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Food and nutrition action plans in the WHO European Region

Past, present and future

REPORT ON A MEETING OF NUTRITION COUNTERPARTS IN THE WHO EUROPEAN REGION,
ATHENS, 28 FEBRUARY – 2 MARCH 2003

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WHO Regional Office for Europe
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2003

ABSTRACT

At the first meeting of nutrition counterparts in Malta in 1999, a draft WHO Food and Nutrition Action Plan was presented. At the WHO Regional Committee for Europe in September 2000, Member States unanimously endorsed the First Food and Nutrition Action Plan for the WHO European Region. The main goal of the WHO Action Plan is for all Member States in the WHO European Region to develop Food and Nutrition Action Plans by 2005. A ministerial conference will be held in 2006 to assess the progress towards this goal. During 2000-2002 workshops were held to assist Member States in developing national food and nutrition action plans. A few countries have finalized action plans, others are nearing completion and many are at the developing stage. Member States are encouraged to network and share experiences during the development of action plans. This second meeting of nutrition counterparts in Athens provided an opportunity to evaluate progress and discussed future priorities for the ministerial conference. The meeting also discussed European input to the Global Strategy on Diet, Physical Activity and Health.

Keywords

NUTRITION POLICY
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1 Introduction

At the first meeting of nutrition counterparts in Malta in 1999, a draft of a WHO Food and Nutrition Action Plan was presented. At the WHO Regional Committee for Europe in September 2000, Member States unanimously endorsed the First Food and Nutrition Action Plan for the WHO European Region and adopted the resolution. One of the main goals of the WHO Action Plan is for all Member States in the WHO European Region to develop Food and Nutrition Action Plans by 2005. A ministerial conference will be held in 2006 to assess the progress made towards this goal.

During 2000, 2001 and 2002 sub-regional workshops were held in the Baltics (Estonia, Lithuania, Latvia) with input from Nordic countries (Denmark, Finland, Iceland, Norway, Sweden), South East Europe (Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Former Yugoslav Republic of Macedonia, Slovenia, Romania, Yugoslavia), CCE (Czech Republic, Hungary, Poland, Slovakia) and Southern Europe (Andorra, Greece, Italy, Israel, Malta, Portugal, Spain, Turkey) to assist Member States in their development of national food and nutrition action plans. A few countries have finalized action plans, others are nearing completion and many are at the developing stage. The WHO Regional Office for Europe has as far as possible encouraged Member States to network and share experiences during the development of national action plans.

In early 2003, the WHO Regional Office for Europe organised a meeting in Athens to provide an opportunity for this networking to continue and for the sharing of experiences. At this meeting in Greece, nutrition counterparts evaluated progress and discussed future priorities for a ministerial conference, especially how to evaluate the progress made between 2000 and 2005 in time for the conference in 2006.

The meeting also provided an opportunity for discussions and recommendations on the Global Strategy on Diet, Physical Activity and Health. The Global Strategy is aimed at preventing and reducing the growing burden of non-communicable diseases worldwide and improving public health through healthy eating and increasing physical activity. A World Health Assembly Resolution in 2002 requested the WHO Director General to develop this Global Strategy in consultation with Member States and other organizations. WHO is therefore arranging consultations, including regional meetings. The recommendations from this nutrition counterparts meeting have been fed into the European Regional Consultation on the Global Strategy.

2 Aim of this report

The aim of this report is to document fully the Meeting held in Athens, to communicate the discussions covered by individual working groups, and to report the recommendations resulting from the meeting.

3 Opening of the meeting

The Organizing Committee of the Ministry of Health and Welfare, Greece addressed the meeting. Professor Antonia Trichopolou was elected as the Chair of the Meeting and Karen McColl and Maria Ellul were elected as Rapporteurs. The provisional programme for the next two and a half days was approved.

The meeting was opened by Professor Costas N. Stefanis, Minister of Health and Welfare for Greece, Dr Pekka Puska from WHO Headquarters in Geneva and Dr Roberto Bertollini, WHO Regional Office for Europe.

3.1 Professor Costas N. Stefanis, Minister of Health and Welfare, Greece

The Minister warmly welcomed all delegates to the meeting and expressed his appreciation of the close cooperation that the Ministry of Health & Welfare enjoys with the WHO regional office and the Directorate for health and consumers of the European Commission.

Health nowadays, more than ever in the past, is accepted as an essential element of individual well-being and as a key factor in shaping our societies' future. It is therefore of primary concern to preserve high health standards by delivering efficient health care.

WHO and the European Commission have highlighted the most important risks to health in Europe. Some well known risks are associated with patterns such as an unhealthy diet and obesity, high blood pressure and blood cholesterol, tobacco and excessive alcohol consumption as well as physical inactivity. Throughout the developed world, unhealthy consumption is replacing healthier patterns of eating and activity.

In December 1992, the FAO/WHO International Conference on Nutrition adopted a World Declaration and Plan of Action, urging the governments to develop and implement food and nutrition policies and plans for action.

The WHO Regional Office for Europe began a process to develop Food and Nutrition Action Plans throughout the Region. In the first counterparts meeting in November 1999 in Malta considerable progress has been achieved.

In September 2000, the WHO Regional Committee for Europe endorsed the Action Plan for 2000-2005, recommending-*inter alia*- that Member States should take steps to implement the Action plans taking into consideration the cultural, social, legal and economic country's differences.

Greece is working on the national nutrition action plan. It involves all the relevant sectors and players in order to develop a successful food and nutrition policy. In 1999 the Greek Ministry of Health endorsed nutrition guidelines for adults. In parallel the Ministry of Health during the last 10 years is supporting the EPIC study, which covers some 28,000 adults from all over Greece. A data bank has been developed and provides relevant information for the development of a nutrition policy.

In 2002 a national committee on nutrition policy was set, with the mandate to develop proposals for the implementation of nutrition policy. This committee is co-coordinated by the Deputy

Minister of Health, in liaison with the Ministry of Agriculture, the Greek Food Agency and Members of the government responsible for national education, research, youth and sports and consumers' rights.

The Committee set four objectives for immediate action and works on improvement of the core competence of country teams, information sharing, development of a better focus on the national needs and support for effective nutrition policies through standard-setting and technical cooperation.

Policy should be focused on the most important issues and on improving methods for attaining our goals. Partnership is the most important requirement for responding properly and effectively to diet-related health risks.

The Greek Ministry of Health has established cooperation with the European countries under accession, particularly those in rapid transition.

Making a difference means building consensus- not just within the health sector, but also across other sectors so that the collective effort maximizes the outcome.

Aware of these issues, Greece, has made nutrition one of the priorities of its presidency of the European Union, and the WHO meeting will be succeeded by another one entitled "Nutrition in the European Union, in view of the EU Enlargement".

Scientists and Public Health experts from the Candidate Countries will be asked to report on recent developments in the field of nutrition in their countries, as well as their Countries' expectations and problems. The issue of Nutrition Education in Medical Schools will be given particular attention.

The Minister mentioned that if we look into the future, it appears necessary to develop a food policy that will secure the supply of safe and wholesome food products which in turn will maximize food quality and healthy eating. This implies the development of a nutrition health policy, in order to prevent illness and more particularly metabolic and cardiac diseases.

The Minister noted that, during the meeting, delegates would evaluate progress and discuss ways of accelerating the implementation of nutrition policies and that the recommendations from the meeting will clarify priorities. This will enable all to build on our regional perspectives and solidarity.

The Minister hoped that all the delegations would benefit from this meeting as much as the Greek Delegation. To conclude the Minister mentioned that he looked forward to hearing the meeting's conclusions: and wished all participants a nice stay in Athens, a crowded but still hospitable and graceful city.

3.2 Dr Pekka Puska, WHO Headquarters, Geneva

On behalf of the Director General and all at WHO Headquarters in Geneva, Dr Puska thanked the Greek Ministry of Health and Welfare and the organising committee, along with WHO Regional Office for Europe for organising this meeting and ensuring that Europe remains instrumental in the establishment of a global strategy in relation to nutrition.

The WHO is now really scaling up its response to the rapidly growing burden of non-communicable diseases (NCDs). Since the Resolution at the World Health Assembly in 2000, WHO has been upgrading its work in relation to prevention and control of the epidemic of NCDs. The World Health Report 2002 further strengthened the basis for action by highlighting how such NCDs are a major public health problem in most parts of the world.

Nutrition is at the forefront of this public health challenge. Few risk factors have been shown to have overwhelming importance - in fact, half of all of the top ten risk factors are related to nutrition and physical activity.

This meeting takes place at a very important time. Friday 28th February was the last day for negotiations on the binding Framework Convention on Tobacco Control, another very important pillar of NCD prevention.

Furthermore, WHO is currently finalising a two year project on diet, nutrition and chronic disease at this time. Last details of the report of this work, entitled Diet, Nutrition and the Prevention of Chronic Diseases, are currently being finalised and the report is planned for release on Monday 3rd March. This report will form the basis for preparing a global strategy on diet and health. The World Health Assembly called on WHO to intensify its work in relation to NCDs. The publication of this report will form an essential part of that. Later in the meeting Dr Puska presented the proposals for a Global Strategy on diet and physical activity in more detail. Dr Puska again congratulated the organisers of the meeting and expressed his hope for a very fruitful meeting.

3.3 Dr Roberto Bertollini, WHO Regional Office for Europe

Dr Bertollini expressed a warm welcome on behalf of WHO's Regional Director for Europe, Dr Marc Danzon. He added his thanks to the Greek government for its hospitality in the wonderful city of Athens.

This meeting takes place half way through the process of implementation of the Food and Nutrition Action Plan endorsed by the Regional Committee for Europe in 2000. The Ministerial Conference to review implementation of the Food and Nutrition Action Plan will take place in 2006. It is time now to look at the work done, identify the achievements and the problems, as well as make use of the positive experience made by some member states to the benefit of others. This meeting is not an isolated event. Several sub-regional events have taken place over the last years facilitating interactions among countries with similar situations and allowing for an exchange of experiences which has certainly facilitated the overall process. This approach is becoming a standard way of addressing common issues among Member States in WHO EURO. We are trying to use this approach in other areas, allowing for Member States to identify synergies and discuss issues in more depth to then facilitate the achievement of a common position in the global negotiation.

Nutritional factors are still an important determinant of public health in the European Region. There is no need to detail the statistics to this meeting of Nutrition Counterparts. What is clear, is that in order to address these very crucial public health issues we need to develop and implement effective policies based on evidence and good practice. Effective policies need to go beyond the old-fashioned lifestyle approach, while considering nutrition as a developmental issue, part of the broader societal context and not just an individual choice.

Poverty is another important issue facing the European Region and it is an issue which is important for nutrition. A recent review by WHO has shown that food choices depend on what is available and affordable as well as on consumer education, marketing strategies and the mass media.

Therefore, proper national policies in the nutrition area need more than ever before an intersectoral approach, involving agriculture, food industry, trade but also the communication sector, information and advertising.

The process leading to the preparation, adoption and implementation of the national Food and Nutrition Action Plans aims to facilitate this intersectoral approach and to allow for it to be not only a theoretical framework but a guidance for effective action.

Planning alone is not enough. Implementation cannot lead to improvement without a mechanism to evaluate the results achieved and to assess the progress made or not made. Surveillance and monitoring are key for the Action Plan.

This meeting will be crucial in developing the WHO EURO input into the consultation on the Global Strategy on Diet, Physical Activity and Health. Dr Bertollini concluded by stating his conviction that the European Region can make a very important contribution to the development of the Global Strategy and wished the meeting much success.

4 Food and Nutrition Action Plan - the past

The first day of the meeting was designed to review progress which had been made in implementation of the First Food and Nutrition Action Plan in the WHO European Region since the endorsement by Member States in September 2000.

Dr Aileen Robertson of the WHO Regional Office for Europe provided an overview of developments at the Regional and sub-Regional levels. Participants then broke into Working Groups and reviewed progress at the national and sub-regional level in implementing the First Action Plan for Food and Nutrition Policy.

Following feedback from the working groups, there were presentations from two other UN agencies involved in nutrition activities. Dr Arnold Timmer of UNICEF's Regional Office for CEE/CIS and the Baltics, described UNICEF's nutrition priorities in Europe. Dr Michael Canon of the FAO subregional office for Central and Eastern Europe, described FAO's nutrition priorities in Europe. The presentations are summarized in the papers below.

4.1 Progress on implementing the First Food and Nutrition Action Plan in the WHO European Region, 2000 - 2005

Dr Aileen Robertson, WHO Regional Office for Europe

At the meeting of the Regional Committee for Europe in September 2000, participating Ministers of Health were shown a video which illustrated the inarguable links between environment, food safety and nutrition and which highlighted the costs of food-related ill-health. The video also demonstrated the need to integrate food safety, nutrition and sustainable development policies through food. Following this video and the ensuing discussions, the Regional Committee unanimously endorsed a regional Food and Nutrition Action Plan along with a commitment to the development of national food and nutrition policies.

Review of developments 2000 - 2002

Dr Robertson reviewed the progress since September 2000 and highlighted a number of activities which have taken place at the Regional or sub-Regional level. These include:

- Three workshops in Baltic countries and the establishment of a Public Health Nutrition network for Baltic/Nordic countries enabling a useful exchange between the Baltic and Nordic states;
- Three workshops in South Eastern Europe including a workshop of the Stability Pact on the Nutrition and Food Safety Project and the DAFNE project. A Public Health Nutrition Network for Stability Pact countries has been established;
- In the Russian Federation, development of regional Food and Nutrition Action Plans started in 1999.

One workshop in Southern Europe took place in 2002. This is followed by this current meeting in Athens on FNAPS past, present and future.

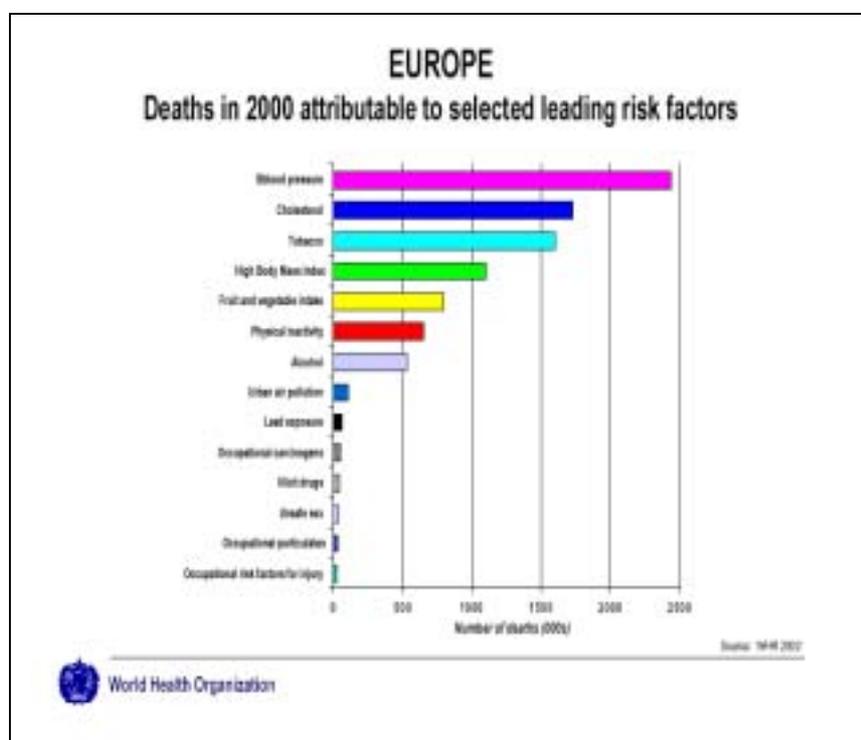
All of the above took place as a result of the Food and Nutrition Action Plan. There have also been other important and relevant activities undertaken by WHO's Nutrition and Food Security Programme between 2000 and 2002. These include:

- A progress report from 2000-2
- A three day training on the 'Intersectoral development of Food and Nutrition Policy' and development of a manual for decision makers
- Three day training programme on 'Healthy Nutrition for Women and their Families'
- A comparative analysis of nutrition policies and publication of long and short reports on this analysis
- Supporting the development of dietary guidelines in European Member States
- Development of CINDI Guidelines
- Publication, with UNICEF, of Guidelines on *Feeding and Nutrition of Infants and Young Children*
- Development of Peri-urban and Urban Food and Nutrition Action Plan along with case studies
- Health Impact Assessment of Agricultural Policy and issuing a report of this Assessment
- Participation in the global burden of disease project 2003 and also in the World Health Report 2002
- Research and development of a new book - *Food and Health in Europe: A new basis for action* which will be published in summer 2003

As Dr Puska has already outlined, the World Health Report 2002 and the European Health Report 2002 both highlighted the importance of coronary heart disease and cardiovascular disease in a way that has never been seen before.

It is now known that more than 50% of deaths attributable to heart disease and stroke can be prevented by reducing major risk factors.

Figure 1: Heart disease and stroke in Europe



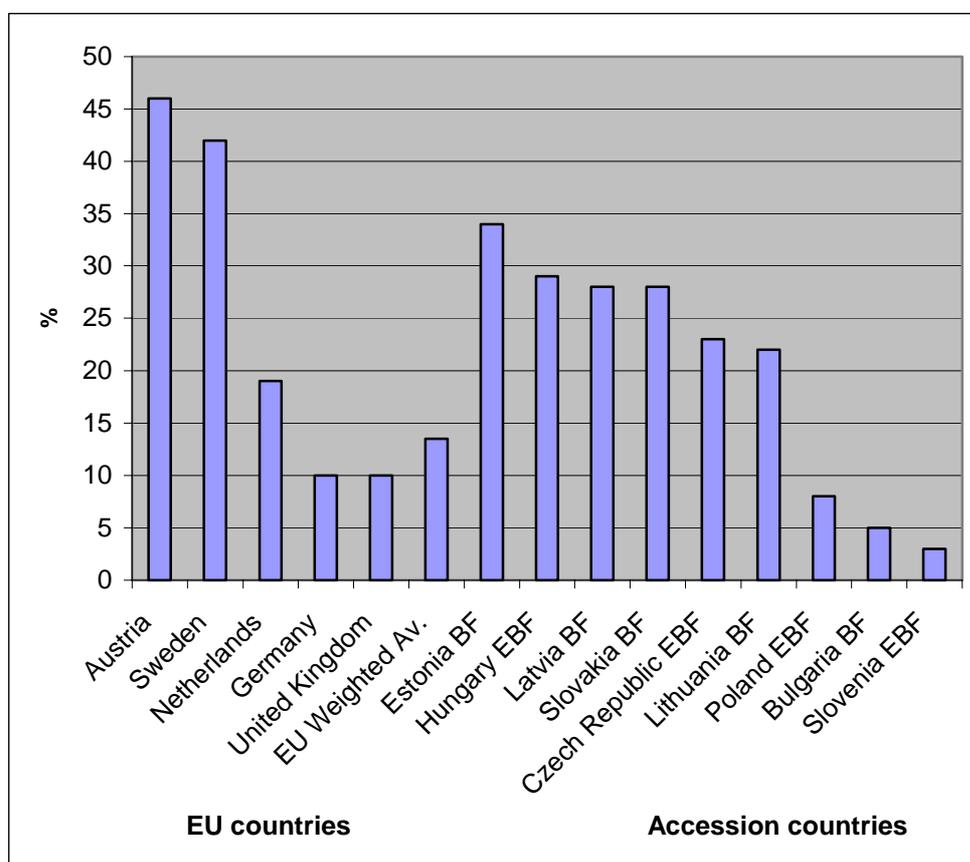
These risk factors include high blood pressure, high cholesterol, low fruit and vegetable intake, tobacco use, obesity and physical inactivity. Five of these seven risk factors relate to nutrition. It is clear, thus, that we now have the necessary evidence about the public health importance of

nutrition and it is important that we now promote this evidence more vigorously. WHO has published two important documents to help in this process: *Diet, Nutrition and the Prevention of Chronic Diseases (WHO Technical Report Series 916)* and *Globalization, Diets and Noncommunicable Diseases and Obesity: Preventing and Managing the Global Epidemic*.

