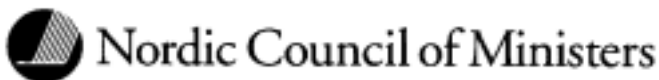




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Nordic Council of Ministers

EUR/02/5041542
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DEVELOPMENT OF FOOD AND NUTRITION ACTION PLANS IN THE BALTIC COUNTRIES

Report on a Third Workshop
Parnu, Estonia, 10-12 June 2002

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2002

ABSTRACT

The first consultation on development of food and nutrition action plans in the Baltic countries took place in Riga in August 2000. A second consultation provided the opportunity for the Baltic countries to present draft food and nutrition action plans, discuss and receive advice on the way forward. Participants at this third consultation were able to present final food and nutrition action plans and present their strategies for implementation. A plan and timeframe to set up a Baltic/Nordic nutrition network was approved. The 38 participants came from eight countries (see Annex 3) and represented the health, welfare, environment and agriculture sectors. This show of interest and commitment across sectors demonstrates that the vital cross-sectoral links between nutrition, food safety and social concerns are being recognised and acted upon by policy makers.

Keywords

NUTRITION POLICY
PROGRAM DEVELOPMENT
STRATEGIC PLANNING
REGIONAL HEALTH PLANNING
BALTIC STATES

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WHO Regional Office for Europe, Copenhagen

Acknowledgements

This workshop was generously supported by the Nordic Council of Ministers. The excellent organization and arrangements for the workshop were due to Sirje Vaask, Nutrition Counterpart for Estonia and Piret Laur, WHO Liaison Officer for Estonia. Many thanks are also due to Dr Arnold Timmer (UNICEF), Dr Karen Lock (London School of Hygiene and Tropical Medicine, United Kingdom), Dr Lars Ovesen (Veterinary and Food Administration, Denmark) and Liisa Valsta (National Public Health Institute, Finland) for their participation and presentations. Dr Laufey Steingrimsdottir, Dr Lars Ovesen and Dr Iveta Pudule are thanked for chairing the meeting.

Ms Eva-May Ohlander is sincerely thanked for her enthusiasm and initiative in leading the process of developing a Baltic-Nordic Public Health Nutrition Network.

Finally, the enthusiastic participation of all the professionals from Estonia, Latvia, Lithuania, Denmark, Finland, Iceland, Norway, and Sweden who attended the consultation is greatly appreciated.



Participants at the Third workshop on development of food and nutrition action plans in the Baltic countries, Parnu, 10-12 June 2002.

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1. Foreword

This report summarizes the proceedings of a Baltic-Nordic consultation, held in June 2002 at Hotel Strand, Pärnu, Estonia. It was jointly organized by the WHO Regional Office for Europe (the Nutrition and Food Security Programme) and the Nordic Council of Ministers. Arrangements at the course site were coordinated by Sirje Vaask, Nutrition Counterpart for Estonia and Piret Laur, WHO Liaison Officer for Estonia.

The purpose of the consultation was to hear about and document the Baltic countries' progress in finalizing their food and nutrition action plans. This consultation was a follow-up to the previous two consultations (held in Latvia 2000 and 2001) on intersectoral development of food and nutrition policies.

The purpose of bringing together countries of the Baltic region and their Nordic neighbours in this initiative was to:

- build on natural advantages and the geo-economic position of the Nordic/Baltic region in relation to food and nutrition policy;
- promote sustainable development in the Nordic/Baltic region as well as regional cohesion through development of food and nutrition policies and action plans;
- improve skills needed to develop intersectoral policies in relation to food and nutrition; and
- establish a Nordic/Baltic Public Health Nutrition Network.

The 33 participants came from eight countries and represented the health, welfare, environment and agriculture sectors. This show of interest and commitment across sectors demonstrates that the vital cross-sectoral links between nutrition, food safety and social concerns are being recognised and acted upon by policy makers.

Dr Aileen Robertson
Regional Adviser for Nutrition
WHO Regional Office for Europe
Copenhagen

2. Opening

Dr Aileen Robertson, WHO Regional Office for Europe

Dr Robertson welcomed the participants to the third consultation and extended special thanks to the Nordic Council and Ms Eva May Ohlander for their generous support of the workshop.

Dr Robertson emphasised the importance of the unanimous endorsement of the First Food and Nutrition Action Plan by member states of the European Region at the September 2000 WHO Regional Committee for Europe meeting. She concluded her welcome by saying how much she looked forward to hearing the Baltic country presentations on the development of their Food and Nutrition Action Plans.

3. Country presentations

Estonia

Sirje Vaask

1. Time frame

The process of developing the action plan started in November 2000, when the committee agreed on objective and contents of the action plan. In May 2001 the draft action plan was sent for the comments to different ministries and institutions. The first Estonian Nutrition Forum was held in 14th November, 2001. The 142 participants, attending the Forum agreed with the action plan. In December 2001 final comments were received for the action plan and in March 2002 the plans, entitled "Healthy Nutrition Action Plan of Estonia" was printed and disseminated. The plan is available through the Internet (in Estonian and English).

2. Collaboration

The Healthy Nutrition Action plan has a working group made up of the following experts: Sirje Vaask (Ministry of Social Affairs), Raivo Vokk (Food Processing Institute of Tallinn Technical University), Sirje Kuusik (expert on local food SK Arendus OÜ), Katrin Puhm, Katrin Lõhmus, Haidi Kanamäe (Ministry of Agriculture), Marje Josing (Estonian Institute of Market Research), Helle Aruniit (Consumer Protection Board), Piret Laur (WHO Liaison officer of Estonia), Mai Maser (Estonian Health Education and Health Promotion Center), Julia Deikina (Health Protection Inspectorate), Anneli Zirkel (Tartu County Government), Külli Mitt (Tartu University Hospital, the Estonian Association of Paediatricians), Margus Viigimaa (Tartu University Hospital, Estonian Union of Hypertension), Maire Sirel (Estonian Heart Association).

The main experts who contributed to the draft action plan were: Sirje Vaask, Raivo Vokk, Sirje Kuusik, Katrin Puhm, Marje Josing, Mai Maser and Külli Mitt.

Local meetings were held in 14. November 2000, 22 February, 27 March and 18. April 2001. The "Healthy Nutrition Action Plan" was corrected by Sirje Mäearu, Institute of Estonian Language and translated into English by Signe Joasoo, WHO Estonian Office. Comments on the "Healthy Nutrition Action Plan" (additional written comments to the working group) were received from Kaie Pappel, Tallinn Pedagogical University, Department of Chemistry (12.10.2001), Margus Viigimaa from Tartu University Hospital and the Estonian Union of Hypertension (30.05.2001), Maire Sirel from the Estonian Heart Association (22.08.2001), Haidi Kanamäe from the Ministry of Agriculture (07.10.2001), Tiina Veisserik from the Estonian Union of Food Processing Industry (31.08.2001), Tiiu Liebert from the Food Processing Institute of Tallinn Technical University (05.10.2001), Liidia Kiisk, dietologist from the Tartu University Hospital (25.10.2001), Lars Johansson from the Council of Nutrition and Physical Activity of Norway (23.10.2001), Merileid Saava from the Estonian Institute of Cardiology (14.11.2001), Oja Ahto from the Estonian Institute of Sustainable Development (14.11.2001) and from Pitsi Tagli from the Food Processing Institute of Tallinn Technical University (14.11.2001).

3. Structure of the Action Plan

The Nutrition Action Plan contains a nutritional situation analysis of the previous five years (1996-2000) and a description of healthy nutrition promotion.

The problems, objectives and necessary activities for the next five years (2002-2007) have been given on six components of healthy nutrition: food and nutrition research and information; accessibility of food; local food for local consumption; food safety; nutrition of population groups; diseases and nutrition.

4. National endorsement

The Estonian Health Policy was introduced at the Estonian Health Forum, held 4th April 2002. The Healthy Nutrition Action Plan is one of the sub-documents of this policy.

The Estonian Nutrition Society has analysed the implementation and financing of the planned actions included in the "Healthy Nutrition Action Plan" and there will be discussions for those actions not already covered.

Latvia

Velga Braznevisa

Development of national food and nutrition action plan in latvia

1. Time Frame

III 2000	Establishment of the Advisory Board of nutrition experts
IX 2000	First WHO workshop on development of action plan for Baltic countries held in Sigulda
II 2001	Letter to MoW substantiating necessity of development a National Food and Nutrition Action Plan (here and hereafter referred to as FNAP) for Latvia
III 2001	The Public Health Strategy was approved by the Cabinet of Ministers. Target 11 "A healthy lifestyle" includes development of FNAP
VI 2001	Conference (forum) of Latvian experts for development of FNAP
VI 2001	Second WHO workshop on development of action plan for Baltic countries was held in Sigulda
XI 2001	Confirmation of FNAP by Advisory Board. Submission to MoW
XI 2001	Translation of FNAP into English
II 2002	Consignment of draft of FNAP to foreign experts
IV 2002	The final amendments in FNAP
IV 2002	Meeting of State Secretaries, FNAP approved as a concept of Cabinet of Ministers (Protocol nr. 18 of 25.04.2002, paragraph 28).

At the present time the FNAP is at the inter-ministerial coordination on the way to Cabinet of Ministers.

2. Collaboration

Regular members of the Council of nutrition experts (Regular meetings of the Council are held):

1. Association of Diet Doctors – A. Bremanis , Dr.
2. Riga Stradina University / Medical Academy of Latvia
 - Faculty of Pediatrics – I. Ranka, as.prof.
 - Faculty of Trade and Environment – B. Aulika, Dr.med.

- Nutrition Laboratory –Z. Zarins, Dr.med., A. Tupins, Dr.
- 3. Ministry of Agriculture
 - Veterinarian and Food Department – I. Svike
 - Agriculture Development Department - L. Drozdovska
- 4. Latvia University of Agriculture, Faculty of Food Technology – D. Karklina, Dr.ing.sc
- 5. Health Promotion Centre – I. Pudule
- 6. Latvian Food Center – O.Stengrevics, Dr.biol., L. Neimane, Dr, G. Selga, Dr.med., R. Berzina – Berzite, Dr.biol.

Invited experts:

1. Ministry of Welfare
 - Public Health Department
 - Health Department
2. Ministry of Agriculture
3. Ministry of Education and Science
4. Centre of Cardiology – A. Dzerve
5. Centre of Gastroenterology of Stradina Clinical Hospital – J. Pokrotnieks, Dr.med.
6. Head of Cancer Register Latvia - A. Stengrevics
7. Western Michigan University, Department of Family & Consumer Sciences – M. Petersons, Ph.D

3. Structure of the action plan

“Healthy nutrition” – concept of the Cabinet of Ministers

Part I Political and Socio-economic Basis

Part II Summary of the Problem

Description of the Present Situation

Factors delaying development

Prevention of delaying factors

Recommendations for development

Action plan “Healthy nutrition for Latvia. 2002 – 2007”

Projects for achieving 11 targets:

A Plan of Action to educate the public on matters of healthy nutrition, emphasizing reduction of the total fat intake, balanced proportion of oleic acids in food intake, increased production and consumption of vegetables, legumes, fruits and berries.

1. Establish a Nutrition Council
2. Draw up a unified information system and compile and analyse food consumption, anthropometric, biochemical and health indicators thereunder
3. Promote breast feeding
4. Implement a healthy nutrition action plan, taking into consideration the special needs of risk groups, in order to reduce inequality of nutrition and thus reduce the differences in spreading of food nutrition related diseases
5. Preparation and implementation of a training programme for healthy nutrition for schools, teachers, health care staff, food technologists, food sales specialists, physical education teachers and coaches etc.
6. Aligning the catering system of pre-school education facilities, schools, health care, social assistance and other similar institutions, including closed type such as colonies, prisons etc.

7. Draw up a scientifically based action plan to determine the status of deficiencies of certain minerals and vitamins and prevention of these
8. Continue to implement the basic principles of food safety strategy in Latvia in accordance with Latvian and EU normative acts. Establish a system of co-operation between the food monitoring service and public health institutions. Continue to introduce EU and other normative acts.
9. Establish a system of normative acts for a sustainable environment friendly and safe agriculture. Draw up a strategy for the development of biological agriculture. Organize a system of subsidies to ensure the development of a sustainable environment friendly agriculture
10. Improve the information system for public education in matters of healthy nutrition, food hygiene and physical activity

4. National endorsement and future steps

The FNAP has been accepted at governmental level as a concept of the Cabinet of Ministers “Healthy nutrition” and Plan of Action “Healthy nutrition for Latvia 2002-2007”.

