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Comparative analysis of food and nutrition policies in WHO European Member States

Full Report

Nutrition and Food Security Programme
WHO Regional Office for Europe
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ABSTRACT

In line with the First Action Plan for Food and Nutrition Policy for the WHO European Region, 2000–2005, endorsed by the Regional Committee for Europe in 2000, Member States are encouraged to develop sound and sustainable food and nutrition policies. Several surveys on food and nutrition policy were carried out between 1994 and 1999. This report presents the data collected during these surveys. The aim is to compare the situation of food and nutrition policies in the Region and to show trends. The analyses present a broad picture of policy development and nutritional health in the WHO European Region. Countries where national food and nutrition coordination bodies exist appear to be the most effective in developing and implementing policies. Both a summary report (presenting data by subregion) and a full report (presenting information by country) are available.

Keywords

COMPARATIVE STUDY
NUTRITION POLICY
DATA COLLECTION
HEALTH PLANNING
EUROPE
EUROPE, EASTERN
EUROPE, SOUTHERN
COMMONWEALTH OF INDEPENDENT STATES
BALTIC STATES

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Summary

In September 2000, the WHO Regional Committee for Europe, in which all 51 Member States of the WHO European Region are represented, endorsed the First Action Plan for Food and Nutrition Policy, WHO European Region, 2000–2005. The resolution recommends that Member States implement the Action Plan for the European Region of WHO for 2000–2005 and report on progress at a ministerial conference to be held in 2006.

The Nutrition and Food Security programme works in the WHO European Region to raise awareness of nutrition policy on the political agenda. The programme encourages and supports WHO Member States to develop sound and sustainable food and nutrition policies.

Several surveys on food and nutrition policy were carried out between 1994 and 1999. This report presents the data collected during these surveys. The aim is to compare the situation of food and nutrition policies in the Region and to show trends. The analyses present a broad picture of policy development and nutritional health in the WHO European Region.

This report provides a summary of: a region-by-region comparison of food and nutrition policies in the WHO European Member States in 1994/1995 and 1998/1999; a comparison of data on Body Mass Index (BMI) and dietary intake between some WHO European Member States; a situation analysis of the European Member States on the basis of their country reports¹; and conclusions and recommendations for future actions in the WHO European Region on food and nutrition policy

- 16 Member States reported having administrative structures for implementing food and nutrition strategies;
- 28 reported having a nutrition council or equivalent technical advisory body;
- 36 reported having national Recommended Nutrient Intake or equivalent tables;
- 27 reported having national dietary guidelines; and
- 17 reported collecting national dietary intake data, using a variety of methods.

Countries where national food and nutrition coordination bodies exist appear to be the most effective in developing and implementing policies. A coordinating body advises the government on developing, implementing, monitoring and evaluating intersectoral policies and their associated guidelines and action plans.

In addition, a national coordinating body can be responsible for ensuring the consistency of information given by different sectors to the public, facilitate and respond to public interest about food issues and advise government on how to meet its international commitments.

This report includes:

- A comparative analysis of food and nutrition policies and plans of action in WHO European Member States was made on the basis of questionnaires returned to the Nutrition and Food Security Policy programme in 1994/1995 and 1998/1999.

¹ Submitted at the WHO Consultation on “Development of the First Food and Nutrition Action Plan for the WHO European Region”, Malta 8-10 November 1999

- A comparison of national BMI and dietary intake data from WHO European Member States returned to the Nutrition and Food Security Policy programme in 1998/1999.
- A situation analysis of WHO European Member States based on reports submitted to the Nutrition and Food Security Policy programme in 1999.

Introduction

In September 2000, the WHO Regional Committee for Europe, endorsed the First Action Plan for Food and Nutrition Policy, WHO European Region, 2000–2005. The resolution recommends that Member States implement the action plan and report on their progress at a ministerial conference to be held in 2006.

The programme aims to encourage and support WHO Member States to develop sound and sustainable food and nutrition policies. Several surveys on food and nutrition policy were carried out between 1994 and 1999. This report is an analysis of the data collected during these surveys. The aim is to compare the situation of food and nutrition policies in the Region and to show trends. The analyses portray a picture of policy development and nutritional health in the WHO European Region.

WHO European Member States are grouped into eight geographic subregions to facilitate comparative analysis and interpretation: Southeast Europe (SEE), Baltic Region, Central Asian republics (CAR), countries of Central and Eastern Europe (CEE), the Commonwealth of Independent States (CIS), Nordic countries, Southern European countries (SE) and Western European countries (WE).

Table 1. Member States in the WHO European Region by geographic grouping included in this analysis

SEE	BALTIC	CAR	CEE	CIS	NORDIC	SE	WE
Albania	Estonia	Kazakhstan	Bulgaria	Armenia	Denmark	Andorra	Austria
Bosnia and Herzegovina	Latvia	Kyrgyzstan	Czech Republic	Azerbaijan	Finland	Greece	Belgium
Croatia	Lithuania	Tajikistan	Hungary	Belarus	Iceland	Israel	France
Former Yugoslav Republic of Macedonia		Turkmenistan	Poland	Georgia	Norway	Italy	Germany
Slovenia		Uzbekistan	Romania	Rep. of Moldova	Sweden	Malta	Ireland
			Slovakia	Russian Fed.		Monaco	Luxembourg
				Ukraine		Portugal	Netherlands
						San Marino	Switzerland
						Spain	United Kingdom
						Turkey	

This report provides: a comparative analysis of food and nutrition policies in the WHO European Member States in 1994/1995 and 1998/1999; a comparison of the available national data on Body Mass Index (BMI) and dietary intake; a situation analysis of the European Member States on the basis of their country reports²; and conclusions and recommendations for future actions in the WHO European Region.

² Submitted at the WHO Consultation on “Development of the First Food and Nutrition Action Plan for the WHO European Region”, Malta 8-10 November 1999

Intersectoral Food and Nutrition Policy Development

To assist Member States in developing and implementing national food and nutrition action plans, WHO developed a 3-day training module “Intersectoral food and nutrition policy development – a training manual for decision makers”. This training module was implemented in the following sub-regions: southeast Europe, Baltic and Nordic countries and southern Europe. A total of 28 countries participated in 7 training workshops (Full reports are available from the Nutrition and Food Security programme):

Southeast Europe: The first workshop on development of national Food and Nutrition Action Plans in southeast Europe was held in Slovenia, June 2000 and participants came from Albania, Bulgaria, Bosnia & Hercegovina, Croatia, Hungary, Poland, Slovenia and the former Yugoslav Republic of Macedonia. Participants were national representatives from many different sectors including health and agriculture. A second workshop, with as far as possible the same national representatives plus Czech Republic, Romania, Slovakia and Yugoslavia, took place in Bulgaria, October 2001. A third workshop took place in Croatia, September 2002 when 12 countries presented their progress on development of national action plans. The First Technical Workshop of the South East Europe Nutrition Project took place in November 2002, under the auspices of the Stability Pact for SEE Social Cohesion Initiative. This meeting finalized the project proposal entitled “Developing and strengthening food and nutrition strategies to prevent cardiovascular diseases in South-East Europe”. Nine countries of the SEE region participated.

Baltic countries: participants from Estonia, Latvia and Lithuania took part in the first workshop on the development of national food and nutrition action plans for the Baltic countries in Latvia, August 2000. Participants were national representatives from different sectors including health and agriculture. A second workshop was carried out with as far as possible the same national representatives in June 2001 to evaluate progress and advise on the way forward. A third workshop took place in Estonia in June 2002 when Estonia, Latvia and Lithuania presented their final drafts of national food and nutrition action plans.

Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) participated in the Baltic workshops with the aim of supporting the Baltic countries and sharing their experiences in the field of nutrition policy development. A proposal was developed to set up a Nordic/Baltic Public Health Nutrition Network. This proposal was successfully submitted to the Nordic Council of Ministers and funding is therefore secured for the first 3 years (2002-2005).

Southern Europe: A workshop was held for countries in southern Europe in Rome, March 2002 and Andorra, Greece, Israel, Italy, Malta, Portugal, Spain, Turkey were invited to participate. Participants were national representatives from different sectors including health and agriculture.

Russian Federation: the Nutrition programme worked with the national authorities to develop a Russian Food and Nutrition Action Plan for different Regions of Russia. The "Arkhangelsk" declaration was endorsed by delegates from around 20 Regions in October 2000. Two Regions, Murmansk and Arkhangelsk, are implementing their Regional Food and Nutrition policy, assisted by funding from the Norwegian government (Barents Initiative).

Development of national food based dietary guidelines.

This document “Comparative analysis of nutrition policies” is supported by an additional survey on food-based dietary guidelines in WHO European Member States that was carried out in 2002. The full report on status of Food Based Dietary Guidelines in Member States is available from the Nutrition and Food Security programme.

An unhealthy diet combined with physical inactivity increase the risk for non-communicable diseases (NCD) enormously. NCD such as cardiovascular diseases, cancer, hypertension, obesity and type 2 diabetes are increasing within the European Region. There is a clear need for political commitment in developing adequate nutrition policies. These should help prevent NCD through the provision of enough healthy, affordable food, especially fresh fruit and vegetables in addition to the reduction of nutritional deficiencies.

Part of this political action should include the translation of nutrient population goals into food-based dietary guidelines (FBDG) at the national level. It is fundamental that the Ministry of Health endorse FBDG that are consistent and easily understood. Many primary care experts and other health specialists have the opportunity to disseminate information on healthy eating.

The aim of the survey in 2002 was to assess the existence of national, government-endorsed food-based dietary guidelines in Member States of the WHO European Region. Of the 48 participating countries, 25 reported having national, government-endorsed food-based dietary guidelines; 8 reported having national food-based dietary guidelines that were either in preparation and/or not yet endorsed by the government; 6 reported not having food-based dietary guidelines and 9 did not reply to the questionnaire.

The findings of this survey illustrate important discrepancies from country to country in national food-based dietary guidelines. Further effort will be required in the development of dietary guidelines as well as in the implementation of national nutrition policies before the ministerial conference in 2006.

Meeting of all Member States, Greece, February 2003

A Meeting of Nutrition Counterparts supported by the Greek Ministry of Health in February 2003, during the Greek Presidency of the EU, provided the opportunity to carry out a mid-term evaluation of progress in implementing the Action Plan.

All 50 national Nutrition Counterparts, officially nominated by their ministries of health, in the WHO European Region were invited to Greece in February 2003. Progress was discussed regarding development of food and nutrition action plans in the European Region (see report of the meeting of nutrition counterparts in the WHO European region, Athens, 28 February – 2 March 2003). This meeting provided an opportunity to plan for the period up to the Ministerial Conference in 2006.

Data Sources

The information presented in this report comes from questionnaires on nutrition policy, body mass index (BMI) and dietary intake; and country reports.

Nutrition policy

The Nutrition and Food Security programme of the WHO Regional Office for Europe carried out surveys on national nutrition policy in European Member States twice: 1994/1995 and 1998/1999. In summary in 1998/1999, it was found that:

- 16 Member States reported having administrative structures for implementing food and nutrition strategies;
- 28 reported having a nutrition council or equivalent technical advisory body;
- 36 reported having national Recommended Nutrient Intake or equivalent tables;
- 27 reported having national dietary guidelines; and
- 17 reported collecting national dietary intake data, using a variety of methods.

Countries where national food and nutrition coordination bodies exist appear to be the most effective in developing and implementing policies. A coordinating body advises the government on developing, implementing, monitoring and evaluating intersectoral policies and their associated guidelines and action plans.

In addition, a national coordinating body can be responsible for ensuring the consistency of information given by different sectors to the public, facilitate and respond to public interest about food issues and advise government on how to meet its international commitments.

Table 2 shows which countries responded to the 1994/1995 and 1998/1999 surveys.

Table 2. Questionnaires submitted by WHO Member States to the Nutrition and Food Security programme, WHO Regional Office for Europe.

Member State	Quest. 1994/ 1995	Quest. 1998/ 1999
Southeast Europe		
Albania		X
Bosnia and Herzegovina		X
Croatia	X	X
Former Yugoslav Republic of Macedonia	X	X
Slovenia		X
Baltic Region		
Estonia	X	X
Latvia	X	X
Lithuania	X	X
CAR		
Kazakhstan		X
Kyrgyzstan	X	X
Tajikistan	X	
Turkmenistan		
Uzbekistan		X
CEE		
Bulgaria	X	X
Czech Republic	X	X
Hungary	X	X
Poland		X
Romania	X	
Slovakia	X	X
CIS		
Armenia		
Azerbaijan	X	X
Belarus		X
Georgia		
Republic of Moldova		X
Russian Federation	X	
Ukraine		X

Member State	Quest. 1994/ 1995	Quest. 1998/ 1999
Nordic Countries		
Denmark	X	X
Finland	X	X
Iceland	X	X
Norway	X	X
Sweden	X	X
Southern European Region		
Andorra		
Greece	X	X
Italy	X	X
Israel		X
Malta	X	X
Monaco		
Portugal	X	X
San Marino		
Spain	X	
Turkey	X	X
Western European Region		
Austria		X
Belgium	X	X
France	X	X
Germany	X	X
Ireland	X	X
Luxembourg	X	X
Netherlands	X	X
Switzerland	X	X
United Kingdom	X	X

Country report

A country report was compiled by each country attending the WHO Consultation on “Development of the First Food and Nutrition Action Plan for the WHO European Region”, Malta 8–10 November 1999. A total of 37 country reports were submitted (response rate 74%). Table 3 shows which countries submitted country reports.

Information was submitted according to the following topics: Nutrition policy, plan of action or strategy; Interdisciplinary collaboration; Examples of normative actions; NCD and related risk factors; Inequity and poverty leading to lack of food and nutrient deficiency; Infant, young children and maternal nutrition; Sustainable food production and distribution; and food safety.

The country reports provided a very diverse content and quantity of data. This probably indicates the level of availability of data in different countries. The variety of information provided by the Member States is not surprising as the Region consists of such a diverse set of countries at different economic and social development levels. This makes comparison between the countries difficult. The analysis is also limited by Member States not providing information on data sources including sample size and collection year of data.

The major cause of death in the Region is cardiovascular disease and cancer. This is linked to dietary patterns low in fruit and vegetables and high in saturated fat. Previously Member States have been more concerned with nutritional deficiencies compared with noncommunicable diseases, but two micronutrient deficiencies remain widespread and have significant detrimental effects on public health in the Region, namely deficiencies of iodine and iron.

Poverty is widespread resulting in food insecurity and consumption of unhealthy monotonous diets. In the Baltic and CIS a large dependency by the disadvantaged on homegrown produce is reported. In contrast, the Nordic countries reports that not poverty, but a lack of education are highly correlated with adverse dietary habits.

Although data is lacking, it is evident that low breastfeeding rates and poor weaning practices are common throughout the Region. The Nordic countries seem to have the highest breastfeeding rates, but even here there is scope for improvement. In many subregions, including the Baltic, CEE, CAR, CIS and the Southern European Region, there are concerns about aggressive promotion of commercial milk substitutes by the industry.

Many former Soviet countries are undergoing socioeconomic transitions and this has affected food availability and public health adversely. Additionally, it is commonly reported that declining agricultural production is a result of lack of financial support, expertise and need for improved agricultural methods.

Table 3. Country reports submitted by WHO Member States, 1999

Member State	Country Report 1999
Southeast Europe	
Albania	X
Bosnia and Herzegovina	X
Croatia	X
Republic of Macedonia	X
Slovenia	
Baltic Region	
Estonia	X
Latvia	X
Lithuania	X
CAR	
Kazakhstan	
Kyrgyzstan	X
Tajikistan	X
Turkmenistan	X
Uzbekistan	X
CEE	
Bulgaria	X
Czech Republic	X
Hungary	X
Poland	X
Romania	X
Slovakia	X
CIS	
Armenia	X
Azerbaijan	
Belarus	X
Georgia	X
Republic of Moldova	X
Russian Federation	X
Ukraine	X

Member State	Country Report 1999
Nordic Countries	
Denmark	X
Finland	X
Iceland	X
Norway	X
Sweden	X
Southern European Region	
Andorra	
Greece	
Italy	
Israel	
Malta	X
Monaco	
Portugal	X
San Marino	
Spain	
Turkey	X
Western European Region	
Austria	X
Belgium	
France	X
Germany	X
Ireland	X
Luxembourg	
Netherlands	
Switzerland	X
United Kingdom	X

Body Mass Index^{3 4}

The BMI data received from 20 WHO European Member States (Table 4) indicates that overweight and obesity is a general problem in the European Region. The greatest prevalence of obesity was observed in the Southern Europe, while underweight was most frequent in Central Asian republics.

The BMI data received from Member States had several limitations, making comparison difficult. For instance, sample size was occasionally very small or not indicated at all; not all Member States used the WHO recommended BMI classifications; the year of data collection was not always reported and the collection period, was very broad (1984–1999); and the anthropometric data was not always measured by investigators, but self-reported which may have created an underestimation of the prevalence of obesity. Despite these shortcomings, the data clearly suggest that overweight and obesity are a serious public health problem throughout the Region. If this trend continues, it will have profound economic and health consequences for the population in the WHO European Region due to the association between noncommunicable diseases and overweight and obesity (*reference: Obesity: preventing and managing the global epidemic. WHO Technical Report Series 894, 2000*).

The high prevalence of overweight and obesity in the Region is likely to be linked to sedentary lifestyles in conjunction with high fat intake and low consumption of fruit and vegetables as suggested by the dietary intake data presented here. No Member States reported having dietary fat intake below the recommended 30% of dietary energy or consumption of fruit and vegetables above the recommendation of 400g daily.

The dietary intake data were collected using different dietary assessment methods making judgement of data quality and comparison difficult. The 24-hour recall method was used by the majority of the Member States probably because the method is relatively inexpensive and easily carried out. A single 24-hour recall is appropriate to assess average intakes of food and nutrients for large population groups, except for people with poor memories and children below 10 years of age.

Assessment of dietary intake and BMI are essential for identifying populations at risk and formulating food and nutrition policies; for developing intervention programmes; and for monitoring the success of implemented programmes and policies.

³ WHO. Physical status: the use and interpretation of anthropometry. Report of a WHO Expert Committee. Geneva, World Health Organisation 1995 (Technical Report Series NO 854) p. 368-9

⁴ No information received from the following countries: Albania, Bosnia, Croatia, Slovenia, Estonia, Kazakhstan, Kyrgyz Republic, Turkmenistan, Czech Republic, Poland, Romania, Armenia, Azerbaijan, Georgia, Moldova, Ukraine, Finland, Iceland, Norway, Andorra, Israel, Italy, Monaco, San Marino, Spain, Turkey, Austria, Belgium, Ireland, Luxembourg, Netherlands

Table 4. Data on BMI submitted by WHO Member States

Member State	BMI data submitted
Southeast Europe	
Albania	
Bosnia and Herzegovina	
Croatia	
Republic of Macedonia	X
Slovenia	
Baltic Region	
Estonia	
Latvia	X
Lithuania	X
CAR	
Kazakhstan	
Kyrgyzstan	
Tajikistan	
Turkmenistan	X
Uzbekistan	X
CEE	
Bulgaria	X
Czech Republic	
Hungary	X
Poland	
Romania	
Slovakia	X
CIS	
Armenia	
Azerbaijan	
Belarus	X
Georgia	
Republic of Moldova	
Russian Federation	X
Ukraine	

Member State	BMI data submitted
Nordic Countries	
Denmark	X
Finland	
Iceland	
Norway	
Sweden	X
Southern European Region	
Andorra	
Greece	X
Italy	X
Israel	
Malta	X
Monaco	
Portugal	X
San Marino	
Spain	
Turkey	
Western European Region	
Austria	
Belgium	
France	X
Germany	X
Ireland	
Luxembourg	
Netherlands	
Switzerland	X
United Kingdom	X

Dietary intake

Dietary intake data was received from 26 Member States (Table 5). The method used for estimating dietary intake varied between the Member States (Table 6). The majority of Member States used the 24-hour recall method, except in the Nordic subregion where food records were mostly used. Several Member States did not provide information on sample size and year of data collection. Consequently, this comparison can only present the broad picture of dietary trends in the WHO European Member States.

Table 5. Dietary intake data submitted by WHO Member States

Member State	Dietary data submitted
Southeast Europe	
Albania	
Bosnia and Herzegovina	
Croatia	X
Former Yugoslav Republic of Macedonia	X
Slovenia	X
Baltic Region	
Estonia	X
Latvia	X
Lithuania	X
CAR	
Kazakhstan	X
Kyrgyzstan	
Tajikistan	
Turkmenistan	
Uzbekistan	X
CEE	
Bulgaria	X
Czech Republic	X
Hungary	X
Poland	
Romania	
Slovakia	X
CIS	
Armenia	
Azerbaijan	X
Belarus	
Georgia	
Republic of Moldova	X
Russian Federation	
Ukraine	X

Member State	Dietary data submitted
Nordic Countries	
Denmark	X
Finland	X
Iceland	X
Norway	X
Sweden	X
Southern European Region	
Andorra	
Greece	
Italy	
Israel	
Malta	
Monaco	
Portugal	X
San Marino	
Spain	
Turkey	X
Western European Region	
Austria	X
Belgium	X
France	X
Germany	
Ireland	
Luxembourg	
Netherlands	X
Switzerland	
United Kingdom	

Table 6. Dietary assessment methods used in the Member States

Subregion	Data received	Year of Collection	Collection Method					
			FBS ⁵	HBS ⁶	24 R ⁷	FFQ ⁸	7-day FR ⁹	Other
South Eastern Europe								
Albania	÷							
Bosnia and Herzegovina	÷							
Croatia	X	1990		X				
Republic of Macedonia	X	1996						No info on method
Slovenia	X	1997			X	X		
Baltic Region								
Estonia	X	1997			X			
Latvia	X	1997			X			
Lithuania	X	1997			X			
CAR								
Kazakhstan	X	1996			X			
Kyrgyzstan	X	No info on provided						No info on method
Tajikistan	÷							
Turkmenistan	÷							
Uzbekistan	X	1984						No info on method
CEE								
Bulgaria	X	1998			X			
Czech Republic	X	No info on provided	X					
Hungary	X	1992–1994						No info on method
Poland	÷							
Romania	÷							
Slovakia	X	1996						No info on method
CIS								
Armenia	÷							
Azerbaijan		1994/1995			X			
Belarus	÷							
Georgia	÷							
Republic of Moldova	X	No info on provided						No info on method
Russian Federation	÷							
Ukraine	X	1997						Express one-day and seven-day questionnaire survey

⁵ Food Balance Sheet

⁶ Household Budget Survey

⁷ 24 hour Recall

⁸ Food Frequency questionnaire

⁹ 7 Day Food Record

Subregion	Data received	Year of Collection	Collection Method					
			FBS ⁵	HBS ⁶	24 R ⁷	FFQ ⁸	7-day FR ⁹	Other
<i>Nordic Countries</i>								
Denmark	X	1995					X	
Finland	X	1997			X			
Iceland	X	1990						Dietary History Method
Norway	X	1993–1994				X		
Sweden	X	1989					X	
<i>Southern European Region</i>								
Andorra	X	1994/1995						Household weighted inventory joint to individual seven day records
Greece	÷							
Italy	÷							
Malta	÷							
Monaco	÷							
Portugal	X	1980			X			
San Marino	÷							
Spain	÷							
Turkey	X	1984						No info on method
<i>Western European Region</i>								
Austria	X	1998			X			
Belgium	X	No info on provided						No info on method
France	X	1994–1997			X			
Germany	÷							
Ireland	X	1990						Dietary history
Luxembourg	÷							
Netherlands	X	1997–1998						2-day notebook method
Switzerland	÷							
United Kingdom	X	1986–1987, 1992–1993, 1994/1995						4-day weighted inventory

Country-by-country information

South East Europe Region

Albania

Questionnaire analysis 1994/1995 and 1998/1999¹⁰

Nutrition policy, plan of action or strategy

The Albanian government has adopted two policies related to nutrition: the “Basic Cooperation Agreement between the United Nations Children’s Fund and government of Republic of Albania” in 1993 and the “Master Plan of Operations” in 1996. The country reported that all components of the World Declaration and Plan of Action are included in these two documents.

Advisory and administrative structures

The “Institute of Public Health” has been established to ensure the implementation of the nutrition policy. The “National Board on Food”, which has a written mandate, was set up in 1995 to provide scientific advice to policy-makers. The Ministry of Food and Agriculture finances the Board.

Interdisciplinary collaboration

The “Institute of Public Health” and the “Institute of Statistics” are responsible for the collection of data on dietary patterns of the population. The “Institute of Public Health” and the “Directory of Health Promotion” are responsible for the public nutrition education in Albania. It appears that intersectoral consultations take place between the ministries of health, agriculture, environment, finance, education, the food industry and consumers.

Examples of normative actions

Albania has a set of recommended nutrient reference values and field-tested dietary guidelines directed at the whole population. Both were established in 1980 by the authority of the “Institute of Public Health”. The country has not had a population representative survey of dietary intake and nutritional status within the previous 10 years.

Country report, 1999

Noncommunicable diseases and related risk factors

In 1998 the life expectancy at birth was 71.4 years in Albania, a slight decrease since the beginning of the 1990s. Information received from Albania indicates that the trend in mortalities from circulatory diseases is decreasing. Mortality from cancers was also low and was decreasing in Albania compared with other WHO European member states. The mortality from diseases of the circulatory system was higher than in the EU, but lower if compared with the average WHO Europe region. The Albanian diet was reported to be lacking in fish, fresh vegetables and fruit, and bread provided almost two thirds of total energy intake.

Inequity and poverty leading to lack of food and nutrient deficiency

In 1999 it was reported that the poor spent 70–75% of income on food. Intake of food such as meat, milk yoghurt, vegetables and potatoes was half that of the non-poor. However, interim nutritional guidelines have been published, financial constraints and lack of collaboration between governments and organizations make it difficult to develop and implement policies and guidelines.

¹⁰ ALBANIA: The questionnaire from 1994/1995 was not returned and therefore only results from the 1998/1999 survey are reported here without comparison with the situation in 1994/1995.

Infant, young children and maternal nutrition

Stunting was reportedly prevalent among children indicating a chronic period of undernutrition during the rapid growth period. Although, the prevalence of malnutrition had declined since 1990, it was still a problem in Albania due to increasing poverty. The prevalence of moderate malnutrition was reported similar in urban and rural areas, but serious malnutrition was more widespread in rural areas. Deficiencies of iodine, vitamin A and iron were also widespread among Albanian children.

Information regarding pregnant and lactating women was not available at the time of the country report, but it was estimated that about half of pregnant women suffered from iron deficiency anaemia. Breastfeeding for 3 month post-partum was high (70%), but only 24% of infants were breastfed the full 6 months. It was reported that weaning foods given to infants consisted of cows' milk, thus exacerbating the incidence of anaemia.

Laws to ensure universal salt iodination and to prohibit advertisements on artificial breast-milk substitutes were being developed. The need to train health personnel, provide public health education, and improve the collection of nutritional data at national level was reported.

Sustainable food production and distribution

In 1999 more than 50% of the population were employed in the agricultural sector.

Food safety

Limited information was available and the national information system on food safety data needs to be strengthened. However, unsatisfactory food safety due to a lack of respect of hygienic handling of food and contaminated water sources was reported as a problem.

It was reported that diarrhoeic diseases in Albania were caused by contaminated water in 54–85% of cases, while foodborne infections cause 28–32% of diarrhoeic cases. Lead intoxication is another problem. The legislation was considered insufficient and difficulties of coordination between national and local structures were reported. Furthermore, there is a lack of trained personnel and mechanisms to implement the law in the area of food safety.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided.

Bosnia and Herzegovina

Questionnaire analysis 1994/1995 and 1998/1999¹¹

Nutrition policy, plan of action or strategy

Bosnia and Herzegovina did not have a nutrition policy document.

Advisory and administrative structures

Bosnia and Herzegovina did not have an advisory body for providing scientific advice to policy-makers.

¹¹ Bosnia and Herzegovina did not return the questionnaire from 1994/1995 and therefore only results from 1999 survey are reported here.

Interdisciplinary collaboration

It appeared that informal consultations on nutritional matters take place between the Ministry of Health and the Ministry of Agriculture. In addition, some coordination occurs between the federal government and some international organizations in the provision of food.

Examples of normative actions

Bosnia and Herzegovina use the former Yugoslavian recommended nutrient reference values from 1979. Dietary guidelines had not been developed and no population representative survey of dietary intake and nutritional status had been carried out during the last 10 years.

Country report 1999

Noncommunicable diseases and related risk factors

In Bosnia and Herzegovina the prevalence of heart disease, hypertension and diabetes was increasing prior to the war in 1992, although less than the WHO European region averages. There is a need for data in order for Bosnia and Herzegovina to develop policies and also more collaboration between ministries involved.

Inequity and poverty leading to lack of food and nutrient deficiency

During the war, the population of Bosnia and Herzegovina relied on humanitarian aid to ensure food supply. The post-war situation presented a continuing lack of food security and detrimental food- and lifestyle habits due to the insecure socioeconomical situation. Policy guidelines had been developed. These include strategies to diagnose and treat anaemia and a law to define the level of iodine added to salt.

Infant, young children and maternal nutrition

The rates of breastfeeding were reportedly low and iodine deficiency disorder and anaemia were prevalent. In 1999 there were no guidelines regarding the issue of infant and maternal health. However, suggestions of policy to promote breastfeeding and intersectoral cooperation to ensure continuous activity were being discussed.

Sustainable food production and distribution

There was insufficient food production to supply the population with a healthy and nutritious diet.

Food safety

No information on disease incidence was reported. Only 5% of food samples undergo testing, out of which bacteria contaminated 16% of the samples. A lack of facilities such as laboratories including personnel, buildings and equipment; as well as sanitary inspection regulations, personal and technical knowledge was reported.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Croatia

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The Croatian parliament, Ministry of Health and the Medical Academy adopted the countries first two policy documents related to nutrition in 1996. Namely, the “Croatian Food and Nutrition Policy” and “Croatian Agriculture at Crossroads”. The documents included all the components of World Declaration and Plan of Action.

Advisory and administrative structures

The advisory body responsible for providing scientific advice to national policy-makers was established in 1992 and was still operating in 1998/1999. The board was represented by participants from the Croatian National Institute of Public Health, clinical medicine, agriculture, consumer association, veterinary and the army. The board had a written mandate. The Ministry of Science and Technology finances the advisory body.

Interdisciplinary collaboration

The Croatian National Institute of Public Health and the State Institute of Statistics are responsible for the collection of information regarding dietary habits of the population. The Croatian National Institute of Public Health is responsible for distribution of dietary information to the relevant policy-makers. This responsibility was previously shared between the two above-mentioned institutions. Public health nutrition education was the responsibility of the Croatian National Institute of Public Health and the ministries of Health and Education. Furthermore, regular collaboration exists between the following sectors: ministries of Health, Education, Agriculture, and Environment and the food industry.

Examples of normative actions

Croatia does not have its own recommended nutrient reference values, but use the US RDA from 1989. Croatia prepared dietary guidelines for the whole population, which were updated in 1996. Croatia reported having carried out a population representative dietary assessment in 1991.

Country report, 1999

Noncommunicable diseases and related risk factors

In Croatia the leading cause of mortality is cardiovascular diseases. The energy percentage distribution of macronutrients is on average according to WHO recommendations. The consumption of vegetables, fruit, milk and milk products is below WHO recommendations. The priorities for the “Croatian Institute of Public Health” and the Ministry of Health is to improve the dietary habits of the population, ensuring food fortification legislation and adaptation of consumer information and regulations to a healthier diet.

Inequity and poverty leading to lack of food and nutrient deficiency

Between 1.5% and 6% of the population are reported undernourished. Iodine deficiency disorder and iron deficient anaemia are prevalent among the population in Croatia. Despite satisfactory average energy intake, sub-clinical micronutrient deficiencies are present in Croatia.

Infant, young children and maternal nutrition

Croatia had low breastfeeding rates and poor weaning of infants. Only 37% of infants were breastfed at 3 months post-partum and at 6 months the percentage was only 13.5%. Use of diluted cow's milk and infant formula was common, as is weaning food. Pregnant women are prescribed iron and folic acid after the 3rd trimester and infants are given vitamin D drops and iron

supplements if they are not breastfed. Nurses carry out home visits to counsel mothers, and five health check-ups during first year of life were offered. There was good collaboration between ministries and hospitals. However, only a small number of public health orientated professionals were employed in the field of nutrition.

Sustainable food production and distribution

Croatia has good conditions for agricultural production due to fertile soils and good climate. In addition, the country has good facilities for food storage and distribution as well as adequate water supplies. Problems were excess imports of food and attempts to harmonize legislation according to EU standards.

Approaches to integrate nutritional objectives with national development policies were being considered as well as methods to ensure food security through a balance between food demands, economic growth and food production. Attention was given to the issue of improving and controlling food quality and safety, including food fortification.

Food safety

There is no information on disease incidence, but 10% of food samples tested were reported to be microbiological contaminated.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake¹²

Table 7. Daily macronutrient and alcohol intake expressed as % of total energy intake, Croatia

Nutrients	% total daily energy
Fat, adults	36
Protein, adults	13
Carbohydrate, adults	48
Alcohol, adults	3

Table 8. Vegetable and fruit intake excluding potatoes, Croatia

Food Groups	Total, mean, g/day
Vegetables (÷ potatoes)	157
Fruit	142
Total	299

¹² The food consumption data provided by Croatia was collected in 1990 by a household budget survey and does only include food consumed in the home.

The former Yugoslav Republic of Macedonia

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In 1991, the Macedonian Parliament and Government adopted a “National Programme of Preventive Health Care” and in 1993, the “National Strategy Health for All”. The documents concern the actions 1–7¹³ of the World Declaration and Plan of Action.

Advisory and administrative structures

It was reported in 1994/1995 that an administrative structure responsible for implementing the nutrition policy called “Republican Institute for Public Health of the Ministry of Health” was established, but no information was given in 1998/1999 regarding this. The country set up an advisory body to provide scientific advice to policy-makers in the years between 1994 and 1998 concerned with breastfeeding promotion and iodine deficiency disorder.

Interdisciplinary collaboration

The National Institute for Public Health was responsible for the collection of information of dietary patterns of the population, providing this information to relevant policy-makers and for the public nutrition education. Furthermore, regular consultations between the Ministry of Health and the Ministry of Agriculture took place, as reported in both 1994 and 1998.

Examples of normative actions

The former Yugoslav Republic of Macedonia had a set of recommended nutrient reference values, which were last revised in 1993. No population representative dietary assessment had been carried out. Existing dietary guidelines were for preschool and school children only.

Country report, 1999

Noncommunicable diseases and related risk factors

Total life expectancy is 72.4 years, while the life expectancy is 70.3 years and 74.5 years for men and women respectively. Mortality from cardiovascular disease was increasing, and in 1999 represented about 56% of total deaths. Also mortality from cancers was on the increase with a 1999 mortality rate of 17%. Diabetes affected approximately 2% of the population. Future strategies to overcome the rise of noncommunicable diseases include nutrition education, promotion of physical activity and production of dietary guidelines.

The diet in The former Yugoslav Republic of Macedonia consisted of large amounts of cereals, pasta and bread. The intake of meat was declining and the consumption of milk and milk products, fruit and vegetables (except potatoes) were low. Macronutrient intakes appeared satisfactory, however deficiency of vitamin A, calcium and iron was reported to be prevalent. In addition, The former Yugoslave Republic of Macedonia was an endemic goitre area, but salt iodization was being implemented to help solve the problem.

Inequity and poverty leading to lack of food and nutrient deficiency

Among children iodine deficiency disorder (19%), iron anaemia (15%) and vitamin A deficiency (30%) was prevalent. Also iron deficiency anaemia was reported in the adult population (12%).

¹³ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Infant, young children and maternal nutrition

There was a low rate of breastfeeding and poor weaning practices in The former Yugoslave Republic of Macedonia. Forty-five percent of infants were breastfed for three months post-partum and only 30% for six months. One fifth of infants received infant formulas, while 5% in urban areas and 12% in rural areas received cow's milk. Twelve percent of mothers had mild to moderate iron deficiency anaemia.