In addition to the publication of these reports, two important global strategies are under development: the *Global Strategy on Infant and Young Child Feeding Policies*, and the *Global Strategy on Diet, Physical Activity and Health*.

There is also an important new project on the *Promotion of Breastfeeding in Europe*. The first meeting of this project took place in Trieste, Italy in February 2003. Results suggest that the current levels of exclusive breastfeeding in many EU Accession countries, especially in the Baltic states, are higher than within the European Union.

Figure 2: Exclusive breastfeeding rate at 6 months in some EU countries and accession countries



UNICEF's input in these accession countries has been important in promoting breastfeeding. It is an area of concern that UNICEF will withdraw its input from countries when they do join the EU with potentially damaging consequences of breastfeeding rates.

It is a very welcome development that there are a number of representatives of the agricultural sector present at this meeting. It is now time for health and agriculture to work together and we have the opportunity to create win-win situations. Hopefully, this will signal the start of a trend for agricultural experts and policy makers to attend food and nutrition meetings.

Implementation of the Food and Nutrition Action Plan

As already outlined, the WHO EURO Regional Committee issued a Resolution on the implementation of a regional Food and Nutrition Action Plan on 14 September 2000. This was followed by a Resolution by the Council of Ministers of the European Union on health and nutrition on 14 December 2000. As previously described, the World Health Assembly has also resolved, between 2000 and 2004, to implement two global strategies relating to food and nutrition.

A Ministerial Conference to review progress in implementing Food and Nutrition Action Plans, at the Regional and Member State levels, will take place in 2006. This meeting in Athens presents an opportunity to evaluate the impact of our work these last three years. It is time to show that we are actually doing things which yield results and that the Action Plan is more than words alone.

4.2 Feedback of sub-regional working groups on progress in implementing the First Food and Nutrition Action Plan

The meeting broke into sub-Regional working groups to review the impact of the WHO Action Plan for Food and Nutritional Policy at the national level. This review included listing achievements directly related to the Action Plan as well as outlining related achievement which could not be directly attributed to the Action Plan. In addition, the working groups reviewed countries where nothing had been achieved in nutrition policy since 2000 and highlighted ways to strengthen political commitment to improving nutrition in countries.

A questionnaire was completed for each country and summaries were presented for seven sub-regional groups. Annex 5 summarises the findings of the country questionnaires. This section summarises the general themes emerging from the sub-regional groups' feedback.

Impact of the first WHO Action Plan for Food and Nutrition Policy at national level

The First WHO Action Plan for Food and Nutrition Policy 2000 - 2005 has clearly had an impact at the national level. In many cases, specific action on nutrition policy had been taken within Member States as a direct result of the FNAP. In other cases, the FNAP had provided support for existing policies and plans. Several respondents noted that it is sometimes difficult to judge the direct impact of the WHO FNAP on policies and actions within countries.

In the **Nordic/Baltic** group, developments in the Nordic countries did not occur as a result of the FNAP even though they were in line with the FNAP. Developments at the national level in the Baltic countries, however, were directly attributable to the FNAP. This process was greatly helped by the creation of a Nordic-Baltic network of nutritionists. Both Estonia and Lithuania, for example, now have Healthy Nutrition Action Plans. In Latvia, a Nutrition Council, a model common in Nordic countries, has been developed and meets regularly.

In **South East Europe**, action was taken in all countries in the sub-region as a direct result of the first WHO Action Plan on Food and Nutrition Policy. All countries had a Food and Nutrition Policy either in place or near to adoption at the time of the meeting and many also had new structures, such as a Food and Nutrition Office, in place. Slovenia had carried out some groundbreaking work on health impact assessment of agriculture.

In **Central and Eastern Europe** action at the national level to implement food and nutrition policy had taken place in the majority of countries as a result of the first WHO FNAP. It was agreed that the WHO FNAP had provided stimulation to develop national action plans.

In **Southern Europe**, Turkey and Israel had already developed a national FNAP as a result of the WHO FNAP and two countries (Greece and Portugal) were in the process of preparing their national action plans. Italy had incorporated elements of a Food and Nutrition Action Plan into its National Health Plan.

In all but one of the **Central Asian Republics**, progress towards implementation of food and nutrition policy had taken place as a result of the WHO FNAP. Kazakhstan, for example, had established a nutrition action plan, but the other countries were conducting nutrition related activities through other programmes, such as micronutrient deficiency prevention programmes, the baby friendly hospital initiative and food safety controls.

In the **Commonwealth of Independent States** it was felt that the WHO FNAP had provided important political support for action at the national level. Strategies had been developed in the Ukraine, Georgia, Russian Federation and Armenia. Action plans or programmes were in the process of being approved. UNICEF had also provided valuable support to governments in the sub-region with prevention of IDD and iron deficiency anaemia, promoting breastfeeding, dietary surveys and promotion of healthy lifestyles.

In **Western Europe**, some of the action taken in the region was as a direct result of the first WHO FNAP but other activities were existing or on-track already. The FNAP had been valuable in supporting these existing policies and plans.

During the period since 2000, many countries have been preparing for accession to the European Union. As a result for many countries there has been a focus on harmonisation of food safety legislation. In some cases, this has diverted efforts away from the implementation of food and nutrition policy and action plans.

There were few countries where nothing or very little has been done in relation to food and nutrition policy since 2000. Andorra was the only country where nothing had been achieved in relation to food and nutrition policy since 2000, although a survey to help define nutrition policy priorities would take place in 2003.

Annex 5 describes the achievements in each country (where a completed questionnaire was received) and the extent to which the first WHO Food and Nutrition Action Plan has impacted on these achievements.

Increasing political commitment

Participants recognised that political commitment to act on food and nutrition issues would be crucial. It was widely recommended that there was a need to create more pressure by increasing awareness about nutrition among politicians and the general public through the media, education and consumer organisations and NGOs. Resolving conflicts of interest between different ministries, where they exist, would be an important step to increasing political commitment within countries.

Strengthening the evidence base on the burden of disease at the national level, along with cost-benefit analyses, was also recognised as important for convincing politicians. Raising awareness

of the importance of the whole food chain, and the need for intersectoral collaboration, would be critical.

It was suggested that more input of WHO at the governmental level would help to put food and nutrition on the agenda. One suggestion was for WHO staff to visit Ministries of Health and promote the case for implementation of national food and nutrition action plans. This could be supplemented with clear guidance on how to draft national action plans.

4.3 UNICEF's nutrition activities in central and eastern Europe and central Asia

Dr Arnold Timmer, Project Officer Nutrition, UNICEF Regional Office for CEE/CIS and the Baltics

Currently, UNICEF's regional office for Central and Eastern Europe, the Commonwealth Independent States and the Baltics covers 21 countries (until December 2002 there were 27, 6 countries stopped receiving UNICEF support). As you know, nutrition is an important aspect of UNICEF's work and is crucial in the early phases of the life of an infant and young child. UNICEF's activities in this region focus on ensuring adequate micronutrient nutrition, infant and young child feeding and breastfeeding. This presentation will focus on micronutrient activities in particular iron, vitamin A and iodine.

Iodine

More than 90 million newborns in the world are now protected from a significant loss in learning ability (10-15% IQ loss) because of the tremendous progress made in salt iodization worldwide. Only a decade ago, less than 20 per cent of the world's households were using iodized salt. Today, that figure stands at 70 per cent worldwide. However it is noteworthy that the highest levels of salt iodization are in Latin America with 88% of households consuming iodized salt and the lowest level in Central and Eastern Europe and Central Asia where only 26% of households use iodized salt. This is lower than South Asia and sub-Saharan Africa.

To illustrate the impact iodine deficiency has on economic and social development UNICEF supported a cost-benefit analysis in the Russian Federation. The analysis shows that without action to reduce iodine deficiency, the Russian Federation will lose over US\$1.4 billion worth of future productivity over the next five years alone. Conversely, immediate action to cut the deficiency rate in half during this period would result in a productivity gain of US\$355 million and would protect some 200,000 newborns from losses in learning ability.

There has been significant progress in the last 10 years in tackling iodine deficiency because of a global partnership involving governments, civil society and private sector that has made iodized salt available to 1.5 billion people, enabling protection of some 90 million infants.

Mild to moderate iodine deficiency has been confirmed in all countries in this region and in some areas, iodine deficiency is severe. Because of the absence of iodized salt in the diet, around 4.5 million out of a total 5.9 million newborns in this region (which is 80%) are unprotected against brain damage due to lack of iodine during pregnancy.

One of the goals in the outcome document of the UN Special Session on Children in May 2002 was the sustainable elimination of IDD through USI. Most governments signed to achieve this goal by 2005. UNICEF is providing support to all countries in this region that want to achieve

this goal by 2005. Elimination of IDD through USI is in fact a main priority of the Regional Office. Our regional strategic objectives to achieve these goals include:

- Full endorsement of IDD elimination through USI by all countries in the region
- Enactment of legislation for mandatory USI by all countries
- Mobilisation of political support for the elimination of IDD and awareness among the sectors of society
- Creation of national alliances promoting iodised salt
- Iodized salt production capacity ensured
- Experience exchange and information sharing among countries
- Establishment of rigorous monitoring of progress at country and regional levels

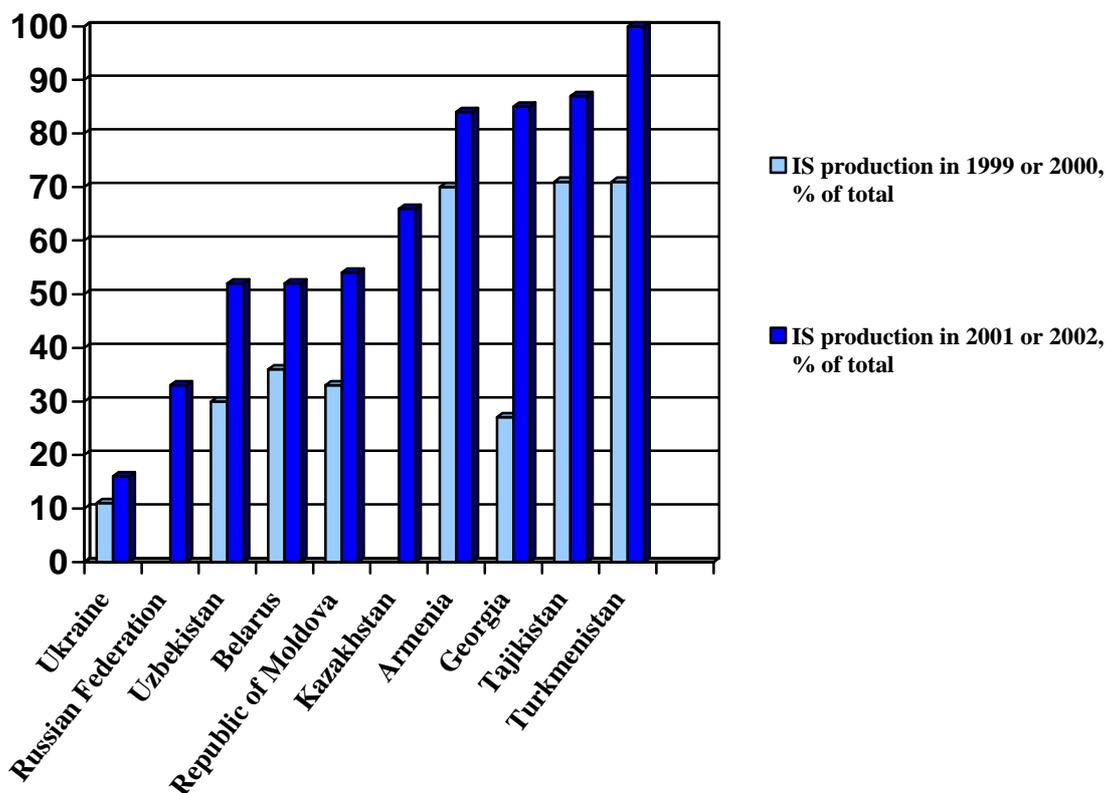
UNICEF supports national efforts aiming at reaching USI in a sustainable way and typically includes activities to increase awareness among the public and main gatekeepers, strengthen national alliances, capacity building, increase iodized salt production and supply, and monitoring.

Some programmatically important principles that are key in the USI approach include:

- Universal salt iodization includes iodization of all salt for human and animal consumption.
- When at least 90% of households use adequately iodized salt we speak of universal salt iodization
- As USI is a national programme trying to ensure adequate iodine nutrition for the entire population there is a need to shift the focus from iodine deficient groups or iodine deficient areas to iodine deficient population as a whole. The solution required is one that therefore reaches the entire population.
- USI efforts are not meant to increase salt consumption, but to shift consumption from non-iodized to iodized salt.
- Very often iodine deficiency is considered a medical problem that should be solved by the public health sector. However, we seem to forget that iodine deficiency is a nutritional problem requiring the involvement of the salt and food industry. Experiences from other regions show that iodine fortification succeeds when producers are fully involved as key partners with national governments to formulate standards and regulations and resolve marketing and technical issues. This is an essential ingredient for success of iodization of salt.
- As iodine is crucial for the brain development of the child during pregnancy, USI should be seen as a smart start for the next generation, protecting the newborn child from decreased intellectual capacity. There has been a shift in focus from the clinical symptom of goitre to IQ loss due to iodine deficiency of 10-15%.
- The USI programme is not meant to increase salt intake but to change consumption of non-iodized salt to iodized salt.

In 2002, the region of Central-Eastern Europe and Central Asia has shown an overall growth in the percentages of salt iodized, and it is also clear that countries are taking the problem of iodine deficiency more seriously. Out of 27 countries in the region, 16 have adopted legislation or at least a decree on salt iodization. Development of legislation for Universal Salt Iodization (USI) began in seven countries in 2002 (Latvia, Uzbekistan, Armenia, Georgia, Moldova, Kosovo and Kazakhstan). One country, Romania, completed and adopted salt iodization legislation.

Figure 3: Production of iodized salt



A major factor in accelerating progress in the region was the appointment of chess champion Anatoly Karpov as Goodwill Ambassador. Mr. Karpov's high-level public profile and political contacts resulted in progress in two of the region's key countries – Russian Federation and Ukraine. In the Russian Federation, Mr. Karpov attended a crucial meeting of salt producers that took place in October and had high-level political meetings. In Ukraine, a major salt producing country that exports to several countries in the Region, Mr. Karpov met with the President and plans to do so again early in 2003. Mr. Karpov visited the Federal Republic of Yugoslavia and Croatia in July, and further political meetings are planned in CARK countries for 2003.

The support of partners both within and outside the region also generated political will and public commitment. USAID and the Centers for Disease Control & Prevention provided technical assistance at national and regional level in a number of countries. The Network for the Sustained Elimination of Iodine Deficiency, the public/private partnership aimed at providing support to ensure salt iodization and monitoring of progress, also supported activities in a number of countries, and a Network member, the European Salt Producers' Association, is providing technical assistance in the region as part of the Network's activities. A partnership on fortification, including salt iodization, is taking place with the Asian Development Bank (ADB) in Kazakhstan, Uzbekistan, Kyrgyzstan, Tajikistan, Uzbekistan and Azerbaijan. The regional offices of WHO EURO and UNICEF jointly emphasized USI at executive level through inclusion of USI in National Food and Nutrition Action Plans, and close cooperation in priority countries Russian Federation, Ukraine, and Turkey.

Another encouraging trend is the indication of renewed salt industry support for iodization. Salt producers' meetings took place in Russia and Uzbekistan, and salt producers became actively involved in social marketing in several countries.

A number of countries, Macedonia, Armenia, Serbia & Montenegro, Slovakia, Turkmenistan, and Bulgaria are close towards elimination of IDD. Macedonia and Armenia, in fact, will undergo an external assessment of “progress toward optimum iodine nutrition” within months.

Next steps:

- Ensure incorporation of USI in national nutrition strategies e.g. National Food and Nutrition Action Plans
- USI legislation and system of enforcement in all countries
- Increase awareness and acceptance by key gatekeeper groups and consumers product promotion
- Build capacity for monitoring (IS production, UI laboratory network)
- Ensure continued political support for USI in all countries (main challenges Russia, Ukraine)
- Strengthen sustainability aspects of USI programme in countries that have achieved 90% coverage of household use of IS, including strengthening of national coalitions (national watch) and production of iodized salt (procurement KIO₃, maintenance of iodization machines, etc)

When asked about other possible sources of iodine, Dr Timmer commented that UNICEF has considered some and that it is known that iodised salt is actually the safest and most cost-effective source of iodine. It is known that populations consume salt relatively homogeneously and it is also relatively easy to work with the industry to promote the consumption of iodised salt.

Iron

Iron deficiency and anemia have detrimental health implications, particularly for mothers and young children. Against the background of socio-economic changes taking place in the former Soviet Union in the last decade, the prevalence of anemia became a great public health concern. The studies and available official national data on anemia done in several countries in the Region showed the high levels of anemia in women and children.

UNICEF supported activities to control and prevent anemia have not reached a similar level in all countries as for iodine. An exception is Central Asia where governments and UNICEF developed a large-scale (1997-1999) Anemia prevention and Control Project. The proposed strategy for prevention and control of iron deficiency anemia was based on UNICEF/WHO Guidelines including the following elements:

National and area-wide education and training efforts aimed at affordable and acceptable dietary change in the environments of economic transition.

Fortification of cereal flours with iron.

A major expansion for a period of two years of iron supplementation (weekly) to encompass

1. women of child bearing age
2. children 6-24 months of age
3. pregnant women

A research agenda of key studies and monitoring activities by the Ministries of Health and other Institutions, beginning with a study of weekly supplementation effectiveness in all groups and action research on channels, messages and other factors that will be developed as part of the programme.

Although programmatically pilot fortification projects were set up and supplementation was partly successful, this success did not result in a substantial reduction in iron deficiency and

anemia prevalence among the target group. The programme will need substantial expansion to national level in order to reduce prevalence rates.

UNICEF's role:

- Advocate and raise awareness on anemia and iron deficiency
- Facilitate national coalition building and ownership
- Facilitate funding to allow effective fortification of flour (e.g. Global Alliance for Improved Nutrition, GAIN)
- Promote harmonization of standards, levels, and protocols (as appropriate) across countries

Vitamin A

Vitamin A deficiency (VAD) was not considered a problem of public health significance in Central Asia until very recently. The results of vitamin A surveys, conducted in 2002, in two Central Asian countries, Kazakhstan, and Tajikistan revealed a problem of public health significance according to WHO criteria.

