World Health Organization

REGIONAL OFFICE FOR Europe

Meeting of WHO Nutrition Counterparts and National Information Focal Points for the WHO/EC monitoring project

Geneva, Switzerland, 24–25 March 2010

Report

ABSTRACT

The WHO Nutrition Counterparts of the 53 Member States of the WHO European Region and the National Information Focal Points for the joint WHO/EC project, "Monitoring progress on improving nutrition and physical activity and preventing obesity in the EU", from 27 European Union (EU) countries met in Geneva, Switzerland, on 24–25 March 2010 to discuss and review progress made in the countries in improving nutrition and physical activity, preventing obesity and implementing policy action. The meeting was hosted by the Swiss Federal Office of Public Health. Representatives of selected nongovernmental and intergovernmental organizations, experts in nutrition, obesity and physical activity, and staff from WHO headquarters and the WHO Regional Office for Europe also took part.

Keywords

NUTRITION
FOOD
PHYSICAL FITNESS
OBESITY – prevention and control
NATIONAL HEALTH PROGRAMS
PROGRAM EVALUATION
EUROPE

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Abbreviations

COSI	Childhood Obesity Surveillance Initiative
DAFNE	Data Food Networking (database)
DG SANCO	Directorate-General for Health and Consumers
EC	European Commission
ESAN	European Salt Action Network
EU	European Union
EUROSTAT	European Commission Statistical Office
FAO	Food and Agricultural Organization of the United Nations
HAPPY	Hungarian Aqua Promoting Program in the Young (project)
HBSC	Health Behaviour in School-aged Children (study)
HIV	human immunodeficiency virus
IDD	iodine deficiency disorders
IPAQ	International Physical Activity Questionnaire
MNP	multiple micronutrient powder
MOSEB	Monitoring-System Ernährung und Bewegung (Nutrition and Physical Activity Monitoring Programme)
NCD	noncommunicable diseases
NFSI	Nutrition-Friendly Schools Initiative
NLIS	Nutrition Landscape Information System
NOPA	Nutrition, Obesity and Physical Activity (database)
POL-HEALTH	Prevention of Overweight, Obesity and Non-Communicable Diseases through Diet and Improved Physical Activity (programme)
UNICEF	United Nations Children's Fund
WHA	World Health Assembly

Acknowledgements

This report is a deliverable of Work Package 5 of the 3-year joint WHO/European Commission (EC) project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union (EU), which began in January 2008 (2007WHO02).

The WHO Regional Office for Europe is grateful to the Swiss Federal Office of Public Health for supporting and hosting the meeting between the WHO Nutrition Counterparts and the National Information Focal Points for the WHO/EC monitoring project in Geneva on 24–25 March 2010. The Regional Office would like to thank: Dr Awilo Ochieng Pernet, Division of International Affairs, Swiss Federal Office of Public Health, Liebefeld, Switzerland, for chairing the meeting; Ms Ursula O'Dwyer, National Nutrition Policy Adviser, Health Promotion Policy Unit, Department of Health and Children, Dublin, Ireland, for acting as Rapporteur; EC for its collaboration in the project and technical input to the meeting; the speakers for their presentations; and the participants for their positive and constructive contributions during the meeting, and for their action and commitment.

The report was drafted by Ms Caroline Bollars, Technical Officer, Nutrition Policy, and Ms Lideke Middelbeek, Technical Officer, Diet and Physical Activity, and finalized by Ms Trudy Wijnhoven, Technical Officer, Nutrition Surveillance, Nutrition, Physical Activity and Obesity Programme, WHO Regional Office for Europe. Thanks are extended to Ms Anna Müller for editing the text.

Introduction

On 24–25 March 2010, the WHO Nutrition Counterparts from 42 WHO European Member States, the National Information Focal Points for the joint WHO/EC project on monitoring progress on improving nutrition and physical activity and preventing obesity in the EU from 25 EU countries, representatives of selected nongovernmental and intergovernmental organizations, experts in nutrition, obesity and physical activity, and staff from WHO headquarters and the WHO Regional Office for Europe met in Geneva to discuss and review progress made in improving nutrition and physical activity, preventing obesity and implementing related policy action. The Swiss Federal Office of Public Health kindly hosted the meeting, which was organized by the Noncommunicable Diseases and Environment Unit of the Regional Office. The programme of the meeting and the list of participants are attached as Annexes 1 and 2, respectively.

The aim of the three-year WHO/EC joint project (2008–2010), which is led by the Regional Office, is to develop an integrated, web-based database on European policies and projects related to nutrition and physical activity. On the first day of the meeting, countries presented reports on the national status of the project and the WHO European Nutrition, Obesity and Physical Activity (NOPA) database was introduced. During working-group sessions, Member States validated the information, which had been collected through the country reporting templates, and evaluated the outputs and main search screen of the database.

On the second day of the meeting, six Member States (Germany, Hungary, Poland, Switzerland, the former Yugoslav Republic of Macedonia and the United Kingdom) presented feedback on their nutrition, physical activity and obesity activities, as well as their expectations and plans. WHO staff reported on various new and ongoing WHO activities and programmes in these areas, provided information about nutrition-related items to be discussed at the Sixty-third session of the World Health Assembly, Geneva, Switzerland, 17–21 May 2010, and described the Regional Office's work plan for 2010–2011 in the area of nutrition and food safety. The EC representative provided an update on EU policy developments and plans.

In opening the meeting, Dr Awilo Ochieng Pernet, Division of International Affairs, Swiss Federal Office of Public Health, Liebefeld, Switzerland, welcomed the participants. She introduced Mrs Andrea Arz de Falco, Vice-Director, who pointed out that the Swiss Federal Office of Public Health has developed a national programme on nutrition and physical activity covering the period 2008–2012 *(1)*.

Dr João Breda, Programme Manager, Nutrition, Physical Activity and Obesity, welcomed the participants on behalf of the WHO Regional Office for Europe and thanked the Swiss Federal Office of Public Health for hosting the meeting, for taking care of its local organization and for providing financial support.

Mr Philippe Roux, Deputy Head of the Health Determinants Unit, EC, welcomed the participants on behalf of EC and gave a short introduction on EC activities related to nutrition, physical activity and obesity.

Dr Juan-Pablo Peña-Rosas, Coordinator, Micronutrients Unit, Department of Nutrition for Health and Development, WHO headquarters, welcomed the participants on behalf of the Department, and made reference to the global nutrition policy review carried out in all six regions of WHO in 2009.

WHO/EC project on monitoring progress on improving nutrition and physical activity and preventing obesity in the EU

WHO introduction

At the WHO European Ministerial Conference on Counteracting Obesity held in Istanbul, Turkey, on 15–17 November 2006 *(2)*, the Member States adopted the *European Charter on Counteracting Obesity*, which lists guiding principles and action areas and highlights the need to perform "regular evaluation and review of policies and actions" *(3)*. In May 2007, EC adopted the *White Paper on a strategy for Europe on nutrition, overweight and obesity-related health issues*, which stresses the need also for monitoring *(4)*. At its 57th session in Belgrade, Serbia, on 15−17 September 2007, the WHO Regional Committee for Europe approved resolution EUR/RC57/R4 *(5)* endorsing the *WHO European Action Plan for Food and Nutrition Policy 2007–2012* and calling on Member States to develop and implement food and nutrition policies *(6)*.

The WHO/EC project on monitoring progress on improving nutrition and physical activity and preventing obesity in the EU includes seven work packages.

1. Surveillance of nutritional status, dietary habits and physical activity patterns
2. National policies and actions
3. Good practice in regional and local initiatives
4. Establishment and management of a database
5. Support to national surveillance and policy intelligence
6. Coordination, management and reporting
7. Dissemination of results.

The main outcome is the development of an integrated, web-based database − the WHO European database on nutrition, obesity and physical activity (NOPA). The aim is to provide information on progress made in Europe in strengthening the promotion of healthy nutrition and physical activity and reducing obesity, as well as to illustrate good practices. The first version of the output interface has been developed. The main tool used in collecting the data is the "country reporting template", which has already been completed by the Member States. The resulting data have been entered in NOPA. These and future data collected for NOPA are to be officially endorsed by Member States before being made publicly available.

EC introduction

The background to the *White Paper on a strategy for Europe on nutrition, overweight and obesity-related health issues (4)* was outlined and the need to monitor the implementation of the strategy reiterated. Submission of the first mid-term progress review report to the European Council and the European Parliament was foreseen for the end of 2010 with the final report due in 2013. EC emphasized the importance of collaboration with the WHO Regional Office for Europe on the joint monitoring project in connection with the compilation of the EC progress report for 2010.

The main sources to be used for monitoring the strategy are: the data collected by the National Information Focal Points (via the project's country reporting template) and analyzed by the WHO Regional Office; other policies that have an impact on overweight and obesity, such as those of the EC Directorates General for Information Society and Media and for Agriculture and Rural Development; and the results of an external evaluation of the EU Platform for Action on Diet, Physical Activity and Health, which was in process at the time of the meeting.

