AMSTERDAM'S APPROACH TO HEALTHY WEIGHT MAINSTREAMS A MAJOR FOOD SYSTEMS CHALLENGE THROUGHOUT THE WHOLE CITY GOVERNMENT. RATHER THAN CONSIDERING CHILDHOOD OBESITY A PUBLIC HEALTH MATTER, IT REQUIRES ALL DEPARTMENTS TO CONTRIBUTE THROUGH THEIR POLICIES, PLANS AND DAY-TO-DAY WORKING. TO ENSURE EFFICACY, AND TO PROVIDE SOUND EVIDENCE TO SUPPORT CONTINUING POLITICAL COMMITMENT ACROSS ELECTORAL CYCLES, IMPACTS ARE CONTINUOUSLY MONITORED, AND ADJUSTMENTS ARE MADE TO THE POLICY WHERE NECESSARY.
The health of Amsterdam's youth is in jeopardy. In 2013 around 21% of under-18s in the Dutch capital were overweight or obese— with children from immigrant families and families with low income and low social status particularly affected (City of Amsterdam, 2013).

The effects of overweight and obesity in childhood — poor health and greater risk of serious illness, social stigma, poor concentration and low educational attainment — can last a lifetime.

In 2012, Amsterdam set its sights on eradicating overweight and obesity in the city by the year 2033. Introduced the following year, the Amsterdam Healthy Weight Programme (AAGG) is aimed at all children under the age of 19 and their parents, care-givers and teachers, but there is a particular focus on children who are already obese and those from high risk social groups (City of Amsterdam, 2013; City of Amsterdam, 2015; City of Amsterdam, 2014).

Unlike obesity programmes in other cities — and previous attempts to address the problem in Amsterdam — the AAGG is not simply a public health plan. Rather, it contains integrated actions across the departments of public health, healthcare, education, sports, youth, poverty, community work, economic affairs, public spaces and physical planning, and organizations from outside local government. What is more, it seeks to address the structural causes of obesity — that is, the individual lifestyle factors and values and psychological aspects underlying them, the social and physical environment, and living and working conditions that make it difficult for people to ensure their children eat healthily, sleep enough and exercise adequately. The city aims to facilitate healthier behaviours by making the healthy choice the easy choice, and creating a healthier urban environment.

Day-to-day running of the programme is informed by seven understandings or principles:

- Eradicating overweight and obesity is a long-term task that will take a generation;
- The programme, actions and activities must be sustainable;
- The programme is inclusive — of all people and across all policy areas;
- Addressing childhood obesity is a matter of shared responsibility;
- The approach is evidence-based — ‘learning by doing, doing by learning’;
- Choices must be made to focus efforts;
- Prevention first, but do not forget children of the present.

The AAGG has 10 pillars for action. The first six, mainly aimed at preventing children from becoming overweight or obese, are:

1. the first 1000 days (from the start of pregnancy until age two)
2. schools-based (including pre-schools and primary schools)
3. neighbourhood-based
4. healthy environment (healthy urban design, healthy food environment)

30. Around 27,000 children, of whom an estimated 2,300 were morbidly obese
31. Amsterdamse Aanpak Gezond Gewicht
32. The ‘neighbourhood-based’ pillar is the practical entry point for activities under all the other pillars. It serves to translate the approach of the AAGG to the ultra-local level in ten of the city’s most disadvantaged neighbourhoods. Signals are also picked up from these neighbourhoods about the reach and effectiveness of the AAGG on the ground, which helps inform development of the overall approach.
The seventh pillar is curative:
7. helping children who are overweight or obese to regain a healthier weight

The final three pillars are secondary or facilitative:
8. learning and research philosophy
9. digital facilities
10. communications and methodologies for behavioural insights

This case study explains the origins of the AAGG, how the policy was developed and how it is being implemented. It shows how Amsterdam was able to take a strong stance on obesity that diverged from policy framing at the national level, and how the programme team has engaged and mobilized partners — from within local government, civil society and, to a degree, the private sector — to work towards an ambitious common goal.