The percentage of children with serum retinol levels less than 0.70µmol/L (or 20µg/l) were 28.6% for Kazakhstan and 27.6% for Tajikistan, both clearly in excess of the cut-off point of 20% above which there is considered to be a serious problem. The results also showed a low consumption of food rich in vitamin A or beta-carotene and high under five mortality rates. The situation is likely to be same in other Central Asian countries where similar surveys have been started (Kyrgyzstan, Uzbekistan and Turkmenistan).

UNICEF's role in Vitamin A programmes is to facilitate the development and introduction of a programme for vitamin A deficiency prevention. During the MCH forum last November in Turkmenistan it was recommended that all countries with identified vitamin A problem to begin implementation of programmes for VAD prevention and control with the following components: Initiate supplementation programmes in 2003 targeting children under five years of age
Changing dietary habits through IEC activities.

Start project development and preparations on long-term programme on vitamin A fortification in 2003.

Activities include:

- Search for other partners and donors for realisation of fortification.
- Identification of appropriate food product(s) for fortification (sugar, vegetable oil, etc.), taking into account local diets.
- Development and approval of standard documents and guidelines.
- Development, publication and distribution of methodological recommendations, training, and communication materials among medical personnel and other target groups.
- State support for producers of fortified foodstuff(s).
- Promotion of consumption of fortified foodstuff(s) among the public.

4.4 FAO nutrition priorities in Europe

Michael Canon, Food Standards and Nutrition Officer, FAO Subregional Office for Central and Eastern Europe

The mandate of FAO is to raise levels of nutrition and standards of living, to improve agricultural productivity, and to better the condition of rural populations. Since its inception

FAO has worked to alleviate poverty and hunger by promoting agricultural development, improved nutrition and the pursuit of food security. The majority of FAO activities in the area of food security take place in developing countries of Asia, Africa and Central and South America. These areas represent the greatest need for food security and FAO development activities give priority to the countries least capable of overcoming often chronic and severe food shortages caused by a wide range of economic and social situations and natural calamities.

Three groups of countries in the Region are currently facing immediate social and economic challenges of major importance and are therefore particularly in need of such assistance. These are:

Countries facing food insecurity and rural poverty

Seven countries of Central and Eastern Europe are classified as Low Income Food Deficit Countries. Their situation is largely due to the serious difficulties experienced in the process of economic transition from centrally planned to market-oriented economies, natural disasters and civil conflicts. FAO is working in partnership with Member Countries and other international organizations to help countries overcome very difficult circumstances. At the same time, the successes of many transition countries must be recognised for their support and assistance to countries less fortunate. Some of the transition countries, as well as the European Union and individual EU Member States are acting as generous donors to support technical assistance projects within the subregion. The objective at the regional level is to bring together the valuable support of donor countries with countries of the subregion having the greatest difficulties. FAO technical assistance activities in the subregion are directed to ensuring that the goals of the World Food Summit will be met in transition countries and elsewhere in the world. Several of the CIS countries and some in the Balkans face chronic food insecurity problems and have seen the collapse of rural incomes for large segments of their populations. These problems are the result of difficulties caused by transition, coupled with social tension and in several instances, internal conflicts. FAO's special Programme for Food Security (SPFS) in an adapted version formulated to respond to local needs and conditions, aims to identify and establish appropriate food security policies and strategies. SPFS programmes are currently operating in two European countries (Albania and Georgia).

Countries affected by natural and man-made disasters

These are mainly located in the Balkans and have an urgent need to rebuild their agricultural and food sector. Concerted action on several fronts is required. This should include the establishment of an appropriate legal, policy and institutional framework; the rehabilitation of the rural sector and revival of its productive capacity, with particular emphasis on sustainable agricultural practices and improvement in agri-food sector efficiency; development of policies and measures to facilitate regional co-operation and trade.

European Union candidate countries

The agricultural sector generally lags the furthest behind during the process and there is a strong need to bring it into line with other EU accession requirements. FAO offers neutral, independent advice and assistance on how to achieve this goal. In particular, additional measures are needed to improve efficiency and competitiveness of the agri-food sector, maximise the potential benefits from accession and soften the social and economic impact of adjustment to new market conditions.

In order to meet unforeseen and urgent requirements of developing countries and countries in transition, FAO provides limited short-term technical assistance that is complementary to the efforts of countries and other sources of assistance. Through the Technical Co-operation Programme (TCP), FAO is able to use funds from its Regular Programme Budget in support of projects to strengthen food control services, provide food safety training (ie HACCP; support nutrition education; food data collection and assist the establishment of National Codex Committees to work with the Codex Alimentarius Countries (CAC). The TCP is designed to play a catalytic role in stimulating the flow of resources to the agricultural sector to provide advisory services, to respond to emergency situations and to provide training in agricultural related matters. Technical assistance through the TCP provides national or international consultants, short term technical services by FAO staff and equipment needed for projects having a maximum duration of 24 months. Similar to Codex Alimentarius activities, technical projects serve as useful tools for Governments to be able to cope with the serious challenges they face concerning issues of food safety and quality, human nutrition and food security and to meet national objectives related to food and agriculture.

Food security issues in the sub-region

With the beginning of the historic process of economic transition from centralised to market oriented economies of countries of central and eastern Europe and the emerging democracies of the former Soviet Union, FAO has increased a wide range of its offices, such as the Office for Central and Eastern Europe in Budapest, was part of decentralization of FAO to bring its technical activities, expertise and support closer to member countries.

The role of the Subregional Office is to monitor and report to FAO Headquarters the major developments and trends in the region; identify priority areas of action for the Organization; provide technical assistance to Member Countries within the area of technical expertise available; and provide administrative support to FAO activities in the region. The 19 countries of central and eastern Europe under the responsibility of the Subregional Office are in various stages of economic transition as are other countries in the Commonwealth of Independent States (CIS) countries.

The transition process is being approached differently in practically every country and each country is at a different stage of the process. Countries such as Hungary, Poland and the Czech Republic are in the most advanced or final stages of the transition process and are negotiating for

the membership in the European Union. There are other countries in transition that are only in the very earliest stages of change, some after false starts and economic setbacks in the initial transition process.

Given the very positive food supply situation in most countries, food security is not an FAO priority in Europe to the degree that it is in developing countries. From the point of view of food supply, central and eastern Europe is very much on the side of abundance rather than crisis level shortages. However, not all the countries of central and eastern Europe, or the CIS, are in a situation of abundance. There are five transition countries which have been identified as having food deficits due to political and social strife and natural calamities. The countries officially recognised as Low-Income Deficit Countries (LIFDC) having serious food shortages include Armenia, Bosnia-Herzegovina, Azerbaijan, Albania and the FYR of Macedonia.

In considering food security issues in central and eastern Europe, it is necessary to examine a much wider range of food related issues and to develop a clearer picture of the situation and issues related to food. Countries have placed particular importance on the development of sound macro-economic social and sectoral policies favourable to rural groups to food, such as the elderly, people on fixed incomes; nursing mothers and pregnant women, small children and families with several children. Importance has also been given to the enhancement of food production to meet population needs as concerns, quality, safety and quantity.

Countries were in agreement that a variety of actions would have to be taken in the subregion to create conditions for

- Sustainable economic development
- Food security
- Political stability and democracy
- Broad-based participation in development activities
- Sustainable population growth

The areas of greatest interest to countries of the subregion were reflected in their conclusions that concrete actions must be taken to:

- Support and develop agricultural production
- Optimise local potential to achieve national food sufficiency
- Give greater attention to nutritional status of the population
- Increase public awareness of nutrition
- Develop national and regional networks of applied research on food security
- Provide food assistance programmes for low income and vulnerable groups
- Strengthen food quality assurance systems
- Encourage sustainable agriculture and rural development programmes
- Harmonise national food standards with international requirements

These areas of highest interest to the countries of the subregion are reflected in the major programmes of FAO and the structure and priority activities of the Subregional Office.

From the point of view of a Food Standards Officer working in the subregion, many food security issues in central and eastern Europe relate directly to priority areas of food safety, nutrition and public health. These are also elements of food security and they must be taken into account along with the elements of food supply, availability, production and sustainable

development. It is worthwhile to note that the definition of food security places emphasis on the “right of everyone to have access to safe *and nutritious* food...”

The areas of food safety and nutrition are of priority concern to countries of the subregion from the viewpoint of the health and welfare of the population as well as the possibility and potential to develop international trade in food. Strengthening food control systems is a practical approach to improving public health, protecting consumers from fraud and unsafe food and facilitating international trade. This issue is directly linked to the necessity to harmonize national standards with internationally accepted standards such as those of the FAO/WHO Codex Alimentarius which have been specifically recommended benchmarks for international food trade. Harmonization of national standards with international norms is an essential element in the process of EU accession already underway in Hungary and in other countries as well.

Although there is an overall food surplus in central and eastern Europe, there are economically disadvantaged segments of the population which require attention to some degree in virtually all countries. Among vulnerable segments of the population of these countries are the elderly living on very limited pensions; nursing mothers and pregnant women unable to obtain adequate food to meet unique nutritional needs; undernourished small children and larger families with inadequate economic means to obtain food for their needs. Similarly, while the percentage of the family budget spent for food may be at an acceptable level in a country such as Hungary, in several other countries of the subregion experiencing more serious economic difficulties, the percentage of the household budget spent for food is as high as 70%. This type of situation relates to the economic availability, or unavailability of food, which is further intensified by nutrition related diseases and unhealthy lifestyles that are evident throughout the sub-region.

Food security issues in central and eastern Europe in most instances are related to the food people eat, as concerns nutritional value and safety, and unhealthy lifestyles. Statistics concerning food consumption in the subregion indicate a common dietary problem of excessive fat, salt and sugar intake and an inadequate intake of fresh fruit and vegetables, dairy products fish and whole grains. The resulting nutrition related diseases such as cardiovascular disease, hypertension, stroke, cancer and diabetes, among others, join with unhealthy lifestyles marked by excessive alcohol consumption, too little physical exercise and excessive smoking to produce particularly high mortality rates in comparison to other developed countries.

Efforts are underway in many countries, including Hungary, to reverse negative trends and to replace them with health promoting nutrition education programmes designed to inform the population of the consequences of certain nutrition and lifestyle choices, positive and negative. With the support of FAO workshops and other activities and publications provided in the languages of the subregion, nutrition based approaches to better lifestyles have been promoted. The purpose of these programmes is to educate the public to make better choices in what they eat and what they do as concerns lifestyle.

FAO and the International Life Sciences Institute have worked through the subregion and in CIS countries to promote the development of Food Based Dietary Guidelines. In many countries these dietary guidelines are being actively used to encourage people of all ages to follow a balanced diet that includes more fresh fruits and vegetables, fish, dairy products and whole grains and less salt, fat and sugar. Linked to this approach is encouragement to reduce alcohol consumption and reduce smoking. Programmes have also been introduced to promote physical exercise and awareness of the nutritional aspects of good health. Health officials in many

countries have recently reported that certain negative dietary patterns have begun to change and choices in favour of better nutrition and healthier lifestyles are becoming more evident.

Similarly, technical co-operation projects have been implemented by FAO and several countries of the subregion to strengthen food control services in the interest of improving food safety and protecting consumers. The food industry in Hungary has been an active participant in national training programmes and workshops on quality assurance systems to improve food safety and quality. Programmes are underway to train trainers in the areas of food safety, good manufacturing practice, nutrition and quality assurance (HACCP systems).

Consumer awareness of the importance of good nutrition is being actively supported through nutrition education materials such as the FAO publication, *Get The Best From Your Foods* which has been translated into Hungarian for publication and distribution to school teachers, students and to the public without charge. This programme is being actively supported by nutrition educators throughout the subregion and by international food manufacturers.

In the area of food composition and food consumption data, an FAO subregional Database Network, known as CEECFOODS, has been established to facilitate communications and collaboration among institutes, universities and government departments working in this field. Hungary is a member of the Steering Committee of the network.

FAO, often working in partnership with other international organizations, is taking action in cooperation with member governments on a comprehensive scale to educate consumers on making healthier dietary and lifestyle choices as a means of improving nutrition and food safety as an element in its contribution to improved food security in the subregion.

5 Food and Nutrition Action Plan - the present

The second session of the meeting focused on the present situation in terms of food and nutrition action plans.

5.1 Status of food and nutrition policies in the WHO European Region, 2003

Participants were shown a draft questionnaire to assess the current status of Food and Nutrition Policies in European Countries. These questionnaires would be used to compile sub-regional summaries to be presented to the meeting of the Federation of European Nutrition Societies in Rome in October 2003.

In sub-regional groups, participants reviewed the format of the questionnaire. Proposed amendments or new items for inclusion were proposed to the plenary session and have since been incorporated by WHO.

5.2 Agreed process for Conference of Federation of European Nutrition Societies (FENS), Rome, October 2003

Each sub-regional group nominated one Regional Coordinator to collate results from within the region and then present the results to the FENS meeting in Rome. Each sub-group also agreed a deadline by which completed questionnaires would be sent to the Regional Co-ordinator.

The following Regional Coordinators were nominated:

Regional Coordinators	Sub-region	Deadline for replies
Dr Iveta Pudule, Latvia	Baltic and Nordic countries	24 April 2003
Dr Zuzana Brazdova, Czech Republic	South-East Europe Countries in central and eastern Europe (CCEE)	20 June 2003
Dr Dorit Kaluski, Israel	Southern Europe and Western Europe	1 June 2003
Professor Viktor Tutelyan, Russian Federation With the assistance of Professor Igor Glasunov, Russian Federation	Central Asian Republics (CAR) Commonwealth of Independent States (CIS)	1 June 2003

5.3 WHO Global strategy on diet, physical activity and health

On Saturday afternoon, the meeting gave participants the opportunity to contribute to the consultation of the WHO Global Strategy on Diet, Physical Activity and Health which had been mentioned by Dr Puska earlier.

Following introductory presentations by Dr Puska, Dr Bertollini and Dr Selilowitz, participants split into working groups. A summary of the the results of the working group discussions to feed into the regional consultation on the Global Strategy is presented below.

Introduction to the WHO Global strategy on diet, physical activity and health

Towards a Global strategy on diet, physical activity and health

Dr Pekka Puska, Director, NonCommunicable Disease Prevention and Health Promotion Department, WHO Geneva

Dr Puska again thanked the WHO Regional Office for Europe for its collaboration and stressed that this meeting would make an important contribution to the consultation on the strategy. The work that is going on in European countries to improve diet and health is very important in, in some ways, paves the way for the global strategy.

The background to the development of this global strategy is the dramatic transition in global public health. There are several key points in this new global reality:

- Noncommunicable diseases (NCDs) contribute 60% of deaths globally and 43% of the global burden of disease;
- Already, 79% of these noncommunicable diseases occur in developing countries;
- Half of NCD deaths are attributable to cardiovascular diseases
- NCDs represent the overwhelming health burden in Europe, and enormous public health gains can be achieved
- By 2020 these deaths will account for 73% deaths and 60% of the disease burden.

On the positive side, there has been a huge amount of research over the last few decades and NCDs are to a great extent preventable diseases. There is enormously strong evidence for prevention. Population-based prevention is the most cost-effective and the only affordable option for major public improvement in NCD rates. It is surprisingly how major changes in population rates can take place quite rapidly.

Up to 80% of cases of coronary heart disease and up to 90% of type 2 diabetes could be avoided through changing lifestyle factors. About one third of cancers could be prevented by eating healthily, maintaining normal weight and being physically active throughout the life-span. It is clear that diet and physical activity are very important risk factors.

The World Health Report 2002 contained several key messages relating to strategies to reduce risk. These included:

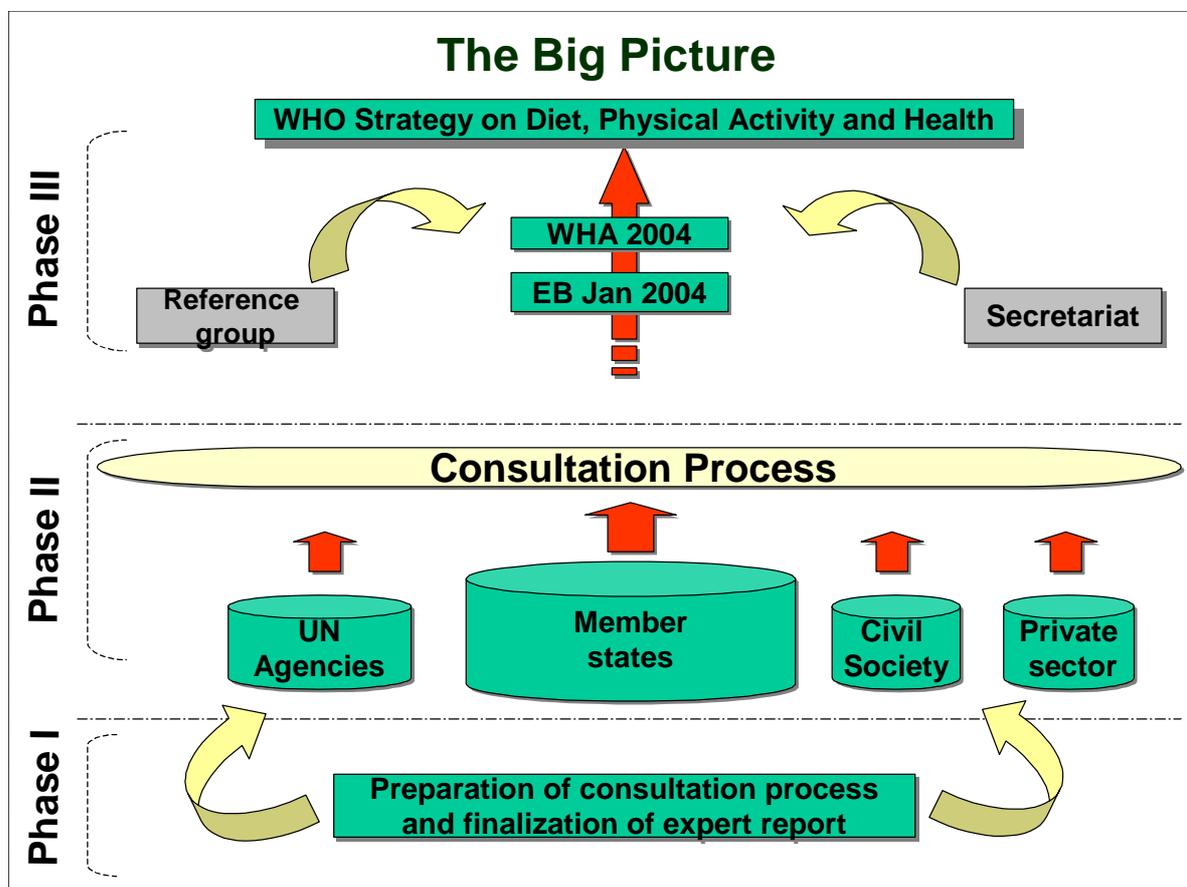
- Very substantial health gains can be made for relatively modest expenditures on interventions
- Changing population distributions of risk factors (like blood pressure, blood cholesterol) through general lifestyle changes
- To reduce cardiovascular disease, population wide strategies to lower cholesterol (quality of fat) and blood pressure (salt reduction) are key.

Speaking to the European Parliament on 19 February 2003, EU Commissioner David Byrne recognised the importance of diet and physical activity and stressed the need for co-ordinated, multisectoral and population wide strategies.