The Latvian Food Center coordinates the process of implementation of FNAP as well as preparation of regulatory documents necessary for nutritional policy development and its implementation.

Within FNAP the following activities are realized:

1. The tasks and functions of Latvian Food Centre are named in the Decision of Government on 20 April 2001 and changes in “Law on Supervision of Food Circulation” (amendments, 13 December 2001). The tasks are revised, changed and increased, including the new task: “...elaboration, co-ordination of enforcement of FNAP, elaboration programme and co-ordination of elimination of nutrient deficiencies in accordance with WHO strategy...” At present the new statement of Latvian Food Centre is under adoption at the Cabinet of Ministers.
2. Latvian Food Center implements EU regulatory acts in the national legislation.
3. Establishment of a Nutrition Council, based on Advisory Board and the Founding Law of Nutrition Council is under adoption at the MoW.
4. The Food Guide Pyramid and Recommended Dietary Allowances for Latvians have been developed and accepted.
5. The information about essential issues (the actual information) on healthy nutrition is available on the home page of the Latvian Food Center, including a special part for healthy nutrition and food security.
6. The Food – based dietary guidelines for adults have been developed and are under adoption in the MoW.
7. The National Committee of IDD was established to coordinate and implement activities for IDD elimination in Latvia.

Lithuania

Dr. A. Abaravicius

1. Time Frame

The process of formation of National Food and Nutrition Action Plan started in autumn, 2000 with the aim to implement regulations established in the some international documents and national legal acts. The draft of Lithuanian Food and Nutrition Action Plan sets the major regulations by the state and ways for their implementation aimed at the improvement of food safety and nutrition of the country's population. In the 2000 the main preliminary activity at the responsible institution – National Nutrition Center was done. In 2001 there have been five local meetings organized. The Draft Lithuanian Food and Nutrition Action Plan on 2 of May 2002 by the National Health Board under the Lithuanian Parliament was approved.

2. Collaboration

Drafting team. The coordinating institution (National Nutrition Center Ministry of Health) 2000 was nominated. A **Task Force**, approved by the State Public Health Service under the Ministry of Health by the order of the Director, No. 16-V, as of December 4, 2001 includes the following members:

- A. Abaravicius** - National Nutrition Center, Doctor, Associate Professor of the Medical Faculty of Vilnius University (head of the task force)
- A. Astrauskiene** - State Public Health Service under the Ministry of Health, Deputy Director
- R. Bartkeviciute** - National Nutrition Center, Head of Division of Actual Nutrition
- D. Bilkiene** - Food Products inspection of the State Food and Veterinary Service, Deputy Head
- A. Liubeckiene** - Quality Division of the Department of the Development of Agriculture and Food of the Ministry of Agriculture, Head
- J. Petkeviciene** - Institute for Biomedical Research, Kaunas University of Medicine, Senior Scientific Researcher
- R. Petkevicius** - WHO, Liaison Officer, Lithuania
- G. Trinkuniene** - Ministry of Education and Science, Senior Specialist of Higher Education and Studies

3. Structure of the action plan

Content of Lithuanian Food and Nutrition Action Plan:

1. Introduction
2. Current Situation in:
 - Food Safety
 - Diet and Health of Lithuanian Population
 - A Sustainable Food Supply System
 - Education and Training of Professionals
3. Analysis of Strengths, Weaknesses, Opportunities and Threats of the Current Situation (SWOT analysis)
4. Vision
5. State Mission
6. Strategic Goal and Directions

7. Conceptual Implementation of the Action Plan, 2002-2010 (including targets, tasks, planned activities, partners)

VIII. Concluding remarks

4. National endorsement

It is planned to complete implementation of the Lithuanian Food and Nutrition Action Plan by the year 2010 (in accordance with regulations of the Lithuanian Health Program). An interim evaluation of the Action Plan and its revision will be carried out in 2005 (in accordance with obligations to the WHO). While implementing an Action Plan of the Lithuanian Government Program 2001-2004, a detailed plan for the implementation of the Food and Nutrition activity will be developed in 2003.

4. Technical presentations

UNICEF activities in the Baltic countries

Arnold Timmer

Elimination of IDD through Universal Salt Iodization and breastfeeding

More than 90 million newborns in the world are now protected from a significant loss in learning ability because of the tremendous progress made in salt iodization worldwide. Only a decade ago, less than 20 per cent of the world's households were using iodized salt. Today, that figure stands at 70 per cent worldwide. However it is noteworthy that the highest levels of salt iodization are in Latin America with 88% of households consuming iodized salt and the lowest level in the Central and Eastern Europe, the Commonwealth of Independent States and the Baltics region¹ where only 26% of households use iodized salt. This is lower than South Asia and sub-Saharan Africa.

There has been significant progress in tackling this deficiency because of a global partnership involving governments and civil society that has made iodized salt available to an additional 1.5 billion people, enabling protection of some 90 million infants.

Mild to moderate iodine deficiency has been confirmed in all countries in this region and in some areas, iodine deficiency is severe. As a result of low salt iodisation, around 4.5 million (80%) newborns are unprotected against Iodine Deficiency Disorders, out of 5.9 million newborns every year in 27 countries of the CEE/CIS and the Baltics region.

Median urinary iodine concentrations of 100 mcg/L and above define a population that has no iodine deficiency. In the Baltic States median urinary iodine excretion (UI) data, an indicator for iodine status at population level, indicate that iodine deficiency is a problem of public health significance. Median UI in Estonia is 65 mcg/L (national survey, 1995), while this is 75 mcg/L in Lithuania (national survey 2000) and 59 mcg/L in Latvia (national survey 2000).

UNICEF is committed to providing support to all Governments of the CEE/CIS and the Baltics region to achieve USI by 2003 and eliminate IDD by 2005. Our regional strategic objectives to achieve these goals include:

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

UNICEF's support takes into consideration the global analysis and recommendations including the need for increased public awareness, sustained government support, personnel training,

¹ Albania, TFYR Macedonia, Georgia, Azerbaijan, Poland, Latvia, Lithuania, Estonia, Bulgaria, Slovakia, Hungary, Romania, Croatia, Federal Republic of Yugoslavia, Turkey, Ukraine, Russia, Belarus, Armenia, Uzbekistan, Tajikistan, Kazakhstan, Turkmenistan, Kyrgyzstan, Moldova, Bosnia Herzegovina

improved technical operations, involvement of producers. With regards to the latter, experiences from other regions show that iodine fortification succeeds when producers are fully involved as key partners with national governments to formulate standards and regulations and resolve marketing and technical issues. This is an essential ingredient for success of iodization of salt.

Over the past 12 months a number of significant developments have been taken globally and in the region for elimination of IDD. To name but a few:

- At the Commonwealth of Independent States (CIS) Heads of States meeting in Minsk during 30-31 May 2001, there was agreement that IDD is a problem that they needed to act upon. A resolution was adopted unanimously by the Heads of States, which calls for USI achievement.
- Renewed governmental and civil society commitments to the World Summit for Children goals including IDD were established through meetings related to the Global Movement for Children in Europe, namely the Conference of CIS Member States in Minsk during 26-27 April 2001; the Inter-governmental Conference for Europe and Central Asia in Berlin during 16-18 May 2001; the Conference on Generation in Jeopardy in Stockholm during 18-20 June 2001.
- One of the goals in the outcome document of the UN Special Session on Children in May 2002 was the sustainable elimination of IDD through USI. The governments of the Baltic States signed to achieve this goal by 2005.

There are a number of issues that are key to understand iodine deficiency and USI better. These are important to keep in mind for all stakeholders involved in USI.

- USI means that at least 90% of all households use iodized salt, now and forever.
- USI includes iodization of all salt for human and animal consumption.
- We should think of deficient population rather than deficient individuals. Iodine deficiency affects the entire population. Surveys results can provide the proportion of the population that is deficient, but the median UI determines the status of the entire population. Moreover, USI is a national programme to ensure adequate iodine nutrition for a population and not to prevent or treat a deficiency of an individual. Iodine deficiency is a public health problem that affects the whole population which therefore requires a solution that reaches the whole population.
- Surveys are often conducted among school children and although results are presented for this group only, conclusions can be drawn for other population groups as well, as their iodine intake show similar patterns.
- As iodine is crucial for the brain development of the child during pregnancy, USI should be seen as a smart start for the next generation.
- The USI programme is not meant to increase salt intake but to change consumption of non-iodized salt to iodized salt.
- Very often iodine deficiency is considered a medical problem that should be solved by the public health sector. However, we seem to forget that iodine deficiency is a nutritional problem requiring the involvement of the salt and food industry

Some observations about the Food and Nutrition Action Plans (FNAP) of the Baltic States:

- The FNAPs recognize that IDD is a public health problem but it is not clearly indicated that USI is the strategy to eliminate IDD
- The suggested activities to eliminate IDD are not necessarily sufficient to reach this goal:

- Intervention activities are targeted at the studies groups (school children) or deficient groups (those with low UI), not at the entire population
- More studies are suggested to map the problem of IDD, while sufficient evidence exists to move towards implementation of the strategy
- It is suggested to analyze iodine content of food items, while total intake of iodine, reflected in UI studies, is already known

A general structure is suggested to be used for the FNAP with specific activities spelled out for each country:

- Sustainable elimination of IDD by 2005 through USI is a goal that has been endorsed at the Special Session on Children (May 2002) by all Baltic States
- Scientific evidence exists that IDD is a public health problem in the entire population and a solution, in the form of USI, is available that covers the entire population
- The essential components that need to be in place include: i) an effective, functional national body responsible to the government for the national programme for elimination of IDD, ii) political commitment/will, iii) USI legislation, iv) cooperation and capacity of the salt industry to provide iodized salt, v) an effective and functional monitoring system for iodized salt supply and the iodine status among the population, and vi) communication activities to increase knowledge, awareness and acceptance among stakeholders and the public.
- The sustainability can be ensured through the establishment of a National Coalition that has an oversight function

Breastfeeding and Baby Friendly Hospital Initiative (BFHI) is also reflected in the FNAPs of the Baltic States. UNICEF is willing to support the Baltic States in these areas. The general observation was that breastfeeding promotion and protection needs to be enforced. Also, the incorporation of the International Code into the health reform is strongly suggested.

By incorporating BFHI into the health system BFHI can be expanded to the Primary Health Care Level and BFHI can be expanded to all hospitals with maternity services.

See Annex 1 for overheads from this presentation.

Global burden of disease

Karen Lock

Introduction

The WHO Global Burden of Disease Comparative Risk Assessment (CRA) Project set out to compare the attributable burden of disease due to major risk factors using common methods. Among the risk factors included were lack of fruit and vegetable consumption, obesity, physical inactivity, smoking, alcohol, cholesterol plus environmental risk factors. The results of these analyses will be published in the WHO World Health Report (October 2002).

Accumulating epidemiological evidence has suggested that fruits and vegetables in the diet can reduce the risk of major diseases such as cardiovascular diseases and certain cancers, thus reducing premature deaths [1-5]. This consistent pattern of findings has led several national and international bodies to advocate an increase in intake to at least 400 grams a day (excluding potatoes) [1],[4].

A previous attempt was later made in Sweden to estimate the burden of disease that could be attributed to different causal factors in the European Union (EU)[6]. It was estimated that diet-related factors directly contributed to 8.3% of the estimated number of disability-adjusted life years lost, almost half of this being attributed to low fruit and vegetable intake (3.5% compared with 3.7% for overweight and 1.1% for high saturated fat intake). However, these figures do not take account of potential interactions between the different factors. In comparison, tobacco smoking accounted for 9% of the burden of disease in the EU. These findings are similar to those of recent studies from New Zealand and Australia [7, 8]. In these countries, it was estimated that about 3% (2.4% in New Zealand and 2.8% in Australia) of the burden of disease could be attributed to low fruit and vegetable consumption. The Australian study also reported that approximately 10% of all cancers could be due to an insufficient intake of fruits and vegetables. These figures do not, however, capture the complexity of the situation and so are likely to underestimate the importance of nutrition.

Methods

This presentation will briefly present the methods for calculating the disease burden due to inadequate fruit and vegetable consumption in the WHO CRA study. This involved systematic reviews and meta-analyses of the impact of low fruit and vegetable intake on main disease outcomes, and calculation of dietary intake for each world region by age and sex based on intake survey data and FAO food balance sheet data. The difficulties of this approach will be discussed including the scarcity of exposure data in many parts of the world, the challenges with identifying interactions with other risk factors especially tobacco, and the lack of knowledge about 'an effect plateau' which could identify the theoretical maximum intake of fruit and vegetables for greatest protection.