Seven percent of children suffered from low-weight-for-height with the highest prevalence in rural areas. Also anaemia was more prevalent in rural areas, where 29% of children had anaemia compared to 23% in urban areas. Furthermore, both rickets and vitamin A deficiency were prevalent in the country.

In 1997/1998, UNICEF carried out an educational programme for health workers and breastfeeding manuals were routinely distributed in maternities and primary health centres. In the future, it was planned to support baby-friendly hospitals, introduce limitations on labelling and prohibit distribution of free samples of infant formulas.

Sustainable food production and distribution

The food production in the country was insufficient and economical transition resulted in problems regarding the national food production and distribution. The main priorities were to increase agricultural production to ensure sufficient food supply while protecting the environment.

Food safety

The main problem with food safety concerned domestic food production and the highest percentage of contaminated food was reported in small firms (8%) and distributors (8–10%). The major food contaminants are *Salmonella*, *Escherichia*, Hepatitis A and *Brucella*.

Imprecise laws resulted in inappropriate premises, equipment, and professional skills of staff and standard hygienic conditions. The problems were greatest for the traditional markets and especially fast food outlets, which had extremely bad hygienic conditions. Approaches to solve the problems included the establishment of a modern system for food control and a common monitoring system. Needed are educational programmes aimed at producers in primary and secondary sector, food distributors, and caterers, and the training of laboratory staff and professionals concerned with health assessment, regulatory supervision and control. Finally, the public must be informed about food safety. However, it was difficult to carry out control of food contamination due to the large number of private farmers, and small production, trade and catering firms.

Prevalence of under- and overweight

In The former Yugoslav Republic of Macedonia obesity is a greater problem among women than men, whereas underweight is 4 times more prevalent in men than women.

Table 9. Prevalence of under- and overweight, adult men and women,
The former Yugoslav Republic of Macedonia

19–64 years (N= n/a)	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Men %	16	45	21	18
Women %	4	48	25	24

Statistics on dietary intake¹⁴

Table 10. Daily macronutrient and alcohol intake by gender expressed as % of total energy intake, The former Yugoslav Republic of Macedonia

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	30	30	14	14	56	56	–	–

Table 11. Vegetable and fruit intake excluding potatoes, The former Yugoslav Republic of Macedonia

Food Groups	g/day
Vegetables (÷ potatoes)	230
Fruit	144
Total	374

Slovenia

Questionnaire analysis 1994/1995 and 1998/1999¹⁵

Nutrition policy, plan of action or strategy

In 1995, the government and the Ministry of Health in Slovenia adopted a nutrition policy document, which had all the components of the World Declaration and Plan of Action incorporated. The Ministries of Agriculture, Environment and Education were mentioned as the most important partners in the development of policy documents.

Advisory and administrative structures

No administrative structure to ensure implementation of the policy was set up, but there were plans to set up a body concerned with nutrition issues within the Ministry of Health. There was not an advisory body, however if necessary Ad Hoc Expert committees were set up for specific problems.

Interdisciplinary collaboration

There was collaboration between a variety of parties involved in control, legislation and nutrition education. The National Office for Statistics and the Institute of Public Health were responsible for collecting information regarding the dietary pattern of the population, whereas the public nutrition education was the responsibility of the Ministry of Health and Ministry of Education. Consultations between the Ministry of Health and Ministry of Agriculture about food legislation took place.

Examples of normative actions

The country based its recommendations of nutrient reference values and dietary guidelines on WHO recommended nutrient reference values and WHO dietary guidelines. A population-representative survey of dietary intake and nutritional status has been published.

¹⁴ FYROM - Dietary data was collected in 1996.

¹⁵ Slovenia: Questionnaire from 1994/1995 was not returned, therefore only the results from 1998/1999 questionnaire are presented here.

Country report, 1999

No country report submitted.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake¹⁶

Table 12. Daily macronutrient and alcohol intake expressed as a percentage of total energy intake, adult men and women, Slovenia

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	44	45	13	13	39	40	4	2

Table 13. Vegetable and fruit intake excluding potatoes, Slovenia

Food Groups	g/day
Vegetables (÷ potatoes)	337
Fruit	179
Total	516

Baltic Region

Estonia

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In March 1995, the Estonian Government adopted a nutrition policy document. However, no information was given regarding which components of the World Declaration and Plan of Action this document includes.

Advisory and administrative structures

An unofficial advisory body was set up in 1994 and became official in April 1997 as the “National Food Commission”, financed by the Ministry of Agriculture and with a written mandate. The members of the Advisory board financed by the Ministry of Agriculture represent the Ministries of Agriculture, Education, Economy, Finance, the Consumer Board and the University of Tartu, Tallinn Technical University.

Interdisciplinary collaboration

It was reported in 1994/1995 that regular government-initiated collaboration between parties responsible for different aspects of nutrition took place. This, however, was no longer the case in 1998/1999. Furthermore, the responsibility for the collection of information regarding the population dietary patterns was in 1994/1995 planned to become the responsibility of a “Nutrition-related Scientific and Applied Research Council”, which was to be established in August 1995. However, in 1998/1999 this responsibility was still with the Statistical Office of Estonia.

¹⁶ Slovenia: Dietary data was provided in 1997 by 24-hour recall and food frequency questionnaires.

Examples of normative actions

In 1994/1995, the responsibility of public nutrition education was with the Department of Medicines, Tartu University and Food Processing Institute, Tallinn Technical University. By 1998/1999, this responsibility was moved to the Ministry of Education and no consultations between the Ministry of Agriculture and Ministry of Health appeared to take place.

In December 1995, the Estonian Ministry of Social Affairs produced the first “Estonian Nutrition Recommendations”. In 1998, the first Estonian adult nutrition survey was published and by 1998/1999 dietary guidelines directed at the whole population was in use.

Country report, 1999

Noncommunicable diseases and related risk factors

In Estonia, the life expectancy is 64 years for men and 75 years for women, which is similar to the WHO European region. The majority of deaths in Estonia are caused by cardiovascular diseases and hypertension followed by cancers.

The diet in Estonia is high in animal fat and salt and low in fruit and vegetables. Moreover, risk factors such as obesity, low physical activity, smoking and high consumption of strong alcohol are prevalent in Estonia. Several projects had been initiated to overcome the detrimental nutritional- and lifestyle habits of the population. Ministries involved in educational prevention of noncommunicable diseases were the Ministries of Social Affairs and Education.

Inequity and poverty leading to lack of food and nutrient deficiency

Inequality in health existed among the unemployed, children, elderly and families with a large number of children. In Estonia, 25% of families, which include almost half of all children, lived on salaries below the minimum income level. In this group, dietary problems included a lower intake of fruit, vegetables and meat than the general population. A council to develop strategies to battle poverty was formed in October 1999 and social subsidies were being granted to poor families by the Ministry of Social Affairs.

Infant, young children and maternal nutrition

The rate of breastfeeding in Estonia was low and weaning practices were poor, especially in younger mothers and those from rural areas and/or with less education. However, in recent years, awareness regarding breastfeeding has led to an increase in breastfeeding. The project “Promotion of breastfeeding” (1995/1996) succeeded in helping increase the number of infants being breastfed at 6 months from 26% in 1995 to 33% in 1997. However, anaemia and vitamin D deficiency were still reported in Estonian children. Regulations from the Ministry of Social Affairs for formulas, weaning food and infant food quality and labelling was under preparation.

Sustainable food production and distribution

The production of vegetables, potatoes, milk, meat and fish decreased considerably since the 1970s, resulting in a slight decline in the consumption of vegetables, milk and milk products. Consumption of grain and grain products had also decreased. In 1997 the “Agriculture Act” was agreed by the Parliament aiming to develop sustainable agricultural production.

Food safety

Food safety was mainly a problem in markets and smaller shops. Incidences of *Salmonella* were increasing, while incidences of *Shigella* was declining. A new “Food Act” had been agreed by the Parliament. Additionally, local administrators prepared regulations for street and market trade, but lack of financial and human resources limited the strengthening of the control of markets, shops and caterers.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake¹⁷

Table 14. Daily macronutrient and alcohol intake, adult men and women, expressed as % of total energy intake, Estonia

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	36	36	15	15	43	47	6	2

Table 15. Vegetable and fruit intake excluding potatoes, Estonia

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (≠potatoes)	241	209	223
Fruit	249	270	276
Total	380	377	378

Latvia

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

It was reported in 1994/1995 that Latvia had a nutrition policy document – including all components of the World Declaration and Plan of Action and a component on the prevention of infectious diseases – adopted by the Cabinets of Ministers in 1994. However, in 1998/1999 it was stated that Latvia did not have a nutrition policy document.

Advisory and administrative structures

Latvia reported having an administrative structure responsible for implementing the nutrition policy in 1994/1995, but not in 1998/1999. No supplementary information regarding the activities of the advisory body was given in either of the questionnaires.

Interdisciplinary collaboration

In 1994/1995, regular government-initiated collaboration between parties responsible for different aspects of nutrition was taking place, but not in 1998/1999. The Latvian Food Centre was established by a decree of Cabinet of Ministers in November 1995. In 1998/1999 the responsibility of public nutrition education was with the Health Education Centre.

Examples of normative actions

Latvia used recommended nutrient reference values from the former Soviet era. In 1998/1999 it was reported that Latvia had carried out a population representative survey on dietary intake and nutritional status, and in 1998 dietary guidelines for the whole population were being developed.

Country report, 1999

Noncommunicable diseases and related risk factors

Mortality from cardiovascular diseases had been increasing since the 1980s and was one of the highest in Europe. In 1998, mortality from cardiovascular diseases accounted for 56% of all

¹⁷ Estonia: Dietary data was collected by 24-hour recall in 1997.

deaths, while cancers represented 17% of total deaths in Latvia. The proportion of Latvians classified as obese were 10% of men and 17% of women.

The dietary energy percentage from fat was very high. The daily average fat intake as a percentage of total energy was 43% for men and 41% for women. Consumption of milk and milk products were high in Latvia and hence contributed markedly to the high fat intake. The consumption of fruit and vegetables was low in Latvia with an average intake of approximately 200 grams per person. Women consumed more fruit, but fewer vegetables than men and only 43% Latvians consumed fresh vegetables daily. The Ministries of Welfare and Education conducted no nutritional programmes due to a lack of funding.

Inequity and poverty leading to lack of food and nutrient deficiency

Iodine deficiency disorders and iron deficient anaemia were major micronutrient deficiencies in Latvia. Only 5% of the population used iodized salt, while it was believed that IDD was responsible for a reduction of approximately 10% of cognitive development of the population. Also iron deficiency anaemia reduced cognitive development in children as well as being a potential health problem for women in the childbearing age. Studies indicated that the prevalence of iron deficiency in pregnant women is 18%.

Low-income groups spent 75% of their income on food and had a high consumption of milk and fat. Families with a lot of children were most likely to live below the subsistence minimum (91% of families with three children).

Infant, young children and maternal nutrition

Only 30% of mothers breastfed three months post-partum and even less (19%) breastfed the full 6 months. Infant formulas or homemade food were used as a substitute for breast-milk. Since 1997, a “Breastfeeding Promotion and Protection Association of Latvia” organized and coordinated public education of breastfeeding. However, the European International Breast-milk Substitutes Codex had not yet been adopted into law in Latvia and consequently industry distributed information and free samples using marketing strategies that violate the international code.

No data was currently available regarding the nutritional situation of preschool children or pregnant/lactating women. The diet of school children was monotonous and only 25% of school children had fruit and vegetables daily, while 49% consumed sweets every day. Moreover, only 10% of children had an evening meal every day and only 17% ate breakfast. Rickets and anaemia (33%) were widespread. No dietary guidelines or nutrient recommendations had been prepared for children and adolescents.

Sustainable food production and distribution

Agricultural cattle and plant production had markedly declined since 1990. Pork, milk and cereal production were the main food items produced in Latvia. Potatoes were predominantly grown for home consumption. It was a high priority for Latvia to produce food in a non-contaminated environment and to meet the requirements to compete markets with such as EU. Main difficulties encountered in the development of policies were a lack of cooperation between institutions involved in the food chain.

Food safety

Food safety regulations in Latvia were in line with EU directives. Foodborne diseases were decreasing in Latvia except Salmonella, which increased 5% in the past 5 years. The main

problems faced were a lack of financial resources and lack of knowledge to improve the current situation.

Prevalence of under- and overweight

In Latvia, more men were overweight at a young age, while women tended to stay at a normal weight for longer, but as they became older there were more obese women than men. For both men and women the prevalence of overweight and obesity increased with age. The average BMI for the total age groups were very similar for men and women: 25.5 and 25.8 respectively.

Table 16. Prevalence of under and overweight, 19–64 years, Latvia

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 338)	7	76	13	4
35–49 years (N= 394)	2	52	34	12
50–64 years (N= 495)	0.8	23	46	31
19–64 years (N= 1227)	3	47	33	17
Men	%	%	%	%
19–34 years (N= 334)	0.6	66	30	4
35–49 years (N= 368)	0.5	45	44	10
50–64 years (N= 358)	1	37	48	14
19–64 years (N= 1060)	0.8	49	41	10

Statistics on dietary intake¹⁸

Table 17. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Latvia

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	43	41	14	14	42	45	1	0.5

Table 18. Vegetable and fruit intake excluding potatoes, Latvia

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	201	167	183
Fruit	66	97	83
Total	267	264	266

Lithuania

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In 1994, Lithuania adopted a nutrition document, replaced in 1998 by the “Health Programme of Lithuania” and adopted by Parliament. In 1998 the components of World Declaration and Plan of Action was expanded from actions 4–6 and prevention of infectious diseases to include actions 1–8.

¹⁸ The dietary data was collected by one 24-hour recall in 1997 and 3000 subjects participated.

Advisory and administrative structures

The first advisory board on nutritional matters was set up in 1991 and represented a variety of different sciences and was financed by the Ministry of Health. However, the board had not met.

Interdisciplinary collaboration

The responsibility for disseminating information regarding population dietary patterns was moved after the survey in 1994/1995 from the Social Statistics Service of the Department of Statistics to the Ministry of Health. In the same period, the National Nutrition Centre collected dietary information and carried out public nutrition education. Consultations between the Ministry of Health and the Ministry of Agriculture took place through the Lithuanian Codex Alimentarius.

Examples of normative actions

In 1994/1995 Lithuania used the recommended nutrient reference values from the former USSR, but since October 1997 “Recommended nutrient reference values for soldiers” had been developed. A population representative survey of dietary intake and nutritional status had been published. Dietary guidelines, which are directed at the whole population, breastfeeding women, children and the army, were developed in 1998.

Country report, 1999

Noncommunicable diseases and related risk factors

In Lithuania, life expectancy had fallen dramatically in the 1990s. Mortality from cardiovascular diseases was increasing. Total mortality for men and women under 65 years was almost three times the average rate for Europe. The incidence of malignant tumours decreased slightly from 1996 to 1997, whereas non-insulin-dependent diabetes mellitus was increasing by 7.75/100 000 per year. In addition, obesity was widespread and distributed equally between men and women and in rural and urban areas.

The consumption of fatty meats and animal fat had decreased, with a concurring increase in vegetable, oils and a decline in the use of full fat dairy products. However, total energy intake from fat was above current recommendations and was specifically 45% for men and 43% for women in Lithuania. The average intake of fruit and vegetables appeared satisfactory, but it was likely that some groups of the population had a low fruit and vegetable intake.

Inequity and poverty leading to lack of food and nutrient deficiency

Iodine deficiency was prevalent in Lithuania as the use of iodized salts in households was only approximately 5% despite the availability of iodized salt. In addition, iron deficiency was prevalent. Anaemia had been detected in approximately 30–40% of women in the first-third trimester of pregnancy. Calcium and selenium deficiency was also reported.

In the lowest income group, 44% were depending entirely on home grown food and 75% were depending on homegrown vegetables and fruit compared with 15% and 58%, respectively, in the higher income group.

Infant, young children and maternal nutrition

Infant mortality had begun to decrease to an infant mortality rate of 10.3 per 1000 live births in 1997. Only 11% of mothers breastfed their infants until the age of 6 months. Milk substitutes were imported from abroad, but only 45% of families could afford to buy these products. There was no programme to ensure safety and quality of infant food. A national programme agreed by

the Lithuanian government was commenced in 1995 to improve feeding of infants and young children under the age of three.

Sustainable food production and distribution

The transition towards a market economy resulted in major increases in food prices. This forced many to consume cheaper, less nutrient dense and more contaminated foodstuffs and to rely on homegrown produce. While purchasing power increased in Lithuania the proportion of expenditure on food had steadily decreased from 58% in 1994 to 45% in 1997. Milk and meat production continue to be the main agricultural production.

Food safety

A “Food Monitoring Programme” was initiated in 1994 to monitor the food safety. It showed that microbiological contamination was a problem as 3% of produce from Lithuania and 2% of imported foodstuffs was contaminated. Foods from markets were more often contaminated. The quality of drinking water varied among the different areas of Lithuania. The groundwater contained high amount of iron due to the low quality of the water supply. Many water sources were from shallow water and often polluted with nitrates and microbes. From 1995 to 1996 an increase in people affected by foodborne infections and parasitic diseases was recorded.

Prevalence of under- and overweight

In Lithuania, more men than women were overweight especially in the younger age groups, but more than twice as many women in the age group 50–64 years were obese. The mean BMI for all age groups were very similar for men and women, 25.8 and 25.9 respectively.

Table 19. Prevalence of under and overweight, 19–64 years, Lithuania

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 348)	8	67	19	6
35–49 years (N= 403)	4	45	36	15
50–64 years (N= 378)	–	26	42	33
19–64 years (N= 1129)	4	45	33	18
Men	%	%	%	%
19–34 years (N= 345)	0.6	59	34	6
35–49 years (N= 352)	0.3	42	46	13
50–64 years (N= 267)	0.4	36	47	17
19–64 years (N= 964)	0.4	46	42	11

Statistics on dietary intake¹⁹

Table 20. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Lithuania

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	45	43	14	14	39	43	2	0.6

¹⁹ Dietary data was collected by one 24-hour recall carried out between July and September 1997. The sample consisted of 1431 men and 1569 women.

Table 21. Vegetable and fruit intake excluding potatoes, Lithuania

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	211	168	190
Fruit	138	202	170
Total	349	369	359

Central Asian republics

Kazakhstan

Questionnaire analysis 1994/1995 and 1998/1999²⁰

Nutrition policy, plan of action or strategy

In November 1998, by a decree of the president, Kazakhstan adopted a nutrition policy document entitled “The Health of the People”. The document incorporates all components of the World Declaration and Plan of Action. Partners in this process include the Ministries of Health and Sport; Science and Higher Education; Agriculture; Labour and Social Welfare; and Industry and Trade.

Advisory and administrative structures

An administrative structure responsible for the implementation of the policy and an advisory body (1995) was established in Kazakhstan. Members of the body include representatives from the Institute of Nutrition, advanced Medical Studies, State Centre for Research and Practical Work on Certification, Ministry of Agriculture, Ministry of Labour and Social Welfare, Government, Ministry of Health, Education and Sport and the national centre. The advisory body had a written mandate, but did not have a budget to cover its activities.

Interdisciplinary collaboration

The Institute of Nutrition, the Ministry of Science and the Academy of Science were responsible for collecting information on the dietary pattern of the population, while it was the governmental council on nutrition issues that was responsible for providing the information to relevant policy-makers. The Institute of Nutrition was responsible for public nutrition education. The Ministry of Health and the Ministry of Agriculture participated in a working group on the implementation of the programme “The Health of the People”.

Examples of normative actions

The country had a set of recommended nutrient reference values from the former Ministry of Health in USSR, which were last revised in 1991. It was reported that a population representative survey of dietary intake and nutritional status had been carried out, however it had not been published. A set of dietary guidelines from 1997 was directed at women, children and infants.

Country report 1999

Not submitted.

Prevalence of under- and overweight

No data provided.

²⁰ Kazakhstan: Questionnaire from 1994/1995 was not returned, therefore only the results from 1998/1999 questionnaire are presented here.

Statistics on dietary intake²¹

Table 22. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Kazakhstan

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	28	12	59	1

Table 23. Vegetable and fruit intake excluding potatoes, Kazakhstan

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	129	130	130
Fruit	31	39	35
Total	163	172	168

Kyrgyzstan

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The Kyrgyzstan adopted a nutrition policy in 1992, 1993, 1994, 1999 and 2000, however they were not comprehensive. The documents have incorporated components 1 through 8²² of the World Declaration and Plan of Action.

Advisory and administrative structures

The country did not have an administrative body to ensure implementation of the policy or an advisory body to provide scientific advice to policy-makers.

Interdisciplinary collaboration

In 1994/1995 it was reported that collaboration occurred between the Ministry of Industry and Trade, the National Committee on Statistics, the Ministry of Labour and Welfare and the State Committee of Economics. In 1998/1999 it was added that quarterly meetings were held with the Prime Minister. The National Committee of Statistics was responsible for collection of information regarding the dietary pattern of the population. In 1994/1995 it was reported that there was no department or ministry responsible for providing information regarding the dietary habits of the population to relevant policy-makers, nor had the responsibility for the public nutrition education been designated. However, in 1998/1999 it was reported that the National Committee of Statistics was responsible for providing data to relevant policy-makers and the Directors of the Sanepid Services in provinces, cities and districts were responsible for public nutrition education. Informal regular meetings took place between the Ministry of Health and the Ministry of Agriculture.

Examples of normative actions

The 1992 recommended nutrient reference values were completely renewed in 1998. It was reported in 1994/1995 that the country did not have dietary guidelines, but in 1999 dietary guidelines targeting special therapeutic need was being used. It was reported in 1994/1995 that a

²¹ Kazakhstan: Dietary data was collected in 1996 by 24-hour recall method.

²² 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

population representative survey of dietary intake and nutritional status was carried out in 1994, but no reference was given and in 1998/1999 it was stated that no survey had been published in the last 10 years.

Country report, 1999

Noncommunicable diseases and related risk factors

Morbidity is reported to have decreased in the period between 1991 and 1998. However, it may indicate a low rate of use of health services. Cardiovascular disease and cancer are prevalent causes of mortality.

The common diet in the Kyrgyzstan was dominated by bread, cereals and milk due to a shortage of meat, fruit and vegetables. The traditional diet, particularly consumed in rural areas, was very high in fat and consumption of vegetables and especially fruit was very low.

Approaches to overcome these problems included educational activities and training of health personnel to raise awareness and professional competence and integrate health issues into policies of other sectors.

Inequity and poverty leading to lack of food and nutrient deficiency

The socioeconomic transition period in the Kyrgyzstan resulted in lower living standards and limited public health services. There was widespread vitamin deficiencies and anaemia, particularly in vulnerable groups such as children, women and older people. Iron deficiency was most prevalent in the southern areas as meat was seldom consumed due to poverty. On average over 60% of children suffered from iron deficiency in the country. In the southern regions up to 80% of children had iodine deficiency manifested as an enlarged thyroid. The number of cases of endemic goitre had increased almost 4 times since 1995, despite several measures being undertaken at national level including a government-approved programme to eliminate iodine deficiency. Nevertheless, a number of planned activities had not been carried out due to lack of funding. Although seven salt iodination facilities have been established in the country, non-iodized salt was commonly used, because it was less expensive.

Infant, young children and maternal nutrition

Since 1994 nutrition-related morbidities increased in children. Too early introduction of complementary feeding and introduction of various liquids was a major problem²³. Since 1995, a national breastfeeding support and promotion programme had been implemented and a National Breastfeeding Policy adopted by the Ministry of Health. The effectiveness of the programme was monitored yearly. Despite these efforts, poor infant feeding practices continued. It was customary in rural areas to give infants “bulamyk” porridge (flour roasted on animal fats), which is too high a solute load on the immature system of the infants, especially the pre-term infants. Undernutrition in children was prevalent (Kyrgyzstan DHS survey 1998).

The main problems encountered to improve infant and maternal health was a shortage of public educational material and continuous training of health personnel. Furthermore, transportation to maternity services and lack of medicine represented a major problem.

²³ Michealsen KF, Weaver L, Branca F, Robertson A. Feeding and nutrition of infants and young children. Guidelines for the WHO European Region, with emphasis on the former Soviet countries. WHO Regional Publications, European Series, No. 87, 2000

Sustainable food production and distribution

No information was available.

Food safety

In the Kyrgyzstan there was a high number of foodborne diseases as a result of microbial food contamination due to the hot climate and poor water quality. In addition, in some areas food was produced in contaminated soil.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Tajikistan

Questionnaire analysis 1994/1995 and 1998/1999²⁴

Nutrition policy, plan of action or strategy

The parliament of Tajikistan adopted a nutrition policy document in 1994, which included components 1, 4, 5, 6, 7 and 8 and prevention of infectious diseases of the World Declaration and Plan of Action.

Advisory and administrative structures

It was reported that an administrative structure was set up and consists of the Ministry of Health and Sanitary and Epidemiological Inspection of Foods. The country did not have an advisory body to provide scientific advice to policy-makers.

Interdisciplinary collaboration

The Ministry of Agriculture and the Committee on Food and Processing Industry have regular collaboration regarding food issues. While it was the Ministry of Economy and Prognoses that were responsible for the collection of information regarding the dietary habits of the population, it was the Ministry of Health, which was responsible to provide this information to the relevant policy-makers. It was the Institute of Preventive Medicine, which was responsible for public nutrition education.

Examples of normative actions

It was reported in 1994/1995 that the country had a set of recommended nutrient reference values from the former Soviet era of 1982. In addition, it was reported that an unpublished population representative survey of dietary intake and nutritional status had been carried out.

Country report, 1999

Noncommunicable diseases and related risk factors

The life expectancy for Tajik men is 64 years and for women, 70 years. The infant mortality rate is among the highest in the region, despite a slight decline during the previous 10 years.

Inequity and poverty leading to lack of food and nutrient deficiency

Iodine deficiency disorder and iron deficiency anaemia was prevalent. Two programmes to fight these nutrient deficiencies had been adopted by the Ministry of Health.

²⁴ Tajikistan: Only the 1994/1995 questionnaire was returned and therefore only those results will be presented here.

Infant, young children and maternal nutrition

Breastfeeding had not been encouraged due to the presence of “milk kitchens”, which provided free milk to children during the time of the Soviet Union. 53% of infants were primarily or exclusively breastfed. Formulas for bottle-feeding were often homemade and introduced infections due to the poor living conditions and level of knowledge. A programme to encourage breastfeeding was being developed by the Ministry of Health. However, problems of implementation had diminished the impact of programmes.

Sustainable food production and distribution

No information provided.

Food safety

The ministries involved in food safety are the ministries of Agriculture, Environmental Protection and Education. Involved in this issue was also the Republican Sanitary and Epidemiological Service.

Prevalence of under- and overweight

In Tajikistan, more men are overweight and obese than women for all age categories. More women are underweight than men except for the 35–49 years age group.

Table 24. Prevalence of under and overweight, 19–64 years, Tajikistan

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 500)	16	78	6	–
35–49 years (N= 470)	11	75	13	2
50–64 years (N= 520)	12	69	15	4
19–64 years (N= 1430)	13	74	11	2
Men	%	%	%	%
19–34 years (N= 530)	13	76	9	–
35–49 years (N= 480)	13	65	19	4
50–64 years (N= 560)	7	63	25	5
19–64 years (N= 1570)	11	68	18	3

Statistics on dietary intake

No data provided.

Turkmenistan

Questionnaire analysis 1994/1995 and 1998/1999²⁵

Country report, 1999

In Turkmenistan the prevalence of circulatory diseases was high, especially among women. An increase in cancers had been registered. The diet was very high in carbohydrates (bread and bakery products) and low in protein due to low consumption of meat, fish, dairy products and eggs. A decreased consumption of vegetables (including potatoes) and fruits was reported.

²⁵ Turkmenistan: neither 1994/1995 questionnaire nor 1998/1999 questionnaire was returned.

Inequity and poverty leading to lack of food and nutrient deficiency

Deficiencies including vitamin C, B1 and B2 and anaemia were prevalent. The incidence of goitre was 20% and food analysis showed that the content of iodine in salt was 2–4 times below the recommended level. Impoverished groups had a very low intake of meat.

Infant, young children and maternal nutrition

Breastfeeding, although traditional in Turkmenistan, was not exclusive and the rate was declining. Infant morbidity increased after the age of 3 months and was related to the decreased rate of breastfeeding: in 1984, 75% of mothers breastfed but only 26% breastfed in 1991. Iodine deficiency disorders were prevalent among children. It had been reported that 64% of children between 8–9 years of age had goitre and 23% had enlarged thyroid gland.

Sustainable food production and distribution

Total food production had decreased and the transition to market economy had resulted in wide social inequalities. The per capita food consumption was highest in the capital.

Food safety

The country had problems with the control of usage of pesticides, which resulted in chemical residuals in agricultural products, soil and groundwater. In 1998, 664 tons of agricultural produce was unsuitable for human consumption due to contamination.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Uzbekistan

Questionnaire analysis 1994/1995 and 1998/1999²⁶

Noncommunicable diseases and related risk factors

The parliament of Uzbekistan adopted a nutrition policy document in August 1997. Only action 4 of the World Declaration and Plan of Action regarding the protection of consumers through improved food quality and safety was reportedly incorporated into the policy.

Advisory and administrative structures

An administrative structure for the implementation of the policy had been set up as well as an advisory body, which was established in June 1995 to provide scientific advice to the policy-makers. The advisory body had three members who represent the Deputy Minister of Health, the Director of Dietetics Centre and doctors. The advisory body did not have a written mandate or a budget to cover its activities.

Interdisciplinary collaboration

The Uzbek State committee for Statistical Forecasting was responsible for the collection of information regarding the dietary pattern of the population and the Republic Health Centre was responsible for public nutrition education. Consultations between the Ministry of Health and the Ministry of Agriculture regarding the national programme on food safety took place.

²⁶ Questionnaire from 1994/1995 was not returned therefore only data from 1998/1999 questionnaire presented here.

Examples of normative actions

Uzbekistan had a set of recommended nutrient reference values that was last revised in January 1998, but did not have dietary guidelines. No population representative survey of dietary intake and nutritional status had been carried out in the previous 10 years.

Country report, 1999

Noncommunicable diseases and related risk factors

Dietary habits in Uzbekistan were characterized by a high consumption of grain products, pulses, farinaceous dishes, meat dishes (only by the more wealthy), animal fat and a low consumption of fish. Also, consumption of vegetables and fruit was low despite their availability and the relative inexpensive price.

Inequity and poverty leading to lack of food and nutrient deficiency

The Ministry of Health adopted in 1997 a National Programme on Food Security of the Republic of Uzbekistan to overcome the problems of inequity of food.

Iodine deficiency disorder was prevalent due to low levels of iodine in soil and undergroundwaters. The Ministry of Health adopted guidelines for the prevention of iodine deficiency in January 1999. In addition, iron deficiency anaemia was widespread in Uzbekistan. However, the official attitude was not to fortify food as local foods contain levels of iron within normal ranges and because of the potential negative effects of a chronic surplus consumption of iron.

Infant, young children and maternal nutrition

The high number of mothers with multiple pregnancies, in conjunction with a poor diet, resulted in widespread hypogalactia²⁷, anaemia and extra-genital disorders. In addition, poor awareness of healthy nutrition for children further added to the morbidity among children and adolescents. To overcome these problems the country suggested carrying out educational programmes to improve the dietary habits among women and children.

The country was experiencing problems in developing policies and guidelines due to a lack of contact between scientists in Uzbekistan and scientific centres concerned with nutrition in developed countries and international organizations. In addition, there was inadequate information services and a lack of resources for programmes for studying nutrition. Needs for investments to begin manufacturing of baby formulas in the country had been voiced and for developing new processes and technologies for the production of children's food.

Sustainable food production and distribution

The country was experiencing a decline in agricultural production, increased prices of manufactured goods and major farm products and a declining purchasing power of the population. A National Programme of Food Security had been developed to ensure economic growth, to reduce risk of low level of food supply and consumption, to reduce social risks related to changes in the living standards and quality of life and to identify threats to the food security and social stability.

Food safety

The main threat to food safety was from bacterial and chemical contamination. In addition, certain geographic zones in the country have excess or deficiency of micronutrients. Moreover,

²⁷ Insufficient maternal production of milk.

small primitive production facilities, which did not meet standards resulted in low quality and contaminated foods. Therefore plans for a project aimed to increase food supply and reduce health threats was underway.

The country had a programme of food safety and objectives for the future was a revision of the list of permitted foreign substances including food additives and maximum levels. Though, a lack of investments in programmes of the development and enforcement of food standards limited the impact. There was a need to integrate approaches by all ministries and agencies in order to prevent the public health risks posed by foods. In addition, there was a lack of basic education and training in food hygiene and safety at technical and educational institutions.

Prevalence of under- and overweight

In Uzbekistan, more women are underweight than men. Obesity and overweight increases slightly with age for both men and women. However, the average BMI is only 22 and 21 for men and women, respectively.

Table 25. Prevalence of under and overweight, 19–64 years, Uzbekistan

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= n/a)	7	42	2	1
35–49 years (N= n/a)	5	12	4	2
50–64 years (N= n/a)	4	14	4	3
19–64 years (N= n/a)	17	68	9	6
Men	%	%	%	%
19–34 years (N= n/a)	3	38	2	2
35–49 years (N= n/a)	2	25	3	3
50–64 years (N= n/a)	2	13	5	4
19–64 years (N= n/a)	7	75	10	8

Statistics on dietary intake²⁸

Table 26. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	29	28	12	12	59	59	–	–

Table 27. Vegetable and fruit intake excluding potatoes

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	352	309	330
Fruit	79	78	78
Total	431	386	408

²⁸ No information regarding methodology employed for the collection of the dietary data was given.

Central and Eastern European Region

Bulgaria

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

Bulgaria adopted two policy documents concerned with nutrition, namely “Health Policy of Bulgaria” in 1996 and National Action Plan for Environment and Health in 1998, including the World Declaration actions 4–8²⁹ and Plan of Action.

Advisory and administrative structures

In 1998/1999 Bulgaria reported having an administrative structure responsible for implementation of the nutrition policy. In 1994/1995 the country stated having an advisory body with no written mandate that was established in 1992, but reported in 1998/1999 that no advisory body existed.

Interdisciplinary collaboration

Government-initiated collaboration occurred between parties responsible for food-related issues to discuss matters of legislation, food safety and quality, projects of decrees and laws and harmonization of legislation with EC directives. The responsibility for assessing the dietary pattern of the population shifted from the National Centre of Hygiene and the Department of Nutrition in 1994/1995 to the National Institute of Statistics in 1998/1999. Also the responsibility of providing information to policy-makers changed in this period from the Ministry of Health to the National Institute of Statistics. In same time period responsibility of public nutrition education changed to the National Centre for Health Education from the Ministry of Health and the National Centre of Hygiene in the Department of Nutrition and Health Promotion. Regular informal consultations on matters related to nutrition took place between the Ministry of Health and the Ministry of Agriculture.

Examples of normative actions

In 1994 Bulgaria finalized the recommended nutrient reference values. The last population representative survey of dietary intake and nutritional status was conducted in 1997 and prior to that a survey took place in 1993. The country’s dietary guidelines targeting the whole population were last revised in 1998 and prior to that in 1985.

Country report, 1999

Noncommunicable diseases and related risk factors

The leading cause of death in Bulgaria was diseases of the circulatory system (65%), especially cerebrovascular and ischaemic heart diseases. Hypertension affected 21–45% of the population and hyperlipidemias were also prevalent. Malignancies were the second leading cause of death and cancer mortality rate increased by 18% in the period 1988–1998. Especially incidences of colon cancer increased markedly. Likewise, incidences of diabetes were also increasing.