In 2000, the World Health Assembly passed a resolution which endorsed the strategy of prevention and control of NCDs. In 2001, the Member States commented that there had been a good start, particularly in relation to tobacco, but that there was a need for more action in relation

to diet and physical activity. In 2002, the World Health Assembly passed a resolution on diet, physical activity and health which called for the preparation of a global strategy.

Figure 4: Global strategy process



Phase I of the development of the strategy, is complete with the preparation of the consultation process and the finalisation of an expert report which summarises the latest science in this area. This report will be launched in April 2003 by the Directors General of FAO and WHO.

Phase II will comprise six Regional Consultations with Member States and other UN agencies, NGOs and the private sector. Limited numbers of countries will be invited to the Regional Consultations, but they will have intersectoral representation. The objective of the consultations is to ensure the contribution to the Global Strategy from the regional and national point of view. It is also to make a contribution to regional action in the field of diet, physical activity and health.

Phase III will be the presentation to the World Health Assembly and WHO's Executive Board in 2004. The whole process is being guided by a Reference Group of Advisory Experts.

The expected outcomes of the process are:

- Regional contributions to the Global Strategy to be submitted to the 113th Session of the Executive Board in January 2004;
- Further the work on diet, physical activity and health at the regional level;
- Increased awareness about the impact of diet and physical activity on population health at the regional and national level.

Dr Puska hoped that all the countries represented at the meeting would contribute to this process. It was worth reiterating that there are few issues which are as important for modern public health. There is an area of tremendous public interest but there are also huge commercial interests involved.

Many lessons have been learnt from the experience in working with tobacco. It is important to remember, however, that this is not tobacco. In this case we are looking at changing, rather than stopping, consumption.

At this stage it is useful to quote WHO's Director-General Dr Brundtland:

“In a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Non-governmental organizations, the private sector and foundations cannot solve them alone. Only through new and innovative partnerships can we make a difference.”

WHO Global Strategy on diet, physical activity and health - the contribution of WHO European Region

Dr Roberto Bertollini, WHO Regional Office for Europe

Dr Bertollini described some of the initiatives taken by WHO Regional Office for Europe on this issue. Diet and physical activity are issues that WHO Euro has taken very seriously in the past. While these risk factors are very important for global health, they are even more important for European health and WHO Euro already has two important programmes which are relevant - nutrition and physical activity.

Development of this Global Strategy has been a very positive collaboration with WHO Headquarters in Geneva. Cecile Knai has been appointed to work on the consultation of the Global Strategy and an internal WHO Euro Task Force has been established to involve the different programmes relevant to this area. The Task Force has met a couple of times to discuss the initiative.

One of the key issues that we want to address is better understanding of the data relating to physical activity and diet in member states. It is also important to understand what actions have been taken, by what mechanism and what has been shown to be effective. This is an opportunity to identify specific activities which have been effective.

This meeting in Athens, which will allow a better contribution from all Member States towards the Regional Consultation, is an important step in the European contribution to the Global Strategy. The Regional Consultation meeting in April will emphasise the intersectoral nature of the issue. There is a need to upgrade WHO Euro's activities in relation to physical activity and to strengthen the existing actions relating to nutrition. Dr Bertollini intends to submit a proposal for tackling this issue more systematically to Member States through the Regional Committee.

Development of the Global strategy on diet, physical activity and health

Dr Sam Selikowitz, University of Oslo

A Reference Group has been created to advise on the development of the Global Strategy. Dr Selikowitz described the mandate of this Reference Group and how it has been working.

Until now many international organisations have focused largely on communicable diseases. There has now been a paradigm shift because of the epidemic of non-communicable diseases and the Global Strategy is of tremendous importance for these reasons. In the world today we have hunger and obesity co-existing in the same extended families.

The expert Reference Group, composed of representatives from the Regions, from other UN agencies and other organisation such as the World Trade Organization, had its first working meeting in October 2002 in Oslo. The Group, chaired by Professor Kaare Norum of Oslo University, will be instrumental throughout the process of developing the Global Strategy.

The Reference Group (Annex 7) has broad terms of reference and also has a mandate to seek expert advice outside the Reference Group when required. Dr Selilowitz outlined the members of the Reference Group, noting that all serve in a personal rather than institutional capacity.

On behalf of the Reference Group, Dr Selilowitz, complimented WHO Euro on the organisation of this regional meeting in Athens and noted that he hoped that Member States would continue to be proactive in the discussions as the Strategy developed. The Reference Group were very keen to receive feedback from within Member States.

Discussion on the introductory session on the WHO Global strategy on diet, physical activity and health

The way ahead will not be easy. The importance of an intersectoral approach has already been emphasised and this will be absolutely fundamental. It was suggested that there will also be a challenge to shift the Food and Agriculture Organization's attention towards the prevention of non-communicable diseases as well as to the prevention of hunger. There will also be a challenge to shift the objectives of the food industry from 'pure profit' to 'profit plus health'.

These challenges are very real and it is vital for different sectors to work together, backed by a very strong case. Prevention of NCDs needs to be addressed alongside other key public health issues including the prevention of hunger and tackling infectious disease. Ultimately, the goal is to develop sensible national nutrition policies which balance *all* the needs of countries.

It is important also to continue to emphasise that the prevention of NCDs is an important issue for developing countries which has huge implications for health resources within countries.

There are enormous commercial interests at stake when addressing diet and health issues. There are, however, sectors of the food and agriculture industries which like the message. It is vital to first get the scientific message right then to lobby and have dialogue with industry. There have already been some preliminary discussions and industry remains sensitive to consumer demand. It is crucial, therefore, to also work on the factors influencing consumer demand as well as those affecting availability of foodstuffs. There will be a role for government intervention, but this will require a balance.

Feedback on the workshop discussions on the WHO Global strategy on diet, physical activity and health

The Global Strategy questionnaire designed by WHO headquarters (Annex 4) was sent to all Member States in advance of the Nutrition Counterparts' meeting. Twenty-four Member States completed the questionnaire. During the actual working groups, the nutrition counterparts were

divided by geographic region into four groups¹. They were asked to complete a short version of the questionnaire and to present their findings in plenary. The findings are presented below and represent the views of 42 Member States from the European Region. Furthermore, many of the nutrition counterparts, who completed the questionnaire, collaborated with colleagues from different sectors before completing the questionnaire. Therefore the findings reported not only come from the nutrition perspective but in many cases, from a multisectoral perspective.

Most European Member States reported **physical inactivity is a problem** in all age groups. The prevalence of inactive lifestyles is reportedly a problem in many countries. It is also indicated that physical activity and healthy diet are often neglected as topics and practices in workplaces and in schools.

Member States reported that there are **certain obstacles in gaining increased political commitment** to implement strategies to reduce levels of obesity and other chronic diseases. Policy-makers in the health sector in many countries of the European Region are generally interested in health and nutrition, but not all are committed to solving the problems. For example, budgetary resources available to the health sector are not always invested into programmes to reduce levels of NCD even though reduction of NCD is stated as a priority. Furthermore, some European countries reported that neither the population nor policymakers consider obesity a disease, and that there is a general lack of understanding about what is meant by prevention. Also, opportunities offered by interventions led by other sectors (e.g. transport for the provision of infrastructures for cycling and walking) seem to be still largely untapped, or not recognised.

Many countries report having such scientific bodies, specifically an **intersectoral working group or a national council** on diet, physical activity and lifestyle (e.g. Italy, Spain, Switzerland, Croatia, Norway).

Many countries report strategies to promote healthy diet and physical activity such as **legislation, regulations, codes, policies, action plans and guidelines**. Here are some examples.

- **Legislation:** e.g. food safety laws (e.g. Bosnia & Herzegovina, Spain, Turkey, Portugal); Food Act, Public Health Act, Water Act Labelling laws (e.g. Estonia), food labelling (e.g. UK, based on EU legislation; Norway, Malta, Romania), Nutritional Guidelines for School Meals (e.g. UK), fortification laws (e.g. Norway); physical activity in curriculum in schools (e.g. Sweden); 2 hours/week physical activity in school (e.g. Italy, Portugal).
- **Regulations:** e.g. Estonia: Inclusion of physical activity in kindergartens, schools, other educational organisations; certain percent of tobacco tax should go to the sport and fitness; a certain proportion of health insurance should be dedicated to health promotion and disease prevention programmes by law; Regulations ensuring financial support to the sport activities through municipality budget; Salt iodisation (e.g. Turkey); MoH regulated the dietary supplements and food enrichment with special indication for subgroups of the population (e.g. Italy);
- **Codes:** e.g. Guidance for labelling; guidance for advertising (e.g. UK); Code of marketing infant formula (e.g. Ireland, Turkey, Malta)
- **Policies:** e.g. Government resolution on health promoting physical activity 2002 (e.g. Finland); public health strategy (e.g. Latvia); food security (e.g. Spain); Infant feeding (e.g.

¹ 1. central Asian republics and CIS; 2. central and eastern Europe & southeast Europe; 3. Nordic & Baltic; 4. western Europe, southern Europe and Turkey

UK); national programme of health protection and promotion (e.g. Slovenia, in preparation, includes diet and physical activity);

- **Action plans:** e.g. food and nutrition action plan (Bosnia & Herzegovina, Latvia, FYR Macedonia; Romania), NEHAP, Strategic plan for reform of health system and health insurance system, physical activity action plan, and Plan for ensuring physical activity and recreation space in all educational institutions (Bosnia & Herzegovina); food security (e.g. Spain); National plan of action for nutrition 1995 (e.g. Sweden); national health promotion strategy (e.g. Ireland); new national strategy for nutrition (e.g. Ireland); nutrition education action plan (e.g. Turkey);
- **Guidelines:** e.g. Self control implementation in catering and retail premises - guidelines for enterprises (e.g. Estonia); Draft guideline regarding Nutrition claims and functional claims used in labelling, presentation and advertising of foodstuffs (e.g. Estonia); Food-based dietary guidelines (e.g. Estonia, Latvia, FYR Macedonia, Portugal); guidelines for children, infants and pregnant and breastfeeding women (e.g. Latvia).

Many countries suggested that **Codex Alimentarius** should take on board the issues of healthy diet in an explicit way. The Codex Alimentarius is reported as having an important role for food standardisation, food safety / quality control of agriculture but has not been much used for healthy eating.

Member States reported that many **sectors are involved directly or indirectly in developing strategies related to diet and increased physical activity**, including: Ministries of Health, Agriculture and Fisheries, Education, Sports and Youth, Economic Development, Labour and Social Welfare (protection), social community and family affairs, Ministry of Finance and Justice to get support for financial backing and to put forth adequate fiscal policies, and Environment. Also mentioned are Trade, Academy of Medical Sciences, NGOs, Private sectors – fitness and sport, Food industry, Transport sector, Urban planning, Communication and advertising consumer associations, and health promotion groups.

Member states reported that the **agriculture sector affects diet, nutrition and health** in a variety of ways. Generally, there are few agriculture policies in countries to promote production of healthy foods (e.g. subsidising low fat dairy products and fish production in Israel), and agriculture policy is not often influenced by nutrition guidelines.

Member States were asked to comment on **existing strategies to promote intersectoral collaboration** regarding a healthy diet and increased physical activity. Examples include:

- policies and action plans for both diet and physical activity (e.g. Switzerland, Turkey, Ireland);
- nutrition and physical activity in schools (e.g. Italy, Malta);
- dietary guidelines in which there is chapter on daily need of physical activity (e.g. Greece);
- mass media campaigns (the Netherlands, Italy, Switzerland); and
- legislation for food safety (e.g. Spain, Ireland, Turkey, Israel).

Health professionals can provide practical advice to patients and families on the benefits of optimal diets and increased levels of physical activity. When Member States were asked whether health services routinely provide patients with advice on healthy diet and increased physical activity, some reported that no formal advice is given (e.g. Malta, the Netherlands) and others reported a sophisticated system, including a computerised global risk assessment of health

whereby standard questions on NCD risk behaviour are asked to patients and recorded (e.g. Israel, Ireland). Some countries reported that obesity and CVD were not routinely addressed in hospitals but in special centres (e.g. Italy, Greece). The UK reported a system whereby primary practitioners can give a prescription for exercise. In some countries dieticians are starting to work with physicians (e.g. Turkey). But most countries reported that advice on diet and physical activity from the health services is *ad hoc*.

Many Member States reported **promotion of healthy diets**. Some countries have programmes to promote vegetable and fruit consumption in schools (Norway, UK). Some countries (e.g. Nordic, Baltic, Ireland, Portugal) reported having programmes to subsidize milk allowances in schools and in some countries this includes reduced-fat dairy products. Finland in particular has worked with the EU to include reduced-fat milk in their school milk programme. In EU countries, though, agriculture policies tend to promote high fat dairy and meat production, while making vegetables and fruit less available and more expensive.

Many Member States reported **promotion of sport but not physical activity**. However some countries are active in promoting physical activity, for example:

- Action plan to support physical activity through the development of recreational spaces in all educational institutions (e.g. Bosnia and Herzegovina)
- The European Network for the promotion of health-enhancing physical activity (HEPA)²
- Health Promoting Schools³;
- enabling children to walk to school in a safe environment (e.g. Israel)
- walking programmes for older people (e.g. local government in Udine, Italy)
- walking and cycling strategies strategy in collaboration with the Ministries of Transport, and Environment (Slovenia);
- collaboration with the Ministry of Tourism – (e.g. Slovenia “healthy tourism” where cycling and waking routes are being built to promote physical activity; this is considered not only in transport strategy but also tourism strategy)
- shifting responsibility for physical activity from national to regional (e.g. Slovakia, where concrete policies have been developed by local authorities at regional level e.g. cycling routes, and where special centres for sports are the responsibility of Government);
- creation of cycling lanes through Healthy Cities projects (e.g. Czech Republic);
- national strategy for cycling (e.g. Norway)

Several European countries **assess population physical activity levels**. These include:

- National surveillance systems which regularly report on eating and physical activity patterns of the population (such as reported by all Baltic and Nordic, Switzerland, Italy, UK); and
- Health behaviour surveys for school children and adults (e.g. HBSC⁴);

Collaboration of the government with industry was reported in countries, for example to:

² chaired by the Finnish UKK institute and consisting of policy development, *Europe on the Move!* information network and the promotion of walking as a simple and safe method of health-enhancing physical activity. Members of HEPA are Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, United Kingdom, Estonia, Iceland, Israel, Norway, Slovenia and Switzerland.

³ <http://www.who.dk/eprise/main/WHO/Progs/ENHPS/Home>

⁴ Currie et al 2000

- reduce fatty dairy, to reduce size of portions and to influence marketing (e.g. the Netherlands);
- increase consumption of dairy products to reduce osteoporosis (e.g. Spain);
- increase fish consumption through collaboration with the fish board (and other non-branded industries) (Ireland);
- improve food quality through collaboration with restaurants and catering services (e.g. Italy);
- support Five-A-Day with the help of the fruit and vegetable industry (e.g. Switzerland, UK, Malta);
- support physical activity through collaboration with the sporting goods industry (e.g. Austria);
- bring about salt reduction in processed foods (e.g. UK); and
- promote physical activity with the fitness industry (e.g. UK: pilot initiatives in nine regions to promote physical activity with private and NGO collaboration).

Collaboration of the government with NGOs occurs in the development of health education campaigns (e.g. the Netherlands); collaboration with national heart foundations (e.g. Ireland, Norway); collaboration with cancer societies (e.g. Switzerland, Norway); and with consumers associations (e.g. Austria, UK).

Some examples of Member States' initiatives to promote healthy diets and physical activity

Many countries reported participating in and initiating many programmes and networks to reduce NCD and to promote healthy lifestyles, including healthy diets and physical activity. Several of these are listed here. This is not an exhaustive list.

- The National Healthy Eating Campaign in Ireland targets the whole population with special focus on low-income groups. Media, NGOs and the private sector are all involved. One of the main success criteria is the raise awareness of the Healthy Eating Guidelines.
- Happy Heart at Work in Ireland is a workplace programme which includes healthy eating, physical activity, smoke-free environment and stress reduction. The Department of Health and the Irish Heart Foundation are involved. One of the success criteria is behaviour change motivated in changes in food supplies i.e. less fat, more fruit and vegetables, less salt and sugar.
- The Public Health Education Programme in Turkey is designed for health workers and the community and aims to promote adequate, balanced and healthy nutrition in the community. It is done through educational materials, training of trainers and education in the community. The programme has an evaluation mechanism built in.
- The Martignacco Project in the Italian municipality of Martignacco aims to improve diet and lifestyle. The success criteria are decreased blood cholesterol levels and decreased CVD morbidity.
- In Spain, the Ministry of Health, the Ministry of Education and Sports and parent-student associations collaborate to promote healthy nutrition and physical activity at school. Activities include speeches, films, and competitions.
- A weight reduction programme in Malta is aimed at adults through education, empowerment and support; Also in Malta is a cancer prevention programme aimed at the whole population through information and increased awareness of risk factors.
- A breastfeeding promotion programme, such as in Bosnia and Herzegovina is aimed at health professionals and mothers through training of health workers and breastfeeding counsellors.

Health and education centres work together. Success criteria include knowledge on breastfeeding and the number of Baby Friendly Hospitals.

