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Organization**

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REGIONAL OFFICE FOR **Europe**

Meeting of the Nutrition  
Knowledge Network  
Tel Aviv, Israel  
10 – 12 March 2013

**Meeting Report**

## ABSTRACT

The World Health Organization Regional Office for Europe organized a meeting of the nutrition knowledge network in March 2013 to advance the agenda of nutrition and health in the European Region.

This meeting was immediately followed by a regional consultation on the preparation of the Second International Conference on Nutrition (ICN2) to take place in Rome in November 2014. The preparatory meeting provided an overview of the three malnutrition problems that affect the population in the region in various proportions (undernutrition, micronutrient deficiencies and obesity) and pointed to priority concerns about overall excess consumption of energy, excessive consumption of saturated fat, trans fats, sugar and salt, insufficient consumption of fruit and vegetables and the strong social gradient in overweight, obesity and noncommunicable diseases (NCDs).

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# Meeting of the Nutrition Knowledge Network

Tel Aviv, Israel, 10 – 12 March 2013

## Introduction

The World Health Organization Regional Office for Europe organized a meeting of the nutrition knowledge network in March 2013 to advance the agenda of nutrition and health in the European Region. The meeting took place in Tel Aviv from 10 to 12 March.<sup>1</sup>

This meeting was immediately followed by a regional consultation on the preparation of the Second International Conference on Nutrition (ICN2) to take place in Rome in November 2014. The preparatory meeting provided an overview of the three malnutrition problems that affect the population in the region in various proportions (undernutrition, micronutrient deficiencies and overnutrition) and pointed to priority concerns about overall excess consumption of energy, excessive consumption of saturated fat, *trans* fats, sugar and salt, insufficient consumption of fruit and vegetables and the strong social gradient in overweight, obesity and noncommunicable diseases (NCDs). Specific concern was expressed about the sub-optimal adoption of policies, the focus on provision of information rather than changes to the food environment and the need to give Member States guidance on the policy options available. There was also a call for a renewed emphasis on early nutrition, before, during and after pregnancy. The recognition that improving nutrition is a multidimensional task points to the need for a comprehensive food systems approach involving multiple sectors, in order to create the policy, institutional, social and physical environments that are conducive to ensuring access by all people to nutritionally adequate diets. The overview of the regional picture, and the situation in individual countries, as well as the analysis of regional priorities, was an extremely valuable contribution to the preparation for the ICN2.

The aims of the Nutrition Knowledge Network meeting were:

- a) to discuss the development of a new generation of nutrition, physical activity and obesity prevention policies in Europe, which could be the basis of a third Food and Nutrition Action Plan for the Region;
- b) to discuss and review the progress made so far by all the 53 WHO European Member States in improving nutrition and physical activity, implementing policy actions and preventing obesity within the framework of the European Charter on Counteracting Obesity as well as of the Food and Nutrition Policy Action Plan 2007 – 2012;
- c) to discuss capacity building on surveillance, monitoring and policy development in the fields of nutrition, physical activity and obesity.

João Breda, Programme Manager for Nutrition, Physical Activity and Obesity at the WHO Regional Office for Europe welcomed participants and thanked the Israeli Ministry of Health for hosting the meeting. In total, 45 Member States were represented at the meeting.<sup>2</sup> In addition, key experts from the Region and representatives of other key partners, such as the European Commission, were invited to participate in the meeting to ensure robust discussions with a focus on evidence and progress on all aspects of diet and health. The meeting presented an opportunity for participants to learn from one

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<sup>1</sup> See Annex 1 for the meeting programme.

<sup>2</sup> See Annex 2 for a list of participants.

another's experiences and to be creative in finding new opportunities to work together for the health and well-being of the European population.

### *Challenges for nutrition and health in the 21<sup>st</sup> century*

To set the stage, prior to the first session of the meeting, Professor Philip James, from the London School of Hygiene and Tropical Medicine and the International Association for the Study of Obesity, presented an overview of the challenges for nutrition and health in the 21<sup>st</sup> century. Global burden of disease data show that five of the top ten risk factors for the global burden of disease are diet-related, and a sixth is physical inactivity. The multiple risk factors interact with and compound one another and other risk factors in complex causal webs to promote noncommunicable diseases, such as coronary heart disease, stroke and cancer. Evidence from various countries shows, however, that it is possible to reduce these risk factors, and that interventions that affect the food supply can be effective.

The falling energy needs that often accompany economic development and ageing populations, coupled with increasing intakes encouraged by greater availability of lower-cost, energy-dense foods, has led to increasing obesity. Furthermore, metabolic changes mean that considerable behavioural change is needed for those who lose a substantial amount of weight to be able to maintain the weight loss in the long term. Other environmental aspects – such as poor transport infrastructure and car-reliant societies – also contribute. In fact, obesity can be seen as a normal 'passive' response to our changed physical and food environment.

In a developing country context, these challenges are further compounded by epigenetics – whereby low birth weight babies fed inappropriate diets may have increased susceptibility to chronic disease. The impact of inappropriate Western diets on most of the world's susceptible populations places an enormous burden on health systems, and most of these systems are already overwhelmed.

The solutions require implementation of two complementary approaches. The first focusing on changes to the 'toxic' environment through policies to change the built environment, implement nutritional standards for public institutions, control marketing to children, selectively increase the prices of foods high in fat, sugar or salt (HFSS) or soft drinks and promotion, support and protection for breastfeeding. The second approach should tackle individual responsibility with education, clear labelling and support from health professionals.

In many ways the current obesity dilemma can be seen as being similar to climate change. It is the outcome of numerous societal developments and forces, and action is now essential as the problem is exceptionally difficult to reverse. Furthermore, like climate change, no single remedy will suffice and coordinated, central and local government, industrial, societal and individual changes are necessary. The changes required are major and action must be immediate – even if some logical approaches have yet to be proven.

## **Background and introductions**

The WHO Regional Office for Europe has a mandate to improve nutrition across the nutrition, through the European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007-2012. The broader context is the Health 2020 framework, which supports action across government and society for health and well-being, including strategic objectives to reduce health inequities and improve health governance.

The current global political focus on NCDs is important, as it links to a number of key areas in nutrition and physical activity, including maternal nutrition, breastfeeding and complementary feeding, childhood obesity, stunting and health-related behaviour in children. Three of the 'best buy'

approaches highlighted by the UN on NCDs relate to nutrition: reducing salt, replacing *trans* fats with unsaturated fats, and promoting public awareness about diet and physical activity. The European Ministerial Conference on Nutrition and NCDs, to take place later in 2013 in Vienna, Austria, would explore those links, provide an opportunity to revisit the commitments made on tackling obesity in Istanbul in 2006 and place nutrition high on the agenda.

Yaakov Litzman, Minister of Health, and Roni Gamzu, Director General for Health, from Israel explained some of the background and recent developments in relation to diet and health in the host country. NCDs are an important issue in Israel and diabetes has been identified as a particular problem which is being specifically targeted. Efforts are focusing on education, starting with investing in educating small children and a school-based healthy lifestyles programme. Misleading labelling has been identified as a contributing factor to the problem of diabetes. The Ministry of Health in Israel is investigating whether use of the misleading label 'No sugar added' can be prevented and replaced by labelling which indicates sugar content.

The Director General of the Ministry of Health in Israel recognized the challenges ahead and the key role that health promotion could play in addressing the current adverse trends. In Israel it is recognized that sedentary behaviour must be addressed and a number of relevant sectors – such as, for example, finance, education, health and transport – must be brought on board to be able to do so. Current crucial questions under discussion in Israel include:

- how to make healthy food more accessible,
- how to improve labelling,
- what should be taxed and what should be subsidized,
- the degree of regulation, as opposed to concentrating on educating and empowering the population.

Israel is inspired by strategies adopted by other countries with similar challenges. Partners have shown that collaboration is possible and is working.

## **Session 1: Situational analysis and challenges ahead in nutrition for Member States within the WHO European Region**

*Challenges ahead for nutrition in the WHO European Region – a focus on epidemiology and policy priorities*

Dr Breda highlighted the challenges ahead for nutrition in the European Region. First, there is the challenge posed by the growing contribution of poor nutrition to the overall burden of disease. Fifteen of the top 20 risk factors which account for the greatest proportion of the global burden of disease are related to nutrition and physical activity.<sup>3</sup>

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<sup>3</sup> Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H et al. (2012). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 380; 9859: 2224-2260. DOI: 10.1016/S0140-6736(12)61766-8

In the European Region, specifically, the estimated prevalence of overweight among adult males is 58.3%.<sup>4</sup> Overweight affects between one quarter to seven out of 10 individuals depending on the country, and obesity affects between five and 30 per cent of adults in the countries of the WHO European Region. Some countries also face the double burden of malnutrition. While 28% of women of reproductive age in Tajikistan, for example, are overweight, the country also has a prevalence of 30% of stunting and a problem with micronutrient deficiencies.