Overweight and obesity was common in Bulgaria. In 1985–90, 20–30% of the adult population was overweight and 35–40% was obese. Moreover, the prevalence was increasing in children,

²⁹ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

adolescents and adults. It was estimated that less than 50% of the population carried out regular physical activity. High total fat intakes of 35–40% were reported. The average consumption of vegetables and fruit was insufficient, but great seasonal variations were observed in consumption with the lowest intakes in winter/spring season. In addition, the intake of milk, dairy products and wholemeal bread were low, while salt consumption was high. The average fish consumption was low at an average of 8–10 g per day.

In 1987–88 goitre areas, which covered 1/3 of the country, had a prevalence of iodine deficiency disorder of 23.3%. A national programme for the prevention existed from 1960s until 1980s where it was suspended due to financial and organizational problems. In 1995 a national programme to eliminate iodine deficiency disorder was commenced and positive effects were registered in a national survey conducted in 1997. It was estimated that 88% of retailed salt was iodized. In addition, inadequate consumption of vitamin A, thiamine, riboflavin, vitamin B6, folate, ascorbic acid, calcium, iron, zinc and magnesium was reported.

There was no integrated food and nutrition policy, but dietary guidelines and recommendations for healthy nutrition in school canteens had been published. The WHO CINDI³⁰ programme has been implemented since 1994 and a Nutrition Surveillance Programme was started in 1997 to monitor the nutritional situation and the efficiency of intervention measures. A health policy to reduce diet-related noncommunicable diseases was under development.

Inequity and poverty leading to lack of food and nutrient deficiency

The main problems encountered in the development of policies and guidelines were frequent changes of governments during the transition period. In addition, lack of financial resources was a main obstacle in the implementation of adopted programmes. The government was mainly concerned with poverty-related issues.

The transition from a centrally planned to a market economy resulted in the transformation of social and economic life leading to increased poverty and unemployment. An expenditure of 36% of income was spent on food in 1990, compared with 48% in 1998. Families most affected by the transition were families with more children, unemployed, disabled and pensioners above 70 years of age, and especially families of Gypsy and Turkish ethnic origin.

There was a decreased consumption of bakery products, milk, yoghurt, eggs, meat and fruit among the poor. Approaches to overcome these problems aimed to provide minimum income to guarantee vital needs in certain social groups (e.g. disabled people and mothers of many children) and for specific needs (e.g. electricity and heating). However, the poverty criteria did not work as intended and resources available for this group was small compared to the number of people affected by poverty. Furthermore, conflicting considerations and reliability of available information made it difficult to develop policies.

Infant, young children and maternal nutrition

Infant mortality rates started declining in 1998 compared with the increasing trend during 1990–1997. However, the proportion of infants with low birth weight had increased possibly indicating a worsening of the nutritional status of the mother.

The rate of mothers who breastfed had declined from an initiation rate of 86% in 1980 to 70% in 1990 and poor weaning practices were widespread. Substitutes for breastfeeding often included

³⁰ Countrywide integrated Non-communicable Disease Intervention

diluted yoghurt. This was particularly noted in rural areas and among low-income groups. Regulations for formulas and foods for infants and young children were currently being developed.

During the transition period food shortage resulted in increased under-nutrition of children and adolescence. Between 10–25% of children were stunted or had low height-for-age. Stunting was especially prevalent in rural villages. The highest prevalence of underweight was seen among young women (15–16%).

Iron deficiency anaemia was observed in 19% of pregnant women from Sofia, and in addition high prevalence of deficiencies of riboflavin (60%), ascorbic acid (29%) and zinc (43%) had been reported. No information regarding the prevalence of these deficiencies in a broader population group was available.

A lack of data to identify micronutrient deficiencies, due to financial shortage and lack of updated methods and equipment to assess vitamin status, made the development of guidelines and policies difficult.

Sustainable food production and distribution

Following the reform there has been a decrease in agricultural and livestock production and most small farms produced for their own consumption only. In addition, a decrease in demand of processed foods had been observed due to reductions of disposable income resulting in increased home processing. The limited range of low quality products and a lack of marketing experience and knowledge for entering the market economy make it difficult to compete outside the country.

No policies had been developed on these issues and health considerations are neglected in agricultural and food production strategies. However, the WHO CINDI³¹ programme had initiated a project on the implementation of production of foods with reduced salt and saturated fat content and increased content of dietary fibre.

Food safety

Higher nitrate levels than permitted had been recorded in 5–7% of tested fruit and vegetables samples. Foodborne diseases were widespread in Bulgaria. *Salmonella enteritidis* and *Staphylococcus aureus*, as well as the more rare cases of botulism and trichinelosis, were rising. Most contaminated food stemmed from private households (59%) followed by kindergartens and school canteens (26%) indicating a lack of knowledge of measures to prevent microbial contamination of foods. The main problems related to control of foodborne diseases were concerned with the diagnosis of foodborne diseases and inadequate system of reporting. Between governmental agencies and nongovernmental organizations a lack of coordination was reported. The food producers and distributors underestimated their responsibility and were not expected to take responsibility by society. Moreover, producers and staff to control food safety had unsatisfactory training.

The Parliament adopted The Food Law in 1999 as it was acknowledged that several aspects related to food safety need to be emphasized such as the reliability of data, lack of coordination of activities between different institutions dealing with the issues and the need for training and education of personnel and the public.

³¹ Countrywide integrated Non-communicable Disease Intervention

Prevalence of under- and overweight

In Bulgaria, more women (especially in the 18–30 age group) were underweight than men. Overweight and obesity increased with age for both sexes, but more men than women were overweight. On average, the prevalence of obesity was similar in women and men.

Table 28. Prevalence of under and overweight, 18–74 years, Bulgaria

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
18–30 years (N= n/a)	16	71	12	1
30–60 years (N= n/a)	2	58	30	11
60–74 years (N= n/a)	2	42	41	16
18–74 years (N= n/a)	6	57	28	9
Men	%	%	%	%
18–30 years (N= n/a)	5	73	20	2
30–60 years (N= n/a)	0	41	44	15
60–74 years (N= n/a)	0.5	37	51	12
18–74 years (N= n/a)	2	51	38	10

Statistics on dietary intake³²

Table 29. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	33	35	13	13	49	51	5	1

Czech Republic

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

It was reported that in 1992 the Czech Republic adopted a policy document, but that in 1998/1999 the policy document was under preparation. Components of the World Declaration and Plan of Action included in the first document were actions 1, 2, 5, 6 and 8, whereas this was changed to 1, 4, 5, 7 and 8 in the later version (1998/1999).

Advisory and administrative structures

No administrative structure had been set up to manage the implementation of the nutrition policy. Although the country had an advisory body since 1991, this body did not have a written mandate or a budget to cover its activities. The advisory body was made up of representatives of the ministries of Health and Agriculture, the Medical Faculty and the Nutrition Society.

Interdisciplinary collaboration

Collaboration between the ministries of Health and Agriculture and the nongovernmental Nutrition Society took place. The responsibility of collecting data on the population's dietary pattern was, in 1994/1995, with the National Institute of Public Health, but in 1998/1999 this changed to the Ministry of Agriculture and the Institute for Agricultural Economy. The

³² Dietary data was collected by 24-hour recall in March 1998. All days of the week is proportionally included and the representative sample size was 2757.

responsibility for providing information to relevant policy-makers was in 1994/1995 with the ministries of Health and Agriculture and no information was provided regarding this in 1998/1999. Also the responsibility for public nutrition education changed in this period from the National Centre for Health Promotion to the National Institute of Public Health. Informal consultations were reported to take place between the ministries of Health and Agriculture.

Examples of normative actions

Recommended nutrient reference values dated from 1989. No population representative survey of dietary intake and nutritional status had been conducted during the previous 10 years. The current dietary guidelines were developed in 1994 and were directed at the whole population. The guidelines were not field-tested.

Country report, 1999

Noncommunicable diseases and related risk factors

Between 1982 and 1993 the standard mortality rate decreased for both men and women from 840.2 per 100 000 to 729.7 per 100 000 for men and from 546.6 per 100 000 to 468.1 per 100 000 for women. Hypertension was more prevalent in women (11.6%) than men (8.6%). Cancer incidence was increasing (from 1996 to 1997 the incidence increased by 5%). The prevalence of smoking was similar in both sexes (men 40% and women 38%).

Dietary habits were characterized by a high saturated fat intake and low consumption of fruit and vegetables. Dietary guidelines, educational programmes for basic and secondary schools and CINDI³³ activities had been initiated to help overcome the problems of noncommunicable diseases. However, the lack of a national nutrition policy made this difficult.

Inequity and poverty leading to lack of food and nutrient deficiency

The most vulnerable group in the country was the Romanian population. It was reported that poor people had a low intake of antioxidants, iodine, but excess energy intake (>3600 kcals) and a high fat consumption (>33% of energy from fat). Dietary guidelines were available in both Czech and Romanian languages. Intervention programmes were aimed at improving the dietary habits of the Romanian children. Lack of legislation regarding vulnerable groups as well as a lack of financial and human resources and communication problems caused difficulties in developing policies and guidelines concerning this issue.

Infant, young children and maternal nutrition

Breastfeeding was initiated by 88% of mothers, but only 23% were breastfeeding at 6 months post-partum. In addition, weaning practices were often poor. However, lack of interest by government in endorsing the international Code of Marketing of Breast-milk Substitutes did not help improve the situation.

Children had a low consumption of fruit and vegetables. Education programmes at schools and school catering followed dietary guidelines. In addition, a governmental programme “ School milk” was designed to ensure milk for the 6–8 years old children in schools. Finally, legislation allowed control and inspection by Hygiene Stations in school catering.

³³ Countrywide integrated Non-communicable Disease Intervention

Sustainable food production and distribution

Low financial support for local agricultural production and a liberal free market without sufficient state protection of the national agriculture did not promote the sector. In addition, less than 1% of the total agriculture was organically produced.

One programme supported sustainable agriculture by giving financial support for grass production in selected marginal regions. Educational projects were ongoing in basic and secondary schools. In addition, Bachelor and Master study programmes in sustainable agriculture and food production were conducted.

Food safety

The incidence of *Salmonella* was increasing, particularly in mass-catering establishments. In 1993 the incidence rate was 417/100 000 and had risen to 493/100 000 in 1998. Conversely, the incidence of *Shigellosis* had decreased from 11.6/100 000 in 1993 to 5/100 000 in 1998.

The Hazard Analysis and Critical Control Point (HACCP) plan was only beginning to be implemented in the food industry. International Standardization Organization norms were only rarely employed and not compulsory. It was recommended that new legislation be introduced to ensure supervision, surveillance and inspection of the food industry to reduce some of the current food safety problems.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake³⁴

Table 30. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	36	12	50	2

Table 31. Vegetable and fruit intake excluding potatoes

Food Groups	Total, g/day
Vegetables (÷potatoes)	219
Fruit	194
Total	413

Hungary

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In 1992 Hungarian government adopted a nutrition policy document, but in 1998/1999 a new policy document was planned to be adopted. The components of World Declaration and Plan of

³⁴ Czech Republic: Dietary data stems from the national statistic on food purchase.

Action that was included in the new document was expanded from action 1, 2, 5, 6, 8 to include all 8 actions.³⁵

Advisory and administrative structures

In 1994 the country reported having an administrative structure responsible for the implementation of nutrition policy, which was set up in 1985, and an advisory body for providing scientific advice to national policy-makers. None of these were reported to exist in 1998/1999.

Interdisciplinary collaboration

In 1994/1995 the government initiated collaboration between the ministries of Agriculture, Welfare, Industry and Commerce and Foreign Affairs and the National Board of Technical Development, but not in 1998/1999. Furthermore, in 1994/1995 the National Institute of Food Hygiene and Nutrition was responsible for the collection of information of the dietary pattern of the population and the Central Food Research Institute was responsible for providing this information to the relevant policy-makers. The National Institute of Food Hygiene and Nutrition was also responsible for the public nutrition education. No information regarding these responsibilities was given in 1998/1999. In 1998/1999 it was reported that informal consultations take place between the Ministry of Health and the Ministry of Agriculture on matters related to nutrition.

Examples of normative actions

Hungary has a set of recommended nutrient reference values from 1994/1995 and has carried out two population representative survey of dietary intake and nutritional status in the periods of 1985–1988 and 1992–1994, which have both been published. Furthermore, the country had dietary guidelines that were last updated in 1988 and was directed at the whole population. The dietary guidelines were not field-tested prior to use.

Country report, 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease mortality accounts for 51% of total deaths, whereas cancer mortality accounts for 25%. In the period 1992–1994, 38% of the population were overweight, 20% moderate obese and 1% seriously obese. Diabetes is affecting between 300 000 and 500 000 of the population and hypertension between 900 000 and 1 000 000 of a population of 10 300 000 people.

The dietary habits were characterized by high total fat intake, high saturated fat intake and high cholesterol intake, whereas intake of polyunsaturated fatty acids was low. In addition, the intake of animal protein and the sodium/potassium ratio was high. In contrast, borderline deficiencies of certain micronutrients were prevalent.

No food and nutrition policy existed, but a committee from the Hungarian Academy of Science had put forward “Proposals for the development of Hungarian food and nutrition policy”. The document did not include practical details, but rather emphasized the need for actions. In 1997 a

³⁵ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Heart Healthy Programme was carried out supported by the World Bank. Nutrition was not considered a priority in health and economic policies.

Inequity and poverty leading to lack of food and nutrient deficiency

The lowest income group spent 37–38% of income on food. Micronutrient deficiencies and mild forms of hypothyroidism were especially widespread in the poor and elderly, but no survey regarding this was carried out.

No policies, guidelines or programmes had been developed to tackle these issues. There was a strong need for programmes to help the homeless and unemployed, catering programmes for single elderly, representative nutrition surveys of the poor and elderly to detect the extent of nutritional problems. Finally, adequate measures to relieve the consequences of poverty were necessary.

Infant, young children and maternal nutrition

Breastfeeding rates were low and weaning practices poor. At 6 months post-partum only 54% of mothers breastfed their children. Children had a diet low in vegetables and consumed high amounts of sweets, snacks and soft drinks. In children between 11–14 years it was reported that 20% were obese and 6% of the obese children had hypertension. In adolescence it was reported that 1% of boys had iron deficiency anaemia, while 3% of girls suffered from this.

Nutritional knowledge of mothers was low and there was a lack of nutrition education in schools.

Sustainable food production and distribution

Since 1985 the agricultural production decreased by 30%, but was reported not to have affected the food security in the country. However, the distribution of food was unsatisfactory and choice of food was limited in rural areas. Main problems faced in developing guidelines and policies was to increase choice of food, which included a more favourable composition from a nutritional point of view. In addition it was desirable to reduce environmental contamination during production. The development of retail trading in villages in the future may improve and broaden the choice of food.

Food safety

Salmonella Enteritidis was the most frequent foodborne disease and accounted for 85% of cases. Most often food contamination occurred in the household due to incomplete heating, toxic mushrooms and other contaminated raw material. To solve some of these problems a law to prevent foodborne diseases and to protect the health of the consumer was adopted. However, the implementation of Hazard Analysis and Critical Control Points system in catering, medium and small enterprises was hindered by lack of financial resources. In addition, the legislation for mass catering was out of date and was being reviewed. Finally, the consumer information regarding food safety was poor and efforts needed to be enhanced.

Prevalence of under- and overweight

In Hungary, more men than women were overweight and on average the prevalence of obesity was similar between the two genders. At the same time more women than men were underweight especially for the age group 18–34 years. The mean BMI values were similar for men and women of 26.7 and 26.1 respectively.

Table 32. Prevalence of under and overweight, 18+ years, Hungary

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
18–34 years (N= n/a)	20	55	17	8
35–59 years (N= n/a)	5	39	31	25
> 60 years (N= n/a)	1	26	40	33
18+ years (N= n/a)	9	42	28	21
Men	%	%	%	%
18–34 years (N= 338)	10	48	33	9
35–59 years (N= 730)	1	25	47	27
> 60 years (N= 55)	4	24	46	27
18+ years (N= 1173)	4	33	42	21

Statistics on dietary intake

Dietary data was collected by a three-day (two working days and one Sunday) dietary record method. The survey was carried out in 1992–1994 and included people above the age of 18 years in Budapest and 11 counties of the 19 counties in Hungary.

Table 33. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Hungary

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	38	38	15	15	44	46	4	0.8

Table 34. Vegetable and fruit intake excluding potatoes, Hungary

Food Groups	Total, g/day
Vegetables (÷ potatoes)	201
Fruit	159
Total	360

Poland

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 was not returned and therefore only results from 1998/1999 questionnaire are presented here.

Nutrition policy, plan of action or strategy

In September 1996 and April 1998, the council of ministers in Poland adopted two policy documents, namely, the National Health Programme 1995–2005 and the Medium-Term Development Strategy for Agriculture and Rural Areas. It appears that all the components of the World Declaration and Plan of Action were incorporated in the documents.

Advisory and administrative structures

Poland had both an administrative structure to ensure implementation of the policy document and an advisory body to provide scientific advice to policy-makers (established in 1963). The advisory body had a budget to cover its activities, which was financed by the State.

Interdisciplinary collaboration

Government-initiated collaboration occurred between committees for milk quality and for soil, plant and food quality and agricultural products.

The National Food and Nutrition Institute was responsible for the collection of information regarding dietary pattern of the population, providing information to the relevant policy-makers and for public nutrition education. Formal consultations between the Department of Public Health and the Veterinary Department occurred on a regular basis.

Examples of normative actions

Poland had a set of recommended nutrient reference values and field-tested dietary guidelines directed at the adult population, which were revised in 1994 and 1998, respectively. Poland had not carried out a population representative survey of dietary intake and nutritional status within the last 10 years.

Country report, 1999

Noncommunicable diseases and related risk factors

In 1999, cardiovascular disease accounted for 50% of total deaths and the cancer mortality rate was 166 per 100 000. Furthermore, non-insulin dependant diabetes mellitus affected 6% of the population and around 30% of men and 27% of women were reported to be overweight in Poland.

Energy intake was excessive and consumption of a high fat diet, especially in saturated fatty acids in conjunction with high intake of cholesterol, salt and alcohol resulted in high rates of noncommunicable diseases in the country. However, a reduction of saturated fat and an increase of fruit and vegetables had been noted more recently. The intake of iodine, calcium, iron and fibre was low.

Several programmes concerned with cardiovascular disease and cancer had been carried out and a long-term health programme "Programme of Health" was planned, whereby it was hoped that the dietary habits of the population would improve.

Inequity and poverty leading to lack of food and nutrient deficiency

Moderate goitre reportedly affected 2.5 million during the mid-1990s. A programme to eliminate iodine deficiency disorder was adopted by Cabinet as part of the National Health Programme 1996–2000. Iron-deficiency anaemia was reported in 10% of women of reproductive age. In addition, calcium deficiency reportedly led to osteoporosis in 30% of women 50 years or above.

Infant, young children and maternal nutrition

In 1999 a low rate of breastfeeding was reported in the country, but estimates were that the rates were increasing. Only 57% of mothers reported breastfeeding 6 months post-partum. In addition, weaning practices were poor and often non-modified cow's milk was introduced too early. Around 8% of infants were born with low birth weight and neural tube defects affected 80 per 100 000 live births. Women were recommended to take folic acid before and during pregnancy, but the awareness among women and health professionals was reported to be low. In addition, the diet of mothers was often low in calcium, iron and B vitamins and high in fat.

Several programmes aimed at improving the health of infants and mothers were reported, including a programme to promote breastfeeding and prevent neural tube defects, the WHO/UNICEF Baby Friendly Hospital Initiative, and a family planning programme.

Sustainable food production and distribution

In 1999 agricultural production was low compared to the number of farms and area of land available. Production and imports of fruit were increased. About 40% of the rural population consumed homegrown produce and in the whole country the demand for food decreased following the abandoning of low retail prices on food protected by state subsidies.

In 1998, rural areas were supported by a medium-term plan to develop the agriculture in these areas. In 1999 this was followed by a more coherent structural policy. However, shortage of financial means to reach the goals resulted in insufficient research. In addition, there was a lack of sufficiently qualified specialists prepared to undertake nutritional education and there were also insufficient teaching aids for the dissemination of information.

Food safety

Salmonella infections were the cause of 82% of bacterial infections. There was a relatively high incidence of diarrhoea in small children. Hepatitis A was also prevalent. The country was experiencing difficulties in introducing the monitoring system for quality of food and safety. In addition, ensuring compliance with hygienic sanitary requirements was a problem. The country also needed to introduce systems such as Hazard Analysis and Critical Control Points and the country sought to adapt the Polish Law on Food to that of EU laws. To overcome some of the problems regarding food safety and quality, the country planned ordinances for food labelling, genetic modified organisms and on licenses of production, import, food additives and water quality. Poland was also planning a long-term programme, which was a reflection of the WHO programme "Food and Nutrition Action Plan".

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Romania

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1998/1999 was not returned and therefore only results from 1994/1995 are presented here.

Nutrition policy, plan of action or strategy

The Ministry of Health in Romania adopted in 1994 a nutrition policy document (full document was reported to be undergoing governmental approval). None of the components of the World Declaration and Plan of Action was included, but prevention of infectious diseases was mentioned in the document.

Advisory and administrative structures

No administrative structure to ensure implementation of the policy had been set up nor had the country an advisory body to provide scientific advice to the policy-makers.

Interdisciplinary collaboration

No governmental initiated collaboration between partners involved in food-related issues had been established. The Institut d'Hygiène et de Santé Publique was responsible for the collection of information of the dietary pattern of the population, the Centre de la Santé Par la Direction

Générale de la Médecine Préventive et Promotion de la Santé was also responsible for providing the information to relevant policy-makers. The Centre National de Promotion de la Santé et d'Éducation pour la Santé was responsible for public nutrition education.

Examples of normative actions

Romania had a set of recommended nutrient reference values from 1992, but had not developed dietary guidelines. It appeared that Romania had carried out a population representative survey of dietary intake and nutritional status, but no additional information was provided.

Country report, 1999

Noncommunicable diseases and related risk factors

It was reported that cardiovascular disease and cancer only accounted for 3% and 2% of morbidity in the country, while nutrition and metabolic disease were reported to account for 0.8% of morbidity. The country had programmes for the prevention of cardiovascular disease and diabetes and other nutritional related diseases.

Dietary patterns were characterized as being in animal fats, salt, sugar and alcohol, while the consumption of fresh fruit, fresh vegetables, dairy products, fish and cereals were low.

Inequity and poverty leading to lack of food and nutrient deficiency

On average 60% of income was spent on food in Romania. IDD was still a problem especially in mountain and sub-mountain areas. No additional information was reported regarding inequity and poverty.

Infant, young children and maternal nutrition

It was reported that paediatricians should advise mothers about breastfeeding instead of prescribing formulas for infants routinely. Breastfeeding rates were higher in the rural areas. Cow's milk was often used as a weaning food and iron deficiency anaemia was not uncommon. A programme had been adopted to reduce some of these problems related to infant and maternal health.

Sustainable food production and distribution

No information concerning problems related to food production and distribution was provided. However, ministerial order regarding hygienic and sanitary norms for food production, preparation, depositing, storing, transportation and commercialization had been given. In addition, a law concerning environmental protection and a Food Law had been adopted.

Food safety

In 1999 2228 cases of foodborne diseases was registered. The main infectious agents were *Salmonella*, *Staphylococcus*, *E. Coli*, *Shigella*, *Proteus* and *Closteridium*. A ministerial order regarding organization and activity of the State Sanitary Inspection, and a governmental order for modification and completion of a law in 1994 was passed regarding hygiene and public health. In addition, the adopted Food Law was concerned with the production, circulation and commercialization regulations.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Slovakia

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The latest nutrition policy document that Slovakia had adopted was in 1997. Prior to this the country had a policy document adopted in 1989. Both the documents appeared to include all the components of the World Declaration and Plan of Action.

Advisory and administrative structures

In 1994/1995 the country appeared to have an advisory body with a written mandate and responsible for providing scientific advice to the policy-makers. This was established in 1954. However, in 1998/1999 the advisory body did no longer exist.

Interdisciplinary collaboration

In 1994/1995 the Research Institute of Nutrition was responsible for the collection of information regarding population dietary patterns, but in 1998/1999 the responsibility was shared between this institute and the Ministry of Health. The Ministry of Health did also take over the responsibility of providing this information to relevant policy-makers from the Research Institute of Nutrition. In 1994/1995 the Institute of Health education and a nongovernmental organization the Society for Rational Nutrition was responsible for the public health education, which in 1998/1999 was solely the responsibility of the Institute of Health Education.

Examples of normative actions

Slovakia had a set of recommended nutrient reference values. The latest update took place in 1997 and prior to this in 1989. It was stated that the country had carried out a population representative survey of dietary intake and nutritional status within the last 10 years. However, no reference was given. Slovakia had dietary guidelines directed at the whole population. These were last updated in June 1997 and prior to this in 1989.

Country report, 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease mortality was 53% and cancer mortality 20%. In Slovakia 20% of women and men were overweight, while 10% of the children were overweight. High-energy intake and low physical activity was resulting in widespread overweight. A programme of Public Health promotion had been carried out in the country.

Inequity and poverty leading to lack of food and nutrient deficiency

Widespread detrimental dietary habits were the result of the economic transformation and increasing unemployment. Low intakes of calcium, vitamin C, B1, B2 and B6 were prevalent. The National Programme for Health Support from 1994 was approved by the Government and was waiting to be adopted by the Parliament. The programme included a programme to promote healthy nutrition for the population.

Infant, young children and maternal nutrition

Low rates of breastfeeding and aggressive marketing of baby-formulas was reported as the main cause of persistent problems of infant nutrition. However, a small increase in the breastfeeding rate at 6 months post-partum had been reported. In 1990 25% of mothers were still breastfeeding at 6 months post-partum. Poor weaning practices were prevalent and consisted of too early introduction of cow's milk, especially in poor social conditions and among the Gypsy population.

Since 1993 UNICEF promoted breastfeeding in the country. In addition, the composition of supplementary formulas for infants and young children was made in line with the requirements of the FAO/WHO as part of the food codex, which came into force January 2000. However, problems persisted, as the introduction of a health insurance system did not enable implementation of sufficient preventive care for young child and infant nutrition.

Sustainable food production and distribution

A decline in the production and therefore in consumption of milk, milk products, fish and potatoes had occurred. In contrast, a high production of fat was resulting in high fat consumption and hence high energy intake. The high fat production was due to financial benefits for food products with high fat content, especially produce of animal origin. Furthermore, a high salt intake was related to the high production and processing methods used in the food industry. The programme of nutrition promotion, which was adopted, was aimed at solving these problems. In addition, ministries were committed to develop and meet the programme targets.

Food safety

No serious problems of foodborne diseases had been experienced since the control of food contamination begun. However, insufficient hygiene control had been observed at old factories, wrong storage conditions of raw materials, a lack of respect of cleaning and sanitation regimes and a lack of knowledge of hygiene rules was common.

Approaches to solve some of these problems included monitoring the food chain and consumption. In addition, the Food Act came into force 1996 and a new act on technical requirements on product assessment came into force in January 2000.

Prevalence of under- and overweight

In Slovakia, more men than women were overweight, but more women were obese except in the age group 19–34 years. In addition, more women were underweight in all age groups except for the 50–64 years. The mean BMI was 26.97 and 26.36 for men and women respectively.

Table 35. Prevalence of under and overweight, 19–64 years, Slovakia

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 289)	7	70	17	7
35–49 years (N= 1284)	1	40	35	23
50–64 years (N= 373)	0	28	39	33
19–64 years (N= 1946)	2	43	33	23
Men	%	%	%	%
19–34 years (N= 118)	0.9	53	34	12
35–49 years (N= 588)	0.3	29	51	19
50–64 years (N= 338)	1	21	52	26
19–64 years (N= 1044)	0.7	29	49	21

Statistics on dietary intake

Table 36. Daily macronutrient and alcohol intake expressed as % of total energy intake, Slovakia

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	33	11	56	–

Table 37. Vegetable and fruit intake excluding potatoes, Slovakia

Food Groups	Total, g/day
Vegetables (÷ potatoes)	296
Fruit	187
Total	483

Commonwealth of Independent States

Armenia

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from neither 1994/1995 nor 1998/1999 was returned.

Country report 1999

Noncommunicable diseases and related risk factors

Morbidity statistics showed a decrease in noncommunicable diseases, however this was likely to be a reflection of the usage of health services, because the actual mortality rate of noncommunicable diseases was increasing.

Inequity and poverty leading to lack of food and nutrient deficiency

It was reported that only 13% of the population spent 25% of income on food. The diet of the poor was monotonous, rich in carbohydrate and often low in energy. The consumption of milk, meat, fruits and vegetables was inadequate.

In 1995, the prevalence of iodine deficiency was 30% of women and 41% of children. Salt iodination had been carried out since 1970, but had been irregular during the economic crisis and was virtually stopped in 1992. A programme to control iodine deficiency disorder was being implemented with support from UNICEF. In addition, a programme on food supply was in 1999 approved by the government.

Infant, young children and maternal nutrition

The diet of mothers was often unbalanced and monotonous dominated by carbohydrates. Anaemia among women of childbearing age was 16% and a ten fold increase was reported among pregnant women. Around 5% of women had a BMI of less than 18.5.

Low breastfeeding rates and poor weaning practices were widespread. Only 21% of mothers ever breastfeed exclusively and early introduction of supplementary food and feeding from 2 months was common. The use of unmodified cow's milk too early was usual.

Severe undernutrition was not reported, but chronic undernutrition appeared to be increasing. In 1995, stunting was affecting 6% of children, while in 1998 this prevalence increased to 13%. In addition, 25% and 35% of children below the age of 5 years and 2 years, respectively, had

anaemia. Rachitic symptoms were reported in 22% of children, while less than 1% suffered from vitamin A deficiency.

The Ministry of Health dealt with infant and maternal health and several programmes had been adopted to ensure the health of these groups. Strategies included improvement of knowledge and skills of professionals and to provide mothers with necessary psychological and practical support. A system to monitor the nutritional status of women and the growth and development of young children was planned and public awareness would be raised through the use of mass-media.

Sustainable food production and distribution

No information regarding this was provided.

Food safety

The number of food samples that fail to meet standards had increased in recent years. In 1993 3% failed to meet standards, while 10% failed in 1997. Botulism was the main type of food poisoning recorded.

Food produced in small private enterprises without the appropriate technology and on-site control resulted in widespread trade of uncontrolled food. In addition, widespread use of home-made canned vegetables posed a health risk. Hazard Analysis and Critical Control Points was not implemented yet, but other programmes had been adopted to ensure safe food for the population.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Azerbaijan

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

Azerbaijan adopted a nutrition policy document in 1992. In 1996, 1997 and 1998 documents regarding consumers' rights, hygiene and breastfeeding respectively were adopted. The document from 1992 included the components 1, 2, 6, 7 and 8 the World Declaration and Plan of Action. In the later documents only actions 4 and 5 was mentioned to be included.³⁶

Advisory and administrative structures

In 1998 the country established an advisory body that had a written mandate and was responsible for providing scientific advice about breastfeeding and health related issues to the policy-makers. The advisory body did not have a budget to cover its activities.

Interdisciplinary collaboration

In 1994/1995 the Cabinet of ministers, local authorities and the Academy of Sciences had regular collaboration on issues related to nutrition. In 1998/1999 the government organized collaboration

³⁶ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

between state, departmental, industrial and social sanitary surveillance in the field of food production, preparation and sale.

In 1994/1995 the Chair of hygiene and communal hygiene was responsible for collection of population dietary patterns while, in 1998/1999, it was reported that the Department of Standards of Living and Domestic Economy and the State Committee was responsible. In 1994/1995 the Head of sanitary epidemiological inspection was responsible for informing relevant policy-makers on nutrition related matters. In 1998/1999 it was reported that this responsibility was shifted to the Ministry of Health (the chief nutrition specialist). Public health education was in 1994/1995 the responsibility of the House of sanitary enlightenment of the Ministry of Health, which in 1998/1999 was reported to have changed to the Republic Centre of Hygiene and Epidemiology and the Centre for Epidemiological analysis and health education.

Informal irregular consultations were held between the ministries of Health and Agriculture on the selection of environmentally friendly farms for the supply of milk and fruit to infant feeding units in dairies and canneries

Examples of normative actions

The recommended nutrient reference values were from the former USSR and reported to be last updated in 1997 and prior to that in 1991 and 1992 and were the responsibility of the Ministry of Health.

The most recent reference for a population representative survey of dietary intake and nutritional status in the country was from 1998 and prior to this a study was carried out in 1997. The latest dietary guidelines were field-tested before publication in 1997 and were directed at the whole population. Prior to 1997 dietary guidelines from 1993 was used.

Country report, 1999

No country report was submitted.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

Dietary data was obtained by 24-hour recall in 1994/1995.

Table 38. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Azerbaijan

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	16	12	69	3

Table 39. Vegetable and fruit intake excluding potatoes, Azerbaijan

Food Groups	Total, g/day
Vegetables (÷ potatoes)	121
Fruit	46
Total	166

Belarus

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 was not returned and therefore only results from 1998/1999 questionnaire are presented here.

Nutrition policy, plan of action or strategy

Belarus did not have a nutrition policy, but the government maintained projects on breast-feeding and fortification of selenium and folic acid.

Advisory and administrative structures

No information was given regarding the existence of an administrative structure responsible for implementation of nutrition policy or an advisory body.

Interdisciplinary collaboration

It was reported that regular government initiated collaboration concerning food-related issues took place. The Ministry of Statistics and Analysis was responsible for the collection of dietary data and for passing this information to policy-makers. Informal or formal consultations between the Ministry of Health and the Ministry of Agriculture took place to jointly prepare documents.

Examples of normative actions

The recommended nutrient reference values used in Belarus originate from the former Soviet Union. The reference values were the responsibility of the Labour Ministry. It was stated that the country had carried out a population representative survey of dietary intake and nutritional status within the previous 10 years, but no reference was given. The dietary guidelines were reported to have been field-tested and were last updated in 1997 and were directed at special groups and children.

Country report, 1999

Ischaemic heart disease mortality was 143 per 100 000 and cancer mortality 115 per 100 000. The dietary pattern in the country was one of high animal fat and sugar consumption, low consumption of fibre, fruit and vegetables. The only policy guideline mentioned was control of food that was produced for consumption.

Inequity and poverty leading to lack of food and nutrient deficiency

The only information reported regarding inequity and poverty was that this group has a low intake of selenium, zinc and iodine.

Infant, young children and maternal nutrition

It was reported that 69% of infants suffered from iodine deficiency disorders. Approaches to solve problems in the country included health education and to provide the population with enough food of good quality.

Sustainable food production and distribution

No information was given regarding this.

Food safety

Between 2–6% of food samples were reported to be microbiologically contaminated. It was most often confectionery, fish and dairy products that were contaminated. Between 43–46% of

examined breast-milk samples exceeded the allowed level of DDT. Several regulations had been adopted to ensure food safety in the country.

Prevalence of under- and overweight

In Belarus, the mean BMI was 25.4 and 24.2 for men and women respectively.

Table 40. Prevalence of under and overweight, 19–64 years, Belarus

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 500)	3	80	17	0
35–49 years (N= 470)	0	54	36	11
50–64 years (N= 520)	0	25	55	20
19–64 years (N= 1430)	1	58	33	9
Men	%	%	%	%
19–34 years (N= 6)	33	50	17	0
35–49 years (N= 18)	0	50	28	22
50–64 years (N= 15)	0	27	53	20
19–64 years (N= 39)	5	41	36	18

Statistics on dietary intake

No data provided

Georgia

Questionnaire analysis 1994/1995 and 1998/1999

Neither the questionnaire from 1994/1995 nor 1998/1999 was returned.

Country report, 1999

Noncommunicable diseases and related risk factors

No information was given.

Inequity and poverty leading to lack of food and nutrient deficiency

For the unemployed the price of food was high and of low quality. Deficiencies of iodine, vitamin A, C and β -carotene was common. A programme had been set up to identify iodine deficiency disorders and import iodinated salt, and to identify deficiencies of fluoride, iron, vitamin A and C.

It was reported that a Centre for Nutrition Studies had been set up to: implement and expand national programmes; integrate intersectoral activities; carry out food fortification activities; improve the legal framework; and carry out activities of public education and awareness raising.