- Active Living in the city is a priority for the cities of the WHO Healthy Cities Network. For this purpose the Multi-City Action Plan on Active Living was established. Belfast, Dublin, Mechelen, Rotterdam and Turku are the lead cities of this group. They have produced guidelines and excellent case studies for promoting active living for all citizens in cities.
- The First Croatian Health Project targets 18-65 year-olds through the education of public health specialists in health promotion. Milestones and indicators defined for evaluating success are the prevalence of obesity, hypercholesterolaemia, prevalence of hyperlipidaemia, knowledge, attitudes and practices in food consumption and physical activity.
- In Estonia, the Heart health project (Heart week, Heart day) (1996-...) is designed for the whole population through activities and materials using media, organizations, schools, kindergartens etc.
- The Health Promoting Physical Activity in Finland targets the whole population through the joint work of members from sports, health, education, health promotion and research;
- Heart and Nutrition programme (1997- ongoing) in Finland, aimed at the whole population. The programme was planned by a Heart Health Committee having members of all sectors of the society. The Committee Report has over 100 recommendations for different sectors. Bi-annual Nutrition Report summarizes the main findings in development of nutrition and so does the Public Health Report on health issues. The programme is evaluated at regular intervals;
- DEHKO-Prevention of type 2 diabetes in Finland, aimed at the whole population but specifically at diabetes high-risk groups and patients with newly diagnosed DM. The main activities include:
 - Health promotion in municipal action and budgeting plans
 - Training in nutrition expertise among primary health care workers
 - Development of postgraduate training for care, nutrition and education personnel in nutrition, weight control, physical activity and prevention of NCD
 - national guidelines on screening for adult population
 - Low threshold model in health promotion to reach groups outside normal services
 - Focus on welfare of children, young people and families
 - Risk test form in use in primary health care and early guidance and care for newly diagnosed persons
 - Effective implementation of the proposals of the Committee on Health Promoting Physical Activity
 - Effective implementation of the recommendations of the National Nutrition Action Plan
 - Health Media-project to support media publicity in implementation of DEHKO
- “A small decision a day” in Finland is a programme on prevention of obesity and on promotion of physical activity; organised by the Finnish Heart Association, Cancer Association, Sport for All Association and Diabetes Association and others (2000-2003); activities include:
 - Group model in weight loss and weight control for the use of health care professionals and training of group leaders
 - Peer group activities in health behaviour changes

- Material for the professionals and the clients
- The material and training programme contains information on weight loss, on changing of eating and activity habits and on group training and leading
- The North Karelia project started in 1972 and was one of the first WHO cooperative programme on CVD community-based prevention, launched in 1974. The name of the programme was "Comprehensive cardiovascular community control programmes in Europe". Finland (North Karelia), the German Democratic Republic, the Federal Republic of Germany, Hungary, Italy, Norway, Switzerland, USSR, Yugoslavia all participated in the programme. The programme was focused on a healthy lifestyle and countries reported numerous activities in the field of diet. The CINDI programme evolved from this programme. The North Karelia (Finland) programme was formulated, launched, further developed and evaluated in close cooperation with WHO⁵.
- In Denmark fat intake has gone down, but not based on just one intervention. Denmark has a new national policy on obesity control (available in English Spring 2003).
- In Norway the rate of heart disease deaths has gone down, but not in association with one particular intervention, and in both Norway and Sweden there has been some increase in vegetable and fruit intake through the influence of varying factors.
- the Baby friendly Hospital Initiative and its positive impact on increasing rates of exclusive breastfeeding (e.g. Spain);
- the development and implementation of National Food and Nutrition action plans in many countries of the Region;
- Health Promoting Schools;
- the 5-a-day programme to increase fruit and vegetable consumption (although it was noted that this initiative needed more focus since at the moment it was not considered sustainable due to a lack of long term results);
- mass media or local interventions on healthy diet that have been measured as being successful (e.g. the Netherlands);
- Physical activity promotion programmes (e.g. "Slovenia on the move", where physical activity is promoted intersectorally and is planned for every municipality. It includes a 2 km walking test to measure fitness test.
- health promotion in rural populations (e.g. in Slovenia);
- healthy eating awareness campaign for low income groups (e.g. in Ireland, where such a programme was evaluated and the group did change their consumption);
- Slovenia has been developing an action plan on nutrition and physical activity. An example of this would be the Radenci Declaration formulated last year with active CINDI participation.
- Salt iodisation programmes (e.g. in Switzerland where iodisation of salt started 8 years ago and now 90% salt iodised, Turkey, Italy);
- Wide dissemination of dietary guidelines (e.g. in Italy, distributed to 8 million families and an improvement of 5-6% in dietary patterns was measured.
- exclusive breastfeeding increased through BF programmes (e.g. Israel)

⁵ e.g. WHO/EURO publish (ISBN 92 890 1006 1) the results of the 1972-1977 evaluation of the North Karelia programme

- programme on reducing salt intake (e.g. in Portugal where blood pressure decreased in community studied);
- community-based programmes to increasing fruit and vegetables (e.g. in the UK where a 1-portion increase was measured in the low consumers).

Following feedback from the Working Groups, Dr Puska of WHO Headquarters expressed his thanks and commented how valuable this information would be for the consultation on the Global Strategy. He also commented on a couple of specific issues which had arisen during the feedback.

It was clear that the physical activity part of the Global Strategy was focused on the type of activity that everyone is involved in throughout day to day to life. It could be useful, however, to link up with bodies involved in promoting sports and, in particular, the Sports for All movement who could make a useful contribution to the promotion of physical activity.

Another issue which arose during the discussion related to Codex Alimentarius. There had been a recent evaluation of Codex's role and this would be on the agenda of the forthcoming World Health Assembly May 2003. Discussions suggest that there is a general view that there is a need to bring health back on to the Codex agenda. This is clearly an issue that will be discussed within countries and Member States could emphasise the importance of Codex for health at the Assembly.

6 Food and Nutrition Action Plan - the future

Having reviewed in detail progress since the adoption of the current Food and Nutrition Action Plan and discussed in depth the forthcoming Global Strategy on Diet, Physical Activity and Health, the discussion turned to future issues relevant to the European Food and Nutrition Action Plan.

6.1 Food security

This session addressed the issue of Food Security and, in particular, the health impact of the Common Agricultural Policy (CAP) and the health impact, through the CAP, of Slovenia's accession to the Union.

Common Agriculture Policy - the mid-term review

Mr Christer Wretborn, Deputy Director General, Swedish Ministry of Agriculture Food and Fisheries

When the policy direction for a Common Agricultural Policy (the CAP) was formulated in Stresa in 1958, the situation was very different from today; the EEC was a net importer of agricultural products and the goal of becoming self sufficient was predominant. European agriculture employed a little over 20% of the population and the sector was characterised by low incomes and low productivity.

At the Stresa conference the Commission representatives emphasised the need for a real modernisation of European agriculture. The ministers however, rejected the idea of structural policies and instead focused on price support policy.

Indeed the policy with guaranteed prices contributed to reaching European self-sufficiency and very soon to costly surpluses in most agricultural products.

Instead of a complete reform approach, getting to the heart of the problem, Europe has only done the strictly necessary changes. One market-regulating instrument after the other has been introduced to counterbalance the incentives to produce within the policy. The lack of long-term goals for the reform work of the Common Agricultural Policy is of course very serious with regard to taxpayers and consumers, but also to farmers. The fixing and patching of the policy has also resulted in an extremely complex legislation. More than half of the legislative texts and almost half of the EU budget are dedicated to agriculture, although agriculture only accounts for 1.5% of the current Member States' total GDP and 4% of the employment in the Union.

When it comes to nutrition effects from the CAP, such probably do exist. Today's support system is entirely focused on the production side, affecting the relative prices of products. Although price elasticity for most food products is relatively low, one can assume that for instance, high tariffs on fruit imports result in lower consumption of fruit and that subsidised sales of butter increase fat consumption.

With every enlargement, the agricultural conditions within the union have become more diverse, and the arguments for a centralised system have weakened. The European Union is now facing its biggest enlargement ever. The new member states that will be integrated into the Union have a structure of their agriculture, which in many ways can be compared with the situation we had in Western Europe fifty years ago. Structural measures would undoubtedly be the best option for

the new member states. Instead, the remainders of the price support system, with quotas and production restrictions will be imposed in the new member states, hampering the restructuring of the sector.

However, enlargement in itself, as well as the WTO negotiations, contribute to creating a pressure to reform the CAP. This has led to the relatively far-reaching proposal in the Mid Term Review of the CAP put forward by the European Commission. The proposal includes two main parts: decoupling of support from production and a cut down in direct support levels to farmers.

The decoupling of support means that the direct support to farmers will no longer be conditioned upon production. The farmer will receive the same amount of support that he has received during a historical reference period. He will then every year receive a lump sum of payments named 'farm income support'. Sectors which currently have a different kind of support, will gradually be reformed and included in the 'farm income support'. The farmer will be free to produce more or less what he likes, but has to comply with legislation and keep the land in good agricultural condition in order to continue receiving the support. The decoupling should allow producers to become more market oriented and respond to a larger extent to the demand of consumers - instead of producing for the support systems.

Due to the enlargement of the union and the increasing costs for agriculture, the head of states in the EU set a limit for agricultural expenditure for the coming years until 2013. The consequence is that there in the future will have to be a certain cut in direct support levels to farmers in order not to violate the budgetary ceiling. The Commission also proposes a reallocation of expenditure from market measures to more production neutral measures such as environmental measures and rural development. This reallocation, called modulation, implies a further small cut in direct support to farmers to the benefit of rural development measures. Two new measures that are to be introduced within the so-called rural development programme are support for improving food safety as well as animal welfare standards.

Although the pace is slow, it is a very positive tendency that we now see in the EU's agricultural policy; with the proposal for modulation we will be moving away from general price and budget support to targeted measures to benefit the environment and rural areas. However, if the transfer of money will be intact, with no cut in total support, the large sums of money will no doubt continue to have an impact on the world market.

The Commission is also proposing to decrease internal price support levels for milk products to approach world market price levels. The producers will be compensated through increased direct support. The reduction of internal prices is a positive step. However, since the Commission is not prepared to go all the way to reach world market price levels it proposed to extend the system with milk quotas to 2015. It would be better to reduce the internal prices to world market levels since there would then be no risk for a costly surplus production and thus no need for production restrictions.

However, one can ask oneself how market oriented European agriculture will be. For many products, production quotas will still remain. Some sectors like durum wheat, rice, protein, crops etc. will receive an extra support in addition to the 'farm income support'. Thus, there is still a differentiated treatment of products. It should also be mentioned that some sectors such as sugar, fruit and vegetables, olive oil, cotton, tobacco etc are not included in the decoupled support. It is positive that the Commission will present a reform proposal for the sugar sector in 2003. The sugar sector is currently one of the most trade distorting sectors.

The proposal of decoupling support from production requirements is a step in the right direction. Reallocating money for more production neutral and less trade distorting measures within the rural development programme is also positive. However, the main problem still remains. The EU still pays large sums of money to the agricultural sector and within the WTO many members, and especially developing countries, are criticising rich countries' considerable support to the sector.

Turning now to the WTO process. The WTO agreement on agriculture has been criticised to benefit developed countries to the detriment of developing countries. Since 1995 about 60 new developing countries have become members of the WTO and today more than 100 out of 144 members are developing countries. The needs of these countries obviously have to play a central role in the ongoing negotiations, which is also reflected in the Doha declaration.

Sweden has two important objectives in the agricultural trade negotiations: to ensure that the focus is on the interests of developing countries in accordance with the Doha agenda and to bring about a genuine liberalisation of trade.

Firstly, agriculture in developing countries should not be constrained by barriers to imports in industrialised countries or by their subsidised exports. We need to further open our markets to their agricultural exports and at the same time reduce our trade distorting support and phase out all forms of export subsidies. This will give the developing countries a more level playing field and a chance to realise their great export potential in agricultural trade and thus develop their economies as a whole. At the same time, developing countries must be allowed flexibility when implementing their own policies.

Sweden's second objective - a genuine liberalisation of trade - speaks for itself. The WTO negotiations must bring vigorous advances towards greater liberalisation, not least for the sake of developing countries, but also so as to increase global welfare.

Chairman Harbinson presented his first draft modalities on February 12 this year. Harbinson lives up to the expectations from a development point of view and the commitments proposed highly reflect the needs of and demands from developing countries. The draft is far reaching in its level of ambition: substantial cuts in tariffs and trade distorting support are proposed as well as an elimination of export subsidies. The draft is however, unbalanced in that it neglects the so-called non-trade concerns. For the EU societal goals such as the protection of the environment, food safety and food quality are very important in these negotiations and these concerns have not sufficiently been taken aboard. From a Swedish perspective we welcome that animal welfare is recognised as a non-trade concern. Tough negotiations on this draft have taken place in Geneva. The traditional camps in the negotiations will strive for the draft to go their way: Big exporting countries such as Brazil and Australia want more and Japan and the EU want less of trade liberalisation on agriculture. A second draft will be presented in the beginning of March.

Our preliminary assessment of the first draft and its effects on the Common Agricultural Policy is that it would have to undergo quite substantial reforms. The WTO will require the Common Agricultural Policy to become more market-oriented. This is why Sweden believes that a decision on the Mid Term Review should be taken as soon as possible in order for the EU to increase its negotiating capital. A Mid Term Review decision is however not a pre-requisite for a decision in WTO.

Summary

Most likely, the EU will need a Common Agricultural Policy in the future. However, it should be a policy with a different objective. The open landscape, the cultural landscape, biodiversity and regional development are important values for the society, which to a large extent can be attributed to the existence of agricultural activities. In a market economy such values are not sufficiently provided for to fulfil the demands of society. For that purpose, targeted support, which is not distorting to trade could, for instance, be used to safeguard agricultural production in certain areas, if it is needed. With more targeted support measures, it will also be possible to cut the overall expenditure on agriculture in the EU. In addition, targeted support measures are better suited to deal with regional differences in the Union. The EU and other rich countries have a responsibility to adapt their future policies to create a level playing field for the less developed countries on the world market.

During discussion the question was asked whether some of the resources of CAP could be used to support an activity with a health objective. There is recognition that agriculture is multifunctional - that it has important environmental, conservation and societal effects, for example. It was interesting to consider whether some of the resources could be put to use for a health objective. Over 1 billion euros are allocated to the support of tobacco production, for example. This needs to be compared to the budget allocated to the public health activities of the Commission. It is difficult to overstate the importance of this issue: half of the European Commission's budget goes to agriculture. If the extra costs to consumers of the CAP regime, in terms of higher prices, are added to the costs to taxpayers, the regime costs 100 billion euros. Foods high in saturated fat, such as butter, which produced with subsidies from European taxpayers, is dumped at cheap prices in schools, care homes and to low income groups.

One area of concern is the nutritional impact of some areas of food safety legislation. Local food markets, for example, have difficulties in meeting new hygiene standards. In reality, however, the destruction of local food production and local food economies can have a far more detrimental impact on health.

There are clearly some difficult issues to be addressed with EU enlargement and there are risks associated with relaxing food safety legislation too much. This is also an important issue for developing countries who, even in the absence of price subsidies or tariffs, would find food safety standards barriers to trade with Europe. Other important issues, such as the role of genetically modified foods and transgenic animals, also require discussion in relation to EU enlargement and international trade.

Slovenian accession to the EU: impacts on the agro-food sector

Dr Ales Kuhar, Chair for Agricultural Economics, Policy and Law, University of Ljubljana, Slovenia

Agriculture is of limited importance for Slovenian economy and its relative weight is constantly decreasing. It only contributes around 3% to the gross domestic product and only 5% in the total employment. The downward trends are expected to continue largely as a result of growing importance of other economic activities. Despite its declining economic importance, agriculture remains an important factor of development and social stability in the rural areas. Slovenia is a country where rural areas cover 89% of total territory and 57% of the total population live in these areas. Only Ireland and Austria of all the European countries have comparable proportions of rural population.

Production of food in Slovenia is characterised by less-favourable natural and structural conditions for agriculture, which also explains its status of a net importer of agricultural products and rather highly protectionist agricultural policy.

The period of transition during the nineties was also a period of a thorough restructuring of the agricultural policy. The policy was gradually brought into line with the goals and mechanisms of the Common Agricultural Policy (CAP) and even before accession Slovenia started to implement CAP-like measures, including direct payments and rural development policy measures. Slovenia is thus the only candidate country for EU accession with the instruments and level of support comparable to the European Union.

The foreseen accession of Slovenia to the European Union in 2004 will bring to an end the process of transition of agricultural policy. Agriculture was the most disputable chapter of the accession negotiations process. The first negotiating proposal which the EU put forward at the beginning of 2002 was rather unfavourable for Slovenia in all three major areas for agriculture, namely, direct payments, quotas and reference quantities, and rural development funds. Some Member States actually required that no direct payments are granted to the farmers of candidate countries, although this measure makes up the major part of CAP funds. Quotas and reference quantities for some products were even set below the actual levels of production. Nevertheless, the final agreements in the area of agriculture may be assessed as favourable for Slovenia.

With regard to direct payments, Slovenia accepted the EU proposal that the level of direct payments increases gradually from 25% in 2004 to 100% in 2013. Furthermore it was granted a right to "top up direct payments" (complement direct payments from the national budget) up to the level recorded in 2003, increasing by 10 percentage points in 2004 and by further 5 percentage points in each of 2005, 2006 and 2007. Thus, in 2007, a 100% level of payments would be reached in Slovenia in comparison with the present Member States. Similarly the final outcome of negotiations on quotas and reference quantities is favourable for Slovenia. The final figures are all above the present production levels, with different levels of reserves left for additional development and restructuring of the sector.

In the area of rural development - the so called second pillar policy - Slovenia managed to attain a favourable solution. Namely, Slovenia was granted funds for the rural development programme amounting the around 250 million euros, which is more than the overall funds for structural and regional policy and which represents the highest share Slovenia was ever granted in the distribution of the EU budgetary funds among the candidate countries. Together with the national funds, the programme for the period 2004 -2006 will be worth more than 330 million euros. A comprehensive rural development programme will enable Slovenia to reorient to the new CAP goals and to pursue a more target-oriented and transparent policy including compensatory payments for agri-environmental payments and Less Favourable Areas (LFA) support measures.

Although the outcome of agricultural negotiations arose hopes of benefits and new opportunities, the very accession may also reveal many weaknesses and potential dangers. The degree of competitiveness of the entire agro-food sector and effectiveness to implement the supporting measures will eventually decide whether the accession was a success or a failure for the Slovene agri-food sector.

Health impact assessment (HIA) of the Slovenian agricultural policy - health impact assessment of national agriculture, food and nutrition policies: lessons learnt from the HIA development in the Republic of Slovenia

Dr Jozica Maucec Zakotnik, State Secretary, Ministry of Health of the Republic of Slovenia

An Health Impact Assessment of European Union accession on Agriculture and Food Policies in Slovenia is being conducted as a joint project between the Slovenian Ministry of Health and the WHO European Region.

A joint Slovenian-International project steering group was created which is responsible for scoping and conducting the appraisal.

The major difficulty was clarifying the policy options to be assessed as part of the HIA. There were ongoing negotiations about the nature and amount of common agricultural policy subsidies Slovenia would be allocated on accession, and the date of accession was not confirmed. For the HIA we had to commission new work to model various alternative policy scenarios. This required the involvement of both the Ministry of Agriculture and agricultural economists. The complexities of the CAP and how this makes conducting an HIA very difficult will be discussed.

Rapid appraisal workshops were held in March 2001 in the north-east region of Promurje. This areas has very high all-cause mortality and low socio-economic status compared with the rest of Slovenia. This is also the region with the largest agricultural sector, with 20% of the population employed in farming or related industries. A wide range of stakeholders were involved including local farmers, consumer organisations, schools, managers of food processing plants, public health professionals, regional development specialists and officials from the Ministry of Agriculture, Economic Development and Health (including the Minister for Public Health). The workshop materials were in Slovenian and the group work was conducted in Slovenian with facilitators who had knowledge of HIA methods.

An expert meeting was held to assess the strength of the evidence. Unsurprisingly, for several key areas the evidence was found to be patchy further evidence reviews were commissioned. Part of the project will now produce a comprehensive evidence-base for how agriculture and food policies affect health.

The Institute of Public Health, Ljubljana have coordinated the National and regional data collection, the findings of which will be presented. The data for the HIA are currently being analysed, and conclusions will be fed back to the intergovernmental committee on Health in Slovenia in March 2003.

Lessons learnt

This was the first time any project had set out to quantify the specific health impacts of the CAP. Although the project evaluation is not yet completed, several learning points have already arisen. The major finding is that cross-governmental working appears to be much better organised in Slovenia compared with many EU member states. This has facilitated an ambitious programme for the HIA in a short period of time. The need for capacity building amongst the public health sector was an important part of conducting the HIA. Even though this was a pilot project, the political time frames created pressure to provide support for the Slovenian government position during the EU negotiations, which were not possible. As the goal of accession is still a moveable target, it has proved very difficult to quantify or assess some outcomes with any certainty. The problem still remains that the public health sector has not yet reached a common understanding

of HIA, and how it should be used in policymaking. The experience gained shows that it has potential as a means of contributing to more integrated policies, not only in agriculture but a range of policy areas.