The second challenge is to improve the quality of the food supply. High levels of salt, saturated fat and *trans* fatty acids give cause for concern. It is important to be aware of the considerable differences in consumption levels both between and within countries. In relation to *trans* fats, for example, while the levels of industrially-produced *trans* fats in foods appear low in Western Europe, they remain high in eastern European Union countries.<sup>5</sup>

The scale of the problem in the European Region underscores the challenge, and the increasing importance, of getting good and reliable data from Member States. There is a need to improve national health reporting and for more work to be done regarding comparability of existing data. It is also important to improve the capacity to disaggregate data, particularly important for the monitoring of progress in tackling inequities.

Experience shows that progress is possible – some countries, for example, have successfully reduced the incidence of cardiovascular disease – and Member States can learn from one another’s experiences and the policies that have contributed to such success. A variety of policies are available to Member States, and a number of ‘best buys’ have been identified for accelerated results.<sup>6</sup> Currently implementation of the various policy options, however, is uneven across the region. The most commonly implemented approaches were provision of free or subsidized school fruit and the implementation of food-based dietary guidelines. Measures that affect food prices, in comparison, are the least frequently implemented. In the Commonwealth of Independent States (CIS) and Georgia, for example, no Member State has fully implemented measures to control marketing of food to children.

#### *The EU Strategy on nutrition, overweight and obesity related health issues*

Philippe Roux, from the European Commission’s DG SANCO, gave an overview of the EU Strategy on Nutrition, Overweight and Obesity-related Health Issues. WHO and the European Commission share the objective and vision to reduce overweight and obesity, with the Europe 2020 strategy as a tool to address health issues. The Commission is working to ensure consistency and cooperation between Member States across a range of relevant policies and to develop action involving different stakeholders, including food industry actors. To do this, it relies on the two key tools:

- The High Level Group for Nutrition and Physical Activity helps coordinate Member State initiatives and has worked on reducing salt and saturated fat levels. A report on the implementation of the EU Salt Reduction Framework was published in December 2012 and reported that 29 European countries have salt reduction initiatives in place.<sup>7</sup> The Group is also focused on the reduction of saturated fat, with a reduction benchmark of 5% in four years from 2012 and an additional 5% by 2020.

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<sup>4</sup> Source: *Global Health Observatory Data Repository. The World Health Statistics 2011*. Geneva, World Health Organization (<http://apps.who.int/ghodata/>).

<sup>5</sup> Stender S, Astrup A, Dyerberg J. A trans European Union difference in the decline in *trans* fatty acids in popular foods: a market basket investigation. *BMJ Open*. 2012; 2(5): e000859.

<sup>6</sup> World Health Organization. *Global status report on noncommunicable diseases 2010*. Geneva, 2011.

<sup>7</sup> European Commission Directorate General Health and Consumers. Survey on Member States’ implementation of the EU salt reduction framework. European Commission, 2012.

[http://ec.europa.eu/health/nutrition\\_physical\\_activity/docs/salt\\_report1\\_en.pdf](http://ec.europa.eu/health/nutrition_physical_activity/docs/salt_report1_en.pdf)



- The EU Platform for Action on Diet, Physical Activity and Health brings together other EU stakeholders to make commitments for action. In 2012, 33 active members of the Platform had 122 active commitments, including several which specifically focus on children.

In addition to numerous platform commitments, other Commission actions included:

- legislation on nutritional labelling and health claims regulations;
- DG Education and Culture has emphasised the health-enhancing dimension of physical activity;
- DG Connect has promoted the self regulation approach to restrict marketing to children (the audio-visual media directive);
- DG Research is funding research that ensures policymaking is better informed;
- the Joint Research Centre has developed a unit responsible for nutrition and is helping to set research priorities towards 2030 and 2050.

There are 24 Member States currently participating in the School Fruits Scheme, run by DG AGRI with a budget of €90 million, and more than 54,000 schools and 8.1 million children have participated since launching the scheme. Pilot projects, supported by European Parliament and implemented by DG SANCO, aim to increase consumption of fresh fruit and vegetables in local communities where household income is below 50% of EU 27 average, covering Romania, Slovakia and Bulgaria. A similar pilot project will be launched in 2014 covering Poland and Hungary. A third pilot project concerns promotion of healthy diets targeting pregnant women, children, as well as elderly people.

Action on food waste has shown a lot of potential savings and win-win opportunities with dissemination of information and exchange of good practices.

A joint WHO/European Commission monitoring project, established in 2008, has proven very successful in collecting and processing the most relevant information on nutrition, physical activity and obesity prevention from Member States. An independent evaluation of the Strategy to reduce overweight and obesity has been undertaken and the preliminary findings suggested some positive results.

During the discussion, there was a plea to make a clear distinction between health education and health promotion, and to recognise that the latter can be effective.

## **Session 2: Global developments and their impact in the WHO European Region**

It is important to take into account recent nutrition-related global developments, and their impact on the European region, as well as experiences from other countries outside Europe.

### *Global initiatives from WHO*

Kaia Engesveen, from the WHO headquarters Department of Nutrition for Health and Development (NHD), and Leo Nederveen of the Department of Prevention of Noncommunicable Diseases at WHO headquarters presented WHO's current global initiatives on nutrition and on noncommunicable diseases.

In May 2012, the World Health Assembly endorsed the Comprehensive Implementation Plan on maternal, infant and young child nutrition and six global nutrition targets to be achieved by 2025.<sup>8</sup>

The Plan sets out five high priority actions for Member States:

1. To create a supportive environment for the implementation of comprehensive food and nutrition policies;
2. To include all required effective health interventions with an impact on nutrition in plans for scaling up;
3. To stimulate the implementation of non-health interventions with an impact on nutrition;
4. To provide adequate human and financial resources for the implementation of health interventions with an impact on nutrition;
5. To monitor and evaluate the implementation of policies and programmes.

Globally, there is raised political awareness of the need to combat NCDs. The focus is on four diseases (heart disease and stroke, diabetes, cancer and chronic lung disease) and four risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol). These four diseases are no longer only a problem of rich developed countries but now cause of 80% deaths in low and middle income countries.

The UN High Level Meeting in New York in September 2011 succeeded in positioning NCDs as a challenge to development and as a problem requiring an intersectoral solution to which all sectors can contribute. The World Health Assembly in 2012 followed up by adopting a global target for a 25% reduction in premature mortality from noncommunicable diseases by 2025. A formal meeting later in 2012 agreed a Global Monitoring Framework, including 25 indicators and a set of nine voluntary global targets for prevention and control of NCDs. This Global Monitoring Framework was endorsed by WHO's Executive Board in January 2013.<sup>9</sup>

The nine voluntary NCD targets for 2025 listed below are directly related to indicators and involve many sectors:

- Premature mortality from NCDs – 25% reduction
- **Diabetes/obesity – 0% increase**
- Raised blood pressure – 25% reduction
- Tobacco use – 30% reduction
- **Salt/sodium intake – 30% reduction**
- Physical inactivity – 10% reduction
- Harmful use of alcohol – 10% reduction
- Essential NCD medicines and technologies – 80% coverage
- Drug therapy and counselling – 50% coverage

Two of the targets (highlighted in bold, above) are directly related to nutrition. A number of the indicators are also relevant to nutrition:

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<sup>8</sup> World Health Organization. Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition. Geneva: WHO, 2012. Available from: [http://www.who.int/nutrition/topics/WHA65.6\\_annex2\\_en.pdf](http://www.who.int/nutrition/topics/WHA65.6_annex2_en.pdf)

<sup>9</sup> Note: This has since been adopted by the World Health Assembly.

*Intake:* Salt intake, proportion of energy intake from saturated fatty acids, low consumption of fruits and vegetables of less than five servings/400 g;

*Biological:* Overweight and obesity in adolescents and adults, raised total cholesterol;

*Policy:* to limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, *trans* fatty acids, free sugars or salt.

WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases outlines the overarching principles and approaches through the life-course approach, based on best buys and evidence-based strategies. The goal is to reduce the burden of preventable morbidity and mortality due to NCDs. The six key objectives are:

1. To strengthen international cooperation and advocacy to raise the priority of NCDs in the development agenda and goals.
2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships.
3. To reduce exposure to modifiable risk factors for NCDs through creation of health promoting environments.
4. To strengthen and reorient health systems to address NCDs through people-centred health care and universal health coverage.
5. To promote and support national capacity for quality research and development for NCDs.
6. To monitor trends and determinants of NCDs and evaluate progress.

