with real-world experiences. Qualitative responses complemented the ratings by providing deeper insights into challenges and successes.

3.1 Pre-implementation phase

The evaluation results for the pre-implementation phase were consistently high, with mean scores ranging approximately from 3.7 to 5.0. In particular, actions related to defining goals, identifying target groups, and preparing implementation were rated very positively. These findings strongly support the relevance of the framework's pre-implementation components, especially: (1) defining a clear vision and goals, (2) identifying and engaging stakeholders, and (3) planning implementation.

> *"We were lucky to have chosen a well established group of people for collaboration. It was extremely easy to motivate them. However, it was somewhat difficult to motivate people with whom we did not have an existing collaboration."*

At the same time, slightly lower scores—particularly related to resource allocation (mean 3.7) and, to a lesser extent, understanding existing working practices—indicate that some countries faced challenges in fully establishing the necessary prerequisites for implementation. This reinforces the importance of the framework's emphasis on readiness, including adequate resourcing and context analysis, as variability in these areas may impact the effectiveness of later implementation phases.

> *"If the pre-implementation phase was repeated, I would conduct a questionnaire among healthcare staff about their current practices in lifestyle counselling to gain a better understanding of their work. This would help us design training that supports them effectively and addresses their specific needs."*

3.2 Implementation phase

The implementation phase received overall high evaluations, with a total mean score of 4.4 and most individual components ranging between 4.2 and 5.0. Core implementation activities—such as the adaptation of Smart Family materials (mean 5.0), training of professionals (4.8), and active monitoring of the implementation process (4.8)—were rated particularly strongly, indicating that the delivery of the method was successfully carried out across participating countries.

These findings confirm the framework's strong emphasis on capacity building and structured implementation support. Training was generally perceived as effective in increasing understanding of the method (4.7) and building confidence (4.3), while access to materials (4.7) and ongoing support (4.5) were also rated positively. This suggests that the key enabling structures for implementation were largely in place.

However, a clear gap emerges between implementation delivery and consistent use in practice. The lowest score was observed in how the use of the method by professionals was monitored (mean 3.5), indicating challenges in systematically tracking and ensuring consistent application. In addition, slightly lower scores related to the practical use of tools (4.2), feedback collection (4.2), and implementation adjustments (4.2) suggest that mechanisms supporting continuous learning and improvement were less consistently established. These findings align with previously identified barriers (e.g. professional adoption

and resource constraints), demonstrating that the framework correctly identifies critical risk areas.

> *"If the implementation phase was repeated, it would be useful to increase communication and motivate included professionals to do more work."*

3.3 Post-implementation (maintenance) phase

The post-implementation phase was evaluated very positively, with a high overall mean score of 4.7 and individual components ranging from 4.5 to 4.8. The majority of responses were at the highest rating level, indicating a strong and consistent perception of successful post-implementation activities across countries. In particular, activities related to collecting and analyzing results (4.8), communicating outcomes and next steps (4.7), and defining goals for further implementation (4.8) were rated highly. These findings suggest that countries were able to effectively reflect on initial implementation, share results with key stakeholders, and plan future actions.The results also indicate that, in most cases, processes supporting continuation and scale-up—such as informing professionals and defining expansion goals—were well established.

> *"We received strong support from the coordinators of various preventive healthcare programs, who greatly contributed to ensuring the sustainability, transferability, and scalability of our work. Their involvement enabled us to bring the Smart Family initiative to a broader audience and include it in the national guidelines. Since it has now become an official tool for nurses to use in their practice, we also decided to develop a manual on applying the method—one that would remain available to them regardless of any future uncertainties related to training organization."*

Although variation in responses was limited, slightly lower scores in the evaluation of implementation success (4.5) indicate that systematic assessment practices may not yet be equally well established across all contexts. This suggests that, while post-implementation activities are generally well in place, further strengthening of evaluation and long-term integration mechanisms is still needed. Overall, these findings reinforce the importance of the maintenance phase as a distinct stage, ensuring that implementation is not only completed but also evaluated, communicated, and translated into sustainable and scalable practice.

Taken together, the responses indicate a positive outlook for the future of the Smart Family method, with strong potential for further integration into existing services. The findings also highlight that a structured implementation approach supports effective and scalable rollout, while capacity building—through training, support, and professional engagement—is critical for successful adoption. At the same time, the importance of context-sensitive implementation and the persistence of resource-related and engagement challenges underline the need for continuous adaptation. Ensuring long-term sustainability will require integration into existing systems, ongoing training, and secure resources (Figure 7).