6.2 Micronutrient deficiencies

In the second part of this session, attention turned to micronutrient deficiencies. More specifically, Dr Natalia Vartapetova described the results of a successful dietary approach to the reduction of micronutrient deficiency in Russian Federation.

Reduction of Iron Deficiency Anaemia in the Russian Federation - dietary approaches

Dr Natalia Vartapetova, John Snow Inc., Moscow

The Women and Infants Health project is a USAID-funded project conducted in Russian Federation by John Snow Inc since 1999. The aim of the project is to improve health and nutrition of women of reproductive age and infants. We are working in cooperation with the National MOH and regional departments of health in two demonstration regions: Novgorod oblast (in north-western russia) and Perm oblast in Ural region.

The project works at 20 facilities in three cities (Perm, Novgorod and Berezniki) and involves more than 1 million of residents of the catchment area of the participating facilities. Target groups for intervention are primary health care providers (physicians, midwives and nurses) working in women's and children's outpatient clinics and maternity hospitals and their clients - pregnant and lactating women and infants.

Nutrition related issues in the project were addressed through the following key intervention activities:

- Integrated counselling and clinical training for providers based on WHO Healthy Food and Nutrition course and Breastfeeding counselling course.
- Information and communication activities as for providers as for women and their families.
- Policy development that included agreement at the national level on key messages to be promoted in the pilot sites and a broader consensus and local guidelines development in the project sites.

Prevalence of anaemia and opportunities for intervention were assessed through a suite of methods. One method was a facility-based survey.

Two rounds of facility-based survey were conducted in 2000 and 2002. Each time over the course of three weeks medical staff from women's consultation centers, maternity hospitals, children's polyclinics and women coming to these facilities for services were interviewed. We used these surveys to assess and compare knowledge and reported practices of health providers and actual experience and demands of clients.

The other method is a routine monitoring system. It tracks indicators using health data routinely collected in facilities. A monitoring system collects data from the facilities quarterly.

For this presentation we analysed data about pregnant women completed their pregnancies from July 2000 through September 2002 and feeding practices and anemia rate among 6-month old infants for the same period of time.

Initially we wanted to understand the magnitude of the problem and the sites reported that 52% of pregnant women had anaemia. We found out that for a diagnosis of anaemia they used a cut-off point for the level of haemoglobin below 120g/l. We discussed with providers issues of physiological anaemia in pregnancy and international criteria and the sites reported back that there were 25% of pregnant women with haemoglobin level below 105g/l and 10% of women with haemoglobin below 100g/l. According the monitoring data for two years proportion of women with the level of haemoglobin below 100g/l were the same despite the geographic area and seasons.

Attempts to promote iron supplementation were not very successful. In 2000 86% of providers prescribed iron supplements, two years later the majority of providers - 98% - reported prescribing supplementation. In the same time only 48% of women in 2000 and 44% 2002 said they did get a prescription and even less proportion of women actually took supplements: 85% in 2000 and 76% in 2002. Women complained that they were afraid of potential adverse side effects of iron supplements. 75% of providers in turn prescribed iron for 4 weeks or less that does not correspond to international recommendations.

On the contrary the demand for diet counselling was very high: 82% of clients in 2000 and 91% two years later said they discussed their diet with providers. 76% of providers in 2000 and all of them two years later reported that they usually talk with women about diet.

To address and support this demand for information on nutrition a set of education materials including brochures, posters and TV spots were developed. These materials were also highly used by clients: In 2002 81% of women had a chance to read and take way education materials when two years earlier only 34% reported on that. In 2002 one third of women said that they got information on nutrition from brochures or saw a poster on nutrition while in 2000 only 8%.

Infant nutrition was addressed through promoting exclusive breast feeding up to 6 months with timely introduction of appropriate complimentary foods in conjunction with continued breastfeeding. Additionally to benefits for infants, breastfeeding also allows to maintain iron stores of lactating women. In our project before the intervention started only 28% of providers counselled on exclusive breastfeeding, 44% of providers advised to supplement with water and 49% of postpartum women could correctly define exclusive breastfeeding. Two years later 94% of caregivers counselled on exclusive breastfeeding for the first six months, less than 3% advised to supplement with water and 88% of postpartum women could correctly define exclusive breastfeeding.

As a result a number of postpartum women exclusively breastfed their babies during hospital stay more than doubled from 41 to 90% and proportion of babies given something else from a bottle during hospital stay decreased from 70 to 10%. Continuous counselling and support allowed to increase proportion of infants exclusively breastfed at 4 and 6 months to 80% and 70% respectively.

Changes in the feeding practices were monitored alongside of prevalence of anaemia among 6 months old infants. For a diagnosis of anaemia we used a cut-off point for the level of haemoglobin below 110g/l. This slide demonstrates data quarterly collected from the facilities for two years. Exclusive breastfeeding rate among 6 month olds has been increasing from 28% to 70% and prevalence of anaemia has been correspondingly decreasing from 13% to 6% (number of observations).

Finally, we can conclude that:

Dietary-based counselling and information materials are demanded by clients and well adopted by health providers and should be considered as a key public health strategy for prevention and control of iron deficiency anaemia.

During discussion after this paper, it was recognised that this is extremely valuable work. The importance of this well evaluated, work which demonstrates the effectiveness of dietary-based approaches to tackling micro-nutrient deficiency cannot be over-emphasised. The training materials used for this intervention are available, in Russian, and can be adapted. This intervention presents an opportunity to place micronutrient deficiency on the political agenda and also to complement the current emphasis on fortification or supplementation as the only solutions.

Dr Vartapetova outlined how the training programme had worked in practice. A group of national master trainers had trained one or two local trainers for each facility. These local trainers then trained local health professionals. The master trainers visited regularly to support the local trainers and this follow-up support was considered to be extremely important.

6.3 The way forward

During the final session of the meeting, participants considered the best way forward and looked beyond the Ministerial Conference in 2006. What could be done to ensure that nutrition and food policy remained important on national agendas? What role can WHO play in supporting Member States in their continuing work in this field?

Suggestions for the second food and nutrition action plan, 2006 - 2010

Dr Chizuru Nishida, WHO, Geneva - presented by Dr Pekka Puska

During regional review meetings held between 1999 and 2001, five factors were commonly cited as affecting nutritional status. These were:

- Infectious disease and parasites
- Poverty
- Physical Inactivity
- Changing dietary patterns and habits
- Poor breastfeeding practices/ household insecurity

It is not surprising that the factors cited did differ from region to region. In Europe the three most commonly cited factors were (i) high fat intake, (ii) physical inactivity and (iii) economic transition and the changing dietary patterns and habits that it brings with it.

The Regional Food and Nutrition Action Plan for 2000 - 2005 has been built on the three crucial pillars of nutrition, food safety and sustainable food supply. A February 2003 review of status of Food and Nutrition Action Plans in Europe, revealed 24 final action plans, 4 draft action plans and 10 other action plans in preparation. This highlights how far advanced the work within the European Region is in this important area. It is clear that the European Region will be making a very, very important contribution to the Global Strategy on Diet, Physical Activity and Health.

Current strategies in effect through the implementation of national Food and Nutrition Action Plans include:

- Prevention and controlling overweight and obesity in four Member States
- Preventing and controlling non-communicable diseases in five Member States
- Promoting physical activity in four Member States

Taking these approaches into consideration, a new food and nutrition action plan for 2006 - 2010 could usefully incorporate a fourth pillar. Introduction of Healthy Lifestyle as a new pillar would ensure a comprehensive food and nutrition action plan that could be implemented throughout the Region.

Once again, new and innovative partnerships will be required to really make progress with the Food and Nutrition Action Plan. There is no dispute that Ministries of Health and WHO must take a lead in getting these partnerships off the ground.

Recommendations for the second food and nutrition action plan and ministerial conference in 2006

Participants reviewed the usefulness of the current Food and Nutrition Action Plan for 2000 - 2006 adopted by Member States in September 2000. There was huge agreement that the Action Plan had been of tremendous value for many different reasons. One key factor was the pressure that the Action Plan exerted on national governments to take action on food and nutrition. There is no question that the Action Plan helped to raise food and nutrition issues on national political agendas. In countries in economic transition, in particular, the respect of UN agencies like WHO and FAO is very important to governments. Similarly, the regional Action Plan encouraged governments to analyse data on food related health issues in their country. The discussion at the start of this meeting, during the first Working Group session, had highlighted the importance of the Food and Nutrition Action Plan.

The three pillar approach of the Action Plan had proved particularly valuable. The support of the WHO Regional Office for Europe in visiting countries and helping to present the issue to other sectors, was greatly appreciated. Some Member States indicated that the Action Plan had helped them to achieve an integrated approach where previously work had been very piecemeal. In some countries, participants had learnt how to organise, collaborate and work with other sectors thanks to the Action Plan. The existence of the Food and Nutrition Action Plan as a 'multisectoral umbrella' was crucial to this development.

Participants indicated their strong support for a new comprehensive food and nutrition action plan to follow on from the current initiative. For all the reasons described above, participants were very keen to see a second Food and Nutrition Action Plan to build on current policies and actions.

There was clear recognition that what happens to diet will be the key to improving public health in this region. Participants were in no doubt that the Food and Nutrition Action Plan had helped their Member States to move forward, in an integrated way, to improve nutrition. A second Action Plan would provide support for them to build on this progress and go further. It would provide a continued impetus for this important work. WHO Headquarters in Geneva would also strongly support the European Region in continuing its strong development in this area.

Recent speeches from European Commissioner Byrne indicate a clear willingness on the part of the European Commission to tackle diet and health issues. It is also important to note that donor agencies look at the agenda of WHO when determining funding priorities - an important factor for future financing of programmes.

There was support also for the inclusion of a fourth pillar - Healthy Lifestyle - in a new Food and Nutrition Action Plan for Europe. It was also suggested that addressing the question of 'why people eat what they eat' might be valuable. Identification of barriers, fears and market forces could be useful.

7 Conclusions

Participants were reminded that WHO remains a civil servant of Member States. It is Member States who take decisions at Regional Committees, the World Health Assembly etc. Dialogue with colleagues within Member States is important to ensure that people are aware of developments in the field of food and nutrition and that they can apply pressure to ensure that the issue is addressed at the political level.

It is the responsibility of national nutrition counterparts to ensure that their governments are - and remain - aware of nutrition issues and that a consensus was reached at this meeting in Athens. That consensus reaffirmed the importance and value of the current Food and Nutrition Action Plan for Europe and called for a new comprehensive Food and Nutrition Action Plan from 2006 - 2010.

The proposal for a new Action Plan will be considered in more detail after this meeting and alongside the developments in the Global Strategy on Diet, Physical Activity and Health. Clearer links also need to be made with other existing Action Plans, such as the European Action Plan on Alcohol.

Development of a second Food and Nutrition Action Plan 2006 - 2010 should begin so that there could be a document in place for discussion at the Ministerial Conference in 2006. The WHO Regional Office for Europe would welcome any comments or feedback on the development of the second Action Plan.

WHO Headquarters urged participants to really act on this issue now. Practical effective action for healthy nutrition and improved public health is possible and necessary. The achievements of the Food and Nutrition Action Plan are many and widespread and it is important to continue disseminating them for many years.

WHO Headquarters and WHO Europe thanked participants for coming and for contributing to a valuable meeting and thanked the Greek hosts for their kind hospitality. The Chair of the Organising Committee, Dr Meropi Violaki, also thanked participants and thanked WHO for their efforts in organising the meeting. In concluding, she stressed the importance of nutrition for the next generation. Taking action to improve food and nutrition is essential to give them the best opportunity in life.

Annex 1

Scope and purpose

At the first meeting of nutrition counterparts in Malta in 1999, a draft of a WHO Food and Nutrition Action Plan was presented. At the WHO Regional Committee for Europe in September 2000, Member States unanimously endorsed the First Food and Nutrition Action Plan for the WHO European Region and adopted the resolution. One of the main goals of the WHO Action Plan is for all Member States in the WHO European Region to develop Food and Nutrition Action Plans by 2005. A ministerial conference will be held in 2006 to assess the progress made towards this goal.

During 2000, 2001 and 2002 sub-regional workshops were held in the Baltics (Estonia, Lithuania, Latvia) with input from Nordic countries (Denmark, Finland, Iceland, Norway, Sweden), South East Europe (Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Former Yugoslav Republic of Macedonia, Slovenia, Romania, Yugoslavia), CCE (Czech Republic, Hungary, Poland, Slovakia) and Southern Europe (Andorra, Greece, Italy, Israel, Malta, Portugal, Spain, Turkey) to assist Member States in their development of national food and nutrition action plans. A few countries have finalized action plans, others are nearing completion and many are at the developing stage. The WHO Regional Office for Europe has as far as possible encouraged Member States to network and share experiences during the development of national action plans. This meeting in Greece will provide a good opportunity for this networking to continue and to share experiences.

At this meeting in Greece, nutrition counterparts will evaluate progress and discuss future priorities for a ministerial conference, especially how to evaluate the progress made between 2000 and 2005 in time for the conference in 2006.

The meeting will also provide an opportunity for discussions and recommendations on the Global strategy on diet, physical activity and health. The Global strategy is aimed at preventing and reducing the growing burden of non-communicable diseases worldwide and improving public health through healthy eating and increasing physical activity. A World Health Assembly Resolution in 2002 requested the WHO Director General to develop this Global strategy in consultation with Member States and other organizations. WHO is therefore arranging consultations, including regional meetings. The recommendations from this nutrition counterparts meeting will be fed into the European Regional Consultation on the Global Strategy.

Annex 2

Programme Food and nutrition action plan – past, present and future

Thursday, 27 February

- 19.30-20.30 Registration
20.30 Welcome Reception hosted by the Ministry of Health and Welfare, Greece

Friday, 28 February

- 08.00–08.30 Registration
08.30-08.45 Address by Organizing Committee of Ministry of Health and Welfare
Election of Chairperson and Rapporteur
08.45-09.00 Adoption of agenda and programme
09.00–09.30 **Opening addresses:**
The Ministry of Health and Welfare, Greece
WHO Regional Office for Europe, Dr Roberto Bertolini
WHO Headquarters, Dr Pekka Puska

Food and Nutrition Action Plan – the past

- 09.30-10.30 Progress on implementing the First Food and Nutrition Action Plan in the WHO European Region, 2000-2005
Dr Aileen Robertson
Introduction to 1st group work by Dr Aileen Robertson
Coffee/tea break (group photo)
10.30-11.00
11.00-13.00 Progress on implementing the First Food and Nutrition Action Plan in the WHO European Region, 2000-2005
1st Group work
Lunch and exercise break
13.00-14.30
14.30-16.30 Progress on implementing the First Food and Nutrition Action Plan in the WHO European Region, 2000-2005
Feedback in plenary of 1st group work
Coffee/tea and exercise break
16.30-17.00
17.00-17.30 UNICEF nutrition priorities in Europe, Dr Arnold Timmer
17.30-18.00 FAO nutrition priorities in Europe, Dr Michael Canon

Saturday, 1 March

- 07.00-08.00 **DAFNE meeting**
Stability Pact – Albania, Croatia, Bosnia and Herzegovina, Bulgaria, Romania, Slovenia, Republic of Moldova, Serbia and Montenegro, the Former Yugoslav Republic of Macedonia, Professor Antonia Trichopoulou

Food and Nutrition Action Plan – the present

- 08.30 –10.30 Status of food and nutrition action plans in the WHO European Region, 2003
Introduction to 2nd group work by Dr Aileen Robertson
Coffee/tea and exercise break
10.30-11.00
11.00-12.30 Status of food and nutrition action plans in the WHO European Region, 2003
2nd Group work

	Agreed process for Conference of Federation of European Nutrition Societies (FENS), Rome, October 2003
12.30-14.00	<i>Lunch and exercise break</i>
14.00-14.20	WHO Global strategy on diet, physical activity and health: Introductions by Dr Pekka Puska and Dr Roberto Bertollini
14.20-16.00	WHO Global strategy on diet, physical activity and health Introduction to 3 rd group work by Dr Aileen Robertson 3 rd Group work
16.00-16.30	<i>Coffee/tea and exercise break</i>
16.30-18.00	WHO Global strategy on diet, physical activity and health Feedback in plenary of 3 rd group work Recommendations to the European Consultation on the Global Strategy on Diet, Physical Activity and Health (Copenhagen, April 2003)
20.00	<i>Farewell dinner by the Ministry of Health and Welfare, Greece</i>
Sunday, 2 March	
07.00-08.00	DAFNE meeting Stability Pact – Albania, Croatia, Bosnia and Herzegovina, Bulgaria, Romania, Slovenia, Republic of Moldova, Serbia and Montenegro, the Former Yugoslav Republic of Macedonia, Serbia and Montenegro, Professor Antonia Trichopoulou
Food and Nutrition Action Plan – the future	
Food Security	
08.30-08.50	Common Agriculture Policy, Dr Christer Wretborn
08.50-09.10	Impact of Slovenia joining the EU, Dr Ales Kuhar
09.10-09.30	Health Impact Assessment of the Slovenian Agriculture Policy, Dr Jozica Zakotnik
09.30-10.00	Discussion
10.00-10.30	<i>Coffee/tea and exercise break</i>
Micronutrient Deficiencies	
10.30-10.50	Reduction of Iron deficiency anaemia in the Russian Federation – dietary approaches, Dr Natalia Vartapetova
10.50-11.00	Discussion
The Way Forward	
11.00-11.20	Suggestions for the second food and nutrition action plan, 2006-2010 Dr Chizuru Nishida
11.20-12.30	Discussions and recommendations for the second food and nutrition action plan and ministerial conference in 2006
12.30-12.45	Conclusions
12.45-13.00	Close of the meeting
13.00	<i>Lunch</i>

Annex 3

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Annex 4

Questionnaire on the Global Strategy for diet, physical activity and health

Name of country	
City	
Name of institution	
Name and title of person filling in this questionnaire	

THE PROBLEM

Discussion Points:
<i>What are the levels and trends of the major risk factors and determinants for chronic diseases in your country?</i>

1. Please provide data on the following behavioural and biological risk factors and score these risk factors for non-communicable diseases in order of importance on population level for your country (1 – low importance; 5 – high importance).

	Score	Prevalence (%) among adult population		Score	Prevalence (%) among adult population
Recommended intake for saturated fats (< 10% of total energy intake)			High blood pressure (>140/90 mmHg)		
Recommended intake for salt (< 5 g / day)			High total blood cholesterol (> 5.2 mmol/l)		
Recommended intake for sugar (< 10% of total energy intake)			Obesity (BMI > 30)		
Recommended intake of fruits and vegetables (> 400 g / day)			Overweight (BMI >25.0 - 29.9)		
			Tobacco consumers		
			Physically inactive persons		

THE SOLUTION

Discussion Points:

Do you anticipate that gaining increased political commitment on implementing strategies to reduce levels of chronic diseases and obesity, will encounter any obstacles, such as policymakers not seeing NCDs as a priority, or cultural constraints? What other potential obstacles do you envisage?

2. Do you anticipate any of the following obstacles in gaining increased political commitment to implement strategies to reduce levels of obesity and other chronic diseases?

Politicians do not see NCD as a priority Yes No
Cultural constraints Yes No

What other obstacles do you anticipate in increasing governmental commitment to implement strategies on diet and physical activity to reduce levels of noncommunicable diseases?