The EC progress report for 2010 will document all activities implemented by Member States, as well as EC-led activities relating to the five priority areas of the White Paper *(4)*, i.e.: (1) better-informed consumers; (2) making the healthy option available; (3) encouraging physical activity; (4) priority

groups and settings; and (5) improving obesity monitoring systems. The following actors will play a key role in collecting information on the implementation of the strategy:

- WHO Regional Office for Europe and the National Information Focal Points for the WHO/EC project on monitoring progress on improving nutrition and physical activity and preventing obesity in the EU;
- Directorate General for Health and Consumers (DG SANCO) Health Determinants Unit;
- other relevant directorates general, such as those for agriculture and rural development and for the information society and media;
- Eurostat (EC Statistical Office);
- members of the EC High Level Group on Nutrition and Physical Activity (as policy-makers); and
- EU Platform for Action on Diet, Physical Activity and Health via monitoring and evaluation reports.

Feedback was solicited during the presentation on the core set of indicators presented during the meeting of National Information Focal Points held in Copenhagen, Denmark, in June 2009 *(7)*.

Results of country reporting templates completed by WHO European Member States

Surveys and data on nutritional status, food availability and nutrient intake

Within the context of the joint monitoring project, WHO European Member States were asked to report on published surveys on nutritional (anthropometry and micronutrient) status, household-food availability, food consumption, and nutrient intake.

A review of the information provided through nationally representative surveys concluded in 2003 or later indicated that, for children aged 0–5 years, measured anthropometric data were available for 16 countries and self- reported data for 2 countries. For the age group 6–10 years, measured data were identified for 6 countries and self-reported data for 3 countries. The WHO European Childhood Obesity Surveillance Initiative (COSI) collected anthropometric data relating to primary-school children in 13 countries during its first round in 2007–2008. For 7 countries, measured anthropometric data were available for adolescents (10–19 years), and for 4 countries self-reported data were available through national surveys. In 2005–2006, the international Health Behaviour in School-Aged Children (HBSC) Study collected self-reported anthropometric data in 26 countries among 11, 13 and 15 year-olds and in 2003 the Pro-Children Study monitored the anthropometric situation in 7 countries. Measured anthropometric data for adults (>19 years) were available for 13 countries and self-reported data for 20 countries. It can be concluded from this review of anthropometric data that, currently, a consistent methodological approach to data collection is lacking, which challenges the comparison of data across countries.

The main identified data source for household food availability was the Data Food Networking (DAFNE) Databank[1], which includes household budget survey data from 27 countries: Albania, Armenia, Austria, Belgium, Croatia, Cyprus, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Poland, Portugal, Serbia, Slovakia, Slovenia, Spain, Sweden and the United Kingdom.

[1] Information available: http://www.nut.uoa.gr/Dafnesoftweb/, accessed 24 November 2010.

Regarding the availability of nationally representative data on food consumption and nutrient intake since 2003, 18 countries reported having conducted surveys among children (0–9 years), 22 among adolescents, and 31 among adults.

Despite the wealth of available data, intercountry data comparison in this field remains difficult due to differences in measurement methods from country to country (e.g. measured versus self-reported body weight and body height; food-frequency questionnaires versus 24-hour recalls; different sample sizes, coverage and response rates; different population groups; different survey years; different age-range cut-offs; different food categories; different food-composition tables; and different references for nutrient intake). Within the context of the WHO/EC monitoring project, it was concluded that all 27 EU Member States had data on the prevalence of overweight and obesity in children, adolescents and/or adults. It was stressed that the lack of weight and height measurements was a concern as it results in an underestimation of prevalence. Data on dietary intake were available in almost all EU Member States and 50% had carried out surveys on micronutrient status (iodine, anaemia or vitamin A).

Surveys and data on physical activity

Information from nationally representative surveys on physical activity and other sources were available for the majority of the Member States; they were missing for Albania, Andorra, Armenia, Azerbaijan, Belarus, Kyrgyzstan, Monaco, Montenegro, Republic of Moldova, Tajikistan, the former Yugoslav Republic of Macedonia, Turkmenistan and Uzbekistan.

All identified surveys were based on subjective measurement methods (questionnaire, interview). The majority of them included all or most of the items from the short version of the International Physical Activity Questionnaire (IPAQ short), which includes information on the frequency and duration of moderate and vigorous physical activity, time and frequency of walking, and time spent sitting. For children or adolescents, only one international survey was identified: the HBSC study, which covered 36 countries in the last collection round in 2005–2006. The Survey on Health, Ageing and Retirement in Europe (SHARE), covering 15 countries, was the only study identified that specifically focused on the elderly.

Information on physical activity levels and patterns for adults was available for 39 Member States; it was missing for Albania, Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Monaco, Montenegro, Norway, Republic of Moldova, Romania, Russian Federation, San Marino, Slovakia and Uzbekistan. Regarding children and adolescents, national surveys/studies generating physical activity data were identified for 19 Member States

Only a few Member States reported using objective measurement methods, such as fitness tests, pedometers and accelerometers. Most of the identified nationally representative surveys were based on subjective measurements of physical-activity levels obtained using non-standardized instruments. Despite the fact that using non-standardized instruments results in indirect information on the prevalence of physical inactivity, using the same instruments over a long period will produce valuable time series data.

As with the surveys on nutritional status, food availability and nutrient intake, the intercountry comparison of data on physical activity remains a challenge due to the differences from country to country in measuring methods and definitions of physical activity, which in turn are based on different recommendations. In addition, the surveys on physical activity were conducted in various settings (work, school, transport, leisure, sports, home and family), some focussing on one specific setting and others aiming to assess the level of physical activity in a population through several settings.

Development of food and nutrition policies

The following definition of "policy" was used in identifying national policies: "a written document that contains strategies and priorities, defines goals and objectives, and is issued by a part of the administration" *(8)*.

More than two thirds of the 129 national food and nutrition or obesity policy documents identified had been drafted after 2004 and 30 had been published after 2008–2009; 74 were reported to have been adopted by national administrations, 39 were in their final versions and 16 were in draft. In most cases, countries reported their ministries of health as the national issuing bodies. The type of nutrition policy documents retrieved varied and related, for example, to national health and nutrition programmes, public health strategies or action plans with a specific targets.

The time frames of the policy documents varied from 3 to 10 years. In 38 of the 129 documents, nutrition was the main area addressed, in 14 documents it was obesity and in 12 of them nutrition and physical activity were the main areas. In 28 policy documents, the approach taken was more general, addressing public health as a whole, and in 9 the focus was on noncommunicable diseases (NCD). The remaining documents targeted children (n=11), education (n=6), agriculture (n=6), healthy ageing (n=2), consumers (n=2) and health inequalities (n=1).

It was concluded that national-level nutrition policy frameworks existed in all 27 EU Member States and that information concerning national nutrition policies was up to date. However, it appeared that, in the relevant documents, only minimal attention had been paid to the disadvantaged or lower socioeconomic groups. The point was made that the definitions and terms used in relation to policy context needed to be better clarified. Therefore, it was agreed that the glossary of terms included in the project's country reporting templates should be used in interpreting policy development indicators.

Development of policies on promotion of physical activity

A total of 161 policy documents containing goals and objectives relating to the promotion of physical activity were identified for 39 countries (compared to 76 identified documents at the time of the WHO European Ministerial Conference on Counteracting Obesity *(2)* in 2006). Policy documents in this area were not yet available in Armenia, Azerbaijan, Greece, Kazakhstan, Kyrgyzstan, Monaco, Montenegro, Republic of Moldova, Romania, Russian Federation, San Marino, Tajikistan, Turkmenistan and Uzbekistan. Most of the identified policy documents pertained to the national level. Belgium, Ireland and the United Kingdom also provided subnational policy documents, which were the result of decentralization of health policy in these countries.

Ministries of health were responsible for the development of the identified policy information in most of the countries. Other main issuing bodies were ministries of social affairs, education, transport, and the environment and national institutes for public health, nutrition, sports, and physical activity.

The main focus of the policy documents was not always solely physical activity, but also nutrition, obesity, cardiovascular disease prevention, public health, sustainable development or environmental health. To which extent physical activity was addressed in the policy document depended very much on the type of document. For instance, in public health strategies, the promotion of health-enhancing physical activity was described mostly in general terms, while in policy documents focussing purely on physical activity, a much more in-depth description was given.

Of the 39 countries for which physical activity policy information was available, 35 had at least one national policy document that took a public health policy approach. In total, 87 documents addressing physical activity and public health were identified, including:

- documents focusing purely on physical activity and health as was the case, for example, in Slovenia (*National health enhancing physical activity programme 2007–2012 (9)*) and Norway (*Action plan on physical activity 2005–2009; working together for physical activity (10)*);
- documents in which physical activity is part of an overarching public health strategy, such as in Albania (*Albanian health reform project. Towards a healthy country with healthy people – public health and health promotion strategy 2002–2010 (11)*)and Hungary (*Johan Bela – national programme for the decade of health 2003 (12)*);
- documents on lifestyles combining nutrition and physical activity, such as in Georgia (*National action plan on food security, healthy eating and physical activity 2006–2010 (13)*) and Switzerland (*National programme on nutrition and physical activity 2008–2010 (1)*); and
- documents in which physical activity is part of an obesity strategy, such as in the Netherlands (*Memorandum on obesity (14)*) and Portugal (*National programme against obesity 2005–2009 (15)*).