Infant, young children and maternal nutrition

There was a widespread lack of parent and health professional awareness of the importance of nutrition. The diet of children was often of poor quality and of low energy value. The diet mainly consisted of bread, dry bread, cereals with water and vegetarian soups without fat.

Sustainable food production and distribution

No information was given regarding this.

Food safety

Outbreaks of *Anthrax*, rabies, *Salmonella*, *Shigella*, Amebiasis, Leishmaniasis and Diphtheria had been reported.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Republic of Moldova

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 was not returned and therefore only results from 1998/1999 questionnaire are presented here.

Nutrition policy, plan of action or strategy

It was reported that the parliament of the Republic of Moldova had adopted two nutrition policies in 1993 concerned with sanitary and epidemiological service/care for the population and consumers' protection. It appeared that all the components of the World Declaration and Plan of Action were included in these policy documents.

Advisory and administrative structures

The country had set up an administrative structure to ensure implementation of policies in the Ministry of Agriculture and Industrial Development/Reconstruction and a National Breastfeeding Promotion Board/Commission. Furthermore, it was stated that the National Breastfeeding Promotion Board/Commission acted as an advisory body to advise policy-makers on scientific matters and was established in 1996. The members of the advisory body represented the Ministry of Health, and related subordinate institutions, UNICEF, WHO, the association of women, national television and the Ministry of Justice. No information was given regarding if the body had a written mandate or a budget to cover its activities.

Interdisciplinary collaboration

The Department of Statistic Analysis and Sociology was responsible for collecting information regarding the dietary data and presenting this information to relevant policy-makers. The Ministry of Health was responsible for the public nutrition education.

Examples of normative actions

It appeared that the country had a set of recommended nutrient reference values from Soviet times. Dietary guidelines directed at children were last revised in 1986. In 1997 a population representative survey of dietary intake and nutritional status was reported as having been carried out with support from UNICEF.

Country report, 1999

The cardiovascular mortality rate accounted for 53% of deaths and a dramatic increase had been registered over the past 5 years. The prevalence of cancer was reported as 1610 per 100 000, while diabetes mellitus affected 7 out of 10 000.

No single integrated nutrition policy existed, but programmes for the prevention and control of cardiovascular diseases and cancer had been launched at national level in which nutrition was a

major element. However, due to poverty and lack of information the access to healthy food and nutrition remained inadequate for the majority of the population. In addition, health education related to food and nutrition had not been conducted systematically and had been rather superficial.

Inequity and poverty leading to lack of food and nutrient deficiency

The poor consumed a diet dominated by bread, cereals and fats. The intake of fruit, vegetables and proteins-rich food was low. The detrimental dietary patterns resulted in high prevalence of rickets (29%), anaemia (20%) and endemic goitre (32%).

Infant, young children and maternal nutrition

The diet of mothers consisted mainly of cereal dishes and was high in fat. The breastfeeding rates had increased in recent years from a prevalence at 6 months post-partum of 50% in 1995 to 66% in 1998. However, due to financial difficulties some families feed their children unmodified cow's milk from the first months of life. Since 1994 the national policy promoted breastfeeding and in 1999 the National Commission for breastfeeding was established. In addition, a programme of improving perinatal health care for the period 1997–2003 was being implemented.

Sustainable food production and distribution

No information was provided.

Food safety

An increase of cases of acute intestinal infections, *Salmonella* and other foodborne diseases was reported. Most food was produced at private farms lacking appropriate hygienic conditions and sold at markets. There was no control of the quality and safety of these foods. Two policy guidelines had been adopted concerned with sanitary and epidemiological issues and the protection of consumer rights. The ministries of health, Agriculture and Food Processing Industry and Industry and Trade was involved in issues related to food safety.

The main problems encountered related to weak legislation regarding safety during transport of food and producers' liability for food safety. Many failed to comply with legislation. There was widespread ignorance of food safety among the economic agents engaged in food production and marketing, government officials and in the population. There was a need for enforcement of the law on food safety and to harmonize this with international guidelines. On a national level cooperation between ministries and agencies was needed in order to improve the system of quality and safety of food. In addition, decision-makers needed to increase their knowledge and understanding of the nutritional problems related to food. There was a need for improving the hygienic training of personnel involved in transport of food.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No information was provided regarding method used to collect the dietary data.

Table 41. Daily macronutrient and alcohol intake expressed as % of total energy intake, Moldova

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	29	11	60	–

Table 42. Vegetable and fruit intake excluding potatoes, Moldova

Food Groups	Total, g/day
Vegetables (÷ potatoes)	158
Fruit	158
Total	317

Russian Federation

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1998/1999 was not returned and therefore only results from 1994/1995 questionnaire are presented here.

Nutrition policy, plan of action or strategy

The Ministry of Science and Technical Policy of the Russian Federation adopted a nutrition policy document in 1994, which included all the components of the World Declaration and Plan of Action.

Advisory and administrative structures

A commission set up by the Ministry of Science and Technical Policy with representatives from the Ministry of Health and the Ministry of Agriculture and the Academy of Medical Sciences acted as an administrative structure to ensure implementation of the nutrition policy. In addition, an advisory body with a written mandate was established in 1993 to provide scientific advice to the policy-makers.

Interdisciplinary collaboration

Government initiated collaboration on issues related to nutrition took place between the following: ministries of Agriculture, Food and the State Committee of Sanitary and Epidemiological Surveillance, the Russian Academy of Medical Sciences and the Russian Academy of Agricultural Sciences. The Institute of Nutrition of the Academy of Medical Sciences was responsible for the collection of information of dietary data, while the Ministry of Science and Technical Policy was responsible for providing the information to relevant policy-makers. The Ministry of Health in conjunction with the State Committee of Sanitary and Epidemiological Surveillance was responsible for public nutrition education.

Examples of normative actions

Recommended nutrient reference values and dietary guidelines directed at the whole population, dated from 1991. Several small studies of dietary assessments had been published in a review in 1994.

Country report, 1999

An increase of noncommunicable diseases had been registered in recent years. Disorders of the circulatory system had increased by 18%, endocrine disorders by 18% and neoplasm by 16% and accounted for 14% of total mortality. The diet was high in animal fat and salt and low in fruit and vegetables. A policy of preventive medicine and an annual conference of prevention of noncommunicable diseases was established. The ministries involved in policies and programmes to ensure health were the ministries of Science and Technology, Health and the Russian Academy of Medical Sciences.

Inequity and poverty leading to lack of food and nutrient deficiency

In poor households the consumption of milk, dairy products, fruit, vegetables, fish and meat was less than the average intake, while, the consumption of bakery products and potatoes was higher. The total energy intake was also less than the average of the general population.

A commission was set up in 1994 to draft a proposal concerning the development and implementation of a national policy in the area of healthy nutrition. This led to the adoption of a policy document. In 1999 a resolution on the prevention of iodine deficiency disorder and other micronutrient deficiencies was adopted.

Infant, young children and maternal nutrition

At 3 months post-partum only 40–60% of mothers breastfed their infants. The low breastfeeding rates were due to: late initiation of breastfeeding after the birth; “hypogalactia”³⁷ in mothers; old traditions of keeping mother and baby separated in maternity homes and use of breast-milk substitutes and other drinks; low knowledge of mothers and health professionals and finally marketing of both domestic and international manufactured milk substitutes. In addition, weaning practises were poor. Often infants received poorly adapted or unmodified milk products such as kefir, yoghurt and cow’s milk from first few weeks. Often porridge was introduced too early and it was common to give meat and fish too late. Iron deficiency anaemia was prevalent among children.

Mothers consumed inadequate amounts of fibre, vegetables, fruit, vegetable oil, milk products and fish. Widespread deficiencies of calcium, iron, and several vitamins (especially vitamin C, folic acid and thiamine) were reported.

Programmes to train health workers and educate mothers about healthy nutrition were needed. Implementation of a simple and accurate system of monitoring children’s dietary patterns was needed.

Sustainable food production and distribution

The agricultural output was low due to lack of development of new science-based processes or farming practices. The policies being proposed included ways to increase agricultural output by land regulations and forms of land ownership; management of production; environment promoting potential of agro ecosystems and agro-landscapes; transgenic forms of plant, animals, fish and micro-organisms. The ministries involved were the ministries of Science and Technology, Agriculture and Food and Russian Academy of Agricultural Sciences.

Food safety

Fish (10%) and milk (10%) samples were those most often contaminated followed by meat (6%) and poultry (5%). Foodborne pathogenic contamination had decreased from 70 per 100 000 in 1994 to 38 per 100 000 in 1998. Hazardous sanitary conditions were most often reported in food enterprises (25%) followed by food trade (20%) and public catering (18%). Contamination in the public catering sector had decreased in recent years, but at the same time there had been an increase in cases of lethal food poisoning in the home.

Several policies and programmes to ensure healthy food had been implemented. The main activities in the field of food safety was to improve standard regulations and harmonize with international standards; improve monitoring systems and laboratories; development of methods

³⁷ Insufficient milk production

to assess health risk associated with various levels of food contamination; improve food production processes and methods of packaging, transportation, storage and sale; improve system of training, education and mid-career training of specialists and finally improve the system of health education and public awareness.

Prevalence of under- and overweight

In the Russian Federation, underweight was most prevalent among women in the age group 19–34 years. More men than men were overweight, while obesity was more prevalent among women in all age groups. The mean BMI was 25 for men and 26.8 for women.

Table 43. Prevalence of under and overweight, 19–64 years, Russian Federation

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 2566)	6	63	21	10
35–49 years (N= 2902)	1	37	35	27
50–64 years (N= 2319)	0.6	23	37	40
19–64 years (N= 7787)	3	41	31	25
Men	%	%	%	%
19–34 years (N= 2200)	2	67	27	4
35–49 years (N= 2430)	0.7	50	39	11
50–64 years (N= 1732)	1	45	39	15
19–64 years (N= 6362)	1	54	35	10

Statistics on dietary intake

No data provided

Ukraine

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 was not returned and therefore only results from 1998/1999 questionnaire are presented here.

Nutrition policy, plan of action or strategy

In the years between 1991–1997 the government had adopted several policy documents, however none explicitly related to nutrition. It was stated that all components of the World Declaration and Plan of Action were included.

Advisory and administrative structures

Ukraine did not have an administrative structure to ensure implementation of nutrition policy or an advisory body to provide scientific advice to policy-makers.

Interdisciplinary collaboration

No governmental initiated collaboration concerning nutrition took place.

No information was given regarding who was responsible for collection of information of the population's dietary pattern or for the public nutrition education.

Examples of normative actions

Recommended nutrient reference values and dietary guidelines directed at the whole population were based on former Soviet norms. It is stated that a population representative survey of dietary intake and nutritional status had been carried out in the last 10 years, but no additional information was provided.

Country report, 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease and Diabetes Mellitus was prevalent. Serum cholesterol was above normal in 50% of the 25–65%. High intakes of sugar, fat (especially animal fat) and inadequate supply of essential amino acids, vitamins, trace elements and dietary fibre were reported.

Inequity and poverty leading to lack of food and nutrient deficiency

Since 1991 dietary patterns had deteriorated especially in urban areas. The consumption of meat, dairy products, egg and fruit had decreased twofold, sugar intake has decreased by one third and fish consumption has declined threefold. Bread and potato consumption had remained high. A government programme had been adopted to protect the poorest of the population, which included assistance to families with many children, housing subsidies, social benefits and income indexation.

Infant, young children and maternal nutrition

Nutritional status of children had deteriorated during the last 5 years. The consumption of animal products, vegetables and fruit had decreased between 22–80%, while consumption of cereals, pasta, sugar and confectionery had increased by 16–61%. Deficiencies in vitamin C, riboflavin, thiamine, nicotinic acid was widespread. About 20% of infants of 3 months old suffered from iron deficiency anaemia. Only 40% of children were regarded as healthy. A programme called “Children of Ukraine” had been adopted to improve health of the children in the country. Approximately 40% of pregnant women and 30–35% of lactating women had iron deficiency anaemia.

Sustainable food production and distribution

No information was given.

Food safety

Drinking water was polluted in the rural areas due to excess application of fertilizers and intensive husbandry polluting groundwater. A programme concerning the quality of food and raw materials was being developed by the Ministry of Health.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data was obtained in 1997 by a one-day and seven-day questionnaire survey.

Table 44. Daily macronutrient and alcohol intake expressed as % of total energy intake, Ukraine

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	25	10	65	–

Table 45. Vegetable and fruit intake excluding potatoes, Ukraine

Food groups	Total, g/day
Vegetables (≠potatoes)	190
Fruit	87
Total	285

Nordic Countries

Denmark

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

Denmark has had a nutrition policy document since 1984, which was adopted by the Parliament. In 1989 the government adopted a new nutrition policy. The document from 1984 incorporated components 4, 6, 7 and 8, of the World Declaration and Plan of Action, whereas the 1989 document included action 1, 2, 4, 5, 6 and 8.

Advisory and administrative structures

In 1994 working groups under the Ministry of Health were set up to be responsible for the implementation of the nutrition policy, but this no longer existed in 1998/1999. The country had an advisory body, which was established in 1997 and it had a written mandate. The members of the advisory body represented relevant medical research societies. The Ministry of Food, Agriculture and Fisheries finance the advisory body.

Interdisciplinary collaboration

In 1994/1995 it was reported that government-initiated collaboration between parties involved in food-related matters took place under the Ministry of Health, but this was no longer the case in 1998/1999.

In 1994/1995 the National Food Agency was responsible for the collection and dissemination of information regarding population dietary patterns. In 1998/1999 this was changed to the Danish Veterinary and Food Administration. Furthermore, the Danish Veterinary and Food Administration, The National Consumer Agency and The National Board of Health was in 1998/1999 responsible for nutrition education of the public whereas this in 1994/1995 was The Government Home Economics Council together with the National Food Agency. There were regular consultations between the Ministry of Health and Ministry of Agriculture in form of steering committees and Ad hoc meetings.

Examples of normative actions

The most recent update of recommended nutrient reference values was in 1996 and prior to this these were updated in 1989. The most recent population representative survey of dietary intake and nutritional status was carried out in 1995 and was published. Denmark had dietary guidelines directed at the whole population, which were continuously revised.

Country report, 1999

Noncommunicable diseases and related risk factors

Ischaemic heart disease accounted for 27% of total mortality, while cancer represented 25%. Obesity affected 7% of men, 8% of women and 1–3.5% of children. It was reported that 10–20% of elderly women had iodine deficiency and one third had vitamin D deficiency. About 30% of fertile women suffered from iron deficiency. The dietary pattern was characterized by high intakes of fats, while the consumption of fruit, vegetables, bread and fish was low.

In 1989 the first nutrition policy was adopted. Campaigns were carried out continuously in the mass-media. A campaign of “six a day” to increase fruit and vegetables consumption had been initiated nationally. Iodination of all salt had been implemented in 2000. In addition,

recommendations directed at exposed groups had been launched to supplement the diet with iron and vitamin D.

Inequity and poverty leading to lack of food and nutrient deficiency

The distribution of public catering was 500 000 meals per day, but the quality of the public meals was inadequate. Consumers of public meals received an unbalanced and insufficient food intake. The nutrition policy from 1989 emphasized improved food quality in private and public catering and dietary recommendations for Danish Institutions were issued in 1997.

There was an increased morbidity and mortality in lower socioeconomical groups, but no measurable difference in food intake had been noted. The problems of increased morbidity and mortality in the lower socioeconomic groups were treated as a social problem, which concerns smoking, drug and alcohol abuse, physical activity and nutrition.

Infant, young children and maternal nutrition

Low breastfeeding rates were reported in individuals of low education. Breastfeeding 6 months post-partum was carried out by 60% of those of high education, while those of lower education only 42% breastfed at 6 months post-partum. The most prevalent problem of maternal nutrition was low intake of folate and iron. Nutritional questions were discussed at regular visits by home-nurse according to regulations for health promotion acts.

Sustainable food production and distribution

No information was given.

Food safety

There were estimated 200 000 cases of foodborne infections. The incidence rate of *Salmonella* was 73/100 000. The incidences of especially *Campylobacter* had increased dramatically from 20/100 000 in 1990 to of *Campylobacter* 64/100 000 in 1999. The government's priority to decrease *Campylobacter* in poultry was high.

A governmental policy concerning food safety was adopted in 1998. Surveillance programmes and consumer guidelines regarding food hygiene had been issued. In addition, a strategy based on risk analysis that incorporates food safety objectives was formulated and instituted.

Prevalence of under- and overweight

In Denmark, the prevalence of overweight and obesity was greater among men than women in all age groups. In addition, more women were underweight than men. The mean BMI for men and women was 25.1 and 23.3 respectively.

Table 46. Prevalence of under and overweight, 19–64 years, Denmark

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 253)	6	76	14	4
35–49 years (N= 235)	4	72	21	3
50–64 years (N= 194)	4	58	27	11
19–64 years (N= 682)	5	69	20	6
Men	%	%	%	%
19–34 years (N= 222)	1	68	26	5
35–49 years (N= 201)	0.5	48	42	10
50–64 years (N= 211)	0.5	40	47	12
19–64 years (N= 634)	0.8	52	38	9

Statistics on dietary intake

The dietary data were obtained by 7-day food record in 1995.

Table 47. Daily macronutrient and alcohol intake by gender expressed as % of total energy intake

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	37	36	14	15	42	45	6	4

Table 48. Vegetable and fruit intake excluding potatoes

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	109	119	115
Fruit	142	174	159
Total	251	293	273

Finland

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In 1989 the National nutrition Council adopted a nutrition policy document, which included components 1, 2, 4 and 8³⁸ of the World Declaration and Plan of Action. However, in 1998/1999 Finland reported not having an official nutrition policy.

Advisory and administrative structures

In 1994/1995 it was reported that the National Nutrition Council was set up to ensure the implementation of the nutrition policy. The council was established in 1952 and had a written mandate and was financed by the Ministry of Agriculture.

Interdisciplinary collaboration

Government initiated collaboration took place between the Ministry of Social Affairs and Health, Ministry of Agriculture and Forestry and the Ministry of Trade and Industry. The National

³⁸ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Public Health Institute was responsible for the collection of dietary data and to provide this information to policy-makers. In 1998/1999 the responsibility for the nutritional education of the public was shared between the Ministry of Social Affairs and Health and the Ministry of Education, whereas in 1994/1995 it was solely the Ministry of Social Affairs and Health responsibility. Formal and informal consultation took place between the Ministry of Health and Ministry of Agriculture through the National Nutrition Council and meetings between civil servants also occurred.

Examples of normative actions

The National Nutrition Council updated nutrient reference values in 1998 and in 1998 dietary guidelines were updated. The most recent dietary survey was carried out in 1997 and was published.

Country report, 1999

Noncommunicable diseases and related risk factors

The four main health problems in Finland were cardiovascular disease, cancer, musculoskeletal disease and mental health problems. The cardiovascular disease mortality had decreased remarkably since 1970s. Cancer mortality had also decreased, but only in men while it had remained stable in women. It was reported that around 50% of men were overweight and 33% women, while 20% of the population was obese and obesity was an increasing problem.

The diet in Finland was high in saturated fat and excessive in salt. The intake of carbohydrate and fibre were less than recommended. Consumption of vegetables had increased since 1970s and consumption of fruit increased until mid-1990s, while the intake of cereals and potatoes had decreased. The meat intake had doubled from 1950s to 1970s. Also the consumption of low-fat milk and skimmed milk had increased. Butter had been replaced with soft vegetable margarine and use of vegetable oils and cheese had increased. Consumption of both alcoholic and non-alcoholic beverages had increased, whilst the greatest increase was recorded for beer.

The dietary recommendations were issued in 1998. The tasks for 1999–2000 were to submit proposals to the authorities and issue statements concerning nutrition and health and monitor the public's compliance with nutrition recommendations. In addition, observation, monitoring and submission of proposals concerning the development of nutritional issues in Europe were on the agenda.

The membership of EU had changed the policy. For instance, fortification programmes and the school milk programme were examples of difficulties faced when joining the EU. Moreover, commercial and nutritional/health interests were contradictory in many cases. The lack of permanent staff and lack of decision power by the National Nutrition Council also made the national situation difficult. In addition, the ad-hoc nature of the implementation of nutrition policies was sporadic. Without a governing strategic body there was a risk that issues of a complex interdisciplinary nature could remain unsolved.

Inequity and poverty leading to lack of food and nutrient deficiency

Differences in income were not related to a lack of food. The Revised Act on Social Assistance came into force in 1998. Problems of the national economy resulted in the funding of health and social services being diminished. In the long term this was expected to worsen the problems of vulnerable groups.

Infant, young children and maternal nutrition

There was a low rate of breastfeeding. At 6 months post-partum only 50% of mothers were still breastfeeding. The short-term hospital care after delivery reduced time for breastfeeding guidance and the resources of the primary health care workers to make home visits and give guidance were not optimal. The health of pregnant women was monitored by frequent (7–10) visits to maternity clinics and doctors. Prevention of obesity during and especially following pregnancy was a key issue. To prevent iron deficiency anaemia of mothers supplements were recommended. Teenage pregnancies and eating disorders were increasing.

There existed no widespread nutritional deficiency diseases in children and children receive vitamin D supplementation from two weeks to two years. However, there was recorded a growing prevalence of food allergies.

International Code on Marketing of Breast-milk Substitute was implemented, but some baby food industries organize “Clubs/circles” and members receive presents and material by mail. This made breastfeeding promotion more difficult. In addition, training of health care personnel in nutrition was not optimal.

Sustainable food production and distribution

Use of pesticides was the lowest in Europe, while the use of fertilizers was the second lowest. Moreover, Finland was the second largest organic food producer in EU. The objectives of the Food Quality Management strategy from 1999 was to develop administration, research, education, consultation to ensure continuous high food quality and to improve competitiveness and profitability of companies. Prior to this programme a Programme on Environmental Health was adopted in 1997.

Food safety

The main microbiological risk came from *Salmonella* and *campylobacteria*. Pesticides were only considered a minor risk. Pesticides were only 5% of acceptable intake and contamination was decreasing. However, the number of food and waterborne outbreaks seemed to be increasing partly due to improved reporting system. Since 1975 there had been a systematic effort to collect information about foodborne outbreaks.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data were obtained using a one-day recall method carried out in 1997 by 2862 responders.

Table 49. Daily macronutrient and alcohol intake by gender expressed as % of total energy intake, Finland

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	33	32	15	16	49	52	2	1

Table 50. Vegetable and fruit intake excluding potatoes, Finland

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (≠potatoes)	115	122	118
Fruit	125	156	140
Total	240	278	258

Iceland

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

Iceland had a nutrition policy, which was adopted in 1989 by the Parliament and Government. In 1994/1995 it was stated that components of the World Declaration and Plan of Action were actions 1, 2, 4, 7 and 8. In 1998/1999 this was reduced to include actions 1, 2, 4 and 8.³⁹

Advisory and administrative structures

In 1994/1995 a Nutrition Council was set up to implement the nutrition policy. In 1998/1999 the responsibility to ensure implementation of the policy was with the Ministry of Health. Iceland had an advisory body to provide scientific advice on nutrition related matters to policy-makers. The advisory body was established in 1978 and had a written mandate and was financed by the Government.

Interdisciplinary collaboration

In 1994/1995 it was reported that regular collaboration took place between the ministries of Health, Trade and Agriculture, Fisheries and Industry. The Icelandic Nutrition Council was responsible for collecting information regarding dietary data and providing this information to policy-makers. In addition, the council was responsible for public nutrition education. There was no regular consultation between the Ministry of Health and the Ministry of Agriculture.

Examples of normative actions

The recommended nutrient reference values were last updated in 1996 and were the responsibility of the Icelandic Nutrition Council. The most recent population representative survey of dietary intake and nutritional status was published in 1993. Dietary guidelines aimed at the whole population were last revised in 1994 and were not field-tested prior to publication.

Country report, 1999

Noncommunicable diseases and related risk factors

The prevalence of cardiovascular disease was the lowest among the Nordic countries, but it was still a common cause of premature death. In the period 1981–1996 the mortality of myocardial infarct had decreased by 57% in men and 42% in women. This could be due to improvement in the management of blood pressure and a decline in smoking by 50%. In addition, blood cholesterol levels had decreased by 7% in men and 11% in women.

The incidence rate of insulin depend diabetes mellitus was low at only 0.8 per 100 000 of children between 0–14 years. The incidence of non-insulin dependent diabetes mellitus had not

³⁹ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

increased significantly and the rate of adults between 34–79 years affected was 4.1% for men and 2.7% for women.

The main dietary concern was to decrease the consumption of saturated fat. The consumption of whole milk, fatty dairy products, butter, hard margarine and fatty meat had decreased dramatically during the last two decades from 115g/person/day in 1973 to 80g/person/day in 1997. The fruit and vegetable intake was gradually increasing and fresh meat and fish had replaced cured products. The high consumption of fish and fish products was being maintained.

Inequity and poverty leading to lack of food and nutrient deficiency

Poverty was not considered a major cause of food or nutrient deficiency in Iceland, while education was a strong predictor of the nutritional quality of diet.

Infant, young children and maternal nutrition

The weight gain during pregnancy was especially high in Iceland. At 4 months post-partum 83% breastfed, and by 6 months post-partum this had decreased to 73%. Use of formula was not common, but cow's milk gradually replaced breastfeeding during the first year. Consequently, 4% of infants received cow's milk at 4 months post-partum, while 38% of infants received cow's milk at 6 month post-partum. It was reported that young women who smoke breastfed for shorter periods. Iron deficiency in 24% of one-year-old infants was reported, mainly due to too early introduction of cow's milk. Mean nutrient intake was above recommendations except for iron intake in infants.

Sustainable food production and distribution

The population of Iceland consumed relatively small amounts of fruit and vegetables. The vegetable consumption was on average 44.5 kg per person/year and fruit intake was 61.6 kg per person/year. High prices of fruit and vegetables in Iceland due to a price policy of high taxes on imports to protect domestic production resulted in the low intake. In addition, there was little competition between farmers, as only a few did not receive governmental support. The main objectives of agricultural policies were to ensure sufficient income for farmers in traditional agricultural production i.e. dairy and sheep raising and to keep rural areas inhabited. Contrasting, the main priority of the nutrition action plan was to reduce vegetable prices and improve availability of vegetables in schools and work canteens. The National Food and Nutrition Policy (1989) stated that "...the national goals shall be taken into account in every decision on import duties and taxes and any other governmental action that affects the prices of foods i.e. subsidies".

Food safety

There had been a growing incidence of *campylobacteriosis* since 1996–1997, while the incidence of *Salmonella* was low. The central and local food control authorities met regularly and had workgroups to coordinate specific tasks. The priorities were that all food businesses should have an officially approved in-house control; control of foodborne pathogens and follow-up enforcement actions; and to control pesticide residues in fruit and vegetables. Food authorities should have more resources to participate in development of food legislation and the principles for the food control, since the EC legislation formed the basis for the food control at the national level. There was a need to simplify the structure of food control and policy-making to increase the efficiency of both food inspection and food legislation. In addition, it was required to increase the cooperation between food control authorities and Chief Medical Officer in matters related to outbreaks of foodborne diseases.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data is obtained from the national nutrition survey employing a dietary history method, which was carried out in 1990.

Table 51. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Iceland

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	43	40	18	18	39	41	1	0.7

Table 52. Vegetable and fruit intake excluding potatoes, Iceland

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	72	71	72
Fruit	134	169	152
Total	206	240	224

Norway

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The most recent nutrition policy document was adopted by the Norwegian Parliament in 1993 and had all the components of the World Declaration and Plan of Action incorporated.

Advisory and administrative structures

By 1994/1995 Norway had established an administrative structure that was responsible for the implementation of the nutrition policy. An advisory body- the National Council on Nutrition and Physical Activity- was established in 1999 and represented independent people chosen for their scientific expertise. The council had a written mandate and is financed by the Ministry of Health and Social Affairs.

Interdisciplinary collaboration

Government initiated collaboration took place in a Forum of Nutrition run by the National Nutrition Council, which included meetings and special projects on nutritional issues. In addition, a Food Policy Forum had been established in the Ministry of Agriculture and the Council of Norwegian Food Control Authority. The National Nutrition Council was responsible for the collection of dietary data (and provided this to relevant policy-makers) and the nutrition education of the public.

Examples of normative actions

Recommended nutrient reference values were revised in 1997. In 1997 a representative survey of dietary intake and nutritional status was published. Norway had dietary guidelines directed at the whole population, which were updated in 1996. No information was given regarding field-testing of the guidelines prior to use.

Country report, 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease decreased by 50% since the 1970s, but cardiovascular mortality was still high and accounted for 50% of total deaths. Cancer mortality accounted for 20% of total deaths and diabetes affected 2% of the population.

Dietary habits changed in recent years resulting in a reduction in fat intake, improvement of fatty acid composition and decreased serum cholesterol levels due to a reduction of intake of margarine, butter and whole milk leading to a lowering of total fat consumption from 40% to 35% of energy intake. In addition, an increase in consumption of vegetables, fruit and low-fat milk had been noted during the last three decades. However, the consumption of fat containing potato-products, meat, sugar and soft drinks had increased. The intake of milk products and meat was low, while fish consumption was low.

Optimal environmental support to enable the individual to choose a nutritionally favourable and safe diet was seen as a public responsibility according to the National Nutrition Policy. The emphasis was on the need to coordinate food and nutrition policy with other policy areas. The objectives of the nutrition policy was to reduce intake of fat to 30% of energy intake; reduce the intake of salt from 10 to 5g/person/day; double consumption of fruit and vegetables; and to increase level of physical activity.

Inequity and poverty leading to lack of food and nutrient deficiency

Lack of food and nutrition deficiency was only a minor problem in Norway and social status correlated to indicators of health. High priority was given to measures, which make it easier to choose healthy food alternatives; appropriate information targeting high-risk groups, legislation promoting the interest of the consumers; and price policy measures. Price policy measures could be employed more than was the case.

It was aimed to have a holistic policy regarding diet and nutrition involving cooperation across sectors and administrative levels. In addition, it was a special goal that children attending nurseries and schools had access to regular meals and a nutritionally sound diet.

Infant, young children and maternal nutrition

Infant mortality was low and had decreased in recent decades. In 1960s infant mortality was reported to be 17 per 1000 births and in 1980s this had declined to 8 per 1000 births. The nutritional condition and health of infants and children was generally regarded as good. However, iron deficiencies occurred especially among groups of immigrant children. In addition, vitamin D deficiency/rickets were increasing due to children of immigrant groups having limited exposure to sunlight.

The nutritional condition of pregnant women was generally good, but 10–15% of pregnant women had too high an intake of energy, sugar and fat, which cause these women to be at greater risk of pregnancy complications. Women were recommended to take folate pre-conceptually and during first 2–3 months of pregnancy and to be physically active. Breastfeeding rate increased and in 1993 only 63% breastfed at 6 months post-partum compared with 80% in 1999.

More knowledge about the diet of infants and young children was needed. In addition, there had been a lack of data of the dietary pattern of children, but the first nationwide dietary survey of dietary habits of children up to the age of two years was carried out in 1998/1999.

Sustainable food production and distribution

Food supplies were abundant and varied. The country was self-sufficient by approximately 50–55%. Vegetables produced in the country made up 60% of the total consumption of vegetables, while fruit produced in the country made up 20%. In addition, the production of meat and milk was abundant and could be reduced. Cereal production for human consumption had increased considerably during the last ten years. The government and producers made a great effort to ensure sustainable production of food and to protect the environment. The objective of the agricultural policy was to integrate health aspects into the agricultural policy. In addition, the National Council of Nutrition and Physical Activity made efforts to stimulate better availability of fruit and vegetables through input to agricultural and price policy.

Food safety

Generally the food safety situation was very good and incidences of foodborne disease were low. Reported cases did not indicate a change in recent years. The dietary pattern of the population was changing due to increasing availability of industrially produced foodstuffs and import of untraditional food. This required monitoring and would be a challenge for the future.

Systematic surveillance and monitoring of contaminants and micro-organisms had been carried out for years. There were efforts to establish good procedures for health risk assessment of genetically modified food and novel foods. Priority was given to strengthen food control systems and to harmonize food legislation according to the EU directives.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data was obtained by using a quantitative food frequency questionnaire covering 180 food items. The survey was carried out in 1993–1994 nationwide.

Table 53. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Norway

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	31	30	15	16	52	53	2	1

Table 54. Vegetable and fruit intake excluding potatoes, Norway

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	125	134	130
Fruit	209	212	211
Total	334	346	341

Sweden**Questionnaire analysis 1994/1995 and 1998/1999***Nutrition policy, plan of action or strategy*

The Government and the Ministry of Agriculture adopted a nutrition policy document in Sweden in 1995 and prior to this a policy document was adopted in 1992. The policy document from

1992 included the components 2, 4, 5–8 of the World Declaration and Plan of Action. The more recent document included 1, 2, 4–6, and 8.⁴⁰

Advisory and administrative structures

In 1994/1995 it was stated that an administrative structure was set up through the National Food Administration and the Public Health Institute, however no information regarding this was provided in 1998/1999. Sweden had an advisory body with a written mandate responsible for providing scientific advice to the policy-makers, which was established in 1969/1970.

Interdisciplinary collaboration

A reference group, which represented 20 different organizations, food production, manufacture, sales and nutrition education met twice a year. The National Food Administration was responsible for collecting information dietary data and providing this information to relevant policy-makers. The responsibility for public nutrition education was shared between the National Food Administration and the Public Health Institute.

Examples of normative actions

Recommended nutrient reference values last updated in 1997 and prior to this in 1989. The most recent population representative survey of dietary intake and nutritional status was carried out in 1989 and published in 1994. Dietary guidelines were last updated in 1992. The dietary guidelines were directed at the whole population, catering industry and small children and were not field-tested prior to use.

Country report, 1999

Noncommunicable diseases and related risk factors

The cardiovascular disease mortality accounted for 50% of total deaths, while cancer accounted for 25%. Osteoporosis was an increasing problem. In addition, non-insulin dependent diabetes mellitus was an increasing problem and the prevalence was 3–4% of the population.

In 1997–1998, fat contributed 34% of energy intake, which was 3% lower than in 1989. The intake of micronutrients was generally satisfactory, but iron, folate and selenium were lower than recommendations. Consumption of milk, dominantly low-fat, and cheese were fairly high, whereas the consumption of meat and fish was moderate and intake of dietary fibre was low. Consumption of vegetables was low, but increasing. In addition, the intake of pasta, rice, soft drinks, edible fat (mainly margarine, butter-vegetable oils and liquid margarine) were also on the increase.

The National Targets and Strategies for Nutrition 1999–2004 was concerned with areas of education, support for local and regional work, consumer support and involvement, and catering and meal services. However, there was a need for more research of which factors determine public eating patterns. There was also a lack of government involvement in setting goals and priorities and uncertainty regarding delegation of responsibility in the main ministries. In addition, there were overlaps between the agencies responsible for the health and food sector.

⁴⁰ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Moreover, dietary guidelines tended to be too general and implementation required better cooperation with several agencies and sectors.

Inequity and poverty leading to lack of food and nutrient deficiency

Poverty did not really exist and therefore widespread food and nutrition deficiencies did not exist. However, nutrition deficiencies possibly occur among marginal groups such as substance abusers and some elderly in institutions. A lower consumption of fruit and vegetables and higher consumption of high fat products were reported among those with less education. Immigrants also had limited access to health and nutrition information. There were not enough resources for monitoring dietary habits, energy and nutrient intake in different population groups i.e. immigrants, unemployed, physically disabled and elderly. More knowledge was required among health workers on cultural, religious and ethical variables in immigrant groups that can affect health in order to overcome the problems. Finally, more research was needed on efficient measures for decreasing diet-related differences in health especially among ethnic minorities.

Infant, young children and maternal nutrition

Breastfeeding rates were 83% at 4 months and 73% at 6 months post-partum. Mothers of immigrant groups breastfed less. Establishment of a national committee and a national breastfeeding coordinator could improve the breastfeeding situation. The situation represented a decline in resources spent on mothers and newborns. In some hospitals mothers and their newborns only stayed for 6 hours.

