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REGIONAL OFFICE FOR EUROPE

INTERSECTORAL FOOD AND NUTRITION POLICY DEVELOPMENT

A MANUAL FOR DECISION-MAKERS

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ABSTRACT

The dynamic world food system makes it hard for governments to keep pace with the changes and at the same time protect public health. Recent food scares such as the BSE crisis in the United Kingdom, the Asian flu crisis with chickens in Hong Kong and China and the breakdown of the food supply system in the Former Soviet Union highlight the importance of global surveillance and response. The changes in public health systems and health protection legislation that is needed can be difficult to introduce both at international and national levels. Consistent food and nutrition policies are important from international, national through to the local level. The need for managing human and financial resources cannot be underestimated when trying to initiate institutional change. Enlightened administrators and policy-makers play a key role in enabling these changes. After high-level decision-makers are sensitized to the need for a food and nutrition policy to ensure public health, decision-makers are more likely to support an intersectoral approach. This workshop is multidisciplinary and intended for policy-makers, and their advisers, working in the sectors connected with food. It is not intended to convey new technical information but focuses on using their current information to develop national action plans. The participants can come from a range of backgrounds: health, agriculture, environment, education, social welfare, finance, academia, the food industry, and the nongovernmental or voluntary sector. A successful food and nutrition policy will be developed by involving all the relevant sectors and key players. It is imperative that the participants attending this workshop represent as many sectors as possible. Participants who complete the workshop will be equipped with some of the skills necessary to develop a food and nutrition policy at a national or local level.

Keywords

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Intersectoral Food and Nutrition Policy Development

A manual for decision-makers

This manual contains materials to run a workshop on food and nutrition policy and the development of a national action plan to improve public health.

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Workshop Guide

Background

The 1992 International Conference on Nutrition (ICN) served as a motivating force for countries around the world to develop and implement food and nutrition policies and plans of action.

The dynamic world food system makes it hard for governments to keep pace with the changes and at the same time protect public health. Recent food scares such as the BSE crisis in the United Kingdom, the Asian flu crisis with chickens in Hong Kong and China and the breakdown of the food supply system in the Former Soviet Union highlight the importance of global surveillance and response. The changes in public health systems and health protection legislation that is needed can be difficult to introduce both at international and national levels. Enlightened administrators and policy-makers play a key role in enabling these changes. Food and nutrition policy is important at international and national through to the local level. After national high-level decision-makers are sensitized to the need for a food and nutrition policy to ensure public health and recognize that this will only be achieved through intersectoral development, they are likely to support this approach. The need for managing human and financial resources cannot be underestimated when trying to initiate institutional change through these new polices.

This workshop is multidisciplinary and intended for policy-makers, and their advisers, working in the sectors connected with food. It is not intended to convey new technical information but focuses on using information to develop national action plans. The participants can come from a range of backgrounds: health, agriculture, environment, education, social welfare, finance, academia, the food industry, and the nongovernmental or voluntary sector. A successful food and nutrition policy will be developed by involving all the relevant sectors and key players. It is imperative that the participants attending this workshop represent as many sectors as possible. The workshop is short (2/3 days), practical, and addresses some issues which need to be considered when developing a national food and nutrition policy. This includes: the international dimensions of food policy, the public health impact of food and nutrition insecurity and safety; how to address barriers to change and how to develop/implement/follow-up a plan of action for food and nutrition policy.

Participants who complete the workshop will be equipped with some of the skills necessary to develop a food and nutrition policy at a national or local level.

Workshop description

The workshop contains 10 sessions and can be presented over a period of two to three days with a review at the end. Each of the sessions contributes to the main outcome: helping to develop a plan of action to implement a national food and nutrition policy.

The participants can come from a variety of backgrounds related to food. For some the link will be a direct, such as food safety specialists or home economic teachers, for others the relationship may be more peripheral, for example transport or finance planners. Participants may work at national or local level, but should be key decision-makers in their respective sector.

The workshop begins by encouraging participants to investigate which stage of the food supply chain they operate at. This introduces the idea of a food system from production to consumption and highlights the different stages in the system. The concept of the food supply chain is the basis on which participants investigate how food impacts positively or negatively on health.

Next, the concept of food and nutrition policy is investigated. This takes account of the broad aspects of food supply and how, directly and indirectly, food can determine public health. Specific UN food and nutrition policy documents are presented along with illustrations of how sustainable development can be linked to food safety and nutrition both at local and national level.

Discussion then centres on how food and nutrition policies and action plans work in practice. Examples of national and local health policies linking food safety and nutrition to sustainable development and the environment are presented. The aim is to investigate successes and failures. If lessons can be learnt from past experiences these help to develop successful food and policies in the future. One of the main keys to success is partnership and intersectoral collaboration. Partnerships and team building is a key theme throughout the workshop. For this reason the role of nongovernmental organizations (NGOs) and the commercial sector, in addition to the government's, is recognized and discussed.

The WHO Regional Office for Europe (WHO/EURO) is recommending that its Member States develop and strengthen their Food and Nutrition Action Plans (FNAP). This is based on three strategies or "pillars": nutrition, food safety and a sustainable food supply (food security).

A copy of the WHO/EURO Action Plan will be given to each participant to assist them develop new, or strengthen existing, food and nutrition action plans. Participants are asked to consider how they will devise a national/local action plan, based on their local situation. Consideration has to be given to how key stakeholders can take action and implement the policy recommendations.

The 10 Sessions in summary

- **Session 1. Mapping yourself in the food supply chain.** This introduces the workshop and participants to each other and provides practical details. Participants are asked to consider their work and role in the food supply chain. The session encourages an understanding of the food supply chain as a whole: where the different actors play a role and what determines what consumers eat; and how the food supply chain can be influenced.

- **Session 2. The impact of food and nutrition on public health**. This session identifies trends in the impact of food on health and considers government responses. Public health is defined and participants are encouraged to think about possible goals for food and nutrition policy. The need for a comprehensive policy is explored.

- **Session 3. What existing food and nutrition policies are there?** The aim of this session is to explain what a food and nutrition policy is. Some of the international commitments are presented (e.g. Food and Agriculture Organization (FAO), UNICEF and WHO). These include the 1992 International Conference on Nutrition (ICN) and the 1996 World Food Summit.

- **Session 4. Developing a comprehensive and integrated national food and nutrition policy**. This introduces the notion that contemporary policy is based on three policy "pillars": nutrition, food safety and sustainable food supply. Policy exists at four levels: local, national, regional and international/global.

- **Session 5. Examples of food and nutrition policies.** Government policies are explored. Local, national and regional initiatives are explored to draw out the lessons that can be learnt: what contributes to a policy's success or weakness? What can be learned and applied to other countries? What experiences are not transferable due to cultural, economic or social reasons? Participants learn that there is considerable experience upon which they can draw.

- **Session 6. NGOs campaigning for food and nutrition policy.** This session illustrates how policies can be shaped by civil society. The role of NGOs in public health policy formation is introduced. Lessons can be learned about what makes NGOs successful and how they can be useful allies in shaping food and nutrition action plans.

- **Session 7. The WHO and national food and nutrition policies and action plans.** This session introduces the WHO European Region's Food and Nutrition Action Plan (FNAP). It shows how WHO/EURO's policy can help governments formulate or strengthen national food and nutrition policies. The WHO/EURO FNAP is explored in detail.

- **Session 8. Putting national policies and food and nutrition action plans into operation.** This session helps participants develop a strategy for a Food and Nutrition Action Plan, by identifying key factors and partners. It also identifies potential gaps and weakness in any implementation strategy.

- **Session 9. Resources for implementation.** Participants consider economic, budgetary and other resource issues necessary for successful implementation. By the end of the session, participants clarify priorities for developing and strengthening their national food and nutrition policy.

- **Session 10. Workshop review.** This session evaluates the workshop.

The Format

Each session is organized using the same format. The session cover sheet provides a quick overview of each session:

- **Aims** of the session;
- **Time** the session should last (approximate and can be adapted by facilitators);
- **Teaching methods** are mainly group work with feed-back and discussion;
- **Plan** which provides an overview of what happens in each session;
- **Outcomes** tell the facilitator what participants should have achieved by the end of each session.
- **Training Materials** are listed
- **Activities** are listed.

After the cover sheet, activities and training materials are provided:

- **Training Materials**: handouts, lecture notes, official documents and other aids.
- **Activities**: exercises, usually in groups but sometimes with the whole group;
- **Activities** contain ***Instructions*** for the facilitator, ***Background***, illustrative outcomes, and a ***Round-up*** of that activity.

References are added in the training notes for participants who would like more information or who would like to review the original research studies. Additional information is provided for facilitators. This includes materials which should be read and assimilated by the facilitator before running the workshop. From this information the facilitator can make overheads for formal presentations although it is recommended that these are kept to a minimum. The workshop is designed to be interactive, succinct and practical. There is some flexibility in that sessions may be shortened or expanded, depending upon the needs of the group and time constraints in specific situations.