Results and Discussion

The results of these analyses show that inadequate consumption of fruit and vegetables in Europe (and worldwide) contributes to a significant burden of disease. This disease burden is greater than that reported for other major risk factors including physical inactivity, cholesterol and unsafe sex, and shows that the effect of fruit and vegetables reaches the significance of smoking in population health terms. The trends in fruit and vegetable availability in Europe will be presented, and the implications of this for future consumption and disease burden will be discussed.

The burden of disease approach has been criticised because it merely quantifies the size of the health problem without looking at the effectiveness of interventions to tackle it. We will discuss the results of this work and draw conclusions about what this means for developing food and nutrition policies in Europe.

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See Annex 1 for overheads from this presentation.

Questionnaire on Food and Nutrition Policy Development, Implementation Processes and Impact

Dr. Robertson informed the participants that an assessment of the First Food and Nutrition Action Plan was to be undertaken in 2005 by means of a questionnaire entitled “*Food and Nutrition policy development, implementation process and impact*”. Before its distribution in 2003, Dr Robertson requested participants, particularly WHO nutrition counterparts, to comment on the draft questionnaire. She also added that the next nutrition counterpart meeting was to take place in Greece in February 2003 during the Greek EU Presidency.

Health Impact Assessment (HIA) of agriculture policies

Karen Lock

Introduction

Health impact assessment (HIA) is a means of improving evidence-based policy making for public health. It is a combination of methods whose aim is to assess the health consequences to a population of a policy, project, or programme that does not necessarily have health as its primary objective. HIA is a multidisciplinary process within which a range of evidence about the health effects of a proposal is considered in a structured framework. It takes into account the opinions and expectations of a wide range of stakeholders who may be affected by a proposed policy. The evidence for potential health impacts of a proposal are analysed and used to influence the decision making process. The HIA approach is very flexible in terms of time and cost. The strengths and limitations of HIA will be discussed.

The application of HIA in Europe

HIA has been used in national policy appraisal, local urban planning, transport, water resource and agricultural projects and policies. Examples are given of its applications in the Netherlands, England, Wales and Sweden. The approaches are very different. In the Netherlands HIA is mainly targeted at National Policy appraisal, whereas in Sweden HIA has been developed as a more bottom-up community approach. At present there is no statutory requirement for carrying out HIA in any European country, although there may become a legal requirement for conducting HIA as part of environmental assessments with adoption of the new UNECE protocol on Strategic Environmental Assessment (see references).

HIA of agriculture and food policies

HIA has not been widely applied to agriculture and food policies. After the enquiry into the BSE epidemic, the UK government proposed that HIA would be a useful means of assessing health impacts of agricultural policies. In Canada, HIA has been applied to pig farming and fruit growing. A recent initiative between WHO Europe and The Department of Health in Slovenia is piloting HIA of food and agricultural policies in relation to EU accession. The initial stages of this project will be discussed.

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- British Medical Journal 2000;320:1395-1398 (20 May) <http://www.bmj.com/cgi/content/full/320/7246/1395>
- HIA web sites: provide links to many free documents
- The UK Health Development Agency: Gateway website with information on HIA toolkits, HIA resources, sources of evidence, HIA case studies. <http://www.hiagateway.org.uk>
- Liverpool University: International Impact Assessment consortium: <http://www.ihia.org.uk/about.html>. A greater international focus with many weblinks and on-line resources including the Merseyside HIA guidelines(a short book outlining procedures and methods for the health impact assessment of policies and projects in a developed world context).
- Health Impact Assessment Database, Netherlands School of Public Health. <http://www.hiadatabase.net/>
- The London Health Strategy: Health Impact Assessment website. <http://www.doh.gov.uk/london/healthia.htm>
- A resource for Health Impact Assessment: 3 volume report provides full details of approaches and tools being used and 20 case-studies across the county. <http://www.doh.gov.uk/london/resource.htm>
- Sweden : <http://www.lf.se/hkb/engelskversion/general.htm>
- Guide to HIA by the Swedish County Councils (in English)
- The WHO Europe HIA programme website has links to background documents that provide an overview of the health impact assessment approach and its relevance to integration of HIA during the negotiations of the new UNECE protocol on Strategic Environmental Assessment. .
http://www.who.dk/eprise/main/who/progs/hms/MainActs/20011128_1
- Canada: "Health Impact Assessment as a tool for population health promotion and public policy":
<http://www.hc-sc.gc.ca/hppb/healthpromotiondevelopment/pube/impact/impact.htm>
- Health impact assessment of environmental and agricultural projects
<http://www.hc-sc.gc.ca/ehp/ehd/oeha/hia/vol2.htm>

See Annex 1 for overheads from this presentation.

Iodine Deficiency Disease Elimination and Universal Salt Iodization

Lars Ovesen

See overheads from this presentation in Annex 1.

NorBaGreen Project

Liisa M. Valsta, Minna Similä and the NorBaGreen project group

Background

The Norbagreen project is a follow-up of the so called Nordgrönt-project started in 1996. As a result of the Nordgrönt project a validated questionnaire on vegetable and fruit and berry consumption was available. In addition, during the preceding Nordgrönt-project it became evident that the vegetable and fruit consumption statistics were not very easy to compare between the Nordic countries.

Aim

The aim of the NorBaGreen study was to measure consumption frequencies of the so called health indicator foods (vegetables, fruit and berries, bread and fish listed by the EU/Eurodiet and Efcosum group) with a method that is as comparable as possible between the Nordic as well as between the Baltic countries.

Methods

The previous Nordgrönt-questionnaire was modified and expanded to include all the NorBaGreen foods. The questionnaire was pretested in the participating countries. The final English version of the questionnaire was translated into 9 different languages (altogether 12 different questionnaires) and the local questionnaires were retranslated back to English to double

check any possible deviations. Some minor local modifications were allowed in the questionnaire. In addition to the food questions, sociodemographic background questions were included in the questionnaire. The field work of the main study was coordinated in the participating 8 countries in spring 2002 (April-May 2002) using a computer assisted telephone interview method in the Nordic Countries (CAPI) and a face-to-face paper assisted personal interview (PAPI) in the Baltic countries by the TOY Research (Taloustutkimus OY, Finland). A representative sample (about 1000 interviews/country), was collected in each country. In addition, a Finnish subsample of 250 was collected in Åland. The CATI sample in the Nordic countries was randomly drawn from the household numbers with a representative geographical distribution. Mobile phone numbers were included in Finland. In the Baltic countries the proportional representation of different regions and cities was guaranteed by dividing each country into several areas. The respondents were chosen by random selection, which ensures the proportional representation of all counties and major cities in the sample. The total number of accepted interviews in the Norbageen was 8397. The ratio between completed interviews/(completed interviews+refused to answer) varied in the Nordic countries from 27% in Denmark to 70% in Iceland (CAPI method). The response rates in the Baltic countries varied between 67% to 82% (PAPI method). Validation studies were carried out in early spring 2002 in Lithuania and Finland.

Results

The first preliminary results of the main study concerning vegetable, fruit and berry, bread, and fish consumption in the Nordic and the Baltic countries was presented at this meeting in Pärnu.

5. Eradication of Iodine Deficiency Disorders in the Baltics

Estonia

Estonia has developed a "Healthy nutrition action plan", which includes nutrition of children.

Problems

The iodine deficiency survey showed that Estonian children often suffer from slight to moderate iodine deficiency that can express itself in the form of development problems or difficulties in studying. In most cases it is possible to prevent the formation of thyroid gland diseases by guaranteeing the intake of sufficient amounts of iodine in food.

Targets and priorities

To decrease the incidence of diseases due to wrong eating habits and nutrient deficiency.

Planned action for 2002-2007

To enforce the recommendations for use of iodized salt in child care institutions, hospitals, caterers.

The new results of the survey of neonatal screening have been published:

Mikelsaar RV, Zordania R, Viikmaa M, Kudrjajtseva G. Neonatal screening for congenital hypothyroidism in Estonia. *J Med Screen* 1998;5:20-21 and Mikelsaar RV, Viikmaa M. Neonatal Thyroid-Stimulating Hormone Screening as an Indirect Method for the Assessment of Iodine Deficiency in Estonia. *Horm Res* 1999;52:284-286

The results 17,7 % indicate, that Estonia has probably mild iodine deficiency (in countries with sufficient iodine availability this number is around 3%). Hypothyroidism indicator is 1:2860, which is slightly higher than in Europe (1:3000 kuni 1:4000).

According to the survey carried out among the children in 1995 and according to the data from newborn screening, we can not consider, that IDD is a major health problem in Estonia.

The Ministry of Social Affairs has worked out the draft regulation for child care institutions and schools, which contains suggestions to use iodized salt.

UNICEF promised to finance a survey among schoolchildren (to have more adequate data about IDD problem in Estonia) in 2001. This was also discussed at the WHO and Baltic meeting in Sigulda in June 2001.

The Endocrinology Hospital of University of Tartu made preliminary actions to carry out the survey, but probably due to the technical misunderstanding, this survey was not funded by UNICEF and due to lack of funding the survey was not carried out in 2001.

Estonia planned the health promotion actions towards use of iodized salt after that new survey among schoolchildren.

Latvia

During the visit of the UNICEF consultants, A. Timmer and F. van der Haar, in Latvia in collaboration with the National Committee of IDD and other responsible persons significant changes were made in the Project Proposal "IDD Elimination in Latvia" as well as in the FNAP.

The necessary objectives for strategy and plan of action for elimination of IDD in Latvia and necessary activities to reach the goals named in strategy were determinate.

The goal is “Elimination of IDD by 2005 and the Strategy is “USI by end 2004”.

The main objectives are:

- Elaborated and approved USI legislation
- Education of public and development of appreciation among public health professionals, medical doctors, politicians
- Developing and implementing of monitoring system at different stages
- Initiation and irreversible process of permanent IDD elimination

The National Committee of IDD will accept the project proposal for first 3 months in 05.05. 2002. The new Project Proposal provides 4 activities:

Preparation of the draft of National Strategy and action plan for elimination of IDD.

- Organising of Parliamentary consultation at Commission of Social and Occupational matters (11 July 2002)
- USI legislation - organising of the work of lawyer to:
- Determine appropriate insertion of USI in the National Legal Framework
- Draft USI law and implementing regulations
- Communication among crucial stakeholders:
- Preparation of materials for Education of medical and public health professionals by involving leading authorities
- Work on the insertion USI/IDD knowledge in educational curriculum in medical schools

Lithuania

Introduction

In the majority of countries, iodine deficiency disorders are a common public health problem. Therefore, despite iodine deficiency is the easiest form of malnutrition to eliminate, it continues to constrain people from reaching their full mental and physical potential.

Iodine deficiency has been identified as a global public health problem and is the main cause of preventable mental retardation with over a billion people at risk worldwide (WHO/UNICEF/ICCIDD 1994). The most important consequences of iodine deficiency are permanent brain damage in the fetus and infant and retarded psychomotor development in the child (Delange et al. 1994). Iodine deficiency causes goiter, increased incidence of stillbirths, abortions, and congenital abnormalities including endemic cretinism. Neonates born in iodine deficient areas are the most vulnerable (WHO/UNICEF/ICCIDD 1994, Maberly et al. 1994). Iodine Deficiency Affects all aspects of brain development, reduces the amount of connections by axons, reduces the intellectual capacity for ever, affects the whole population called “hidden hunger”. Intelligence Quotient (IQ) relationships is largely fixed during brain development and does not change through life, is strongly related to learning ability, and is strongly related to level of educational achievement.

Despite Iodine deficiency disorders has been recognized by World Health organization as one of the most important factors determining public health, IDD are still not fully recognized as an important public health problem in Baltic States.

The first attempt to assess the magnitude of IDD problems and to develop a national control programme was made in 1995 when IDD surveys were carried out in the 3 Baltic states with financial and technical support of UNICEF and KIWANIS. Iodine deficiency investigations in Lithuania were carried out in 28 secondary schools. More than 2000 children (8 - 10 years of age) were examined. The data of thyroid size palpation showed that about 50% of examined children have goitre (goitre stage I cases made up 38,2% and goitre stage II cases - 14,6 %). Urinary iodine was used as an indicator of the present iodine intake because the measurement of iodine in the food is difficult.