Of the identified documents, 29 (15 countries) took a sports-related approach to the promotion of physical activity, such as the *National programme on sports development for all (16)* developed by the Ministry of Education, Youth and Sport of the Czech Republic, and the *National sports development programme for 2006–2012 (17)* adopted by the Cabinet of Ministers in Latvia.

The existence of policy information on physical activity and transport was identified for 11 countries (25 documents). The United Kingdom, for instance, had many subnational transport-related documents, such as *Transport Scotland. Framework document (18)*, *Travelling to school – an action plan, England (19)* and *Walking and cycling strategy for Wales (20)*.

The existence of documents on physical activity and the environment were identified only for 6 countries; examples are the *Austrian strategy for sustainable development (21)* and the French *Second national action plan on environment and health (22)*.

Implementation of nutrition-related policy

In the country reporting template, Member States were requested to report the status of 56 policy actions, classified according to the six action areas of the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6)*), by indicating whether they had been fully implemented, partly implemented or not implemented at all (Annex 3). Thirty-eight of the policy actions listed related to nutrition. Thus, the Regional Office was able to ascertain the national levels of nutrition-related policy implementation and, at the same time, gain information on existing enforcement mechanisms, interaction between the different policy levels (decentralization), and action in line with national policy frameworks.

To obtain a concrete assessment, policy implementation was categorized at three levels: not implemented; partly implemented/enforced; and fully implemented/enforced, as well as indicators to allow the assessment of the implementation mechanisms used, such as regulatory bodies and regulation or non-legislative tools, and their impact on the context and implementation of policy. For example, for the first action area, "Supporting a healthy start," 90% of the Member States reported ongoing action related to the promotion of breastfeeding. It was considered difficult to assess to which extent nutrition education had been included in school curricula. Some countries reported having clear healthy-school policies that do not entirely focus on nutrition, while others indicated the existence of more thematic school policies focusing, for example, solely on nutrition. The institutional mechanisms behind the policy actions were public national bodies, such as ministries of health. Collaboration with other ministerial departments, such as ministries of agriculture or transport, was also mentioned.

The conclusion of the assessment was that a large number of countries had implemented action related to food and nutrition policy. However, additional information was needed about the levels of and mechanisms used for implementation of the policy actions listed under the six action areas of the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6)* (Annex 3). Policy implementation is crucial to ensuring delivery of the goals and objectives set out in international policy frameworks and national policy documents. Therefore, it is of the utmost importance to make use of available national and international information in monitoring and evaluating the implementation of national food and nutrition policy.

Implementation of policy actions related to physical activity

Eighteen of the 56 policy actions listed in the country reporting format related to the promotion of physical activity (Annex 3). At the time of the meeting, information on the implementation of these had been received from 39 Member States.

The school setting is an important environment for the promotion of physical activity among children and adolescents. Thirty-five countries reported having taken policy action on the mandatory inclusion of physical education in the curricula for primary- and secondary-schoolchildren. With regard to the promotion of active travel to schoolchildren, 18 countries reported having a clearly formulated programme in place. A total of 29 countries reported that physical activity had been promoted in teacher training and 25 countries that the provision of sport facilities and equipment to schools had been addressed.

The workplace is another relevant setting for increasing opportunities to engage in physical activity: 20 countries reported taking action to promote active travel to work; 6 countries had worked with a government subsidy scheme as an incentive for companies to support active travel; 15 countries reported taking action on the provision of facilities for physical activity at the workplace; and 6 countries had taken action to promote the use of stairs at the workplace.

Through active travel, for example cycling or walking, the transport setting also offers opportunities to increase physical activity. Thirty-two countries indicated having partly or fully implemented programmes to increase traffic safety for pedestrians and cyclists; 28 countries reported action to expand pedestrian zones (car-free zones) in cities; and 34 to expand cycle and walking lanes.

The built environment can either greatly encourage or act as a barrier to physical activity and active living. Adequate urban planning is, therefore, essential to the promotion of physical activity. Twenty-eight countries indicated having taken action to expand the number of green spaces and play areas in urban areas. The promotion of better urban design to provide safe and attractive structures for everyday physical activity, such as cycling and walking, was reported by 18 countries.

The health sector also has a significant role to play in the promotion of physical activity. Counselling on physical activity within primary health care had been undertaken in 26 countries and action to include physical activity in the training curricula of health professionals was reported by 23 countries.

Thirty-three countries reported having physical-activity guidelines in place, 18 that they were working with incentives (e.g. subsidy schemes) to increase access to recreational or exercise facilities and 5 that action was being taken to reduce time spent on television viewing.

Countries were also asked to report on the existence of a specific coordinating mechanism (working group, advisory body, coordinating institution, etc.) for the promotion of physical activity. Twenty-five countries reported having such mechanisms in place, involving governmental departments in the areas of health, sport, education, transport and urban planning, as well as NGOs, academia, civil society and the private sector.

Twenty-nine countries reported the existence of national programmes/campaigns to create public awareness of the importance of physical activity. Examples are “Get moving” (Denmark), “Healthy Israel 2020” and the “Move for Health Initiative” (Malta).

In conclusion, a considerable number of countries reported taking action to promote physical activity and active travel in schools, while action in relation to the work setting, the built environment and the health sector was reported less often. Additional information on implementation levels and mechanisms would be needed before the implementation of policy action to promote physical activity could be fully assessed.

WHO European Nutrition, Obesity and Physical Activity Database (NOPA)

The NOPA database contains four major sections.

1. Surveillance:
    - nutritional status (anthropometry and micronutrient status);
    - dietary habits (household food availability, per capita food supply, food consumption and nutrient intake at individual level);
    - physical activity and sedentary behaviour; and
    - awareness, knowledge, attitudes and other behaviours related to nutrition and physical activity.

2. National policies and actions:
    - policy documents on food and nutrition, physical activity promotion, and obesity; and
    - action to implement the policies (governmental programmes and policy instruments, legislation in the different areas of action, public–private partnerships and voluntary actions by stakeholders).

3. Good practices:
    - national, regional and local obesity-prevention programmes, projects, initiatives and interventions in different settings (e.g. school, work place, community, primary health care, hospital).

4. Action to meet key commitments:
    - implementation of action to meet key commitments contained in the *European Charter on Counteracting Obesity (3)*, the *EC White Paper on a strategy for Europe on nutrition, overweight and obesity related health issues (4)* and the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6)*.

Surveillance data are obtained from survey reports provided by the National Information Focal Points of the joint WHO/EC monitoring project and from existing databases, such as the Food and Agricultural Organization of the United Nations (FAO)[2] database (food balance sheets), the DAFNE databank[3] (household budget surveys) and related WHO global databases (WHO Vitamin and Mineral Nutrition Information System (VNMIS)[4], WHO Global Database on Body Mass Index[5], WHO Global Database on Child Growth and Malnutrition[6], and WHO Global Data Bank on Infant and Young Child

[2] Information available: http://faostat.fao.org/, accessed 24 November 2010.
[3] Information available: http://www.nut.uoa.gr/Dafnesoftweb/, accessed 24 November 2010.
[4] Information available: http://www.who.int/vmnis/database/en/, accessed 24 November 2010.
[5] Information available: http://apps.who.int/bmi/index.jsp, accessed 24 November 2010.
[6] Information available: http://www.who.int/nutgrowthdb/database/en/, accessed 24 November 2010.

Feeding[7]). Information on obesity prevention programmes is also obtained through the country reporting templates and through Internet searches. The first three sections of NOPA mentioned above are conducive to the development of the fourth section where indicators will show the status of action taken towards fulfilling key commitments.

Examples of possible search scenarios were presented to show how the NOPA database functions and how it can serve users' needs.

Feedback from the working groups on the NOPA database

In the afternoon of the first day, the participants split into three working groups: (1) to evaluate the data collected through the NOPA country reporting template (Group 1); and (2) to review the functionality of NOPA (e.g. search options and output mock-ups) and the possibilities it offers to the various actors in the fields of nutrition, physical activity and obesity (e.g. policy-makers, researchers and NGOs) (Groups 2 and 3). The following points emerged.

- A group should be established before the official launch of the NOPA database to test its design and outputs with the aim of tailoring it more to users' needs.
- After the launch, users should have the possibility of providing feedback.
- Links to original documents found in the database should be provided to give users the possibility of reviewing sources of information.
- The homepage could contain a map of the WHO European Region showing the availability of, for example, data relating to surveillance, policy documents and obesity-prevention programmes (relative to the sections and indicators in the database), as well as an option which would allow users to retrieve data related to the country of their choice.
- With regard to the proposed filter search, consideration should be given to having the option between an action-area filter and a country filter. Furthermore, when for instance the user chooses the option "nutrition", the next step should be for the user to indicate the area in which exploration should continue (surveillance, policy documents, policy implementation, interventions, WHO policy framework and/or EU policy framework).
- Not only ministries of health but also other relevant governmental sectors, such as those dealing with agriculture and the media, should be approached regarding the inclusion of their policy documents on healthy nutrition and/or the promotion of physical activity in NOPA.
- In addition to a standardized filter search, there should be the possibility of carrying out a free text field search.
- A search should not involve more than 5 clicks.
- With regard to the proposed filter options, the suggestion was made to add topics related to food supply, active transport, the built environment and environmental issues.
- With regard to health inequalities, it was emphasized that surveillance data should be disaggregated by various socioeconomic determinants (e.g. gender, income, education and occupation) or minority groups.
- Consideration should be given to including information on cost–benefit analyses related to the implementation of national policies and actions.
- A standardized citation should be introduced for use in connection with data/information retrieval.

