WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020

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Vienna, Austria

Final report
ABSTRACT

The WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 was held at the Hofburg Palace in Vienna, Austria on 4 and 5 July 2013. The Conference located work on diet and physical activity within the new European health policy framework, Health 2020. Successful and sustained improvement of nutrition required a new generation of integrated policies with emphasis on better governance, intersectoral action and a life-course approach, and the reduction of inequalities in nutrition, obesity and NCDs. The Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 was adopted as a major output of the Conference.

Keywords

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Executive summary

The WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 was held at the Hofburg Palace in Vienna, Austria on 4 and 5 July 2013. Opening addresses were delivered by Ms Zsuzsanna Jakab, WHO Regional Director for Europe, Mr Alois Stöger, Federal Minister of Health, Austria, Dr Margaret Chan, WHO Director-General, and Dr Heinz Fischer, Federal President, Austria.

Ms Zsuzsanna Jakab set the scene for the Conference by locating work on diet and physical activity within the new European health policy framework, Health 2020. Successful and sustained improvement of nutrition required a new generation of integrated policies with emphasis on better governance, intersectoral action and a life-course approach, and the reduction of inequalities in nutrition, obesity and NCDs. Dr Pamela Rendi-Wagner, Director-General for Health, Austria, described her country’s recent experiences in that regard, and Dr João Breda, Programme Manager, Nutrition, Physical Activity and Obesity, WHO Regional Office for Europe gave details of the current situation at European level.

Four ministerial panel sessions were held. The first, on a whole-of-government approach to promoting well-being in the WHO European Region, was introduced by Dr Philip James, International Obesity Task Force, with panel members drawn from Slovenia, Finland, France, Ukraine, Uzbekistan and the Republic of Moldova. The keynote speaker for the second panel session, on specific policies to tackle diet-related noncommunicable diseases, was Professor Carlos Monteiro, University of São Paolo, Brazil; the panellists came from Serbia, Spain, Greece, Hungary, United Kingdom of Great Britain and Northern Ireland, Switzerland and Portugal.

The third ministerial panel session, on childhood obesity and inequities, had Mr John Ryan, Directorate-General for Health and Consumers, European Commission as the keynote speaker, and panel members from Latvia, the Russian Federation, Albania, Azerbaijan and Malta. The fourth panel session, on the future of monitoring and surveillance of diet- and physical activity-related noncommunicable diseases, was introduced by Professor Adrian Bauman, University of Sydney, Australia and involved a panel consisting of representatives of Armenia, Bulgaria, Tajikistan, Turkmenistan, Estonia, the Czech Republic, Turkey and Germany.

Conference participants reviewed in detail a draft of the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 that had been prepared following three written consultations and two technical group meetings. Agreement was reached by consensus on the finalized version of the draft Declaration, as well as on a number of additional technical points that should be included in the WHO European Regional Food and Nutrition Action Plan 2014–2020 that would be drawn up after the Conference.

At the conclusion of the Conference, the Vienna Declaration was signed by the WHO Regional Director for Europe and, on behalf of participants, by the Federal Minister of Health of Austria.
Introduction

1. The WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 was held at the Hofburg Palace in Vienna, Austria on 4 and 5 July 2013, attended by ministers of health and high-level representatives of Member States, specialized agencies of the United Nations system, and intergovernmental and nongovernmental organizations (for list of participants, see Annex 1). The Conference was opened by the Chairman, Dr Gauden Galea, Director, Division of Noncommunicable Diseases and Life-course, WHO Regional Office for Europe.

2. In her opening address Ms Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe, thanked the Government of Austria for hosting the Conference. She noted that unhealthy diets and physical inactivity had a negative impact on people’s quality of life and well-being, and they imposed a heavy and growing burden on countries’ health systems and economies. The rise in childhood obesity was of particular concern. It was therefore important to revisit and revitalise the European Charter on Counteracting Obesity that had been adopted at the WHO European Ministerial Conference held in Istanbul, Turkey on 15–17 November 2006.

3. Mr Alois Stöger, Federal Minister of Health, Austria, welcomed participants and drew attention to the overriding objective of his ministry, which was to narrow health inequities by giving people the means to improve their health and ensuring the social circumstances in which they could do so. His country’s national action plan on nutrition that had been adopted in 2011 aimed to reduce malnutrition and undernutrition and to reverse the upward trend in overweight and obesity by 2020. The underlying principle of the national action plan on physical activity was to “make the healthy choice easier”. It was clear that only healthy societies would be competitive in the future.

4. In a video message Dr Margaret Chan, WHO Director-General, acknowledged that the causes of obesity were complex, but population-wide obesity was a signal that something was wrong in the environment in which people made their food choices. While the science of nutrition was challenging and imprecise, and regulatory approaches could be problematic, the health sector needed to work with all stakeholders, including industry, to find public health solutions. The ideal solution was to make healthy foods the norm, and not a market niche.

5. Dr Heinz Fischer, Federal President, Austria, observed that noncommunicable diseases (NCDs) such as cardiovascular disease, cancer, chronic respiratory diseases and diabetes, were responsible for 63% of all deaths worldwide and for 35 000 deaths in Austria each year. One major cause of the increase in NCD prevalence lay in people’s dietary habits, notably the consumption of food products with a high energy content and too much fat, salt and sugar. Only by cooperating and interacting with other sectors and by developing cross-cutting public policies (in other words, by living the “health in all policies” approach) would the health sector be able to bring about a long-term and sustainable improvement in people’s health. The Federal Health Commission of Austria and the Austrian Government, in cooperation with a wide range of societal and governmental stakeholders, had accordingly developed 10 health targets in line with
Health 2020, the new European health policy framework, that gave priority to determinants with a profound influence on health, such as education, employment, social security and the environment.

Diet and physical activity in the context of Health 2020

6. Ms Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe, said that the WHO European Region had a tradition of developing nutrition- and diet-related policies that went back almost 20 years. Considerable progress had been made with implementing the WHO European Action Plan for Food and Nutrition Policy 2007–2012: of the 53 Member States in the European Region, 49 had developed or updated their national policies in the previous six years, and a majority had taken policy action to restrict the marketing of high fat, sugar and salt (HFSS) foods to children and initiatives to reduce the consumption of salt. Nonetheless, overweight (including obesity) was affecting more than 50% of the population in most Member States, while over 20% of the population in 40 countries of the Region were obese.

7. Health 2020, the European policy framework adopted by the WHO Regional Committee for Europe at its sixty-second session in 2012 (resolution EUR/RC62/R4), supported action across government for better health and well-being. Successful and sustained improvement of nutrition required a new generation of integrated policies with emphasis on better governance, intersectoral action and a life-course approach, and the reduction of inequalities in nutrition, obesity and NCDs.

8. High-level political commitment to those three dimensions was enshrined in the draft Declaration that would be discussed during the Conference. It had been drawn up following extensive technical web-based consultations and meetings held in Tel Aviv, Israel and Ankara, Turkey by a drafting group consisting of representatives of 16 Member States, chaired by a member of the office of the Federal Minister of Health of Austria. A “senator group” had given advice on the scientific dimension and ensured that the Declaration was evidence-based.

The Austrian story: experiences in nutrition and physical activity

9. Dr Pamela Rendi-Wagner, Director-General for Health, Austria, said that the 10 health targets her country had set were based on the definition of health as contained in the WHO Constitution and the guiding principles of health determinants, health equity and health in all policies. The targets, adopted by the Council of Ministers on 14 August 2012, had been developed in cooperation with more than 30 different institutions and following extensive citizen participation. Two targets were of direct relevance to nutrition and physical activity: target 7 – to provide access to a healthy diet with food of good quality for all, and target 8 – to provide healthy, safe exercise and activity in everyday life through appropriate environments.

10. A national nutrition action plan had also been adopted by the Council of Ministers in January 2011 and updated in 2012. In addition, a national plan on physical activity, drawn up jointly by the ministries of sport and of health and launched in April 2013, set out recommendations for children and young people, and for adults.
11. Campaigns were currently under way to reduce salt consumption by 15% by 2015 and to limit the proportion of *trans* fatty acids to less than 2% in fats and oils and to less than 4% in processed food. Up-to-date information and standardized guidelines for a balanced diet had been provided for the target groups of pregnant and breastfeeding women and children up to three years of age, as part of a campaign under the slogan “Richtig essen von Anfang an!” (“Healthy eating from the start”). An initiative to make school food healthier already involved 20% of school cafeterias, covering 40% of schoolchildren.

**Towards a new milestone in European nutrition and physical activity policies**

12. Dr João Breda, Programme Manager, Nutrition, Physical Activity and Obesity, WHO Regional Office for Europe noted that, according to the Global Burden of Disease study 2010, 15 of the 20 risk factors to which the highest proportion of disability-adjusted life years (DALYs) could be attributed were related to nutrition and physical activity¹. Twenty countries in the WHO European Region were monitoring the prevalence of overweight (body mass index or BMI ≥ 25.0 kg/m²) among adults and found increasing trends in both men and women. The WHO European Childhood Obesity Surveillance Initiative (COSI) had been set up following the Istanbul Conference: in 2008, one in every four children aged 6–9 years had been overweight or obese; by 2010, that proportion had increased to one in three children.

13. Country-based surveys showed that all but one European country exceeded the maximum level of salt intake per person of 5 g/day recommended by WHO and the Food and Agriculture Organization of the United Nations (FAO), and most countries exceeded the FAO recommendation of a maximum of 10% of energy to be derived from saturated fatty acids. However, no data were available from a large number of countries. While the picture was more mixed with regard to fruit and vegetable supply, the European Region had the lowest prevalence of exclusive breastfeeding under or at six months of age of any WHO region. WHO estimated that 63% of adults in the European Region did not reach the minimum recommended level of physical activity (20% of whom were rated as “inactive”), and 41% did not engage in any moderate physical activity in a typical week.