The order of the sessions can be changed if absolutely necessary but it is recommended that the order be adhered to. The logic underpinning the workshop is that participants first locate their role within the food supply chain. Next they investigate the burden caused by food-related ill health to society and how this provides the rationale for food and nutrition policy, before moving on to investigate existing national food and nutrition policies and action plans.

Because of the logic flowing through the entire workshop participation at all sessions is essential. While some participants will be familiar with individual sessions it is important to stress the interactive nature of the workshop and that participation is not just about attending but contributing and working within a group. The workshop is intensive and hard work. It has to be run briskly in order to keep to time.

The facilitator should remember to consider the time needed for opening and/or closing ceremonies. This has not been included in the workshop duration estimate. If one or both ceremonies are important to the success of the process, the time will be well spent. Mid-morning and mid-afternoon breaks are essential, as are question/discussion periods during and after each session; remember to plan for them. Social events are optional but highly recommended to foster team building. Similarly it is recommended that residential workshops with accommodation facilities are provided. A review of joint learning experiences is encouraged. Ideally this could take place at the end of each day but definitely at the end of the workshop during Session 10.

The facilitator and workshop organizers can decide whether to have additional sessions. Some groups may suggest they would like more information on specific topics. One way to provide this is to use local experts who have a vision and understanding of the aims of the workshop.

What are the Aims of the Workshop?

The aims are to:

- bring together participants from different professional and organizational backgrounds to explore different policies related to food and nutrition;
- strengthen skills needed to develop intersectoral policies and action plans that incorporate food, nutrition and sustainable development;

- assess current policies in the light of circumstances in relation to food production and global trade.

What are the Objectives of the Workshop?

The objectives are to:

- encourage debate over a range of issues related to food policy;
- identify local, national and international barriers and opportunities;
- help participants gain knowledge, skills and confidence about developments in food and nutrition policy and apply these to a their situation;
- clarify possible future directions for policy;
- identify actions participants can take to influence food policy
- begin to develop an intersectoral action plan and an agreed schedule of development.
- help participants identify what is needed to successfully implement an action plan.

Workshop preparation

Budget

Cost will affect all workshop-planning decisions and thus need to be determined early. If the decision is made to charge participants, the fee should be as low as possible while still recouping costs. Offering continuing education credits provides added incentive for participants to pay. The workshop has been developed to involve key national players. Where this is done it is recommended that liaison should be with the WHO Regional Nutrition Advisors. Where the workshop is run at a local level the appropriate national or regional person, preferably those with responsibility for implementation of the recommendations of the 1992 WHO/FAO International Conference on Nutrition, should be consulted and involved.

If workshop costs are a substantial problem, consideration can be given to adjusting the selection of participants and the workshop schedule so that participants can return home at the end of the day; however, a residential workshop, with participants remaining overnight, is preferable, as the interaction and networking among facilitators and especially among participants after each session and in the evening is extremely valuable.

Organization of the Workshop

It is recommended that a committee be organized to oversee workshop planning, and implementation of follow up activities. Members should include those who will be involved in follow up. There are many different inputs needed when running the workshop and it is difficult for one person to run a successful workshop alone. This team should consist of:

- Two facilitators, responsible for most of the teaching during the workshop. They should work as a team and should clarify how they will work in advance. Duties and sessions can be split as appropriate.
- World Health Organization and preferably FAO and UNICEF representation.
- A number of local experts, who will recruit local participants (such as those who represent national food and nutrition policy interests). This could be: a department of state; a university department; or other designated authority.
- Some local experts on nutrition, food culture and food safety legislation.

- Translators, where necessary.
- People responsible for support and logistics such as collecting people from trains and planes, getting photocopying done (if available), etc.
- A rapporteur to take notes, collate materials from working groups and write the final workshop report.

The responsibilities of the organizers include liaison with local organizers or sponsoring organizations. Recruitment is best left to the local organizations. Responsibilities include final selection of workshop presenters, participants, workshop venue, schedule protocol (ceremonies or socials events), opportunities for media coverage, evaluation and follow-up activities. A workshop coordinator may be appointed to see that the necessary secretarial and other support services are provided. Chairpersons and report writers for the different sessions or group work should be assigned and advance notice given to those selected if possible.

Chairpersons in addition to facilitators may be needed to be responsible for serving as "master of ceremonies", coordinating one or several session(s). They introduce the speaker(s), keep the session(s) moving on schedule, and distribute and collect the evaluation forms and giving information on domestic arrangements.

The facilitators and other resource persons

The materials assume that the facilitators carry out most of the training but in some circumstances this will be best supplemented with guest presenters. Presenters should be well briefed, know their task and how it fits into the workshop and how much time they have. Presenters should be credible and convincing in order to convince the high-level policy-makers and participants attending the workshop.

The presenters can be from those attending the workshop or, preferably only in a few cases, be an outside resource person who is scheduled just for a particular session. It is essential that the presenters be extremely knowledgeable.

Most sessions involve group work. One person should be appointed as group chair and another as *rapporteur* (someone who takes notes and can report back). Ideally, these group facilitators (chairs and rapporteurs) should have some experience working in groups.

Pre-workshop planning activities/session for speakers

It is essential that workshop organizers meet or correspond actively several months prior to the workshop. The organizing committee will need to assign teaching responsibilities and distribute materials to facilitators several weeks before the workshop. The key people involved need plenty time to become familiar with the materials and to obtain or prepare overheads or documents that describe the local situation. National food and nutrition policies and action plans or other relevant documents, such as a situation analyses or country reports submitted at the WHO consultation in Malta 1999 (report of Malta Consultation is available from the WHO European Regional Office), should be available.

Selection of participants

The workshop is intended for those who have some part to play in food and nutrition policy-making – whether at a national or local level. Participants should be key decision-makers responsible for food safety, nutrition or representing other sectors such as agriculture or food production or the voluntary sector.

The wider the representation the more lively the workshop will be. This workshop will normally be organized by those in government and/or responsible for public health and working in the following sectors:

- Nutrition
- Food safety
- Public health
- Agriculture
- Consumer interests
- Social welfare
- Mass catering
- Education
- Environment
- Finance

It is possible to run the workshop for a single group of professionals who later become advocates for food and nutrition policy. If this approach is taken some of the aims, objectives and exercises should be modified and there is likely to be a loss of breadth in the way food and nutrition policy is perceived. Budget constraints and judgements of which participants are likely to effect change should guide selection.

Another decision concerns whether participants will all be from one region or from one country. One advantage of inviting participants from one region is that the interaction during the workshop can encourage networking among the participants and their institutions after the workshop. Again, budget considerations will probably influence these decisions, as well as how many workshops of this type are planned.

Workshops of around 20 participants in total are ideal for promoting discussion during the sessions, although some countries may find it more cost efficient to invite more than this.

Pre-workshop communications with participants

A high-level person within the health system, such as the Minister of Health, should issue a letter of invitation in order to ensure attendance of key administrators and policy-makers who have influence and authority. Letters of invitations should ask for details of the participant's name, mailing address, phone, place of work, title/job position and responsibilities.

Participants should be requested to bring to the workshop data related to food and nutrition policy in their local area or region (such as copies of the country reports submitted at the Malta Consultation 1999). This could include examples of policies to ensure food security, local epidemiological data including prevalence and incidence of relevant diseases, figures on local food supply and production, the development of local alliances and consumer concerns.

This information will be helpful during discussion on the situation and for use during the sessions on planning for the future and development of action plans.

Consider distributing the following materials prior to the workshop:

1. WHO/FAO 1992 *World Declaration and Plan of Action for Nutrition.* FAO/WHO International Conference on Nutrition, Rome, December.

2. The Impact of Food and Nutrition on Public Health. *The First Action Plan for Food and Nutrition Policy: European Region of WHO, 2000–2005*. The World Health Organization Regional Office for Europe, Copenhagen 2000.

3. Any other national or subregional policies or country reviews that might be relevant to the nutrition, food safety and sustainable food supply situation.

Emphasize in the letter to participants to bring these pre-workshop reading materials to the workshop, as they will use them in the workshop.

Workshop venue

Site selection is important to the success of the workshop. The workshop facility needs to be attractive to senior level participants with a decision making capacity, and yet within the budget. If possible, it should be outside the main city, so that participants can concentrate at the workshop without being distracted by other responsibilities. Travel time and costs of transportation are other important considerations.

The availability of support services and communications systems, such as copy machine, computer and printer, telephones and fax greatly facilitate organizing and conducting of the workshop. Nevertheless, if some elements are missing, organizers should do their best to adapt to local conditions. Appropriate audiovisual equipment and room conditions should be available for presentations (source of electricity, projectors, screens, and room darkening curtains).