[7] Information available: http://www.who.int/nutrition/databases/infantfeeding/en/index.html, accessed 24 November 2010.

- The need to keep the database updated was highlighted with a view to safeguarding its sustainability.

Country presentations on nutrition, physical activity and obesity

Switzerland

The Swiss Nutrition and Physical Activity Monitoring Programme (Monitoring-System Ernährung und Bewegung (MOSEB)) was set up in the autumn of 2007 and will continue until spring 2013. Intersectoral action is ensured through the active involvement of non-health departments, such as the Sport and Transport Department. "Action santé", an initiative of the Federal Office of Public Health, was launched under the umbrella of MOSEB and also falls under the *National diet and physical activity programme 2008–2012 (23)*. The initiative has three basic principles: action, openness and subsidiarity. Its basic objective is to improve the quality of life of individuals by enabling them to live in a health-promoting environment conducive to the adoption of healthy lifestyles that include sufficient physical activity and healthy diet. It contains four essential action areas: (1) consumer information; (2) marketing and advertising; (3) food composition; and (4) the promotion of an environment conducive to physical activity. The added value for participating institutions is the possibility to promote their image, use the logo of the initiative and participate in a large network. More than 100 representatives of institutions and companies dealing with nutrition and physical activity attended the first annual conference of the initiative in Bern on 9 November 2009. An external evaluation is planned for December 2011, leading to the publication in 2013 of a final report on good practices.

Germany

In Germany, the national IN FORM initiative aims to promote healthy diet and physical activity *(24)* and refers to the national action plan on the prevention of poor dietary habits, lack of physical activity, overweight and related diseases. It includes setting-based activities focusing on specific target groups (especially children and young people). The national action plan ensures cooperation and networking among policy-makers, the health-care system, civil society, business, the media and actors in the social field. Measures being taken by the Federal Ministry of Health at the time of the meeting included: the establishment, in each of the 16 regions, of centres that promote physical activity by providing an overview of the opportunities available and information about good practices; and the facilitation of networking among the actors. Coalitions for healthy lifestyles and settings have been formed with the aim of establishing structures conducive to the promotion of a healthy living environment for the population. Different pilot projects on, for example, low-threshold access, sedentary target groups and quality assurance, are also in place.

Hungary

As part of the Biennial Collaborative Agreement between WHO and the Hungarian Ministry of Health for 2008–2009, Hungary undertook a national survey of nutrition in schools in relation to the prevalence of childhood obesity in order to determine the objectives of a future food and nutrition action plan. The results of the survey, which involved 3133 primary and secondary schools, revealed that in many schools neither the circumstances surrounding meal-taking nor the quantity or quality of the food offered were in line with the national guidelines on healthy diet and nutrition. Free fruit and vegetables were provided by only 14% of the schools. In more than half of the schools, there was no access to free drinking-water apart from that available in the restrooms. On a more positive note, 70% of the school canteens sold fresh fruit and 90% of them sold mineral water. On the other hand, 75% of the school canteens still offered sugar-sweetened beverages and energy drinks were available in almost 25% of them. In addition, one third of the schools had vending machines but only 2% of these offered fruit.

The findings of the survey were reflected in the trend of childhood obesity. According to data resulting from representative research carried out in Budapest in 2005–2006, every fourth child aged 7–14 was overweight or obese. Based on the results of school health check-ups, the incidence of obesity had increased threefold over the last 10 years.

With the aim of improving children's knowledge about healthy diet and fluid intake, Hungary has implemented the Hungarian Aqua Promoting Programme in the Young (HAPPY), based on the hypothesis that the promotion of healthy-fluid intake in schools, combined with the availability of free mineral water in classrooms, would significantly decrease the consumption of soft drinks and increase the intake of mineral water among primary-school children. After 2 months, the study, which involved nearly 400 students, showed significant changes both in the level of the children's knowledge in this area and in their putting it into practice; these results were independent of social and economic factors. A follow up evaluation after a year confirmed the positive changes and indicated that they were permanent.

Based on the results of the national survey mentioned above and the HAPPY project, the following action was defined in the second national food and nutrition action plan (2009–2013):

1. to create healthy public catering;
2. to make healthy choices available;
3. to produce extensive consumer information; and
4. to carry out monitoring and evaluation.

Poland

A nationwide survey of dietary habits and nutritional status carried out in 2000 showed a 50% prevalence of overweight or obesity among the adult population and 12% prevalence among children. The burden of cardiovascular diseases is also high in Poland: in 2006, the standardized mortality rate for those aged 25–65 years was more than 70%. In 2007, as a response to this situation, Poland developed the national programme for the prevention of overweight, obesity and NCD through diet and improved physical activity 2007–2011 (POL-HEALTH).

POL-HEALTH was developed by the National Food and Nutrition Institute and approved by the Minister of Health. The programme is financed from the Ministry's budget for health programmes and its activities are aimed predominantly at increasing the awareness of society about the importance of healthy diet and physical activity through health promotion, and at educating and providing comprehensive information to consumers.

One of the programme's deliverables was the release in September 2008 of revised national recommendations on dietary intake, which were developed by the National Food and Nutrition Institute. These quantitative recommendations also included guidance on their actual implementation and on their use by the adult population. In the same year, the following were published: *Principles of proper nutrition and guidelines for children and adolescents on healthy lifestyle* (2008 – in Polish only); a document on school lunches (in Polish only), which takes good hygiene practices and the Hazard Analysis and Critical Control Point System into consideration; and national food-based dietary guidelines for school-aged children and adults. Food-based dietary guidelines for the older population are currently being developed.

The National Food and Nutrition Institute, in collaboration with the Polish Commission for the Control of Iodine Deficiency Disorders, prepared a position paper on undertaking initiatives aimed at reducing salt consumption. A consultation on this document was organized under the auspices of the Minister of Health on 8 September 2008 when consensus was reached among the relevant stakeholders. As a result, a salt-reduction programme was developed for 2009–2011 by the National Food and Nutrition Institute and incorporated as specific task in POL-HEALTH. One of the outcomes

of this programme was the publication of a report in 2009 presenting time trends in salt consumption by socioeconomic determinant. Furthermore, a questionnaire was developed for use in a survey on the quantity of salt used by food producers and caterers and an analytical examination was carried out of the salt content in selected food products and meals served in cafeterias and fast food-restaurants. In addition, efforts were strengthened to increase the awareness of consumers, food producers and caterers about the health risks associated with excessive salt intake.

The tasks planned for 2010 include: the publication of a practical manual on dietetics; the publication of recommendations for physicians and nurses on the diagnosis of eating disorders (brochure); the printing of additional copies of the leaflet on reducing salt consumption; activities to improve diet and physical activity among schoolchildren; monitoring of salt intake and salt content in foodstuff and meals; the implementation of the principles of healthy diet and dietary counselling in hospitals and in the primary and specialist health-care system; the promotion of the principles of healthy diet and physical activity among the general public.

Furthermore, the Ministry of Health started discussions with the National Food and Nutrition Institute on continuing POL-HEALTH for another five years and it is envisaged that monitoring diet and nutrition among a sample population (about 10 000 individuals) will take place in the near future.

The former Yugoslav Republic of Macedonia

NCD are accountable for the highest burden of disease in the former Yugoslav Republic of Macedonia. The obesity trend is particularly alarming in children and adolescents. As a response to the underlying risk factors of NCD, in 2002, the Ministry of Health established a national intersectoral committee for food and nutrition, followed by the first national action plan for food and nutrition (2004–2008). The second national action plan for food and nutrition was endorsed in 2009 and a new public health law was endorsed in early 2010.

The first action plan addressed the elimination of iodine deficiency disorders (IDD) and stipulated that all salt for use in households and the food industry should be iodized (20–30 mg of iodine per kg using only potassium). As a result, the incidence of goitre in schoolchildren fell from 18.7% in 1999 to 0.99% in 2007. In 2003, an international team of experts from the International Council for the Control of Iodine Deficiency Disorders, the United Nations Children Fund (UNICEF) and WHO carried out a thorough assessment of the universal salt iodization programme and its achievements with a very positive outcome. Studies on the iodine status of pregnant and lactating women conducted in 2006–2007 showed that the programme provided adequate iodine to these vulnerable groups.

Unfortunately, the rate of exclusive breastfeeding for the first 6 months of life dropped significantly from about 65% in 2001 to about 20% in 2008. The implementation of the Baby-Friendly Hospital Initiative has resulted to date in the certification of 28 (out of 31) maternity departments. Ninety per cent of all babies born each year are delivered in baby-friendly hospitals. Future efforts will involve strengthening community support for breastfeeding. Municipalities will establish committees for the protection of the rights of health services' users with the aim of improving citizens' knowledge about exclusive breastfeeding and helping them make informed decisions in this connection.