The Action Plan also sets out a series of aims for Member State policies and actions to promote a healthy diet. These include: promoting and supporting breastfeeding; measures directed at food producers and processors; measures directed at food retailers and caterers; ensuring provision of healthy food in all public institutions and in workplaces; consider use of taxes and subsidies; conduct public campaigns and social marketing initiatives; create health and nutrition promoting environments; implement Codex Alimentarius labelling standards, and implement WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children.

Other relevant initiatives by WHO headquarters include the updating of dietary goals, development of guiding principles and a methodological framework for nutrient profiling models, a manual on the development of food-based dietary guidelines, the nutrition-friendly schools initiative, the Electronic Library of Evidence for Nutrition Action (eLENA), the development of four diet and physical activity toolkits (data to action; childhood obesity; Surveillance, evaluation and monitoring, Awareness, Labelling, legislation and industry commitments, Tackling fortification (SALT); physical activity).

#### *Nutrition in the WHO European Region*

Trudy Wijnhoven and Caroline Bollars, from the WHO Regional Office for Europe, described the progress in nutritional status, nutrition and diet-related surveillance in the context of Health 2020 and the related 'best buys' for the improvement of health.

A key source of data is the European Childhood Obesity Surveillance Initiative (COSI). The COSI data have highlighted a number of key trends:

- Prevalence of overweight (including obesity) ranged from 19% to 49% among boys and from 18% to 43% among girls.
- There is a north-south gradient with the highest levels of overweight in southern European countries.
- Although some countries have seen a decrease in overweight and obesity, this is not consistent as data shows an increase in girls compared to boys.
- Examples from Italy and Portugal indicate that we should look for markers when looking at the data e.g., where prevalence is higher for inland compared to coastal areas.

The COSI data offers an evidence base to address the new needs in the public health arena and provides valuable data for addressing inequities. In the discussion during this session, some of the challenges in standardization of data collection for COSI were highlighted, such as, standardization of the measurement period which varies according to national schemes for child health checks. COSI is, however, an attempt to set up a system in Europe where we are comfortable with the comparisons available and attempts to harmonize groups are being evaluated.

Two key pieces of work fed into the European strategy, Health 2020. The first, Governance for health in the 21<sup>st</sup> Century by Ilona Kickbusch, pointed to the need for a whole-of-society and whole-of-government approach.<sup>10</sup> The second, the review on social determinants of health and the health divide in Europe led by Michael Marmot, emphasised the need to apply an equity lens to tackling problems.<sup>11</sup> Health 2020's two strategic objectives (governance and inequities), therefore, were, in turn, translated into four common policy priorities for health:

- to invest in health through a life-course approach and empower citizens;
- to tackle Europe's major disease burdens of noncommunicable and communicable diseases;
- to strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and
- to create supportive environments and resilient communities.

#### *Next steps for nutrition policy in WHO European Region*

In the coming two to three years, the intention is to go further with implementation in collaboration with Member States, to conduct more in-depth analyses of nutrition policy documents and identify best buys, to validate policy information, and to include information in WHO's Nutrition, Obesity, Physical Activity (NOPA) database.

The policy implementation toolkit is one of the ways to:

- quantify nutrition policy actions and compare with WHO's policy priorities;
- use the tool to assess country activity within their policy frameworks;
- use the assessment to obtain a regional overview.

Member States were requested to participate in the monitoring tool.

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<sup>10</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf)

<sup>11</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf)

*Evidence-based nutrition policies for NCDs: powerful, prompt, proper & profitable*

Simon Capewell, Professor of Clinical Epidemiology at the University of Liverpool, examined the evidence base for nutrition policies to prevent NCDs. Guidance from the UK's National Institute for Health and Clinical Excellence (NICE) on prevention of cardiovascular disease at population level advocated for policymakers to look critically at the evidence.<sup>12</sup>

There is a trend at regional level towards an obesogenic environment – with an abundance of fast food, snack foods and sugary drinks and where alternatives are often more expensive and difficult to purchase.

The WHO goals to reduce salt consumption by 30% and to reduce saturated fats and eliminate *trans* fats are ambitious but powerful goals. Member States should look carefully at the policy options available and consider their impact.

There are various different approaches and it is useful to compare, for example, implementation of voluntary versus regulatory measures in three areas:

**Salt reduction** – the UK has used a voluntary approach and achieved salt reduction from 9.5 g to 8.1 g per person per day. This should be seen in comparison to Finland, which has achieved much bigger effects using a regulatory approach, with a fall from 14 g to 8 g per person per day.

**Industrially-produced *trans* fats** – the UK's Food Standards Agency voluntary policies have had some success with a decrease from 2% to 1% of energy. In Denmark, in comparison, the introduction of regulations has reduced industrial *trans* fats from 4% to 0% of energy. This approach is now being followed by many other countries and jurisdictions, such as New York, Iceland, Sweden, Seattle, Canada, Austria and Switzerland. Evidence shows that reducing *trans* fats by 1% has major gains to public health.

**Saturated fats** – there have been some extraordinary success stories in reducing saturated fat consumption. In Poland, for example, removal of animal fat subsidies in 1992 had a powerful effect reducing coronary heart disease mortality and showed rapid benefits.

Cardiovascular disease (CVD) is a good marker to measure the impact of public health measures, as CVD death rates are dynamic and there is evidence of rapid effects in several countries. In addition, a population-based approach to CVD prevention is equitable, and may narrow the inequalities gap while high-risk strategies to screen and treat individuals typically widen social inequalities. Furthermore, population-based approaches are cost-effective and actions that consistently save money are of great interest to ministries of finance – this can be instrumental in gaining support from other sectors.

The review of evidence on CVD prevention for the 2010 NICE guidance found that the evidence base – through meta-analyses and natural experiments – is surprisingly strong for a population-based approach. There is a lot of support for policies to protect people (by, for example, removing *trans* fats from food), and there is evidence that these are cost saving, rapid, equitable and acceptable. The question remains, therefore, as to why such policies are not implemented. The core problem is opposition from industry sectors, such as the food and tobacco industries. To counter this, governments must use the levers available to them – in nutrition there are good arguments and powerful tools in terms of legislation, regulation, taxes and subsidies. The choice is between public health, our health and that of our children, or profit for the industry.

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<sup>12</sup> NICE. Prevention of cardiovascular disease at population level. NICE public health programme guidance 25. June 2010. Available from: [www.nice.org.uk/guidance/PH25](http://www.nice.org.uk/guidance/PH25)

During the discussion, concern was expressed about the failure to confront food industry interests. The value of a partnership approach between government and industry was questioned. The food industry is very powerful and there are many political compromises. It was also argued, however, that it is important to find ways to work with industry and to not always be in opposition. Over half (51%) of the turnover of Europe's food and drink industry is from small and medium enterprises (SMEs) – policymakers should consider how to support SMEs.<sup>13</sup>

In terms of regulation, at the sub-national level there have been many attempts. There is a large body of literature showing that voluntary approaches are weak, ineffective and delay implementation. The example of tobacco control was cited, whereby voluntary industry initiatives were implemented to no effect until regulation came in to place. For leadership on this issue, EU Member States should not necessarily look to the Commission, but can look to WHO, through Health 2020, and to particular individual countries.

The discussion also evoked the issue of the economic crisis, which has consequences for consumer behaviour and, therefore, should be taken into account – as an important element of the context – when developing nutrition policies.

There was further discussion of the role of economic tools, such as taxes and subsidies. There was recognition that taxes are a powerful tool and that there are success stories. Again, the example of tobacco was cited, where taxation has been successful where taxes have been raised considerably. One approach could be to cut taxes on healthy foods. It is important to learn and share experiences regarding taxation and subsidies – reductions in the cost of healthy foods, for example, can be subsidized through taxes on unhealthy foods.

The issue of promoting local and traditional foods was also raised, with a call to move towards more local produce.

## **Session 3: Country examples of recent developments in the WHO European Region**

A number of examples of recent developments, from different Member States within the region, were highlighted, with a particular focus on policy areas relevant to the WHO Second Food and Nutrition Action Plan.

### *Israel – working together to improve nutrition*

Ruth Weinstein, Director of the Department of Health Promotion in the Israeli Ministry of Health, described the experience in Israel of working together to improve nutrition. For the past four years, ministries in Israel have worked together to inform each other of activities and the ministry Director Generals (DGs) and Ministers have been on board with this process. Israel's experience suggests that implementation of inter-ministerial cooperation should start at mid-level rather than at the top of the hierarchies. The cooperation has included coordinating activities, working together and pooling resources.