A POLITICAL CHAMPION

The impetus for developing the AAGG came from 2012 data showing that childhood overweight and obesity in Amsterdam was above the Dutch average, and that children from certain social groups were particularly at risk. The City Council’s Alderman (Deputy Mayor) responsible for public health, care and sports, Eric van der Burg of the VVD (the liberal-conservative People’s Party for Freedom and Democracy), understood the gravity of the problem and propelled childhood obesity to the top of the city’s agenda. As a result of van der Burg championing the issue, in late 2012, the College of Mayor and Alderpersons, the executive governing the city, formally committed to Amsterdam’s new approach to childhood obesity.

This initial commitment did not include funding — and deliberately so. The Alderman insisted that implementation should draw on existing resources from across city departments, to show what could be achieved through cooperation and taking joint responsibility. Directors of all departments were instructed to provide the programme manager — who was paid by the Department of Social Development — with any assistance required.

Following the municipal elections in March 2015, the follow-up plan for 2015-18 was put to the vote by the new Mayor and College of Alderpersons — and again it passed unanimously. By now inter-departmental cooperation had been established and annual funding of €2.5 million was assigned to the AAGG out of the city budget. This is supplemented by additional funds of around €2.81 million from national government, mostly consisting of short-term funding for specific projects or objectives.

33. 15% of under 18s across the whole of the Netherlands are overweight (City of Amsterdam, 2013).
34. The College of Alderpersons is the Mayor’s executive council. Each alderperson has a policy portfolio. Amsterdam’s policies are developed through cooperation between the City Council and the Mayor and College of Alderpersons.
35. At the time the VVD was the largest party in the Dutch coalition government.
36. The incumbent Mayor Eberhard Edzard van der Laan was reappointed for a second term in 2014 and Alderman van der Burg also held his seat, but there were some changes amongst the other six Alderpersons, from various political parties.
37. Around 0.04% of Amsterdam’s total annual budget of €6.3 billion.
CLASH OF POLICY APPROACHES

In the opinion of Alderman van der Burg, the city is responsible for tackling the obesity epidemic, on the grounds that when people lack the knowledge and capability to maintain a healthy weight of their own accord, it is the (local) government’s job to help them. In this respect the Alderman has gone against the grain of his own political party, which maintains that a healthy lifestyle is a matter of individual (parental) responsibility. The Dutch government — in which the VVD has been the senior coalition partner since 2010 — runs information campaigns to persuade people to eat healthily, whilst favouring voluntary commitments by food companies on healthy food and advertising (Coojie Dijkstra et al., 2016).

The different policy approach at the national level has not prevented Amsterdam from charting its own course over obesity. Under the national Public Health Act of 2000, local governments are responsible for devising, implementing and funding public health policies that are tailored to local issues and circumstances. However, some aspects of the urban food environment, such as advertising directed at children and the low cost of unhealthy food, are outside the control of local governments. Consequently, the AAGG focuses primarily on actions that fall within the sphere of control and influence of local government and takes a public stand on issues outside of its control when the opportunity arises.

38. This includes all children, but it is especially true for those whose parents or care-givers lack the knowledge and skills to ensure they have healthy lifestyles.

39. Such as the ‘Wheel of Five’ (Schijf van Vijf), a graphic depiction of a healthy diet by food type, and slogans such as ‘two hundred grams of vegetables and two pieces of fruit a day’ (Voedingcentrum, 2016; Coojie Dijkstra et al., 2016).

40. For example, in 2015 Amsterdam became the first city in the Netherlands to join the national ‘Stop Kindermarketing’ Alliance to curb advertising aimed at children.
PARTICIPATORY, RESEARCH-BASED POLICY DESIGN

The programme manager put together an inter-departmental and multi-disciplinary team to draw up the first AAGG programme plan, which included actors from the departments of Health, Housing and Social Support, Sports, and Work and Income (City of Amsterdam, 2013).