All day care centres for infants, children and primary schools (6–16 years) served warm meals free of charge. When too many ministries and institutions were involved in developing policies and guidelines this process became problematic.

Sustainable food production and distribution

In agricultural production large amounts of energy and pesticides were used. The approach was to work toward a goal of “food for all” produced and distributed in a way which did not deplete natural resources. Consequently, the agricultural policy incorporated environmental aspects and the objectives were to protect the environment, obtain sustainable supply and efficient resource utilization.

Food safety

Salmonella affected 50 per 100 000, but 80% of these cases were contracted abroad and national surveillance of *Salmonella* at slaughter showed less than 1% *Salmonella*. *Campylobacter* affected 75 per 100 000, where again 60% were contracted abroad and not in Sweden.

Food producers were considered competent and conscious of their responsibilities. The supervision of food handling was effective and worked satisfactorily, but new food preparation techniques may present a new risk. Poor kitchen hygiene in restaurants was an increasing cause of infection and poor temperature control was the second cause. In addition, consumer knowledge of food safety had declined.

EU legislation was the basis of the national policy. Food control was based on compulsory self-control in food handling and a system of monitoring imported meat and compulsory testing of *Salmonella* at place of origin had been implemented. However, use of Precautionary Principles caused problems in creating accurate guidelines because of lack of scientific data. Regular and national food control programmes were costly.

Prevalence of under- and overweight

In Sweden, the prevalence of overweight among men was almost twice that among women, while the prevalence of obesity was similar in the two genders. More women were underweight than men. The mean BMI was 25.2 for men and 23.9 for women.

Table 55. Prevalence of under and overweight, 19–64 years, Sweden

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 827)	7	75	14	4
35–49 years (N= 771)	4	64	25	78
50–64 years (N= 651)	2	50	37	10
19–64 years (N= 2249)	5	64	24	7
Men	%	%	%	%
19–34 years (N= 809)	1	66	29	5
35–49 years (N= 746)	0.7	45	46	9
50–64 years (N= 599)	0.2	39	51	10
19–64 years (N= 2154)	0.7	51	41	7

Statistics on dietary intake

The dietary data is obtained from a pre-coded 7-day record with photographs for portion estimates. The survey was carried out in 1989.

Table 56. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Sweden

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	37	36	15	15	45	47	3	2

Table 57. Vegetable and fruit intake excluding potatoes, Sweden

Food Groups	Men, g/day	Female, g/day	Total, g/day
Vegetables (÷ potatoes)	80	93	87
Fruit incl. juice	158	198	178
Total	238	291	265

Southern European Region

Andorra

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1998/1999 was not returned and Andorra was not a member state in 1994/1995.

Country report 1999

No country report was submitted.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Greece

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

Greece had not yet adopted a nutrition policy document

Advisory and administrative structures

Greece reported having an advisory body with a written responsible for providing scientific advice to policy-makers. It was established in 1992 and then reorganized in 1997, but only in 1999 was the emphasis on nutrition.

Interdisciplinary collaboration

In 1998/1999 it was stated that the Hellenic Food Authority was going to organize collaboration between parties involved in nutritional matters. In 1994/1995 it was reported that the National Centre for Nutrition was responsible for collection of dietary data and for providing information to relevant policy-makers. However, in 1998/1999 it was stated that this was the responsibility of the medical school of the University of Athens. In 1994/1995 it was stated that the Ministry of Health and Ministry of Commerce was responsible for the nutrition education of the public. Though, this in 1998/1999 was a shared responsibility between the Directorate for Health Education, the Ministry of Health, the Ministry of Education and the Hellenic Food Authority. Ministries collaborated when it was necessary, but the Hellenic Food Authority was expected to undertake the coordination of regular intersectoral consultations between different governmental, private or voluntary sectors.

Examples of normative actions

Recommended nutrient reference values used in the country dated from 1992. Dietary guidelines were last updated in 1986 and no information was given regarding to whom the dietary guidelines were directed. It was stated that there had been population representative surveys of dietary intake and nutritional status within the recent 10 years and two references from 1998 and 2000 were given.

Country report 1999

No country report was submitted.

Prevalence of under- and overweight

In Greece, the prevalence of overweight was higher among men than women, though obesity was more prevalent among women especially for the younger and older age groups. Underweight was slightly more common among men in all age groups. The mean BMI was 28 for men and 28.3 for women.

Table 58. Prevalence of under and overweight, 19–64 years, Greece

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 4943)	2	17	35	46
35–49 years (N= 4895)	2	37	37	24
50–64 years (N= 5865)	2	18	38	43
19–64 years (N= 15 703)	2	24	37	38
Men	%	%	%	%
19–34 years (N= 3353)	2	20	48	29
35–49 years (N= 3396)	2	21	54	23
50–64 years (N= 3321)	2	16	51	31
19–64 years (N= 10 070)	2	19	51	28

Statistics on dietary intake

No data provided

Israel

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 was not returned and therefore only results from the 1998/1999 questionnaire are presented here.

Nutrition policy, plan of action or strategy

In 1997 the Ministry of Health in Israel adopted a nutrition policy document, which included action 2,4,5,6 and 8⁴¹ of the World Declaration and Plan of Action.

Advisory and administrative structures

A department of nutrition within the Institute of Public Health was responsible for the implementation of the nutrition policy. An advisory body was established to provide scientific advice to the policy-makers. However, the advisory body that was established in 1996 did not have a written mandate or a budget to cover its activities (however the body was financed by the Ministry of Health). The members of the advisory body were representatives of ministries, academics and NGO's.

Interdisciplinary collaboration

Government initiated collaboration occurred within the Ministry of Health between parties responsible for food control services, legislation and education. In addition, representatives from the food industry and NGO's collaborated within the Nutrition Council.

The Department of Nutrition was responsible for the collection dietary data and providing this information to relevant policy-makers. The Ministry of Education and the Department of Nutrition were responsible for the nutrition education of the public in Israel. There was no regular consultation between the Ministry of Health and the Ministry of Agriculture on matters related to nutrition.

⁴¹ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Examples of normative actions

The recommended nutrient reference values were revised in August 1997. The first National and Health Survey was to be commenced in December 1998. Dietary guidelines were established in August 1997 and were directed towards the whole population and were field-tested prior to use.

Country report 1999

No country report was submitted.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Italy

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The first nutrition policy document adopted in Italy was in 1998 and had actions 1, 3, 7 and 8 of the World Declaration and Plan of Action incorporated.⁴²

Advisory and administrative structures

In 1990, the first advisory body for providing scientific advice to policy-makers on matter related to nutrition was set up. It was stated in the 1994/1995 survey that the advisory body had a written mandate. However, no information regarding this was provided in 1998/1999. At the time of the 1998/1999 survey an administrative body under the Ministry of Health was set up to ensure implementation of the nutrition policy.

Interdisciplinary collaboration

No information regarding the responsibility of the collection dietary data was given in 1998/1999. In the 1994/1995 survey it was stated that this responsibility was under the National Institute of Nutrition. It was stated that the Ministry of Health was responsible for nutrition education of the public. Informal and formal consultations between the Ministry of Health and the Ministry of Agriculture took place.

Examples of normative actions

The recommended nutrient reference values were updated in 1997 and prior to this in 1986. The most recent reference for a population representative survey of dietary intake and nutritional status was from 1980–1984. In the 1998/1999 survey no information regarding population representative survey of dietary intake and nutritional status was given. An update of the dietary guidelines directed at the whole population was carried out in 1997.

Country report 1999

No country report was submitted.

⁴² 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data was obtained from a household weighted inventory joint to individual seven-day record from a sample of 1200 households. The survey was carried out in 1994/1995.

Table 59. Daily macronutrient and alcohol intake expressed as % of total energy intake, Italy

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	32	16	48	3

Table 60. Vegetable and fruit intake excluding potatoes, Italy

Food groups	Total, g/day
Vegetables (+ potatoes)	260
Fruit	219
Total	479

Malta

Questionnaire analysis 1994/1995 and 1998/1999

Malta adopted a policy document in 1988. It was stated in 1994/1995 that components of the World Declaration and Plan of Action included were 1, 2, 4 and 8, whereas in 1998/1999 it was reported that only components 4 and 8 was included in the nutrition policy document.⁴³

Advisory and administrative structures

In 1994/1995 it was reported that the Nutrition Unit of the Ministry of Health was responsible for the implementation of the nutrition policy, whereas in 1998/1999 it was stated that the National Advisory committee on food and nutrition had become non-functional. In 1999 the Health Promotion Department advised on nutrition policy matters. The Health Promotion Department acted as an advisory body for policy-makers and was established in 1992. The Government covered the budget.

Interdisciplinary collaboration

Government initiated intercollaboration between parties involved in food took place as the need arose. In 1994/1995 a Nutrition Unit was responsible for collection of dietary data and providing this information to relevant policy-makers. No information was given regarding this in 1998/1999. The Nutrition Unit at the Health Promotion Department was responsible for the nutrition education of the public in 1998/1999.

Examples of normative actions

In 1994/1995 Malta did not have a set of recommended nutrient reference values and no information was given regarding this in 1998/1999. A country population representative survey of dietary intake and nutritional status was published in 1992. Dietary guidelines were updated in

⁴³ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

1996/1997 and were directed at the whole population. The guidelines were not field-tested prior to use.

Country report 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease mortality accounted for 48% of total deaths in the country, while cancer accounted for 27%. Just below 8% of the population was affected by diabetes. The ministry of Health was mainly responsible for issues related to noncommunicable diseases, whereas the Health Promotion Department developed campaigns. The intersectoral support from other ministries was not strong due to a lack of interest in health. In addition, campaigns were run on low budgets and there was a lack of commitment to health promotion.

Inequity and poverty leading to lack of food and nutrient deficiency

Iodine deficiency and iron deficiency anaemia was a problem especially in the poor, though no data existed on the prevalence. Poverty was not of national concern due to initiatives in social welfare. National health education was covered by an annual budget, however research funding was inadequate for carrying out needs assessment. There was not a perceived need to increase focus on inequity and poverty.

Infant, young children and maternal nutrition

In 1998, infant mortality was 7%. Low breastfeeding rates and poor weaning practices were widespread in Malta. In the years 1996–1998 breastfeeding rates were between 45–49%. Weaning tended to commence too early and consisted of biscuits mixed with milk. Supplementation of the maternal diet with folic acid and iron was needed. About 14% of pregnant women showed signs of impaired glucose tolerance. In addition, 42% of mothers were overweight, while 14% were obese. Obesity at 3 years of age was reported to affect 11% of boys and 14% of girls.

Mothers were invited to attend antenatal classes and Well-Baby clinics were run in community based health centres. School Medical Services offered health screening for primary children. A “Breastfeeding Policy” was to be launched in 2000.

Sustainable food production and distribution

The country imports most of its food supply. There was no formal agricultural policy, but laws were being updated. The government had taken initiative to improve food products for consumers and to ensure suitable income for farmers and herdsmen. Water and electricity bills of farmers and herdsmen had recently been reduced.

Food safety

Cases of foodborne disease increased from 625 cases in 1995 to 834 cases in 1998. Type of cases includes *salmonella*, *Campylobacter*, *Escherichia*, *B. cereuse* and some unspecified cases. Problems were encountered at all levels in the food industry.

Local authorities inspect the food industry and enforce the local Food Laws and regulations. New food laws and food hygiene regulations had to be enacted within a couple of years to be in line with EU directives. In addition, new laboratories were set up to strengthen testing capabilities and the Hazard Analysis and Critical Control Points system had been introduced. However, more rigid enforcement of new legislation was required.

Prevalence of under- and overweight

In Malta, more men than women were overweight, but more women are obese than men. No information regarding the prevalence of underweight was given. The mean BMI was 27.1 for men and 28.3 for women.

Table 61. Prevalence of under- and overweight, 25–64 years, Malta

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
25–34 years (N= n/a)	–	55	30	15
35–44 years (N= n/a)	–	38	33	29
45–54 years (N= n/a)	–	21	32	47
55–64 years (N= n/a)	–	15	31	54
24–64 years (N= n/a)	–	34	32	35
Men	%	%	%	%
25–34 years (N= n/a)	–	41	45	14
35–44 years (N= n/a)	–	29	46	25
45–54 years (N= n/a)	–	29	47	24
55–64 years (N= n/a)	–	24	49	28
24–64 years (N= n/a)	–	32	46	22

Statistics on dietary intake

No data provided

Monaco

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 and 1998/1999 were not returned.

Country report, 1999

No country report was submitted.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Portugal

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The country did not have a nutrition policy, however a policy document was presented to the government in 1989.

Advisory and administrative structures

Portugal did have an advisory body with a written mandate for providing scientific advice to the policy-makers. The advisory body- the National Food and Nutrition Council- was established in 1980, but has no budget to cover its activities.

Interdisciplinary collaboration

No regular government–initiated collaboration between parties involved in nutritional matters was carried out.

The National Food and Nutrition Council was responsible for the collection of dietary data and providing this information to relevant policy-makers. Whereas it was the Ministry of Health and Ministry of Education that were responsible for nutrition education to the public. Informal consultations took place between the Ministry of Health and Ministry of Agriculture on matters related to nutrition.

Examples of normative actions

Recommended nutrient reference values dated from 1982 and Portugal had not carried out a population representative survey of dietary intake and nutritional status within the last 10 years. Dietary guidelines in Portugal were updated 1982. The guidelines were directed at the whole population, but were not field-tested prior to use.

Country report, 1999

Two policies the “National Health Strategy 1998–2002” and “Health Promoting Schools” had been adopted to reduce diet related non-communicable diseases. The National Council of Food and Nutrition was involved in policymaking and health education.

Inequity and poverty leading to lack of food and nutrient deficiency

Inequity and poverty leads to lack of food and nutrient deficiencies in Portugal. A minimum income was guaranteed. Programmes to provide school milk, free lunch in schools to poor children and flour supplementation were implemented to help solve the problems related to poverty. Ministries involved were the ministries of Health, Social Solidarity, Education and Agriculture.

Infant, young children and maternal nutrition

Breastfeeding was promoted. Primary health care centres provided health education to pregnant women. Since 1992 the “Baby Friendly Hospital Initiative” had been implemented and advertising of infant formulas was not allowed.

Sustainable food production and distribution

No information was provided.

Food safety

Food legislation was according to EU directives and the ministries of Health, Agriculture and Education was involved in policy and health education related to food safety.

Prevalence of under- and overweight

In Portugal, more men than women were overweight, but more women were obese than men. In addition, more women than men were underweight.

Table 62. Prevalence of under- and overweight, 18–64 years, Portugal

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
18–34 years (N= 5108)	4	85	7	4
35–44 years (N= 3363)	2	71	16	11
45–64 years (N= 6842)	1	59	21	18
Men	%	%	%	%
18–34 years (N= 4962)	1	87	13	5
35–44 years (N= 2956)	0.2	68	21	11
45–64 years (N= 922)	0.4	61	25	16

Statistics on dietary intake

Dietary data was obtained from a one-day record and was carried out in 1980.

Table 63. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	38	32	13	13	50	56	–	–

Table 64. Vegetable and fruit intake excluding potatoes

Food groups	Men, g/day	Women, g/day	Total, g/day
Vegetables (÷ potatoes)	233	219	226
Fruit	172	174	173
Total	405	393	399

San Marino

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaires from 1994/1995 and 1998/1999 were not returned.

Country report, 1999

No information provided.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Spain

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1998/1999 was not returned and therefore only the results from 1994/1995 questionnaire are presented here.

Nutrition policy, plan of action or strategy

The Ministry of Public Health in Spain adopted a nutrition policy document in 1991. The document included components 2, 3, 4, 7 and 8 of the World Declaration and Plan of Action.⁴⁴

Advisory and administrative structures

An administrative structure had been set up to ensure implementation of the nutrition policy, by the Ministry of Health, Directorate of Public Health and the Department of Food and Nutrition Services. Spain did not have a nutrition advisory body responsible for providing scientific advice to policy-makers.

Interdisciplinary collaboration

Government-initiated collaboration between parties involved in nutritional matters took place between the Ministry of Health, Directorate of Public Health and the Ministry of Agriculture, Fisheries and Food.

The General Directorate of Public Health was responsible for the collection of information regarding dietary pattern of the population, providing this information to relevant policy-makers and for the nutritional education of the public.

Examples of normative actions

The country had a set of recommended nutrient reference values, which at the time of the 1994/1995 survey was undergoing revision. The country stated to have carried out a population representative survey of dietary intake and nutritional status within the last 10 years, but no reference were given. Dietary guidelines were established in 1991.

Statistics on dietary intake

No dietary data was provided.

Country report, 1999

No information provided.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Turkey

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The Ministry of Health in Turkey adopted a nutrition policy document as part of the National Health Policy in 1993. The document included all the actions stated in the World Declaration and Plan of Action.

⁴⁴ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Advisory and administrative structures

In 1994/1995 it was reported that the General Directorate of Health and the Department of Child Health and Maternal Health was responsible for the implementation of the nutrition policy. While in 1998/1999 this was stated to be the responsibility of the State Planning Organization and the Ministry of Health and Agriculture and Rural Affairs.

In 1994/1995 it was reported that an advisory body was set up to provide scientific advice to policy-makers on matters related to breastfeeding and iodization. In 1998/1999 advisory bodies on several matters related to nutrition existed. The advisory bodies did not have a written mandate. The National Budget and International Agencies covered activities of the advisory bodies.

Interdisciplinary collaboration

Government initiated collaboration took place between parties responsible for a variety of food-related issues. The State Statistics Institute, Ministry of Health State Planning Organization and the Ministry of Agriculture and Rural Affairs was responsible for the collection of dietary data. In addition, the State Planning Organization was responsible for providing this information to relevant policy-makers. In 1994/1995 the State Planning Organization was also responsible for public nutrition education, while this in 1998/1999 was shifted to the Ministry of Health and the Ministry of Agriculture and Rural Affairs. Formal regular consultations between Ministry of Health and Ministry of Agriculture occurred when developing food legislation, nutritional training programmes and food consumption surveys.

Examples of normative actions

Recommended nutrient reference values were updated in 1997 and prior to this in 1991. Turkey had not carried out population representative survey of dietary intake and nutritional status within the previous 10 years. Furthermore, Turkey did not have dietary guidelines, but used guidelines prepared by Hacettepe University from 1994 if necessary. These were directed towards infants, children and pregnant and lactating women, as well as the general population.

Country report 1999

Cardiovascular disease mortality caused 130 000 deaths a year and cancer mortality was 11% of total deaths. In addition, 7% suffer from diabetes and more than 25% of the population suffered from hypertension.

The dietary pattern was characterized by high-energy intake and high consumption of salt. An increase in fast-food consumption had been recorded and physical activity levels were low. There was a lack of awareness of healthy eating habits in the population and increasing urbanization, smoking and stress.

Educational programmes concerning cancer, hypertension and diabetes were mentioned as ways to reduce the diet related noncommunicable disease problems in the country. However, there was a lack of collaboration between organizations involved in these issues.

Inequity and poverty leading to lack of food and nutrient deficiency

Iodine, iron and other vitamin deficiencies including rickets were widespread among the poor. In addition, protein-energy malnutrition was mentioned to be a problem. Reasons for the dietary problems among the poor were reported to be that the diet was mainly vegetable based; there were common parasite infections among children; high frequency of births; pica and lack of exposure to sunlight due to dress traditions.

Policy guidelines stated that national dietary surveys should be carried out and according to the results national programmes should be developed. In addition, regional nutrition surveys should be conducted regularly. The National Health Policy aimed to decrease nutrition problems by 50% by year 2000. Programmes carried out include: public health nutrition; salt iodization; fluoride supplementation; promotion of milk consumption and incentives for milk production. However, financial difficulties to carry out planned nationwide surveys resulted in the last survey being carried out in 1984. In addition, lack of effective intersectoral cooperation and interdepartmental cooperation within the government made planning and implementation of policies and programmes difficult.

Infant, young children and maternal nutrition

The problems of infant and maternal health were mainly related to large family sizes and poor hygiene.

In the first months post-partum almost all infants were breastfed and by the end of the first year 52% were still breastfed. The mean duration of breastfeeding was 12 months, but most children received complementary feeding by 6 months. Too early introduction of supplementary foods was a problem as supplementary food was given to infants in the first 15 days post-partum. A 20% increase of bottle-feeding had been recorded since 1993. In addition, many infants below 4 months received solids or mushy food and other liquid supplements. In rural areas, it was still the practice to wait to breastfeed until the call to prayer had been heard three times. The maternal diet was characterized by being dominated by bread and cereal products. The lack of meat consumption among pregnant and lactating women resulted in 50% having anaemias.

In 1998 stunting affected 16% of children and 1% were wasted, while more than 8% of children were underweight. Children in rural areas and in the east regions were most affected by stunting. In 1993 it was reported that iron deficiency anaemia affected 21% of children between the ages of 13–19 years. In addition, endemic goitre affected, in 1995, 28% of boys and 33% of girls of 6–12 years. Rickets affected 8–10% of children. Other deficiencies reported to be widespread were deficiencies of riboflavin, B6 and vitamin A.

Education programmes included programmes to promote maternal and infant health and nutrition, prevention and management of protein-energy malnutrition, overcoming micronutrient deficiencies, prevention of anaemia in pregnancy, promotion of breastfeeding and baby friendly hospital initiative and growth monitoring. However, a lack of collaboration between departments of the Ministry of Health made planning and implementation difficult.

Sustainable food production and distribution

The country is self-sufficient regarding agricultural production. Though, in rural areas it was reported that 27% had inadequate energy intakes and 23% consumed insufficient protein.

High rates of inflation during recent years had affected the buying power of families, especially those of low-income. These families largely depend on bread, cereals and seasonal vegetables, while high-income families consume more high fat foods such as meat and meat products, eggs, cheese and high salt processed foods.

To increase food production a project to increase animal food production and to eradicate and control epidemic and communicable animal diseases has been adopted. However, lack of

coordination among organizations, ministries and interdepartments made development and implementation of policies difficult. In addition, inadequate budgets added to the problems.

Food safety

The traditional manufactures were not aware of importance of hygiene and street foods were not controlled. In addition, food additives were widely used in processed food. Fertilizers, insecticides, herbicides, growth promoters and other veterinary chemicals were used in agricultural production. Though, the national food control system was designed to protect consumer's health, promote food trade, prevent chemical or biological hazards, supervise adulteration or mishandling of food and control the use of chemicals in the agricultural production. Food policies and approaches mentioned to solve problems in the field of food safety was the Food Law in 1995 and updated in 1998 on production, consumption and inspection of food stuff; regulation of production and food sale in 1996; and finally The Turkish Food Index in 1997. However, lack of collaboration between ministries and producers caused problems in the development and implementation of food safety policies. In addition, there was inadequate numbers of qualified laboratories for analysing chemicals.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data was obtained of the national nutrition and food consumption survey from 1984.

Table 65. Daily macronutrient and alcohol intake expressed as a percentage of total energy intake

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	24	12	64	0

Table 66. Vegetable and fruit intake excluding potatoes

Food groups	Total, g/day
Vegetables (÷ potatoes)	–
Fruit	173
Total	–

Western European Region

Austria

Questionnaire analysis 1994/1995 and 1998/1999

Questionnaire from 1994/1995 was not returned and therefore only the results from 1998/1999 questionnaire are presented here.

Nutrition policy, plan of action or strategy

Austria has not yet adopted a policy document concerned with nutrition.

Advisory and administrative structures

The country did not have a nutrition advisory body to advice policy-makers on scientific matters.

Interdisciplinary collaboration

Collaboration between parties responsible for nutrition took place in the frame of the Austrian Codex Alimentarius Commission. However, the Commission was not responsible for nutrition education and no information was provided as to who was responsible. No consultations between the Ministry of Health and the Ministry of Agriculture were reported, but regular intersectoral consultations took place between the Ministry of Health and the Ministry of Consumers.

Examples of normative actions

In Austria the responsibility of the collection of dietary data was with the Central Statistics Institute. No information was provided regarding who had the responsibility for public nutrition education.

No information was provided regarding recommended nutrient reference values or national surveys of dietary intake and nutritional status. Austria used dietary guidelines directed at the whole population and these were revised in 1997.

Country report 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease mortality accounted for 54% of total deaths, while cancer and diabetes mellitus accounted for 23% and 2% respectively. The dietary habits were characterized by a high consumption of fat (40%). Animal fat intake was especially high. The dietary problems started in childhood with a growing number of obese children; especially boys overate and had low levels of physical activity. Recommendations were issued to lower consumption of animal products. Promotion of healthy eating and physical activity was carried out using leaflets and a nutrition hotline.

Inequity and poverty leading to lack of food and nutrient deficiency

The country had a good economic situation and a comprehensive social security system and therefore food and nutrition deficiencies, because of inequity and poverty, was not reported to be widespread.

Infant, young children and maternal nutrition

A dramatic increase of 28% of breastfeeding had been recorded since 1985. In 1999, 92% of mothers breastfed one month post-partum, while 70% continued to breastfeed at 4 months. A variety of information leaflets, legal acts, lactation consultants and baby friendly hospitals carried out the promotion of breastfeeding. The Ministry of Health, the Midwife Organization and the lactation consultants' league were involved in policies and programmes related to maternal and infant health.

Sustainable food production and distribution

Since 1990 agriculture subsidy programmes in Austria were restructured and reoriented to meet the requirements for joining the EU and in preparation of the Uruguay round of the GATT talks. Furthermore, a programme adopted in 1995 on environmental sound and sustainable agriculture resulted in a decline of use of fertilizers, pesticides and a significant growth in organic farms had been recorded. In 1998 8% of farms were organic.

Food safety

Foodborne diseases were stated to be rare in Austria. Cases of Salmonella and microbiological intoxication occurred at a rate of 12 per 10 000 and there had not been any significant change during the past 10 years. Public concern was mainly related to genetic modified food, which

resulted in a ban in most stores. Austria had a comprehensive food control system based on a variety of legal acts covering all aspects of food safety.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary data was obtained from 24-hour recall survey carried out in 1998.

Table 67. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Austria

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	38	38	16	15	41	46	5	1

Table 68. Vegetable and fruit intake excluding potatoes, Austria

Food groups	Men, g/day	Women, g/day	Total, g/day
Vegetables (÷ potatoes)	119	110	114
Fruit	102	139	121
Total	221	249	235

Belgium

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The Ministry of Public Health in Belgium adopted a nutrition policy document in June 1998, which incorporated the components 1, 4, 5, 7, 8 of the World Declaration and Plan of Action.⁴⁵

Advisory and administrative structures

The Federal Minister of the Health Plan of Action for Nutrition had the responsibility for implementation of the nutrition policy. In addition, Belgium had an advisory body to provide scientific advice to policy-makers, which was set up in 1992. The body had a written mandate and budget to cover its activities, financed by the Federal Ministry of Health.

Interdisciplinary collaboration

Government initiated collaboration between parties involved in nutrition took place. There were no regular consultations between the Ministry of Health and the Ministry of Agriculture on matters related to nutrition.

Examples of normative actions

Belgium developed recommended nutrient reference values in the years following the 1994/1995 survey and in 1998 dietary guidelines directed at the whole population was also established. The

⁴⁵ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

most recent reference of a population representative survey of dietary intake and nutritional status was from 1989.

Country report 1999

No country report was provided.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No information was provided regarding where the dietary data was obtained.

Table 69. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Belgium

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	42	43	13	15	39	41	5	2

Table 70. Vegetable and fruit intake excluding potatoes

Food groups	Men, g/day	Women, g/day	Total, g/day
Vegetables (÷ potatoes)	207	205	206
Fruit	139	172	155
Total	346	377	360

France

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

France did not have a nutrition policy, but stated that components 1, 2, 4, 5, 7 and 8 were incorporated in other documents.⁴⁶

Advisory and administrative structures

In 1994/1995 France reported having an administrative structure to implement nutrition policies and an advisory body to provide scientific advice to policy-makers. The body had a written mandate and a budget to cover its activities.

Interdisciplinary collaboration

Government initiated meetings between parties responsible for nutritional matters took place on a regular basis. In 1994/1995 it was reported that the Observatoire des Consommations Alimentaires was responsible for the collection of dietary data, and both this body and the Conseil National de l'Alimentation provided information to relevant policy-makers and published guidelines. In 1998/1999, it was stated that the responsibility of the collection of dietary data was changed and was divided between the Observatoire des Consommations Alimentaires, Comité Français d'Éducation pour la Santé and the Institut National de la Veille

⁴⁶ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles.

Sanitaire. In both 1994/1995 and 1998/1999 the Comité Français d'Éducation pour la Santé was reported as responsible for public nutrition education.

In France regular formal consultations between the Ministry of Health and the Ministry of Agriculture took place in Conseil National de l'Alimentation.

Examples of normative actions

France updated its recommended nutrient reference values in 1999 and prior to this in 1992. Dietary guidelines were aimed at the whole population and particular groups. No information was given regarding when these guidelines were established. The most recent population representative survey of dietary intake and nutritional status was published in 1996 and prior to this in 1988.

Prevalence of under- and overweight

In France, more men than women were overweight and obese and the prevalence of underweight was higher among women. The mean BMI was 25 for men and 23.4 for women.

Table 71. Prevalence of under- and overweight, 19–64 years, France

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 3846)	12	71	12	4
35–49 years (N= 3843)	5	66	20	8
50–64 years (N= 2684)	3	53	33	12
19–64 years (N= 10 373)	7	65	20	8
Men	%	%	%	%
19–34 years (N= 3977)	3	71	22	4
35–49 years (N= 3812)	0.5	52	39	9
50–64 years (N= 2481)	1	36	49	14
19–64 years (N= 10 270)	2	53	35	8

Statistics on dietary intake

The dietary data were obtained from 6 registrations of 24-hour recall per year in three years. The survey was carried out in 1994–1997.

Table 72. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, France

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	36	38	16	16	39	40	9	5

Table 73. Vegetable and fruit intake excluding potatoes, France

Food groups	Men, g/day	Women, g/day	Total, g/day
Vegetables (÷ potatoes)	219	204	212
Fruit	235	216	226
Total	454	420	437

Germany

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In 1996 the Ministry of Health and Ministry of Food, Agriculture and Forestry in Germany adopted a nutrition policy, which was stated to incorporate components 1–8 of the World Declaration and Plan of Action.

Advisory and administrative structures

There was not an administrative structure to ensure implementation of the nutrition policy, but an advisory body to advice policy-makers was established. No additional information was provided regarding the advisory body.

Interdisciplinary collaboration

There was no government-initiated collaboration between the parties responsible for nutritional matters. In 1994/1995 it was reported that Deutsche Gesellschaft für Ernährung at the request of the Ministry of Health was responsible for the collection of dietary data of the population and for providing this information to relevant policy-makers, while in 1998/1999 it was stated that no single organization was responsible. In 1994/1995 the Minister of Culture was responsible for public nutrition education, but due to the federal structure it was stated in 1998/1999 that a number of bodies were working in this area. Both formal and informal consultations between the Ministry of Health and the Ministry of Agriculture were reported to take place regularly.

Examples of normative actions

Germany had recommended nutrient reference values from 1991, which were being revised in 1999. Dietary guidelines were directed at the whole population and were revised in 1997, but these were continuously updated. Germany carried out its most recent population representative survey of dietary intake and nutritional status in 1989. The survey had been published.

Country report 1999

Noncommunicable diseases and related risk factors

Cardiovascular disease mortality accounted for 200 000 deaths per year, but strong regional disparities in relation to ischaemic heart disease were recorded. Cancer mortality accounted for 28% and 20% for men and women respectively. Osteoporosis was prevalent among women: 17–19% of postmenopausal women suffer from fractures of the neck of femur and 31% from fracture of vertebra or forearm.

Large differences in eating habits were recorded, but generally the diet was too high in fats, salt and sugars and too low in carbohydrates, dietary fibres, fruit and vegetables. In addition, there was a tendency not to be physically active.

Inequity and poverty leading to lack of food and nutrient deficiency

There was no good nutritional data to determine nutritional status of the disadvantaged in the population, but iron deficiency anaemia was recorded among children and women. Dietary intake data suggested that there was a lower consumption of fruit, fish, dairy products, fruit juice, and alcoholic beverages (except beer) among the poor. In addition, this group had less frequent consumption of a sound breakfast and had a poor variety in meals. This group also consumed more carbonated soft drinks and fast food, and eating while watching television is common.

Around 1996 the subsidization of canteen meals for children from disadvantaged areas had reversed the trend of children failing to attend school meals and so improved their diet. However, there was no policy directed at the disadvantaged families and individuals, but social measures ensured families received a minimum income. Laws ensured free access to health services and there were welfare shops and distribution of food at reduced prices for the disadvantaged.

A lack of coordination between sectors had made the development and implementation of new policies difficult. There was no supervisory system for the evaluation of the nutritional status and eating habits of the disadvantaged and so the outcome of special programmes was uncertain.

Infant, young children and maternal nutrition

During pregnancy two thirds of women suffer from iron deficiency and between 20–30% had iron deficiency anaemia. Routine haemoglobin testing by six month of pregnancy allowed the practitioner to decide if iron supplement was needed, but there was no specific nutrition policy targeting pregnant women. Dietary advice was provided by the national health education agency.

In 1981 5% of newborns were underweight (< 2500 g) and 4.4 per 10 000 was born with Spina bifida. In children a rapid increase in the prevalence of obesity has been recorded and is now a priority that needed to be tackled.

In 1970 37% of mothers breastfed their children and this increased to 54% in 1980s, but rates had reversed to those of 1970 again in the 1990s. The length of breastfeeding was unknown, but one study suggested that at 4 months post-partum only 5–10% of infants were breastfed. A decree came into force in 1998 aimed at regulating the law regarding gifts of baby products and information material on such products in conformity with EU directive.

Sustainable food production and distribution

The General Food Directorate of the Ministry of Agriculture was responsible for food quality defined at three levels: health related quality ensuring products meets safety standards; nutritional quality ensured by labelling meets national, EU and international standards and finally technical quality ensuring that industrial producers undertake commitment with regard to manufacturing procedures. The Ministry of Agriculture and the Ministry of Economy, Finance and Industry was involved in policy-making in this area, but the nutritional quality of products needed to be improved via public health policy on nutrition.

Food safety

In 1997, 3.4 million people consulted their GP because of diarrhoea. In addition, 478 food poison outbreaks affecting 7817 persons was notified. About 60% of outbreaks happened in mass catering and 44% was due to Salmonella enteritis and one third was attributed to eggs and egg-based products.

In 1998 the establishment of three new bodies strengthened the control of health and food safety. However, the different policies needed to be coordinated. The assessment procedures were in line with the Codex Alimentarius.

Prevalence of under- and overweight

In Germany, overweight was more prevalent among men than women, while obesity was more prevalent among women. Slightly more women than men were underweight. The mean BMI was 26.9 for men and 26.2 for women.

Table 74. Prevalence of under- and overweight, 19–64 years, Germany

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
19–34 years (N= 1013)	3	65	23	9
35–49 years (N= 1219)	1	51	30	17
50–64 years (N= 1223)	0.5	27	39	32
19–64 years (N= 3455)	2	47	37	20
Men	%	%	%	%
19–34 years (N= 917)	0.3	50	39	11
35–49 years (N= 1232)	0.2	30	51	19
50–64 years (N= 1191)	0.8	20	55	25
19–64 years (N= 3340)	0.4	32	49	19

Statistics on dietary intake

No data provided

Ireland**Questionnaire analysis 1994/1995 and 1998/1999***Nutrition policy, plan of action or strategy*

Ireland only had a policy recommendation from 1991 and not an explicit nutrition policy document. All the components of the World Declaration and Plan of Action were stated to be included in the recommendation except action 3.⁴⁷

Advisory and administrative structures

No administrative structure had been set up to ensure implementation of the nutrition policy, but the Health Promotion Unit was implementing many of the nutrition recommendations. An advisory body to provide scientific advice to the policy-makers was established in 1991. The advisory body had a written mandate and the budget, funded by The Food Safety Authority of Ireland, was for publication of reports only. Funding for specific projects had to be applied for.