Smaller breakout rooms or areas for small group work are necessary for most of sessions. They should be easily accessible to the larger room so facilitators and participants do not waste time going from one site to the other.

Workshop materials

A copy of this pack should be provided for those participants who are likely to be a future trainer/facilitator of similar workshops. Other participants need only receive a copy of each hand-out. Some publications are considered core resources for the workshop. There may be a charge for these documents. If budget permits, it would be best to have a copy for each participant. Facilitators should use them for preparation and the materials should, at least, be available to participants as a library during the workshop.

Core resources include the following:

- WHO/FAO 1992 *World Declaration and Plan of Action for Nutrition.* FAO/WHO International Conference on Nutrition, Rome, December.

- WHO (1997). *Food Safety and Globalisation of Trade in Food: a Challenge to the public health sector*. Geneva, World Health Organization (WHO/FSF/FOS/97.8)
- *Urban and Peri-Urban Food and Nutrition Action Plan.* Copenhagen, WHO Regional Office for Europe, 2001.
- The CINDI dietary guide, Copenhagen, WHO Regional Office for Europe, 2000.
- The Impact of Food and Nutrition on Public Health. *The First Action Plan for Food and Nutrition Policy, European Region of WHO, 2000–2005*.
- World Health Assembly Resolution 53.15 on Food Safety, WHO 2000 (included in The First Action Plan for Food and Nutrition Policy).

Educational supplies and equipment

The following check-list can be used to ensure that the participants have resources:

- ❑ Binder, folder or special bags with schedule and handouts inserted.
- ❑ Notebooks or paper
- ❑ Name tags and place cards (stand up cardboard)
- ❑ Registration forms
- ❑ Necessary paperwork for "out of pocket" money, if applicable
- ❑ Evaluation forms
- ❑ Lists of names and contact information for presenters, facilitators, and participants

Have available during the workshop:

- ❑ Blue-Tak
- ❑ Copier + paper
- ❑ Computer and printer, paper
- ❑ Video player, monitor, videos in correct format
- ❑ Overhead projector, extra bulbs
- ❑ Slide projector, extra bulbs
- ❑ Projection stand or table
- ❑ Extension cords
- ❑ Projection screen
- ❑ Flip charts, flip chart stands, markers (ideally one for each small group)
- ❑ Chalk and erasers is using a blackboard
- ❑ Overhead transparencies and markers (if used for reporting group work
- ❑ Stapler, staples, paper clips, tape
- ❑ Scissors, hole puncher
- ❑ Pencils, pencil sharpener, pens
- ❑ Books and other document

Initial workshop activities

- **Registration**: Distribution of nametags and folders with workshop schedule etc.
- **Questionnaire**: The questionnaire overleaf can be distributed and collected at the beginning of the workshop or could be sent out earlier (for instance with a letter of confirmation). The pre-workshop questionnaire is optional and facilitators can decide whether they want to have this information to compare with the evaluation information given in Session 10, the final session of the workshop.

- **Introductions**: Introduction of speakers/facilitators and participants (there should be name cards in front of each participant).
- **Opening ceremonies**: (Optional) keep as simple and short as possible.

Evaluation and reporting

Responsibility for distribution and collection of evaluation forms and compilation needs to be assigned. Final evaluation forms are provided in Session 10. A debriefing/evaluation meeting for workshop organizers and facilitators can be held after the workshop is over. If additional workshops of this type will be held in the future, organizers can learn from this experience in planning for the next one. The organizers should decide prior to the workshop what type of report is needed (its purpose and content), and should assign responsibility for report preparation and distribution. This way, those responsible can take notes.

Follow-up

Successful implementation of action plans is usually greater if participants know they will need to submit progress reports at a later date and whether technical and financial support is available. As budget permits, follow-up activities may be carried out following the workshop by either the national food and nutrition coordinator or the person responsible for coordinating the activities related to WHO-Europe Food and Nutrition Action Plan. At an appropriate period after completing the workshop, participants can be sent letters/forms requesting progress reports and statistical data. Lessons learned can be applied to future workshops.

It will be necessary to announce at the end of the workshop exactly what type of monitoring/follow up will be conducted when, and what support will be available.

Programme

Session	Timing	Title	Presenter
	30 min	Official welcome and launch	
1	3 hrs	Mapping yourself in the food supply chain	
2	2 hrs	The impact of food and nutrition on public health	
3	2 hrs	What existing food and nutrition policies are there?	
4	2 hrs	Developing a comprehensive and integrated national food and nutrition policy	
5	2 hrs	Examples of food and nutrition policies	
6	2 hrs	NGOs campaigning for food and nutrition policy	
7	2 hrs	The WHO and national food and nutrition plans	
8	1–2 hrs	Putting national policies and Food and Nutrition Action Plans into operation	
9	1–2 hrs	Resources for implementation	
10	1 hour	Review of workshop	

Workshop on Intersectoral Food and Nutrition Policy Development

Pre-workshop questionnaire

Name: _____

Mailing Address:_____

_____

Telephone and fax numbers:_____

Title/position: _____

Institution:_____

Key responsibilities related to food and nutrition:

_____

_____

_____

Date: _____ Place: _____

Please answer these questions before the workshop begins:

1. What is the status of your organization in relation to either the development or furthering the action of a national food and nutrition action plan? (Please check one of the following.)

[ ] Has not been involved in either the development or actioning of the food and nutrition initiative
[ ] Has not yet decided whether to become involved
[ ] Has received an invitation to become involved
[ ] Has been officially designated resonsibilities in relation to the food and nutrition action plan.

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2. Please list and describe any positive changes that have been made by your organization to support the food and nutrition action plan.

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3. What are the most important difficulties/challenges your facility still faces in supporting the food and nutrition action plan?

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4. How could this workshop be most useful in helping you address these difficulties/ challenges and in assisting your organization to fully support the development or the actions outlined in the food and nutrition action plan?

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5. Please list any other expectations you have of this workshop.

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Materials

1. A copy of the pack should be available for each participant.

2. The following key documents are also required for each participant (see also list of background documents on next page):

- WHO/FAO 1992 *World Declaration and Plan of Action for Nutrition.* FAO/WHO International Conference on Nutrition, Rome, December.

- WHO (1997). *Food Safety and Globalisation of Trade in Food: a Challenge to the public health sector*. Geneva, World Health Organization (WHO/FSF/FOS/97.8).

- WHO (2001). *Urban and Peri-Urban Food and Nutrition Action Plan.* Copenhagen, WHO Regional Office for Europe.

- *HEALTH21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).

- *The First Action Plan for Food and Nutrition Policy*, *European Region, of WHO, 2000–2005*. Copenhagen, WHO Regional Office for Europe.

- CINDI Dietary Guide. WHO Regional Office for Europe. EUR/00/5018028, 2000.