The normal value of urinary iodine was found only in 40 percent of all children. The iodine excretion in urine showed that 25 % of examined children made up mild IDD cases, 23 % of examined children - moderate and severe IDD cases made up 11%. These surveys showed existence of generally mild to moderate IDD in Lithuania. Despite, that mild iodine deficiency was confirmed in Lithuania by 1995 survey, IDD problem was recognize as a public health problem only in 1997 when elimination of iodine deficiency disorders has been defined as the Health priority in the Lithuanian Health Programme adopted by Lithuanian Seimas – Parliament.. Recently, elimination of IDD is one of main target of National Public Health Strategy, Public Health Action Plan, National Nutrition Action Plan. Unfortunately, the IDD problem has not attracted sufficient attention and financial support from Lithuanian health administrators and decision-makers so far.

Thus, the government showed clear commitment to launch activities aimed at elimination of iodine deficiency in this country. However, the policy of the government is to promote mostly voluntary methods for iodized salt use through the increase of the demand for iodized salt, health education, information and communication.

Iodine deficiency arises from environment deficit of iodine in soils and waters. Thus, all foods that are harvested on these soils contain much less iodine than needed for human body. The Baltic sea does not help because its water contains relatively small amount of iodine while fish and seafood does not supply population with sufficient amount of this element.

Universal salt iodization is the agreed-upon worldwide strategy for the elimination of iodine deficiency. Iodized salt is safe, economic and proven effective in preventing iodine deficiency disorders.

Lithuania and other Baltic States do not produce salt and thus import its entire amount from Ukraine, Belarus, Denmark, Germany and other countries. Results of SSA revealed that only insignificant amount of edible salt (5-9%) is consumed in iodized form in Lithuania.

Since 2000 by initiative of the Ministry of Health, the Government iodized salt has been included to the list of products exempt from the 18% Value Added Tax (VAT). This measure is aimed to make iodized salt cheaper and more attractive to consumers. Lithuania has not established any customs duty for salt import. Price of iodized salt was 5 - 30% higher that uniodized one. The use of iodized salt was more frequent in the urban population than those living in country.

However, importers face problems with distribution due to the low awareness of consumers and lack of their knowledge in benefits of iodized salt. All salt importers are interested in further cooperation and are willing to take part in the promotion of iodized salt along with government agencies and medical community.

These elements will be the main focus of activities in the next 1-2 years to promote the use of iodized salt from present insignificant level (<9%) to acceptable level (at least 50% by the end of 2003). Further international support may be needed for this component of national IDD control program.

Additionally we have tended to solve the problem of IDD by iodization of staple foodstuffs, for example bread, meat products, mineral water, other. But it is unlikely that the Lithuanian Government will adopt legislation on USI. The policy of the Ministry of Health is to promote voluntary use of iodized salt and increase demand for iodized salt through health education.

The Ministry of Health with support from the National Committee for UNICEF conducted an "IDD Month" in November 2000. To reach this goal, guidelines for public health educators and schoolteachers and also for salt producers/importers were developed. UNICEF provided with rapid test kits to check salt specimens brought by schoolchildren from households. The National Committee for UNICEF, with the support of UNICEF Regional Office and Kiwanis funds published leaflets and posters (wall calendars), and produced TV spots with information on iodine deficiency and its elimination through iodized salt, methodological recommendation about prevention of IDD, use, requirements for quality, labeling of the iodised salt were prepared. The TV spot were broadcasted 90 times on national TV channels free of charge by the initiative of National Committee for UNICEF. At the same time it is quite clear that only voluntary methods of iodized salt promotion, without some measures aimed at mandatory use of iodized salt (in retail trade and/or food industry) will not seriously change the picture.

The World Health Organization clearly stated that universal salt iodization is a safe and reliable method to eliminate iodine deficiency. Monitoring system should be established in each country to control quality of iodized salt and biological impacts of this intervention. This system can be easily build on the existing public health system. It is necessary also not forget about raising consumer awareness and demand for iodized salt. In collaboration with private salt importers we have to improve product image and commercial marketing. Awareness raising campaigns in the media must reach all sectors of society. Problems of IDD are also included in the educational programmes of medical and pedagogical students.

According to the Lithuanian IDD programme and opinion of the Health of Ministry mandatory use of iodized salt should be introduced in educational institutions (schools and childrengardens). Such draft decision of Ministry of Health h been prepared. However, this regulation was not completely supported by Ministry of Education. Now it is necessary to set up effective monitoring system in respect to the quantity and quality of the iodized salt distribution at the national and regional levels. Again, it should be emphasized that the problem of iodine deficiency has not been solved yet. The Table below shows a real situation in Lithuania according to criteria for tracking progress towards elimination of IDD as a public health problem.

Third workshop on development of food and nutrition action plans in the Baltic countries
Parnu, Estonia, 10-12 June 2002

Indicator	Goal	Situation in Lithuania
Iodised salt Proportion of food grade salt effectively iodised	>90%	7 –9 %
Thyroid size In school children 8- 10 years of age Total goitre rate by palpation	<5%	>40%
Biochemical TSH Proportion of newborns with levels>5 mU/l whole blood Median urinary iodine µg/dl	<3% >10%	According to data provided by Human Genetic Centre, in 20% of blood samples obtained from new-borns, TSH levels were above 5 mu/L (in iodine sufficient populations no more than 3% of samples may have TSH level below 5 mu/L). These results are in good agreement with previously obtained data and confirm existence of mild iodine deficiency in Lithuania. <10

6. Establishment of a Nordic-Baltic Network on Public Health Nutrition

Purpose of the Network

The meeting was chaired by Dr Iveta Pudule from Latvia. After the adoption of the agenda she reminded participants that the main purpose of the Nordic-Baltic Network was to “provide a permanent forum for cooperation, strategic discussions, and exchange of experiences in the field of public health nutrition”. Eva-May Ohlander informed the participants that the funding provided by the Nordic Council of Ministers was mainly meant for enhancing discussion among the Nordic and Baltic countries, and that there was no obligation for the Network to come up with products, however, the money could also be used for projects.

Participation in the Network

Regarding the participation in the Network it was decided that two people, from each of the eight Nordic countries as well as the three Baltic ones, should be chosen. Members should represent the national organizational structure in the field. Selection of these participants should, however, be flexible and should involve the persons present at this meeting rather than the consecutive ministries. In addition to the core group, a third member could be nominated in case participation of the two other members was not possible. All members should, however, be familiar with the general structure of the Network. Sweden will chose two formal members in addition to Eva-May Ohlander.

Activities for the year 2002

Activities for the remaining year include:

1. Discussion of the three year plan of the network & its application
 - To ensure funding in the future, a good three-year plan needs to be developed. Participants are requested to send questions and comments regarding this topic before the next meeting and the Baltic countries should extract, from their national action plans, the main activities for discussion.
2. Nordic country presentations
 - The Nordic countries are to present an overview of their nutrition activities, success stories and problems should be emphasised
3. Discussion of seminar topics for three year plan
 - Seminar topics are to be discussed at the next meeting.
4. Discussion of health signs
 - Estonia suggested to discuss the possibility of using common signs to indicate special types of food i.e. as the keyhole sign used in Sweden

Next meeting

The next meeting is to be held in Copenhagen, or its vicinity, September 12-13, 2002, following the obesity meeting, which takes place September 11-12, during the Danish EU Presidency. Countries are requested to select the participants and to send their names to Eva-May Ohlander as soon as possible. Lars Ovesen will be in charge of the local arrangements.

Annex 1: Slide presentations

Estonia

Slide 1

Development of Estonian Food and Nutrition Policy

Sirje Vaask
11.06.2002

Slide 6

Development of national food and nutrition action plan

Time frame:

- November 2000, committee agreed objective and contents of the action plan.
- December 2000 – February 2001 – expert work
- May 2001 - draft action plan for the comments to different ministries and institutions.
- 14th November 2001- Estonian Nutrition Forum with 142 participants, the action plan was agreed.
- December 2001 – final comments to the action plan.
- 03. 2002 – printing and dissemination "Healthy Nutrition Action Plan of Estonia". Available through Internet.

Slide 2

Topics

- Health and nutrition indicators
- Overview of the process
- Actions since June, 2001

1. food and nutrition research and information
2. accessibility of food
3. local food for local consumption
4. food safety
5. nutrition of population groups
6. diseases and nutrition

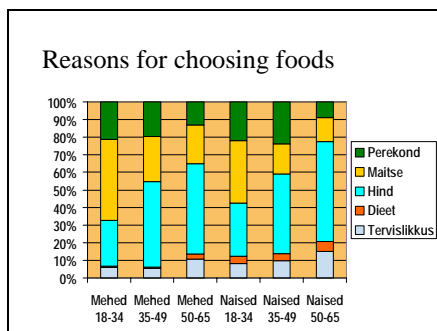
Slide 7

Development of national food and nutrition action plan

Collaboration:

- Ministries:** Ministry of Social Affairs Ministry of Agriculture
- Governmental institutions:** Health Protection Inspectorate, Consumer Protection Board, Estonian Health Education and Health Promotion Center, Estonian Institute of Cardiology
- Universities:** Food Processing Institute of Tallinn Technical University, Tallinn Pedagogical University, University of Tartu
- NGO-s:** Estonian Association of Paediatricians, Estonian Union of Hypertension, Estonian Heart Association, Estonian Union of Food Processing Industry.
- Other:** Estonian Institute of Market Research, Tartu University Hospital, Estonian Institute of Sustainable Development

Slide 3



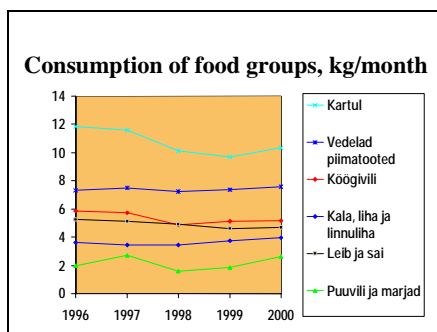
Slide 8

Development of national food and nutrition action plan

Structure of the Action Plan:

- The Nutrition Action Plan contains the nutritional situation analysis of previous five years (1996-2000) and the description of healthy nutrition promotion.
- The problems, objectives and necessary activities for the next five years (2002-2007) have been given on six components of healthy nutrition: food and nutrition research and information; accessibility of food; local food for local consumption; food safety; nutrition of population groups; diseases and nutrition.

Slide 4



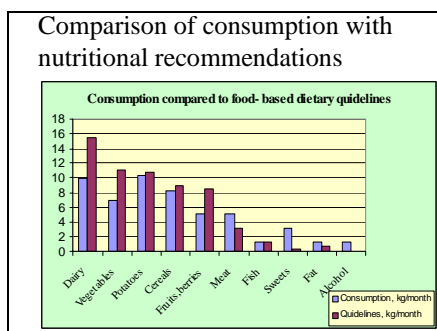
Slide 9

Development of national food and nutrition action plan

National endorsement:

- Estonian Health Forum was held in 04th April 2002 where the Estonian Health Policy was introduced. Healthy Nutrition Action Plan is one of the sub-documents of this policy.
- Estonian Nutrition Society has analysed the implementation and financing of planned actions in "Healthy Nutrition Action Plan" and there will be discussions for those actions not already covered.
- Healthy Nutrition Action Plan does not have separate funding from state budget.

Slide 5



Slide 10

Food and nutrition research and information

2002 – NoBaGreen survey
Results of the surveys available through Internet.
Lectures and practical lessons for students in Tallinn Technical University (Food Engineering and Product Development
Comparison of regular surveys

Slide 11

Accessibility of food

1. Development of action plan of Estonian Food Processing Industry
2. Preparation of subsidies for alternative agriculture and development of new products
3. Successful implementation of school milk programme
4. Local municipalities paying subsidies of meal for children from poor families
5. President of Estonia set up a proposal for free school meal, including rye bread daily.