Some early inspiration was drawn from the French EPODE\(^{41}\) programme (known as JOGG\(^{42}\) in the Netherlands), a method that mobilizes the whole community in a collective effort to prevent obesity. However the team found that while EPODE is applicable in small communities, it does not provide a practical method for designing and implementing an integrated programme in a metropolitan context.

To develop a model that would be applicable in Amsterdam, the working group enlisted the help of academics, including Professor Karien Stronks, a well-known specialist on the links between poverty and public health (e.g. Stronks et al., 2014; Stronks & Droomers, 2014). Stronks' Rainbow Model (based on Dahlgren & Whitehead, 1991) for identifying factors at various policy levels that influence healthy or unhealthy weight in individuals and in groups of children was adapted to the Amsterdam context, and incorporated into the underlying framework of the programme in 2014. Another significant contributor has been Professor Jaap Seidell, a renowned obesity specialist who has shown that addressing obesity requires a change in the way people live their lives, not just a change in diet (e.g. Seidell, 1999; Seidell et al., 2012; Seidell, 2012).

\(^{41}\) Ensemble, Prévenons L’Obésité des Enfants (‘together, let’s prevent childhood obesity’)

\(^{42}\) Jongeren Op Gezond Gewicht (‘young people at a healthy weight’)
MAKING THE MARATHON MANAGEABLE

The programme team laid out the overarching policy framework in an initial plan for 2013-14. Using the analogy of the sustained effort required to run a marathon, the plan outlines the steps to address childhood obesity over a 20-year period, at the end of which all children under the age of 19 are to be a healthy weight. The ‘marathon’ is broken down into a series of shorter ‘races’ with specific targets:

- **2018** – the 5000 metre race: a healthy weight for 0-5 year olds in Amsterdam
- **2023** – the half marathon: a healthy weight for 0-10 year olds in Amsterdam
- **2033** – the marathon: a healthy weight for young people in Amsterdam

In 2015 the team released the follow-up plan for the 5000 metre stretch. The Plan contains actions to meet the interim goal of all under fives being a healthy weight (City of Amsterdam, 2015).

This step-wise approach is intended to reduce the threat posed by electoral cycles. The next municipal elections will take place in 2018, and initial evidence on the outcomes will help make the case for continuing the AAGG should there be a change of city administration.

LEARNING BY DOING, DOING BY LEARNING

The guiding principle of ‘learning by doing, doing by learning’, means that the AAGG, and activities and policies under it, are subject to constant, rolling review. Two new teams were established to

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43. The City collects data on obesity prevalence part of the Youth Health Care system in the Netherlands, under which every child has an appointment with a nurse at fixed points up to the age of 18. This enables the AAGG team to track weight status of children, their physical activity, screen time and consumption of sugary drinks, fruits and vegetables.
facilitate this: an external ‘academic expert team’ (including Professors Stronks and Seidell), and an internal ‘public health service expert team’ made up of staff who track and interpret health data. The role of both teams is to provide new evidence-, practice- and eminence-based insights on obesity, to advise on interventions, to consult on lessons to be drawn from experience, and to participate in new research.

The AAGG uses a dedicated online platform to keep track of the progress of all the projects and activities. The programme team actively consults with the internal ‘public health service expert team’ concerning questions, dilemmas or unexpected outcomes. Where practice or evidence shows that an intervention is not yielding expected results, remedial actions are taken rapidly to avoid wasting valuable resources. For example, a new policy for schools to provide children with only tap water to drink had the unexpected effect of increasing sugar consumption, because some parents perceived juice to be healthier than water and, thinking their children were missing out on vitamins, gave them more juice to drink outside of school. When the AAGG team realized that this was cancelling out the benefits of the tap water policy, they addressed it by engaging and educating parents (see below).

AAGG is also supported by Sarphati Amsterdam, which reviews the efficacy and sustainability of measures to tackle childhood obesity, such as the impacts of school gardens on children’s vegetable consumption in deprived areas (Coosje Dijkstra et al., 2016).