Background documents

Document	Distribution
General	
Provisional Programme	All participants
Provisional list of participants	All participants
Intersectoral Food and Nutrition Policy Development: A Manual for Decision Makers	All participants
Pre-course questionnaire	All participants
Questionnaire on evaluation of sessions	All participants
Nutrition	
World Declaration and Plan of Action for Nutrition. FAO/WHO International Conference on Nutrition, Rome, December WHO/FAO 1992	All participants
Urban and Peri-Urban Food and Nutrition Action Plan. WHO Regional Office for Europe. 2001	All participants
HEALTH21. WHO Regional Office for Europe. 1999	All participants
The First Action Plan for Food and Nutrition Policy, European Region of WHO, 2000–2005. WHO Regional Office for Europe.	All participants
Comparative analysis of nutrition policies in WHO European Member States. WHO Regional Office for Europe, 1998 and 2001	All participants
Comparative analysis of elimination of Iodine Deficiency Disorders in the WHO European Region. WHO Regional Office for Europe, 2000	All participants
Elimination of IDD in Central and Eastern Europe, the Commonwealth of Independent States and the Baltic States, Munich, September 1997. ICCIDD and WHO	2 per group
Development of the First Food and Nutrition Action Plan for the WHO European Region. Report on a WHO Consultation, Malta, November 1999. EUR/ICP/LVNG 010210. WHO Regional Office for Europe, 2000.	All participants
CINDI Dietary Guide. WHO Regional Office for Europe, 2000	All participants
CINDI posters	All participants
Prevention and control of Iron Deficiency Anaemia in Women and children. Report of UNICEF/WHO Regional Consultation. Geneva, 3–5 February 1999	2 per group
Healthy Living: what is a healthy lifestyle? WHO Regional Office for Europe, 1998.	All participants
List of Nutrition and Food Safety documents and publications	All participants
Healthy Food and Nutrition for women and their Families. Training manual for health professionals. 2001	1 per group
Healthy English Schoolchildren: a new approach to physical activity and food. W.P.T. James and K.A. McColl. Rowett Research Institute, Aberdeen. October 1997	1 per group
Health Behaviour Survey of schoolchildren	1 per group
Agriculture, environment, rural development. Facts and Figures. A Challenge for Agriculture. European Commission.	1 reference copy
A sustainable Food Supply Chain. A Swedish Case Study. Swedish Environmental Protection Agency.	1 reference copy
Guidelines for consumer policy in Central and Eastern Europe. Consumers International. 2000	1 reference copy
Nutrition and Lifestyle in the Baltic Republics. EUR/ICP/LVNG 020304. WHO Regional Office for Europe. 1999	All participants
United Kingdom Dietary Reference Values	1 reference copy
Nordic Dietary Reference Values	1 reference copy
Infant Feeding	
Comparative analysis of implementation of the Innocenti Declaration in WHO European Member States 1999	All participants
Feeding and Nutrition of Infants and Young children. Guidelines for the WHO European Region, with emphasis on the former Soviet countries. WHO Regional Office for Europe, ISBN 9289013540	Order forms 1 per group
Healthy Eating during Pregnancy and Breastfeeding – a booklet for mothers	1 per group
Breastfeeding: How to Support Success. Manual for health professionals	1 per group
Evidence for the ten steps to successful breastfeeding. WHO headquarters	1 per group
Infant feeding in emergencies. Booklet for mothers	1 per group
Food Safety	
WHO (1997). Food Safety and Globalisation of Trade in Food: a Challenge to the public health sector. Geneva: World Health Organization (WHO/FSF/FOS/97.8)	2 per group
HACCP Introducing the Hazard Analysis and Critical Control Point System, Food Safety Unit, WHO headquarters, Geneva WHO/FSF/FOS/97.2	2 per group
Guidelines for strengthening a National Food Safety Programme, Food Safety Unit, WHO Headquarters, Geneva. WHO/FNU/FOS/96.2	2 per group
ICN: A challenge to the food safety community, Food Safety Unit, WHO headquarters, Geneva. WHO/FNU/FOS/96.4	2 per group

Glossary

Access means the right to reach, use or obtain the foods necessary for an affordable, healthy diet.

Availability refers to the production, physical presence, or supply of food items on the market.

Codex Alimentarius Commission is an international committee of the Food and Agricultural Organization and the World Health Organization that sets world food standards.

Ecological public health refers to the changing nature of health issues and their interface with emerging global environmental problems. These new problems include global ecological risks such as the destruction of the ozone layer, uncontrolled and unmanageable air and water pollution, and global warming. These developments have a substantial impact on health which often elude simple models of causality and intervention.

Externalities are the costs to the environment that are side effects of the economic activity. These costs are not part of the prices paid by the producers or consumers directly involved.

Food and Nutrition Policy is a general term to mean the use of public policy measures to deliver improved public health. Measures to improve diet-related health may be very varied. They range from health education to taxation and setting regulations. A Food and Nutrition Policy refers not so much to those measures themselves as to the setting of desired public goals. It is the application of public policy to the area of food and nutrition in order to lead to more concerted intersectoral action.

Food Control a mandatory regulatory activity of enforcement by national or local authorities to provide consumer protection and ensure that all foods during production, handling, storage, processing and distribution are safe, wholesome and fit for human consumption; conform to quality and safety requirements; and are honestly and accurately labelled as prescribed by law.

Food miles/kilometres refers to distance that food travels between primary producer and end consumer.

Food poverty means having inadequate access to a healthy diet. Food poverty may be due to a lack of financial resources, a lack of local provision, or a lack of transport to gain access to range of suitable foods. The elimination of food poverty, along with the creation of sustainable food supplies, are two main elements of a programme for food security

Food quality refers to food's sensory, hygienic (food safety), functional and nutritional characteristics; quality is the outcome of how food is produced, distributed and cooked.

Food safety assurance that food will not cause harm to the consumer when it is prepared and/or eaten according to its intended use.

Food security

- All people at all times have both physical and economic access to enough food for an active, healthy life.

- The ways and means by which food is produced and distributed are respectful of the natural processes of the earth and are thus sustainable.
- Both the consumption and production of food are grounded in and governed by social values that are just and equitable, as well as moral and ethical.
- The ability to acquire food is assured.
- The food itself is nutritionally adequate and personally and culturally acceptable.
- The food is obtained in a manner that upholds human dignity.

Food supply chain refers to the fact that food arrives to consumers' plates after a complex set of processes. Food travels from farm to plate due to the efforts of growers, processors, distributors, caterers, traders and many more industrial sectors. The food supply chain is a term used to refer to this whole system of supply.

Globalization refers to a process of economic, social and political change under which national structures and exchanges are gradually being replaced by global ones.

HACCP is Hazards Analysis Critical Control Point and refers to a system for analysing and controlling risks in a food supply chain.

Health promotion refers to the process of enabling citizens to take greater control over their health.

HEALTH21 is the World Health Organization policy document on general public health goals and approach for Europe.

Locally produced foods are produced in close proximity to point of sale or consumption. It is a relative term, the closer the production is to consumption, the more local the food, perceived from a freshness and environmental point of view.

Life course strategy refers to the evidence that both disease and health are the outcome of a complex interaction of factors across time. Degenerative diseases may emerge later in life after patterns of consumption are laid down in childhood, for instance. Health analysts now argue that to help deliver public health, interventions have to be made throughout the life course to prevent ill health and to promote health.

Nongovernmental organizations (NGOs) are voluntary, non-profit organizations.

Public health refers to the task of using public measures to promote health, preventing disease, and prolonging life through the organized efforts of society. Public health is a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.

Social exclusion is a phrase used to denote the social aspects of individuals and groups' absence of economic power and influence within society.

Sustainable development is development, which meets the needs of the present, without compromising the needs of future generations, or alternatively "positive socioeconomic change which does not undermine the ecological and social systems upon which communities and societies are dependant" *(Our cities, our future)*.

Transnational corporations (TNCs) are large multinational economic enterprises.

Vulnerable groups are those individuals, households, social groups or whole communities at risk of adverse impact on mental or physical health. They tend to be economically impoverished, socially dependant or socially excluded. Vulnerability and capacity are the two opposite faces of the same spectrum.

World Trade Organization (WTO) is the body set up following the 1994 General Agreement on Tariffs and Trade. It is a member state organization with over 130 countries as members.

Session 1: Mapping yourself in the food supply chain

Aims

1. Allow participants to identify their role in the food supply chain.
2. Introduce the concept of the food supply chain.
3. Highlight the factors determining what consumers eat.
4. Demonstrate that participants have responsibilities both at work and as citizen/consumer.

Time

3 hours: 2 hours for group work and one for feedback and provision of handouts and discussion.

Teaching Methods

Work in groups supported by feedback discussion, and short lecture or the provision of handouts.

Plan

This Session introduces participants to each other, introduces the whole workshop and gets participants to map themselves in the food supply chain. It is done as one rolling activity that begins with a simple model of the food supply chain and gradually introduces greater complexity.

Outcomes – participants should have:

- An understanding of the food supply chain;
- A clear idea of where everyone fits into the supply chain;
- An understanding of the factors determining what consumers eat;
- An idea of how participants both in a professional capacity and as consumers can influence the food supply chain.

Training Materials

1.1 The Food Supply Chain.
1.2 Factors determining what consumers eat: from policy to consumption.
1.3 Mapping "actors" in policy-making: who influences?
1.4 Marketing – a key driving force to influence consumers.

Activity 1

Your role in the food system and the forces driving food and nutrition policy

Activity Instructions

In groups, or altogether if the total number is not too large, participants are asked to:

- Introduce themselves and locate themselves on the food supply chain "map" given in Training Material 1.1.
- Modify, as appropriate, the "map" given in Training Material 1.1.
- Do this by answering these questions: What is your role in relation to the food supply chain? (i.e. What does your work involve? What is its rationale/ purpose? And where are you located in the food supply chain?)

Activity Background

Having noted and possibly modified, this simple model, as participants present their experience, the facilitator should draw attention to Training Materials 1.1, 1.2, 1.3 and 1.4. These offer a more sophisticated account of how the supply chain works and what affects it. Note the complexity of the factors, actors and forces which determine what people eat.

Activity

Table 1.1. Your job in relation to the food supply chain

Occupation	Professional role in relation to food	Location within the food chain
Medical Doctor		
Food Inspector		
Etc.		

Activity Round-up

The purpose of this activity is to get participants to:

- List the factors that determine what consumers eat.
- Get them involved in thinking about the complexity of the food supply chain and the factors which affect it.
- List what and who the main "stakeholders" or "agents" are behind these factors.
- Consider which stakeholders have the most influence: those locally? nationally? regionally? internationally?