In 2007, the Government launched a campaign entitled "Health for All", offering free preventive health check-ups for people aged 20 and above. Check-ups include measuring for anthropometric data, cholesterol and glucose blood levels and blood pressure levels, as well as counselling on healthy diet and physical activity. Around 30 000 check-ups are carried out each year. The nutritional status and diet of elderly people living in hospices has also been evaluated, including biochemical lipid analyses and anthropometric and blood-pressure measurements.

In 2008, an evaluation was undertaken of the nutritional status and dietary habits of the Roma population in Skopje. Besides anthropometric data on the adult population, levels of glucose, cholesterol and blood pressure were also measured. For children aged 0–5 years, anthropometric and anaemia data were collected.

The second national action plan for food and nutrition is seen as a strong commitment to facilitating a more organized approach and as a guide for the authorities. It has been fully endorsed by the public health sector and is in line with the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6)*.

United Kingdom

In January 2009, "Change4Life", a social marketing component of England's response to tackling the rise in obesity, was launched. It is a social movement with a mission to encourage people to eat well, move more and live longer that works in close partnership with the health service, local government, businesses, civil society, schools, families and communities. Initially, the campaign focused on 5–11 year-olds but it was extended to cover the early years of life and adults aged 45–65. An evaluation of the programme after one year showed that nearly 400 000 families had signed up and that there was 99% brand recognition.

The campaign involved:

- advertising (television commercials, newspaper advertisements, roadside posters, etc.);
- sponsorship of the TV show, "The Simpsons";
- direct and relationship marketing (including a customer-relationship programme delivered both online and offline);
- digital communications (including a website, email marketing and online display advertising);
- partnership marketing (the creation and dissemination of messages and offers by Change4Life partners);
- communications aimed at stakeholders (health and teaching workforces);
- distribution of materials to health-care professionals and schools; and
- making brands and materials available to local authorities and health services to facilitate local marketing.

Regional developments

WHO European Childhood Obesity Surveillance Initiative

During the process leading to the Ministerial Conference on Counteracting Obesity *(2)*, it was recognized that there was a need for standardized and harmonized Europe-wide surveillance systems on which to base policy development within the European Region. Hence, the Regional Office established COSI, a European childhood-obesity surveillance system for monitoring policy response to the emerging obesity epidemic.

COSI was designed to fill the current gap in available comparable intercountry prevalence and trend data on the nutritional status of primary-school children in some countries of the WHO European Region. It targets primary-school children aged 6.0–9.9 years and draws nationally representative samples. Core measurements are body weight, body height and some school-related environmental characteristics. Optional measurements are waist and hip circumference, associated comorbidities, dietary intake and physical activity/inactivity patterns, as well as more detailed school-related environmental characteristics. Each participating country is free to develop a system that fits its local circumstances, although it is imperative that data are collected according to the common agreed protocol and that the stipulated core items are included.

The first round of data collection took place during the school year 2007–2008. Thirteen countries participated: Belgium (Flemish region), Bulgaria, Cyprus, Czech Republic, Ireland, Italy, Latvia, Lithuania, Malta, Norway, Portugal, Slovenia and Sweden. To date, four meetings have been convened with the principal investigators (the latest in Rome, Italy, in February 2010) with the aim of discussing drafts of the protocol, reviewing experience gained, challenges faced and lessons learnt during implementation, and discussing the data resulting from the first round and their use by national policy-makers. The second round will take place from autumn 2009 to autumn 2010 when 4 more countries have planned to join: Greece, Hungary, Spain and the former Yugoslav Republic of Macedonia.

Update on the European Salt Action Network

The European Salt Action Network (ESAN) was established following WHO recommendations to Member States contained in: *Reducing salt intake in populations. Report of a WHO forum and technical meeting, 5–7 October 2006*, *Paris, France (25)*; *World Health Assembly resolution WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strateg*y (2007) *(26)* and the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6)*.

To date, ESAN consists of 23 of the 53 Member States of the WHO European Region. Meetings of the Network are also attended by external experts, EC representatives and invited guest speakers. The only condition for a country to join is that it is working on salt reduction or planning to do so, and that its representatives are persons that either work for government or have been nominated by government. The working language at meetings is English.

ESAN's aims and objectives are to:

- establish, within the WHO European Region, a network of countries committed to reducing salt intake and building international action on salt reduction;
- provide opportunities for information exchange on the implementation of salt-reduction strategies, as well as on related activities and achievements;
- provide opportunities for information exchange on technological progress and developmental processes related to salt reduction; and
- develop guidance for Member States wishing to develop salt-reduction strategies and provide technical expertise on the different aspects of a salt-reduction strategy, such as setting salt targets, monitoring levels of salt intake and salt in products, and communicating with the public.

Update on European Member States action network on reducing marketing pressure on children

The marketing of unhealthy food to children is extensive and is having an impact. The growth of marketing activities in transition and developing countries is of special concern. National action to regulate marketing is inadequate on its own because of the cross-border nature of many marketing techniques. International collaboration and action are essential.

Both the *European Charter on Counteracting Obesity (3)* and the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6)* called for action on marketing within Europe. Globally, action on marketing was stipulated in the *Global strategy on diet, physical activity and health (27)* and in the *2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases (28)*.

The European Member States action network on reducing marketing pressure on children was set up in 2008 as a response to these calls for action. The long-term goal of the network is to protect children's health by sharing experiences and best practices with a view to identifying and implementing action, which will substantially reduce the extent and impact of all marketing to children of energy-dense, micronutrient-poor foods and beverages. The Norwegian Directorate of Health acts as the secretariat of the network, which is chaired by the Director General, Division of Public Health.

The objectives of the network for 2008–2010 are to:

- identify and demonstrate specific action to protect children against pressure from the marketing of energy-dense, micronutrient-poor foods and beverages;
- share experiences and best practices in monitoring exposure to marketing;
- discuss alternative approaches to regulation;
- discuss nutrient profiling as a tool in restricting the marketing of food and beverages;
- report to various international meetings (World Health Assembly and WHO European Regional Committee); and
- finalize revisions of the extended mandate and objectives for the period 2010–2012.

For the period 2010–2012, the network will continue to work on developing tools for monitoring marketing to children and on supporting the process of setting recommendations on the marketing of foods and non-alcoholic beverages to children *(29)*. It will also continue to provide support and assistance to member countries in implementing these recommendations.

To date, the network counts 18 participating countries: Belgium, Bulgaria, Cyprus, Denmark, Finland, France, Greece, Ireland, Israel, Latvia, Montenegro, the Netherlands, Norway, Portugal, Serbia, Slovenia, Sweden and the United Kingdom. Representatives of Consumer International, EC, FAO, the International Obesity Task Force, the United Nations Scientific Committee on Nutrition and WHO attend network meetings as observers. Since the network was set up, five meetings have been held and two working groups established (one on regulation content and one on monitoring).

The network has developed the European Network Code on Marketing of Food and Non-Alcoholic Beverages to Children *(30)*.

Launch of the 4th European Member States action network on the Nutrition-Friendly Schools Initiative

The Nutrition-Friendly Schools Initiative (NFSI) is based on the principle that common policy options are required if the increasing global public health problem of the double burden of malnutrition is to be addressed effectively. Developed originally as a follow-up to the WHO Expert Meeting on Childhood Obesity (Kobe, 20-24 June 2005), the NFSI provides a framework for implementing integrated intervention programmes to improve the health and nutritional status of school-age children and adolescents by targeting the school setting (including pre-schools, such as nurseries and kindergartens).

The main NFSI objectives are to:

- develop a nutrition-friendly school policy (objectives, actions, results, reward);
- develop an action plan identifying roles and responsibilities, as well as methods for monitoring and reporting;
- focus on capacity-building using a community approach (teachers, school staff, parents, schoolchildren and local community);

- ensure curriculum development (education on healthy nutrition and physical activity); and
- provide a supportive school environment (healthy foods and opportunities for physical activity).

Over the last few years, there has been a lot of interest in NFSI in the WHO European Region and the initiative has been pilot tested in several countries. In spring 2009, a first region-wide NFSI capacity-building course was organized jointly by the Regional Office and the Wolfson Research Unit of Durham University, United Kingdom. Representatives of 18 Member States participated in the course during which the suggestion was made to establish a Member States action network on NFSI to facilitate an exchange of experiences in implementation. The Dutch Ministry of Health kindly offered to lead this new action network. The following national and international partners will be involved:

- Ministry of Health, Welfare and Sports of the Netherlands together with the Ministry of Agriculture, Nature and Food Quality, Netherlands;
- WHO Regional Office for Europe;
- WHO Collaborating Centre for Nutrition, Durham University, United Kingdom; and
- WHO Collaborating Centre for School Health Promotion, The Netherlands Institute for Health Promotion, Netherlands.

The Netherlands has several programmes on improving nutrition and physical activity within the school setting, such as the Healthy School Canteen and Go for Health – an integrated programme for primary schools. Representatives of these programmes may be invited to participate in the first meeting of the action network, which is planned to take place in the Netherlands in autumn 2010.