14. The WHO Regional Office for Europe had monitored European countries’ implementation of policy actions on nutrition, obesity and physical activity since 2007. Of 143 nutrition policies, 39 obesity policies and 184 physical activity policies, only 16 clearly focused on low-income groups and eight were addressed at health professionals. Four countries in the European Union (EU) had introduced bans on *trans* fatty acids, and several others had effective self-regulatory approaches. Some countries had engaged in social innovation by using taxes for public health purposes, some had restricted the marketing of food to children, and others had engaged in mainstream food reformulation. Countries should themselves undertake more extensive monitoring and

surveillance, and more evaluation of the impact of their policies: it was evident that greater success was achieved where more accountability was demanded.

**Whole-of-government approach to promoting well-being in the WHO European Region**

15. The first ministerial panel session was chaired by Ms Nina Tangnaes Grønvold, State Secretary, Ministry of Health and Care Services, Norway. Introducing the session, she noted that a public health act had been adopted in her country in 2012, and a white paper had been discussed and given broad support in Parliament in June 2013. The main policy objectives were to make Norway one of the three countries in the world with the highest life expectancy; to enable people to enjoy more life years with good health and well-being; to focus on equity, and to create a societal environment conducive to health. The Ministry of Health was working with municipalities and the ministries of transport and the environment on promoting cycling and walking, with the Ministry of Education on encouraging physical activity in schools, and with the food industry on regulation of trans fatty acids and self-regulation of the marketing of unhealthy foods. At the international level, Norway had hosted a regional high-level consultation on NCDs (Oslo, 25–26 November 2010), had chaired the formal meeting of Member States on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of NCDs (Geneva, 5–7 November 2012), and chaired a European action network on reducing marketing pressure on children.

16. The keynote speaker, Dr Philip James, International Obesity Task Force (IOTF), placed emphasis on the fact that, according to a recent World Bank study, central Europe and central Asia were the area with the slowest improvement in life expectancy since 1960. The top risk factors underlying the disease burden of high-income countries were all preventable, so changes in societal practices needed to be brought about, such as eliminating smoking, markedly limiting alcohol intake and transforming dietary and inactivity patterns. Obesity was a normal biological response to a changed physical and food environment and reflected “the failure of the free market”. The Organisation for Economic Co-operation and Development (OECD) had shown that approaches using the media alone had an insignificant effect on obesity prevalence rates: legislative and regulatory measures were much more effective and less costly.

17. The key to successful prevention of NCDs and obesity was action on the marketing, price and availability of food products. Evidence from a number of European countries (notably Denmark, Finland, France, Netherlands and Sweden) showed that there were profitable opportunities to be taken by governments in areas such as banning the production of trans fatty acids and introducing taxes on HFSS foods, soft drinks and saturated fats. Other worthwhile measures included enforcing a policy of exclusive use of healthy foods in all government-supported institutions, defining progressively lower

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salt content in foods, banning all marketing of food and drink to children and adolescents, and controlling the density of fast food outlets.

18. As identified at the third Pan American Conference on Obesity with special attention to childhood obesity (PACO III) (Aruba, 6–8 June 2013), a minister of health’s primary role was to act as a leader and advocate of change in other government departments, such as education, transport, finance, business, agriculture and food. High priorities in nutrition included substantially reducing the intakes of total fat, trans fat, saturated fat, sugar and salt; in addition, anaemia and poor pre-pregnancy and maternal nutrition should be prevented by iodizing salt and ensuring folate and iron supplements.

19. The following panel discussion was moderated by Ms Sarah Boseley, a journalist at the Guardian newspaper. Panellists were asked to describe how their countries had adopted a whole-of-government approach to tackling obesity.

20. Dr Tomaz Gantar, Minister of Health, Slovenia, said that, having adopted its first strategy on safe food and nutrition in 2005 and a national health-enhancing physical activity programme in 2007, his country had put in place certain systems measures in which several ministries were cooperating successfully. A national system offered subsidized school meals in line with healthy nutrition guidelines, and food and beverage vending machines had been banned in schools and educational establishments. In cooperation between the agriculture, education and health sectors, a scheme would be implemented in the coming year by more than 90% of schools to provide children with free fresh fruit and vegetables, while kindergartens and schools were promoting the use of locally grown food. A new strategy was being prepared that would include fiscal measures, and special attention would be paid to economically weaker population groups and the elderly, in cooperation with the social affairs sector.

21. Ms Sirpa Sarlio-Lähtenkorva, Ministerial Adviser, Ministry of Social Affairs and Health, Finland, emphasized that health was largely created outside the health sector. Multisectoral community interventions had a long history in her country: the North Karelia Project had been initiated in 1972, to reduce morbidity and mortality from cardiovascular diseases. Diet-related activities had included promoting the production of and access to healthy foods, media campaigns and collaboration with the agriculture sector, trade and business enterprises, and nongovernmental organizations. As a result, cardiovascular mortality had decreased, especially among men of working age, to one tenth of its previous level. A continuation of Finland’s long-term horizontal health policy, “Health in all policies” had been the main theme during the country’s presidency of the Council of the European Union in 2006. Health and well-being were shared values across the various sectors of society. Finland had hosted the Eighth Global Conference on Health Promotion (Helsinki, 10–14 June 2013), at which participants had affirmed the compelling need for effective policy coherence for health and well-being.

22. Mr Cyril Cosme, Head, European and International Affairs, Ministry of Work, Employment, Professional Training and Social Dialogue and Ministry of Social Affairs and Health, France, underlined the importance of the link between public health objectives and economic growth. France’s third national programme on nutrition and health and a national obesity plan had been launched in 2010, guided by an intersectoral steering committee that included representatives of ministries of health, agriculture, consumer affairs, education and research, as well as of professional bodies and civil
society organizations. “Nutrition” was seen as encompassing all factors affecting people’s dietary behaviour and lifestyles, including physical activity, and therefore called for a wide range of interventions, actors and tools. Instruments being used included regulation, taxation and voluntary approaches, all of which needed to be evidence-based and cover the whole population. Creating a healthy environment was both an individual and a collective responsibility.

23. Dr Raisa Bogatyrova, Minister of Health, Ukraine, said that the Ukrainian NCD Action Plan, which provided for implementation of best practices for tackling NCDs as identified by WHO, would be launched in the near future. It envisaged broad intersectoral cooperation engaging a number of ministries, as well as research institutions and civil society organizations. High on the agenda were building a legal framework to regulate the practice of marketing and promoting processed foods, and addressing “hidden sugars”, salt and excess saturated fats in food, as well as taxation and marketing of alcohol and tobacco. Other priorities included ensuring increased consumption of fruit and vegetables and, generally, healthy nutrition at all stages of the life course. Successful implementation would depend on a good scientific basis and a comprehensive intersectoral approach.

24. Dr Asamidin Kamilov, Deputy Minister of Health, Uzbekistan, said that the Ministry of Health had initiated an intersectoral process, involving 20 ministries and government bodies as well as research institutions and the food industry, to draw up a national strategy and action plan on the prevention and control of chronic NCDs covering the period 2014–2020. Policy measures envisaged in the document would entail a whole-of-government approach, including the use of economic tools (taxes and subsidies), the review of food standards, the adoption of good marketing practices and the need for alignment with the NCD global monitoring framework endorsed by the World Health Assembly in May 2013. Priority actions would be aimed at reducing the content of trans fats, salt and sugar in processed foods, preventing childhood obesity and creating a system for monitoring risk factors using the WHO STEPwise approach to Surveillance (STEPS). A national public health committee, under the Council of Ministers, would coordinate and monitor implementation of the strategy and action plan.

25. Mr Octavian Grama, Deputy Minister of Health, Republic of Moldova, also acknowledged the impact of NCDs and their risk factors on socioeconomic development. His country’s parliament had adopted a national strategy on NCD prevention and control in April 2012. A ban on the production, distribution and sale of unhealthy food products (including sweetened drinks) in schools and kindergartens had been introduced in September 2012. National programmes on iodine deficiency disorders and on iron and folate deficiencies were also being carried out. The intersectoral committee chaired by the Deputy Prime Minister was a good example of the whole-of-government approach to NCD prevention and control. A draft of a national programme on nutrition and food products, drawn up by the Ministry of Health, was currently the subject of public consultation. The first round of data collection under WHO’s COSI had taken place in May 2013, and the first survey of NCD risk factors using the STEPS methodology was scheduled for the autumn of 2013. Intersectoral cooperation was being further promoted through a national health forum that had been established in 2012.

26. In response to questions from the Moderator, panellists agreed that both voluntary approaches and regulatory measures should be adopted for tackling NCDs, although the
latter had proved to be more effective and created a “level playing field”. It was important for governments to engage in dialogue with food manufacturers, and to ensure that incentives were in place for both producers and consumers. Support from the general public had to be secured if legislative initiatives were to be successful. Resistance from other government departments could be overcome through the establishment of interministerial steering committees.

**Specific policies to tackle diet-related noncommunicable diseases**

27. The second ministerial panel session was chaired by Dr Fernando Leal da Costa, Secretary of State and Assistant to the Minister of Health, Portugal.

28. The keynote speaker, Professor Carlos Monteiro, University of São Paulo, Brazil, examined dietary trends in the WHO European Region, with a focus on the extent and purpose of food processing. As previously noted, overweight/obesity was the third (in western and central Europe) or fourth (in eastern Europe) most important risk factor in terms of DALYs, and between six and nine of the 20 top risk factors were also diet-related. Data from FAO showed that per capita total food supply in western Europe had increased from just over 3000 kcal/day in 1961 to approximately 3550 kcal/day in 2009.