Slide 16

Nutrition of population groups

Children

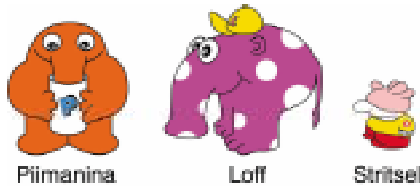
- Training project for personnel of kindergardens, including nutrition education
- World Food Programme, Global Survey of National School Feeding Programmes
- Heart week in kindergardens and schools

Elderly

- Radio shows targeted to the elderly and to the russian-speaking population
- Empowerment of NGO-s within heart week

Slide 12

School Milk Programme



Slide 17

Diseases and nutrition

- Availability for nutrition counselling through Internet
- Contest "Best Estonian Food" introduced contest "Best food for health"
- Weight Watchers had a contest "Healthiest food"
- TV- shows- nutrition and food preparation
- Articles in newspapers and journals

Slide 13

Local food for local consumption

Regional training for small enterprises – food safety, product development, indirect marketing
National contests, media campaigns, events and fairs for promotion of local food
Promotion of regional foods and national foods through tourism
The sign "Fair trade" was introduced from 6 meat-processing companies

Slide 18

Diseases and nutrition

- 2002 – programme for prevention of cardiovascular diseases (30-60 years), training of family doctors regarding nutrition counselling and counselling of patients with risk factors
- 2002- Training project for parents of children with diabetes
- Draft material for hospitals – diets, catering etc.

Slide 14

Food safety

Training materials have been worked out from Health Protection Inspectorate for enterprises to introduce self-control system
Regional training of personnel of schools and kindergardens
Draft regulation for catering at schools and kindergardens
Consumer Protection Board implemented food safety campaign

Slide 19

Further plans

- To introduce actions in those fields, which are not yet covered.
- To work out the strategy for overall population to increase consumption of vegetables and fruits
- To introduce special nutrition counselling program to those adults, participating in programme for prevention of cardiovascular diseases
- To increase international collaboration (science, projects, peer evaluation etc)

Slide 15

Nutrition of population groups

Infants and children under 1 year

- Nutrition information for pregnant and lactating women and nutrition counselling through Internet.
- National training project for midwives to increase their competence in nutrition and physical activity of women
- UNICEF organized seminar on breast feeding and BFHI
- Estonian Union for Breast-feeding Counselling introduced mother to mother support groups in Tallinn

Latvia

Slide 1

**Latvian Food and
Nutrition Policy**

Latvian Food Center
Velga Brazneviča
Head of Nutrition Policy Department

Slide 6

Development of FNAP 2001

II 2001 - letter to MoW substantiating necessity of development of FNAP

III 2001 - Public health Strategy approved by the CM

VI 2001 - Conference of Latvian experts
- 2 - nd workshop for Baltic countries

XI 2001 - confirmation of FNAP and submission to MoW
- translation of FNAP in English

Slide 2

Structure of presentation

- Legislative background for Latvian Food and Nutrition Policy
- Development of FNAP 2001 - 2002
- Current problems, implemented parts of FNAP
- Conclusions and future plans

Slide 7

Development of FNAP 2002

II 2002 - consignment of draft of FNAP to foreign experts

IV 2002 - the final amendments in FNAP
- meeting of state Secretairs, FNAP approved as a Concept of Cabinet of Ministers

VI 2002 - FNAP is at the interministerial coordination on the way to Cabinet of Ministers

Slide 3

Legislative background for Food and Nutrition Policy (1):

"Law on Supervision of Food Circulation" 1998 (last amendments, 13 December 2001)

- the last amendments of law foresee
 - *establishment of Nutrition Council
 - *affirmation of RDA and dietary based guidelines by MoW
 - *new tasks for the Latvian Food Center targeted to nutrition policy
 - * one responsible service for the state surveillance and control of food safety
- there are regulations of Cabinet of Ministers consequent to law

Slide 8

Structure of the Latvian Food and Nutrition Action Plan

I Concept of Cabinet of Ministers "Healthy Nutrition"

- summary of each problem
- factors delaying development and prevention of delaying factors
- recommendations for development

II Action Plan "Healthy nutrition for Latvia 2002-2007"

- 11 targets to realize the Action Plan
- specific activities, responsible institutions and deadlines for each target

Slide 4

Legislative background for Food and Nutrition Policy (2):

"Statement of Latvian Food Centre" (accepted at Comitee of CM)

- tasks and functions of Latvian Food Center, including the new tasks targeted to nutrition policy named :

"...elaboration, co-ordination of enforcement of FNAP, elaboration programme and co-ordination of elimination of nutrient deficiencies in accordance with WHO strategy..."

Slide 9

Current problems, implemented parts
PROBLEM 1

The impact of food and nutrition on the health of the population of Latvia:

- high level of deaths caused by coronary heart diseases (55% of all deaths)
- the number of people suffering from oncogenous diseases has increased (to 30%)
- the span of human life in Latvia is one of the lowest in Europe (65 - M; 76 - F years)
- low percentage of local agricultural production for consumption
- about 1/2 of population has overweight
- food consumption is inadequacy to RDA, Food Guide nvramid etc.

Slide 5

Legislative background for Food and Nutrition Policy (3):

Public Health Strategy (march 2001)
where the target 11 Healthier Living determines:

"By 2010, people across Latvian society should have adopted healthier patterns of living"

and in order to reach this target:

"...there should be developed Food and Nutrition Action plan for Latvia, based on the current Europe -wide initiative led by WHO..."

Slide 10

Current problems, implemented parts
Implemented parts (1):

- the new "Statement of Latvian Food Centre" (authorised by Food Law)
- determines its responsibility for scientific advice and information on all matters having a direct or indirect impact on consumer health and safety arising from the consumption of food
- Establishment of the Nutrition Council, the statement of NC is under establishment by MoW
- LFC participates in working group by MoA for establishing of "The goals of development of agriculture" including parts of FNAP targeted to principles "local production for local consumption" and development of biological agriculture, production of bioorganic foods

PROBLEM 1

Slide 11

Current problems, implemented parts

Implemented parts (2):

- development and presentation at the Postharvest Unlimited conference in June 2002 of report "Quality of raspberries and blackcurrants after frozen storage"
- The Food Guide Pyramid and Recommended Dietary Allowances are developed and accepted
- the Food based dietary guidelines for adults are under adoption in the MoW
- introducing materials about healthy nutrition are developed and outspread

PROBLEM 1

Slide 16

Current problems, implemented parts

PROBLEM 4

Nutrition for the Sick:

- more than 50% of hospital patients in Latvia have malnutrition
- inadequate education of medical personnel in matters of clinical and healthy nutrition
- Choice of hospital food is determined by economic factors rather than the actual dietary needs of the patient

Slide 12

Current problems, implemented parts

PROBLEM 2

Children's Health and Nutrition:

- more than a quarter of new-born babies are not breast fed during the first hours following birth
- only 33% of infants born in Latvia are breast fed for the first four weeks
- school Nutrition teaching programmes do not include sufficient information on healthy nutrition and breast feeding
- existing legislative acts must be supplemented, to ensure healthy quality food at pre-school education facilities, schools and other child institutions

Slide 17

Current problems, implemented parts

The solutions:

- Drawing up and implementing training programmes on healthy nutrition for health care personnel
- Draw up and implement training of nutrition specialists
- Align catering systems of health care facilities

Implemented parts:

- under development is the project proposal for "Education and training of nutrition specialists" in various levels

PROBLEM 4

Slide 13

Current problems, implemented parts

The solutions:

- Promote breast feeding
- Align the catering system in pre-school education facilities, schools and other child institutions

Implemented parts:

- established and working "National Comitee of Breastfeeding Promotion"
- the food based dietary guidelines for children are under development by Nutrition Council

PROBLEM 2

Slide 18

Current problems, implemented parts

PROBLEM 5

Deficiency of Micro Nutrients:

- There is approved iodine deficiency in Latvia (UNICEF and the Latvian Food Centre study in 2000)
- There is a suspicion of iron, vitamins A, Se and folic acid deficiency in Latvia (needs to be proved)

Slide 14

Current problems, implemented parts

PROBLEM 3 *achieved goals*

Nutrition for the Poor and Low Income Groups of the Population:

- in Latvia is a relatively high number of poor people (~40 %)
- in many household budgets a large proportion, almost half, goes to pay for costs based not on free choice but necessary for survival - costs of health care and housing, transport, telephone

Slide 19

Current problems, implemented parts

Implemented parts:

- IV 2002 - establishment of the national Comitee of IDD
- the founding Law of National Comitee of IDD is adopted by the MoW
- IV 2002 - project proposal "IDD Elimination in Latvia"
- V 2002 - visit of UNICEF consultants A.Timmer and F.van deer Haar in Latvia
- V 2002 The new Project Proposal including suggestions is accepted by National Comitee of IDD

PROBLEM 5

Slide 15

Current problems, implemented parts

The solutions:

- Implement a healthy nutrition action plan, taking into account the specific needs of groups subject to the highest risk in order to help reduce inequality in nutrition
- Promote aligning the catering systems for social assistance and similar facilities

Implemented parts:

- under development is the content of an economic nutrition basket determining the amount of low cost but quality food items

PROBLEM 3

Slide 20

Current problems, implemented parts

PROBLEM 6

Food safety

- transposition of EU legal acts into national legislation according to AQUIS and White Paper
 - horizontal approach directives - responsibility of MoW and LFC (except official control and hygiene directives in the future)
 - vertical approach directives - responsibility of MoA
- Realising the principles of "comprehensive and integrate approach" and "from farm to table" through transforming of the food control system

Slide 21

Current problems, implemented parts
Implemented parts (1):

- the Food and Veterinary Service carry out state surveillance in the whole food circulation chain (White Paper guiding principle - food safety policy must be based on a comprehensive, integrated approach "from farm to table", last amendments in "Food Circulation Law")

PROBLEM 6

Slide 26

Current situation, problems, solutions
The solutions:

- Improve the information system to educate the public on healthy nutrition, food hygiene and increased physical activity

Implemented parts:

- Health Promotion Centre achieves regular campaigns to inform the public on matters of healthy nutrition and lifestyle and surveys to research health behavior among Latvian Population
- the information about essential issues on healthy nutrition is available on the home page of the Latvian Food Center

PROBLEM 7

Slide 22

Current problems, implemented parts
Implemented parts (2):

- Latvian "Food safety strategy" including FNAP targets referred to food safety is developed and accepted by CM
- Latvian Food Center is nominated as a National Contact Point in Latvia for the Food Safety Programme of WHO Regional Office for Europe
- the Latvian Food Center is responsible for harmonising EU normative acts and keeping in sight the general requirements of food safety and nutrition, the LFC is responsible for establishing a system to identify new food risks (ERIS) and also for joining and participation in European Food safety network (EFSN)
 - at present time there are harmonised 106 EU horizontal approach directives

PROBLEM 6

Slide 27

Conclusions and future plans (1)

- Implementation of Latvian Food and Nutrition Action Plan will advance the health and quality of life of all Latvian people
- The implementation of this plan will meet the requirements of the EU states, recommendations of WHO, UNICEF and other international authorities

Slide 23

Legislation harmonisation programme in accordance with the ACQUIS under the management of DG III

	Implemented	Draft, advanced	Except
Horizontal approach			
• Labelling	✓✓	49/2000/EEC, 50/2000/EEC, 88/2001	
• Food additives	✓✓		
• Processing aids	✓✓		
• Materials and articles in contact with food	✓✓		
• Foodstuffs for particular nutritional uses	✓✓		
• Control and hygiene	✓		85/591/EEC
• Contamination	✓✓		
• Manufacturing and processing of foodstuffs		22/97/EEC, 88/2001, 89/187/EEC, 12/2001	83/5/EEC
• Scientific examination			94/63/EEC, 94/62/EEC

✓✓ - implemented completely, in accordance with ACQUIS
✓ - implemented partly

PROBLEM 6

Slide 28

Conclusions and future plans (2)

- In accordance with the comments received from other Ministries, having regard the experience of previous years as well as the new Regulation of CM "On Procedure of Cabinet of Ministers" (Nr. 111;12.03.2002) we have decided to change FNAP as "Basic goals for development of Nutrition Policy in Latvia for 2002-2012"
- The main priorities to realize the Action Plan will be the problems related to children nutrition and optimizing and modernizing existing food monitoring laboratories to fortify monitoring of nutritional status of Latvian population

Slide 24

Legislation harmonisation programme in accordance with the ACQUIS under the management of DG III

	Implemented	Draft, planned	Except
Vertical approach			
• Erucic acid	✓✓		
• Cocoa and chocolate products		December/2002	
• Sugars	✓✓		
• Honey	✓✓		
• Fruit juices and similar products		December/2002	
• Fruit jams, jellies, marmalades and chestnut purée		December/2002	
• Dehydrated preserved milk		December/2002	Standard for analysis, 2001
• Caseins and caseinates	✓✓		
• Mineral water	✓✓		
• Coffee and chicory extracts		December/2002	Standard on coffee and chicory analyses, 2001