If the activity is done in small groups, results should be summarized by each rapporteur and the feedback should be presented in plenary to the whole group.

The feedback from all the groups should be collected and collated on a flip chart by the facilitators. To prevent repetition, since most groups will come to the same conclusions, after the first group has presented its summary invite the others to only give additional points that have not been mentioned by the first group. The food supply chain is presented in training material 1.1 and some examples of the different professional roles and where they are located

in the food chain is given below. These answers could be presented similar to Table 1.1 or fitted into the participants own version of the food supply chain. The results of the group work should be placed on the wall for everyone to read in the breaks. Remember to allow for the fact that some participants may think that they have only a marginal role in food. Also remind participants of their responsibility as citizens and consumers. Emphasize that throughout the workshop the role of food and nutrition policy within the food supply chain will be explored in order to strive to make the food system sustainable and environmentally friendly.

The training materials may be used by the facilitator to give a short presentation, or be given to participants after their feedback to re-assure them that they are thinking along the correct lines.

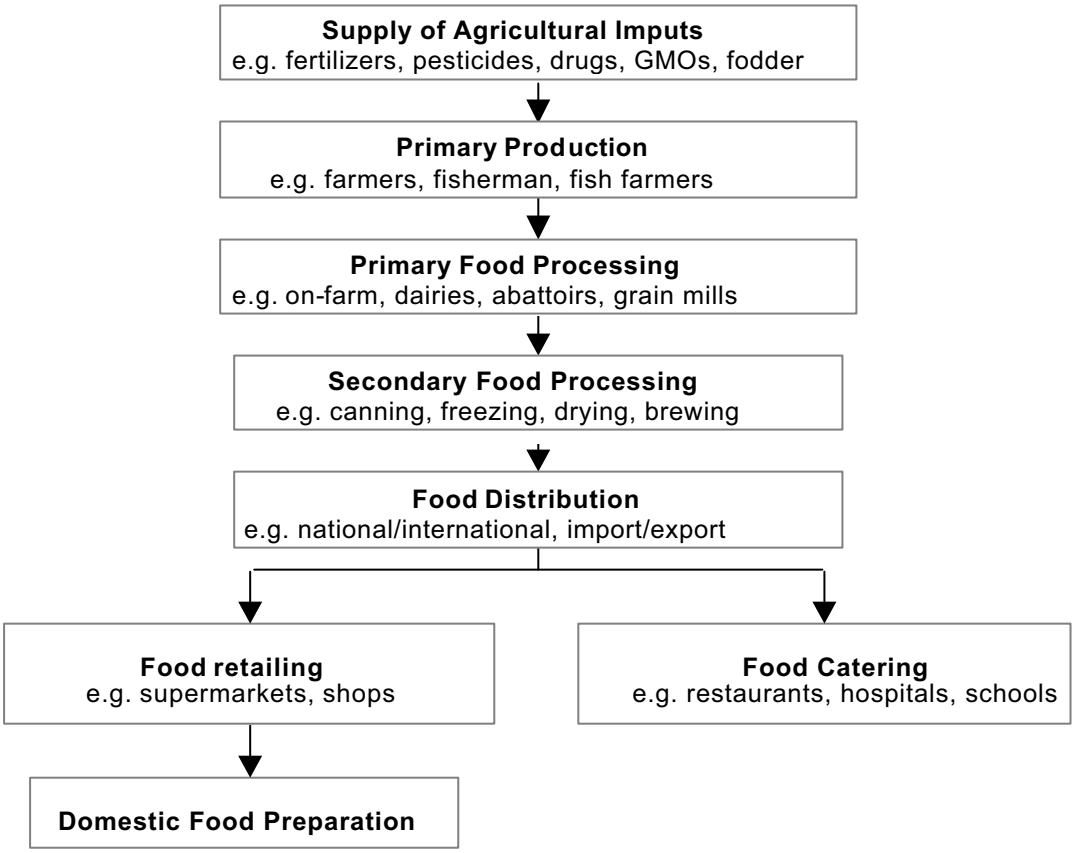
Activity Example Table 1.1.
Your job in relation to the food supply chain

Occupation	Professional role in relation to food	Location within the food chain
Medical Doctor	– I see patients with diet-related disease – I give advice on diet and health – I work with public health hygiene	Influencing consumers
Food Inspector	– I inspect food sources and sales outlets – I enforce food laws set by government – I report to my local authority	Influencing retail outlets and food processing companies
Nurse	– I give advice to people on the wards – I am training to be a health educator	Influencing consumers
Pharmacist	– I provide drugs to tackle food-related ill health, e.g. obesity and food poisoning; – I give advice to people on diet when they come to the pharmacy	Influencing consumers
Lab technician	– I have no direct contact or impact	No influence
Food retailer	– I provide/sell food – I give advice to customers	Influence producers/wholesalers and consumers
Agriculture adviser	– I advise policy makers/farmers	Influence producers
Farmer	– I grow food	Influence food production
Work with a NGO	– I campaign for better food supply – I give public advice on food	Influence demand for healthy food by consumers

Many of the participants, especially those from the health sector will have the view that they are attempting to influence what their patients/clients eat either by giving them medical advice or by enforcing food laws and legislation. This could lead the facilitator to pose a question about how successful health personnel are in influencing patients/consumers or enforcing laws. There are many strong forces, driving food and nutrition policy (see training material 1.4) and their influence may overwhelm the advice given by the health sector.

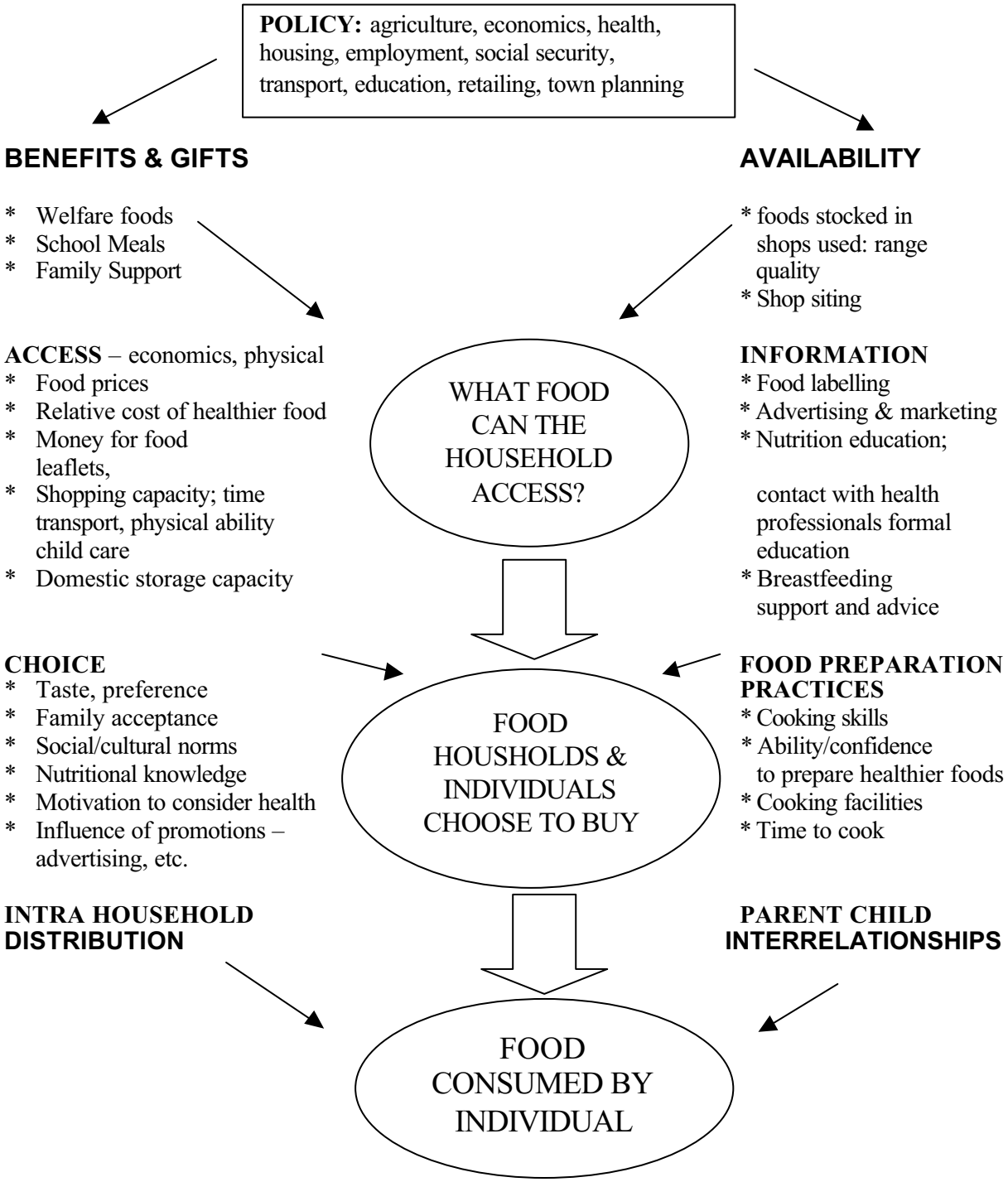
Training Material 1.1
A simple model of the food supply chain