29. Euromonitor International, an independent company, provided information on retail sales of (a) minimally processed foods (vegetables, fruits, nuts, pulses, roots, and meat, fish and eggs); (b) processed culinary ingredients (oils and fats, and table sugar); and (c) ultra-processed ready-to-consume food products (savoury and sweet snacks, frozen and chilled ready meals, and soft drinks). Euromonitor International’s data showed declining retail sales of minimally processed foods and processed culinary ingredients in western Europe between 1999 and 2012, whereas sales of ultra-processed food products had increased by between 15% (savoury and sweet snacks) and 30% (soft drinks) in the same period, accounting for an additional 50 000 kcal (or 3–4 kg) per person per year.

30. Ultra-processed foods were displacing minimally processed foods and processed culinary ingredients because they were accessible (relatively cheap), highly convenient and very attractive in terms of their sensorial properties. They were also extremely profitable. However, as assemblages of industrial ingredients obtained from the extraction, refinement and transformation of constituents of raw foods, with usually little or no whole food, they tended to have less protein, less dietary fibre, more free sugar, more total, saturated and trans fats, more sodium and less potassium than dishes made up from foods and culinary ingredients.

31. Several intrinsic features of ultra-processed products were liable to disrupt energy balance regulation and to induce overeating and therefore obesity. They had high energy density (between 50% and 100% more energy-dense than foods and culinary ingredients), they contained liquid calories, they were hyper-palatable, they induced mindless eating and (for some products) habituation or addiction, and they were all

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4 See footnote 1 on page 3.
aggressively marketed. In both middle- and high-income countries, there was a close correlation between the percentage of total energy supplied by ultra-processed products and the prevalence of obesity in adults.

32. The Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016\(^5\) included two categories of specific policies to tackle diet-related NCDs: those designed to reduce the consumption of processed foods, and those aimed at the reformulation of processed foods. In the light of the evidence presented, governments should consider taxation and labelling and marketing controls on ultra-processed products, government-driven product reformulation, and policies to promote, support and protect traditional food systems and healthy dietary patterns.

33. The following panel discussion was moderated by Mr Michael Moss, a journalist at the New York Times newspaper. Panellists were asked to give examples of specific policies to tackle diet-related NCDs in their countries.

34. Mr Vladimir Đukić, State Secretary, Ministry of Health, Serbia, reported that NCDs were the leading cause of morbidity and mortality in his country. A multi-indicator cluster survey supported by the United Nations Children’s Fund (UNICEF) had found that 2% of children aged 0–5 years were underweight and 5% experienced stunting, whereas up to 17% of children and adolescents were obese. While the Government had adopted numerous policy documents, including a national youth strategy, an action plan for children, a strategy on NCDs and a children’s environment and health action plan, it did not yet have a national action plan on nutrition or obesity, and it looked forward to the Vienna Declaration offering a framework and support for current and future activities.

35. Dr Mercedes Vinuesa-Sebastian, Director-General, Ministry of Health, Social Services and Equity, Spain, said that her Government had launched a strategy for nutrition, physical activity and prevention of obesity (NAOS) in 2005 and had adopted a food safety and nutrition law in 2011. In 2009, per capita salt consumption had been found to be 9.8 g/day, much higher than the WHO-recommended maximum of 5 g/day, with processed food accounting for 72% of salt consumed. The Ministry of Health, Social Services and Equality had therefore reached agreement with the Spanish Confederation of Bread Manufacturers to reduce the salt content of bread flour by 20% within four years, a goal that was largely achieved. Similarly, an agreement had been signed in 2012 with associations of meat manufacturers and small retail businesses to reduce the amount of salt in food products by 10% and the amount of saturated fat by 5%. Public awareness campaigns were also being carried out as part of the NAOS strategy. The scope of a code of self-regulation for food advertising aimed at children (PAOS) had recently been extended to cover the internet and young people up to 15 years of age. Compliance was ensured by means of a monitoring committee, a specific monitoring methodology and a system of mandatory consultation before transmission of television advertisements.

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36. Mrs Zoi Makri, Deputy Minister of Health, Greece, said that the Ministry of Health was trying to reverse unfavourable trends in obesity and dietary behaviour, placing emphasis on disadvantaged groups. Physical activity was being encouraged at school and through the provision of facilities for the general public. The WHO Collaborating Centre for Food and Nutrition Policies at the University of Athens Medical School was helping to shape national policy on nutrition: official dietary guidelines for adults were being developed, and efforts were being made to promote the restoration of a “Mediterranean diet” as the dietary pattern of choice for the whole population.

37. Dr Miklós Szócska, State Minister for Health, Ministry of Human Resources, Hungary, reported that his country had made significant progress in tackling diet-related NCDs. A public health product tax had been introduced in 2011, with taxation of unhealthy products such as those containing added sugar or salt, as well as of “alcopops”, and bans on the sale of such products in schools. The tax had a dual impact, with consumption reduced on financial grounds and because products were identified as unhealthy. Regulations on public catering had also been introduced, and the use of trans fats had been banned. Having taken all possible regulatory measures, the Government was currently concentrating on behaviour change, offering cessation support for tobacco smokers and launching campaigns to change people’s dietary habits.

38. Mr Richard Cienciala, Deputy Director, Obesity, Nutrition and Food Policy, Department of Health, United Kingdom of Great Britain and Northern Ireland, said that, under the guidance of the Food Standards Agency, a target had been set to reduce population salt intake by 40%. Since 2001, voluntary reformulation targets had been in place for 80 categories of food; as a result, salt consumption had fallen from 9.5 g/day to 8.1 g/day. With regard to calorie reduction, 34 companies (including the largest food retailer) had committed themselves to product reformulation, reduction of portion size and provision of healthier alternatives. A new “front of pack” nutrition labelling scheme had been launched throughout the country on 19 June 2013, with provision of more consistent details based on percentage reference intakes and a “traffic light” system of colour coding, to meet consumers’ demand for honest and reliable information. Companies representing two thirds of the food products on the market had joined that scheme. Those initiatives demonstrated the benefits of working with business, undertaking behavioural and social marketing campaigns, and engaging in measurement, surveillance and monitoring.

39. Mr Pascal Strupler, State Secretary, Federal Office of Public Health, Switzerland said that the Foodstuffs Act in his country had been revised to ensure clearer labelling of food products and better nutritional information. A four-year national nutrition strategy had been approved in January 2013. A combined approach of legal regulation and voluntary agreements was being implemented: cooperation with the food industry had led to the agreement of targets for reduction of the salt content in soups, cheese, bread, etc. and the reformulation of food products (with less salt, sugar and fat). Quality criteria had been agreed with community organizers of cafeterias, and campaigns had been run (targeted at doctors, in particular) to increase awareness of the importance of nutrition. At international level, the European Salt Action Network was led by Switzerland.
40. Dr Fernando Leal da Costa, Secretary of State and Assistant to the Minister of Health, Portugal, reported that his Government was taking steps to change the composition and supply of certain foods: a national strategy for reducing salt intake had been published, a law had been enacted concerning the salt content of bread, and guidelines had been issued to schools about reducing the availability of HFSS foods (with legislation in that area under consideration). Iodized salt had been used in school meals since September 2012 and iodine supplementation was available to women of childbearing age. Media campaigns had been carried out to increase food and nutrition literacy, especially among children. Multisectoral action was being taken with ministries of agriculture, the environment, social security and tourism, as well as with local government bodies. Portugal had been instrumental in having the Mediterranean diet recognized by the United Nations Educational, Scientific and Cultural Organization (UNESCO) as an “intangible cultural heritage”.

41. Concluding the session, Ms Nina Tangnæs Grønvold, State Secretary, Ministry of Health and Care Services, Norway, reported on a stronger self-regulatory framework that had recently been agreed by the Government and the food industry in her country concerning the marketing of unhealthy foods to children. The framework, including a mechanism for “naming and shaming” companies that did not comply with good practice, would be evaluated after two years; if it was not found to be operating satisfactorily, the Government would introduce the necessary legislation. That approach, an example of the “Nordic model” of dialogue and cooperation, could be extended to other areas, such as product innovation and food labelling.

Childhood obesity and inequalities in the WHO European Region

42. The third ministerial panel session was chaired by Dr Raymond Busuttil, Superintendent of Public Health, Malta.

43. The keynote speaker, Mr John Ryan, Directorate-General for Health and Consumers (SANCO), European Commission, recalled that the Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues called for action in six strategic areas:

- Better informed consumers
- Making the healthy option available
- Encouraging physical activity
- Focusing on vulnerable groups such as children
- Developing the evidence base
- Developing monitoring systems

44. The European Commission was adopting a horizontal approach to action in those areas, involving (in addition to SANCO) the directorates-general of education and

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culture (expert group on sport, health and participation), research, agriculture (school fruit and school milk schemes) and communications networks, content and technology.

45. A High-Level Group on Nutrition and Physical Activity, led by the European Commission, brought together representatives of the 28 EU Member States, as well as two member countries of the European Free Trade Association (EFTA) and WHO. It sought European solutions to obesity-related health issues by offering an overview of all government policies on nutrition and physical activity; helping governments to share policy ideas and practice (e.g. redesigning the physical environment to encourage cycling, walking and other forms of daily activity, or reformulating food products to contain less salt, fats or sugars); and improving liaison between governments and the EU Platform for Action on Diet, Physical Activity and Health, so that relevant public-private partnerships could be quickly identified and agreed on.

46. The EU Platform had started to operate in March 2005, to provide a common forum for all interested actors at European level. Membership was conditional upon making a commitment to action. Its 32 members including representatives of industry, public health NGOs, health professionals and community groups, had made a total of more than 300 commitments, 122 of which were currently active (29 of them targeting children). The number of commitments to food product reformulation had increased each year, “education” had consistently received the largest number of commitments, and children and adolescents were the second most frequently addressed target group.