✓✓ - implemented completely, in accordance with ACQUIS
✓ - implemented partly

PROBLEM 6

Slide 25

Current problems, solutions
PROBLEM 7

Public Information
Surveys on nutrition in the Baltic States show that both the economic factors of consumers as well as lack of information on safe and healthy nutrition obstruct the choice of safe and healthy food, because:

- more than 60% of the population admit that price is the determining factor in their choice of food;
- less than 33% of the population know that different fats in food pose different health risks;
- 67% of respondents know that excessive use of salt in food may be harmful to health

Lithuania

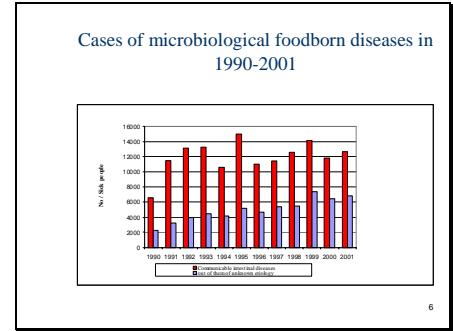
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LITHUANIAN FOOD AND NUTRITION ACTION PLAN

2002-2010

1

Slide 6



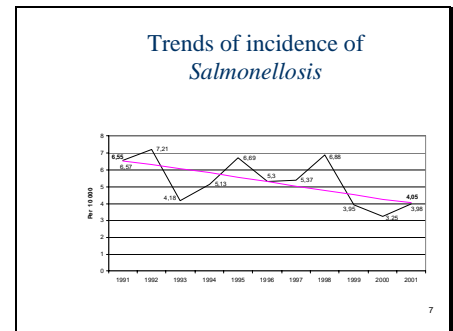
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TIMING

- The process of formation of National Food and Nutrition Action Plan started in Autumn 2000 with the aim to implement regulations established in many international documents and national legal acts
- 2001 the first version of National Food and Nutrition Action Plan was prepared
- In December 2001 a Task Force, devoted to finalize the National Food and Nutrition Action Plan, was approved by State Public Health Service under the Ministry of Health
- In May 2002 The Draft Lithuanian Food and Nutrition Action Plan (version 2) was approved by National Health Board under the Lithuanian Parliament

2

Slide 7



Slide 3

DRAFTING TEAM

- A Task Force (2001) consists of the following members:
 - A. Abaravicius - National Nutrition Center, Doctor, Associate Professor of the Medical Faculty of Vilnius University (head of the task force)
 - A. Astrauskiene – State Public Health Service under the Ministry of Health, Deputy Director
 - R. Bartkeviciute - National Nutrition Center, Head of Division
 - D. Bilkienė - Food Products Inspection of the State Food and Veterinary Service, Deputy Head
 - A. Liubeckiene - Chief Specialist, Food Board Agriculture Development and Food Department Ministry of Agriculture
 - J. Petkeviciene - Institute for Biomedical Research, Kaunas Medical University, Senior Scientific Researcher
 - R. Petkevicius – WHO, Liaison Officer, Lithuania
 - G. Trinkuniene - Ministry of Education and Science, Senior Specialist of Higher Education and Studies

3

Slide 8

Dietary habit of Lithuanian population highlights the current situation in:

- Food supply for Lithuanian population
- Nutritional status of pregnant women
- Nutritional status of infants, young children, adolescents and school - children
- Nutritional status of the elderly

8

Slide 4

Lithuanian Food & Nutrition Policy contains the analysis of:

- Food Safety in Lithuanian Republic
- Diet and Health of Lithuanian Population
- Sustainable Food Supply System in Lithuanian Republic
- Education and Training of Professionals

4

Slide 9

Food supply for Lithuanian population emphasizes insufficiency of vegetables, fruits and berries (1990-2000: in kilograms, per capita per year)

	Year	1990	1995	1996	1997	1998	1999	2000
Meat and meat products, expressed as meat	39	52	51	48	48	53	53	49
Milk and milk products, expressed as milk	476	238	213	208	187	203	245	245
Eggs, units	304	172	167	174	172	168	163	163
Fish and fish products	18.6	9.9	11.4	11.4	12.5	12.6	13.2	13.2
Sugar	43.2	22.2	23.5	22.6	21.0	20.0	24.0	24.0
Oil	7.3	11.5	12.8	12.8	12.8	12.5	15.6	15.6
Potatoes	146	127	133	124	131	125	127	127
Vegetables, water-melon, melon, etc.	79	65	71	70	78	83	81	81
Fruits and berries (not processed into wine)	33	48	52	60	60	55	59	59
Cereal products (bread, macaroni, expressed in flour, flour, grains)	108	136	142	148	146	135	129	129

9

Slide 5

Food safety in Lithuanian Republic:

- Recognizing the position of the European Commission regarding prioritization of food safety, Lithuania has drafted a "Food Safety Strategy". It was approved by the Order No. 124 of the Minister of Agriculture of the Republic of Lithuania on April 24, 2001. The Strategy provides the evaluation of the current situation and describes the competency of state institutions with respect to the formulation and implementation of the food safety policy and its control. The Strategy also provides an analysis of the approximation of the Lithuanian legal framework with the EU law, and describes the preparedness of each sector (food phytosanitary, veterinary and feedstuffs) to administrate food safety issues
- A food safety strategy highlights the need to prevent contamination, both chemical and biological, at all stages of food chain
- A food safety strategy emphasizes the high prevalence of biological contamination of food

5

Slide 10

According to the data of the Baltic Nutrition and Health Survey (1997), the diet of Lithuanian population is unhealthy:

- Fat constituted about 44% of daily energy intake
- Carbohydrates - around 41E%
- Proteins - 13.5-14E%

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Slide 11

According to the data of Health Behaviour Survey among Lithuanian Adult Population (1994-2000) nutrition has become more healthy:

- The proportion of persons using mostly vegetable oil for cooking has doubled
- There is seen a clear decreasing trend in use of butter on bread
- The positive changes in consumption of vegetables have occurred

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Slide 16

Production of right sorts of agricultural foodstuffs in Lithuania (since 1990 production of vegetables, fruits and berries has still been insufficient)

Year	1990	1995	1996	1997	1998	1999	2000
Cereals	876	526	729	824	762	571	739
Potatoes	422	429	551	494	499	462	485
Vegetables	79	99	117	112	118	88	89
Fruits and berries	23	35	26	74	32	32	30
Meat (carcass)	142	56	54	54	55	52	50
Milk	847	490	494	526	521	463	467
Eggs, units	342	213	202	215	214	197	197

Production of agricultural foodstuffs per person (in kilograms)

Source: Data by the Lithuanian Department of Statistics, 2001

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Slide 12

Health status of Lithuanian population highlights the current situation in:

- Cardiovascular diseases
- Cancer
- Caries
- Obesity and overweight
- Osteoporosis
- Diabetes

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Slide 17

Development of sustainable agriculture (the number of ecological farms in the country is growing steadily)

Year	1996	1997	1998	1999	2000	2001
Number of farms	65	106	144	171	220	260
Area of certified land plots (ha)	1118	1598	4006	3995	4709	6158

Development of ecological agriculture in Lithuania

Source: Data by "Ekogems", body for certification of organic agriculture, 2002

17

Slide 13

The mortality of CVD, which kept increasing from 1990 through 1994, has begun to decrease:

13

Slide 18

Lithuanian Food and Nutrition Action Plan Includes:

- Analysis of Strengths, Weaknesses, Opportunities and Threats of Current Situation (SWOT analysis)
- Vision
- State Mission
- Strategic Goal and Directions
- Conceptual implementation of the Action Plan, 2002-2010

18

Slide 14

Irrespective of positive changes, the rate of CVD mortality in Lithuania is much higher than that in EU countries (death cases per 100 000 of population):

14

Slide 19

Strategic Goal and Directions

- The goal of the Lithuanian Food and Nutrition Policy is to protect and promote health, and to reduce the prevalence of diseases related to unhealthy nutrition, while contributing to social and economic development of the country, and sustainability of the environment
- The major directions of Lithuanian Food and Nutrition Policy are as follows:
 - Food safety improvement
 - Promotion of healthy nutrition
 - Implementation of a sustainable food supply of all population groups in Lithuania with food of good quality produced in sustainable environment
 - Monitoring of the changes in nutritional status of the population, and nutrition - related health issues

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Slide 15

Sustainable Food Supply System in Lithuanian Republic comprises:

- Production of right sorts of agricultural foodstuffs in Lithuania
- Development of sustainable agriculture
- Nutrition of the Lithuanian population in emergency situation

15

Slide 20

Conceptual implementation of the Action Plan, 2002-2010

- Actions designed to maintain food safety
- Actions designed to improve nutrition of population
- Measures targeting an equitable supply of the Lithuanian population with quality foodstuffs produced in the sustainable environment
- General activities

20

Slide 21

National Endorsement

- It is planned to complete implementation of the Lithuanian Food and Nutrition Action Plan by the year 2010 (in accordance with regulations of the Lithuanian Health Program).
- An interim evaluation of the Action Plan and its revision will be carried out in 2005 (in accordance with obligations to the WHO).
- While implementing an Action Plan of the Lithuanian Government Program 2001-2004, a detailed plan for the implementation of the Food and Nutrition activity will be developed in 2003.

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IDD Elimination and Breastfeeding

Slide 1

IDD Elimination & Breastfeeding

Workshop on Development of Food
and Nutrition Action Plans
Estonia 10-12 June 2002

Arnold Timmer
UNICEF - Regional Office for
CEE/CIS and the Baltics

Slide 6

IDD ... A Challenge

*IDD is a medical problem and should be solved by public
health sector*

versus

*IDD is a nutritional problem and requires involvement of
food sector*

Prevention of iodine deficiency

versus

Ensuring adequate iodine nutrition

Slide 2

IDD Elimination through USI

Goal: sustainable elimination of IDD by 2005
Strategy: Universal Salt Iodization (USI) by end
2003

Key issues:

- Smart start for next generation
- Iodine needs to be provided to the entire population
regularly and forever
- USI: 90% of households use iodized salt (IS)
- All salt for human and animal consumption
- Not to increase salt use but to use iodized salt

Slide 7

**IDD in the Baltics: a Public
Health Problem?!**

- Standard: mean urinary iodine >100 mcg/L
- Estonia:
 - Mean urinary iodine: 65 mcg/L
 - 10,800 newborns/year unprotected (total=12,000)
- Lithuania:
 - Mean urinary iodine: 75 mcg/L
 - 35,000 newborns/year unprotected (total=37,000)
- Latvia:
 - Mean urinary iodine: 59 mcg/L
 - 18,000 newborns/year unprotected (total=19,000)

Slide 3

**The Agreement:
IDD Elimination through USI**

- Special Session January 1994: Joint
UNICEF-WHO Committee on Health
Policy
- UN Special Session on Children 2002
-A World Fit for Children-

Your governments signed the goal to
eliminate IDD by 2005!

Slide 8

Some Remarks about Surveys

- Urinary Iodine:
 - Measure of iodine intake
 - Not for individual use, only for population assessment
 - Not only look at % < 100 mcg/L: median is used for the
entire population
- Study group is school children:
 - Easy to reach (in one central location: school)
 - Represent entire population
- Results:
 - Reflect all population groups, not only school children!