GOVERNANCE STRUCTURES TO PROMOTE CROSS-DEPARTMENTAL INTEGRATION

In 2012, the Mayor and Alderpersons assigned responsibility for programme development to the director of the Department of Social Development. While the director of Public Health might have been a more obvious choice, this sent a clear signal that children’s weight is not just a public health issue, but that all departments have an equal obligation to act and develop supportive policies.

In 2015, at the end of the strategic phase and once inter-departmental responsibility was established, coordination for the current phase (2015-18) was transferred to the Public Health Service, which has expertise in developing interventions, and compiles databases on health indicators.

We like people to adopt healthy lifestyles. I could not imagine that before. The Healthy Weight Strategy and the Food Strategy has changed the focus of urban planning and of our Health department. We just did not think like this before... It was a change in the way we all think.

Official from the Amsterdam Department of Physical Planning and Sustainability

44. Eminence-based means based on the opinions of prominent health professionals or medical specialists.
45. www.uitvoeringgezondgewicht.nl
46. Sarphati Amsterdam is a research institute founded in 2015 by the City of Amsterdam in partnership with several universities in the city. Research is based on a dynamic cohort of children under 19 in the city (around 180,000 at any time).
An inter-departmental working party has been established for each of the ten pillars of the AAGG, to enable close integration across city departments and services, and within local areas and communities — and, as a result, ensure that no child at risk of obesity goes undetected (City of Amsterdam, 2013).

The AAGG team also works closely with complementary city programmes, such as Moving Amsterdam, the Amsterdam Poverty Programme and the Amsterdam Food Strategy, which originally focused on urban agriculture, local economy and sustainability but now has a workstream on healthy weight. The respective programme managers of each initiative constantly seek ways to be mutually supportive, which has helped to put public health on more agendas within the city and helps avoid duplicate spending of precious city funds.

**OVERCOMING BARRIERS TO CROSS-DEPARTMENTAL WORKING**

Several barriers to cross-departmental cooperation nonetheless had to be tackled. For example, the Public Health Service and the Department of Physical Planning needed to work closely together to implement actions under the ‘healthy urban environment’ pillar. Thinking about food in public spaces was relatively new to public health officers, while planners had little understanding of how their work affected public health, having previously focused on large-scale infrastructure and housing projects. The key to changing mindsets in both departments was their shared involvement in the Amsterdam Food Strategy and Moving Amsterdam. Encouraged by these experiences, Public Health and Physical Planning began cooperating over specific, small-scale activities and sub-
sequently formalized their relationship by each assigning an officer as a contact point for the other department\(^47\).

Another example concerns the Board of Education, which was approached by the AAGG team to endorse Jump-In, the programme to promote healthy eating and drinking and exercise in schools. The Board initially declined on the grounds that schools have to be selective about topics they can address alongside their core role of educating children. Undeterred, the team went knocking on doors of individual school directors. This was more fruitful as teachers at the operational level appreciated the educational benefits of addressing overweight and obesity: overweight children have psychological problems that affect learning ability and school atmosphere, and healthy children ultimately leave school with more qualifications. Once a critical mass of schools had signed up, the team returned to the Board of Education, and this time secured endorsement.

**ENGAGING EXTERNAL PARTNERS**

Implementation of the AAGG also relies on partnerships with non-governmental partners, such as local civil society and community-based organizations, universities, small and large retailers, and Zilveren Kruis, the principal health insurer in Amsterdam\(^48\).

The way in which the AAGG team works with non-governmental partners varies from pillar to pillar.

Community groups, religious organizations and citizens are particularly involved in the ‘neighbourhood-based’ pillar of the AAGG. The AAGG team holds public meetings to determine programmes that would be most beneficial to each neighbourhood, and to help individuals and community groups change their practices and policies to promote healthier eating and exercise.

It was at one such meeting in a neighbourhood in Eastern Amsterdam that a mother asked a question about fun and healthy activities for Mothers’ Day. The ideas shared in response promoted an ‘oatmeal revolution’, with dozens of women and organizations preparing oat-based breakfasts and sweets with their children — and even using oats in healthier versions of traditional Ramadan recipes.