The evaluation results also provide supportive evidence for the functionality of the Smart Family Implementation framework. The consistently high scores across all phases, combined

with the alignment between identified challenges and observed implementation experiences, suggest that the framework successfully captures the key components required for effective implementation (figure 7).

> *"I believe there is strong potential for the method to grow and be sustained in the future. There is solid support from management, as the Smart Family method aligns well with ongoing efforts in prevention and health promotion. Through the project, we have built a strong foundation for continued work, which will hopefully develop in two directions — on one hand, by providing ongoing training for healthcare professionals and expanding the available materials, and on the other, by addressing systemic barriers such as lack of time and heavy workloads."*

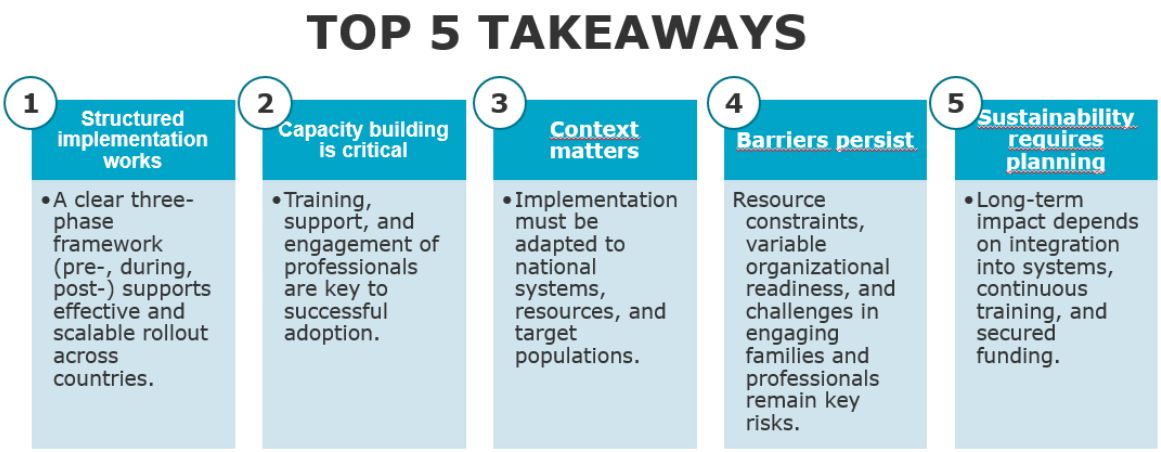

Figure 7. Top 5 Takeaways: Smart Family Implementation

3.4 Conclusions from Evaluation

The Webropol survey results provide strong validation for the implementation strategy adapted from CHRODIS Plus Joint Action and specifically developed into Smart Family Implementation framework. The key components of the framework correspond closely with the experiences of implementing countries (figure 7). Thus, the framework can be considered both empirically grounded and practically applicable, it supported the structured and scalable implementation of the Smart Family method across diverse European contexts.

The Smart Family Implementation Framework provides in future a systematic, scalable, and transferable model to support the implementation and integration of the Smart Family method across diverse European contexts, bridging the gap between evidence-based approaches and real-world practices.

In addition, Joint Action activities in WP4 on sustainability, scalability and transferability supported capacity building through shared learning mechanisms, including e-learning components and cross-country knowledge exchange. The WP6 leader developed an e-learning plan outlining the specific thematic areas that each MS would address, and these plans were implemented accordingly. Each MS, together with the WP6 leaders (THL and FHA),

prepared and submitted a video introduction to the WP4 leader. The link for the e-learning platform is found here: https://www.epicentro.iss.it/en/obesity/joint-action-health4EUkids-wp4-programme-capacity-building.

4. Results of the Implementation and Post Implementation Phases M25-M36

4.1 Results of the chosen key performance indicators

All implementing teams from the implementing countries agreed to monitor a shared key performance indicator focused on the counselling process: change in professionals' self-assessed quality of lifestyle counselling. The partners chose to assess professionals' motivation and capability using a modified version of the 'Encouraging Professional' self-evaluation checklist, adapted into a Likert-scale questionnaire. The checklist (Annex 2) is based on the validated Health Care Climate Questionnaire.

It should be noted that the original purpose of the 'Encouraging Professional' checklist was to support professionals' self-reflection rather than to evaluate their way of working. In this project, however, it was decided to explore whether the tool could also be used to assess changes in counselling practices, as this aspect lies at the core of the Smart Family method. While the participating countries adopted the indicator, it ultimately proved challenging to use it to reliably assess change over time or to make comparisons between countries.