In Israel, the major risk factors and morbidity are related to NCDs, and the relation between socioeconomic status and morbidity is clear. Israel has one of the highest rates for prevalence of childhood obesity and for consumption of sugary drinks. A national programme to promote active

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<sup>13</sup> <http://www.fooddrinkeurope.eu/industry-in-focus/topic/small-and-medium-sized-enterprises-smes/working-on-behalf-of-smes/>

healthy lifestyle was signed in December 2011. The vision is to foster an environment for the population of Israel to integrate physical activity into daily life, to make healthy choices the easy choice and to use fiscal policies to regulate consumption of healthy and unhealthy foods. Legislation will be used to support these goals. One of the policies relates to introduction of clear, simplified, front of package food labelling.

Currently, there is a pilot project putting all efforts into 25 municipalities divided between Arab and Jewish municipalities. There are tailor-made actions for each municipality, using an expert in social marketing in each one. Knowledge and capacity building are increased through seminars and health promotion takes place in formal and informal educational settings, including parenting skills for better health. There is an emphasis on participatory social marketing – a need to be more present in social media and build capacity. Another tool being used is to incentivize health maintenance organizations by giving them more money if they make health-promoting choices.

The collaboration revealed that there are many good databases and surveys, but that these are not connected. Work is underway to obtain an overall perspective on what is lacking. This has emphasized that there is room for other stakeholders to be involved.

#### *Albania – A participatory process to develop a new Food and Nutrition Action Plan*

Pellumb Piperi described the participatory process used in Albania to develop a new food and nutrition action plan. NCDs account for 89% of all deaths in Albania (59% attributable to CVD and 18% to cancer). Regarding food security there is a steady increase in agriculture and agro-industrial production. There have been decreases in child stunting, wasting and underweight. To address these issues, Albania has developed a new Food and Nutrition Action Plan.

Health and health care are considered as multisectoral responsibilities and a whole-of-government approach was applied. The participatory approach involved a large working group, with the participation of five ministries led by the Ministry of Health. There was also comprehensive participation at the local level.

The cooperation between several ministries was important for implementation, and using expertise of partners was one way of increasing the human resources available.

#### *Tajikistan – Nutrition and Food Safety Strategy*

Khotambeg Khayrov, from the Nutrition Centre in the Ministry of Health in Tajikistan, described the nutrition and food safety strategy developed for Tajikistan. Currently, 59% of mortality is related to NCDs. Despite the decline in poverty, there are still significant levels of poverty and areas of food insecurity. Ten per cent of children suffer from acute malnutrition, 28% of children are stunted and iron and iodine deficiencies remain a serious problem in the country.

An intersectoral working group was established to address these issues. The priorities were:

- strengthening capacity (development of personnel)
- improving infant and young child feeding
- strengthening intersectoral cooperation
- developing school nutrition
- developing a set of initiatives to address diet-related NCDs
- ensuring gender issues are integrated.

The Nutrition and Food Safety Strategy has now been ratified and the prime minister chairs the coordination mechanism (the Food Security Council), reflecting the importance attributed to the issue. All sectors of government are involved.

*Norway – Evaluation of the Norwegian nutrition policy with a focus on the Action Plan on Nutrition (2007-2011)*

Bodil Blaker, from the Ministry of Health and Care Services in Norway, described an evaluation of Norwegian nutrition policy, which was first developed in 1976, focusing particularly on the Action Plan on Nutrition, 2007-2011. Twelve ministries agreed upon the action plan, which was launched in January 2007, mainly under the responsibility of the Ministry of Health. The vision of the action plan was for better public health through a healthy diet and the focus was on primary prevention and children. It detailed 73 measures in 10 focus areas. The green keyhole labelling scheme was an important measure, introduced in cooperation with other Nordic countries. This was facilitated through close and effective cooperation with industry. A free cookbook with basic recipes was given to children in school; it also proved popular with adults. A project to increase consumption of fish among children was introduced and free fruit was provided in schools for children (Grades 1 -10).

In 2011, as the action plan was coming to an end, only two of 73 measures had not been implemented. There were measurable changes in diet between 2005 and 2011, including an increase in consumption of fruit and vegetables, berries, fish for dinner three times a week etc. WHO evaluated the Action Plan at the request of Norway and has published a report.<sup>14</sup>

The evaluation concluded that the Action Plan was considered to be a useful tool by both authorities and other stakeholders. In a series of recommendations, the evaluation recognised a need for:

- continued cross-sectoral cooperation and stronger ownership in sectors other than health;
- more focus on social inequality and priority to vulnerable groups;
- increased competence among consumers/strengthened communication;
- capacity building in the health sector and implementation of formal procedures;
- increased effort at the local level and better coordination between national/regional and local levels;
- better monitoring and evaluation data;
- an earmarked budget for nutrition activities.

The next steps are for Norwegian policymakers to consider the findings of WHO. The Directorate of Health has developed a report with recommendations to the Minister of Health based on the WHO report and a new white paper on an Interdepartmental Strategy on Public Health is under development. A national salt strategy will be implemented and a project on marketing of unhealthy foods and beverages to children is a focus of current work.

Engagement with the food industry has been successful, and the nutrition authorities in Norway have cooperated with the food industry for many years. This cooperation has taken the form of, for example, dialogue at an annual meeting with industry about what action industry is requested to take. The cooperation on keyhole labelling of products was successful, while the industry is following the

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<sup>14</sup> World Health Organization Regional Office for Europe. Evaluation of the Norwegian nutrition policy with a focus on the Action Plan on Nutrition 2007 – 2011. Copenhagen: WHO; 2013.



arguments closely on salt reduction. The industry is not in a position to decide what is healthy or healthy, but cooperation is possible when there is a very clear division of roles.

#### *Malta – Developing the Food and Nutrition Policy and Action Plan for Malta (2013-2020)*

Lucienne Pace described the process of developing the Food and Nutrition Policy and Action Plan for Malta (2013-2020).

Overweight and obesity are increasing in Malta – with 22% of adults aged 15 year or over obese and a further 36% overweight, prevalence is above the EU average. NCDs are responsible for 82% of deaths in Malta. The country has low consumption of vegetables, and increasing daily sugary drinks intakes among youth and adults. In Malta, therefore, there was a need to revise the existing strategy and develop an action plan.

The Biennial Collaborative Agreement between WHO and Malta made it possible to initiate the project for a new policy and action plan in 2012. There have been a series of multisectoral meetings over several months with WHO and involving many different sectors. The vision of the Food and Nutrition Policy and Action Plan is to promote better dietary habits to maximise health, and to address the main public health challenges associated with diet-related NCDs.

A think tank session was organised to identify the action areas for promoting healthy eating. There was also a two-day workshop on setting priorities to promote healthy eating and physical activity in a multisectoral setting. Using the ANGELO framework, the process identified barriers and benefits for other sectors, and 10 priority action areas were defined.

#### *Austria – How to make nutrition policy a success*

Petra Lehner presented Austria's experience in developing nutrition action plans. In developing the first Nutrition Action Plan in 2010, Austria did not reinvent a plan from scratch but adapted something that had already been developed and give it an Austrian flavour. The Action Plan specifies targets and how to reach them, and was approved by the Council of Ministers. The main objective is to decrease the prevalence of diet-related diseases and/or corresponding determinants, and to at least halt the increase of overweight and obesity by 2020.

The Nutrition Action Plan is embedded in, and linked to, other Ministry of Health strategies (Austrian Health Targets, Austrian Action Plan to Enhance Physical Activity, Austrian Childhood Health Dialogue). An appendix with documents makes it possible for local regions to implement what others have already done.

The Action Plan considers a mix of measures which are culturally appropriate and reach people in the places in which they play, work, live, etc. Food labelling legislation has also been enhanced, to require mandatory labelling in order to ensure consumers are better informed. Other actions include legislation (e.g., regulation on *trans* fatty acids), contracts (e.g., contracts with bakers for a 15% reduction in salt content by 2015), economic interventions (e.g., standards for school tuck shops and free support for implementation of the voluntary standard provided to nearly a third of shops affecting 170,000 children; school fruit and school milk programmes), and introduction of new services (e.g., nutrition counselling for pregnant women by health insurance funds on the basis of a new national standard for maternal and infant nutrition). There have also been media campaigns and provision of basic information about balanced diet.

The next steps include connecting the Action Plan to the strategies of other Ministries. There is, for example, a window of opportunity to get involvement of Ministry of Agriculture. There is a need to convince other stakeholders of the widespread benefits of implementing this agenda.

In conclusion, it can be said that measures and policies need to be both carefully planned and evidence based. They also need to tackle specific environments and be linked to other policies.

In the discussion following the country examples, political commitment was singled out as being the most important factor in achieving action plan goals. This entails commitment from three to four ministers to achieving success. It is important to identify and spell out wins for the all ministers involved.