For the ‘curative’ pillar (focused on already obese children), engagement of more than 20 umbrella organizations in the civil society, sport, welfare, care and healthcare domains was obtained through the Healthy Weight Pact, an initiative of Zilveren Kruis and the AAGG team in 2012\(^49\). Signatories of the Pact committed to ensuring overweight children receive appropriate care — and it served to introduce them to the preventative work of the AAGG too.

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\(^47\). The Department of Physical Planning has now adopted Moving Amsterdam and the AAGG serves as advisor.

\(^48\). In 2012, health insurers were important actors as they funded children’s care at the local government level. In Amsterdam — and the rest of the country — standards of care for obese children were inadequate. In 2015 the role of health insurers changed when decentralization of the youth care system gave new responsibilities for children’s care, mental health, and protection services, and parental education, to local governments.

\(^49\). The Pact, and the curative pillar to which it applies, is based on the idea that a care plan for treating overweight and obesity should strengthen a family’s own management system by reducing threats (e.g. psychological problems) and providing positive tools (e.g. parenting skills). All actors involved in the chain of care participate in this vision. The AAGG commissions a number of interventions designed to strengthen the chain of care and, thanks to an agreement between Zilveren Kruis and the AAGG, each family with an obese child is assigned a Central Care Manager (from the youth public health team) to coordinate the care plan and act as a point of contact for all professionals involved.
The early commitments under the Pact notwithstanding, the AAGG team had to take an experimental approach to some of its external relationships, and has adapted its approach to overcome barriers. For instance, the team seeks to work with retailers who are willing to experiment with stocking healthier food. Some small retailers have been amenable to the idea in principle, but they fear they will lose business if they remove confectionery and sugary drinks from the shelves. As a result, the project team has developed a strong business case based around demand for healthy products. Of the larger retailers, so far only Ahold (Albert Hein) has agreed to trial changes in store layout and the use of sales assistants as coaches to start discussions with customers. The AAGG leaders hope to engage retailers beyond these pilots, whilst remaining selective about the companies they will partner with — particularly big firms which claim to heed the national government’s call for voluntary action on obesity but continue to produce and market food products with a relatively high fat and sugar content.

**ENGAGING WITH PEOPLE AFFECTED BY THE PROBLEM**

The AAGG team has learned over time that it is vitally important to engage with the people affected by the problem. For example, the unexpected outcome of the school tap water policy mentioned above had come about because parents had not been adequately involved in the policy process. They moved to address the problem by developing an educational programme using interactive theatre to engage and inform parents in a bid to change their attitudes to after school ‘sugar compensation’.

In addition, the team has learned that the most useful information can be obtained by listening to individuals’ needs and wishes, rather than asking pre-set questions. This is particularly applicable in the ‘area based’ and ‘health care’ pillars. For example, during a conversation with a youth public health care nurse, the mother of a morbidly obese child mentioned that she feared visiting the paediatrician. The nurse offered to accompany the mother and scheduled an appointment. During the appointment, the nurse ensured that the mother understood the paediatrician and could comply with their recommendations. In this way, the nurse established a good relationship with the mother, and the mother felt confident enough to ask for a bicycle that would help her to get around more easily during school hours. The nurse introduced the mother to a welfare partner, who helped arrange for her to receive a bicycle and cycling lessons — and as a result of her increased mobility she began visiting the market to buy healthy foods. This positive outcome meant the mother was willing to discuss her child’s weight and lifestyle with the nurse, and agreed to visit health professionals regularly.
OUTCOMES TO DATE

While it is still somewhat early to judge the success of the AAGG, the indications so far are promising. Outcomes monitoring has shown that overweight and obesity prevalence is levelling off, with a 10% decrease in prevalence in children of all age groups between 2012 (just before the programme began) and 2014. There was an even greater decrease — of 18% — among very low social economic groups (City of Amsterdam, 2016). A causal relationship with the AAGG is not certain, however, and national data from the Dutch Bureau of Statistics indicate a levelling out of the percentage of children and adolescents (age 4-20 years) affected since 2012\(^{51}\).