The questionnaire was decided to be sent to the target group professionals before and after the implementation period, so that possible changes could be measured. Each country also defined complementary local indicators aligned with their pilot actions (e.g., training participation, reach of professionals or families, or specific behavior-related aims).

As a result a questionnaire was sent from 4/6 countries (Greece, Poland, Slovenia, Balearic Islands in Spain) to the professionals before, training and during the implementation period. Questionnaires were sent just once during the implementation period by 2/6 MS (Croatia and Lithuania). The targeted number of professionals varied greatly as also offered the amount of and content of training. Also, professionals were not all available consistently to questionnaires. The team from Poland was the only country that reported the results in separate, published articles.

- Greece trained nurses and pediatricians and received 16 answers to the questionnaire before the training and 11 professionals after the training.
- Poland trained future dietitians and nurses and targeted to reach 200 students. They received 139 answers before and after the training offered.
- Slovenia trained community nurses and coordinators of community nursing. They received 13 answers before the implementation and 50 after the training.

- Spain (Balearic Islands) trained paediatric professionals and received 8 answers before the training and 3 answers after the training.
- Croatia trained professionals from kindergartens in three different trainings and used the questionnaire each time**.** The first questionnaire from the first training received 50 answers, the second 98 and the third 108 answers.
- Lithuania received 8 answers from the professionals.

4.2 Results of the implementation and future plans of each country

4.2.1 Policy dialogues

Policy dialogues are more than just a discussion on a specific policy issue or on a project´s outcome. A Policy Dialogue can be the start of a longer policy process or be embedded into an ongoing one. A single dialogue session will not trigger changes. Policy Dialogues gather relevant policymakers and decision makers from relevant domains, also other than health (e.g. finance, environment, infrastructure, etc). The main goal should not be to disseminate information about the results but rather to engage groups of influencers and senior change-agents in a practical and solution-oriented policy discussion.[1,2]

Policy dialogues were carried out between M25 and M36. Each MS was requested to plan and carry out a policy dialogue, including relevant stakeholders and community members, to discuss the sustainability and transferability of the Smart Family method based on the planned results they had from the implementation. The WP6 leaders (THL and FHA) provided support through discussions during monthly meetings and by offering guidance during one-on-one meetings with brand owners (FHA) and Policy dialogue template as additional support. All the six MSs (Slovenia, Croatia, Lithuania, Spain, Poland and Greece) completed the task within the given timeline (M25-M36), reporting the actions of each dialogue (Table 1, Annex 3).

Table 1. Summary of stakeholders, topics and results of policy dialogues in each country.

Country	Stakeholders	Topics discussed	Results / Agreements
Croatia	Ministries (Health, Education), Public Health Network, UNICEF, universities, NGOs, Finnish team	Pilot in kindergartens, evaluation results, training and integration into early childhood education	Action plan: development of materials, continuation of trainings, integration into curricula, cooperation with UNICEF and municipalities
Slovenia	National Institute of Public Health, Ministry of Health, community nursing coordinators, Finnish team	Pilot in community nursing, integration into national preventive programmes (NOW), challenges in workload and resources	Integration into protocol of child health visits, publication and webinar, open access to materials, funding plan through EU projects
Lithuania (Kaunas)	Kaunas municipality, Ministry representatives, PAB/SAB/GAB, implementation team, Finnish team	Families' experiences from the pilot, need for continuation plan and funding	Agreed to prepare a continuation plan (by October 2025), sustainability depends on funding
Poland	Ministry of Health, national institutes (Nutrition, Mother & Child), professional chambers, NFZ, Finnish team	Childhood obesity situation, pilot results, e-learning and training, need for a national strategy	Integration into national guidelines, continuation of trainings and dissemination of materials, commitment at different levels
Spain (Balearic Islands)	Regional health services, child and youth programme coordinators, mental health representatives, nurses and doctors, Finnish team	Local adaptation of Smart Family, integration into Child Health Programme and Positive Parenting programme	Longer consultation times, advanced practice nurses, group sessions, integration of materials into programmes and digital portal, cross-sectoral collaboration
Greece	Representatives from WHO Europe, UNICEF Greece, the Hellenic Ministry of Health, the European Public Health Association (EUPHA), the food sector, and leading clinical and public health scientists.	Childhood obesity situation and modifiable and non-modifiable factors affecting obesity, barriers to reducing obesity, breastfeeding and its role, equal opportunities for all children, different policy-suggestions	Maintaining mandatory professional training certification in the 6th YPE, elevate inter-ministerial coordination proposals, work towards a formal co-ownership structure for the child obesity programme in Greece, produce a white book of policy recommendations to be produced from this dialogue, ensure that the food sector engages constructively and acknowledge its role in shaping the food environment