European Union developments

In monitoring the implementation of the EC strategy for Europe on nutrition-, overweight- and obesity-related health issues, the main areas in focus relate to:

- health and consumer food safety (e.g. food labelling and health and nutrition claims);
- agricultural policy (e.g. in connection with school fruit and milk schemes and the Free Food for Europe's Poor programme);
- the information society perspective (*Audiovisual Media Services Directive (31)*);
- research projects on food, nutrition and health;
- education and culture (EC *White Paper on sport (32)* and *EU physical activity guidelines(33)*);
- commitments of the EU Platform for Action on Diet, Physical Activity and Health, for example, in the field of reformulation and marketing to children; and
- the priority of the EC High-level Group on Nutrition and Physical Activity to reduce salt intake in the population (*EU framework for national salt initiatives (34)*).

EC organized consultations on food labelling and health claims between 2003 and 2006 to review the existing rules on food labelling and between March and June 2006 on all aspects of food labelling. From December 2006 to July 2007, EC carried out an impact assessment of the proposed regulation on labelling, which it adopted on 30 January 2008 and submitted to the European Parliament and Council for a first reading by end May 2010. It was envisaged that the new regulation would be finally adopted by the end of 2011. A transition period of 4–5 years for adaption to the new rules was foreseen.

Twenty-three EU Member States participated in the EC school fruit scheme during the first period (2009–2010) and 25 Member States confirmed their involvement for the following period (2010–

2011). EC has provided financial support amounting to €90 million for the distribution of fruit and vegetables in schools in the EU on the principle of co-financing (a total of €157 million is required). As part of the school-milk scheme, 384 059 tons of milk and milk products were distributed to schools in 26 EU Member States during the period 2008–2009, expenditure for which amounted to €74.68 million. To support the school fruit and milk schemes, a campaign entitled "Tasty Bunch" was organized in 2009 to spread information about healthy eating. The campaign included web-based events and communication activities and 7 EU Member States organized local events reaching about 17 000 schoolchildren. The EC programme, "Free food for Europe's poor" was set up in 1987 and had a funding scheme of up to 500 million Euros in 2009. Nineteen of the 27 EU Member States participate in the programme, which is voluntary.

The new *Audiovisual Media Service Directive* adopted on 11 December 2007 is a legal framework covering all audiovisual media services, both traditional broadcasts and on-demand services. It obliges Member States and EC to encourage media-service providers to develop codes of conduct on the advertising of fatty foods to children and to monitor and assess the extent to which the Directive is being adhered to *(31)*.

In the first three calls of the Seventh EC framework programme for research and technological development (2007–2013), about €125 million were allocated for research on diabetes and obesity. The EC Directorate-General for Education and Culture adopted the *White Paper on Sport (32)* in July 2007 and released the *EU Physical Activity Guidelines (33)*, which were endorsed by the ministers for sports of the 27 EU Member States at the EU Sport Forum held in Biarritz, France, 26–27 November 2008 *(35)*.

The commitments made by the members of the EU Platform on Diet, Physical Activity and Health related, for example, to consumer information, education physical activity, marketing and advertising, and the composition of food. Progress towards fulfilling these commitments has been monitored annually since 2006. The last report will be published in May 2010.

The High-level Group on Nutrition and Physical Activity has set the reduction of salt intake in the population as a priority for the achievement of national or WHO recommendations. This is done through supporting and/or reinforcing national plans and through implementation of the *EU framework for national salt initiatives (34)* adopted by the Group on 1 July 2008, requiring Member States to introduce the monitoring of salt intake. Different public-awareness initiatives had been implemented by the end of 2009 and the first progress report was to hand at the end of that year. Most initiatives included awareness-raising, reformulation, monitoring, data collection and introducing benchmark for food categories as part of a broader programme. The Group also agreed to work on reformulation to reduce the content of saturated fat, trans-fatty acids and added sugars in foods.

Global developments

WHO evidence-based guidelines on nutrition development

The development of global guidelines to ensure the appropriate use of evidence represents one of the core functions of WHO. The Global Review Committee was established by the Director-General in 2007 to ensure that WHO guidelines are of high methodological quality and developed through a transparent, evidence-based decision-making process. In this context, the development of new and the updating of existing nutritional guidelines started in 2009.[8] The following areas are currently covered.

[8] Information available: http://www.who.int/nutrition/topics/evidence_informed_guidelines_NHD/en/index.html, accessed 17 November 2010.

- Micronutrients:
  - effects and safety of home (point-of-use) fortification with multiple micronutrient powders (MNPs) for infants and young children;
  - effects and safety of home (point-of-use) fortification with MNPs for pregnant women;
  - effects and safety of fortifying wheat with micronutrients as a public health intervention;
  - effects and safety of fortifying corn/maize flour with micronutrients as a public health intervention;
  - effects and safety of fortifying oil with micronutrients as a public health intervention;
  - effects and safety of fortifying sugar with micronutrients as a public health intervention;
  - effects and safety of fortifying condiments with micronutrients as a public health intervention;
  - effects and safety of fortifying salt with iodine;
  - effects and safety of iron supplementation for infants, young children and preschool children;
  - supplementation with iron alone or iron + folic acid for women of reproductive age;
  - iron interventions in malaria-endemic areas (food fortification, MNPs and supplementation);
  - calcium supplementation for women during pregnancy;
  - zinc supplementation for children to improve growth and other health outcomes;
  - fortification of foods with zinc to improve health outcomes in populations;
  - vitamin D supplementation for women during pregnancy;
  - vitamin D supplementation for patients under active TB treatment; and
  - multiple micronutrient supplementation for women during pregnancy.

- Diet and health:
  - effects of the level of total fat intake on obesity and other related NCD;
  - effects of sugar intake on health;
  - effects of salt/sodium intake on health;
  - WHO guidance on developing the framework of nutrient profiling;
  - waist circumference and waist–hip ratio as indicators for NCD risk assessment;
  - dietary goals for the prevention of diet-related NCD; and
  - carbohydrates in human nutrition.

- Nutrition in the life course and undernutrition:
  - nutritional care for adolescents (>14 years) and adults with the human immunodeficiency virus (HIV);
  - nutritional care and support for patients with tuberculosis;
  - framework on essential action related to complementary feeding;
  - essential nutrition-related action;
  - management of nutrition in major emergencies (update);
  - hospital-based management of severe malnutrition (update);
  - specifications on supplementary foods for the dietary management of moderate acute malnutrition;
  - management of moderate malnutrition (wasting); and
  - management of moderate malnutrition (stunting).

WHO advice on nutrition: e-library

WHO is currently developing a global e-library of evidence for nutrition-related action. Its goal is to provide comprehensive programme guidance and support to WHO Member States and their partners in the implementation of safe and effective nutritional interventions. Furthermore, it will become the single, exhaustive resource of the most current nutrition-related guidelines, for instance on micronutrient supplementation or fortification. The main topics of the database will be: NCD, undernutrition, maternal and child nutrition, HIV, tuberculosis and other communicable diseases,

micronutrients, growth and nutrition surveillance, emergencies and humanitarian crises, dietary advice, and agriculture and the environment.

WHO Nutrition Landscape Information System

The Nutrition Landscape Information System (NLIS) was developed as a component of the Landscape analysis on countries' readiness to accelerate action in nutrition with a view to facilitating the monitoring of country progress.[9] This web-based tool provides nutrition and nutrition-related health and development data in the form of automated country profiles and user-defined downloadable data.

NLIS draws data for the country profiles from available databases, such as those of the Demographic and Health Surveys, FAO, the International Food Policy Research Institute, the International Labour Organization, UNICEF, the United Nations Development Programme, the United Nations Statistics Division, The World Bank and WHO.

Data presented in the country profiles are intended to give a snapshot overview of a country's nutrition, health and development landscape at the national level. Key nutrition and nutrition-related indicators are organized around the following areas: child malnutrition (including low birth weight), maternal malnutrition, vitamin and mineral deficiencies, health services, food security, caring practices, commitment, capacity and meta-indicators, which describe general conditions and contextual factors that affect the impact of nutrition-related actions. The country profiles are printable in a two-page PDF format for use as advocacy tools. Selected indicators from the WHO nutrition global databases can be viewed and generated in an Excel spreadsheet for download.

A NLIS interpretation guide has been developed, covering all indicators in the country profile *(36)*. The following aspects are addressed for each indicator: what the indicator tells us; how it is defined; what the consequences/implications are, including cut-off values of public health significance where these have been established; and source(s) and further reading.

WHO Global Salt Initiative

As part of the implementation of the *WHO global strategy on diet, physical activity and health (27)* and the *2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases (28)*, the WHO headquarters' Department for Chronic Disease and Health Promotion will be establishing a series of three platforms.

The goal is to develop a framework for WHO Member States and other stakeholders for interventions to reduce population-wide salt intake and to investigate the role of salt as a vehicle for fortification with particular emphasis on low- and middle-income countries. The platforms will comprise experts from academia, the private sector, professional associations, NGOs, other United Nations agencies and interested Member States.

The main objectives of the platforms will be to discuss:

1. how to create an enabling environment to help consumers make the necessary behavioural change through:
    - consumer education; and
    - reformulation of foods;
2. how to evaluate and monitor dietary-salt intake through:
    - updated sodium consumption data; and
    - updated food-composition tables;

[9] Information available: http://apps.who.int/nutrition/landscape_analysis/en/index.html, accessed 24 November 2010.