SUMMARY OF ENABLERS

This case study has shown that, in his role as Alderman, van der Burg played a key enabling role in instigating the AAGG, as he identified the need to address childhood obesity from statistical data and secured political commitment. Powers afforded to the city under the 2000 Public Health Act enabled development of the programme, despite opposing views on weight management at the national level. The ongoing involvement of academics in policy design and delivery facilitated a robust, research-based framework, while continuous gathering of impact data means the programme can be adjusted along the way.

While core funding from the city has enabled implementation, this was of secondary importance to establishing strategic, integrated ways of working between government departments. The initial institutional home of the AAGG was chosen to this end. Budgetary constraints have been addressed not only by obtaining supplementary funds under national programmes but also by close monitoring of impacts to ensure no money is wasted on ineffective actions — as well as close involvement with other city strategies to avoid duplication.

\(^{51}\) In 2012 13.2% of 4 to 20 year olds in the Netherlands were overweight, compared to 11.8% in 2013, 12.5% in 2014, and 12.1% in 2015.
The AAGG focuses actions on using local government powers and responsibilities to render the urban food environment healthier, and it is keenly aware of their limits. In so doing, it has found a way to pursue its objectives in spite of the conflict that exists between Amsterdam’s approach to obesity and that of the national level in the Netherlands. Despite being a top-down policy, with no civil society involvement in the initial policy development, it has generated considerable support by listening to community needs. This also encourages take-up of services by those who need them most.

Although as yet untested, the AAGG team has sought to enable longevity by breaking down the 30-year strategy into shorter periods that correspond with election cycles. The intention is to ensure there is solid, fresh impact data available to support ongoing political commitment.

**TABLE 3: KEY ACTORS AND THEIR ROLES**

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<thead>
<tr>
<th>ACTORS</th>
<th>ROLES</th>
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<tbody>
<tr>
<td>Alderman van der Burg</td>
<td>• Made childhood obesity a political priority</td>
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<td></td>
<td>• Instigated the AAGG</td>
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<td>Mayor and College of Alderpersons</td>
<td>• Provided political commitment and funding</td>
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<td></td>
<td>• Required all city departments to contribute to addressing obesity</td>
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<tr>
<td>Department of Social Development</td>
<td>• Provided initial programme leadership to demonstrate that obesity is not just a public health issue</td>
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<td>Pillar working groups</td>
<td>• Enable integrated day-to-day working across government departments and other city strategies</td>
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<td>Public health service expert team</td>
<td>• Tracks programme outcomes</td>
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<td>Academics</td>
<td>• Contributed to conceptual model for AAGG</td>
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<td></td>
<td>• Participate in expert team to provide new evidence-, practice- and eminence-based insights</td>
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<tr>
<td>Sarphati Amsterdam</td>
<td>• Reviews efficacy and sustainability of childhood obesity measures</td>
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<tr>
<td>Central Care Managers (from youth public health team)</td>
<td>• Work with parents and caregivers of obese children to coordinate care, listen to individual needs</td>
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<tr>
<td>Schools/teachers</td>
<td>• Support AAGG objectives</td>
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<td></td>
<td>• Implement Jump-In programme to promote healthy eating and drinking and exercise in schools</td>
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<tr>
<td>Parents and care givers of obese children</td>
<td>• Reinforce policies outside of the school environment</td>
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<td></td>
<td>• Work with healthcare professionals to ensure individualised care for obese children</td>
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<td></td>
<td>• Empowered to improve families’ lifestyles by professionals listening and responding to their needs</td>
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<tr>
<td>Community groups</td>
<td>• Participate in public meetings to provide local information to AAGG</td>
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<td></td>
<td>• Make decisions about their own healthy environment</td>
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AMSTERDAM