Fig. 1. Principal stages of the food supply chain



Training Material 1.2

Factors determining what people eat: from policy to consumption



Training Material 1.3

Some of the main forces that drive the food supply – mapping the "actors" in policy-making

It is useful to consider the key forces driving food supply *in 4 core blocks/sectors*:

- The state (ministries of health, agriculture, industry, trade etc.)
- Industry (private/commercial sector)
- NGOs (voluntary sector)
- The consuming public (civil society)

These 4 core sectors and actors may operate at different levels:

- local
- national
- agreements between neighbouring countries on a regional basis
- global/international

A "map" of food decision-making includes:

(Officials and scientific institutions may be either governmental or independent: scientists, doctors, teachers, law enforcement officers)

GROUP 1 – THE STATE

Local Government: food control/safety authorities**,** statutory responsibilities fulfilled by public health doctors and nutritionists (e.g. monitoring nutrition status of populations), veterinarians (e.g on food hygiene in abattoirs), legal officers (e.g. on trading standards, schools (teaching, school meals,) health services (from school nurses to laboratories), etc.

National Government: ministries (covering agriculture, health, education, economy, trade, consumers, environment), Members of Parliament, national Institutes of Public Health.

Agreements between neighbouring countries on a regional basis: e.g. European Free Trade Area, European Union and the Commission, C.I.S., CCEE, Stability Pact in SE Europe; Baltic States.

International and global governmental institutions: World Trade Organization (WTO), United Nations (UN), Food and Agriculture Organization (FAO), World Health Organization (WHO), United Nations Conference on Trade and Development (UNCTAD), United Nations Conference on Environment and Development (UNCED), UNICEF etc.

GROUP 2 – INDUSTRY (PRIVATE/COMMERCIAL SECTOR)

Financial services:

- local – banks and micro-credit
- national – national banks and lending facilities
- agreements between neighbouring countries on a regional basis – stock-markets and share-holdings
- global/international – World Bank & International Monetary Fund (IMF)

Primary producers:
- local – urban agriculture and horticulture; allotments
- national – cooperative farms and marketing boards
- agreements between neighbouring countries on a regional basis – Common Agriculture Policy (CAP) in EU
- global/international – e.g. a company like Cargill, the grain company

Agricultural input industries:
- local – seeds
- national – machinery, agrochemicals
- agreements between neighbouring countries on a regional basis – veterinary products
- global/international – life sciences (Novartis, Aventis, Monsanto)

Food processing:
- local – preserving vegetables and fruit; milk and dairy products; bread
- national – meat and meat products
- agreements between neighbouring countries on a regional basis – confectionary and cereal products
- global/international – transnational corporations – Kellogg, Nestlé

Distribution:
- local – direct from producer to consumer without any "middle-man"
- national – wholesalers; marketing boards
- agreements between neighbouring countries on a regional basis – EU trade agreements
- global/international – World food trade has increased at a phenomenal rate (Food Miles/ Kilometres – increasing transport and packaging costs and storage time)

Food retailing:
- local – corner shops and farmers markets
- national – supermarkets and supermarket chains or stores with a franchise
- agreements between neighbouring countries on a regional basis – hypermarkets with their own wholesale outlets and distribution infrastructure
- global/international – hypermarkets (internet); mail order

Catering:
- local – small private restaurants and canteens
- national – mass catering institutions associated with governmental authorities
- agreements between neighbouring countries on a regional basis – franchise between different restaurant chains
- global/international – McDonalds, Pizza Hut, Kentucky Fried Chicken

Marketing/advertising industries (also see training materials 1.4):
- local – newspapers; local media; through hospitals and health facilities
- national – newspapers; women's magazines; TV
- agreements between neighbouring countries on a regional basis – EU directives and Health Claims; sponsorship in sporting events
- global/international – transnational companies – Burston Marsteller and transnational public relations corporations

Scientists:

- local – universities and local institutes
- national – independent authorities; working for industry
- agreements between neighbouring countries on a regional basis – EU consortium projects
- global/international – Transnational corporations (GMOs and genetic engineering)

GROUP 3 – NONGOVERNMENTAL ORGANIZATIONS

Public interest nongovernmental organizations (PINGOs):

- Local: e.g. a food poverty action group
- National: e.g. consumer associations
- Regional: e.g. European Public Health Alliance (EPHA) ; Bureau Européen des Union de Consommateurs (BEUC)
- International: Consumers International

Government "organized" nongovernmental organizations (GONGOs): National consumer panel, National Consumer Council

Business and industry nongovernmental organizations (BINGOs): Industry organizations, industry-funded organizations, industry lobbying organizations, e.g. ILSI – International Life Sciences Institute; CIAA; EUFIC; IDACE.

GROUP 4 – THE CONSUMING PUBLIC

The public are organized at a local level (individuals) or at a national level via mechanisms in all democratic countries. More and more mechanisms are evolving to allow the public to exercise their democratic rights within the EU and globally (e.g. protests in Seattle during the WTO in November 1999). Societies and the public are stratified: income; social class; gender; location; aspiration; food preferences/taste; culture.

Training Material 1.4

Marketing – a key driving force to influence consumers

The food industry has assumed a powerful place in the food chain both by catering to and influencing consumer demands.

As urbanization is breaking the connection between farmer and consumer, and as changing lifestyles encourage more processed, packaged and fast food, the food industry has assumed a powerful place in the food chain. To maximize revenues, food sellers invest heavily in the creation of a "food environment" that makes unhealthy food, its promotion and over-consumption a normal part of modern life.

The most powerful tool to shape this environment is advertising. In the US food companies spend more on advertising than any other industry – an estimated US $30 billion annually (2000). Unfortunately the most heavily advertised foods tend to be those high in fat and energy and low on micronutrients. In 1996 Consumers International study found that candy, sweetened breakfast cereals, and fast food restaurants accounted for over half of all food adverts in Australia, Norway, US, and 10 countries in Europe. In the US fast-food restaurants alone account for one third of all food advertising expenditures. Moreover food advertisers disproportionately target children – the most easily exploited – with worrying implications on their long term health. While a "sweet-tooth" is a natural human characteristic research shows that repeated exposure to sweet and fatty foods in children results in a life-long craving for these less healthy items. Since 1990 companies have offered millions of dollars to schools in US for the exclusive rights to sell their products in the schools. Indeed almost 20% of the schools in the US had contracts with fast-food establishments to provide either food service, vending machines or both.

In theory health authorities should encourage companies to promote more nutritional foods such as vegetables and fruit, or promote them with governmental resources. Two factors compel food companies – one is humans have a natural instinct for sweet and salty tastes and secondly processed foods are most likely to have so-called "added-value" – the alterations or packaging that allow a company to earn higher profits. Doughnuts or other cookies will fetch a greater profit than if the flour, oil, eggs and sugar in them were sold separately. Part of the profit is invested in advertising the product, which keeps the cycle of promotion and sales in constant motion.

Consumers may be unaware of the quantities of salt and sugar, the most widely added ingredients to food, and fats and oils are next. In 1909 when the range of processed food was much smaller two thirds of discretionary sugar consumed in US was added in the household. Today three-quarters is added during food processing, out of sight from the consumer. The same is true for salt.

Whatever the marketing strategy, in most countries its presence dwarfs efforts on health education. This imbalance in information and power between industry, consumers and government results in unprecedented access to energy-dense food at low cost – that are promoted heavily and taste good.

Despite these unfavourable trends the emergence of counter-trends offers some hope for a more sustainable food consumption. Food and nutrition policies can highlight unfavourable trends and counter strategies can be implemented to protect and promote health.

Marketing Strategies to Promote Public Health

Marketing has to be used by those trying to promote health and sustainable food consumption. Pressures on farming in the form of: collapsing prices; overproduction; market saturation; internal and global competition; concentration of powerful buyers; and agricultural policy reform are pushing the marketing of alternative foods (such as organic) into the main-stream.

Many groups who are interested in marketing sustainable food supply are isolated and seek inspiration from successful strategies. Fortunately in Europe there is a long history of niche marketing and "green" consumerism, as well as a tradition of culinary regionalism – this presents opportunities for marketing a more sustainable food supply in Europe. Sustainable means a food supply that protects the natural environmental and social capital upon which our food supply depends.