In Norway, the regulation on marketing to children has now been revised in response to comments received. Politicians now have to decide whether to issue a new proposal for further consultation. The food industry is arguing that it can implement self-regulation that is stronger than proposed legislation by policymakers.<sup>15</sup>

## **Paving the way for a new WHO European Region Nutrition Policy Framework**

João Breda, of the WHO Regional Office for Europe, set out the case for, and process of, developing, a new food and nutrition action plan for Europe. This process is driven by a vision of a health-promoting Europe which is free from preventable disease and the impact of diet-related NCDs, undernutrition and micronutrient deficiencies, premature death and avoidable disability at every age, and in which those diseases and deficiencies are no longer a barrier to socioeconomic development.

The mission of a new food and nutrition action plan is to guarantee universal access to food, equity and gender equality for the nutrition of all citizens of the WHO European Region through intersectoral nutrition policies.

Any action plan will be underpinned by overarching principles and approaches:

- human rights: right to food;
- diet-related NCDs, undernutrition and micronutrient deficiencies are a challenge to social and economic development;
- universal access, equity and gender equality;
- life-course approach;
- evidence-based strategies;
- empowerment of people and communities.

The goal is to avoid premature death and significantly reduce the burden of preventable diet-related NCDs, undernutrition and micronutrient deficiencies by taking integrated action, improving the nutrition-related quality of life and making healthy life expectancy more equitable within and between Member States. Four key objectives were proposed to help the new action plan achieve this overall goal.

The process of developing the action plan is only beginning, with the setting out of these general principles and objectives. The technical consultation will take place during the present meeting in Tel Aviv. Stakeholder and political consultations would follow, according to WHO rules, and these would be mainly web-based consultations. The next steps for the document would be to go forward to the

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<sup>15</sup> A government-monitored self-regulation system has since been adopted.

Standing Committee of the Regional Committee (SCRC) of the WHO Regional Office for Europe the following week and then to a Ministerial Conference in Vienna in July.

The meeting was invited to split into three working groups to consider specific aspects of the draft Food and Nutrition Action Plan – including the strategic dimensions, priorities, indicators and targets – and were asked to consider six specific questions.

## **Session 4: Public health innovative approaches to promote healthy nutrition; prevent and tackle NCDs**

### *Early nutrition and later NCDs*

Trudy Wijnhoven, of the WHO Regional Office for Europe, discussed the links between early nutrition – preconception, pregnancy and infant feeding – and the development of NCDs. Studies suggest that obesity and NCDs may be programmed in foetal and early postnatal life and that this is particularly determined by maternal nutritional status before, during and after pregnancy. A large evidence base has been established, suggesting that there are direct consequential effects of maternal nutritional status on adult offspring's overall health and that birth weight and intrauterine growth restriction serve as strong indirect markers. Intrauterine growth restriction, or retardation, leads often to low birth weight and, consequentially, has an influence on the development of, for example, type II diabetes, central adiposity, obesity, hypertension, and cardiovascular disease later in life.

On the other hand, several studies, in varying populations report on a decreasing incidence of diabetes mellitus type II with an increase in birth weight.

Obesity before and after conception is suggested to increase almost all pregnancy complications including for instance gestational hypertension, preeclampsia, gestational diabetes mellitus and delivery of large-for-gestational-age infants.

An analysis of data from on-going early childhood growth studies at the University of Oklahoma showed that maternal pre-pregnancy BMI was positively associated with offspring lean body mass at one year of age with a possibility of adiposity tracking across childhood and further into adolescence and adulthood.

Excess maternal weight gain during pregnancy increases the risk of multiple maternal and neonatal short-and long-term complications and may increase the risk of developing childhood, adolescent and adult obesity. A number of studies suggest that rapid weight gain in very early infancy predisposes to obesity and NCDs in later life. However, it is not clear whether the risk is due to a rapid increase of lean body mass, or excessive acquisition of fat mass, or the increased percentage of body fat, or all together.

In relation to infant feeding, protein is the most studied nutrient as related to NCDs in early age. Infant formulas still have higher protein content than human milk, due to the need to meet amino acid requirements since the protein in formula is not perfectly similar to the amino acids pattern present in human milk. At the moment is not clear whether the overweight/obesity development is facilitated only by an excessive intake of protein in the complementary feeding period, or whether the risk is favoured by specific amino acids.

In infants under two years there is little evidence for correlations between fat intake and body weight, fatness or later obesity. After two years of age positive correlations between dietary fat intakes and adiposity are more likely. An area that should be better investigated is the role of the quality of fatty acids in the young infant's diet as risk factor of NCDs development.

The roles of carbohydrate quality and quantity in the complementary feeding diet are unclear. Taste for sweet foods develops in early life and can be influenced by experience over time. Discouraging sweetened drinks in the weaning diet, reducing unnecessary sucrose in commercial products and avoiding sucrose added to foods in the home are possible approaches to reduce possible markers (such as obesity) for NCDs later in life.

The breastfed infant has a low sodium intake which changes significantly with the introduction of complementary feeding. Studies suggest that infants fed low salt diets have significantly lower systolic and diastolic blood pressures at the age of six months and fifteen years later when compared with controls fed random weaning diets. Unnecessary salt intakes in early life should therefore be discouraged, since high salt intakes in adult life are associated with increased cardiovascular problems, most notably high blood pressure.

It is important to stress the difficulty of evaluating the impact of early feeding on development of later disease because of many confounding issues, even though some research findings do suggest that early nutrition could be highly significant for later NCD risk.

#### *Possible strategies to substantially reduce undernutrition including micronutrient deficiencies*

Vilma Tyler, from UNICEF, described the double burden of malnutrition in central and eastern Europe and the newly-independent states (NIS). Optimising infant and young child feeding is an important strategy and improving complementary feeding is the most cost-effective intervention for achieving proper growth.

UNICEF is implementing strategies for improving exclusive breastfeeding. These include the development of national legislation to give force to the International Code of Marketing of Breast-milk Substitutes, the Baby Friendly Hospital Initiative and provision of counselling and support by primary healthcare services and community health workers. Other strategies include mother-to-mother support groups and evidence-based communication strategies to address knowledge gaps in the community.

Strategies to specifically improve complementary feeding include: counselling on infant and young child feeding; behaviour change communication; improving the availability and affordability of local foods; and, involving mothers in creating and testing recipes for complementary foods. Sometimes it is necessary to supplement the diet with alternative sources, such as fortified foods, to fill nutrition gaps. Home visits are used to strengthen communication to promote behaviour change and to increase awareness of available services. There are also strategies to improve micronutrient status and to improve infant and young child feeding during emergencies. Although these strategies focus on undernutrition, it is also important to address the early causes of obesity, especially in vulnerable groups.

A particular problem with a lack of data on vitamin D was highlighted. UNICEF is working closely with governments on data collection.

#### *Marketing of foods and non-alcoholic beverages to children*

Jane Landon, from the National Heart Forum in the UK<sup>16</sup>, outlined the situation in relation to marketing of foods and non-alcoholic beverages to children. Children's exposure to food and drink marketing is increasing and intensifying with new emerging channels. Television is still important but marketing is moving into mobile and interactive media, and regulatory approaches are not keeping pace with the dynamic marketing environment.

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<sup>16</sup> Now known as the UK Health Forum

The internet has emerged as an important marketing channel and there has been a considerable increase in access to the internet across the region. There has been a huge increase in early ownership of mobile phones/smartphones, and this can subvert parental control and expose children to social media at early ages. In the UK, for example, it is estimated that a third of children aged between eight and 12 years of age are active on social networking sites.<sup>17</sup>

Marketers of food and drink are well aware of how to use social media to reach young people. Techniques to market food and beverages to children include advergames, sponsorship, direct marketing, product placement and branding, viral marketing, online advertising, etc. These all give exposure to brands, embedding the ideas of fun and food. Consequently, children are surrounded by advertising for fast food and soft drinks.

A new update from the WHO Regional Office on the marketing of foods high in fat, salt and sugar to children<sup>18</sup> covers these changes in the marketing environment. It also covers developments in policy responses and reviews the latest research on the relationship between marketing and dietary behaviour.

Marketing is often used to build brand awareness and consumer loyalty. It is difficult to disaggregate the influence of advertising on children from other exposure and, thus, to document its impact. There are also examples of how social media has been used to market healthy foods. However, those producers do not have the same level of resources for campaigns as the producers of processed foods.

#### *Price policies to promote healthy nutrition*

Sinne Smed and Jørgen Dejmård Jensen, from the University of Copenhagen, presented a case study on the Danish experience of introducing a tax on saturated fat.