3. the role of fortified salt in the prevention of IDD by:
    - dispelling misconceptions about how the two strategies (salt reduction and iodine fortification) can efficiently and effectively work together; and
    - identifying strategies on preventing IDD and potential barriers to doing so to ensure that the *WHO global strategy on diet, physical activity and health (27)* and the *2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases (28)* can be run in parallel and with equal success.

The conclusions of the platforms will be used by the WHO Secretariat in developing a framework for the reduction of salt intake in the population and in defining applicable levels of salt for use in fortification.

This work will also support that of the three regional networks that have been established in recent years. ESAN, which is led by the United Kingdom, has looked at strategies for the reduction of salt in specific foods as well as strategies for monitoring and evaluating salt consumption in the population. The network in the Americas has focused so far on collating the most effective salt-reduction strategies, as well as on mapping the way forward. On the other hand, the network in the Western Pacific has committed to identifying the countries that have started working in the area of salt reduction and to sharing success stories that can be used as models by other countries in the region to reduce salt intake in the population.

Infant and young child nutrition

On the basis of the quadrennial progress report on infant and young child nutrition *(37)*, which was submitted to the 126th session of the Executive Board in January 2010, the latter recommended a resolution on infant and young child nutrition for adoption by the World Health Assembly at its 63rd session in May 2010 *(38)*.

The quadrennial progress report *(37)* provides information on the implementation of the *Global strategy for infant and young child feeding (39)*, the status of national measures taken in relation to *the International code of marketing of breast-milk substitutes (40)*, complementary foods, the 2006 WHO child growth standards[10] and types of malnutrition and childhood obesity.

National strategies and action plans have been developed worldwide and the *Global strategy for infant and young child feeding (39)* has been integrated in strategies for child survival, child nutrition and newborn survival.

An overview of the implementation of the *International code of marketing of breast-milk substitutes (40)* is in the process of being finalized and six action areas have been identified: advocacy, operational research, training, technical assistance in policy development, technical assistance in legislative reform, and monitoring.

Priorities for scaling up action to improve infant and young-child feeding were discussed at a meeting convened by UNICEF and WHO in 2008 *(41)*, including the effectiveness of locally produced fortified foods, micronutrients powders and lipid-based nutritional supplements in improving micronutrient status. Recommendations on the marketing of complementary foods were being studied and tools to help identify recommended low-cost balanced complementary diets were being developed.

The WHO child growth standards have, so far, been officially adopted by more than 100 countries and, currently, a nutrition surveillance system to monitor the double burden of malnutrition is under

[10] Information available: http://www.who.int/childgrowth/en/index.html, accessed 24 November 2010.

development. The system will use the growth standards in defining the physical status of children under five and the 2007 WHO growth references for school-aged children and adolescents.[11]

The quadrennial progress report *(37)* addressed moderate and severe malnutrition in a statement on the community-based management of severe acute malnutrition. With regard to childhood obesity, a rapid rise in the number of children in this category worldwide was highlighted. WHO was providing Member States with technical assistance with a view to mapping the extent of the global epidemic.

As a result of a global review of nutrition policy carried out by WHO in 2009, Member States were asked to report on the development of national policies and strategies on nutrition and to provide information about practices, policies and programmes related to infant and young-child nutrition, the *International code of marketing of breast-milk substitutes (40)*, nutrition in schools, vitamins and minerals, obesity and diet-related NCD, food security and agriculture. Twenty-three countries of the WHO European Region had completed the questionnaire.

Recommendations on the marketing of foods and non-alcoholic beverages to children

Through resolution WHA60.23 (May 2007) *(26)*, WHO was given the mandate to develop a set of recommendations on the marketing of foods and non-alcoholic beverages to children with the aim of reducing the impact of foods high in saturated fats, trans-fatty acids, free sugars or salt, in dialogue with all relevant stakeholders. An ad-hoc expert group on marketing foods and non-alcoholic beverages to children was appointed by the Director-General to support WHO in drafting the recommendations.

WHO held two dialogues in response to resolution WHA60.23 (May 2007) *(26)*, one with civil society *(42)* and one with private stakeholders *(43)*, which enabled the participants to report on work being carried out by their organizations in this area. Reports on these dialogues *(42, 43)* were presented to the Ad hoc expert group on marketing foods and non-alcoholic beverages to children.

WHO developed a working paper for presentation during regional consultations with Member States (face-to-face and/or written) between June and August 2009 on the development of a set of recommendations on the marketing of foods and non-alcoholic beverages to children. The paper synthesized the evidence in this area and included specific questions to guide the consultation process. The aim was to obtain the input of Member States on the policy objectives, policy options and monitoring and evaluation mechanisms presented in the paper. Sixty-six Member States provided input to the consultation process whereby some requested technical support in connection with policy development and monitoring and evaluation. Concerns were related to cross-border marketing and marketing in schools.

The regional consultations resulted in the *Set of recommendations on the marketing of foods and non-alcoholic beverages to children (29)*, which were presented to the Executive Board at its 126th session in January 2010.

Sustaining the elimination of iodine deficiency disorders

WHA resolutions, WHA 45.33 *(44)*, WHA 58.24 *(45)* and WHA 60.21 *(46)*, urge Member States, as part of their health and nutrition monitoring systems, to establish a micronutrient monitoring and evaluation system capable of assessing the magnitude and distribution of vitamin A, iron deficiency anaemia and IDD and of monitoring the implementation and impact of related control programmes.

[11] Information available http://www.who.int/growthref/en/, accessed 24 November 2010.

Iodine status in school-aged children is measured through iodine excretion. Within the period 2004–2008, only 37 of the 193 WHO Member States submitted national data on urinary iodine concentrations for school-aged children, covering 36.3% of the world's school-aged population. The data showed that, of the 37 countries, 9 had a prevalence of low iodine status considered to be of public health significance, 17 had iodine intakes that were adequate, 8 had iodine intakes that were excessive and 3 had a documented an increased risk of thyroid disorders in susceptible groups. It was reported that it remains difficult to generate a global estimate of iodine deficiency based on national data alone; more data on women of reproductive age need to be generated as this group is an important target of public health programmes.

The strategy for IDD control continues to be universal salt iodization because the concentration of iodine in salt can easily be adjusted to meet the requirements of policies aimed at reducing human consumption of salt. Iodine supplementation is recommended for susceptible groups, such as pregnant women and young children living in high-risk communities who are unlikely to have access to iodized salt or as a temporary strategy when salt iodization has not been successfully implemented.

The use of salt as a vehicle of fortification came from an expert consultation held in 2007 when it was concluded that policies related to salt iodization to eliminate IDD could be harmonized with those for the reduction of salt consumption aimed at the prevention of cardiovascular diseases *(47)*.

A meeting will be organized in December 2010 to discuss possible methods of generating regional and global estimates of IDD and other vitamin and mineral deficiencies, especially in situations where country data are lacking.

The Network for Sustained Elimination of Iodine Deficiency supports national efforts to accelerate the elimination of IDD.[12] The Network has drawn up a communication plan to alert decision-makers and public health authorities to the importance of iodine deficiency.

WHO Regional Office for Europe nutrition activities and initiatives in 2009 and workplan for 2010–2011

The WHO Regional Office for Europe provides technical support to Member States upon request in connection with developing and implementing national policies and strategies, strengthening surveillance systems, sharing experiences, building capacity, developing tools to support implementation and promoting networking and partnerships. In this context, the importance was stressed of linking with the international policy frameworks of WHO and EU for monitoring progress.

More information was needed on how national policies have been and will be implemented. In this connection, special attention should be paid to how the disadvantaged and low socioeconomic groups are addressed in these policies.

The WHO Member States action networks on COSI and NFSI, as well as ESAN, the Marketing Network, the Action Network on Nutrition and Inequalities and the Hospital Nutrition Action Network are examples of tools used by the Regional Office to support Member States in networking and sharing experiences.

Work in the countries is arranged through biennial collaborative agreements between the countries' ministers of health and the WHO Regional Director for Europe where the focus is on policy development and implementation, improving national surveillance and capacity building.

[12] Information available: http://www.iodinenetwork.net/About.htm, accessed 24 November 2010.

The vision for the WHO European Nutrition, Physical Activity and Obesity Programme is to streamline action in the European Region towards reducing health inequalities related to nutrition, physical activity and obesity.

Conclusions

The meeting provided the countries with an excellent opportunity to share their experiences in implementing the joint WHO/EC project on monitoring progress in improving nutrition and physical activity and preventing obesity in the EU. The countries reiterated their commitment to cooperating on the project.

The results achieved through completion of the country reporting templates highlighted that survey data had been identified for the majority of the countries, although the surveys had not always been conducted using standardized tools, making comparability of the data a challenge.

A considerable increase was noted in the availability of policy documents on nutrition, physical activity or obesity, but challenges had been faced in validating information received on policy implementation.

Member States asked for more WHO guidance on fortification and supplementation.

Member States stressed the need for future support from and collaboration between EC and the WHO Regional Office for Europe in connection with continuing to monitoring their activities in the field of nutrition, physical activity and obesity prevention.