47. A recent external evaluation of the Strategy for Europe had found that one area deserving particular attention in the future was the promotion of physical activity. Careful consideration should be given to the effects of actions on obesity among lower socioeconomic groups, and more work should be done on labelling (e.g. nutrient profiles) and monitoring of self-regulation. The EU Platform should focus on generating better evidence of the efficacy and impact of commitments made by its members.

48. Dr Francesco Branca, Director, Nutrition for Health and Development, WHO headquarters, welcomed the fact that the close cooperation between WHO and the European Commission dating back to before the Istanbul Conference was continuing. In a global perspective, the WHO European Region was seen as playing a leading role in tackling obesity and nutrition. Action at community level was essential, focusing not only on low-income groups and on infants and children but also on maternal obesity. The growing body of evidence about the effectiveness of economic tools and multisectoral action would be reviewed at the Second International Conference on Nutrition, being organized jointly by WHO and FAO and to be held in Rome, Italy in November 2014.

49. The following panel discussion was moderated by Mr Clive Needle, EuroHealthNet. Panellist were asked to describe the main priorities in their countries for tackling childhood obesity and inequalities.

50. Ms Ingrida Circene, Minister for Health, Latvia, said that the recently adopted national public health strategy 2011–2017 placed emphasis on maternal and child health, including better information and services for pregnant and breast-feeding women. The healthy nutrition action plan 2003–2013 contained recommendations on how to promote consumption of healthy foods among different social groups, as well as
school milk and school fruit schemes. Dietary standards had been set for school meals and were to be extended to long-term social institutions and hospitals. In 2006 a regulation had been adopted restricting the marketing of soft drinks and salty snacks in schools and kindergartens. With regard to action at local level, guidelines had been drawn up for municipalities concerning healthy lifestyles, healthy diet and physical activity, and a pilot project had been launched in May 2013 on carrying out health checks (weight, blood pressure, blood cholesterol, etc.) of 9–11 year-old children in general practitioner settings.

51. Dr Zoya Sereda, Head of Division, Department of Health and Sanitary/Epidemiological Well-being, Ministry of Health, Russian Federation, said that the Russian State Commission on the Protection of Public Health, headed by the Prime Minister, also placed emphasis on maternal and child health. The Ministry of Health had developed a package of documents and measures to support breastfeeding, and all constituent republics in the country had adopted legislation to provide for a healthy diet for pregnant women, breastfeeding mothers and children up to three years of age. Food and micronutrient standards had been laid down for kindergartens and schools, and they formed the basis for promoting the sale of foods low in fat, salt and sugar. Manufacturers were producing special foods for use by children in institutional settings, and a national strategy on children envisaged a range of preventive measures, including school milk and school fruit projects. Preventive health centres in all republics were carrying out early diagnosis of children, to detect NCD risk factors and implement both collective and individual recommendations.

52. Dr Halim Kosova, Minister of Health, Albania, said that his country was still experiencing the double burden of malnutrition: stunting and anaemia were present in some communities, while 21.6% of children aged 7–10 years were overweight and 7.7% were obese. A programme had been implemented jointly by Government bodies, specialized institutions, regional authorities and civil society organizations in the previous three years, focused on designing models and tools, carrying out pilot projects and strengthening capacities. The national food and nutrition action plan 2013–2020 had the following objectives: to give 10% more households access to safe and nutritious food; to keep the proportion of children and adults with normal body weight unchanged, at the least; to increase the proportion of individuals eating a balanced diet by 10%; to reduce the proportion of children aged 0–5 years with growth retardation by 6%; and to raise people’s awareness of the importance of a healthy diet.

53. Professor Oktay Shiraliyev, Minister of Health, Azerbaijan, acknowledged that legislation was an important approach for the prevention of nutrition-related disorders: his country’s Parliament had introduced a ban on the importation of non-iodized salt, for instance, and all health-related advertisements now had to be approved by the Ministry of Health. However, measures should also be taken to influence public opinion and people’s behaviour. The Government placed emphasis on protecting children’s health, as in Latvia, and (like the Russian Federation) had introduced a programme of preventive medical care for children in outpatient health care establishments, as well as a system of central catering for kindergartens in the capital city.

54. Dr Raymond Busuttil, Superintendent of Public Health, Malta, said that a new action plan on food and nutrition had recently been drawn up in his country, based on the European health policy framework, Health 2020, and whole-of-government and life-course approaches. The Government was reviewing its policy on breastfeeding and was preparing to conduct a comprehensive food and nutrition survey. A programme would
be implemented the following year targeting overweight in 8-year old children, with revision of previous policy on health eating in schools (in cooperation with the Ministry of Education) and its extension to cover healthy lifestyles in the general public. Measures were also being taken with the public broadcasting authority to analyse health-related advertisements, and a feasibility study would be conducted with the Ministry of Finance on taxes on the consumption of unhealthy foods and subsidies on healthy ones. It was expected that those intersectoral initiatives would help to reduce childhood obesity.

55. In answer to a follow-up question from the moderator about the role of the health ministry as an “ambassador” in intersectoral work, panellists agreed that all laws and programmes involved other ministries, although it was sometimes difficult to overcome the assumption that one sector was more important than another. Fiscal measures, behaviour change and physical activity were seen as good “entry points” for intersectoral cooperation, while an important role could be played by civil society and charitable organizations. The Conference itself would, it was hoped, plant many seeds that would come to fruition in the years ahead.

The future of monitoring and surveillance of diet- and physical activity-related noncommunicable diseases

56. The fourth ministerial panel session was chaired by Dr Ute Winkler, Head of Division, Federal Ministry of Health, Germany.

57. The keynote speaker, Professor Adrian Bauman, Director, Prevention Research Collaboration, University of Sydney, Australia, set out the principles of an NCD surveillance system. As the ongoing and systematic collection and analysis of data on health-related events or behaviour at the population level, it should begin with the surveillance of key behaviours (smoking, alcohol, physical activity, diet) and then incorporate additional elements, such as the monitoring of programmes, environments and policies. Measures must be standardized, in order to ensure comparisons of trends over time and between countries.

58. The WHO global monitoring framework and targets for NCD prevention, approved at the Sixty-sixth World Health Assembly in May 2013 (resolution WHA66.10, Appendix 2) were based on the “global burden of disease” approach: using epidemiological evidence about the health risks posed by an unhealthy diet, obesity and low physical activity (including high levels of sitting), it estimated the health gains (i.e. how many deaths or how much disability could be prevented) that would result if the risk factor were to be reduced or eliminated. The global monitoring framework enabled the burden of disease and risk factor contributions to be monitored over time. The European health report 2012 and a recent article in the Lancet both contained analyses of the changes in risk factors contributing to the global burden of disease, from 7

8 See footnote 1 on page 3.
which it was apparent that in the WHO European Region the “traditional” risk factors of poor water supply and sanitation, air pollution and under-nutrition had been replaced by tobacco use, hypertension, obesity, alcohol use and physical inactivity.

59. Systems were in place for the surveillance of obesity and overweight in the Region, using data from direct measurement of weight and height in representative samples of the populations in Member States. Information on the prevalence of overweight among adults in the European Union, for instance, was available up to 2012, while WHO’s COSI, in its 2010 round, had found the prevalence of overweight and obesity ranging from 24% to 57% for boys and from 21% to 50% for girls.

60. For surveillance purposes, a distinction needed to be made between physical activity, “exercise” and sport. A Eurobarometer survey conducted by the European Commission had covered physical activity in 2002/2003 and had found levels below the guidelines (five times a week, for a total of 150 minutes) in all 16 EU countries surveyed. Sport participation rates had been examined in a 2009/2010 Eurobarometer survey. WHO’s Health Behaviour in School-aged Children (HBSC) surveys had been carried out every four years since 1983, most recently in 2009/2010. Multi-country projects (such as the Finbalt Health Monitor carried out in Estonia since 1990, Finland since 1978, Latvia since 1998 and Lithuania since 1994) and country-specific surveys also provided information on physical activity.

61. Independent of the level of physical activity, total time spent sitting was correlated with increased levels of mortality from all causes. The 2002/2003 Eurobarometer survey had found that an average of 40% of the adult population of 16 countries spent more than 6 hours a day sitting, and the most recent HBSC survey had revealed that between 65% and 80% of 15 year-olds watched television for more than two hours each weekday. A comparison was being made of the prevalence of sitting among adults, using data from the 2005/2006 Eurobarometer survey. Consideration could be given to including that indicator in one standardized system for surveillance of NCD risk factors over time and between countries.

62. Dr Godfrey Xuereb, Programme Officer, Surveillance and Population-based Prevention, WHO headquarters, confirmed that the recently approved global monitoring framework for NCD prevention used harmonized and standardized indicators that would make it possible to monitor trends within and across regions, to learn from experience and to identify those policies that were successful.

63. The following panel discussion was moderated by Dr Fiona Godlee, Editor-in-Chief, British Medical Journal. Panellists were asked to describe the monitoring and surveillance systems in place in their countries.

64. Dr Aleksandr Bazarchyan, Director, National Institute of Health, Armenia, said that three main instruments were used in his country: a health and demographic survey was carried out every five years, there was intensified national monitoring of specific risk factors twice or three times a year (institutionalized in the 1990s and involving specific departments of the Ministry of Health), and Armenia participated in the HBSC survey conducted by WHO. Other sources of information included surveys organized by the State Committee on Statistics and nutrition research studies.