4.2.2 Results -Thematic Analysis

Across participating countries (Croatia, Greece, Lithuania, Poland, Slovenia and Spain – Balearic Islands,), policy dialogues consistently demonstrated that the Smart Family approach is perceived as relevant, practical, and suitable for scaling beyond pilot phases. The

discussions focused primarily on sustainability, institutional integration, and implementation capacity rather than on validating the approach itself.
A key cross-country theme is that long-term sustainability depends on embedding Smart Family within existing systems, including healthcare, education, and community services. Countries identified different entry points: early childhood education (Croatia), primary healthcare (Slovenia, Poland), regional programs (Spain), and continuation planning (Lithuania). Greece further emphasized that sustainability is constrained by fragmented governance structures and the absence of inter-ministerial coordination.

Workforce development and training emerged as central implementation requirements. All countries highlighted the need for continuous professional training; however, Greece provided additional insight into professional gaps, role conflicts, and workforce shortages, particularly in peripheral regions.

Resource constraints were identified as the most persistent barrier across all contexts. These include lack of time, personnel, funding, and organizational support. Greece additionally highlighted territorial inequalities between urban and rural areas, which significantly affect implementation capacity.

Family engagement was recognized as both essential and challenging. While several countries noted low participation or the need for practical activities, Greece introduced a cultural dimension, emphasizing the role of food in social and emotional life, which influences behavior and intervention effectiveness.
Early intervention was consistently emphasized across countries, with strong support for targeting the prenatal period, early childhood, and school environments. Greece reinforced this with biological and clinical evidence on early-life determinants of obesity.

4.2.3. Results - Policy Recommendation Analysis

Policy recommendations across countries can be grouped into five main categories: structural integration, workforce development, service delivery redesign, governance and coordination, and regulatory action.

Structural integration represents the strongest and most consistent recommendation, with countries advocating for embedding Smart Family into national programs, guidelines, and curricula. Workforce development focuses on establishing sustainable training systems for professionals.

Service delivery redesign includes proposals such as extended consultation times, group-based interventions, and integration into routine healthcare contacts. Governance-related recommendations, particularly highlighted in Greece, stress the need for formal inter-ministerial coordination mechanisms.

Regulatory actions include taxation, marketing restrictions, and food labelling reforms, often requiring EU-level coordination. Greece provides the most comprehensive policy package approach, combining multiple interventions simultaneously.

Feasibility varies across recommendations. Short-term actions include dissemination of materials and training, while structural reforms require political commitment and long-term investment.

4.2.4. Discussion and Conclusions

The policy dialogues confirm strong cross-country agreement on the value of the Smart Family approach. However, long-term impact depends on transitioning from project-based activities to institutionalized systems.

Greece provides critical additional insight by highlighting governance fragmentation as a central barrier and emphasizing the need for coordinated multi-level policy action. The Greek case also underscores the importance of cultural, socioeconomic, and regional factors in shaping implementation outcomes.

Overall, the findings suggest that the main barriers to scale-up are organizational rather than conceptual. Future efforts should prioritize institutional integration, workforce capacity, stable funding, and effective cross-sector collaboration.

In conclusion, the Smart Family approach has strong potential for scale-up across EU Member States, provided it is embedded within existing systems and supported by coherent policy arrangements and governance structures.

4.3 Detailed results from Poland as an example

The Smart Family practice was successfully adapted and implemented in Poland within the EU Joint Action Health4EUKids, addressing the growing burden of childhood overweight and obesity and their long-term health and economic consequences. The approach is based on a family-centered, preventive model that actively engages primary healthcare professionals and educational staff who maintain regular contact with children and their families. The implementation and its outcomes are described in detail in *Children*[3] and *Pediatric Reports* [4], with supporting evidence from earlier research on family-based lifestyle interventions.