Slide 4

IDD ... A Reminder

- From affected individuals to deficient populations:
iodine deficiency affects the whole population
- Iodine = mental performance intelligence
- Iodine deficiency decreases IQ by 10-15 % of
ALL individuals and all population groups
- In an iodine deficient population, goiter, cretinism,
and mental or cognitive deficits coexist

Slide 9

Food and Nutrition Action Plans

- Recognize that IDD is a public health problem
- Goal: programme for IDD elimination through USI not
clearly indicated in FNAPs
- Activities not sufficient to achieve goal, in time:
 - targeted at: studied groups, groups with low Urinary Iodine
 - conduct more studies
 - decrease goiter %
 - monitor iodine deficiency in food
 - iodized salt for certain population groups

Slide 5

*A Public Health Problem
that Affects the Whole
Population requires a
Solution that reaches the
Whole Population!*

Slide 10

Food and Nutrition Action Plans

- Example: study showed that children suffer
from iodine deficiency
- Solution: prevention of goiter by using iodized
salt in child care institutions
- Ensure adequate iodine nutrition for all
- Protect all people from intelligence loss

Slide 11

Food and Nutrition Action Plans

- Suggestions for improvement:
 - Scientific evidence exists that IDD is a public health problem in entire population and all population groups which requires population wide intervention
 - IDD elimination by 2005 endorsed goal by all Baltic States in SSC 2002
 - To achieve the goal, and in time: USI is the strategy to eliminate IDD
 - Sustainability to be ensured through National Coalition with oversight function

Slide 12

Latvia

- In May 2002, UNICEF-supported mission to advise on National POA for IDD
- Achieve IDD elimination by 2005:
 - USI endorsed as the strategy
 - Legislation: all table salt and salt for bread baking has to be iodized
 - Public Health Parliamentary Sub-committee for society-wide consultation in July 2002
 - Formulation of National Plan of Action
 - Monitoring system and communications plan

Slide 13

Breastfeeding and BFHI in FNAPs

- Attention areas:
 - Breastfeeding promotion and protection needs to be enforced
 - The International Code to become part of health reform
- Incorporate BFHI into the health system:
 - expand BFHI to Primary Health Care level
 - expand BFHI to all hospitals with maternity services
 - UNICEF willing to support

Global Burden of Disease

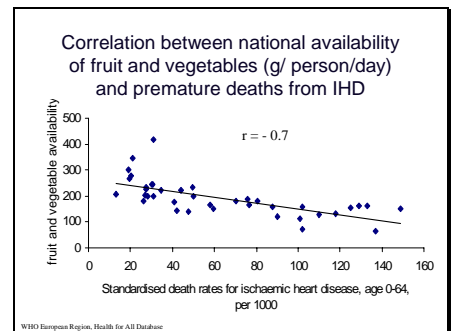
Slide 1

The Global Burden of Disease attributable to low Fruit and Vegetable Consumption

Karen Lock, Joceline Pomerleau and Martin McKee
London School of Hygiene and Tropical Medicine

A WHO Collaborating Centre on Health of Societies in Transition
<http://www.lshtm.ac.uk/centres/ecohost/>

Slide 6



Slide 2

Global Burden of Disease (1990)

- Previous estimate in 1990 only considered 10 risk factors
- The only nutrition- related was protein energy malnutrition
- In the revision for the year 2000- felt important to get nutritional risk factors included as this is a high profile WHO report and important policy tool

Slide 7

Attributable burden: methods

- Calculating intake for each region by age and sex (g/person/day)
- Combine intake survey data by country and FAO food balance sheets where no survey data available
 - Adequate national data only from 26 countries- this includes Estonia, Latvia, Lithuania
 - Had to make assumptions about whether population distribution of intake similar in different countries

Slide 3

% total DALYs lost, estimated 1990
source: Murray & Lopez, WHO 1996

Infectious diseases	7.10%
- diarrhoeal	0.23%
Nutrient deficiencies	0.87%
CVD	18.60%
- CHD	9.00%
- strokes	5.00%
Diabetes	2.40%
Cancer	15.00%
Mental Health	25.00%
Accidents	11.90%
TOTAL	100.00%

Slide 8

Included studies

Data available for 26 countries within 9 WHO Regions

Amr A: USA
Amr B: Argentina, Mexico
Emr B: Kuwait
Eur A: Belgium, Denmark, Finland, France, Germany, Ireland, Israel, Italy, Norway, UK
Eur B: Bulgaria
Eur C: Estonia, Kazakhstan, Latvia, Lithuania, Russian Fed.
Sear D: Bangladesh, India
Wpr A: Australia, Japan, Singapore
Wpr B: China

No survey data: Afr D, Afr E, Amr D, Emr D, Sear B

Slide 4

New revision of the Global Burden of Disease (2002)

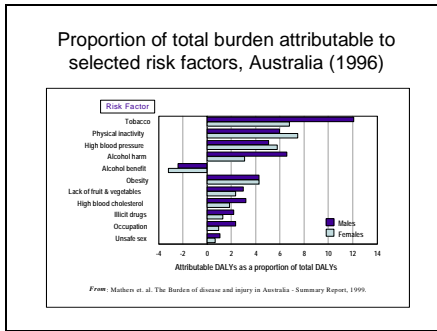
- GBD revised for year 2000- to be published in WHR 2002
- New approach- comparative risk assessment
 - Burden of disease attributable to about 20 risk factors assessed using common methods
 - Lifestyle, environmental and occupational factors
- Nutrition-related risk factors included:
 - low fruit and vegetables, obesity, serum cholesterol, physical activity

Slide 9

Attributable burden (2)

- Conducting systematic reviews for 6 major risk factors and estimating summary relative risk: Ischaemic heart disease, stroke, lung, colorectal, stomach and oesophageal cancers
 - Assume linear relationship (?minimum threshold or plateau effect)
 - Interactions with other risk factors and residual confounding
- Working with WHO Geneva to calculate the number of DALY's attributable assuming maximum ideal intake 600g/day

Slide 5



Slide 10

Avoidable Burden

- Predict regional availability using linear regression from FAO FBS trends
- Calculate proportional change in F&V at 5 year interval to 2030 (vs 2000 intake)
- Apply to intake by age and sex already modelled
- Estimate risk reversibility over time (but limited evidence)
- CAUTION required in interpreting this as several limitations: lack of time trend data on food intake, rapid changes can occur in diet, did not take into account culture, socio-economic status etc

Slide 11

Implications of the GBD 2000 for policymaking

- Criticised for merely quantifying what we already know, does not look at the effectiveness of interventions to alter risk factors
- + Puts nutritional risk factors on national and global policy agendas

Slide 12

Implications of diet-related disease

- GBD confirms high public health cost of diet-related disease
 - Both years of life and quality of life lost
- Does not account for social costs e.g. 25% of EU women widowed before 65 due to CHD

All the costs fall on health care systems/ health insurance

- externalities of agricultural or food sectors

[NB CAP expenditure = over €38 million (1998)]


Health Impact Assessment

Slide 1


Health Impact Assessment

Dr Karen Lock

London School of Hygiene and Tropical Medicine




A WHO Collaborating Centre on Health
of Societies in Transition



Slide 6

3 levels of analysis

- **Screening:** minutes/ hours
– e.g all organisational policy
- **Rapid appraisal:** days
- **In-depth analysis:** months
– e.g. selected project or policy



Slide 2

Definition of HIA

“A combination of procedures, methods, and tools by which a policy, programme, or plan may be judged as to its potential effects on the health of population and the distribution of those effects within the population”

(Gothenburg consensus paper, 1999).

Slide 7

What has it been used for?

- **Urban Planning:** 
– Urban regeneration, transport strategies
- **Lobbying:** Manchester Airport Inquiry
- **National Policy Appraisal:** Canada, Holland
- **Developing countries:** appraisal of donor aid projects e.g. World Bank, FAO


Slide 3

What is Health Impact Assessment?

- Potential method of improving evidence-based decision making
- Broad model of health
- Structured framework for informing more transparent decision-making
- Multidisciplinary, inter-sectoral
- Brings together other existing methods
 - policy appraisal, stakeholder analysis, public involvement, EBM

Slide 8

HIA on Environmental Energy Tax Policy, The Netherlands



- Parliamentary concern for the impact of an increase in environmental energy tax (1996).
- The HIA led to better government insight into the energy needs and income status of chronically ill and handicapped.
- Extra money was provided in the budget to provide for subsidies.


Slide 4

Determinants of health

Pre-conceptual/ in-utero	Maternal nutrition, health during pregnancy
Behaviour/ lifestyle	Diet, smoking, exercise, risk taking behaviour
Psycho-social environment	Community networks, culture, social exclusion
Physical environment	Air, water, housing, transport, noise.
Socio-economics	Employment, education, training.
Public services	Transport, shops, leisure, health & social services.
Public Policy	Economic, welfare, crime, health policies

Slide 9

HIA and the London Mayor



- Rapid HIA of all the City strategies at an early stage
– E.g. Urban planning / Transport / Air quality
- Early lessons from process
 - Benefits for intersectoral working
 - Put health on the agenda in city authority
 - Tensions between political timeframes and ability to provide ‘evidence’

Slide 5

Stages in an HIA process

Policy and programme development phase for prospective assessments

Policy implementation phase

Screening	Quickly establishes ‘health relevance’ of the policy, programme or other development.
Scoping	Where health relevance exists, identifies questions the appraisal needs to ask
Appraisal	Assessment of health impacts using available evidence – may be rapid appraisal or in-depth assessment
Reporting	Conclusions and recommendations to remove/mitigate negative impacts on health or to enhance positive aspects
Monitoring	Action, where appropriate, to monitor actual impacts on health to enhance existing evidence base

Slide 10

Other examples in Europe

- The Welsh Assembly: HIA integrated into the assembly policymaking e.g HIA of EU objective 1 funds
- Swedish County Councils guide to health impact assessment
- C.E. Europe - focus on Environmental health impacts e.g waste, water

Slide 11

Integrating HIA into other processes

- HIA similar to other impact assessments
- Traditionally EIA has not considered human health
- European Union legal requirement for EIA
- Current work with WHO to strengthen HIA in Strategic Environment Assessment (SEA) as part of UNECE protocol negotiations

Slide 16

Limitations of HIA

- No agreed methods
 - All are currently unevaluated
- Difficulty measuring health impacts
 - Managing expectations of evidence Vs limited evidence often available
 - Not decision-making tool
- Unclear methods to prioritise evidence
- Trade-off between timing, resource costs and depth of analysis

Slide 12

Examples of HIA of agricultural policies

- Swedish Institute of Public Health
 - HIA of CAP (descriptive)
- Canadian EHIA
 - Pig farming
 - fruit growing
- UK Dept of Health
 - Health risk assessment of the food and mouth disease outbreak



Slide 17

How to take HIA forward?

- Just get involved
 - “Learning health impact assessment by doing”
- Look for opportunities e.g. public or political concern
- Manage expectations of process
 - Not '1 perfect method' & No 'absolute answers'
 - Insufficient resources for every project/ policy in depth
- Decide on your focus
 - 'cheerleader' (public health advocacy) or 'analytical'
 - Projects versus policies, Rapid versus in depth

Slide 13

HIA of accession on food and agricultural policies in Slovenia

- Collaboration between WHO and Slovenia MOH
- Initial scoping meeting February 2002
 - wide range of stakeholders
 - opinions on potential health impacts
- Policy appraisal: working with agricultural economists at Univ of Ljubljana to look at the policy implications of the CAP in Slovenia

Slide 14

HIA Slovenia (2)

- Planning data collection:
 - Review the evidence for the links between the effects of agricultural policy and health outcomes via determinants (food safety, social capital, nutrition)
 - What indicators we need to look at the impacts in Slovenia- what data is available, both health and non health
- Appraising the most important health impacts with Slovenian colleagues
- Making recommendation of mitigation measures- to interdepartmental committee

Slide 15

Positive results of the HIA process

- Provides a mechanism for health to inform decision making
- Improves inter sectoral working
 - Demonstrating the broad health agenda to other agencies
- Raises community awareness of health
 - Encouraging public participation in decision making
- Transparent decision making

Iodine Deficiency Disease elimination and universal salt iodization

Slide 1

Food Administration of Denmark

Iodine deficiency disease elimination and universal salt iodisation

The Danish Investigation of Iodine Intake and Thyroid Disorders

Lars Ovesen

1

Slide 6

The Danish Investigation of Iodine Intake and Thyroid Disorders

Cohort Study

Study population

Invited: 9,274

Full participation: 4,649 (50.1%)

Short questionnaire: 2,485 (26.8%)

No response: 2,139 (23.1%)

6

Slide 2

The Danish Investigation of Iodine Intake and Thyroid Disorders

The Basic Questions

- What is the need and reference intake?
- What is the actual consumption?
- Which are the susceptible groups?
- What strategies are best to improve supply?
- What measures are best to prevent consumption of excess?
- Will fortification influence dietary habits?