65. Professor Chavdar Slavov, Deputy Minister of Health, Bulgaria, said that the national monitoring system consisted of three levels: the Ministry of Health, the
National Centre for Public Health Analysis, and 28 regional health inspectorates. Surveys of dietary intake and nutritional status in 1997, 1998 and 2004 had revealed negative trends and had led to formulation of the first national food and nutrition action plan 2005–2010. Monitoring of breastfeeding, dietary intake and nutritional status in children under five years of age had started in 2007. Bulgaria had joined COSI in 2008, and a survey of children aged 7–8 years had found the prevalence of overweight to be 30.6% and of obesity to be 13.6%. A second COSI study was currently under way. In 2011 dietary intake, nutritional status, physical activity and the risk of eating disorders had been surveyed in pupils aged 7–19 years. Other studies had concerned sodium intake and excretion, and iodine deficiency disorder. The national programme for NCD prevention 2013–2020 included monitoring of the main risk factors for chronic disease.

66. Professor Azamdzhon Mirzoev, Deputy Minister of Health, Tajikistan, said that NCD monitoring and surveillance were carried out by the Ministry of Health and other bodies. Undernutrition and malnutrition were still being seen: 8% of the population had an inadequate diet and 21% experienced illnesses related to malnutrition. It was therefore necessary to continue monitoring food and nutrition patterns. Laws had been adopted on iodization of salt, breastfeeding, smoking and other health-related matters; many of those legislative acts contained provisions concerning monitoring.

67. Dr Leyli Shamuradova, Deputy Minister of Health and Medical Industry, Turkmenistan, said that a targeted programme for NCD prevention that had begun in 2011 included a WHO-recommended surveillance component. Her Government was implementing health education and outreach campaigns to make the population aware of NCDs and had launched a programme in 2013 to promote sport among teenagers and adults. The Government also placed emphasis on food safety and security, encouraging breastfeeding and adopting policies against the use of trans fats, and had taken steps to promote a healthy diet among schoolchildren and students. Salt iodization was carried out with the aim of preventing iodine-deficiency disorders, so salt consumption needed to be carefully monitored; food safety in general was monitored through interagency cooperation. A WHO ministerial conference on the prevention and control of NCDs was scheduled to be held in Ashgabat on 3–4 December 2013.

68. Ms Maris Jesse, Director, National Institute for Health Development, Estonia, said that efforts were being made to ensure that the biennial Finbalt surveys yielded data that were comparable to the indicators used by WHO at European and global levels. A second population-based nutrition survey was to be conducted in her country in September 2013; a pilot scheme had found that the response rate could be improved by giving respondents individual feedback on their dietary habits. The national food safety agency and the Ministry of Agriculture would cooperate on and co-finance the survey. Interventions such as the provision of free school meals with regulated content were also being monitored. To secure rapid, up-to-date information on food consumption, the Ministry of Health was cooperating with retailers in the private sector, in addition to its work in the public sector.

69. Dr Jarmila Razova, Director-General, Public Health Protection and Promotion, Ministry of Health, Czech Republic, said that an environmental health monitoring system had been in operation since 1994, assisting with characterization of the health risks associated with the population’s dietary habits and assessment of the probability of chronic exposure doses, where appropriate. Trends in the nutritional status of children
and adolescents had been regularly monitored by means of national anthropological surveys carried out at 10-year intervals since 1951. The Czech Republic also participated in the WHO COSI study and HBSC surveys.

70. Dr Öner Güner, General Director, Foreign Affairs and EU, Ministry of Health, Turkey, said that his country had also joined the WHO COSI study: the findings of the national survey, carried out in 67 provinces, would be announced at the sixty-third session of the WHO Regional Committee for Europe (Çeşme Izmir, 16–19 September 2013). National guidelines on physical activity (for children, adults, the elderly, and disabled people) would be issued by the end of 2013. Teachers were being trained through an “e-school programme” prior to the launch of a school exercise programme. Other measures being taken included the provision of free milk to the country’s 6 million primary schoolchildren, a ban on the supply of high-energy drinks and HFSS foods in school canteens, a reduction in the salt content of bread (to 1.5 g/loaf), and mass media campaigns to promote physical activity.

71. Dr Ute Winkler, Head of Division, Federal Ministry of Health, Germany, said that sustained and continuous monitoring was essential. Health surveys were carried out on a regular basis in all age groups, either telephone-based or through general practitioner settings, looking at overall health status (including obesity). Surveys were also made of people’s physical activity levels, and nutrients and nutrition were monitored on an annual basis. The information obtained had been used when drawing up the national initiative to promote healthy diets and more physical activity, which had been adopted in 2008 and was due to run until 2020. Epidemiological data served as the underpinning for (but could not replace) policy.

72. Asked what was the greatest challenge their countries faced, panellists singled out the question of process monitoring, the lack of a specific nutrition action plan, the need for behaviour change and the sustainability of surveillance systems. The latter was not merely a question of funding; commitment had to be secured from a large number of actors, not least survey respondents themselves. Results had to be presented in easily understandable and accessible ways. For her part, Dr Fiona Godlee pledged the support of the British Medical Journal to disseminate good intercountry NCD surveillance data for evidence-based policy-making.

Statement by nongovernmental organizations

73. Mr Jo Jewell, representing World Cancer Research Fund International and also speaking on behalf of the European Consumer Organisation (BEUC), the European Heart Network, the European Public Health Alliance, the International Association for the Study of Obesity, the International Diabetes Federation (Europe) and the NCD Alliance, called on WHO and Member States to consider three recommendations from civil society:

- Ensure a healthier media environment for children. As a priority, Member States should commit to fully implement the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children, in order to protect children from the harmful and misleading effects of food and beverage marketing in all its forms.
- Create a healthy food environment in schools. School settings should promote healthy lifestyles and the creation and maintenance of healthy preferences.
Governments should establish standards for the foods provided in schools and other formal educational settings, including restrictions on the provision of foods high in fats, salt and sugar. Other effective measures would include the provision of fresh fruit and vegetables and the incorporation of food preparation and nutrition skills in school curricula.

- Improve the quality of the food supply. Ministers were urged to introduce measures that would encourage and incentivize the agricultural sector, including primary producers, as well as food processors, manufacturers and retailers, to produce, distribute and sell a healthier food supply that was accessible to all sectors of society. That would require multisectoral action all along the food supply chain and might include the use of targeted economic tools.

Awards ceremony

74. The WHO Regional Office for Europe had been invited to participate in evaluation of the Norwegian nutrition policy 2007–2012. In a formal ceremony, Ms Zsuzsanna Jakab, WHO Regional Director for Europe handed over the results of that evaluation to Ms Nina Tangnæs Grønvold, State Secretary, Ministry of Health and Care Services, Norway.

75. A civil society organization, NCDFree, had been asked to organize a competition to produce the best video or short film on NCD solutions of worldwide importance. Dr Gauden Galea, Director, Division of Noncommunicable Diseases and Life-course, WHO Regional Office for Europe presented awards to the organizer of the competition, Dr Alessandro Demaio, NCDFree, and to the winners of the competition, Ms Nora Bünemann and Mr James Cook, followed by a showing of their films.

Informal sessions

76. A lunchtime seminar on salt, sugar and fat, moderated by Mr Michael Moss, New York Times, was held on the first day of the Conference. A lunchtime seminar on noncommunicable diseases: the role of the private sector, moderated by Ms Eve Heyn, GBC Health, was held on the second day of the Conference, followed by a special briefing on Middle East Respiratory Syndrome coronavirus and avian influenza A(H7N9) virus, given by Professor David Harper, Special Adviser, Health, Security and Environment, WHO headquarters and Dr Diana Gross, Technical Officer, Influenza and Other Respiratory Pathogens, WHO Regional Office for Europe.

The Vienna Declaration and the WHO European Regional Food and Nutrition Action Plan 2014–2020

77. Mrs Petra Lehner, Office of the Federal Minister of Health, Austria and Chair of the Drafting Group for the Vienna Declaration, said that the draft Declaration had gone through many iterations during three written consultations and two technical group meetings, resulting in a concise and carefully crafted document. Written comments on the latest draft had recently been received from 14 Member States.
78. Professor Ibrahim Elmadfa, speaking on behalf of the “Senator Group” of experts convened by the Regional Director, confirmed that the Group had reviewed successive drafts of the Declaration in the light of the European health policy framework, Health 2020. In the words of one member of the Group, Dr Walter Willett, it believed that the current draft was “masterfully worded and highly consistent with the best available evidence”. The Senator Group therefore fully supported and endorsed the draft Declaration.

79. In general, representatives of Member States welcomed the draft Declaration, and in particular its emphasis on an intersectoral and life-course approach to tackling nutrition and NCDs, its advocacy of action on the social determinants of health and in different health settings, and the consideration it gave to the promotion of equity. More prominence should be given, however, to aspects related to physical activity.

80. Participants then made a detailed review of each paragraph of the draft Declaration, entrusting to an ad hoc drafting group the task of completing that review after the close of the first day’s proceedings. The Conference subsequently commended the work of that drafting group and reached agreement by consensus on the version of the draft Declaration that would be presented for signature.

81. It was agreed that a number of additional technical points should be included in the WHO European Regional Food and Nutrition Action Plan 2014–2020 that would be drawn up after the Conference:

- Strengthen the International Code of Marketing of Breast-milk Substitutes and take decisive action to reduce marketing of breast-milk substitutes and premature introduction of complementary foods to infants
- Develop a physical activity strategy to promote health-enhancing physical activity and reduce sedentary lifestyles
- Consider, according to national context, the use of economic tools and incentives to promote healthy eating and encourage its affordability and accessibility
- Promote food product reformulation and action on all components of the food supply chain
- Support surveillance, monitoring, evaluation and research of the population’s nutritional status and behaviours by ensuring adequate institutional capacity and skills.

82. At the conclusion of the Conference, in a session chaired by Dr Karin Schindler, Technical Officer, Nutrition, Physical Activity and Obesity, WHO Regional Office for Europe, the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 (Annex 2) was signed by the WHO Regional Director for Europe and, on behalf of participants, by the Federal Minister of Health of Austria. It would be presented for adoption by the WHO Regional Committee for Europe at its sixty-third session in September 2013.