The implementation in Poland pursued three main objectives: (1) developing an integrated support model for families with children with non-normative body weight, (2) increasing public awareness and promoting healthier dietary behaviors, and (3) strengthening professional competencies through a “Train the Trainers” approach. The process was carried out in three phases: pre-implementation (months 1–13), which included contextual analysis and adaptation of Finnish Smart Family tools to the Polish setting; implementation (months 14–30), which involved deployment of the program, including a dedicated website, adaptation of 11 existing tools and development of 2 new ones, training of professionals, and introduction of educational materials and an e-learning course; and post-implementation (months 31–36), focusing on evaluation and policy dialogue with key stakeholders.[3]

Since March 2024, the model has been implemented through structured training sessions targeting professionals working, or planning to work, with families of children with excess weight. In total, 295 participants were trained, including dietitians (52.2%), nurses (34.9%),

and school staff (12.9%). The results of the training are reported in a published article in *Pediatric Reports* [4].

Before the training, nearly half of the participants reported no prior experience with family-based lifestyle interventions. Following the training, over 70% expressed readiness to implement the Smart Family method, alongside high levels of interest (80.7%), motivation (76.5%), and satisfaction (83.6%). Most participants (>85%) recognized its potential to promote healthy lifestyles and enhance parental engagement. However, key barriers included limited family cooperation (87.8%), staff shortages (81.0%), insufficient training (78.4%), and constrained resources (43%).[4]

The pilot demonstrated that the Smart Family methodology is practical, acceptable, and applicable in both clinical and community settings. It supported professionals in engaging families through motivational and non-judgmental communication, facilitating sustainable changes in nutrition, physical activity, sleep, and daily routines.[3,4]

The findings highlight the need for stronger national-level support to ensure sustainability and scalability, the development of unified standards for child health promotion, and increased involvement of media and local authorities in creating supportive environments. Broad stakeholder engagement, including ministries, national institutes, and professional organizations—indicated strong potential for long-term integration into routine healthcare and educational systems.[3,4]

Overall, the Polish experience confirms that Smart Family is a scalable, evidence-based approach that strengthens professional capacity and provides practical tools for engaging families. Its integration into healthcare and education systems represents a promising strategy for the long-term prevention of childhood obesity and related non-communicable diseases.[3,4]

5. Awareness-raising and communication activities supporting implementation

Within WP6, the transnational awareness-raising campaign related to the Smart Family method and Childhood Obesity was implemented through decentralized and context-specific communication activities rather than through a single, centrally coordinated transnational campaign. Communication was embedded in national pilot actions and aligned with each country's implementation strategy, target groups and service structures.

Across Member States, different communication approaches were adopted depending on whether the primary focus was on professional capacity building, direct engagement with families, or integration into existing service pathways. In some countries, communication activities were mainly directed at professionals. For example, in Poland, awareness-raising focused on healthcare and education professionals through training and complementary professional events, including seminars organized alongside capacity-building activities.

In other countries, communication activities also target families. Slovenia, Croatia, Greece and Lithuania implemented direct communication towards families through national or local

websites, service-based events and interactions within existing care or educational settings. These activities made use of Smart Family materials designed for families and addressed lifestyle-related themes such as nutrition, physical activity, sleep, children's overweight and obesity. Communication towards families was closely linked to service delivery and pilot activities and supported discussions between professionals and families.

In the Balearic Islands (Spain), communication was primarily based on personal and service-level contacts within primary healthcare settings. Although no broad digital or media-based campaign was implemented, family-oriented Smart Family materials were used to support counselling and discussions within existing care structures, contributing to awareness-raising at the point of service delivery.

At the transnational level, awareness-raising related to childhood obesity prevention and professional practice change was further supported by the WP6 leader (THL and FHA). This included assistance in the production and adaptation of communication materials, such as translating and subtitling videos for families and professionals and developing animations for both professionals and families. The materials addressed topics such as the use of Smart Family tools and obesity-related stigma and were made available for use by Member States according to their local communication needs.

Overall, the transnational awareness-raising campaign under WP6 was implemented as an integrated part of national pilot actions rather than as a stand-alone campaign. Consequently, no common campaign strategy, reach indicators or formal evaluation of campaign effectiveness were defined at the WP level. Instead, communication activities were designed to support local implementation goals, professional engagement and family-level interaction within existing systems and services.

In addition, Member States reported these communication and awareness-raising activities as part of their WP2 communication actions, in line with the Joint Action's overall dissemination and communication approach.

6. References

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7. Annexes

1. Wepropol -report. Experiences on the Implementation of Smart Family-method
2. Modified version of the 'Encouraging Professional' self-evaluation checklist, adapted into a Likert-scale questionnaire.
3. Policy dialogue reports from each member state
4. Smart Family policy dialogues – presentation in Patras Meeting /Nella Savolainen THL