The impact of farming on the countryside and rural environment continues to draw increased attention from the general public. With issues of biotechnology and food safety and widespread attention on production systems, the social contract between agriculture and society is under increasing strain. The effects of BSE and Foot and Mouth Disease hit the United Kingdom beef sector very hard. Other factors represent a more permanent shift in power away from family farmers. Trade liberalization is exposing more farmers to global prices and to competition with farmers who operate under less stringent food safety regulations, welfare or environment standards or who have access to cheaper animal feed. Almost every product can be grown and imported cheaper than local produce. The only thing that importers cannot compete on is local identity. Marketing strategies should attempt to stimulate or re-build local markets for regional food, especially by incorporating aspects of ecology, animal welfare, trace ability and food safety. In addition increasingly farmers have no control and see the profits being made elsewhere, further along the food chain. However, although relatively slow, farmers are making attempts to take control by either selling direct or by becoming owners of the processing and distribution chain.

Marketing innovations that promote health and sustainable food consumption vary, yet all are based on one or more of the following characteristics: Regionalism; fair trade; human and environmental health; culture; biodiversity; animal welfare, social justice and rights.

Some marketing examples from Europe are presented in "Marketing Sustainable Agriculture" report ($15) available from Ms Van Tran, Environment and Agriculture Program, Institute for agriculture and trade policy (IATP), 2105 First Avenue South, Minneapolis, MN 55404, US E-mail vtran@iatp.org

Session 2: The impact of food and nutrition on public health

Aims

1. Identify trends in food and society.
2. Identify the impact of food and nutrition on public health.
3. Identify government responses to food and its impact on health.
4. Begin to consider the need for a comprehensive food and nutrition policy.

Time

2 hours.

Teaching Methods

Work in groups supported by feedback, discussion, a short lecture or the provision of handouts.

Plan

The session considers the trends in society and how food impacts on public health and how a food and nutrition policy can limit the damage and promote the positive aspects. The session is activity-centred and there are three activities. They can be done in the whole group or in smaller groups. Allow about 20 minutes for the 1st and 2nd and 40 minutes for 3rd activity.

Participants explore trends in the food supply chain and where health and other interests, already highlighted in session 1, have an impact. It introduces the notion that public policies are needed to ensure that health is at the heart of the food supply chain. Participants should begin to identify how they can influence trends.

Outcomes

At the end of this session participants should:

- Have an understanding of the impact of food and nutrition on health;
- Be able to identify the need for a comprehensive food and nutrition policy;
- Be aware that this policy has to operate within society-wide trends, such as globalization, but governmental action can help protect public health.

Training Materials

2.1 A definition of public health
2.2 Notes on an integrated approach to food, nutrition and health
2.3 A list of possible goals for food and nutrition policy
2.4 The nutrition transition and globalization

Activities

2.1 Identify trends in food and society
2.2 Describe the impact of food on public health
2.3 Identifying government action

Activity 2.1
Identify trends in food and society

Activity Instructions

In this exercise, ideally in the whole group, participants are invited to consider:

(i) What was the food supply chain like 20 years ago? (what foods did you buy? where? what are the major differences in context, range, quality, availability, variety, cost, freshness, sources? etc). Spend about 10 minutes on this.

(ii) What changes do you expect in the food supply chain 20 years from now? How will socioeconomic changes have an impact on food? Spend about 10 minutes on this.

The facilitator, or an appointed writer, should note the trends that people identify on a flip chart. Encourage people to call out single words or short phrases to summarize the trends that they think important. The flip charts should be put up on a wall afterwards for everyone to look at.

Activity Background

All participants, using their personal experience (there is no need for any technical knowledge at this stage so everyone can participate) can see how food and society have changed over the past twenty years. Participants should also be able to see that not all changes are inevitable.

As changes happen in agriculture; food security and availability; food retailing; advertising and in society in general they inadvertently impact on health issues such as: nutrition; food safety and hygiene; environmental health; health education and promotion and consumer behaviour.

The purpose of the second question is to stimulate participants to think ahead about social change, likely changes in the food supply and how governments can shape things in order to create sustainable food production and consumption in the interests of public health.

Participants should begin to see that unless public policies are developed, trends in the food supply chain will be shaped mainly by interests other than health. So future public policies are needed to ensure that health is at the heart of food and nutrition policy. Participants should feel optimistic about their ability to influence future trends. There is no “right” answer. The point of this exercise is to illustrate the complexity of the changes in food supply and demand; and society.

Activity Examples

Participants are likely to mention many different issues. Countries vary enormously. Western and Eastern Europe, North and South Europe have all different experiences. Examples might look like the following:

Activity Examples

Participants are likely to mention many different issues. Countries vary enormously. Western and Eastern Europe, North and South Europe have all different experiences. Examples might look like the following:

Activity Example Table 2.1.1
What was the food supply chain like 20 years ago?

Context:	war – peace
Range of foods:	more / less
Quality:	improved / worsened
Price:	up / down
Quantity:	less / more
Availability:	less / more
Fresh foods:	less / more / better / worse
Sources:	local / national / village
Etc.	

Activity Example Table 2.1.2
What changes do you expect in food 20 years ahead?

Increase in organic food – cheaper	Less home cooking
More local food but fewer local shops	Decline in food poverty
Province and prices	Variety diversity and availability
Scattered/fragmentation	Easier choice (labels & information)
Food technologies/food markets	Lower food prices
More specialized food markets	Allotments (land) for all
More Supermarkets	Brand diminution and resistance

Activity Example Table 2.1.3
What changes do you expect in society 20 years ahead?

Single households	Social divisions – rich and poor
Smaller families	More waged domestic labour
Isolation	Americanization
Selfish/"me-ism	China having more impact on our lives
Multi-skilling	More government control
"Portfolio" careers/lifestyles	Ageism and elderly activism
Europeanization of street culture	Living longer
Geography changes – countries fragmenting and joining new alliances	New diseases and ill health
	More people in rural areas
Psychological "space" more home-based but borderless	More liability cases, civil actions
	Militarism
Information technology – confident and literate	Society more soul-less
Social fragmentation increased	Leasing versus owning (people will lease TVs, cars and not own them)
Poverty and inequalities increased	
Working lives longer	Virtual experience replace the real e.g. holidays.
More non-homeowners	Homogenization of culture
24-hour working	Reaction to Americanization
Religious identity will be more important Rise of "fundamentalism"	Leisure more important

Activity Round-up

The purpose of this activity is to:

- Demonstrate that change does happen in the food supply
- Identify why these changes occur
- Identify that as these changes happen they may inadvertently/unintentionally impact on health and consumer behaviour
- Establish the views of the participants
- Illustrate the links between the trends in the food supply and in society.

The facilitator at this stage can introduce Training Material 2.4 on the Nutrition Transition and Globalization. If not appropriate now, this Training Material can and should be referred to after Activities 2.2 or 2.3.

Participants should begin to see that unless public policies are developed, trends in the food supply chain will be shaped mainly by interests other than health. So future public policies are needed to ensure that health is at the heart of food and nutrition policy. They should feel optimistic about their ability to influence future trends. For example, the group might come up with a table like this:

Activity Example Table 2.1.4
A Summary of Trends in Food and Society

Food and nutrition policy will be high profile. Consumers will be more demanding both of supply chain and authorities. Food Safety will be central to food culture Quality will be a big theme. The pace and scale of change will be hard for public policy to address. Food will get better for some but not all.	Social inequalities are likely to increase. Cultures are likely to be more fragmented Skills will be a key theme. Big differences between local and global. Food is likely to be associated with identity. There will be many conflicts and consensus in public policy on food and nutrition.

Activity 2.2
The impact of food on public health

Activity Instructions

In the large group, participants should be asked to give the "positive" and "negative" impact of food on health in their country/region.

Activity Background

If there is confusion over what public health means, refer participants to Training Material 2.1: Defining public health.

To help participants untangle the issues, the facilitator could encourage them to consider:

- What is the issue?
- How long has this been the case?
- What is the evidence?
- What are the trends?

Activity

Members of the group or the facilitator should list the participants´ responses concerning the impact of food on public health onto a flip chart. A blank sheet should look~~start~~ like this:

Table 2.2.1. The impact of food and nutrition on health

Negative impact of food on health	Positive impact of food on health

A complete example might look like this:

Activity Example Table 2.2.2
The impact of food and nutrition on health

Negative impact of ~~things in~~ food on~~and~~ health	Positive impact~~things~~ of ~~happening about~~ food on~~and~~ health
Coronary heart disease	Longevity
Cancers	Quality of life improving
Diabetes	Increased availability of food
Obesity rising rapidly	Improved health services
Hypertension	Government is aware
Food safety problems rising	Public Awareness and Interest is rising

Activity Round-up

The idea of this activity is to get participants to state the important food and public health issues in their country. They should be encouraged to "state the obvious", e.g. to say that heart disease is a main cause of premature death. And then to list all other food and diet-related ill health. Draw upon their expertise which they reported in Session 1.