**Closure**

83. Professor Toregeldy Sharmanov, former Minister of Health of Kazakhstan and winner of the Léon Bernard Foundation Prize, who had chaired the conference at which the Declaration of Alma-Ata on Primary Health Care had been adopted in 1978,
welcomed the signature of the Vienna Declaration. As Director of the WHO Collaborating Centre for Nutrition at the Kazakhstan Academy of Nutrition, Professor Sharmanov recognized obesity as the “epicentre” of the fight against NCDs and underlined the importance of nutrition in efforts to promote better health.

84. The Conference was closed by Ms Zsuzsanna Jakab, WHO Regional Director for Europe and Mr Alois Stöger, Federal Minister of Health, Austria.
Annex 1

List of participants

I. Member States

Albania

Dr Halim Kosova
Minister of Health

Dr Gazmend Bejtja
General Director of Health Policy and Planning

Dr Durim Kraja
Director, Minister’s Cabinet

Andorra

Mr Jesus Galindo
Head, Food and Environment Safety Area, Ministry of Health and Welfare

Armenia

Dr Vahan Poghosyan
Deputy Minister of Health

Dr Aleksandr Bazarchyan
Director, National Institute of Health

Austria

Mr Alois Stöger
Federal Minister of Health

Mr Fabian Fusseis
Cabinet of Minister, Spokesman

Mrs Judith delle Grazie
Head of Department Health Promotion and Prevention

Dr Verena Gregorich-Schega
Head, Department of Coordination, International Health Policy and WHO

Mr Alexander Hagenauger

Deputy General Manager, Main Association of the Austrian Social Insurance Institutions

Mrs Petra Lehner
Cabinet of Minister and Chair, Drafting Group for the Vienna Declaration

Dr Pamela Rendi-Wagner
Director General for Public Health and Medical Affairs

Dr Aleksander Zilberszac
Head, Department of Nutrition, Specific Goods and International Food Affairs

Dr Pia Feichtenschlager
Public Affairs, Ministry of Health

Dr David Fliesser
Public Affairs, Ministry of Health

Azerbaijan

Professor Oktay Shiraliyev
Minister of Health

Dr Samir Abdullayev
Head, International Relations Department, Ministry of Health

Belarus

Dr Siarhei Sychyk
Director, Republican Scientific and Practical Center for Hygiene
Dr Viya Shukevich  
Head, Department of Hygiene of Nutrition, Republic Center for Hygiene, Epidemiology and Public Health

**Belgium**

Mrs Laurence Doughan  
Attaché, FPS Health, Food Chain Safety and Environment

**Bosnia and Herzegovina**

Mr Sredoje Novic  
Minister of Civil Affairs of Bosnia and Herzegovina

Dr Slobodan Stanic  
Minister of Health and Social Welfare of Republika Srpska

Dr Andja Nikolic  
Head, Department for Health and Other Services, Brcko District

**Bulgaria**

Professor Chavdar Slavov  
Deputy Minister of Health

Professor Vesselka Duleva  
Head, Food and Nutrition Department, National Center of Public Health and Analysis, Ministry of Health

**Cyprus**

Mr Ioannis Adamou  
Second Secretary/Consul, Embassy of the Republic of Cyprus and Permanent Mission of the Republic of Cyprus to the United Nations and Other International Organizations in Vienna

**Czech Republic**

Dr Jarmila Razova  
Director General, Public Health Protection and Promotion, Ministry of Health

Dr Dana Mullerova  
Director, Institute of Hygiene and Preventive Medicine

**Denmark**

Mr Morten Carllmann Andersen  
Danish Veterinary and Food Administration

**Estonia**

Ms Ivi Normet  
Deputy Secretary General on Health, Health Policy Department, Ministry of Social Affairs

Ms Maris Jesse  
Director, National Institute for Health Development

Ms Katrin Karolin  
Head, Public Health Department, Ministry of Social Affairs

**Finland**

Ms Sirpa Sarlio-Lähtenkorva  
Ministerial Adviser, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health

Dr Suvi Virtanen  
Head of Nutrition Unit, Department of Lifestyle and Participation, National Institute for Health and Welfare

**France**

Mr M. Cyril Cosme  
Head of European and International Affairs
Dr Michel Chauliac  
Programme National Nutrition Santé, Direction générale de la Santé

Ms Ursula O'Dwyer  
Adviser, Health Promotion Policy, Department of Health

Georgia

Dr Lela Sturua  
Head, Non-communicable Diseases Department, National Center for Disease Control and Public Health

Israel

Ms Ruth Weinstein  
Director, Department of Health Promotion, Ministry of Health

Germany

Dr Ute Winkler  
Head of Division, Federal Ministry of Health

Dr Astrid Potz  
Desk Officer, Federal Ministry of Food, Agriculture and Consumer Protection

Italy

Dr Roberto Copparoni  
Medical Officer, Directorate-General for Nutrition and Food Safety

Dr Daniela Galeone  
Senior Medical Officer, Department of Public Health and Innovation

Greece

Mrs Zoi Makri  
Deputy Minister of Health

Professor Antonia Trichopoulou  
Director, Department of Hygiene, Epidemiology and Medical Statistics, University of Athens, School of Medicine

Kazakhstan

Dr Nurkan Sadvakassov  
Deputy Director, State Sanitary/Epidemiological Surveillance Committee, Ministry of Health

Kyrgyzstan

Mrs Tursun Mamyrbaeva  
Deputy Director, National Center of Mother and Child Care

Dr Boris Dimitrov  
Adviser to the Minister of Health, Ministry of Health

Mrs Roza Sultanalieva  
Chief Endocrinologist, Ministry of Health

Latvia

Ms Ingrida Circene  
Minister for Health

Ms Santa Livina  
Public Health Department

Ireland

Ms Ursula O'Dwyer  
Adviser, Health Promotion Policy, Department of Health
Dr Ilze Straume  
Head, Research, Statistics and Health Promotion Department, Center for Disease Prevention and Control

Ms Nina Tangaas Grønvold  
State Secretary, Ministry of Health and Care Services

Ms Bodil Blaker  
Specialist Director, Ministry of Health and Care Services

Lithuania

Ms Ieva Gudanaviciene  
Chief Specialist, Nutrition and Physical Activity Division, Public Health Department, Ministry of Health

Professor Knut-Inge Klepp  
Deputy Director-General, Directorate of Health

Mr Joachim Nilsen  
Senior Adviser, Ministry of Health and Care Services

Mr Arnhild Haga Rimestad  
Senior Adviser, Directorate of Health

Luxembourg

Mr Sven Majerus  
Licencié en Sciences de la Santé Publique, Direction de la Santé

Dr Yolande Wagener  
Médecin chef de division, Direction de la Santé, Division de la Médecine Scolaire

Malta

Dr Raymond Busuttil  
Superintendent of Public Health, Superintendence of Public Health

Dr Lucienne Pace  
Scientific Officer (Nutrition), Health Promotion Department, Ministry of Health, Elderly and Community Care

Poland

Ms Anna Trzewik  
Specialist, Ministry of Health

Dr Dariusz Poznański  
Department of Public Health, Ministry of Health

Portugal

Dr Fernando Serra Leal da Costa  
Secretary of State, Assistant to the Minister of Health

Professor Pedro Graça  
Director, National Programme to Promote Healthy Nutrition, Directorate-General of Health

Republic of Moldova

Mr Octavian Grama  
Deputy Minister, Ministry of Health

Ms Svetlana Coteleà  
Head, Department of Public Health, Ministry of Health

Ms Galina Obreja

Montenegro

Professor Ljilja Music  
Medical Director, Clinical Center of Montenegro

Netherlands

Dr Hajm Reinen  
Ministry of Health

Norway
Hygienist Physician, National Center of Public Health

**Russian Federation**

Dr Zoya Sereda
Head of Division, Department of Health and Sanitary/Epidemiological Well-being, Ministry of Health

Dr Pavel Esin
Chief expert, Department of International Cooperation and Public Affairs, Ministry of Health

**Spain**

Dr Mercedes Vinuesa-Sebastian
Director-General, Public Health, Quality and Innovation, Ministry of Health, Social Services and Equity

Dr Teresa Robledo De Dios
Technical Adviser, Spanish Agency for Food Safety and Nutrition, Ministry of Health, Social Services and Equity

**Serbia**

Mr Vladimir Dukic
State Secretary, Ministry of Health

Mr Vuk Zugic
Permanent Representative of Serbia to the United Nations

**Switzerland**

Ms Pernilla Ivarsson
Deputy Director-General, Animal and Food Division, Ministry for Rural Affairs

Ms Anette Jansson
Dietitian, National Food Agency

**Slovakia**

Dr Iveta Truskova
Head, Department of Food Safety and Improvement of Nutrition, Public Health Authority

Dr Katarina Kromerova
Public Health Authority

**Sweden**

Ms Katarina Wahlgren
Deputy Director, Animal and Food Division, Ministry for Rural Affairs

**Slovenia**

Dr Tomaz Gantar
Minister of Health

Ms Mia Marasović
Ministry of Health

Dr Vesna-Kerstin Petric
Head, Division for Health Promotion and Prevention of Noncommunicable Diseases, Ministry of Health

Ms Katja Povhe Jemec
Expert, Ministry of Health

**Tajikistan**

Ms Marjeta Reccek
Expert, Ministry of Health

Professor Azamdzhon Mirzoev
Deputy Minister of Health

Professor Khotambej Khyrov
Director, Republic Center for Nutrition, Ministry of Health
Dr Zafar Khuseynov  
Director, National Oncology Research Center  

Mr Alexei Shulga  
Head of Department, Ministry of Health  

Dr Oleg Shvets  
Director, State Research Center for Food Hygiene, Ministry of Health  