Following some preliminary studies and modelling, a number of ‘health taxes’ were agreed as part of the general tax reforms in 2010. These includes increased taxation on products high in added sugar, ice-cream and sugar-sweetened beverages. The tax on saturated fat was approved in the Danish parliament in March 2011. The tax was paid on the weight of saturated fat in foods and used in the production of foods with saturated fat contents above 2.3 g per 100 g at a rate equivalent to €2.15 per kg of saturated fat. Drinking milk was exempt.

The preliminary estimates of the effect of the Danish fat tax suggest a large decrease in consumption of oils and fats (10-20%). There was hoarding prior to the introduction of the fat tax and this needs to be taken into account. The tax does seem to have affected consumption, at least in the short term. Assessments of the impact of the tax on the whole diet are underway.

Retailers used the tax as a window of opportunity to adjust price structures, product sizing and marketing. Discount stores used the introduction of the tax as an opportunity to increase price margins to boost profits.

The fat tax did generate revenues – generating about €160 M in revenue for the government annually, equivalent to about €72 per household per year.

There was, however, high political resistance from the food industry and the measure was unpopular with consumers. In November 2012, the parliament abolished the fat tax and the extension of the sugar tax. The food industry was active in highlighting cross-border trade and convincing the public

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<sup>17</sup> UK Ofcom 2011. Children and parents: media use and attitudes report.

<sup>18</sup> World Health Organization Regional Office for Europe. *Marketing of foods high in fat, salt and sugar to children: update 2012-2013*. Copenhagen: WHO; 2013.

that this was a significant problem. This played into political fears of job losses. The food industry also put the case that the costs of administering the tax were prohibitive.

There are some important issues to consider in implementing taxes. Firstly, it is important that the cost burden is not solely put on the consumer. The impact on low-income groups will depend on the substitution effects, according to what alternatives are available. There can be adverse side effects from taxes, but there are ways to control these with careful planning and consideration.

There are a number of market, administrative and political challenges to the use of economic instruments. Different dietary patterns in various countries mean that dietary regulation is needed to a differing degree – countries with higher consumption levels have greater potential for reduction. The current pricing structure also plays a role – higher current prices reduce the impact of taxes – as do the price elasticities of affected products. There is a need for a meta-analysis of food price elasticities across Europe to assess the viability of food taxation. The risk of a regressive effect of food taxation depends on the degree of income inequality and the budget share of taxed foods in low-income households.

It can be concluded that price instruments may have the potential to promote healthy diets internationally. Differences between countries need to be taken into account, as these can impact on the suitability of food taxation schemes at the European level.

Éva Martos, from the National Institute for Food and Nutrition Science in Hungary, described Hungary's experience in using price policies to promote healthy nutrition. A public health product tax was introduced in September 2011 (and has since been amended five times). The tax was based on the sugar, salt and methylxanthine content of pre-packed foods which have healthier alternatives, e.g. sugar-sweetened drinks, energy drinks, salty snacks, condiments, sweets, ice cream, alcopops, etc.

A preliminary impact assessment studied public awareness and opinion on the tax, the changes in consumption of taxable products and the opinions of affected producers on the impact of the tax. The study found that two-thirds of the population were aware of the tax and the proportion of consumers who decreased consumption ranged from 25% to 32%, depending on the product. For most people (from 61% to 81% depending on the product) the reason for changing their behaviour was the price increase, but becoming aware of the product's adverse effects on health was also commonly cited (from 19% to 38%).

Energy drinks pose a serious health risk to children in Hungary; where over 30% of students (10 -14 years old) in low socio-economic groups have energy drinks for breakfast. Almost all of the energy drinks were expected to be taxable under the Act, but manufacturers responded quickly by changing the product formulation to avoid taxation. New ingredients were introduced and some existing ingredients removed, and only 33% of products were taxable. This resulted in dangerous new products being placed on the market. The definition of products to be taxed has now been modified and the tax rate applied from January 2013.

The tax has succeeded in meeting the fiscal target and there has been discussion within government on how the generated revenue will be used – it may be used to increase health workers' salaries.

#### *Nutritional profiling to prevent NCD*

Mike Rayner, from the British Heart Foundation Health Promotion Research Group at Oxford University, outlined how nutrient profiling can be used to prevent noncommunicable diseases.

Nutrient profiles are used as the basis for classifying foods as healthy or unhealthy, based on the principle that the healthiness of foods impacts on the healthiness of a diet which, in turn, impacts on health. WHO defines nutrient profiling as “the science of classifying or ranking foods according to

their nutritional composition for reasons related to preventing disease and promoting health” and has developed a catalogue of nutrient profile models.<sup>19</sup> The catalogue identified 119 models, of which 54 met the inclusion criteria and only 19 have been validated in any way. It has also developed some guiding principles and a manual on planning, developing and adapting, validating, implementing, monitoring and evaluating a nutrient profile model.

Different models exist and there are variations on how different foods are classified according to various models. Development of a common nutrient profile model for regulating the market of foods and non-alcoholic beverages to children in the WHO European Region is underway.

#### *Improving nutrition capacity within the health sector*

Barrie Margetts, from the World Public Health Nutrition Association, addressed how to improve nutrition capacity within the health sector. Europe’s Health 2020 strategy recognises the challenges and importance of a skilled and sustainable workforce, but gives little detail about what this means and how it can be achieved.

Action plans and policies need strategic investment in capacity building for implementation. Workforce development is a central pillar of capacity building, but this needs to be accompanied by investment in other forms of development (leadership, organizational, community, etc.). The emphasis should be on developing professional practitioners to work on the ground, and nutrition specialization and professionalization of the workforce is needed. It is unrealistic, and reflects a lack of appreciation of the skills required, to think that existing primary healthcare workers can also cover nutrition.

It is important to build the evidence base on effective interventions and to develop systems to integrate and network academic capacity internationally.

In the short term, in-service training is needed for existing staff to be able to deliver immediate specific interventions. In the medium term, agreement is needed on roles and job descriptions for existing nutrition practitioners, and workforce planning for future needs should be carried out. In the long term, organizational structures and systems need to be developed, along with pre-service training, revision of training curricula, etc.

#### *Action on saturated and trans fat*

Philip James, of the International Association for the Study of Obesity, outlined the evidence on the relationship between saturated fat, *trans* fats and cardiovascular disease and presented some approaches for reducing intakes. Studies clearly show the relationship between blood cholesterol levels and coronary heart disease mortality, and volunteer studies show that saturated fat and dietary cholesterol raise blood cholesterol levels, although there is considerable individual variation, probably genetic, in response. This combination of metabolic epidemiology and volunteer feeding studies clearly demonstrates the effect of saturated fats on cardiovascular disease (and the causal pathway) in a way that is more difficult for cohort studies alone.

Taking Finland as an example, examination of the factors contributing to the 25-year decline in serum cholesterol in the country found that reducing saturated fat intakes did play the principal role, especially initially, and that the more marked decline observed later was due to a combination of dietary changes and use of lipid-lowering drugs.<sup>20</sup>

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<sup>19</sup> World Health Organization. Catalogue of nutrient profile models. Draft 4 March 2013.

<sup>20</sup> Valsta LM, Tapanainen H, Sundvall J, Laatikainen T, Pietinen P, Vartiainen E. Explaining the 25 year decline of serum cholesterol by dietary changes and the use of lipid lowering medication in Finland. *Public Health Nutrition*. 2010;13(6A):932-938. doi: 10.1017/S1368980010001126.

There are a number of different approaches to removing *trans* fats from national diets. These include, compulsory removal from the food chain as implemented, for example, in Denmark, Austria, Switzerland and New York City. Other approaches are voluntary, as in the UK – although it is recognised that such voluntary measures may have little impact on disadvantaged groups with particularly high intakes. Other measures to consider include limiting *trans* fats to less than 2% in oils, soft margarines and in food service establishments. Care is also needed to ensure that appropriate fats are used to substitute for the *trans* fats – avoiding substitution, for example, with palm oil or ghee.

There are various types of interaction with industry that may be appropriate to help eliminate *trans* fats and bring about a very marked reduction in saturated fat intakes. Examples include working with all government supported institutions to progressively change the food they provide, or involving big non-food companies to serve only healthy food in their staff restaurants. Such changes could start to impact on market forces (i.e., by creating demand and encouraging supply for fruit and vegetables). In addition, many major established food companies already publicly accept the value of coordinated progressive, time-specified, regulation for reformulation.

There are, however, a number of key factors to bear in mind. Scientific and policy analysis must remain clear of potential conflict of interests. Compulsory legislation may be required to keep marketers under control; voluntary measures are less successful. Development of novel governmental/non-governmental types of collaboration, with transparent rules of engagement, are also advisable.