Interdisciplinary collaboration

Regular government initiated collaboration took place between parties involved in nutritional matters via the Consultative Committee on Health Promotion.

The National Nutrition Surveillance Centre was responsible for collection of information regarding the populations' dietary pattern and providing this information to relevant policy-makers. Consultations between the Ministry of Health and Ministry of Agriculture occurred via the Consultative Committee on Health Promotion.

Examples of normative actions

Ireland used EU Recommended dietary allowances since 1998. An update of dietary guidelines was published in 1994. The guidelines were directed at the whole population as well as special groups. The most recent population representative survey of dietary intake and nutritional status was published in 1990.

⁴⁷ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Country report 1999

Cardiovascular disease mortality accounted for 23% of total deaths, while cancer mortality accounted for 24%. The diet in Ireland was characterized by being too high in fat, especially saturated fat. Intake of dietary fibre was very low and young women had especially low consumption of calcium and iron. There was unacceptable socioeconomic variation in dietary habits in the population.

Lack of sufficient resources to target different population groups, especially the disadvantaged, made reversal of the situation difficult. More community dieticians were needed to put healthy eating guidelines into practice.

Inequity and poverty leading to lack of food and nutrient deficiency

Vitamin C and iron intake was markedly reduced in disadvantaged groups. This group lacked variety in the diet. Cooking and storage facilities were inadequate and lack of information and skills to prepare food limited food choices. Low-income families' made the best use of their resources and poor dietary habits were not due to poor budgeting. Women were more likely to have nutritional inadequacies, especially in single parent families.

Approaches to solve the dietary problems of the disadvantaged included: the provision of community dieticians for the lower economic groups; nutrition education programmes, which use a peer led community development approach aimed at low income women; and health boards organized food cafes and food coops. In addition, school lunch schemes, organized by the local authorities to provide a free school lunch for disadvantaged, was being revised. However, financial, housing and access difficulties were all major barriers to the success.

Infant, young children and maternal nutrition

Iron deficiency in infants, young children and women was prevalent and anaemia in infants aged 1 to 3 years was reported. In addition, the country experienced high incidences of neural tube defects. Infants were commonly given solids too early. Baby Friendly Hospital Initiative was established at 50 hospitals to provide the best conditions for new mothers and infants. In addition, a programme to promote breastfeeding and educational programme focusing on the importance of folic acid supplementation, was carried out throughout the country. However, statistics on breastfeeding, especially in socially disadvantaged groups, were lacking. In addition, financial, personnel and in-service resources were lacking.

Sustainable food production and distribution

Progress was being made using sustainable agricultural methods. A programme of Rural Environment Protection was carried out to help stimulate rural economies, promote social cohesion and improve general well being within rural areas. Other measures based on sustainable food production included: aid for pollution control; environmentally friendly farming policies; and high standard of food safety.

Food safety

A recent increase in foodborne diseases and especially *E. coli* 0157 was the main concern. Practices to be improved included: information gathering; coordination of control services; more information on dietary intakes; consumer education; and creation of a food safety culture/ethos. The main approach to meet these goals was to establish a single agency responsible for law enforcement "Food Safety Authority of Ireland". The media would be used and the new authority would publish a series of publications for consumers addressing food safety. However,

lack of consumer confidence and of financial and personnel resources reduced the success of some initiatives.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

Dietary data was assessed using dietary history method and was collected in 1990. Sample size was representative and consisted of 670 subjects.

Table 75. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, Ireland

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	34	34	15	16	49	49	3	0.7

Statistics on dietary intake

No data provided

Luxembourg

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The country had adopted a document in which nutrition was discussed in 1994. In 1994/1995 it was stated that the document included actions 1 and 4–8 plus prevention of infectious diseases, but in 1998/1999 it was reported that only action 1 and 8 of the components of the World Declaration and Plan of Action was included.⁴⁸

Advisory and administrative structures

Luxembourg did not have an administrative structure to ensure the implementation of nutrition policy or an advisory body to provide policy-makers with nutritional advice on scientific matters.

Interdisciplinary collaboration

Government initiated collaboration between different bodies concerned with nutrition took place between ministries and organizations. There was no central coordination of the collection of information regarding dietary data. Public nutrition education was the responsibility of the Division of Preventive and Social Medicine. There were no consultations on nutritional matters taking place between the Ministry of Health and the Ministry of Agriculture.

Examples of normative actions

In 1994/1995 it was reported that Luxembourg did not have international recommended nutrient reference values, but in 1998/1999 it was stated that the country used the same reference values as neighbouring countries. In 1994/1995 Luxembourg did not have dietary guidelines, but in 1998/1999 dietary guidelines had been developed. The guidelines were to be continuously

⁴⁸ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

updated and were directed at the whole population and special groups. No population representative survey of dietary intake and nutritional status had been carried out in the last 10 years.

Country report 1999

No country report provided.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

No data provided

Netherlands

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

The Councils of Ministers and the Parliament in the Netherlands adopted a new nutrition policy document in September 1999. It was stated that the policy incorporated all the components of the World Declaration and Plan of Action.

Advisory and administrative structures

In 1994/1995 the Food and Nutrition Unit in the Ministry of Health, Welfare and Social Security was set up to ensure the nutrition policy was implemented. Whereas in 1998/1999 a Steering Group for Proper Nutrition was established to ensure its implementation. It was reported that an advisory body to provide policy-makers with scientific advice had been established since 1952. The advisory body had a written mandate and a budget to cover its activities funded by the Ministry of Health, Welfare and Social Security.

Interdisciplinary collaboration

In 1994/1995, it was reported that the Ministry of Health, Welfare and Social Security, the Ministry of Agriculture and the Ministry of Financial Affairs took part in government-initiated collaboration on nutritional matters. In 1998/1999, it was stated that the Steering Group for Proper Nutrition devised action plans to improve the nutritional situation in the Netherlands. In 1994/1995, the Food and Nutrition Unit in the Ministry of Health, Welfare and Social Security was responsible for the collection of dietary data, while in 1998/1999 this was the responsibility of the Nutrition Centre. In 1994/1995 the national Nutrition Council was reported to provide information to relevant policy-makers concerning public health nutrition, while these responsibilities, in 1998/1999, were with the Nutrition Centre. Informal consultations occurred between the Ministry of Health and the Ministry of Agriculture.

Examples of normative actions

Recommended nutrient reference values were updated in 1999. Dietary guidelines were targeted at the whole population. The Netherlands had carried out population representative survey of dietary intake and nutritional status three times within the last 10 years.

Country report 1999

No country report was submitted.

Prevalence of under- and overweight

No data provided.

Statistics on dietary intake

The dietary information was obtained from a 2-day notebook method, which was carried out in 1997/1998.

Table 76. Daily macronutrient and alcohol intake expressed as a percentage of total energy intake, Netherlands

Nutrients	Fat	Protein	Carbohydrate	Alcohol
% Total energy intake	36	15	46	3

Table 77. Vegetable and fruit intake excluding potatoes

Food groups	Total, g/day
Vegetables (÷ potatoes)	105
Fruit	123
Total	228

Switzerland

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

By 1996 the Swiss Nutrition Council had adopted a nutrition policy, which was stated to include action 1, 2, 7 and 8 of the World Declaration and Plan of Action.⁴⁹

Advisory and administrative structures

In 1994/1995, a working group for the follow-up of the International Conference on Nutrition had been established, and by 1998/1999 an administrative structure was being prepared to ensure the implementation of the nutrition policy. Switzerland has an advisory body to provide policy-makers nutritional advice on scientific matters. The body had a written mandate and a budget to cover its activities funded by the government.

Interdisciplinary collaboration

In 1998/1999, the government initiated collaboration concerning nutrition which took place within the Swiss Nutrition Council. The Federal Office of Public Health was responsible for the collection of dietary data and providing information to relevant policy-makers. It was reported that several organizations were responsible for public nutrition education. Within the Swiss Nutrition Council consultations between the Ministry of Health and the Ministry of Agriculture took place.

⁴⁹ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Examples of normative actions

Recommended nutrient reference values were developed in 1995 and revised in 1998. Dietary guidelines were developed in 1995 and directed at the whole population. The most recent population representative survey of dietary intake and nutritional status was carried out in 1998.

Country report 1999

Noncommunicable diseases and related risk factors

The incidence of cardiovascular disease was low compared with the European average, but risk factors such as high serum cholesterol and obesity were prevalent.

Inequity and poverty leading to lack of food and nutrient deficiency

Minor nutrient deficiencies were found and most often the result of an unbalanced diet and food insecurity. About 80% of salt for human consumption was iodinated.

Infant, young children and maternal nutrition

The rate of exclusively breastfed infants had increased since 1978. In 1999, 80% of mothers breastfed one month post-partum, 62% at 2 months post-partum and at 4 months 48% still breastfed. The number of Baby Friendly Hospitals was among the highest in Europe. A programme for the prevention of neural tube defects was planned.

Sustainable food production and distribution

The agricultural policy encouraged farming and food production methods that reduced environmental effects e.g. water pollution, soil erosion and reduction in biodiversity. The national plan of action on environment and health included several targets for further improvement of sustainable food production and distribution.

Food safety

It was reported that 95% of food samples were below the legal limit of pesticides residues. The most frequent foodborne diseases were *Campylobacter* and *Salmonella*. The main problem of food safety was of microbiological origin, but the Hazard Analysis and Critical Control Points concept was being enforced since 1995.

Prevalence of under- and overweight

In Switzerland, BMI increased with age for both genders and all age groups. However, more women were underweight than men, while a larger proportion of men were overweight and obese.

Table 78. Prevalence of under- and overweight, 15+ years, Switzerland

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
15–34 years (N= n/a)	37	53	8	2
35–49 years (N= n/a)	23	57	15	5
50–64 years (N= n/a)	12	56	25	8
65+ years (N= n/a)	11	51	30	8
Men	%	%	%	%
15–34 years (N= n/a)	12	66	20	3
35–49 years (N= n/a)	5	53	36	7
50–64 years (N= n/a)	3	41	46	10
65+ years (N= n/a)	3	47	42	9

Statistics on dietary intake

No data provided

United Kingdom

Questionnaire analysis 1994/1995 and 1998/1999

Nutrition policy, plan of action or strategy

In 1992, the United Kingdom adopted the policy document “Health of the Nation” in which the components 3–5 and prevention of infectious diseases of the World Declaration and Plan of Action were included.⁵⁰ However, in 1998/1999 it was stated that the country did not have a policy document solely concerned with nutritional issues.

Advisory and administrative structures

In 1994/1995, the Nutrition Task Force was stated to be responsible for the implementation of nutrition policy, but no information regarding this administrative structure was given in 1998/1999. A nutritional advisory body to provide scientific advice had been established in United Kingdom from 1961. The body consisted of independent health experts, scientists and the food industry. The body had a written mandate and a budget to cover its activities funded by the Department of Health.

Interdisciplinary collaboration

In 1994/1995, it was stated that the government-initiated collaboration between parties involved in nutritional matters, but this was not the case in 1998/1999. Furthermore, in 1994/1995 it was reported that the Nutrition Branch and the Food Science Division, Ministry of Agriculture, Fisheries and Food was responsible for the collection of dietary data, while this in 1998/1999 was stated to be the Nutrition Unit, Ministry of Agriculture, Fisheries and Food. The Health Education Authority, the Nutrition Branch and the Food Science Division, Ministry of Agriculture, Fisheries and Food was, in 1994/1995, reported to be responsible for public nutrition education, while in 1998/1999 this responsibility was shared between the Health Education Authority and the Ministry of Agriculture, Fisheries and Food. Informal consultations took place between the Ministry of Health and the Ministry of Agriculture.

Examples of normative actions

Recommended nutrient reference values were updated in 1991. Dietary guidelines were updated in 1993 and were directed at the whole population. A population representative survey of dietary intake and nutritional status was published in 1995.

Country report 1999

Noncommunicable diseases and related risk factors

Coronary heart disease mortality accounted for 200 000 deaths out of 500 000, while 200 000 new cases of cancer emerged every year and the death rate from cancer was increasing. Stroke was the leading cause of disability resulting in 350 000 severely disabled at a time. High blood pressure affected 22% of the population.

⁵⁰ 1: Nutritional objectives and targets, 2: Assessing, analysing and monitoring nutrition situations, 3: Improving household food security, 4: Protecting consumers through improved food quality and safety, 5: Promoting breastfeeding, 6: Caring for the socioeconomically deprived and nutritionally vulnerable, 7: Preventing and controlling specific micronutrient deficiencies, 8: Promoting appropriate diets and healthy lifestyles

Noncommunicable diseases affected some population groups more e.g. people from Asian and Afro-Caribbean backgrounds were more likely to suffer from high blood pressure, to develop heart diseases and to have a stroke. Death rate from coronary heart disease was three times higher for men of working age in social class V than for social class I. In addition, people from the lower social classes were more likely to be obese.

Approaches to reduce noncommunicable diseases included targeting risk factors of smoking, physical inactivity, diet, blood pressure, and obesity and improve medical and community services. The government was: developing a National Health Service Framework for coronary heart disease and for older people's services; increasing the cost of smoking through taxation; investing up to £60 million in England for new NHS services to help people stop smoking (this was starting in the most deprived areas in Health Action Zones); investing £1 million in purchase of defibrillators and a further £1 million in training to enable people to use them; and finally improving conditions for safe walking and cycling, especially for children's journeys to and from school. All government departments were involved in these programmes.

Inequity and poverty leading to lack of food and nutrient deficiency

Anaemia affected 4% and 11% of men and women respectively. Vitamin D status was poor in some elderly people (65 years and above) particularly those living in institutions and during the winter months. In addition, folate status was poor in a large proportion of elderly.

Certain vulnerable groups had special needs and required supplementary vitamins and minerals. The consumption of fruit and vegetables was amongst the lowest in Europe. Especially people of the lower socioeconomic group eat less fruit and vegetables and food rich in dietary fibre. The lower income groups tended to have to pay more for their food because of the physical inaccessibility of large retail outlets necessitating expenditure on transport or paying higher prices in small local shops.

A number of initiatives were ongoing to improve the well-being of people on low income: a New Deal Programme aiming to get unemployed people back into work; employment zones had been launched to improve opportunities for long-term unemployed in the poorest areas; the National Minimum Wage was increased so that the hourly wage of almost two million low-paid workers went up by an average of 30%; 26 Health Action Zones had been designated to tackle health inequalities; and finally the Social Exclusion Unit was looking at ways of improving shopping access in deprived areas. However, some deprived areas did not have easy access to shops, which sell food at reasonable prices, and people on low income had additional difficulties in affording a wide variety of foods. It will take many years to ensure that everyone can enjoy healthy eating choices.

Infant, young children and maternal nutrition

There was a low prevalence of breastfeeding and poor weaning practices were common. About 50% of women in social class V breastfed compared with 90% in social class I. The lowest breastfeeding rate was seen among mothers without a partner. In addition, only 53% of mothers who left full education at 16 years breastfed, whereas mothers who continued in education beyond the age of 18 years were more likely to breastfeed (90%).

A National Network of Breastfeeding Coordinators was established to promote breastfeeding at local level and to share ideas nationally. In addition, the Health department supported the National Breastfeeding Awareness Week each year and two part-time Infant Advisers were appointed. A number of cross government initiatives to improve quality of life for children and

families e.g. Sure Start, Teenage Pregnancy Initiative and support of working families were carried out continuously.

Sustainable food production and distribution

Approaches to sustainable development were based on four objectives: social progress that meets the needs of everyone; effective protection of the environment; prudent use of natural resources; and maintenance of high and stable levels of economic growth and employment. In rural areas the agricultural industry had a vital role in ensuring sustainable development: to supply good quality food and other products efficiently; to minimize consumption of non-renewable and other resources; to safeguard the quality of water, air and soil; to ensure high standards of farm animal welfare; and to enhance biodiversity and the appearance of the landscape inclusive the archaeological heritage. A range of policies to achieve the aims had been adopted, in particular advice and encouragement, incentive, regulations, research and development was mentioned. Indicators for sustainable agriculture were being developed to measure the main impacts of agriculture and its contribution to sustainable development. The Ministry of Agriculture, Fisheries and Food were responsible for these issues.

Food safety

In 1998 a total of 93 932 cases of food poisoning was notified. *Campylobacter* accounted for most of the cases followed by *Salmonella* and *E. coli*. Currently the major problem was to improve the public confidence in the way that food safety and standards were handled. Food chemicals and novel foods were not major contributors to foodborne illness, although concerns about possible long-term effects have been voiced. There had been an increased emphasis on establishing controls in primary production to reduce the numbers of pathogens entering the food chain. Control of food contamination was based on Hazard Analysis and Critical Control Points concept and the approach pursued was consistent with food safety standards developed by Codex Alimentarius and EU food control legislation. The two major national laws on food safety were the Food Safety Act from 1990 and the Food Standards Agency.

The main problem encountered in the promotion of safe food was the lack of information on the true level of foodborne diseases. Knowledge of current trends is crucial to the development of effective food safety policies and strategies. There was a need to understand the main sources of *Campylobacter* and *E. coli* and the methods most effective in controlling them. The public has high anxiety about the effectiveness of food safety mechanisms and reliability of scientific advice. It was very important to restore public confidence and trust. The diversity in the food industry is large and the changing of long held practices necessitate continuous monitoring.

Prevalence of under- and overweight

In the United Kingdom, the prevalence of overweight was higher among men than women, though was obesity slightly more prevalent among women than men. In addition, more women than men were underweight. The mean BMI was 26.2 for men and 25.8 for women.

Table 79. Prevalence of under- and overweight, 16–64 years, United Kingdom

	Underweight BMI >18.5	Normal BMI 18.5–24.9	Overweight BMI 25–29.9	Obese BMI > 30
Women	%	%	%	%
16–24 years (N= 1016)	17	56	19	9
25–34 years (N= 1500)	8	49	28	16
35–44 years (N= 1493)	6	47	30	19
45–54 years (N= 1385)	3	38	39	21
55–64 years (N= 1007)	4	28	41	29
65–74 years (N= 986)	5	27	43	26
75+ years (N= 677)	6	33	40	21
16–64 years (N= 6401)	7	44	31	19
Men	%	%	%	%
16–24 years (N= 908)	16	55	22	6
25–34 years (N= 1290)	4	41	43	13
35–44 years (N= 1348)	2	34	48	17
45–54 years (N= 1247)	2	27	49	22
55–64 years (N= 938)	1	25	51	24
65–74 years (N= 831)	3	26	52	20
75+ years (N= 435)	3	34	47	16
16–64 years (N= 5731)	5	36	43	16

Statistics on dietary intake

Dietary data was assessed by a seven-day weighted food diary and was collected in 1986–87. No sample size was provided.

Table 80. Daily macronutrient and alcohol intake by gender expressed as a percentage of total energy intake, United Kingdom

Nutrients	Fat		Protein		Carbohydrate		Alcohol	
	Men	Women	Men	Women	Men	Women	Men	Women
% Total energy intake	38	39	14	15	42	43	7	3

Table 81. Vegetable and fruit intake excluding potatoes, United Kingdom

Food groups	Men, g/day	Women, g/day	Total, g/day
Vegetables (÷ potatoes)	149	123	136
Fruit	67	79	73
Total	215	202	209

Conclusion and recommendations

Traditionally, policymakers viewed issues concerning nutrition, health, food safety and food production as separate disciplines. However, nutrition is an interdisciplinary science. Hence, optimal public health and policymaking will require a holistic approach, which incorporates issues related to healthy nutrition, sustainable food production and distribution and food safety.

The following conclusions and recommendations are presented following analysis of the comparison between different subregions in WHO EURO.

Food and Nutrition Policy

A large number of WHO European Member States had developed national food and nutrition policies although 25% of the Member States returning questionnaires in 1998/1999 reported not to have adopted a national food and nutrition policy at time of the survey. Several Member States recognized that an effective national food and nutrition policy requires intersectoral collaboration and assignment of responsibility for the implementation of the policy. However, there were still a notable number of Member States that were lacking established advisory and administrative structures to ensure successful and sustainable implementation of national food and nutrition policies. Many WHO European Member States had developed reference values for nutrient intakes and dietary guidelines; though scope and population groups targeted varied considerably between Member States.

Recommendations:

1. Establish an advisory body to provide scientific advice to relevant policy makers;
2. Develop scientific based recommended nutrient reference values and dietary guidelines directed at the whole population and special groups;
3. Encourage interdisciplinary collaboration across sectors involved in food and nutrition policy;
4. Designate responsibility for implementation of food and nutrition policy;
5. Establish guidelines for the monitoring and evaluation of the impact food and nutrition policy.

Nutritional Health

Noncommunicable diseases and related risk factors

In the majority of the WHO European Member States, noncommunicable diseases presented a serious problem and the rise in the prevalence of overweight and obesity across the WHO European Region calls for urgent action. The problems of noncommunicable diseases and overweight/obesity were mainly linked to the consumption of an energy dense diet high in saturated fat and low in fruit and vegetables in conjunction with sedentary lifestyles. The rise in prevalence of overweight and obesity increases the risk of noncommunicable diseases including cardiovascular diseases, certain cancers, and diabetes.

Recommendation:

1. Develop and implement scientific sound policies and programmes to encourage healthy lifestyles;
2. Surveillance of trends in BMI compared with WHO recommendations;
3. Surveillance of dietary habits compared with WHO recommendations.

Inequity and poverty leading to lack of food and nutrient deficiency

The majority of WHO European Member States had yet to develop policies and programmes targeting the disadvantaged groups. The most often mentioned nutrient deficiencies were iodine deficiency disorder and iron deficiency anaemia. Several Member States had developed programmes to tackle problems of these deficiencies, but often a lack of human and financial resources limited the implementation of effective programmes.

Recommendation:

1. Identify and monitor vulnerable groups with regards to dietary intake patterns;
2. Develop policies and programmes aimed at enhancing health and living conditions of the disadvantaged groups to promote equity;
3. Develop and implement guidelines on the elimination of iodine deficiency disorders and the control of iron deficiency anaemia.

Infant, young children and maternal nutrition

Many WHO European Member States provided little information regarding child and maternal health indicating a general lack of data collection in these groups. However, it was clear that low breastfeeding rates and poor weaning practices were common throughout the Region. Aggressive marketing of commercial milk substitutes can have adverse effects on breastfeeding rates. In addition, there is a general lack of professionals employed in the health sector to guide mothers on nutritional and health issues.

Sustainable Food Production and Distribution

Many of the former eastern block and CIS Member States were going through a transition period from a centrally controlled economy to a market economy. This transition had negative influences on agricultural food yield. Additionally, collaboration between the different sectors involved in the food chain was commonly lacking.

Recommendation:

1. Encourage close collaboration between the agricultural and health sectors and other sectors involved in sustainable food production and distribution;
2. Ensure sufficient production of healthy food in a sustainable environment to meet international nutrient recommendations and dietary guidelines for healthy eating.

Annex I

COMPARISON OF RESULTS OF THE 1994/1995 AND 1998/1999 QUESTIONNAIRES

Tabel A1. GENERAL INFORMATION (1-1.1)

Member State	Questionnaire returned	Name/title	Address	Telephone	Telefax	Email
Albania	20.2.98	Adriana Bardhoshi Head of Health and Environment, Head of Food and Nutrition Section Institute of Public Health	Instituti, Shendetit Public Rruga "Aleksander Moisiu" Ne 80, Tirana, Albania	+3554270057	+3554270058	iphealth@icc.al.eu.org
Austria	15.9.98	Dr. Fritz Wagner	Bundesministerium für Arbeit, Gesundheit und Soziales, Stubenring 1, A-1010 Wien	+43-1-71172 4426	+43-1-71172 8 4426	fritz.wagner@bmg.gv.at
Azerbaijan	8.9.98	Prof. Marina Kerimova Chief Nutrition Specialist, Ministry of Health and Head, Dep. of Nutrition and Food Hygiene, Medical University	Department of Nutrition and Food Hygiene, Medical University of Azerbaijan, 23, ul. Bakikhanova, 370022 Baku - 22	+99412-92 29 74	+99412-93 82 78	ROOT@UNICEF.BAKU .AZ
Belgium	31.12.98	Van Havere Rudi, Chief Inspector and Director	Ministry of Social Affairs Public Health and the Environment Boulevard Pachero 190 Boite 5 B-1010 Bruxelles Belgium	3222106387	3222104816	Rudi.vanhavere@health.fgov.be
Belarus	10.9.98	Natalia Kolomiets Deputy-Director	Ministry of Health, Republican Scientific-Practical Centre for Food- Stuffs Quality and Safety Assessment, 3 P. Brovka Str, 220013 Minsk	+375-17-232-30- 93	+375-17-232-54- 21	fdcenter@hsys.minsk.by
Bosnia and Herzegovina	28.12.98	Prim. Dr. Fatima Yusupovic	Seadbega Kulovicá-6 Tuzla	387252136	387252137	Not available
Bulgaria	16.11.98	Dr. Stefka Petrova MD Senior Researcher/Associate Prof.	National Centre of Hygiene, Medical Ecology and Nutrition, 15 Dimitar Nestorov Street, Sofia 1431	+3592 5812505	+3592 95 81 277	S.Petrova@NCH.Aster. Net
Croatia	8.7.98	Dr. Antoinette Kaić-Rak	Rockefellerova 7, 10000 Zagreb	+385-1-46-83- 006	+385-1-46-83- 007	hzziz-fp@zq.tel.hr

Member State	Questionnaire returned	Name/title	Address	Telephone	Telefax	Email
Czech Republic	15.9.98	Dr. Bohumil Turek MD Prof. Michal Andél MD Dr. Ctibor Perlin	<ul style="list-style-type: none"> National Institute of Public Health Šrobarova 48, 10042 Prague 10 3rd Medical Faculty of Charles Univ., Ruská 87, 100 00 Prague 10 Institute of Agriculture and Food Inf., Londýnská 55, 12021 Prague 2 	+420-2-67082317	+420-2-67310291	Jaroslav.Kriz@czu.cz
Denmark	20.1.99	Lars Ovesen Sisse Fagt Senior Research Nutritionist, and Anja Biltoft-Jensen Research Nutritionist	Head of Department of Danish Veterinary and Food Administration, Merkhue Bygade 19 DK-2860 Soborg	4533966000	4533956696	SFA@VFD.DK vfd@vfd.dk
Estonia	11.98	Dr.Sirje Vaask	Ministry of Social Affairs, Public Health Department, Gonsiori str. 29, EE0104 Tallinn	+372-6269739	+372-6269738	SIRJE@SM.EE
Finland	10.15.98	Dr. Kaija Hasunen Government Counsellor	Ministry of Social Affairs and Health, P.O. Box 197, 00531 Helsinki	+358-9-1604035	+358-9-1604144	kaija.hasunen@vn.fi
France	15.12.98	Dr. Le luong Thau Dr. Hercberg Serge Dr. Basdevant Arnaud Dr. Pierre Valeix	<ul style="list-style-type: none"> Secretant d'Etat a 'la Saute, DGS, 8 Avenue de Se'gur, 75007 Paris CNAM 2 rue CONTE', 75003 PARIS Hôtel-Dieu, 1 place Parvis Notre-Dame, 75181 PARIS CNAM, 2 Rue Conte', 75003 PARIS 	33-1-40564218	33140565056	Thanh.loung@sante.gouv.fr
Germany	17.8.98	Dr. Blatt (Ms) Dr. Petry (Mr)	<ul style="list-style-type: none"> Bundesministerium für Ernährung, Landwirtschaft and Forsten (BML), Rochusstr. 1, 53123 Bonn Bundesministerium für Gesundheit Am Propsthof 78a, 53121 Bonn 	0228-9414230	0228-9414944	-

Member State	Questionnaire returned	Name/title	Address	Telephone	Telefax	Email
Greece	24.7.00	Dr. Antonia Trichopoulou	Ass. Professor of Preventive Medicine and Nutrition, University of Athens Medical School and Professor Emeritus of Nutrition and Biochemistry, National School of Public Health Dept of Hygiene and Epidemiology, University of Athens Medical School, 75M Sdrias Street, Gourdi GR-115 27, Athens, Greece	0030 1 74 88 042	0030 1 74 88 902	Antonia@nut.uoa.gr
		Dr. Georgios Papoutsakis Director General of Health, Hellenic Ministry of Health and Welfare	Directorate General of Health, Hellenic Ministry of Health and Welfare, 17 Aristotelous St., Gr-101 87, Athens, Greece	0030 1 52 34 430	0030 1 52 34 078	
Hungary	27.8.98	Dr. Gábor Zajkás Deputy Director	National Institute of Food Hygiene and Nutrition of "Fodor József" Public Health Centre, Gyáli út 3/a, H-1097 Budapest, Mailing address: Budapest 100, P.O. Box 52, H-1476 Budapest	+36-1-215-4130	+36-1-215-1545	H11447ZAJ@ELLA.HU
Iceland	4.12.98	Laufey Steingrimsdottir Director Holmfriour Porgeirsdottir Senior Researcher	Icelandic Nutrition Council, Baronsstigur 47, 101 Reykjavik, Iceland	+354-552 2400	+354 -5622415	Laufye@mannelldi.is Holmfidur@mannelldi.is
Ireland	16.12.98	Ursula O'Dwyer Consultant Dietitian	Health Promotion Unit Department of Health and Children Hawkins House Hawkins Street Dublin 2	353 1 6354118	353 1 6354372	
Israel	21.11.98	Dr. Dorit Nitzan Kaluski MD Director	Department of Nutrition, Ministry of Health, 20 King David st., P.O. Box 1176 Jerusalem 91010	(02)6255223	(02)6247173	Can't read!
Italy	20.11.98	Dr Romano Marabelli Chief of Veterinary Services	Department of Food, Nutrition and Veterinary Public Health, Ministry of Health, P. le Marconi 25, 00144 Rome,	+39 06 59943946	+39 06 59943217	-

Member State	Questionnaire returned	Name/title	Address	Telephone	Telefax	Email
Kazakhstan	11.3.99	Toregel'dy Sharmanovich Sharmanov, Director of Institute of Nutrition, Ministry of Science and Higher Education and Chair of the National Council on Nutrition Issues	66, al. Klochkova, 480008 Almaty, KAZAKSTAN	83272429203	83272420720	nutrit@kaznet.kz
Kyrgyzstan	21.7.00	Ljudmila N. Darydova Head, Directorate, Ministry of Health	NI.Frunze 535, Bishkek	66 07 68	66 05 38	-
Latvia	2.2.99	Iveta Pudule- Head of Health Behaviour Study Unit	Health Promotion Centre Skolas Iela 3. Riga LV-1010 Latvia	3717240446	3717240447	iveta.vvc2parks.lv
Lithuania	14.12.98	Dr. Kamelija Kadziauskiene Director	National Nutrition Centre of the Ministry of Health, Kalvarijy 153, 2042 Vilnius	3702778919	3702778713	RMC@post.omnitel.net
Luxembourg	11.11.98	Dr. Yolanda Wagener Mrs Sylvie Paquet (Dietician)	Direction de la Santé Division de la Médecine Préventive et Sociale 22, rue Goethe, L-1637 Luxembourg	478-5544	401261	yolande.wagener@ms. etat.lu
Malta	1.7.98	Maria Ellul Principal Scientific Officer for Nutrition	Health Promotion Department, 1 Crucifix Hill, Floriana,	+356-242862	+356-235107	maria.ellul@magnet.mt
Netherlands	21.4.99	Robbert Top- Coordinator of Food and Nutrition Policy	Ministry of Health, Welfare, and Sports P.O. Box 20350 2500 EK DEN HAAG Netherlands	31703406963	31703405554	r.topeminuws.nl
Norway	7.12.98	Blodil Blaker Arnhild Haga Rimestad	National Nutrition Council, Box 8139 Dep, 0033 Oslo	4722249061	4722249091	
Poland	17.9.98	Dr. Wlodzimierz Sekula	National Food and Nutrition Institute, Powsińska 61/63 St, 02-903 Warsaw	+48-22-423741	+48-22-423741	sekula@izz.waw.pl
Portugal	16.11.98	J.A. Amorim Cruz, Prof. Dr. Ilda Matins, Dr.	Instituto Nacional de Saude Avenida Padre Cruz 1699 Lisboa Codex	7519308	7590441	
Republic of Moldova	15.9.98	Nicolae Opopol - Deputy Director CNSPMP Moraru Mihai - Dep. Minister Chicu Valeriu - Dep. Minister	Ministry of Health 2028 Chişinău, str Gh. Asachi 67A Ministry of Economics and Reforms, 2009 Chişinău, str. V. Alecsandri I Ministry of Health, 2033, Chişinău, Piaţa Marii Adunări Nationale, I	735822 729983 727178 234064 234122 728781		
Slovakia	18.12.98	Robert Simoncic MD PhD	Research Institute of Nutrition Limbova 14 833 37 Bratislava Slovakia	4379 500	373 968	

Member State	Questionnaire returned	Name/title	Address	Telephone	Telefax	Email
Slovenia	10.11.98	Dr. Marusa Adamic MD	Department of Food/Nutrition, Institute of Public Health of the Republic of Slovenia, Trubarjeva 2, 1000 Ljubljana	+386 61 1323245	+386 61 323955	-
Sweden	16.9.98	Ulla Hagman, Cecilia Lindvall (nutritionist) Dr. Wulf Becker (nutritionist)	National Food Administration BOX 622 75126 Uppsala	+46-18175500	+46-18692138	ulha@slv.se
Switzerland	14.9.98	Dr. Jürg Lüthy	Federal Office of Public Health, Division of Food Science, Nutritional Service	+31-322 94 75	+31-322 95 74	
The Former Yugoslavia Republic of Macedonia	15.9.98	Dr. Lence Kolevska	Section of Food Hygiene and Nutrition, National Public Health Institute, 50 Divizija, 6, P.O. Box 577, 91000 Skopje		+389- 91-223-354	hrana@unet.com.mk
Turkey	2.9.98	Ministry of Health, General Directorate of Primary Health Care	Ministry of Health, General Directorate of Primary Health Care, 06434 Sihhiye, Ankara,	+90-312-4314827	+90-312-4344449	n.cakmak@saglik.gov.tr
United Kingdom	25.11.98	Ms Oldreive	Nutrition Unit, Department of Health, Skipton House, 80 London Road, London SE1 6LH	+44 171 972 5108	+44 171 972 5143	soldreiv@doh.gov.uk
Ukraine		V.G. Peredery- Director, Ukraine Institute for Research on Nutrition T. Matasar- Head of the Department of Food Hygiene Toxicology and Ecology of Food Products	18, ul. Chigorina 252042 Kyiv Ukraine	296-34-55	294-40-17	
Uzbekistan	5.11.98	Sherzod Jakh- Director, Dietetics Centre, Ministry of Health	Ul. Ujgir 313 Taskkent 700042 Uzbekistan	431087		

Table A2. NUTRITION POLICY, PLAN OF ACTION OR STRATEGY (2–2.5)

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1–8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
SOUTH EAST EUROPE												
Albania	–	Yes	–	BCA between UNICEF and Albanian government. “Master Plan of Operations”	–	7/ 1993 5/ 1996	–	Gov’t. of Albania (MoFA)	–	No info	–	1–8
Bosnia and Herzegovina	–	No	–	No info	–	No info	–	No info	–	No info	–	No info
Croatia	Coming	Yes	n/a	Croatian FNP (<i>Hrvatska Prehrambena Politika</i>) Croatian Agriculture at Crossroads (<i>Hrvatska Poljoprivreda Na Raskrižju</i>)	End 1994	11/ 1996	MoH Medical Academy	Parl’t; MoH; Medical Academy	n/a	MoH; MoAg; State Bureau of Statistics; NIPH	1–8	1–8
Republic of Macedonia	Yes	Yes	n/a	National Prog. of Preventive Health Care (<i>Programa za preventivna zdravstvena zastita</i>) National Strategy “Health for All” (<i>Strategija zdravje za site</i>)	1. 1991 2. 1993	1. 1991 2. 1993	Parl’t Gov’t.	Gov’t.	n/a	MoH	1,2,4,5,7	1, 2, 4, 5, 6, 7,
Slovenia	–	Yes	–	National Health Care Plan of Slovenia until the year 2000 (Plan Zdravstvenega Vastva Rep. Slovenide Do L. 2000)	–	1995	–	Gov’t. MoH	–	MoAg; MoEnv; MoEd (most important partners)	–	1–8
BALTIC												
Estonia	Yes	Yes	n/a	Health Policy (Tervisepoliitika)	1994	2/ 3/ 1995	MoSA	Gov’t.	n/a	MoSA	Not yet decided	No info

⁵¹ It may be a document only concerned with nutrition or it may be part of a document concerned with other policy areas.