H.E. Ihor Prokopchuk  
Ambassador, Permanent Representative of Ukraine to the International Organizations in Vienna  

H.E. Andrii Bereznyi  
Ambassador, Embassy of Ukraine  

Mrs Nataliia Galibarenko  
Deputy Head of Permanent Mission of Ukraine to the International Organizations in Vienna  

Mr Dmytro Gryniiv  
Attaché, Permanent Mission of Ukraine to the International Organizations in Vienna  

Turkey  

Dr Oner Guner  
General Director of Foreign and EU Relations, Ministry of Health  

Ms Ayse Sezgin  
Ambassador of Turkey in Vienna  

Dr Lale Agusman Uribeechevarria  
Counsellor, Embassy of Turkey in Vienna  

Dr Nazan Yardim  
Head, Obesity, Diabetes and Metabolic Diseases, Department, Public Health Institute, Ministry of Health  

Turkmenistan  

Dr Leyli Shamuradova  
Deputy Minister of Health and Medical Industry  

Dr Guzaliya Gazizova  
Head, State Sanitary Control Department, State Sanitary/Epidemiologic Surveillance Service  

United Kingdom of Great Britain and Northern Ireland  

Mr Richard Cienciala  
Deputy Director, Obesity, Nutrition and Food Policy, Department of Health  

Uzbekistan  

Dr Asamidin Kamilov  
Deputy Minister, Main Department on Mother and Child Health, Ministry of Health  

Professor Dilorom Akhmedova  
Institute of Pediatrics  

Dr Matluba Alimova  
Director, National Center of Development and Medical Education, Ministry of Health  

Ukraine  

Dr Raisa Bogatyryova  
Minister of Health  

Ms Ludmila Khariv  
Minister Assistant  

Dr Nadia Polka  
Marzeyev Institute for Hygiene and Medical Ecology  

Dr Mukola Prodanchuk  
Director of Institute, Ministry of Health  

Mr Alexei Shulga  
Head of Department, Ministry of Health  

Dr Oleg Shvets  
Director, State Research Center for Food Hygiene, Ministry of Health  

H.E. Ihor Prokopchuk  
Ambassador, Permanent Representative of Ukraine to the International Organizations in Vienna  

H.E. Andrii Bereznyi  
Ambassador, Embassy of Ukraine  

Mrs Nataliia Galibarenko  
Deputy Head of Permanent Mission of Ukraine to the International Organizations in Vienna  

Mr Dmytro Gryniiv  
Attaché, Permanent Mission of Ukraine to the International Organizations in Vienna  

Turkey  

Dr Oner Guner  
General Director of Foreign and EU Relations, Ministry of Health  

Ms Ayse Sezgin  
Ambassador of Turkey in Vienna  

Dr Lale Agusman Uribeechevarria  
Counsellor, Embassy of Turkey in Vienna  

Dr Nazan Yardim  
Head, Obesity, Diabetes and Metabolic Diseases, Department, Public Health Institute, Ministry of Health  

Turkmenistan  

Dr Leyli Shamuradova  
Deputy Minister of Health and Medical Industry  

Dr Guzaliya Gazizova  
Head, State Sanitary Control Department, State Sanitary/Epidemiologic Surveillance Service  

United Kingdom of Great Britain and Northern Ireland  

Mr Richard Cienciala  
Deputy Director, Obesity, Nutrition and Food Policy, Department of Health  

Uzbekistan  

Dr Asamidin Kamilov  
Deputy Minister, Main Department on Mother and Child Health, Ministry of Health  

Professor Dilorom Akhmedova  
Institute of Pediatrics  

Dr Matluba Alimova  
Director, National Center of Development and Medical Education, Ministry of Health  

Ukraine  

Dr Raisa Bogatyryova  
Minister of Health  

Ms Ludmila Khariv  
Minister Assistant  

Dr Nadia Polka  
Marzeyev Institute for Hygiene and Medical Ecology  

Dr Mukola Prodanchuk  
Director of Institute, Ministry of Health
II. Representatives of other intergovernmental organizations

European Commission

Mr John F. Ryan
Acting Director, Public Health Directorate, Directorate-General of Health and Consumers

Ms Gundula Maria Kjaer
Seconded National Expert, Directorate-General for Health and Consumers,

Mr Pedro Velazquez
Deputy Head of Unit, Directorate-General of Education and Culture

III. Observers, Ministry of Health, Austria

Professor Gerhard Aigner
Director-General, Federal Ministry of Health

Mr Maurice Androsch
Office of the State Government of Lower Austria

Dr Edith Bulant
Office of the State Government of Lower Austria

Mrs Veronika Daucher
Department for Coordination, International Health Policy and WHO

Mrs Ursula Dlouhy
Department for Coordination, International Health Policy and WHO

Dr Johanna Geyer
Department of Health, Federal Ministry of Health

Mrs Gabriela Goetz-Ritchie
Public Affairs, Federal Ministry of Health

Mrs Andrea Haderer

Public Affairs, Federal Ministry of Health

Mrs Anita Hoellmuller
Public Affairs, Federal Ministry of Health

Mrs Regina Kuhn
Department for Nutrition, Specific Goods and International Food Affairs

Dr Franz Leisch
Cabinet of Minister, Advisor for e-Health, EU and International Affairs

Mr Martin Mühlbacher
Deputy Head, Department for Coordination, International Health Policy and WHO

Mr Jan Pazourek
Generaldirektor der Niederösterreichischen Gebietskrankenkasse

Mrs Verena Sgarabottolo
Department for Nutrition, Specific Goods and International Food Affairs

Mr Bernhard Stocker
Department for Coordination, International Health Policy and WHO

Mrs Ilana Ventura
Department for Public Health and Medical Affairs, Project Coordination for the Director-General of Public Health

Dr Fritz Wagner
Deputy Head, Department for Health Promotion and Prevention

Dr Walpurga Weiss
Department for Public Health and Medical Affairs

Mrs Lisa-Maria Wagner
Federal Ministry of Health
Mag Martina Brix  
Federal Ministry of Health

Mrs Irina Goferman  
Federal Ministry of Health

Dr R. Kolle

Dr G. Stevrer

Dr Katharina Maierhofer

Dr Süglinde Neudorfer  
Federal Ministry of Health

Dr Dorota Sienkiewicz  
European Public Health Alliance

Dr Kurt Widhann  
Austria Academy for Nutrition

European Association of the Study of Obesity  
Ms Nathalie Farpour-Lambert  
Dr Lauren Lissner

European Society for Clinical Nutrition and Metabolism  
Ms Regina Komsa-Penkova  
Professor Pierre Singer

European Community of Consumer Cooperatives  
Ms Chiara Tomalino

European Consumer Organisation  
Ms Ruth Veale

European Heart Network  
Mrs Susanne Logstrup

European Public Health Association  
Dr Christopher Birt

European Nutrition for Health Alliance  
Mr Frank de Man

FH JOANNEUM - University of Applied Science; Institute of dietetics and nutrition  
Mrs Elisabeth Pail

FHG - Zentrum für Gesundheitsberufe Tirol  
Ms Anna Elisabeth Purtscher

Food Drink Europe  
Mr Dirk Jacobs

European Fresh Produce Association  
Dr Saida Barnat  
Mrs Raquel Ines Izquierdo de Santiago

Gesundheit Österreich GmbH  
Mr Florian Bachner  
Mrs Gudrun Braunegger-Kallinger  
Mrs Sabine Haas  
Mrs Katharina Habimana  
Mrs Rita Kichler  
Mrs Christine Knaller  
Mrs Joy Ladurner  
Mrs Christa Peinhaupt  
Mr Klaus Ropin

IV. Observers

AKS Austria - Forum österreichischer Gesundheitsarbeitskreise  
Mrs Karin Reis-Klingspiegl

Austrian Agency for Health and Food Safety (AGES)  
Mrs Karin Blagusz  
Mrs Bernadette Bürger  
Mrs Birgit Dieminger  
Mrs Sonja Greisinger  
Mrs Ariane Hitthaller  
Dr Manuel Schätzer  
Mrs Nadja Wuest

Austrian Association of Dieticians  
Professor Andrea Hofbauer  
Mrs Christine Pall

Association of European Cancer Leagues (ECL)  
Dr Wendy Tse Yared

Carinthian Health Insurance  
Mr Johann Lintner

Choices International Foundation  
Mr Rutger Schiplzand

European Association of the Study of Obesity  
Ms Nathalie Farpour-Lambert  
Dr Lauren Lissner

European Society for Clinical Nutrition and Metabolism  
Ms Regina Komsa-Penkova  
Professor Pierre Singer

European Community of Consumer Cooperatives  
Ms Chiara Tomalino

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Dr Saida Barnat  
Mrs Raquel Ines Izquierdo de Santiago

Gesundheit Österreich GmbH  
Mr Florian Bachner  
Mrs Gudrun Braunegger-Kallinger  
Mrs Sabine Haas  
Mrs Katharina Habimana  
Mrs Rita Kichler  
Mrs Christine Knaller  
Mrs Joy Ladurner  
Mrs Christa Peinhaupt  
Mr Klaus Ropin
VI. Secretariat

Headquarters

Dr Francesco Branca
Director, Nutrition for Health and Development

Mr Meindert Onno van Hilten
Office of the Assistant DG

Dr Godfrey Xuereb
Programme Officer, Surveillance and Population-based Prevention

Regional Office for Europe

Ms Zsuzsanna Jakab
Regional Director

Dr Gauden Galea
Director, Division of Noncommunicable Diseases and Life-Course

Dr João Breda
Programme Manager, Nutrition, Physical Activity and Obesity Programme

Ms Gitte Andersen Havn
Assistant, Division of Administration and Finance

Ms Paola Bennati
Programme Assistant, Nutrition, Physical Activity and Obesity Programme