Please provide details:

PRINCIPLES FOR ACTION

Discussion Points:

Do the existing institutional mechanisms in your country, both within and between government agencies, address diet and physical activity in a coherent and integrated way? What role does the Health Ministry have in these mechanisms? Do governments interact with private entities, NGOs or academic groups? Is interaction done in an effective way, and does it address both diet and physical activity *together*?

3. Are there existing institutional mechanisms between government agencies in your country that address both diet and physical activity in an integrated way, such as an intersectoral working group / committee ?

Please mark:	
Yes, please provide details:	
There is no committee on diet and physical activity, but there is an intersectoral committee on nutrition / diet .	
There is no committee on diet and physical activity, but there is an intersectoral committee on physical activity .	
No, there is neither of the above	

4. If an intersectoral committee as described in question 3 exists, what role does the Ministry of Health play?

- Lead role
 Partner
 No role
 Other..... Please provide details:

THE GOAL

Discussion Points:

What is the status of your country's legislative, regulatory and national policy in the area of diet and physical activity? (e.g. are there food labelling, marketing codes) Do policies involve different sectors, such as health, transport and agriculture? Does the agriculture policy address issues such as national food security, trade and exports and agri-environmental issues? Has your country investigated barriers to access to healthy foods?

5. Does your country use any of the following strategies to promote a healthy diet and physical activity?

	Healthy Diet			Physical Activity		
	Yes	No	Details	Yes	No	Details
Legislation						
Regulation						
Codes						
Policies						
Action Plan						
Other						

6. Please describe briefly what influence, if any, CODEX ALIMENTARIUS provisions have on strategies mentioned in the area of a healthy diet in question 5.

- No influence
 Yes Please provide details:

7. Which sectors or ministries in your country are involved in formulating and implementing legislation, action plans and guidelines related to healthy diet and physical activity?

	Yes	No
Health		
Agriculture & Fisheries		
Environment		
Transport		
Education		
Trade		
Finance		
Other, please specify		

8. Please describe any agricultural policy or activity/action plan where production of enough food to ensure availability for all, especially the poor (i.e. to ensure enough food is available to meet the international dietary recommendations), has been explicitly considered (e.g. production subsidy of fruits and vegetables; subsidy of low fat milk production and not high fat milk).

Please provide title of the policy, date of issue and the influences it had. If possible, please attach a copy of the document.

9. Has your country considered ways to reduce access barriers to healthy foods and/or enhance possibilities to engage in physical activity?

- Yes, for access to healthy foods Please provide details:
Yes, for promotion of physical activity Please provide details:
Neither

10. Are there international policies or strategies that your government believes would expedite national progress towards reduced rates of noncommunicable diseases and obesity?

- No
Yes Please specify:
-
-

11. Has your government decided on any new activities to start in the near future in the area of promoting a healthy diet and physical activity? Please describe briefly.

- Yes, in the area of healthy diet. Please provide details:
 Yes, in the area of physical activity. Please provide details:
 Yes, in the area of healthy diet and physical activity combined.
Please provide details:
 Neither

FROM SCIENCE TO ACTION

Discussion Points:

Do your country's health and surveillance systems adequately advise on prevention, and report on chronic disease risk factors at the various levels, i.e., hospitals, clinics, primary health care, private and public health sectors?

12. Please list in the table below main research centres of excellence with high expertise in the fields of diet and physical activity from your country.

Name of Centre	Field of expertise

HUMAN RESOURCES

13. Do the health services routinely provide advice to patients and families on a healthy diet and physical activity as preventive measures for maintaining good health and preventing noncommunicable diseases ?

	Yes on healthy diet , please specify	Yes, on physical activity , please specify
Hospitals		
Polyclinics		
Primary health care		
Public health sector		
Private health sectors		
School health authorities		
Others, please specify		

14. Does your country provide education for health professionals in the following areas?

Undergraduate education in healthy diet and physical activity for:				
	Yes	No	Provided by	Details
medical students				
nursing students				
other health professionals, please specify				

Postgraduate education in healthy diet and physical activity for:				
	Yes	No	Provided by	Details
medical doctors				
nurses				
Public health nutritionist				
dieticians				
other health professionals, please specify				

Training in leading intervention programmes/projects or promoting policies to promote a healthy diet and physical activity for:				
	Yes	No	Provided by	Details
medical doctors				
nurses				
Public health nutritionist				

dieticians				
other health professionals, please specify				

SURVEILLANCE

15. Does the national surveillance system regularly monitor and report on key risk factors for noncommunicable diseases including...

	Physical Activity, please define	Dietary Aspects, please specify
Yes, please state method used		
No		

COLLABORATION

16. Has your country had a particular experience in **public-private partnerships** in the area of healthy diet and physical activity?

No	
Yes, please provide:	
Name of the initiative /programme	
Subject	
Partners involved	
Objective / goal	
Level (national, regional, local)	
Time frame	
Information about the evaluation	

17. Has your country had a particular experience in working with **nongovernmental organizations** in the area of healthy diet and physical activity?

No	
Yes, please provide:	
Name of the initiative /programme	
Subject	
Partners involved	
Objective / goal	
Level (national, regional, local)	
Time frame	
Information about the evaluation	

18. What role do the **media** play in your country in the activities to promote a healthy diet and physical activity?

	Yes	No	Please specify (TV, radio, etc.)
They are a main collaborator			
They are among other collaborators			
They show little interest			

19. How would you describe the level of awareness among the general adult population of the influences of unhealthy diet and physical inactivity on the development of noncommunicable diseases? Please give scores: 1- very low awareness through 5- very high awareness. If possible please distinguish between men and women and urban and rural population. If not possible, please fill in only the column "general".

Score: 1 – very low awareness - through - 5 – very high awareness	Urban		Rural		
	General	Men	Women	Men	Women
In general, how aware is the adult population of dietary influences on the development of noncommunicable diseases such as heart disease					
In general, how aware is the adult population of influences physical inactivity has on the development of noncommunicable diseases such as heart disease					

20. How would you describe the level of awareness among school children of the influences of unhealthy diet and physical inactivity on the development of noncommunicable diseases? Please give scores: 1- very low awareness through 5- very high awareness. If possible please distinguish between boys and girls and urban and rural population. If not possible, please fill in the column "general".

Score: 1 – very low awareness - through - 5 – very high awareness	Urban		Rural		
	General	Boys	Girls	Boys	Girls
In general, how aware is the school age population of dietary influences on the development of noncommunicable diseases such as heart disease					
In general, how aware is the school age population of influences physical inactivity has on the development of noncommunicable diseases such as heart disease					

21. Please share any additional ideas and thoughts you may have regarding the development of the Global Strategy on Diet, Physical Activity and Health, especially in regard to how your country may wish to participate.

22. Please share with us the expectations your country has from the Global Strategy on Diet, Physical Activity and Health.

INTERVENTIONS

23. With the help of the table provided below, please briefly describe the most important intervention projects or programmes or permanent activities carried out on a national level to promote a healthy diet and/or physical activity. If an innovative, successful project/programme is carried out at regional or local level you may wish to add this as well. Please provide reference to background documents (project reports, journal article etc.) where available.

Please fill the table below, one table for each project/programme/permanent activity you would like to describe. There are 2 tables provided. If you would like to report on more than 2 activities, please copy/paste the table into another Word file to fill in and attach to your reply. Thank you.

Project/programme/permanent activity 1	Answer		
Name of the project/programme/permanent activity			
What is the target group?			
What is the target setting?			
What are the main activities?			
Has the intervention programme provoked intersectoral collaboration?			
What milestones and indicators have you defined for evaluating success?			
Has the programme been evaluated?			
Has sustainability of the activity been taken into account?			
Does the project/programme/permanent activity have...	Yes	No	Details
a population focus?			
a focus on the individual?			

Project/programme/permanent activity 2	Answer		
Name of the project/programme/permanent activity			
What is the target group?			
What is the target setting?			
What are the main activities?			
Has the intervention programme provoked intersectoral collaboration?			
What milestones and indicators have you defined for evaluating success?			
Has the programme been evaluated?			
Has sustainability of the activity been taken into account?			
Does the project/programme/permanent activity have...	Yes	No	Details
a population focus?			
a focus on the individual?			

Annex 5

Impact of the First Action Plan for Food and Nutrition Policy: feedback from Working Group 1

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
NORDIC/BALTIC GROUP			
DENMARK	Action has been taken on nutrition policy but not because of FNAP.	Action taken (not as result of FNAP): <ul style="list-style-type: none"> - Political Action Plan. Under the previous government this included promotion of a school feeding programme. Since November 2001, the current government has tried to limit the budget. - Iodine fortification of salt - Information campaign on folic acid 	It is important to support: <ul style="list-style-type: none"> - Research in methodologies for health promotion to strengthen the evidence for implementation of strategies; - Create public demand for political action on nutrition and food safety
FINLAND	Action has been taken on nutrition policy but not because of FNAP	The National Nutrition Council started the work on the Nutrition Action Plan already before the FNAP was adopted. The Action Plan will be published before summer 2003.	Political commitment could be strengthened before the Ministerial Conference in 2006 by: <ul style="list-style-type: none"> - Raising awareness among politicians by, for example, providing health and nutrition reports to politicians - Having more evidence on the implementation of programmes which shows what has really been effective
NORWAY	Action has been taken in line with the FNAP. It is difficult to judge the role of the FNAP.	Action taken includes: <ul style="list-style-type: none"> - A Whitepaper on Public Health Nutrition - Surveillance of 4,9 and 13 year old children and infants from 6 months to 2 years - Structural changes in work places and schools, including cross sectional 	

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		<p>collaboration on school meals (Min of Agriculture, Min of Health and Ministry of Education)</p> <ul style="list-style-type: none"> - Revising nutrition recommendations (to be released in 2004) - Implementation of the EU Directive on infant foods - Increasing competence in nutrition among health personnel and in general education. 	
SWEDEN	Action has been taken on nutrition policy but not because of FNAP	<p>Another national policy was already in operation:</p> <ul style="list-style-type: none"> - Swedish national Aims and Strategies for Nutrition, 1999 - 2004 - Swedish National Plan of Action for Nutrition was signed by Minister of Health in 1995. 	
ESTONIA	Yes, action has been taken as a result of the FNAP.	<p>The process of developing the Estonian nutrition action plan began in November 2000 and was published in the first quarter of 2002.</p> <p>The Estonian Health Forum was held in April 2002 where the Estonian Healthy Public Policy - 2010 was introduced. Healthy Nutrition Plan is one of the sub documents of this policy and can be used as a public agreement in setting priorities, developing action plans and planning the necessary resources.</p>	Healthy Nutrition Action Plan does not have separate funding from state budget. Mostly the healthy nutrition activities are financed through health promotion projects from Health Insurance Fund.
LATVIA	Yes, action has been taken as a result of the FNAP.	<p>A Food and Nutrition Action Plan has been published in two parts - 'Healthy Nutrition 2003 - 2013' and plan of action.</p> <p>Nutrition Council has been developed and meets regularly.</p>	<p>There are a number of problems:</p> <ul style="list-style-type: none"> - Political commitment (there are many changes happening, including changes in politicians) - Bigger financial support from government is required - Closer collaboration between the Ministers

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		<p>Several dietary guidelines have been issued.</p> <p>Founding a Commission on Iron Deficiency Anaemia elimination and has carried out 6 months work.</p>	involved - health, agriculture, welfare - is needed.
LITHUANIA	Yes, action has been taken as a result of the FNAP	<p>Actions taken include:</p> <ul style="list-style-type: none"> - Since 1994 - transposition of Codex Alimentarius and the EU legal acts provisions (including HACCP in food establishments) - 2000 - drafted National Food and Nutrition Action Plan - 2000 - approved national norms for nutrient consumption - 2002 - started to create the National Food Composition Database - 2001 - first version of the National Food and Nutrition Action Plan was approved by the State Public Health Service under the Ministry of Health - 2001 - approved the National Food Safety Strategy - 2002 - draft of the national Food and Nutrition Action Plan was approved by the National Health Board under the Lithuanian Parliament and revised by WHO Regional Office for Europe - 2002 - revised Food Contamination Monitoring - 2002 - launched Monitoring of Nutrition of Population - 2003 - drafted programme for Reducing Nutrient Deficiency 	

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		<ul style="list-style-type: none"> - 2003 - approved National Environment Health Action Plan (NEHAP) by Government - 2002-2003 - participation in the Nord-Balt network meetings - 2003 - draft of the National Nutrition Strategy and Lithuanian Food and Food and Nutrition Action Plan ready to be approved by Parliament. 	
SOUTH-EAST EUROPE			
ALBANIA	Action was taken on nutrition policy as a result of the FNAP.	<p>An order of the Minister of Health in 2000 was signed to set up a working group in charge of development of a Food and Nutrition Action Plan. The first draft of the FNAP was finalised in June 2002.</p> <p>A request for other Ministries involved in the process was sent in July 2002 for suggestions and recommendations to improve the draft document. Most of the Ministries have made some recommendations, which are reflected, in the last document.</p> <p>The WHO CINDI Dietary Guide has been translated to Albanian and delivered to the members of the working group in charge of the development of FNAP.</p> <p>The first draft of the FNAP has been improved based on the suggestions of other ministries.</p> <p>A priority remains the development of dietary guidelines for Albanian population.</p>	

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
CROATIA	Yes, action was taken as a result of the FNAP	<p>The FNAP was the basis for development of a national food and nutrition policy and action plan. The Croatian Food and Nutrition Policy was accepted in 1999.</p> <p>In the meantime, other activities were initiated:</p> <ul style="list-style-type: none"> - Food Law - process of establishing a food agency - Consumer Protection Law - Health Promotion Law (in the process of acceptance) - Harmonisation of food safety regulations with the EU - Preparation of Dietary Guidelines for Adults and Children - Established different nutrition committees at the Ministry of Health - Strengthened collaboration with the food industry on production of healthier foods. 	<p>The Programme of IDD elimination started in 1996 and has been successfully conducted. Croatia is now considered as an iodine sufficient country, according to urinary iodine concentration data.</p> <p>Updating of the Action Plan will be discussed on the occasion of the First Croatian Congress of Preventive Medicine (Autumn 2003).</p>
SERBIA & MONTENEGRO	Yes, action was taken as a result of the FNAP	<p>Action taken as a result of the FNAP includes:</p> <ul style="list-style-type: none"> - UNICEF project on prevention of iodine deficiency - UNICEF projects on nutritional status of children up to 5 years old <p>Other actions taken include:</p> <ul style="list-style-type: none"> - Governmental project on strengthening of food safety with recent onset of work on Food Safety Strategy (an initiative of the European Commission through the European Agency for Reconstruction). 	<p>The onset of the project of Strengthening the Food and Nutrition Policy WHO & Stability Pact will have an important impact on policy makers in Serbia and Montenegro since they fully agree with its major proposals. It is essential to proceed with this project, because the European Agency for reconstruction activities have made good ground in Ministries of Health and Agriculture for further initiatives.</p> <p>Serbia and Montenegro is coming out of a transformation from federal status and this has delayed the work on policy, legislation and implementation. There has, however, been major</p>

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
			success in the field of food safety, because it is closely linked to the economy. Further work is required on nutritional part of the policy.
SLOVENIA	Yes, action was taken as a result of the FNAP	<p>Action taken includes:</p> <ul style="list-style-type: none"> - A health care and health insurance law which prescribes the working area of the national and regional institutes of public health and set goals for Health. - A framework law on health and hygiene safety of foods, and of materials and articles intended to come into contact with foods. This established a Food and Nutrition Office and provides for a Food and Nutrition Committee to operate as an expert advisory body. - A national programme of health protection and promotion which includes food security, safe foods, healthy nutrition and physical activity - A Food Safety Strategy was adopted jointly by the Ministry of Health and the Ministry of Agriculture and was presented to the European Commission in April 2001 - A Food and Nutrition Office of the Ministry of Health has been established and will start activities in February/March 2003 - Vertical Food Legislation, harmonised with EU legislation, was adopted (food hygiene, food inspection, foods for particularly nutritional uses, novel and GM foods) - Since April 2001 a Food and Nutrition Action 	<p>Different problems have emerged during the preparation of the national Food and Nutrition Action Plan. The main obstacle is that other sectors don't see FNAP with its goals as a priority and mostly they don't see the sense including these goals in their plans or they feel disturbed by Ministry of Health activities in this field.</p> <p>That is why the Government of the Republic of Slovenia has adopted a resolution which binds the Ministry of Agriculture, Forestry and Food, the Ministry of Labour, Family and Social Affairs, the Ministry of Education, Science and Sport and the Ministry of the Environment, Spatial Planning and Energy, the Ministry of the Economy, the Office for Consumer Protection and the Ministry of Finance actively to cooperate in the preparation of a national food policy programme. The Ministry of Health is coordinating the programme.</p> <p>The Government binds the Ministry of Health, in cooperation with other Ministries, to prepare by 30 May 2003 a proposal for a national food policy programme. Intensive preparations are underway.</p>

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		Plan for Slovenia has been in preparation and should be ready by May 2003. This follows the lines of the WHO First FNAP.	
MACEDONIA	Yes, action was taken as a result of the FNAP	The National Committee for Food and Nutrition within the Ministry of Health has developed the Macedonian First Action Plan for Food and Nutrition Policy and its final version is now under the Governmental procedure for its acceptance. Acceptance of the policy by the government is expected in coming months and will start with the implementation of the National Policy and Strategy.	The support of WHO Regional Office for Europe has been very important in the preparation of the national Action Plan for Food and Nutrition.
COUNTRIES IN CENTRAL AND EASTERN EUROPE			
BULGARIA	Yes, action was taken as a result of the FNAP	<p>A Food and Nutrition Action Plan for Bulgaria is under development and will be finalised in May 2003 to be adopted by the end of the year.</p> <p>Training of specialists working in the field of nutrition along the lines outlined in the WHO FNAP has taken place.</p> <p>A programme for postgraduate training in nutrition and diabetics for medical colleges has been developed.</p> <p>The FNAP acted as an impetus for the successful implementation of the national programme for IDD control and the CINDI programme.</p> <p>It has also helped stimulate activities relating to public education, including a website which is under development.</p>	<p>Activities related to food safety and food related regulations were initiated by Bulgaria's application for membership of the EU. A lot of work has been done towards harmonisation of Bulgaria's food related legislation.</p> <p>Another WHO Programme - Environmental Health - initiated some other activities. A national food safety strategy was developed and a National Council on Food Safety at the Ministry of Health was established. There have also been structural reforms of the Hygiene and Epidemiology Inspectorate.</p> <p>The national FNAP has to organise all efforts in the field of food safety control including Ministry of Health and Ministry of Agriculture bodies, There is some resistance to development of new programmes related to foods and nutrition. Money is needed to realise these new programmes, and until now only small sums have been available.</p>