⁵² No.1: Nutritional objectives and targets, No. 2: Assessing , analysing and monitoring nutrition situations, No. 3: Improving household food security, No. 4: Protecting consumers through improved food quality and safety, No. 5: Promoting breast-feeding, No. 6: Caring for the socioeconomically deprived and nutritionally vulnerable, No. 7: Preventing and controlling specific micronutrient deficiencies, No. 8: Promoting appropriate diets and healthy lifestyles

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Uzbekistan	–	Yes	–	Law on the quality and safety of food products	–	8/ 1997	–	Parl't	–	MoH; MoAg; State Committee on Standards	–	4
CEEE												
Bulgaria	Coming	Yes	n/a	Health Policy of Bulgaria (Zdravna politika na Bulgaria) NAP for Environment and Health	End 1994	1996 1998	Gov't. MoH	MoH; MoEnv and Waters	n/a	MoH; MoEnv and Waters	1–8	4–8
Czech Republic	Yes	No ⁵³	n/a	No info	1992	No info	Gov't.	No info	n/a	MoAg	1, 2, 5, 6, 8	1,4,5,7,8,
Hungary	Yes	Yes To be adopted by a political body	n/a	FNP	1992	To be adopted	MoW, MoAg	No info	n/a	No info	1, 2, 4, 7, 8	1–8
Poland	–	Yes	–	National Health Prog. 1995–2005 (<i>Narodowy Program Zdrowia 1996–2005</i>) Medium-term dev't strategy for ag. and rural areas (<i>Sredniokresowa strategia rozwoju rolnictwa i obszarów wiejskich</i>)	–	3/9/1996 21/4/1998	–	Council of Ministers Council of Ministers	–	Inter-ministerial Coordinating Committee of National Health Prog. includes members from 13 Ministries and 8 other agencies/offices	–	1–8 (included in operational goal no. 2)
Romania	Yes	–	n/a	–	1994	–	MoH, full plan in prep. for Govt. approval	–	n/a	–	Preventing infectious diseases	–
Slovakia	Yes	Yes	n/a	Prog. of Healthier Nutrition for Population	1989	6/ 1997	MoH	MoH	n/a	MoAg; MoEd; MoL SAandfamily	1–8	1–8

⁵³ Currently under preparation

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
CIS												
Armenia	–	–	–	–	–	–	–	–	–	–	–	–
Azerbaijan	Yes	Yes	n/a	Law of the Republic of Azerbaijan on “Protection of consumers’ rights” Order on “ Hygiene certification of production in the Rep. of Azerbaijan” Order and Prog. on “BF and the health of the nation”	1992	1.1.96 3.2.97 6.1.98	Parl’t MoH MoH	Parl’t (<i>Melli-Majlis</i>) MoH MoH	n/a	Cabinet of Ministers No info No info	1, 2, 6, 7, 8 4 5	4 4 5
Belarus	–	No	–	No info	–	No info	–	No info	–	No info	–	No info ⁵⁴
Georgia	–	–	–	–	–	–	–	–	–	–	–	–
Republic of Moldova	–	Yes	–	Legislation/Laws of the Republic of Moldova on the sanitary and epidemiological service/care for the population Legislation/laws of the Republic on Consumers’ Protection National Prog. on IDD Eradication by the year 2004 On measures for improving the management of the children’s nutrition in the Republic On measures for improving children’s nutrition in the Republic of Moldova	–	1993 1993 16.1.98 14.5.85 17.9.91	– Parl’t Gov’t. Gov’t. Gov’t.	Parl’t Parl’t Gov’t. Gov’t. Gov’t.	–	MoAg and Industrial Development /Reconstruction MolandT MoEd and Science Other Ministries and Dep’ts	–	1–8

⁵⁴ Ministry of health is maintaining projects on breastfeeding, and fortification (selenium and folic acid)

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Russian Fed.	Yes	-	n/a	-	1994	-	MoSci and TP	-	n/a	-	1-8	-
Ukraine	-	Yes	-	Decree of Cabinet of Ministers of Ukraine on "Standardization and Certification" Law of Ukraine on "Ensuring the sanitary and epidemiological wellbeing of the population." Decision of the Praesidium of the Supreme Soviet of Ukraine on "The status of medical services and health promotion for the children suffering from the consequences of the Chernobyl disaster." Decision of the Cabinet of Ministers of Ukraine on "Measures for mass prevention of diseases related to iodine deficiency." National Prog. on "The children of the Ukraine." Decision of the Cabinet of Ministers of Ukraine on "Further improving control of the quality and safety of food products." Law of the Ukraine on "The protection of consumers' rights."	-	1993 1994 1995 1997 1996 1996 1991	-	Gov't.	-	Cabinet of Ministers of Ukraine Supreme Soviet of Ukraine Ukraine State Committee for the Food Industry Ukraine State Committee for Standards Academy of Agricultural Sciences Academy of Medical Sciences Ministries: Health, Economics, statistics, Labour and Social Policy Press, Radio, and Television	-	1-8

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
NORDIC												
Denmark	Yes	Yes	n/a	Nutrition and food Policy is part of the "Prevention and Health Promotion Programme" of the Danish Gov't.	1. 1984 2. 1989	5/ 1989	1. Parl't 2. Gov't.	MoH	n/a	MoH; MoEd; Ministry of Research; Ministry of Industry; MoAg	4, 6, 7, 8	1,2,4,5, 6, 8
Finland	Yes	No	n/a	No info	1989	No info	NNC	No info	n/a	No info	1, 2, 4, 8	No info
Iceland	Yes	Yes	n/a	A Parliamentary Resolution on an Icelandic Nutrition Policy (Pingsalyktun um manneldis – og neyslustefnu)	1989	19.5.89	Parl't MoH	Parl't Gov't.	n/a	MoH	1, 2, 4, 7, 8	1, 2, 4, 8
Norway	Yes	Yes	n/a	Challenges in Health Promotion and Prevention Strategies (Utfordringer I helsefremmende og forebyggende arbeid)	1. 1975 2. 1994	2.4.93	1. Parl't 2. Parl't	Parl't	n/a	MoH and Social Affairs; National Nutrition Council Norwegian Food Control Authority MoAg Ministry of Fishery Authorities for Consumers	No info	1-8

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Sweden	Yes	Yes	n/a	NAP for Nutrition (<i>Nationell handlingsplan för nutrition</i>)	1992	26.10.95	MoH; MoAg	Gov't. MoAg	n/a	National Food Administration; NIPH; National Board of Health and Welfare; National Board of Agriculture	2, 4, 5, 6, 7, 8	1, 2, 4, 5, 6, 8
S. EUROPE												
Andorra	-	-	-	-	-	-	-	-	-	-	-	-
Greece	No	No	n/a	No info	No info	No info	No info	No info	n/a	No info	No policy	No info
Israel	-	Yes	-	Sensible nutrition for Israel Shfayim Declaration and Israel's PHS declare nutrition as one of the priority areas for 1997-98	-	1997	-	MoH	-	MoH	-	2, 4, 5, 6, 8
Italy	No	Yes	n/a	Piano Sanitario Nazionale 1998-2000	<i>No info</i>	<i>No info</i>	No info	No info	n/a	No info	No policy	1, 3, 7, 8,
Malta	Yes	Yes	n/a	Malta FNP	1988	21 st 11/1988	Cabinet of Ministers	Parl't (Cabinet)	n/a	MoAg; MoEd	1, 2, 4, 8	4, 8
Monaco	-	-	-	-	-	-	-	-	-	-	-	-
Portugal	No	No	n/a	No info	<i>Policy paper was presented to govt. 1989</i>	<i>No info</i>	No info	No info	n/a	No info	No policy	No info
San Marino	-	-	-	-	-	-	-	-	-	-	-	-
Spain	Yes	-	n/a	-	1991	-	MoPH	-	n/a	-	2, 3, 4, 7, 8	-

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Turkey	Yes	Yes	n/a	National Health Policy of Turkey (Ulusal Saglik Politikasi)	1993, as part of national health policy	1993	MoH	MoH	n/a	MoAg MoEd All public sectors and Universities	1-8	1-8
W. EUROPE												
Austria	-	No	-	No info	-	No info	-	No info	-	No info	-	No info
Belgium	Coming	Yes	n/a	Federal Gov't.: Nutritional recommendations for Belgium	End 1994	6.98	Political bodies	Federal: MoPH	n/a	MoPH Council of Hygiene	1, 2, 4, 7	1,4,5,7,8
France	No	No	n/a	No info	No info	No info	No info	No info	n/a	MoLabour and solidarity; State Health Secretariat; MoAg and Fisheries; MoEcon and Finance	No info	1,2,4,7,8
Germany	Coming	Yes	n/a	Nutrition Policy Bundesrepublik Deutschland 1996	End 1994	1996	Federal; Regional	MoH MoF, Ag and F	n/a	MoH MoF, Ag and F	n/a	1-8

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Ireland	Yes	No (only policy recommendation)	n/a	Recommendations for a FNP for Ireland	1991	Not yet adopted (Printed 1991)	HP Unit, Dep't of Health	Not formally adopted	n/a	Dep't of health and children Dep't of Agriculture, Food and forestry FOS Authority of Ireland National Nutrition Surveillance centre	2, 5, 6, 7, 8	1,2,4,5,6, 6,7,8
Luxembourg	Yes, as part of HFA policy	Yes	n/a	HFA /White book (Santé pour tous)	1994	4/ 1994	Not formally adopted	MoH	n/a	MoAg; MoEcon MoEd; MoEnv; Nat. Consumer Organization Professionals of Health	1, 4, 5, 6, 7, 8 + preventing infectious diseases	1,8
Netherlands	Yes	Yes	n/a	The Netherlands: Well Nourished?	1984 1987 1993	29 th Sept 1999	Parl't	Council of Ministries Parl't	n/a	MoH, Welfare, and Sport MoAg and Natural Management of Food MoEd, Art and Sciences	1-8	1-8
Switzerland	Coming	Yes	n/a	Plan of action for the improvement of dietary habits (Aktionsplan zur Verbesserung des Ernährungsverhaltens)	1995, based on recomm. end 1994	4 Sept. 1996	No info	Swiss Nutrition Council	n/a	No info	n/a	1, 2, 7, 8,

Member State	2. Does country / region have a policy document adopted by a political body concerned with nutrition ⁵¹		2.1 Name of policy document/ document in which this nutrition policy statement is contained		2.2 Date of adoption of policy document		2.3 Name of body by whom policy document was adopted		2.4 Ministries/ governmental bodies mentioned as partners to the nutrition policy		2.5 Components of World Declaration and Plan of Action which have been included in documents (1-8) ⁵²	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
United Kingdom	Yes	No	n/a	No info	1992, part of "Health of the Nation"	No info	Gov't.	No info	n/a	No info	3, 4, 5 + preventing infectious diseases	No info

Table A3. ADVISORY OR ADMINISTRATIVE STRUCTURE (3–3.3)

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	1994/1995	1998/1999	1994/1995	1998/1999	English		National language		1994/1995	1998/1999
SOUTH EAST EUROPE										
Albania	–	Institute of Public Health	–	No	–	The National Board on Food	–	No info	–	6/ 1995
Bosnia and Herzegovina	–	No info	–	No	–	No info	–	No info	–	No info
Croatia	Parl't, represented by: NIPH; State Institute of Statistics; Nutrition Policy Board; MoAg; MoH; Ch. of Comm	MoH and Medical Academy of Croatia Nutrition Policy Board	Yes	Yes	n/a	Nutrition Board of Croatian Medical Academy	n/a	Odbor za prehranu Medicinske akademije Hrvatske	1992	1992
The Former Yugoslav Republic of Macedonia	Republican IPH of the MoH	No info	No	Yes	n/a	National Committee for BF Promotion National Committee for IDD	n/a	Nacionalen komitet za podrka na doenje Nacionalen komitet za jod deficit poremetovanja	No info	No info
Slovenia	–	No: plans to set up FandN Unit/Office or Agency for FandN issues within MoH	–	No: Ad Hoc Expert Committees for specific issues	–	No info	–	No info	–	No info
BALTIC										
Estonia	No	No info	Yes, unofficially	Yes	n/a	National Food Commission	n/a	Riigi toidukomisjon	1994	1/ 4/ 1997

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	English	National language	English	National language	English	National language	English	National language	English	National language
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Latvia	Yes (described in Latvian)	No	Coming	N/a	n/a	N/a	n/a	N/a	1994	No info
Lithuania	National Nutrition Centre MoH	National Nutrition Centre of MoH Public Health Division of MoH	Yes	Yes	n/a	National Nutrition Centre	n/a	Respublikinis Mitybos Centras	1994	10/ 1991
CAR										
Kazakhstan	–	National Gov't. Council on Nutrition Issues	–	Yes	–	National Gov't. Council on Nutrition Issues	–	No info	–	8/ 1995
Kyrgyzstan	No	No	No	No	n/a	No info	n/a	No info	No info	No info
Tajikistan	MoH, San and Epi Inspection of Foods	–	No	–	n/a	–	n/a	–	No info	–
Turkmenistan	–	–	–	–	–	–	–	–	–	–
Uzbekistan	–	Institute of Strategic Research; State Committee for Statistical Forecasting; MoH	–	Yes	–	Dietetics Centre, MoH	–	Dietologija Markazi	–	6/ 1995
CEE										
Bulgaria	Under preparation	MoH; MoEnv and Waters; National Centre of Hygiene; Medical Ecology and Nutrition; National Centre for Health Ed.; Regional Hygiene and Epi Inspectorates	Yes	No	n/a	No info	n/a	No info	1992	No info
Czech Republic	No	No info	Yes	Yes	n/a	NNC MoH	n/a	Rada výživy Ministerstva zdravotnictví	1991	3/ 1991

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	1994/1995	1998/1999	1994/1995	1998/1999	English		National language		1994/1995	1998/1999
Hungary	Focal point: Central Food Research Institute, coordinating the Inter-governmental Consultative Body	No	Yes	No	n/a	No info	n/a	No info	1985	No info
Poland	–	Inter-ministerial Coordinating Committee ⁵⁵ ; Dep't of Health Policy and System Reforms and MoH and Social Welfare ⁵⁶ ; National FandN Institute ⁵⁷	–	Yes	–	National FandN Institute	–	Instytut Żywności Żywienia	–	1963
Romania	No	–	No	–	n/a	–	n/a	–	No info	–
Slovakia	MoAg and Nutrition	MoH Section of health care	Yes	No	n/a	No info	n/a	No info	1954	No info

⁵⁵ Coordinating body for the implementation of the National Health Programme 1996-2005

⁵⁶ Administrative body for the implementation of the National Health Programme 1996-2005

⁵⁷ Responsible for the Implementation of the operational goal No.2 of the National Health Programme 1996-2005 “Improvement of the dietary pattern and health quality of food”

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	English	National language	English	National language	English	National language	English	National language	English	National language
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
CIS										
Azerbaijan	Head specialist on hygiene of feeding MoH, health specialists on hygiene of Administration of San-epi control of MoH	No info	No	Yes	n/a	National Committee on BF and the Health of the Nation	n/a	No info	No info	6/1/ 1998
Armenia	–	–	–	–	–	–	–	–	–	–
Belarus	–	No info	–	No info	–	No info	–	No info	–	No info
Georgia	–	–	–	–	–	–	–	–	–	–
Republic of Moldova	–	MoAg and Industrial Development/ Reconstruction National BF Promotion Board/Commission	–	Yes	–	National BF Promotion Board / Commission	–	<i>Comisia Nationala de sustinere a alimentatsiei la san</i>	–	18/ 9/ 1996
Russian Fed.	Commission created by MoSci and TP with reps from MoH, MoAg and Acad. Of Med Sci.		Yes		n/a		n/a		1993	
Ukraine	–	No	–	No	–	No info	–	No info	–	no
NORDIC										
Denmark	Working gps. In MoH	No	Yes	Yes	n/a	The Danish NNC	n/a	Det Statslige Ernæringsråd	1969	1997
Finland	NNC	No info	Yes	Yes	n/a	Icelandic NNC	n/a	Valtion ravitsemusneuvottelukunta	1938	1952

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	English	National language	English	National language	English	National language	English	National language	English	National language
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Portugal	No	No info	Yes	Yes	n/a	National FandN Council	n/a	<i>Conselho Nacional de Alimentacao e Nutricao</i>	1980	8/ 1980
San Marino	–	–	–	–	–	–	–	–	–	–
Spain	MoH and Consumers; Directorate of PH, general sub directorate of Food and Hygiene; Dep't of FandN Services	–	No	–	n/a	–	n/a	–	No info	–
Turkey	General Directorate of Health Dep't of MCH	State Planning Organization MoH and Agricultural and Rural Affairs	Yes, related to MCH and IDD	Yes	n/a	BF Committee; IDD and Salt Iodization; Committee Public Nutrition Education; Advisory Group Fluorine using in Dental Health; Prevention of Congenital Disorders; National Diabetes Prog.	n/a	<i>Anne Sütü Üst Komitesi; İyot Yetersizliği Hastalıkları ve Tuzun İyotlanması; Sağlık Bakanlığı Beslenmede Biliclendirilmesi Projesi Eğitim Grubu; Ağız ve Diş Sağlığında Florür Kullanılması; Genetik Hastalıkların Önlenmesi; Ulusal Diyabet Programı</i>	1994	1. 1992 2. 1/ 1995 3. 2/ 1997 4. 1994 5. 7/ 1998 6. 1996

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	English	National language	English	National language	English	National language	English	National language	English	National language
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
W. EUROPE										
Austria	–	No info –	–	No	–	No info	–	No info	–	No info
Belgium	No	Yes Federal MoH; NAP in Politics for Nutrition	Yes	Yes	n/a	NNC	n/a	<i>Conseil National De La Nutrition Nationale Raad Voor De Voeding</i>	1991	1992
France	Yes MoEcon and Finance; Service de Repression des Fraudes, de la Concurrence et de la Consommation ; Direction Générale Alimentaire	No info	Yes	Yes	n/a	No info	n/a	<i>Conseil Supérieur d'Hygiène publique de France : CSHPF</i> <i>Commission inter- ministérielle d'études des denrées alimentaires destinées à une alimentation particulière (CEDAP)</i>	CSHPF 1906 CNA 1981	1848
Germany	No	No	Yes	Yes	n/a	Subordinate Research Institutes; German Society for Nutrition; Other scientific associations	n/a	<i>Deutsche Gesellschaft für Ernährung (DGE)</i>	No info	No info
Ireland	Assigned to Unit of HP	No (HP Unit is implementing many of the recommendations)	Yes	Yes	n/a	Nutrition Committee (previously known as Nutrition Advisory Group); FOS authority of Ireland (FSAI)	n/a	No info	1991	1991
Luxembourg	Under preparation	No	Coming	No	n/a	No info	n/a	No info	No info	No info

Member State	3. Has a special <i>administrative</i> structure responsible for the implementation of the nutrition policy been set up		3.1 Does country have a nutrition council/advisory structure/body responsible for providing scientific advice to national policy-makers?		3.2 Full name of advisory body				3.3 When was advisory body first established	
	1994/1995	1998/1999	1994/1995	1998/1999	English		National language		1994/1995	1998/1999
Netherlands	Food and Nutrition Unit in the MoH, Welfare and Social Security	Steering Group For Proper Nutrition	Yes	Yes	n/a	NNC Netherlands	n/a	Beraad voediij von de Gezondheids Raad	1952	Long ago
Switzerland	working gp. for follow-up of the ICN has been established	No (in preparation)	Yes	Yes	n/a	Swiss NNC	n/a	Eidgenössische Ernährungskommission	1948	1948
United Kingdom	Yes, The Nutrition Task Force	No info	Yes	Yes	n/a	Committee on Medical Aspects of FNP(COMA)	n/a	No info	1961	1963

Table A4. ADVISORY AND ADMINISTRATIVE STRUCTURE (3.4 –3.9)

Member State	3.4 When did advisory body last meet		3.5 How many members does the advisory body have		3.6 Whom do the members of the advisory body represent		3.7 Does advisory body have a written mandate or terms of reference		3.8 Does advisory body have a budget to cover its activities		3.9 Who finances this budget	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
SOUTH EAST EUROPE												
Albania	–	No info	–	No info	–	No info	–	Yes	–	Yes	–	Ministry of Food and Agriculture
Bosnia and Herzegovina	–	No info	–	No info	–	No info	–	No	–	No	–	No info
Croatia	n/a	5/ 1998	10	10	n/a	Croatian NIPH; Clinical Medicine; Agriculture; Consumer Association; Food Technology; Veterinary; Army	no	Yes	n/a	Yes	n/a	Ministry of Science and Technology
Republic of Macedonia	n/a	No info	No info	No info	n/a	No info	No info	No info	n/a	No info	n/a	No info
Slovenia	–	No info	–	No info	–	No info	–	No info	–	No info	–	No info
BALTIC												
Estonia	n/a	9/ 1998	18	17	n/a	MoAg; MoEd; Consumer Protection Board; MoEcon; MoFin; Univ. of Tartu, Tallinn; Technical Univ. etc.	Coming	Yes	n/a	Yes	n/a	MoAg

Member State	3.4 When did advisory body last meet		3.5 How many members does the advisory body have		3.6 Whom do the members of the advisory body represent		3.7 Does advisory body have a written mandate or terms of reference		3.8 Does advisory body have a budget to cover its activities		3.9 Who finances this budget	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Latvia	n/a	No info	No info	No info	n/a	No info	No info	No info	n/a	No info	n/a	No info
Lithuania	n/a	15 / 10/ 1991	10	53	n/a	Nutritionists; Physicians; Biochemists; Chemists; Biologist; Technicians; Technical Assistants	No	No	n/a	Yes	n/a	MoH
CAR												
Kazakhstan	-	5/ 1995	-	24	-	The Institute of Nutrition; Advanced Medical Studies; The State Centre for Research and Practical Work on Certification; MoAg; MoLandSW; The Office of the Gov't.; The Health Committee of the MoH, Ed. and Sport; The National Centre	-	Yes	-	No	-	No info
Kyrgyzstan	n/a	No info	No info	No info	n/a	No info	No info	No info	n/a	No info	n/a	No info
Tajikistan	n/a	-	No info	-	n/a	-	No info	-	n/a	-	n/a	-
Turkmenistan	-	-	-	-	-	-	-	-	-	-	-	-
Uzbekistan	-	No info	-	3	-	Deputy MoH; Director of Dietetics Centre; Doctors	-	No	-	No	-	No info
CEE												
Bulgaria	n/a	No info	15	No info	n/a	No info	No	No info	n/a	No info	n/a	No info
Czech Republic	n/a	1997	20	16	n/a	MoH; MoAg; Medical Faculty; Nutrition Society	No	No	n/a	No	n/a	No info
Hungary	n/a	No info	20	No info	n/a	No info	No	No info	n/a	No info	n/a	No info
Poland	-	No info	-	No info	-	No info	-	No info	-	Yes	-	State
Romania	n/a	-	No info	-	n/a	-	No info	-	n/a	-	n/a	-

Member State	3.4 When did advisory body last meet		3.5 How many members does the advisory body have		3.6 Whom do the members of the advisory body represent		3.7 Does advisory body have a written mandate or terms of reference		3.8 Does advisory body have a budget to cover its activities		3.9 Who finances this budget	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Slovakia	n/a	No info	15	No info	n/a	No info	Yes	No info	n/a	No info	n/a	No info
CIS												
Azerbaijan	n/a	26/ 5/ 1998	No info	10	n/a	MoH; UNICEF; Paediatrics Research Institute; Med Uni; BF Training Centre; Institute of Physiology of the Academy of Sciences	No info	Yes	n/a	No	n/a	No
Armenia	-	-	-	-	-	-	-	-	-	-	-	-
Belarus	-	No info	-	No info	-	No info	-	No info	-	No info	-	No info
Georgia	-	-	-	-	-	-	-	-	-	-	-	-
Republic of Moldova	-	No info	-	16	-	MoH and related subordinate institutions; UNICEF; OMS; Association of Women; National Television; MoJ	-	No info	-	No info	-	No info
Russian Fed.	n/a	-	38	-	n/a	-	Yes	-	n/a	-	n/a	-
Ukraine	-	No info	-	No info	-	No info	-	No info	-	No info	-	No info
NORDIC												
Denmark	n/a	12/ 1998	It is an agency	15	n/a	Relevant Medical Research Societies	Yes	Yes	n/a	Yes	n/a	Ministry of Food, Agriculture, and Fisheries
Finland	n/a	9/ 1998	18	12	n/a	MoH; MoAg; NIPH; Food Research Institute; NGOs; Ag Producers	Yes	Yes	n/a	Yes	n/a	MoAg
Iceland	n/a	10 th /9/ 1998	5	5	n/a	MoH; Uni of Iceland; Faculty of Medicine and Faculty of Food Science; Teachers College	Yes	Yes	n/a	Yes	n/a	Gov't.
Norway	n/a	10/ 1998	14	23	n/a	Independent people chosen for personal skills	Yes	Yes	n/a	Yes	n/a	MoH and Social Affairs

Member State	3.4 When did advisory body last meet		3.5 How many members does the advisory body have		3.6 Whom do the members of the advisory body represent		3.7 Does advisory body have a written mandate or terms of reference		3.8 Does advisory body have a budget to cover its activities		3.9 Who finances this budget	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Sweden	n/a	28/ 5/ 1998	18	13	n/a	Uni Institutions; NIPH; National Board of Health and Welfare; National Food Administration	Yes	Yes	n/a	No	n/a	No info
S. EUROPE												
Andorra	-	-	-	-	-	-	-	-	-	-	-	-
Greece	n/a	22/ 10/ 1999	Approx. 20	21	n/a	MoHandW; Med schools of all Greek universities; Hellenic Drug Administration; Hellenic Medical and Dental Association	Yes	Yes	n/a	No	n/a	Advisory body: honorary (unpaid) members
Israel	-	11/ 1998	-	5-12 (for each topic)	-	Ministries; Academics; NGOs	-	No	-	No	-	MoH
Italy	n/a	No info	28	No info	n/a	No info	Yes	No info	n/a	No info	n/a	No info
Malta	n/a	No info	11	No info	n/a	No info	Yes	No	n/a	Yes	n/a	Gov't.
Monaco	-	-	-	-	-	-	-	-	-	-	-	-
Portugal	n/a	5/ 1997	16	15	n/a	Ministries of several Gov't. Institutions related to food	Yes	Yes	n/a	No	n/a	n/a
San Marino	-	-	-	-	-	-	-	-	-	-	-	-
Spain	n/a	-	No info	-	n/a	-	No info	-	n/a	-	n/a	-

Member State	3.4 When did advisory body last meet		3.5 How many members does the advisory body have		3.6 Whom do the members of the advisory body represent		3.7 Does advisory body have a written mandate or terms of reference		3.8 Does advisory body have a budget to cover its activities		3.9 Who finances this budget	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Austria	n/a	No info		No info		No info		No info		No info		No info
Belgium	n/a	No info provided	40	20	n/a	Federal MoPHealth	Yes	Yes	n/a	Yes	n/a	Federal Mof PH
France	n/a	8/ 12/ 1998	CSHPF 40 CAN 60	23	n/a	Experts Administration	Yes	Yes	n/a	Yes	n/a	Ministere de l' Emploi et de la Solidarite'
Germany	n/a	No info	No info	No info	n/a	No info	No info	No info	n/a	No info	n/a	No info
Ireland	n/a	2/12/ 1998	15	12	n/a	Nutritionists; Nutritional Academics/Scientists and Epidemiologists; FOS representatives Dep't of agriculture representative; Irish business Employers confederation reps	Yes	Yes	n/a	Yes (for reports only); Have to apply for funding for specific projects e.g. folic Acid survey	n/a	The FOS Authority of Ireland
Luxemburg	n/a	No info	No info	No info	n/a	No info	No info	No info	n/a	No info	n/a	No info
Netherlands	n/a	Meet frequently	24	15	n/a	Science	Yes	Yes	n/a	Yes	n/a	MoH, Welfare, and Sports
Switzerland	n/a	26/ 8/ 1998	25	26	n/a	Uni Institutions; Consumer Orgs; Food Industry and Retailers; Agriculture; Health Care and Ed.; Food Control Labs	Yes	Yes	n/a	Yes	n/a	Gov't.
United Kingdom	n/a	10/ 1998	16	11	n/a	Independent doctors and scientists; Food industry;	Yes	Yes	n/a	Yes	n/a	Dep't of Health

Table A5. INTER-DISCIPLINARY COLLABORATION (4-4.5)

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
SOUTH EAST EUROPE												
Albania	-	Yes	-	NIPH; Institute of Statistics	-	NIPH; Directory of HP	-	NIPH; Directory of HP	-	Yes	-	1-6 7: Ministry of Finance
Bosnia and Herzegovina	-	No	-	No info	-	No info	-	No info	-	Informal	-	Federal gov't. works with global orgs for food provision
Croatia	MoH MoAg State Institute of Statistics NIPH	Ch. of Comm MoH Human Nutrition Dep't of the Croatian NIPH	Croatian NIPH State Institute of Statistics	Croatian NIPH State Bureau of Statistics	Croatian NIPH; State Institute of Statistics	Croatian NIPH	Croatian NIPH; MoEd	Croatian NIPH; MoH; MoEd	n/a	Yes Collab on Ch. of Comm and inspection matters	n/a	1-6
Republic of Macedonia	Yes: MoH; Rep IPHe	Yes	Rep IPH	NIPH	Rep. IPH	NIPH	NIPH; PHC service; Red Cross; Ed institute	NIPH	n/a	Yes Informal	n/a	1-6

⁵⁸ 1: Ministry of health, 2: Ministry of agriculture, 3: Ministry of Environment, 4: Ministry of education, food Industry, 5: consumers, 6: others (please state)

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Slovenia	-	Collaboration in the field of official control, legislation and nutrition education	-	National Office for Statistics (food consumption surveys in households) Institute of Public Health	-	No info	-	MoH MoEd	-	Yes In the field of food legislation	-	1-6
BALTIC												
Estonia	MoAg Ministry of Environment Ministry of finances Health Protection Centre Centre of Health Education and Promotion Consumer Protection Agency Universities and Institutes	No	Formerly different institutions coordinated from Aug. onwards in "Nutrition related scientific and applied research council"	Statistical Office of Estonia	Public Health Dep't of MoSA	Statistical Office of Estonia	Dep't of Medicines, Tartu University Food Processing Institute, Tallinn Technical University	MoEd	n/a	No	n/a	No info

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Kazakhstan	-	Yes	-	Institute of Nutrition MoSci Academy of Science	-	National Governmental Council on Nutrition Issues	-	Institute of Nutrition	-	Yes Working group on implantation of the nutrition component of the state Prog. on "The Health of the People"	-	1,2,4,5
Kyrgyzstan	MolandT National Committee on Statistics MoL and SW State Committee on Economics	-Yes, quarterly meetings with the Prime Minister	National Committee on Statistics	National Committee on Statistics	None	National Committee on Statistics	None	Directors of the Sanepid Services in provinces, cities and districts	n/a	Yes, informal	n/a	1-6 7: National Committee on Statistics, Kyrgyz Standards Institute, MoL and SW
Tajikistan	MoAg Committee on Food and Processing Industry	-	MoEcon and Prognoses	-	MoH	-	Institute of Preventive Medicine	-	n/a	-	n/a	-
Turkmenistan	-	-	-	-	-	-	-	-	-	-	-	-
Uzbekistan	-	Within the national Prog. on FOS	-	Uzbek State Committee for Statistical Forecasting	-	Institute of Strategic Research	-	Republic Health Centre (MoH)	-	Yes On the national Prog. on FOS	-	1,2

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
CEE												
Bulgaria	MoAg Ministry of Finance MolandT MoEnv MoEd and Science Ministry of labour and Social Cares Federation of Consumers	Meetings to discuss matters on legislation and FOS and quality; consultations related to projects of decrees and laws, harmonization of legislation with EEC Directives	National Centre of Hygiene, Dep't of Nutrition	National Institute of Statistics (annual HBS)	MoH	National Institute of Statistics	MoH National Centre of Hygiene, Dep't of Nutrition and of HP	National Centre for Health Education	n/a	Yes Informal/formal Meetings, consultations, workshops	n/a	1-6 7: Ministry of Trade and Tourism
Czech Republic	MoH MoEd, Youth and Physical Culture	Nongovernmental Society of Nutrition collaborates with MoH and MoAg. Only MoH and MoAg can make legislation	NIPH	MoAg Research Institute for Agricultural Economy	MoH MoAg	No info	National Centre for HP	NIPH	n/a	Yes-formal Food Law No. 110/1997 Sb	n/a	1, 2, 4 5, 6, 7 (under Czech Society of Nutrition)

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Hungary	MoAg MoW Ministry of Industry and Commerce Ministry of Foreign Affairs National Board of Technical Development	No	National Institute of Food Hygiene and Nutrition	No info	Central Food Research Institute	No info	National Institute of HP	No info	n/a	Yes-formal	n/a	1, 2
Poland	-	Examples include: Committee on the Improvement of the Quality of Milk; Council of the Monitoring of the Quality of Soil, Plants, Food and Agricultural Products	-	National Food and Nutrition Institute	-	National Food and Nutrition Institute	-	National food and Nutrition Institute	-	Yes Formal Consultation between Dep't of Public Health (MoH and Social Welfare) and the Veterinary Dep't (MoAg and Food Economy)	-	1-6

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Romania	No partners identified	-	Institut d'Hygiène et de Santé Publique	-	Ministère de la Santé Par la Direction Générale de la médecine Préventive et Promotion de la Santé	-	Centre National de Promotion de la Santé et d'Éducation pour la Santé	-	n/a	-	n/a	-
Slovakia	MoH MoAg and Nutrition	Cooperation activated in the gov't.	Research Institute of Nutrition	MoH Research Institute of Nutrition	Research Institute of Nutrition	MoH	Institute for Health Education and Society for Rational Nutrition (NGO)	Institute of Health Education	n/a	Informal	n/a	1-5

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Belarus	-	Yes	-	Ministry of Statistics and Analysis	-	Ministry of Statistics and Analysis	-	Republican Health Centre MoH	-	Yes Informal and Formal Joint preparation of documents	-	1-6 7: State Standard
Georgia	-	-	-	-	-	-	-	-	-	-	-	-
Republic of Moldova	-	No info	-	Dep't of Statistic Analysis and Sociology	-	Dep't of Statistic Analysis and Sociology	-	MoH CNSPMP	-	No info	-	1,4
Russian Fed.	MoAg Ministry of Food State Committee of San and Epi Surveillance Russian Academy of Medical Sciences Russian Academy of Agricultural Sciences	-	Institute of Nutrition of the Academy of medical Sciences	-	MoSci and TP	-	MoH State Committee of San and Epi Surveillance	-	n/a	-	n/a	-
Ukraine	-	No	-	No info	-	No info	-	No info	-	Yes Informal	-	1,2,5

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
NORDIC												
Denmark	Working groups under the MoH	No	National Food Agency of Denmark	Danish Veterinary and Food Administration	National Food Agency of Denmark	Danish Veterinary and Food Administration	The Gov't. Home Economics Council National Food Agency of Denmark	Danish Veterinary and Food Administration The National Consumer Agency The National Board of Health	n/a	Yes Steering committees and AD HOC meetings	n/a	1,2
Finland	Ministry of Social Affairs and Health Ministry of Agriculture and Forestry Ministry of Trade and Industry	Yes	National Public Health Institute	Public Health Institute	National Public Health Institute	Public Health Institute	MoSA and H	MoSA and H MoEd	n/a	Yes Formal/in formal Through Nutrition Council and through meetings between Civil servants	n/a	No info
Iceland	MoH Ministry of Trade MoAg, Fisheries and Industry	No	Icelandic Nutrition Council	Icelandic Nutrition Council	Icelandic Nutrition Council	Icelandic Nutrition Council	Icelandic Nutrition Council	Icelandic Nutrition Council	n/a	No	n/a	No info

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Norway	MoH and Social Affairs NNC Norwegian Food Control Authority	Forum for Nutrition (Ernæringsforum), run by NNC, includes meetings and special projects on nutritional questions Food Policy Forum in MoAg The Council of Norwegian Food Control Authority	NNC	NNC	NNC	NNC (main responsibility)	NNC	NNC (main responsibility)	n/a	No info	n/a	5,6 7: NNC and Norwegian Food Control
Sweden	MoAg Ministry of Foreign Affairs MoH and Social Affairs Swedish International Development Authority National Board of Health and Welfare National Food Administration University of Agricultural Sciences	A reference group representing 20 different Orgs, food production, manufacture, sales, nutrition education. Meets twice a year	National Food Administration	National Food Administration	National Food Administration	National Food Administration	Public Health Institute and National Food Administration	National Food Administration (NIPH)	n/a	No	n/a	6

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
S. EUROPE												
Andorra	-	-	-	-	-	-	-	-	-	-	-	-
Greece	No info	Yes, EFET whose regulation is currently being formed, is going to coordinate collaboration between the various parties	National Centre for Nutrition	University of Athens Medical School, Dep't of Epidemiology, Unit of Preventive Medicine and Nutrition	National Centre for Nutrition	University of Athens Medical School, Dep't of Epidemiology, Unit of Preventive Medicine and Nutrition	MoH Ministry of Commerce	Directorate for Health Education MoH MoEd Hellenic Food Authority (EFET)	n/a	Yes, up till now there were joint committees for issues related to public health Regular consultation between the ministries of Health and Agriculture on matters related to nutrition is expected to be undertaken by EFET	n/a	1-4 Up till now ministries collaborated when it was necessary. From now on EFET is expected to undertake the coordination of regular intersectoral consultation between different governmental, private or voluntary sectors (all the above mentioned ministries, the food industry and consumers Orgs).