2

Slide 7

The Danish Investigation of Iodine Intake and Thyroid Disorders

Cohort study

Examinations performed:

Ultrasonography

Physical examination

Questionnaire (alcohol, smoking)

Blood biochemistry (TSH, free T₄, free T₃)

Spot urine (I)

7

Slide 3

The Danish Investigation of Iodine Intake and Thyroid Disorders

Iodine intake (µg/10 MJ)

Frequency distribution from the Danish Dietary Survey 1995

3

Slide 8

The Danish Investigation of Iodine Intake and Thyroid Disorders

Cohort study

Iodine excretion, and thyroid enlargement and pathology in areas with mild and moderate ID

	Iodine excretion (µg/L)	Enlarged thyroid (%)	Palpable goitre (%)	Solitary nodules (%)	Multiple nodules (%)
Copenhagen 68 (n = 2,419)	15.1	9.8	5.6	11.5	
Aalborg 53 (n = 2,174)	22.5	14.6	6.3	11.0	
P	< 0.001	< 0.001	< 0.001	0.33	0.69

8

Slide 4

The Danish Investigation of Iodine Intake and Thyroid Disorders

Aims:

In two areas in Denmark (Aalborg - west, and Copenhagen - east)

- Examine changes in the occurrence and distribution of clinical and subclinical thyroid disorders
- Examine changes in intake of sodium and iodine

in order to

- Estimate optimum levels of iodine fortification

4

Slide 9

The Danish Investigation of Iodine Intake and Thyroid Disorders

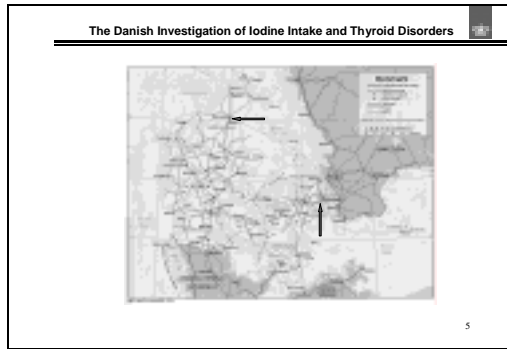
Strategies to improve supply

Policy instruments

- Nutrition information and education
Advantage: No toxicity risk
Disadvantage: Dietary habits stable
- Recommendation of the use of supplements
Advantage: Same dosage
Disadvantage: Less effective
- Food fortification
Advantage: Effective towards target group
Disadvantage: All will be exposed

9

Slide 5



Slide 10

The Danish Investigation of Iodine Intake and Thyroid Disorders

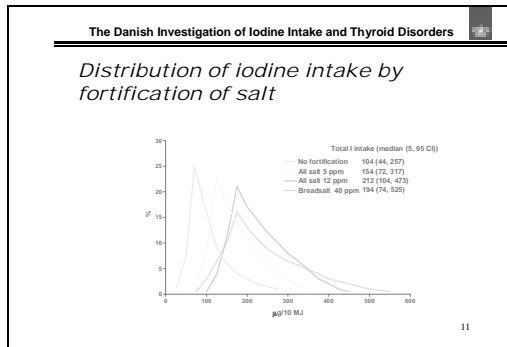
How much iodine in a recommended diet (estimated 24 h iodine excretion)?

	1	2	3
Copenhagen	75 (53-115)	93 (67-133)	114 (85-165)
Aalborg	48 (32-62)	63 (43-91)	70 (54-101)

1: <100 g of fish per week and < ½ glass of milk per day
3: 200 g of fish per week and ½ litre of milk per day

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Slide 16

The Danish Investigation of Iodine Intake and Thyroid Disorders

Why did it fail?

- Technological concerns
- Costs
- Claims

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Slide 12

The Danish Investigation of Iodine Intake and Thyroid Disorders

Principles for fortification
Selective vs. non-selective approach

Selective approach
Risk perception focused on avoidance of nutrient deficiencies

Non-selective approach
Risk perception focused on upper safe intake

- Only permissible if nutritionally justifiable, *i.e.*, deficiency in a larger part of the population
- Fortification must effectively increase intake and remedy deficiency
- Mandatory vs. voluntary

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The Danish Investigation of Iodine Intake and Thyroid Disorders

Consequences of fortification

07/2000: Mandatory fortification

Salt for household and bread: 13 µg/g
Median (5-95 percentile): 50 (23-142) µg/day

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The Danish Investigation of Iodine Intake and Thyroid Disorders

Iodine fortification in Denmark

- 1920: Voluntary fortification of table salt
- 1982: Iodine fortification prohibited
- 06/1998: Voluntary fortification of all salt

All salt: 8 µg/g (market share: 75%)
Median (5-95 percentile): 50 (28-99) µg/day

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Slide 18

The Danish Investigation of Iodine Intake and Thyroid Disorders

Shifts in hyper- and hypofunction of the thyroid with iodine intake

Low intake areas	High intake areas
Hyperthyroidism	Hypothyroidism

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Slide 14

The Danish Investigation of Iodine Intake and Thyroid Disorders

Implementation of a voluntary iodine fortification programme

- Political support – passage of statutory instruments and budgetary allocation
- Support from salt industry, and major professional and industrial bodies
- Communication to health professionals and the public
- Establishment of a monitoring and evaluation system

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The Danish Investigation of Iodine Intake and Thyroid Disorders

Types of hyperthyroidism in high and low intake areas

Laurberg et al
J Intern Med 1991

Slide 15

The Danish Investigation of Iodine Intake and Thyroid Disorders

Voluntary fortification
iodine fortification of household salt (% market share)

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Slide 20

The Danish Investigation of Iodine Intake and Thyroid Disorders

Measures to prevent excessive intakes

- Aim for the lowest effective dose
- Establish a system for monitoring intake and adverse effects
- Perform regular inspection of salt production facilities and analytical control of level of fortification

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The Danish Investigation of Iodine Intake and Thyroid Disorders

Will fortification influence dietary habits?

A gradual decrease in average sodium intake corresponding to 5 gram of salt per person per day is desirable

Nordic Nutrient Recommendations, 1996

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Slide 22

The Danish Investigation of Iodine Intake and Thyroid Disorders

Conclusions

- Improve data for upper and lower safe intake levels
- Improve data on intake, especially the tails of intake
- Establish a system which effectively can monitor effect *and* toxicity
- Involve all stakeholders in the "project"

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Slide 23

The Danish Investigation of Iodine Intake and Thyroid Disorders

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Norbagreen Project


Slide 1



Liisa Valsta and Minna Similä, Finland
Wulf Becker, Sweden
Lars Johansson, Norway
Lars Ovesen, Denmark
Janina Petkeviciene, Lithuania
Iveta Pudule, Latvia
Holmfridur Thorgeirsdottir, Iceland
Sirje Vaask, Estonia

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Slide 6




Methods

- FFQ contains frequency questions (not portions) on
 - total consumption of each food category
 - different preparation forms
 - individual items (vegetables, fruit and berries)
- eating usually mixed/vegetarian food
- demographic background questions (13)

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Slide 2




Background

- Increased consumption of fruits and vegetables is an important goal in public health work.
- At EU level, in addition to fruit and vegetables, also bread and fish are included in the list of diet indicators for health (at food level) that should be monitored (Eurodiet2000 project, Report from the French presidency, EFCOSUM project).

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Slide 7




Validation of the NorBaGreen FFQ

- One Nordic and one Baltic validation study are carried out in 2002 parallel with the main study.
 - Lithuania: sample (n=105)
 - April FFQ and 24h recall
 - May-June 24h recall
 - August 24h recall
 - September FFQ and 24h recall
 - Finland: a FINDIET 2002 subsample (n=213)
 - January-March FFQ vs. 3-d food records (n=125, 59%)
 - September FFQ vs. 3-d food records repeated

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Slide 3




Background

- The NorBaGreen project is a follow-up of the work done by the Nordic project group NORDGRÖNT (1996-1998).
- The Nordic project group NORDGRÖNT proposed an outline for a FFQ concerning vegetable and fruit consumption.
- The NORDGRÖNT FFQ was validated in Sweden. Spearman's r_s (FFQ vs. 4x 24h recalls) was 0,52*** for vegetables and 0,63*** for fruit and berries. (Persson 1999).

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Slide 8




NorBaGreen main study

- Information collected from ≈1000 persons/country (+250 in Åland).
- Age range 15-74 years (in Sweden and Denmark 16-80 years)
- Interviews were carried out in April-early May 2002 in every country coordinated by TOY Research (Taloustutkimus OY) in Finland. (GfK Danmark A/S, ES Turu-uuringute AS, Gallup Iceland, Latvian Facts, Vilmorus Ltd, Opinion AS, GfK Sverige AB)

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Slide 4




Goals

- Produce and formally test a FFQ monitoring the consumption of the proposed food based diet indicators for health: vegetables, fruit and berries, bread and fish. In addition questions concerning potato consumption were included.
- Study consumption of these foods with a comparable method in all the Nordic and Baltic countries.

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Slide 9




Data collection and sampling

- In the Nordic countries a Computer Assisted Telephone Interview method (CATI) was used.
- Country representative CATI sample: randomly drawn from the household numbers with a representative geographical distribution (mobile phone numbers were included in Finland).
 - Respondent selected by using the last birthday or next birthday method. If not reached, time for an interview was scheduled.

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Slide 5




Methods

- A pre tested joint FFQ in English
 - local modifications (max. 3 additional rows/country)
 - translations into 9 languages
 - translations back to English
- 12 different versions of the FFQ including 3 Russian versions for the Baltic countries and an additional Swedish version for Åland/Finland

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Slide 10




Data collection and sampling

- In the Baltic countries face-to-face paper assisted personal interviews (PAPI) were used.
- Country representative PAPI sample: 100-120 different sampling points/country taking into account the number of inhabitants in each area. Selection of the household by the random route procedure and starting address method.
 - Respondent selected by the following rules:
 - Estonia: younger man rule in cities and towns, in villages and country areas randomly chosen from the list of residents.
 - Latvia: Kish table
 - Lithuania: Birthday rule or Kish tables.

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Slide 11

 **Results / participation**

- Country representative samples (≈1000 completed interviews/country; 250/Åland)
- Number of refusals differ between countries:

Iceland	429
Denmark	2699
Finland	996 (Åland 48)
Norway	992
Sweden	1352
Estonia	328
Latvia	228
Lithuania	346

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Annex 2: Programme

Monday 10 June

1900 Welcome Reception

Tuesday 11 June

0800-0830 **Registration**

Opening

Chairperson: Dr Laufey Steingrimsdottir

0830-0900 Introductions

Country Presentations

Chairperson: Dr Laufey Steingrimsdottir

0900-0930

Estonia – Development of Estonian Food and Nutrition Policy

0930-1000

Latvia - Development of Latvian Food and Nutrition Policy

1000-1030

Coffee break – group photo will be taken

1030-1100

Lithuania - Development of Lithuanian Food and Nutrition Policy

1100-1230

General discussion

1230-1300

UNICEF work in the Baltic countries, Dr Arnold Timmer

1300-1430

Lunch

Technical Presentations

Chairperson: Dr Lars Ovesen

1430-1500

Global burden of disease, Karen Lock

1500-1530

Discuss updated nutrition policy questionnaire re comparative analysis of food and nutrition policies for ministerial conference in 2005

1530-1600

Coffee break

1600-1630

Health Impact Assessment (HIA) of agriculture policies, Karen Lock

1630-1700

Iodine Deficiency Disease Elimination and Universal Salt Iodization,
Lars Ovesen

1700-1730

Norbagreen Project, Liisa Valsta

1900

Dinner and social programme organized by Estonian hosts

Wednesday 12 June

0830-1130

Nordbalt Public Health Nutrition Network (see attached agenda)

Chairperson: Iveta Pudule

1000-1030

Coffee break

1130-1200

Closure

1200-1300

Lunch

1300

Departure for Tallinn by mini-bus

**Nordbalt Public Health Nutrition Network
Proposed Agenda**

Chairperson: Ms Iveta Pudule (Latvia)

1. Establishment of the Nordic-Baltic Public Health Nutrition Network

Opening of the meeting

Adoption of the agenda

2. Purpose of the network

As expressed in the application for funds, the purpose of the Nutrition Network is to provide a permanent forum for cooperation, strategic discussions, and exchange of experiences in the field of public health nutrition. All aspects in connection with national food and nutrition action plans (from creation and development to rewriting and evaluation) are included.

3. Participation in the network

According to the application, participants in the Nutrition Network are the eight Nordic countries as well as the three Baltic ones, on equal grounds. Members of the network will be appointed nationally, ideally two persons per country, representing the national organisational structure in the field. The number of members is to be adjusted according to the national structure.

4. Long-term programme for the network

Discussions and decisions.

1. Follow-up of FNAP
2. Think-tank (ideas and topics to be developed)
3. Annual meetings
4. Budget and application for funds
5. Other subjects

5. Other activities in 2002

A second meeting in 2002? Suggestions are welcome!

6. Background information

Nordic Committee of Senior Officials for Food Issues / Nordic Council of Ministers

Baltic Council of Ministers

International organisations

7. Evaluation of the meeting

8. Next meeting – date and topic

Annex 3: List of participants

Participants from Baltic countries

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