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
CZECH REPUBLIC	Action has been taken, but not as a result of the FNAP	<p>A short term strategy relating to nutrition and food policy was adopted by the government in 2002.</p> <p>There have also been health promotion projects, monitoring activities and the harmonisation of food legislation with EU regulations.</p>	<p>There has been some success in elimination of IDD, increase in exclusive breastfeeding, nutrition education and dietary assessment instruments.</p> <p>Procedures to get official approval or recognition of dietary guidelines etc are difficult because responsibilities are not clear.</p>
HUNGARY	Yes, action was taken as a result of the FNAP	The elements of the Food and Nutrition Action Plan are included in the Healthy Nutrition & Food Safety sub-Programme of the Johan Bela National Programme of Decade of Health.	Currently, the Nutrition programme is a Parliamentary decision. It would be stronger if this was formulated in a law.
POLAND	Yes, action was taken as a result of the FNAP	<p>A representative epidemiological study in Poland to reveal the current state of nutrition was carried out.</p> <p>A Food Safety Strategy for Poland was prepared in February 2001.</p>	<p>In May 2001, the Parliament prepared an Act on Food and Nutrition. This was carried out in strong cooperation with the government, the Food and Nutrition Institute and other scientific institutions. In 2002, 30 regulations under this Act were prepared.</p> <p>The Minister of Health is the coordinator of the Food Safety Strategy.</p> <p>Some progress has been made in relation to elimination of IDD.</p>
ROMANIA	Action has been taken, but not as a result of the FNAP	<p>Between 1999 and 2001 there has been a FNAP within the framework of the national Environmental Health Action Plan.</p> <p>From 2002 a National Committee for Food and Nutrition has been created which has developed a draft for a new FNAP which will be approved in the coming months.</p>	<p>One major success is that a multidisciplinary team has been put together to act in the food and nutrition field. This includes: ministries, nongovernmental institutions, food industry and researchers.</p> <p>In the last two months two meetings were organised in relation to food security with the Ministry of Agriculture in the lead, with support from research institutes.</p>
SLOVAK REPUBLIC	Yes, action was taken as a	A state health policy was adapted by the	The strengthening of public education has not been

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
	result of the FNAP	government at the end of 2000. The programme for the improvement of nutrition includes monitoring programmes, creation of an intersectoral food safety managing board with working groups in 2002.	so satisfactory. There is a need for improvement of evaluation processes of state policy and programmes.
SOUTHERN EUROPE AND TURKEY			
ANDORRA	Nothing has been done on nutrition policy since 2000	A study on nutritional habits will be conducted during 2003 and following that the definition of priorities for nutrition policies will take place.	Some activities relating to food safety legislation have been undertaken, although these do not relate to any national plan for nutrition.
GREECE	Yes, action was taken as a result of the FNAP	<p>The Ministry of Health developed a Committee on Nutrition Policy which has four goals:</p> <ul style="list-style-type: none"> - Reduce meat consumption, increase fish consumption - Reduce obesity in childhood - Increase the consumption of vegetables and legumes - Improve food quality and safety in mass catering 	
ISRAEL	Yes, action was taken as a result of the FNAP	<p>A food and nutrition policy has been developed and there has also been a merging of food control services with the Department of Nutrition and the Veterinary Department.</p> <p>Although not as a direct result of the FNAP, there has been a national health and nutrition survey and a breastfeeding survey.</p>	<p>Political commitment would be strengthened by agreement on the different responsibilities of different ministries and by strengthening consumer organisations, NGOs and the media interested in nutrition and food safety.</p> <p>There is also a need to strengthen professionals and academics in this area. Increased collaboration with the suppliers side of the food chain would also be valuable. Increasing awareness and knowledge of consumers, along with promotion of culinary habits would also be helpful.</p>
ITALY	Yes, action was taken as a result of the FNAP	A national plan, with government commitment, includes nutrition as an important issue. Dietary	A systemic multi-purpose survey is carried out with regard to the health status of the population.

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		<p>guidelines have been generated by the Ministry of Health and the Ministry of Agriculture. A food safety campaign for domestic food handling has been carried out. Iodised salt promotion has been regulated by law.</p>	<p>Systematic information through the media and press is actually active in healthy nutrition and lifestyle.</p>
MALTA	<p>Action has been taken, but not as a result of the FNAP</p>	<p>The Health Promotion Department is undertaking a feasibility study into collaboration with other sectors in order to produce a nutrition policy. However, stronger political commitment is required. Harmonisation with EU food regulations has had a big impact.</p> <p>In 1988 a nutrition policy was developed. Activities carried out included a breastfeeding policy in 2000. Intersectoral collaboration was not continued.</p>	<p>In the last few years, the focus has been very much on EU accession and the adoption of regulations to harmonise EU laws and directives. It is difficult to know what could increase political commitment to act on nutrition given the forthcoming referendum and general elections.</p>
PORTUGAL	<p>Some action has been taken as a result of the FNAP. Other relevant action has taken place, but not because of the FNAP</p>	<p>A report of the Rome Consultation (March 2002) was presented to the Portuguese food and nutrition council (PFNC) in September 2002.</p> <p>The PFNC decided to prepare a food and nutrition action plan by the end of 2003 and then to submit it to the government. Ad hoc groups were created to update the diagnosis of the food and nutrition situation in Portugal and to make an inventory of the food and nutrition programs in course in the country. These data will be used to update the Portuguese dietary guidelines.</p> <p>Although not as a result of the FNAP, there has also been:</p>	<p>The Portuguese Food and Nutrition Council is now very active. The new Food authority seems to be interested in stimulating a good intersectoral collaboration. These two bodies may have a key role on policy development. Besides, at the national health plan for 2003, reference is made to the need to develop a nutrition policy in Portugal. Some elements of nutrition policy are already included in the health plan.</p> <p>One problem is that health promotion is not yet given due attention even within the health services. Primary prevention is often seen by the medical sciences as something that does not work and so much more emphasis is given to a high risk approach than to a population approach.</p>

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		<ul style="list-style-type: none"> - Reorganisation of the Portuguese Food Authority - A project including a national dietary survey and establishment of mechanisms for updating the portuguese food composition tables is likely to be funded soon - Several food education materials are being produced by the Ministries of Health, Education, Agriculture, Consumer Organisations, NGOs etc. 	<p>One suggestion is to increase intersectoral collaboration, including the private sector. Another proposal is to pay more attention to the media.</p>
SPAIN	Yes, action was taken as a result of the FNAP	<p>In line with the WHO FNAP Spain has developed multisectoral food and nutrition policies in order to protect and promote health, while contributing to a sustainable environment. The main actions have been:</p> <p>Food Safety - greater control of foodborne disease, increased surveillance, HACCP systems, Hygiene education and training of food handlers, increased toxic traceability, more research on food safety, improving on food labelling, greater cooperation between ministries and local authorities and creation of a Spanish agency for food safety law.</p> <p>Nutrition - Creation of the Spanish Agency for Food Safety (some nutrition aspects), setting up a committee on nutrition and physical activity within the Public Health Commission, more nutrition education in schools, postgraduate nutrition education for health professionals, increased research on nutrition and health, collection of data</p>	<p>The WHO First FNAP has had a moderate impact in Spain. Food safety has been the most important area because this has been perceived as a relevant problem by the population after suffering a number of incidents with clear impact in the media which has raised political awareness on this issue.</p> <p>The success of the FNAP in Spain is due to the fact that it integrates the health policy framework for the European Region (HEALTH21) and the sustainable development expressed in Agenda 21.</p>

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		<p>on food availability and food consumption and dietary guidelines for the Spanish population.</p> <p>Sustainable food supply - promotion of good agricultural practices, improvement of water management, promotion of traditional food production, education on production methods, better control of the use of pesticides, more research on sustainable food supply and waste management.</p>	
TURKEY	Yes, action was taken as a result of the FNAP	The National Plan of Action on Food and Nutrition, coordinated by the State Planning Organisation, has three topics including nutrition, food safety and food security.	<p>National Food and Nutrition Survey is needed by the updating of the Action Plan in the future.</p> <p>Establishment of a National Food and Nutrition Committee is required.</p>
CENTRAL ASIAN REPUBLICS			
KAZAKHSTAN	Yes, action was taken as a result of the FNAP	<p>National nutrition policy has been developed by the Kazakh Academy of Nutrition.</p> <p>The Kazakh Academy has initiated a number of laws, government resolutions and decrees on the prevention of nutrition related disorders. The government is currently considering legislation on IDD, food safety and food quality.</p> <p>An Asian Development Bank project has been implemented since October 2001 on the improvement of diets of women and children in low income families in Asian countries in transition (includes production & promotion of iodised salt, and iron-, mineral- and vitamin- fortified flour.</p> <p>The Academy has also initiated amendments to</p>	The bills listed need to be adopted or implemented. A special Government decree is needed to adopt the National Nutrition Policy. Awareness-raising campaign is needed to prevent major nutrition-related disorders and micronutrient deficiencies.

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		the National Programme 'Health of the People' related to industrial production of flour fortified with iron, vitamins, and minerals.	
KYRGYZSTAN	Yes, action was taken as a result of the FNAP	<p>A law on Food Safety and Quality has been drafted and a law on IDD prevention has been adopted. A national programme to reduce IDD has been approved for 2003-7. A national food security policy is being implemented.</p> <p>Minimal intake values have been revised for major nutrients for various populations.</p> <p>A series of workshops and meetings on nutrition problems have been conducted.</p>	Nutrition matters are dealt with by various ministries and institutions. There is no co-ordination between these institutions.
TAJIKSTAN	Action has been taken, but not as result of FNAP	There has been work to prevent iron-deficiency anaemia, goitre, vitamin A deficiency within the framework of Tajikistan's government and UNICEF project "Action against Famine".	<p>Political commitment would be enhanced by a visit from WHO Europe to see government officials.</p> <p>One problem is a lack of laboratory facilities. Another key issue is the lack of coordination between Ministries in the area of nutrition.</p>
TURKMENISTAN	Action has been taken but not as a result of FNAP	<p>A national programme for Health has been in place since 1995, providing for activities to prevent micronutrient deficiency disorders. A presidential decree was adopted in 1996 on universal salt iodization, which also provides for iron fortification of flour.</p> <p>An interdepartmental coordination committee has been established to control salt iodisation and iron fortification of flour.</p> <p>Laws on food security, rural development and cereals have been adopted and are being</p>	<p>Further efforts towards continued universal salt iodization and flour fortification are needed.</p> <p>A survey of vitamin A deficiency needs to be conducted. At present, 100% of households in Turkmenistan receive iodised salt.</p>

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		<p>implemented.</p> <p>A breastfeeding programme is being implemented with UNICEF's support. The law on food safety and quality has been drafted and will soon be passed.</p>	
UZBEKISTAN	Yes, action was taken as a result of the FNAP	<p>A national food safety programme was adopted in 1999.</p> <p>A food fortification programme is being implemented with the assistance of the Asian Development Bank and UNICEF.</p> <p>Legislation of sanitary and phytosanitary measures has been drafted in view of Uzbekistan's accession to WTO.</p> <p>A law on sports and physical exercise in the population has been adopted aiming to reduce cardiovascular disease and obesity. The Ministry of Health developed hygienic standards of physical load and nutrient intakes for athletes.</p> <p>Guidelines have been developed on nutrition of women of reproductive age and breastfeeding.</p>	
COMMONWEALTH OF INDEPENDENT STATES			
ARMENIA	Yes, action was taken as a result of the FNAP	<p>The concept of a national Food and Nutrition Policy has been developed.</p> <p>An intersectoral programme and action plan with short term (up to 2001) and long term (up to 2003) activities have been approved.</p>	With UNICEF support a series of activities has been conducted including prevention of IDD, prevention of iron-deficiency anaemia and promotion of breastfeeding.

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		<p>The legal framework has been improved with laws on food safety and consumer protection. Promotion of healthy eating and prevention of diet related disorders has improved.</p>	<p>Problems have included a lack of a common food safety monitoring system and duplication of food control functions by the Ministry of Health, the Ministry of Agriculture and the Standards Committee. Another problem has been a lack of activities to increase physical activity. It is suggested that countries should include physical activity in FNAPs and that WHO documents and resolutions of meetings and conferences should be sent to Governments.</p>
AZERBAIJAN	Action has been taken, but not as a result of FNAP	<p>In 2001, a food law was adopted. In 2002 a law on the prevention of IDD was adopted. In 2003, parliament is considering a bill on breastfeeding. Salt iodisation and flour fortification programmes are being implemented jointly with UNICEF and the Asian Development Bank.</p>	<p>A joint programme (with the World Bank) for 2003-5 has been adopted to reduce poverty and promote economic development problems. There is a need to develop and adapt a FNAP.</p>
GEORGIA	Yes, action was taken as a result of the FNAP	<p>A national concept, strategy and action plan have been developed. Some of the sections of the first FNAP have been incorporated into other national programmes (iodine, iron deficiency anaemia, vitamin C and A deficiencies).</p> <p>Although not as a result of the FNAP, there has also been a reorientation of the health care system towards the prevention of NCDs.</p>	<p>It is important to strengthen international legislation with a view to improving national legislation and programmes.</p>
REPUBLIC OF MOLDOVA	Yes, action was taken as a result of the FNAP	<p>A draft law on food has been developed along with a Mother and Child Nutrition Programme.</p> <p>Standards of food safety have been harmonised with international recommendation.</p> <p>Although not as a result of the FNAP, a national report on the status of nutrition in Moldova has</p>	<p>One problem is that difficulties in addressing nutrition issues depend on economic factors.</p>

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		been published.	
RUSSIAN FEDERATION	MISSING		
UKRAINE	Yes, action was taken as a result of the FNAP	<p>The National Environmental Action Plan (2000) contains a chapter on the quality and safety of food.</p> <p>The concept of a national nutrition policy has reached a draft cabinet resolution.</p> <p>An amendment to the law on the quality and safety of food was passed on 2002.</p> <p>Programmes on breastfeeding and reproductive health have been implemented.</p>	<p>Political commitment could be strengthened by developing guidelines on the development of national action plans. Regional consultations and meetings are also helpful. The division of monitoring and control functions is also important.</p> <p>Support is needed for national institutions responsible for state surveillance and control over food safety, giving priority to health-care institutions.</p>
WESTERN EUROPE			
AUSTRIA	Yes, action was taken as a result of the FNAP	The Government has implemented the Austrian strategy for the sustainable development which also focuses on food security, agriculture and sustainability, food variety, food quality and organically grown food and prevention of diseases through prevention.	
IRELAND	Some action has been taken as a result of the FNAP, other action has been taken but not directly related.	<p>One pillar of the FNAP - the Lifecycle strategy - has been addressed:</p> <ul style="list-style-type: none"> - National breastfeeding coordinator has been appointed and a national conference held - Childhood nutrition guidelines for pre-schools and schools are being developed - Adult focus on healthy eating and physical activity is being considered and the EU has had an impact here. <p>The National Health Service Shaping a Healthier Future and Quality and Fairness documents have</p>	<p>Nutrition is addressed independently of food safety and food security.</p> <p>Some intersectoral difficulties between agencies with food safety and nutrition remits have been experienced. Clear direction is needed.</p>

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		been produced in 2001. There have been an annual national healthy eating campaigns in 2002 and 2003. A Cardiovascular Disease Strategy 1999 - 2004 is being implemented alongside the National Heart Health Promotion Strategy from 2000 - 2005. The National Framework for Nutrition Strategy is being developed in 2003.	
NETHERLANDS	Some action has been taken as a result of the FNAP, other action has been taken but not directly related.	<p>In general, the FNAP supports the existing policy and future actions. New developments include:</p> <ul style="list-style-type: none"> - An emphasis on overweight, nutrition and physical activity - reducing fat intake, increasing fruit and vegetable consumption and increasing breastfeeding remain important - An experiment in seven cities with free fruit for school children (there is no tradition in the country of providing food at school) - An independent food and non-food authority covering all stages of the production chain. - Awareness of low breastfeeding rates and stimulation of baby friendly hospitals - Inclusion of both a food section and a nutrition section in the Ministry of Health - New consumer information/education on foodborne diseases and the complete production chain 	<p>Challenges include:</p> <ul style="list-style-type: none"> - How to collaborate with producers in reducing overweight (collaboration in reducing fat levels in food works well) - Continuation of monitoring of food consumption. This is expensive and requires more discussion about the methodology.
SWITZERLAND	Yes, action was taken as a result of the FNAP	An action plan on nutrition and health has been developed by a working group of the Swiss Nutrition Council and intensively discussed with interested groups. The final paper is used in the Federal Office of Public Health as a basis for actions. The most important activities are Suisse Balance, a campaign to promote a healthy body	<p>Two further action plans (closely linked to Nutrition Policy) have been developed and already started:</p> <ul style="list-style-type: none"> - Environment and health (with a nutrition part) - Physical activity and health <p>One problem is that it is very time consuming to bring</p>

COUNTRY	Has the WHO First Action Plan for Food and Nutrition Policy had an impact?	Actions which have taken place at the national level	Comments
		weight and 5 a Day to promote consumption of fruits and vegetables and a project for the 5 th Swiss Nutrition Report (to be published in 2005)	the interested parties together and to raise the necessary financial support.
UNITED KINGDOM	Action was taken, but not as a result of FNAP	<p>At the time of the WHO FNAP a programme of work on diet and nutrition in England had just been announced as part of the 10 year NHS Plan for England, including a five a day programme, welfare food reform, work on salt, fat and sugar.</p> <p>More recently, the intention to develop a wider cross-Governmental Food and Health Action Plan for England was announced in December 2002.</p> <p>There have also been nutrition plans published in Scotland - FSA Diet and Nutrition Strategy (April 2002) and in Wales - the Food and Well Being Nutrition Strategy (February 2003).</p>	Political commitment to improving diet and nutrition, which is already high, will be further focused on the forthcoming Food and Health Action Plan.

Annex 6

Presentations

The following slide presentations (*microsoft powerpoint*) are available on request:

- Progress on implementing the First Food and Nutrition Action Plan in the WHO European Region, 2000-2005, Dr Aileen Robertson
- UNICEF nutrition priorities in Europe, Dr Arnold Timmer
- Status of food and nutrition action plans in the WHO European Region, 2003, Dr Aileen Robertson
- WHO Global strategy on diet, physical activity and health, Dr Pekka Puska
- Impact of Slovenia joining the EU, Dr Ales Kuhar
- Health impact assessment of the Slovenian agriculture policy, Dr Jozica Zakotnik
- Reduction of iron deficiency anaemia in the Russian Federation – dietary approaches, Dr Natalia Vartapetova
- Suggestions for the second food and nutrition action plan 2006-2010, Dr Chizuru Nishida

Annex 7

Reference Group for the Global strategy on diet, physical activity and health

Terms of reference

To advise WHO on the elaboration of the WHO Global strategy on diet, physical activity and health.

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Annex 8

Abbreviations

CAP:	Common Agricultural Policy
CAR:	Central Asian republics
CCEE:	Countries in central and eastern Europe
CIS:	Commonwealth of Independent States
EC:	European Community
EU:	European Union
FAO	
DGSANCO:	
DAPHNE:	Data Food Networking project
FNAP:	Food and Nutrition Action Plan
GATT:	General Agreement on Tariffs and Trade
ICCIDD:	International Council for Control of Iodine Deficiency Disorders
IDD:	Iodine deficiency disorders
IIH:	Iodine induced hyperthyroidism
IR£:	Irish pound
JECFA:	Joint FAO/WHO Expert Committee on Food Additives
JMPR:	Joint FAO/WHO Expert Meetings on Pesticide Residues
NIS:	Newly independent states
UNDP:	United Nations Development Programme
UNICEF:	United Nations Children's Fund
USI:	Universal salt iodization
WHO	
WHO EURO	