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Annexes

Annex 1. Programme

Wednesday, 24 March 2010	
09.00 – 09.30	**Opening** • Swiss Federal Office of Public Health *(Mrs Andrea Arz de Falco)* • WHO Regional Office for Europe *(Dr João Breda)* • European Commission *(Mr Philippe Roux)* • WHO headquarters *(Dr Juan-Pablo Peña-Rosas)*
09.30 – 10.00	**WHO/EC project on monitoring progress on improving nutrition and physical activity and preventing obesity** • Introduction on behalf of the WHO Regional Office for Europe *(Ms Trudy Wijnhoven)* • Introduction on behalf of the EC Directorate-General for Health and Consumers *(Mr Philippe Roux)*
10.00 – 10.45	**Results of country reporting templates completed by WHO European Member States** ***Overview of current available surveys and data*** • Nutritional status, food availability and nutrient intake *(Ms Trudy Wijnhoven)* • Physical activity *(Ms Lideke Middelbeek)*
11.15 – 12.30	**Results of country reporting templates completed by WHO European Member States** ***Information on policy development*** • Food and nutrition policies *(Ms Caroline Bollars)* • Physical activity promotion policies *(Ms Lideke Middelbeek)* ***Information on policy implementation*** • Nutrition-related policy actions and instruments *(Ms Caroline Bollars)* • Physical activity -related policy actions and instruments *(Ms Lideke Middelbeek)*
12.30 – 13.00	**Discussion on the results of the country reporting templates**
14.00 – 14.30	**European Database on Nutrition, Obesity and Physical Activity (NOPA)** • Presentation of the database *(Ms Trudy Wijnhoven)* • Discussion
14.30 – 14.40	**Introduction to working group sessions** *(Ms Trudy Wijnhoven)*

14.40 – 15.45 and 16.00 – 16.45	**Working group sessions** • Group 1: data validation by EU Member States *(National Information Focal Points, WHO Nutrition Counterparts and Members of the EC High Level Group on Nutrition and Physical Activity)* • Groups 2 and 3: evaluation of NOPA database outputs (regional and country profiles) *(participants not involved in Group 1)*
16.45 – 17.15	**Feedback from working groups 2 and 3 on the evaluation of NOPA database outputs** • Group 2 *(Group Rapporteur)* • Group 3 *(Group Rapporteur)* • Discussion
17.15 – 17.45	**Time line for progress reports 2010** • WHO Regional Office for Europe *(Ms Trudy Wijnhoven)* • EC Directorate-General for Health and Consumers *(Mr Philippe Roux)* • Discussion

Thursday, 25 March 2010

09.00 – 09.30	**Nutrition policy in Switzerland** • Developments in Switzerland since previous WHO nutrition counterparts' meeting (September 2008) *(Dr Awilo Ochieng Pernet)* • Discussion
09.30 – 10.30 and 11.00 – 12.00	**Country presentations on developments since previous WHO nutrition counterparts' meeting (September 2008)** • Hungary *(Dr Eva Martos)* • Germany *(Dr Ute Winkler)* • United Kingdom *(Dr Sheela Reddy)* • Poland *(Dr Wlodzimierz Sekula)* • The former Yugoslav Republic of Macedonia *(Professor Vladimir Kendrovski)* • Discussion
12.00 – 13.00	**Regional developments** • Results of the first round of the WHO European Childhood Obesity Surveillance Initiative *(Ms Trudy Wijnhoven)* • Update on European Member States action network on reducing salt intake in the population *(Ms Alette Addison)* • Update on European Member States action network on reducing marketing pressure on children *(Ms Arnhild Haga Rimestad)* • Launch of the 4th European Member States action network on the Nutrition-Friendly Schools Initiative *(Mr Tjerk Halbertsma)* • Discussion
14.00 – 14.30	**European Union developments** • EC nutrition initiatives and developments *(Mr Philippe Roux)* • Discussion

14.30 – 15.45 and 16.15 – 17.15	**Global developments** • WHO evidence-based guidelines on nutrition development *(Dr Juan-Pablo Peña-Rosas)* • WHO provision of scientific advice in nutrition: e-library *(Dr Juan-Pablo Peña-Rosas)* • WHO Nutrition Landscape Information System *(Ms Ann-Beth Møller)* • WHO Global Salt Initiative *(Dr Godfrey Xuereb)* • Discussion • World Health Assembly – infant and young child nutrition *(Dr Maria del Carmen Casanovas)* • World Health Assembly – Set of recommendations on the marketing of foods and non-alcoholic beverages to children *(Dr Godfrey Xuereb)* • World Health Assembly – Sustaining the elimination of iodine deficiency disorders *(Dr Juan-Pablo Peña-Rosas)* • Discussion
17.15 – 17.30	**WHO Regional Office for Europe nutrition activities and initiatives in 2009 and work plan for 2010–2011** • Presentation *(Dr João Breda)* • Discussion
17.30 – 17.45	**Recommendations and conclusions** ▪ Presentation by Rapporteur *(Ms Ursula O'Dwyer)*
17.45 – 17.50	**Introduction to Capacity-building Day** *(Ms Trudy Wijnhoven)*
17.50	**Closure of plenary meeting**
Friday, 26 March 2010	
08.45 – 18.00	**Capacity-building Day** For Nutrition Counterparts, National Information Focal Points and invited facilitators

Annex 2. Participants

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Annex 3. Policy action for implementation of the WHO European Action Plan for Food and Nutrition Policy 2007–2012

By means of the country reporting template of the WHO/EC project on monitoring progress on improving nutrition and physical activity and preventing obesity in the EU (2008–2010), countries were asked to indicate the status of implementation (i.e. fully, partly or not implemented) of 56 policy actions, which were classified within the six action areas of the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (6).*

Action area 1. Supporting a healthy start

1. Provision of nutrition counselling for pregnant women
2. Provision of micronutrient supplementation for pregnant and lactating women (if required)
3. Implementation of the Baby -friendly Hospital Initiative
4. Promotion of breastfeeding
5. Implementation of the International code of marketing breast milk substitutes
6. Promotion of breastfeeding breaks at the workplace
7. Promotion of nutrition school policy
8. Mandatory inclusion of nutrition education in the curricula for primary and secondary schools
9. Provision of teacher training in promoting healthy nutrition
10. Removal of energy-dense nutrient-poor foods and beverages from school vending machines
11. Provision of free or subsidized school fruit and vegetable schemes
12. Provision of free or subsidized school milk schemes
13. Provision of free or subsidized school meals
14. Provision of nutrition training for school staff (other than teachers)
15. Promotion of school policy on physical activity
16. Mandatory inclusion of physical education in the curricula for primary and secondary schools
17. Provision of teacher training in promoting physical activity
18. Promotion of active travel
19. Provision of sport facilities and equipment to schools

Action area 2. Ensuring a safe, healthy and sustainable food supply

20. Introduction of incentives to increase the production of fruits and vegetables
21. Promotion of horticulture in urban settings
22. Improvement of food availability at the local level through regulation of location and size of food outlets
23. Introduction of initiatives to reduce salt content in processed foods
24. Introduction of initiatives to increase the availability of processed foods with reduced content of total fat and/or added sugars
25. Ensuring healthy food choices at the workplace
26. Promotion of healthy meal options in private catering services
27. Development of guidelines on the advertising, promotion and marketing of food products for use at point of sale
28. Introduction of measures for the regulation of food prices (e.g. taxes on soft drinks, chocolate and confectionary) and/or incentives to increase the consumption of fruits and vegetables)
29. Introduction of schemes to increase access to recreational or exercise facilities (e.g. subsidity schemes)
30. Introduction of schemes for food support or the distribution of healthy food commodities (for example. to single mothers or deprived families)

Action area 3. Providing comprehensive information and education to consumers

31. Development of national Food Based Dietary Guidelines
32. Development of national physical activity guidelines
33. Reduction of salt intake
34. Promotion of the use of iodized salt
35. Introduction of regulations on marketing unhealthy foods and non-alcoholic beverages to children
36. Introduction of legislation requiring labelling of foods with nutritional information, such as ingredients and corresponding energy intake
37. Introduction of signposting on food products[13]

Action area 4. Taking integrated action to address related determinants

38. Promotion of active travel (walking or cycling) to work
39. Introduction of government subsidy schemes to encourage companies to support active travel
40. Establishment of programmes to increase traffic safety for pedestrians and cyclists
41. Expansion of pedestrian zones (car-free zones) in cities
42. Expansion of green spaces and play areas in urban areas
43. Expansion of cycle and walking lanes
44. Promotion of better urban design to provide safe and attractive structures for everyday physical activity (for example, through Healthy Urban Planning)
45. Promotion of stair use at the workplace
46. Reduction of television viewing
47. Provision of facilities for physical activity at the work place (e.g. gym, basketball court, field, etc.)

Action area 5. Strengthening nutrition and food safety in the health sector

48. Ensuring the availability of low-cost or free nutrition counselling in primary health care
49. Ensuring the availability of physical activity counselling in primary health care
50. Inclusion of nutrition in the curricula for health professionals' training
51. Inclusion of physical activity in the curricula of health professionals' training
52. Introduction of clinical guidelines on the assessment and treatment of obesity
53. Promotion of quality nutrition for the elderly
54. Introduction of risk screening for undernutrition in all in-patient facilities

Action area 6. Monitoring, evaluation and research

55. Monitoring of individual growth in pre-school children (0-5 yrs)
56. Monitoring of individual growth in school-aged children

[13] Labels containing brief information about nutritional content (e.g. traffic-light schemes).