Morten Andersen, of the Danish Veterinary and Food Administration, presented some case studies of initiatives on *trans* fatty acids and saturated fat in Denmark. In fact, Denmark was the first country in the world to have adopted legislation on the industrial use of *trans* fatty acids in foods, with legislation which has applied since January 2004. The Danish legislation sets a maximum level of 2 g per 100 g of fat or oil intended for food, and only applies to industrially-processed *trans* fatty acids. Food producers have largely respected the legislation and no major sanctions have been necessary. The industry has not indicated any problems in adjusting to the legislation. Since the introduction of the legislation, survey results have shown that the level of industrially-produced *trans* fats has gradually declined and the observed transgressions of the legislation have been marginal.

In relation to the saturated fat tax referred to previously (see *Price policies to promote healthy nutrition*), the expected annual revenues from the tax were €201.7 million and the tax was expected to reduce saturated fat consumption by 4%. The registered impact was described as an unspecified increase in tax revenue, an increase in border trade and subsequent job losses in Denmark, inflation of food prices in retail outlets, a shift towards lower-cost alternatives and an undocumented effect on public health and consumer habits. The abolition of the tax was due largely to the heated political debate following increased border trade and subsequent reported job losses.<sup>21</sup>

### *Salt and iodine*

Joop van Raaij, from the National Institute for Public Health and the Environment (RIVM) in the Netherlands, described the Dutch experience in relation to salt and iodine.

Prevention of iodine deficiency is a global public health issue and iodine deficiency is also prevalent in Europe. The main intervention strategy is universal iodization of salt. However, current salt intakes

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<sup>21</sup> For a detailed description of the Danish fat tax experience see the 2014 publication by the WHO Regional Office for Europe, *Using price policies to promote healthier diets*. This reports a data analysis that suggests that in the short-term consumption of some products subject to the tax dropped by 10-15%, along with a decrease in packet or portion sizes for butter and chocolate. Given the short duration of the policy, however, it is not possible to determine whether such decreases would have been sustained in the longer term.



are too high and there are many initiatives underway to reduce salt intakes. The consequences for iodine intake are not always mapped out.

A simulation tool was developed to estimate habitual iodine intake and to predict the effect of salt reduction strategies or changes in iodine policies or fortification practices on iodine intake. The tool used a number of information sources, including food consumption data, food composition data and information on national iodine policy and practices. The tool enables scenarios to be mapped in which both the risk in inadequate intakes and the risk of excessive intakes might be low.

The Dutch simulation tool could be made more generic and would, therefore be appropriate for use in other countries, depending on the availability of data. Other programmes currently available (e.g., WHO Intake Monitoring, Assessment and Planning Program) do not take into account discretionary use. A generic simulation tool specific to iodine would, therefore, seem to be useful.

Liliane Bruggmann, from the Swiss Federal Office of Public Health, described the experience in Switzerland on reformulation. Issues to be considered in developing a broad reformulation strategy include whether you are interested in reducing portion sizes of food or calorie reductions. The Swiss approach is to concentrate reformulation efforts on salt and *trans* fat, and action on portion size is voluntary. Monitoring of reformulation shows a small amount of progress has been made. Legislation will not, therefore, be proposed but the next report on monitoring reformulation will be critical for the next steps.

#### *Forecasting obesity trends and obesity's NCD impact in the WHO European Region*

Tim Marsh, from the National Heart Forum in the UK, described some modelling work to forecast obesity trends across Europe. Prevalence of overweight and obesity in 2030 across the Region was predicted. The projects show that although some countries show decreases in future obesity levels, the levels of pre-obesity in these countries are often projected to increase rapidly.

A computer model also enabled simulation in 53 countries to compare the impact and cost of various public health interventions in different case scenarios. The impact of an 11% and a 5% reduction in obesity on the incidence and prevalence of various NCDs was estimated. The question was raised as to whether it would be possible to model the impact of interventions at different points in the life-course to assess which would have greatest efficiency. In theory this could be done, but it would require more time and resources.

There is a clear need for more data, for countries to collect data disaggregated by socioeconomic groups and for data checking at the national level.

#### *European Commission research activities in the fields of nutrition and health*

Sandra Caldeira, from the European Commission's Joint Research Centre in the Institute for Health and Consumer Protection, described activities relevant to nutrition and health. On work in defining future scenarios, experts identified food prices and societal values as main drivers. A project on innovative ways of tackling obesity is looking at ways of using information, communication and technology (ICT). In relation to developing incentives for young people to engage in physical activity, for example, the project is examining whether individual rewards work better than team or peer rewards.

The Nutrition team at the Institute for Health and Consumer Protection of the European Commission works with four key projects:

- *trans* fatty acids exposure in the EU
- school meals and environments

- dietary cancer prevention
- sustainability and food waste.

At the end of the morning's proceedings, João Breda summed up the evidence and considered the implications for establishing priorities.

## **Session 5: Updates from the WHO European Region Action Networks, and the WHO Collaborating Centres for Nutrition**

A series of speakers presented updates from relevant Action Networks and Collaborating Centres across the Region.

### *WHO European Childhood Obesity Surveillance Initiative (COSI)*

Ana Rito, from the National Institute of Health in Portugal, gave an update on WHO's Childhood Obesity Surveillance Initiative (COSI). The initiative was introduced to meet the need for a harmonized surveillance system among primary school children on which to base policy development within the European Region.

The first data collection took place during the 2007/2008 school year and, with coverage of 170,000 children aged between 6.0 and 9.9 years, COSI is one of largest studies in Europe. The 22 participating countries are led by a WHO team and by teams at the national level. Each country is responsible for financing its own data collection. WHO is responsible for developing the protocol, and each country signs a cooperation arrangement with WHO specifying core and optional activities.

Although each country is free to develop a system within its own particular context, data must be collected according to a common agreed protocol containing core items. The intention is not to replace countries' existing surveillance systems, but rather to integrate this surveillance within them.

### *Action network on reducing salt intake*

The Action Network of the Member States in the WHO European Region on reducing salt intake in the population is led by Switzerland and has membership of 23 countries, with the European Commission and WHO Regional Office for Europe as observers. The main aims and objectives are to establish a network of countries committed to reducing salt intake and building international action, to provide opportunities for information exchange on implementing salt-reduction strategies, technology and other developments, and to develop guidance and technical expertise for Member States.

Nazan Yardim, from the Turkish Public Health Institution, described the experience of one of the network members, Turkey, with its salt reduction programme. The goal of the Turkish salt reduction programme is to reduce salt consumption to less than 5 g per person per day. The programme involves a series of activities, including reducing salt content in some processed foods, prohibiting sale of chips in schools and compulsory health messages on salt packaging. Future planned activities will include reducing salt in cheese and olives and public awareness campaigns with, for example, a salt reduction message on national lottery tickets, a website and information documents.

### *Action network on reducing marketing pressure in children of foods high in fat, sugar and salt*

Bodil Blaker gave an update on the Action Network of the Member States in the WHO European Region on reducing marketing pressure on children on HFSS foods. The network was established in January 2008 in Oslo following various calls for action, in World Health Assembly resolutions, at WHO European regional level and at the national level in several countries. The network is made up of countries that want to work together to find ways to reduce the marketing pressure on children of

high salt, energy-dense, micronutrient-poor foods and beverages. The long-term goal is to protect children's health through sharing experiences and best practices.

The network consists of 20 countries and new countries are encouraged to join. The Secretariat is led by Norway and there are a number of observers (WHO, EU, Food and Agriculture Organization, the UN Standing Committee on Nutrition, Consumers International and the International Obesity Task Force).

The network has developed a code of marketing of foods and non-alcoholic beverages to children to provide an example of how such a code may look. The network is currently developing a manual for monitoring the marketing of foods to children. In addition, the network is pursuing a series of specific objectives on exchange of information and experiences, exploration of different approaches to control marketing, development of tools and other support with implementation.<sup>22</sup>

#### *School nutrition initiatives in the WHO European Region*

Michael Nelson, from the Children's Food Trust<sup>23</sup> in England, provided an update on school nutrition initiatives. Such initiatives offer opportunities to change children's health through school health nutrition programmes.

Every school food programme needs to be accountable and schools need to ensure that outcomes of policies and interventions are appropriate. There is a need for evidence in relation to school nutrition to be able to understand the policy impact and value for money. The Children's Food Trust and WHO Regional Office for Europe co-hosted a meeting in January 2012 to explore the research in relation to school food and to help build the evidence base for policy. The meeting explored three themes: policy, guidelines and standards; political engagement; and the wider evidence base and cost-effectiveness.