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Spain	MoH and Consumers Directorate of Public Health MoAg, Fisheries and Food	-	General Directorate of Public Health	-	General Directorate of Public Health	-	General Directorate of Public Health	-	n/a	-	n/a	-
Turkey	MoAg MoEd All Public Sectors and Universities	In some nutritional conferences and courses and food legislation studies, relevant Ministries and University officials have collaborated Collaboration on the production and fortification of foods (iodization, low caloric foods, baby foods)	State Statistics Institute State Planning Organization MoH MoAg and Rural Affairs	State Statistics Institute MoH State Planning Organization MoAg and Rural Affairs	State Planning Organization	State Planning Organization	State Planning Organization	MoH MoAg and Rural Affairs	n/a	Yes Formal Collaboration on developing food legislation, nutritional training Progs and food consumption surveys	n/a	1-6 7: Universities and Associations, NGOs

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
W. EUROPE												
Austria	-	Austrian Codex Alimentarius Commission (not responsible for nutrition education)	-	Österreichisches statistisches Zentralamt (Central Statistics Institute)	-	No info provided	-	No info provided	-	No	-	1, 7: Ministry of Consumer Protection
Belgium	Not yet decided	Yes	Conseil national de la nutrition + Conseil Supérieur d'Hygiène	Niveau Federali au sein ou conseil de la nutrition: Les consommateurs, le secteur alimentaire.	Conseil national de la nutrition + Conseil Supérieur d'Hygiène	General Inspector of Health Boulevard Pachero 19 Boite 5 B-1010 Bruxelles	No info	General Inspector of Health Boulevard Pachero 19 Boite 5 B-1010 Bruxelles	n/a	No	n/a	1,2,4 7: communautés flamande et française

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
France	Ministère de l'Agriculture DG de l'Alimentation Ministère de l'Économique et des Finances Ministère de la Santé Service de Répression de Fraudes de la Concurrence et de la Consommation	Conseil National de l'Alimentation (CAN)	Observatoire des Consommations Alimentaires	Comite Français d'Education pour le sante'(CFES), 2 Rue A. Comte- 92170 VANVES Observatoire des Consommations Alimentaires (O.C. A), c/o CNERNA- 16 Rue Claude Bernard 75005 Paris Institut National de la Veille Sanitaire (INVS), 14 Rue Vald' Osne- 94415 St. Maurice Cedex	The advice of the Observatoire des Consommations Alimentaires and Conseil National de l'Alimentation are officially published	No info	Centre Français d'éducation pour la santé	CFES 2 Rue Auguste Comte 92170 VANVES	n/a	Formal : CNA	n/a	1-8

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Germany	No policy No info	No (necessary agreements are reached respectively with the parties concerned)	Deutsche Gesellschaft für Ernährung on request of Ministry of Health and Ministry of Food, Agriculture and Forests	No single special organization responsible ⁵⁹	MoH and Ministry of Food, Agriculture and Forests	No single special organization responsible ⁶⁰	Minister of Culture in the sixteen Federated States	Due to the federal structure a number of bodies are working in this area at Federal, Land and local level	n/a	Yes Informal and formal	n/a	1-6
Ireland	MoEd MoAg	Via Consultative Committee on HP	National Surveillance centre, Dep't of HP	National Nutrition Surveillance centre (NNSC)	National Surveillance centre, Dep't of HP	NNSC	National Surveillance centre, Dep't of HP	HP Unit	n/a	Formal Agriculture represented on Nutrition committee and on Consultative Committee on HP	n/a	1,2,3,4 consultative Committee on HP 6,7 HP Unit
Luxembourg	In preparation	Different forms of concerted bodies between ministries and Orgs	No info	No central coordination	No info	No info	Ministère de la Santé	Division of Preventive and Social Medicine	n/a	No	n/a	1-6, 7: Restaurant and alimentary branch, health professionals

⁵⁹ Every four years Federal Ministry for Health and the Federal Ministry of Food, Agriculture and Forestry commission the German Society for Nutrition to issue a nutrition report evaluating the different data sources regarding the state of nutrition and health.

⁶⁰ Every four years Federal Ministry for Health and the Federal Ministry of Food, Agriculture and Forestry commission the German Society for Nutrition to issue a nutrition report evaluating the different data sources regarding the state of nutrition and health.

Member State	4. Is there any form of regular government-initiated collaboration between parties responsible for: food production, manufacture and sales, control and legislation and nutrition education		4.1 Who is responsible for the collection of information regarding population dietary patterns		4.2 Who is responsible for dissemination of this information (4.1) to relevant policy-makers		4.3 Who is responsible for nutrition education of the public		4.4 Is there any form of regular consultation between the MoH and the Ministry of Agriculture on matters related to nutrition		4.5 Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors ⁵⁸	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Netherlands	MoH, Welfare and Sports, MoAg, Ministry of Financial Affairs	The Steering Group for proper nutrition devises action plans to improve the nutritional situation in the Netherlands	Food and Nutrition Unit in the MoH, Welfare and Sports	Nutrition Centre	NNC	Nutrition Centre	Nutrition Information Centre	Nutrition Centre	n/a	Yes Informal	n/a	1,2,5,6 7: Trade Organizations e.g. Heart and Cancer Foundations and PR – bureau for Fruits and Vegetables
Switzerland	Not yet decided	Yes Within Swiss Nutrition Council	Bundesamt für Gesundheitswesen und EEK	Federal Office of Public Health	Bundesamt für Gesundheitswesen und EEK	Federal Office for Public Health	Bundesamt für Gesundheitswesen und EEK	Several Orgs (Governmental and Private Orgs)	n/a	Within Swiss Nutrition Council	n/a	1-6
United Kingdom	Dep't of Health MoAg, Fisheries and Food Other Dep'ts	No	Nutrition Branch Food Science Division, MoAg, Fisheries and Food	Nutrition Unit, MoAg, Fisheries and Food	Nutrition Branch Food Science Division, MoAg, Fisheries and Food	Nutrition Unit, Ministry of Agriculture, Fisheries and Food	Health Education Authority and Nutrition Branch, Food Science Division, MoAg, Fisheries and Food	Health Education Authority MoAg	n/a	Yes Informal	n/a	1,2,4,5,6,

Table A6. EXAMPLES OF NORMATIVE ACTION (5-5.4) – Recommended nutrient reference values

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
SOUTH EAST EUROPE										
Albania	-	Yes Project: Norms for quantity of energy and nutrients according to need for groups, ages, sex, and worker groups	-	1980	-	Institute of Public Health	-	No	-	No
Bosnia and Herzegovina	-	Yes Former Yugoslavia recommendations of daily needs	-	1979	-	No info	-	No	-	No
Croatia	Yes	Use USA developed RDA	Using RDA, making own	1989	n/a	No info	Yes	Yes	Reference from 1984-90	Yes Annual yearbook of the State Bureau of Statistics 1991 (Statistički godišnjak)
Republic of Macedonia	Yes	Norms of physiological nutritional needs of different population groups (Fiziološki normi za ishrana na populacioni grupi)	1993	1993	n/a	NIPH	No	No	No	No info

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Uzbekistan	-	Yes Average Daily Rational Norms for Consumption of Food Products by Age and Professional group in Uzbekistan	-	1/ 1998	-	MoH	-	No	-	No
CEE										
Bulgaria	Yes	Yes Energy and nutrient reference values for Bulgaria, <i>Governmental Newspaper No. 64, 1994</i> (Fizyologichni normi za hranene na naselenieto v Bulgaria)	1994	1994	n/a	MoH National Centre of Hygiene Medical Ecology and Nutrition (Expert Committee for the Reference Values of Energy and Nutrient Intake)	Yes	Yes	Reference from 1993	Data from 1997 survey are being published Data from 1998 Survey will be published in 1999
Czech Republic	Yes	Yes Recommended daily intake of nutrients (Výživové doporučené dávky)	1989	1989 (currently revised)	n/a	MoH	No	No	No	No

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Hungary	Yes	Recommended daily energy and nutrient intake (Ajánlott napi Energia -És Tápanyagbevitel) Food Composition Tables (Tápanyagtáblázat) (Bíró Lindner: Medicina, Budapest, 1995)	1994 Food composition tables	1995	n/a	Institute of Food Hygiene and Nutrition	Yes	Yes	Reference from 1985-88	Yes First Hungarian Representative Nutrition Survey (1985-88) Results (Vol.1 1992; Vol.2 1993; Ed. G. Bíró, Budapest) Bíró G., Antal M; Zajkás G.: Nutrition Survey of the Hungarian Population in a randomized Trial between 1992-1994 (<i>Euro. J. of Clin. Nutr.</i> ; 1996, 50:201-208)Zajkás G, and Bíró, G: Some data on the prevalence of obesity in Hungarian adult population between 1985-88, and 1992-94 (<i>Z. Ernährungs - wissenschaft</i> , 1998, 37 Supl.1, 134-135)

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Poland	-	Recommended dietary allowances for the Polish population (energy, protein, fat, vitamins and minerals). <i>Polish J. of Human Nutrition and Metabolism</i> 1994 ,4, 303 in English: <i>New Medicine</i> 1996, 1, 1 Normy żywienia dla ludności w Polsce (energia, białko, tłuszcze, witaminy i składniki mineralne). <i>Żywnie Człowieka i Metabolizm (quarterly)</i> , 1994, 4, 303	-	1994	-	National Food and Nutrition Institute	-	No	-	No info
Romania	Yes	-	1992	-	n/a	-	Yes	-	No info	-
Slovakia	Yes	Recommended dietary allowances (odporucane vyzivove davky pre obyvateľstvo Sr Vestnik MZ)	1989	4/ 1997	n/a	MoH	No, but several small studies	Yes	No	Yes No reference given

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Republic of Moldova	-	Yes Physiologic norms/standards of nutrients for different population groups (ratified in 1992) (Norme fiziologice necesare in substantse nutritive pentru diverse grupe de populatsie)	-	No info provided	-	No info provided	-	Yes	-	Yes Study of the nutrition level of children in the Republic of Moldova. <i>Curier Medical</i> , 1997. 6;27-29 Studii privind nivelul nutritiional al copiilor din Republica Moldova
Russian Fed.	Yes	-	1991	-	n/a	-	Yes	-	Reference from 1994, review of small studies	-
Ukraine	-	Standards of physiological requirements for basic foods and energy for the population of Ukraine	-	10/1998	-	MoH of Ukraine Ukraine Institute for research on Nutrition	-	Yes	-	No info
NORDIC										
Denmark	Yes	Yes Nordic Nutrient recommendations 1996 Nordiske Næringsrekommandationer 1996	1989	1996	n/a	The Nordic Council of Ministries	Yes	Yes	Reference from 1985, population representative	Yes <i>Dietary Habits of Denmark 1995</i> National Food Agency, MoH Publication No. 235, 5/ 1996
Finland	Yes	Yes Finnish Dietary recommendations (Suomalaiset ravitsemussuositukset)	No info	15 10/1998	n/a	NNC	Yes	Yes	Reference from 1992, survey of Finnish adults	Yes The 1997 Dietary Survey of Finnish Adults. <i>National Public Health Institute B8/1998</i> (Finravinto 1997 – Tutkimus)

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Greece	Yes	Yes, European Commission, Scientific Committee for Food, Report of the Scientific Committee for Food, 31 st series	1992	Never	n/a	No info	Yes	Yes, The EPIC study provides data on approximately 300 000 adult men and women from all over Greece; though the study participants are volunteers, EPIC is the best existing approximation of representative dietary data for the Greek population.	Not published	Yes, Public Health Nutrition 1998; 1:131-7 Epidemiology 2000 May;11(3):333-6 Other papers submitted for publication

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Israel	-	Yes Daily Recommended Intakes	-	8/, 1997	-	Dep't of Nutrition	-	No The first National Nutrition and Health Survey will commence 12/1998	-	No info
Italy	Yes	Yes Livelli di Assunzione Giornalieri Raccomandati (L.A.R.N. 1996)	1986, under revision	1997	n/a	National Institute of Nutrition	Yes	No info	Reference from 1980-84	No info
Malta	No	No info	No	No info	n/a	No info	Yes	No	Reference from 1992	No
Monaco	-	-	-	-	-	-	-	-	-	-
Portugal	Yes	Recommended Daily Allowances	1982	1982	n/a	National Institute of Health	No	No	No	No info
San Marino	-	-	-	-	-	-	-	-	-	-
Spain	Yes	-	Being revised	-	n/a	-	Yes	-	No info	-
Turkey	Yes	Daily Recommended Energy and Nutrients Allowances for Turkey (Türkiye için önerilen günlük enerji ve besin öğeleri tüketim standartları)	1991	1997	n/a	Dep't of Nutrition and Dietetics (Hacettepe Univ)	No	No	No	No info

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
W. EUROPE										
Austria	-	No info	-	No info	-	No info	-	No info	-	No info
Belgium	No, coming	Consel National De La Nutrition " Nutritional Recommendations for Belgium "	No	No info	n/a	Voire 5.	Yes	No	Reference from 1989	No info
France	Yes	Recommended Daily Allowances	1992	1999	n/a	Centre National d'Etudes et de Recommendations sur la Nutrition et l'Alimentation (CNERNA)	Yes	Yes ;CFE S, SUVIMA X, and ASPCC	Reference from 1988	Yes; Baromitre Saute`Nutrition 1996 En cours par OCA-CREDOC
Germany	Yes	German Society for Nutrition: Recommendations on nutrient intake (DGE Empfehlungen für die Nährstoffzufuhr)	1991	1991 (currently revised)	n/a	German Society for Nutrition	Yes	Yes	Reference from 1989	Yes The National Food Intake Study (Nationale Verzehrsstudie) – results of the basis evaluation. Vol. 18 of Health Research , Former Federal Ministry for Research and Technology Small table of nutritional values (Kleine Nährwertabelle), German Society for NutritionBig table of nutritional values (Die grosse Nährwertabelle), German Society for Nutrition

Member State	5. Does country have a set of recommended nutrient reference values (physiological norms)		5.1 When were reference values last revised		5.2 Who is responsible for the revision of the reference values		5.3 Has a population representative dietary assessment been made in the last 10 years		5.4 Has the study (5.3) been published	
	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Ireland	Yes	Yes Adopted EU Recommended dietary allowances	1983	1998	n/a	Nutrition committee (FSAI)	Yes	Yes	Reference from 1991, population representative study	Yes Irish National Nutrition Survey 1990
Luxembourg	No	Use internationally established nutrient reference values from neighbour countries	No	No info	n/a	No info	Coming 1995	No	No	No info
Netherlands	Yes	Guidelines for Proper Nutrition	1989	1999	n/a	Health Council of the Netherlands	Yes	Yes- 3 times	Reference from 1987 and 1992, each reference published as booklet by MOHWandS, next study planned for 1997	Yes-Will be published soon
Switzerland	Yes, on food quality, being revised	Yes Nährwert – VO 6/ 1995	No info	27 th Februar y 1998	n/a	Federal Office for Public Health	Yes	Yes	Reference from 1991	Yes Fourth Swiss Nutrition Report, <i>Federal Office for Public Health, 1998</i> (Vierter Schweizerischer Ernährungsbericht , 1998)
United Kingdom	Yes	Dietary reference values for food energy and nutrients for the United Kingdom, (London, <i>The Stationery Office, 1991</i>)	1994	1991	n/a	COMA	Yes	Yes	Annually	Yes The Dietary and Nutritional Survey of British Adults, Gregory J, Foster K, Tyler H, Wiseman M, <i>LondonThe Stationery Office, 1990</i> National Diet and Nutrition Survey: children aged 1 ½ - 4 ½ . Gregory J, Collins D, Davies P, Hughes J, Clark P, <i>The Stationery Office, 1995</i> National Diet and Nutrition Survey: people aged 65 years and over, Finch S, Doyle W, Lave C, Bates C, Prentice A, Smithers G, Clarke P, London: <i>The Stationery Office, 1998</i>

Table A7. EXAMPLES OF NORMATIVE ACTION (6-6.4) – Dietary guidelines

Member State	6.Does country have dietary guidelines with/without food selection guides			6.1 When were dietary guidelines last updated		6.2 To which population group are dietary guidelines directed		6.3 Which type of food selection guide is used		6.4 Were any of the dietary guidelines field-tested before publication	
	1994/1995	1998/1999	2001/2002 ⁶¹	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
SOUTH EAST EUROPE											
Albania	-	Yes	No	-	1980	-	Whole population	-	Pyramid	-	Yes
Bosnia and Herzegovina	-	No	No	-	No info	-	No info	-	No info	-	No
Croatia	Yes	Yes	Yes	1991	1996	n/a	Whole population	n/a	Pyramid	n/a	Yes
Republic of Macedonia	Yes	Yes	Yes	No info	No info	children	Preschool children School children	n/a	No info	n/a	No info
Slovenia	-	Yes WHO guidelines	In process ⁶¹	-	No info	-	Whole population	-	No info	-	No info
Federal Republic of Yugoslavia	N/a	N/a	-	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a
BALTIC											
Estonia	Coming	Yes	Yes	No	No info	n/a	Whole population	n/a	Pyramid	n/a	Yes

* See full WHO report on food based dietary guidelines

⁶¹ Country is in the process to develop FBDG or is waiting for them to be endorsed

Member State	6.Does country have dietary guidelines with/without food selection guides			6.1 When were dietary guidelines last updated		6.2 To which population group are dietary guidelines directed		6.3 Which type of food selection guide is used		6.4 Were any of the dietary guidelines field-tested before publication	
	1994/1995	1998/1999	2001/2002 ⁶²	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
<i>Latvia</i>	No	Yes	In process ⁶²	No	5/ 1998	n/a	Whole Population	n/a	Pyramid	n/a	No
<i>Lithuania</i>	No	Yes	Yes	No	2/ 7/ 1998	n/a	Whole population BF women Children Army	n/a	Pyramid	n/a	Yes
CAR											
<i>Kazakhstan</i>	-	Yes	No info	-	1997	-	Special Groups: Women Children and infants	-	Plate	-	No
<i>Kyrgyzstan</i>	No	Yes	No	No	1999	n/a	Special groups: Therapeutic diets	n/a	None	n/a	No info
<i>Tajikistan</i>	Yes	-	No info	No info	-	n/a	-	n/a	-	n/a	-
<i>Turkmenistan</i>	-	-	No info	-	-	-	-	-	-	-	-
<i>Uzbekistan</i>	-	No	No info	-	No info	-	No info	-	No info	-	No info
CEE											
<i>Bulgaria</i>	Yes	Yes Developed in 1996	Yes	1985	1998	n/a	Whole population BF women	n/a	Pyramid	n/a	No
<i>Czech Republic</i>	No	Yes	Yes	No	1994	n/a	Whole population	n/a	Pyramid	n/a	No
<i>Hungary</i>	Yes	Yes	In process ⁶³	1987	1988	n/a	Whole population	n/a	Other- text	n/a	No
<i>Poland</i>	-	Yes	Yes	-	1998	-	Whole adult population	-	Pyramid and plate	-	Yes
<i>Romania</i>	No	-	Yes	No	-	n/a	-	n/a	-	n/a	-

⁶² Country is in the process to develop FBDG or is waiting for them to be endorsed

⁶³ Country is in the process to develop FBDG or is waiting for them to be endorsed

Member State	6.Does country have dietary guidelines with/without food selection guides			6.1 When were dietary guidelines last updated		6.2 To which population group are dietary guidelines directed		6.3 Which type of food selection guide is used		6.4 Were any of the dietary guidelines field-tested before publication	
	1994/1995	1998/1999	2001/2002*	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Slovakia	Yes	Yes	Yes	1989	6/ 1997	n/a	Whole population	n/a	Plate	n/a	No
CIS											
Azerbaijan	Yes	Yes	No info	1993	1997	n/a	Whole population Children 0-6 Children 7-15 Adults 18-59 Elderly ≥60	n/a	Other: A list of products and their daily amounts	n/a	Yes
Armenia	-	-	Yes	-	-	-	-	-	-	-	-
Belarus	-	Yes	No info	-	1997	-	Cardio-vascular disease Diabetes Gastro-digestive diseases Children	-	Other: No info of kind	-	Yes
Georgia	-	-	No info	-	-	-	-	-	-	-	-
Republic of Moldova	-	Yes	No info	-	1986	-	Children	-	None	-	No
Russian Fed.	Yes		No	1991		n/a		n/a		n/a	
Ukraine	-	Yes	Yes	-	1998	-	Whole Population	-	Pyramid	-	No
NORDIC											
Denmark	Yes	Yes	Yes	1989	At different times, The National Consumer Agency has been considering revision of the circle	n/a	Whole Population	n/a	Pyramid and circle	n/a	No info
Finland	Yes	No info	Yes	1987	No info	n/a	No info	n/a	No info	n/a	No info
Iceland	Yes	Yes	Yes	1993	1994	n/a	• Whole population	n/a	Circle	n/a	No

Member State	6.Does country have dietary guidelines with/without food selection guides			6.1 When were dietary guidelines last updated		6.2 To which population group are dietary guidelines directed		6.3 Which type of food selection guide is used		6.4 Were any of the dietary guidelines field-tested before publication	
	1994/1995	1998/1999	2001/2002 ⁶⁴	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
Norway	Yes	Yes	Yes	1989	1996	n/a	• Whole population	n/a	No info	n/a	No info
Sweden	Yes	Yes	Yes	1992	1992	n/a	• Whole population • Food and large scale catering industry Parents (guidelines for small children)	n/a	Plate and Circle Other: Keyhole	n/a	No
S. EUROPE											
Andorra	-	-	-	-	-	-	-	-	-	-	-
Greece	Yes	Yes	Yes	1986	1999	n/a	Whole population (healthy adults)	n/a	Pyramid	n/a	No
Israel	-	Yes	Yes	-	8/ 1997	-	Whole population	-	Pyramid	-	Yes
Italy	Yes	Yes	In process ⁶⁴	1986	1997	n/a	Whole population	n/a	No info	n/a	No info
Malta	Yes	Yes	Yes	1988	1996-97	n/a	Whole population	n/a	Pyramid	n/a	No
Monaco	-	-	-	-	-	-	-	-	-	-	-
Portugal	Yes	Yes	Yes	1982	No info	n/a	Whole population	n/a	Circle	n/a	No
San Marino	-	-	-	-	-	-	-	-	-	-	-
Spain	Yes	-	Yes	1991	-	n/a	-	n/a	-	n/a	-
Turkey	No	No Guidelines have been prepared by Hacettepe University and are used when necessary	Yes	No	1994	n/a	Infants Children Pregnant and Lactating Women	n/a	Other: clover (four food group plan)	n/a	No

⁶⁴ Country is in the process to develop FBDG or is waiting for them to be endorsed

Member State	6.Does country have dietary guidelines with/without food selection guides			6.1 When were dietary guidelines last updated		6.2 To which population group are dietary guidelines directed		6.3 Which type of food selection guide is used		6.4 Were any of the dietary guidelines field-tested before publication	
	1994/1995	1998/1999	2001/2002 [*]	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999	1994/1995	1998/1999
W. EUROPE											
<i>Austria</i>	-	Yes	No	-	1997	-	Whole population	-	None	-	No
<i>Belgium</i>	No	Yes	No info	No	1998	n/a	Whole Population	n/a	Pyramid	n/a	Yes
<i>France</i>	Yes	Yes	In process ⁶⁵	No info	No info	n/a	Whole Population and particular groups	n/a	No info	n/a	No info provided
<i>Germany</i>	Yes	Yes	Yes	No info	1997 (continuously adjusted)	n/a	Whole population	n/a	Circle	n/a	No
<i>Ireland</i>	Yes	Yes	Yes	1983	1994	n/a	Whole Population Special Groups	n/a	Pyramid	n/a	Yes
<i>Luxembourg</i>	No	Yes	No	No	Continuously adjusted	n/a	Whole population Special groups	n/a	Pyramid	n/a	No info
<i>Netherlands</i>	Yes	No info	Yes	No info	No info	Whole population and specific groups separate	Whole population	n/a	No info	n/a	Yes
<i>Switzerland</i>	Coming	Yes	Yes	No info	11/12/1995	n/a	Whole population	n/a	None	n/a	No
<i>United Kingdom</i>	Yes	Yes	Yes	1992	1993	n/a	Whole population	n/a	Plate	n/a	Yes

⁶⁵ Country is in the process to develop FBDG or is waiting for them to be endorsed

Annex 2

QUESTIONNAIRE 1998/1999

Questionnaire
to all WHO European Member States

Progress following the:
1992 International Conference on Nutrition
World Declaration and Plan of Action for Nutrition
and the
1996 Follow-up consultation to the ICN for Europe and
OECD countries

<i>This questionnaire should be completed by Government administrators or advisers responsible for food and nutrition policy-making in WHO European Member States.</i>		
<i>General</i>		
1.	Responding country:	
1.1	Names/titles of those completing questionnaire:	
	Address:	
	Telephone:	Telefax: Email:
1.2	Questionnaire completed	
	Date:	

Nutrition policy, plan of action or strategy	
2.	Does your country or any Region within the country have a written policy document adopted by a political body, explicitly concerned with nutrition? <i>(It may be a document only concerned with nutrition or it may be part of a document concerned with other policy areas).</i>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<i>If yes, go to 2.1</i>
2.1	What is the name of the written policy document or the document in which this nutrition policy statement is contained? <i>(in the national language and if possible with an English translation).</i>
2.2	When was it adopted? State the date.
2.3	By whom was it adopted? State name of body (Ministry, Parliament or other):
2.4	Which Ministries or high-level governmental bodies are mentioned as partners to the nutrition policy?
2.5	Are any of the following components of the World Declaration and Plan of Action for Nutrition included in the document? <i>(Please mark x for those included).</i>
	<input type="checkbox"/> Nutritional objectives and targets
	<input type="checkbox"/> Assessing, analysing and monitoring nutrition situations
	<input type="checkbox"/> Improving household food security
	<input type="checkbox"/> Protecting consumers through improved food quality and safety
	<input type="checkbox"/> Promoting breast-feeding
	<input type="checkbox"/> Caring for the socioeconomically deprived and nutritionally vulnerable
	<input type="checkbox"/> Preventing and controlling specific micronutrient deficiencies
	<input type="checkbox"/> Promoting appropriate diets and healthy lifestyles

Advisory and administrative structures	
3.	Is a special <i>administrative</i> structure set up to be responsible for the implementation of the policy? (Describe, or enclose an organigram).
3.1	Does the country have a nutrition council or other advisory structure or body responsible for providing scientific advice to national policy-makers? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, please answer 3.2 to 3.9</i>
3.2	What is the full name of the advisory body? (In the national language, and if possible with an English translation) National language: English translation:
3.3	When was the advisory body first established? Date:
3.4	When did the advisory body last meet? Date:
3.5	How many members does the advisory body have?
3.6	Whom do they represent?
3.7	Does the advisory body have a written mandate or terms of reference? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please enclose a copy in the national language and if possible with a translation into either English, German, French or Russian.
3.8	Does the advisory body have a budget to cover its activities? Yes <input type="checkbox"/> No <input type="checkbox"/>
3.9	Who finances this budget?

Interdisciplinary collaboration	
4.	Is there any form of regular government-initiated collaboration between the various parties responsible for food production, manufacture and sales, control and legislation and nutrition education? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe briefly:
<i>Continue on separate sheet if necessary.</i>	
4.1	Who is responsible for the collection of information regarding population dietary patterns? Name of body: Address:
4.2	Who is responsible for dissemination of this information to relevant policy-makers? Name of body: Address:
4.3	Who is responsible for nutrition education of the public? Name of body: Address:
4.4	Is there any form of regular consultation between the Ministry of Health and the Ministry of Agriculture on matters related to nutrition? <i>State whether informal or formal (please describe).</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Informal <input type="checkbox"/> Formal <input type="checkbox"/> Description:
4.5	Is there any form of regular intersectoral consultation between different governmental, private or voluntary sectors. Please indicate below: <input type="checkbox"/> Ministry of Health <input type="checkbox"/> Ministry of Agriculture <input type="checkbox"/> Ministry of Environment <input type="checkbox"/> Ministry of Education <input type="checkbox"/> Food industry <input type="checkbox"/> Consumers <input type="checkbox"/> Others (please state): _____

Examples of normative action

5. Does the country have a set of recommended nutrient reference values (physiological norms)?
If yes, please give title in national language and an English translation.

Reference:

English translation:

5.1 When were these last revised?

Date:

5.2 Who is responsible for the revision?

Name of body:

5.3 Has a population representative dietary assessment been made in the last 10 years?

Yes

No

5.4 Has the study been published? *If yes, please give the main reference.*

Yes

No

Reference:

6.	Does the country have dietary guidelines with/without food selection guides (advice to the public)?
	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.1	When were the dietary guidelines last updated? Date:
6.2	To which population group are the dietary guidelines directed? Whole population <input type="checkbox"/> Special groups <input type="checkbox"/> <i>If special groups, please specify:</i>
6.3	Food Selection Guide: None <input type="checkbox"/> Pyramid <input type="checkbox"/> Plate <input type="checkbox"/> Circle <input type="checkbox"/> Other <input type="checkbox"/> <i>(Please attach sample)</i>
6.4	Were any of the dietary guidelines field-tested before publication? Yes <input type="checkbox"/> No <input type="checkbox"/>
Other information	
7.	Please supply any other information that you feel would be useful to us in carrying out this progress survey. Include future plans even if tentative.
<i>Continue on separate sheet if necessary.</i>	

Statistical information

8. Please complete the tables below giving national statistics on dietary intake (if these statistics are available). *(Use data from surveys carried out using 24 hour recall, food frequency questionnaires, food records etc.)*

Method: *(give brief description)*

Year:

Macronutrient intake

Table 8.1 Daily macronutrient and alcohol intake by sex and age

Nutrients		Age(years)			
		19–34	35–49	50–64	total
	units\day	Mean(SE)	Mean(SE)	Mean(SE)	Mean(SE)
Energy					
men	kcal				
Women	kcal				
Fat					
men	grams				
Women	grams				
Protein					
Men	grams				
Women	grams				
Carbohydrate					
men	grams				
Women	grams				
Alcohol					
Men	grams				
Women	grams				

Table 8.2 Daily macronutrient and alcohol intake by sex and age expressed as a percentage of total energy intake

Nutrients	Age(years)			% total daily energy
	19-34	35-49	50-64	
	% total daily energy	% total daily energy	% total daily energy	% total daily energy
Fat				
men				
Women				
Protein				
men				
Women				
Carbohydrate				
men				
Women				
Alcohol				
Men				
Women				

Micronutrient and mineral intake

Table 8.3 Daily micronutrient and mineral intake by sex and age (grams/day)

Nutrients		Age(years)			total
		19-34	35-49	50-64	
	units\day	mean(SE)	mean(SE)	mean(SE)	mean(SE)
Vitamin C					
men	grams				
Women	grams				
Vitamin D					
men	ugrams*				
Women	ugrams*				
Vitamin A					
Men	ugrams*				
Women	ugrams*				
Carotenoids					
Men	ugrams*				
Women	ugrams*				
Iron					
men	mg				
Women	mg				
Calcium					
men	mg				
Women	mg				

*micrograms u=mew

Intake by food groups

Table 8.4 Daily intake of food groups by sex and age

Food Groups	Age(years)			Total
	Mean (SE) g\day	Mean (SE) g\day	Mean (SE) g\day	Mean (SE) g\day
	19-34	35-49	50-64	g\day
Vegetables/Fruit (including potato) men				
Women				
Cereals, pasta, bread men				
Women				
Milk and milk products Men				
Women				
Meat and meat products men				
Women				
Fats and oils Men				
Women				

Table 8.5 Vegetable and fruit intake excluding potatoes

Food Groups	Men	Women	Total
	Mean (SE)	Mean (SE)	Mean (SE)
	g\day	g\day	g\day
Vegetables without potatoes			
Fruit			
Total			

Annex 3

BMI^{66 67} QUESTIONNAIRE

Body Mass Index (BMI) questionnaire

N= number of subjects measured

**Table 1: BMI classification by age (measured weight and height)
– Percentage of MEN in different categories**

BMI category	Age (years)			Total
	N=	N=	N=	N=
	19-34	35-49	50-64	19-64
	%	%	%	%
Underweight BMI < 18.5				
Normal BMI 18.5-24.9				
Overweight BMI 25-29.9				
Obese BMI ≥ 30				

**Table 2: BMI classification by age (measured weight and height)
– percentage of WOMEN in different categories**

BMI category	Age (years)			Total
	N=	N=	N=	N=
	19-34	35-49	50-64	19-64
	%	%	%	%
Underweight BMI < 18.5				
Normal BMI 18.5-24.9				
Overweight BMI 25-29.9				
Obese BMI ≥ 30				

Table 3: BMI by age and sex (measured weight and height)

	Age (years)			Total (19-64)
	19-34	35-49	50-64	
	BMI mean(SE)	BMI mean(SE)	BMI mean(SE)	BMI mean(SE)
Men				
Female				

From:
Country: _____

Name and address:

Fax no: _____

Date of data collection:

⁶⁶ WHO. Physical status: the use and interpretation of anthropometry. Report of a WHO Expert Committee. Geneva: World Health Organisation, 1995 (Technical Report Series No 854): 368-9.

⁶⁷ BMI = Weight (kg)
Height (m)²

Vegetable and fruit intake excluding potatoes

Food Groups	Men	Women	Total
	Mean	Mean	Mean
	g/day	g/day	g/day
Vegetables (without potatoes)			
Fruit			
Total			

References

WHO. Obesity. Preventing and managing the global epidemic. Report of a WHO consultation on obesity. Geneva, 3-5 June 1997. Geneva: WHO, 1998

Gibson RS. Principles of nutritional assessment. New York: Oxford University Press, 1990.

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