Ms Caroline Bollars
Technical Officer, Nutrition Policy, Nutrition, Physical Activity and Obesity Programme

Mr Sasa Delic
Assistant, Printing and Conference Services

Ms Mirona Eriksen
Executive Assistant, Office of Regional Director

Ms Yulnara Kadirova

V. Guests and Temporary Advisers

Professor Adrian Bauman
Sydney University

Dr Sarah Boseley
The Guardian

Ms Nora Buenemann

Mr James Cook

Dr Alessandro R. Demaio

Professor Fiona Godlee
British Medical Journal

Ms Eve Heyn
GBC Health

Ms Misha Kouzeh

Professor Carlos Monteiro
University of Sao Paulo

Mr Michael Moss
New York Times

Mr Clive Needle
EuroHealthNet

Mr Charles Robson
(Rapporteur)

Senator Group

Professor (Emeritus) Ibrahim Elmadfa
Professor Philip James
Dr Hildegard Przyrembel
Programme Assistant, Division of Noncommunicable Diseases and Life-Course

Ms Tina Kiaer
Communication Officer, Division of Noncommunicable Diseases and Life-Course

Ms Faith Kilford Vorting
Communications Officer, Office of the Regional Director

Mr Theodoros Kaloumenos
Technical Assistant, Information and Communications Technology

Dr Karin Schindler
Technical Officer, Nutrition Policy, Nutrition, Physical Activity and Obesity Programme

Ms Liza Jane Villas
Secretary, Nutrition, Physical Activity and Obesity Programme

Ms Trudy Wijnhoven
Technical Officer, Nutrition Surveillance, Nutrition, Physical Activity and Obesity Programme

Special session on coronavirus

Dr Diane Gross
Communicable Diseases, Health Security & Environment, WHO Regional Office for Europe

Professor David Harper
Special Adviser, Office of the Assistant Director-General, WHO headquarters

VII. Interpreters

Ms Elisabeth Bernecker
Mr David Budgen
Mr Francois Butticker
Mr Pavel Cherednik
Ms Hélène Ciolkovitch
Mr Vladislav Glasunov
Mr Christian Koderhold
Ms Aimée Linekar
Ms Naomi Osorio- Kupferblum
Mr Jonathan Pocock
Mr Aleksandr Reshetov
Mr Andrei Reshetov
Ms Friederike Schlegl
Mr Grigory Shkalikov
Ms Elisabeth Schwarz
Mr Andrey Taranichev
Ms Helene Witkowska
Ms Eva Wolf-Calmet
Mr Alexander Zigo
Annex 2

The Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020

17. We, the Ministers of Health and representatives of the Member States of the World Health Organization in the European Region, together with the WHO Regional Director for Europe and health experts and representatives of civil society and intergovernmental organizations, have gathered in Vienna, Austria, on 4 and 5 July 2013 to face the challenges posed by the burden and threat of noncommunicable diseases (NCDs) and reaffirm our commitment to existing European and global frameworks to address important NCD risk factors, notably unhealthy diet and physical inactivity.

18. We confirm our commitment to relevant United Nations-led global processes following from the United Nations Political Declaration on the Prevention and Control of Noncommunicable Diseases 2011, in particular, the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, endorsed by the 66th World Health Assembly, and the 8th WHO Global Conference on Health Promotion in Helsinki.

19. We recognize that a healthy diet can contribute to achieving the global targets on NCDs adopted by the 66th World Health Assembly, including achieving a 25% relative reduction in premature mortality from NCDs by 2025. Focused common action to support better nutrition will assist us in our efforts to achieve this voluntary global target. We acknowledge the importance of multisectoral action and health systems’ capacity, universal health coverage and science-based methods in preventing and treating NCDs within comprehensive and integrated national strategies.

20. We acknowledge the high, and still increasing, burden of disease caused by unhealthy dietary and lifestyle patterns in many countries of the Region; in particular, we are concerned about the rapid rise of overweight and obesity, especially in children. We recognize its negative impact on the quality of life and well-being of the individual and of society as a whole and the high burden it puts on health systems and the economy. We believe it is timely to revisit, revitalize and strengthen the European Charter on Counteracting Obesity – the Istanbul Charter, especially in the field of nutrition.

21. Building on the new European policy framework Health 2020, we agree to facilitate decisive action to prevent and tackle overweight, obesity and undernutrition. This includes supporting food systems that encourage healthy eating and are sustainable and ensure equity. Investing in diet-related NCD prevention and control will support a country’s human capital and its economy. This requires the widespread and active engagement of all relevant sectors and players and their engagement in whole-of-government, whole-of-society and health-in-all-policies approaches is crucial. Policy options for governments to consider include production, consumption, marketing, availability, access, economic measures and education-based interventions, taking into account the cultural dimensions of nutrition.
22. We are committed to addressing inequities in health and diet. Access to healthy and affordable diet is an integral part of the effort to tackle social inequalities. Supporting the most vulnerable groups in order for all citizens in the WHO European Region to attain the important and affordable benefits of a healthy diet and active life at a time of limited resources is an ethical imperative. Increasing the availability and affordability of healthy diets for all population groups will require us to address gaps in food system governance in Europe.

23. We will contribute significantly to the reduction of NCDs by addressing priority concerns such as excessive intake of energy, saturated fats and trans fats, free sugars and salt, as well as low consumption of vegetables and fruit. These are important risk factors for obesity and diet-related NCDs.

24. We urge the WHO Regional Committee for Europe to mandate the development of a new food and nutrition action plan.

25. We urge the WHO Regional Committee for Europe to mandate the development of a physical activity strategy, alongside the new food and nutrition action plan.

26. We will work on ensuring that healthy options are accessible, affordable and attractive. We concluded that there is no blueprint or “one size fits all” solution, but that evidence points clearly in the direction of creating conditions that make the healthy choice the easiest choice. Policies must rely on best available evidence translated into common practice. They will be most effective when used in the context of overarching health promotion strategies.

27. With this in mind, we will intensify our political and strategic efforts in the context of Health 2020, in the following priority areas, to take us towards a sustainable and healthy life. Due consideration should be given to options appropriate to the different national contexts, and maintaining an appropriate balance between increasing public awareness and facilitating healthy choices.

28. Create healthy food and drink environments and encourage physical activity for all population groups by:

- taking decisive action to reduce food marketing pressure to children with regard to foods high in energy, saturated fats, trans fatty acids, free sugars or salt, implementing common approaches to promote product reformulation, consumer-friendly labelling and nutrient profiling tools which facilitate a healthy choice;
- considering, according to national context, the use of economic tools and incentives to promote healthy eating;
- engaging in intersectoral collaboration to facilitate healthier food choices by taking into account socioeconomic inequality in settings such as schools, kindergartens, nurseries, hospitals and workplaces, for example, school fruit/meal schemes; and
- implementing effective programmes at various levels of administration, with a focus on communities and the role of local governments, to promote healthy diets, encourage physical activity and prevent childhood obesity.

13. Promote the health gains of a healthy diet throughout the life-course, especially for the most vulnerable by:
• investing in nutrition from the first stages of life, starting from before and during pregnancy, protecting, promoting and supporting of adequate breastfeeding, providing appropriate complementary feeding, followed by healthy eating in the family and school environments during childhood and adolescence;

• improving the ability of the citizen to make informed choices, taking into account different population groups (age, gender, education), through encouraging reliable consumer information, improving food and health literacy and strengthening consumer rights;

• encouraging the use of social media and new techniques to promote healthy food choices and healthier lifestyles, particularly among children and adolescents; and

• developing approaches to address the special nutrition needs of the aged population.

17. Reinforce health systems to promote health and to provide services for NCDs by:

• scaling up healthy eating and physical activity schemes in people-centred primary health care and ensuring an appropriate continuum of nutrition and physical activity ranging from health promotion to prevention and care throughout the life-course;

• ensuring universal health coverage for the core avoidable, preventable and treatable diet-related NCDs;

• ensuring appropriate human resources to provide evidence-informed nutrition interventions, including counselling and care, as well as technologies compatible with a people-centred health system based on strong primary health care; and

• setting up nutritional assessment and intervention procedures in the most relevant settings for different age groups, especially the aged.

17. Support surveillance, monitoring, evaluation and research of the population’s nutritional status and behaviours by:

• consolidating, fine-tuning and scaling up existing national and international monitoring and surveillance systems, and ensuring the transparency and accessibility of data to promote new research and better returns on investments, including identifying and sharing existing intersectoral health and consumer data;

• supporting nutrition and health surveillance systems for different population groups which have the capacity to disaggregate by socioeconomic indicators and gender and ensure nutritional risk screening procedures; and

• monitoring and evaluating nutrition interventions, diet-related activities and policies in different socio-economic and socio-demographic population groups in order to identify effectiveness and disseminate good practice.

17. Strengthen governance, alliances and networks and empower communities to engage in health promotion and prevention efforts by:

• strengthening coordinated actions between different administrative levels, encouraging and supporting local actions such as food councils and community coalitions and work with regional and local producers, including recovering traditional diets when and where appropriate;
strengthening multistakeholder action at local and regional levels such as developed in the Healthy Cities, Health Promoting Schools and other initiatives; and

- strengthening networks of countries committed to implementing specific action such as the Action Network on Salt Reduction and the Action Network on Reducing Marketing of Foods to Children.

17. The Vienna Ministerial Conference has been an outstanding setting for sharing experiences and success stories in the development, implementation and evaluation of nutrition, physical activity, obesity- and other diet-related NCD policies in Member States.

18. We declare our commitment to health promotion and NCD prevention in line with this Declaration and to raise the priority accorded to this issue on the political agenda of our governments at all levels. We also recognize the leadership on this issue provided by WHO at all levels, including the WHO Regional Office for Europe.