The workshop set out a series of recommendations for the development of an evidence base on school nutrition. These are:

1. Establish an international network:
  - a. Facilitate the sharing of learning outcomes from evidence e.g., the use of regulation as a mechanism or tool for implementation
  - b. Work via webinars, workshops, conferences, training (both direct and distance learning), bilateral visits, etc.
2. Develop a questionnaire disseminated through the network
3. Define the scope and conduct a comprehensive review of research on school nutrition in order to identify good evidence, good practice and gaps in both knowledge and technique.
4. Develop and publish a comprehensive guide to monitoring, evaluation and research of school food policy and programmes, including approaches to translating evidence into policy.
5. Map the evidence against stakeholders to ensure that the right messages are reaching the right decision-makers and implementers in the right format
6. Support wider alliances between campaigning and special interest groups
7. Develop a manual for professionals who wish to run public health nutrition programmes in schools

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<sup>22</sup> For more information see: <http://www.helsedirektoratet.no/english/topics/food-marketing-children/Sider/default.aspx>

<sup>23</sup> Formerly the School Food Trust.

8. Design strategies and tools for workforce development relating to school food and nutrition, including teachers, school nurses, cooks and caterers.

#### *Action network on hospital nutrition*

Ziva Stahl, from the Department of Nutrition in the Ministry of Health in Israel, gave an update on the action network on hospital nutrition. This network was established in March 2010 and has held one meeting. The network is led by Israel and supported by Bosnia and Herzegovina, Denmark and Finland. The network aims to establish healthy nutrition in hospitals and focuses on the importance of promoting healthy environments involving health care workers.

An electronic questionnaire was sent to all Member States to get a picture of what is happening in the European Region. The aims of the questionnaire being to collect information from health promotion, to connect with physical activity and to indicate how clinical nutrition issues are dealt with in countries. The results of the questionnaire are intended to help define the next steps.

#### *Action network on obesity and inequalities*

Pedro Graça, from the Directorate-General of Health in Portugal, presented the action network on obesity and inequalities. This network was established in 2010, is led by Portugal and has eight member countries (Bosnia & Herzegovina, Bulgaria, Ireland, Italy, Netherlands, Slovenia, Serbia and the UK).

Inequalities are increasing across Europe and the financial crisis has had a huge impact and led to increasing unemployment. Data from Portugal show the increasing prevalence of food insecurity and the coexistence of food insecurity and obesity among Portuguese adults. The network was established, therefore, to exchange information at the European level concerning the relationship between obesity and social inequalities in order to instil greater efficiency in actions to combat obesity. The network also intends to contribute to policy development in both social and health policies throughout Europe and will provide an opportunity to share country experiences, establish policy dialogue and coordinate actions.

The key steps for the future work of the network are to:

- implement a model for calculating obesity costs;
- develop an agreed framework/checklist to evaluate policies and interventions to combat obesity;
- evaluate of the use of taxation in food regarding to health inequalities;
- develop a policy paper with arguments for action on obesity and inequalities;
- analyse the impact of European programmes with the aim of reducing social inequalities in obesity.

#### *WHO Collaborating Centres for Nutrition in the WHO European Region*

Joop van Raaij presented an update from WHO Collaborating Centres for nutrition in the Region. WHO Collaborating Centres are institutions designated by the Director-General to form part of an international collaborative network carrying out activities in support of WHO's programmes. Through this collaboration WHO gains access to top institutions worldwide that can support its work and ensure the scientific validity of global health work. The Collaborating Centres, in turn, receive greater visibility and recognition, attract more public attention, and have more opportunities to exchange information, develop technical cooperation and mobilize additional resources.

Over 800 institutions in over 80 countries globally are WHO Collaborating Centres. Worldwide, there are 20 Collaborating Centres for nutrition and eight of these are in the European Region. The Regional network of WHO Collaborating Centres for Nutrition, Physical Activity and Obesity meets periodically. Eight WHO Collaborating Centres and eight collaborating institutions met at the second Regional Meeting in Erlangen in October 2012. A number of overarching action points were identified and the potential role of Collaborating Centres in the upcoming work plan of WHO on nutrition, physical activity and health was discussed. Before the next network meeting of the Collaborating Centres and the Collaborating Institutions there will be further work on strengthening contact and collaboration with nutrition knowledge network, indicating to WHO which issues the network could contribute to the WHO work plan, and ongoing work to identify other Collaborating Centres or Collaborating Institutions for starting bilateral collaborations on WHO issues.

#### *Working groups: Paving the way for the Vienna Declaration*

The meeting broke into working groups to discuss paving the way for the Vienna Declaration and the groups reported back to the plenary session.

## **Recommendations, conclusions and closing remarks**

Petra Lehner gave a very brief overview of the WHO European Ministerial Conference on Nutrition and NCDs in the framework of Health 2020 to be held in Vienna a few months later.

Boaz Lev from the Israeli Ministry of Health commented, in concluding remarks, on the progress made in sharing challenges as well as success stories during the meeting. Thanks are due to WHO for facilitating this mutual learning process.

João Breda wrapped up the meeting, welcoming the rich exchange of experiences that had taken place, involving Member States from all over the Region. The frank and open discussion about the future of the action plan for Europe was particularly valuable and it is to be hoped that this ensures participants have a sense of ownership of the eventual action plan.

WHO is an organization committed to taking action based on evidence. It may seem that there is never enough science and that more evidence is always needed. Enough evidence does exist, however, to take action. The meeting has provided a fantastic overview of what is available in European Region, constituting a toolbox which others can use. The process of bringing experiences together and discussing the way forward is immensely valuable and has provided an exciting appetizer of what lies ahead in terms of improving nutrition across the European region.

## **Annexes**

- Annex 1: Meeting programme
- Annex 2: List of participants

**Annex 1**  
**Meeting programme**

08:00-09:00	Registration of participants	
<b>Opening and morning session</b>		
<b>Chairs: Dr. Eleonora Dupouy (FAO) and Dr. João Breda (WHO)</b>		
09:00-09:30	<p><b>Welcome addresses:</b></p> <ul style="list-style-type: none"> <li>- Mr. Joseph Ishay, Director General of the Ministry of Agriculture and Rural Development of Israel</li> <li>- Dr. Boaz Lev, Associate Director General, Ministry of Health of Israel</li> </ul> <p><b>Opening address:</b></p> <ul style="list-style-type: none"> <li>- Dr Francesco Branca, WHO</li> <li>- Dr Brian Thompson, FAO</li> </ul> <p><b>Objectives of the meeting</b> <b>Introduction of participants</b></p>	
09:30-09:50	Roadmap to the Second International Conference on Nutrition: Introducing the ICN2 and preparation actions	<i>Brian Thompson, ICN2 Secretariat, FAO HQ Rome</i>
09:50-10:10	Global nutrition situation: burden and policy response	<i>Dr Francesco Branca, Director Nutrition for Health and Development, WHO/HQ</i>
10:10-10:30	Coffee break	
10:30-10:50	The development of global diets since ICN 1992: influences of agri-food sector trends and policies	<i>W. Bruce Traill Professor of Food Economics, School of Agriculture, Policy and Development University of Reading, United Kingdom</i>
10:50-11:10	Challenges for Nutrition in the WHO European Region of Europe	<i>Dr João Breda Programme Manager Nutrition, Physical Activity and Obesity Programme WHO/Europe</i>
11:10-11:30	Agricultural development and sustainable food systems: entry point for improving nutrition and the role of FAO	<i>Dr Eleonora Dupouy, Food Safety and Consumer Protection Officer, FAO REU</i>
11:30-11:50	Addressing malnutrition through nutrition sensitive food and agriculture based approaches	<i>Leslie Amoroso, FAO HQ</i>
11:50-12:10	Role of local and centennial diets in relationship with health, wellbeing and sustainability	<i>Antonia Trichopoulou – Greece</i>
12:10-12:40	The effect of food and agricultural policies (CAP and other regional policies) on nutrition, both within and outside the EC – <i>pros and cons!</i>	<i>Leonard Mizzi European Commission Directorate-General for Agriculture &amp; Rural Development</i>
12:40-13.00	Linking agricultural policies with obesity and noncommunicable diseases: a new perspective	<i>Dr Corinna Hawkes WCRF International</i>

13:00-14:00	Lunch	
<b>Afternoon session</b>		
<b>Chair: Professor. Phillip James</b>		
14:00-14:20	<i>Discussion</i>	
14:20-15:40	<b>Country presentations (4 countries, 20 min each)</b>	Albania, Germany, Israel, Republic of Moldova
15:40-16:00	Coffee break	
16:00-16:40	<b>Country presentations (continuation, 2 countries)</b>	Sweden, Slovenia
16:40-17:00	Discussion	
17:00-17:30	Wrap-up, endorsement of meeting conclusions and recommendations for follow-up	

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