Activity 2.3
Identifying government action

Activity Instructions

In this exercise, either in small groups or the whole group led by the facilitator, participants consider how government can have an impact on food supply with reference to health.

They consider the following question:

- how can government ensure that health is at the heart of food and nutrition policy?

Participants should be asked to give their ideas under THREE headings:

- Nutrition
- Food Safety
- Sustainable food supply

Activity Background

This activity is the first time that the 3 "pillars" on which the WHO European Region is based are introduced. The exercise asks participants to clarify what they think their governments can do.

This is the first time participants have had to think on these three levels. This will be a theme throughout the workshop. The facilitator does not need to elaborate why these three headings are being used at this stage. But if someone asks, the reason is that these are the three main public health strategies underpinning the WHO food and nutrition policy and action plan for the WHO European region. Food is the theme linking these three areas of policy and action.

It is recommended to use the sector headings in table 2.3.1 (agriculture, food processing, distribution, mass catering, retail, marketing and consumers) as a guide to help the groups categorize their responses in a systematic and logical way.

Remind all groups to appoint a chairperson and a rapporteur to report back to the plenary. Put all responses on a flip chart or on OHPs. Keep these. If there are flipcharts, display results, on the wall afterwards.

Activity

In this activity participants complete the cells within Table 2.3.1:

Table 2.3.1 Identifying Government Action, by nutrition, safety and sustainable food supply

Sector	Nutrition	Food Safety	Sustainable Food Supply
Agriculture			
Food processing			
Distribution			
Mass catering			
Retail outlets			
Marketing/media			
Consumers			
Common to all			
Other			

The results of the Activity might be a table like 2.3.2:

Activity Example Table 2.3.2
Identifying government action

Sector	Nutrition	Food Safety	Sustainable Food Supply
Agriculture	"good": olives, vegetables and fruit "bad": dairy	Contamination: pesticides Food poisoning & hygiene	Pesticides; soil structure – mineral; iodine?
Food processing	Preservatives; additives Added fats, salt & sugars	Hygiene; Spoilage Cosmetic; additives	GM foods; Irradiation; wastage; packaging; transportation
Retailing & distribution	Nutrient preservation or not? Added fats, etc.	Temp. Control In lorries & on display; Staff hygiene skills	Transportation; Packaging (this has +ve and –ve aspects)
Catering & hotels	Fat & sugar high Fruit & Veg low	Hygiene; Microwaves?	Waste
Consumers	Choice, skills, taste, affordability	Skills?	Waste
Common to all?	Imbalance of supply and health	Temperature control Hygiene	Genetic engineering; waste: Energy use
Other			

Activity Round-up

This activity presents the core concepts upon which the Food and Nutrition Action Plan is based.

It introduces the fact that governments have immense challenges in tackling food-related public health problems. Training Material 2.2 gives an integrated model for thinking about the role of governments in food and health. Training Material 2.3 provides an overview of general goals a government might aspire to in its public policies for food and nutrition. If it has not already been introduced after Activities 2.1 and 2.2, Training Material 2.4 should now be introduced.

Training Materials 2.1
Defining Public Health

Public health

"The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society." Adapted from Sir Donald Acheson, former Chief Medical Officer for England, 1988

Public health is a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. A distinction has been made in the health promotion literature between public health and a new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the determinants of health, and the methods of solving public health problems. This new public health is distinguished by its basis in a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and a recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health. Such a distinction between the "old" and the "new" may not be necessary in the future as the mainstream concept of public health develops and expands.

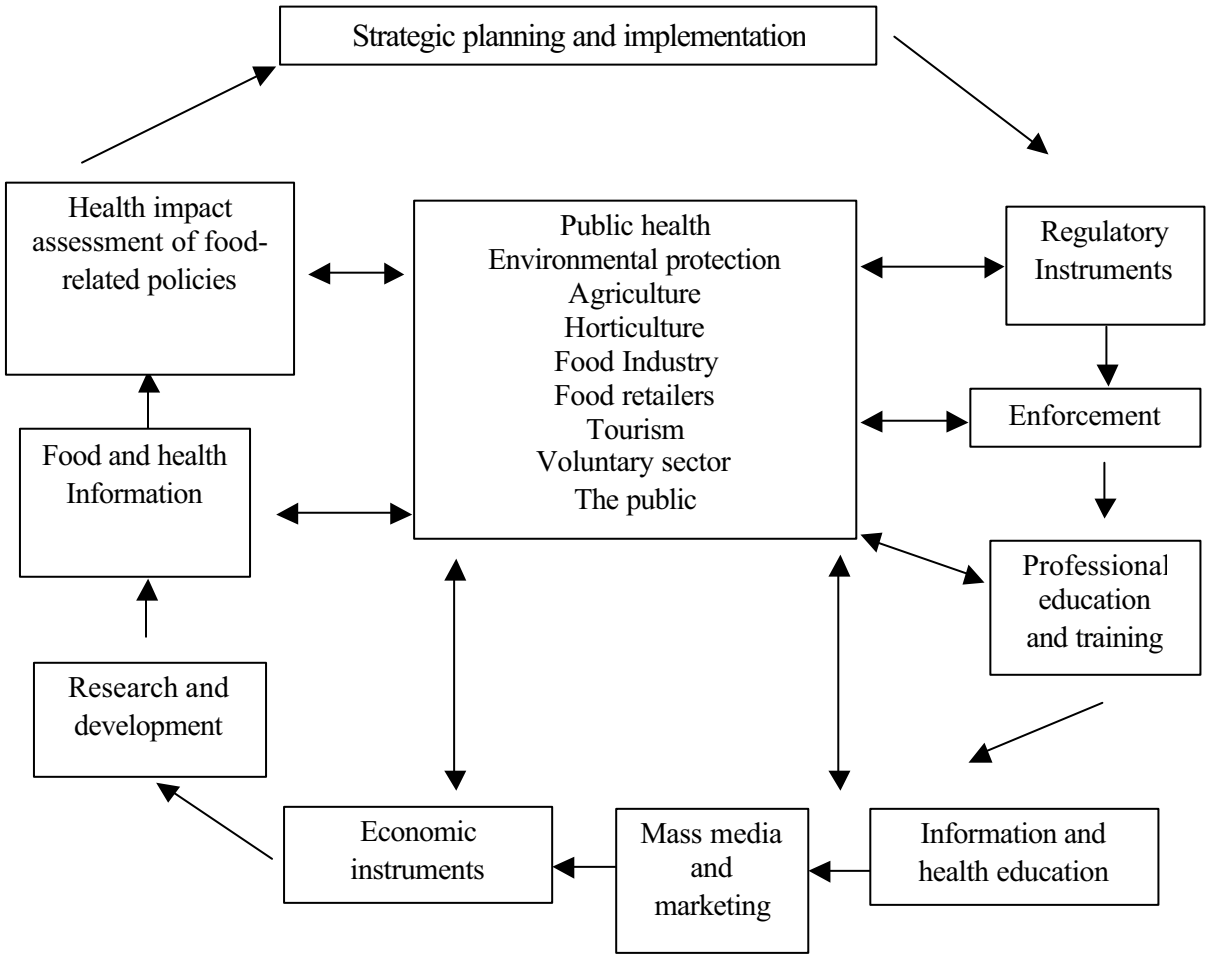
The concept of ecological public health has also emerged in the literature. It has evolved in response to the changing nature of health issues and their interface with emerging global environmental problems. These new problems include global ecological risks such as the destruction of the ozone layer, uncontrolled and unmanageable air and water pollution, and global warming. These developments have a substantial impact on health which often elude simple models of causality and intervention.

Ecological public health emphasizes the common ground between achieving health and sustainable development. It focuses on the economic and environmental determinants of health, and on the means by which economic investment should be guided towards producing the best population health outcomes, greater equity in health, and sustainable use of resources.

Source: Nutbeam, D. (1998) *Health Promotion Glossary.* Geneva, World Health Organization.

Training Materials 2.2

An integrated approach to food, nutrition and health



Source: *The First Action Plan for Food and Nutrition Policy, European Region of WHO, 2000–2005* Copenhagen, WHO Regional Office for Europe.

Training Materials 2.3
A list of possible goals for food and nutrition policy

Supply: to ensure security of supply for all the population. To ensure that this is both available and affordable.

Public health: to prevent diet-related ill health and disease and to promote good health by prevention and safe food, from production to consumption.

Environmental protection: to ensure that food and agricultural production fulfils environmental goals, such as sustainability and biodiversity from farm to plate.

Consumers: to create the conditions where consumers have sufficient information and education to enable them to choose a diet that meets their cultural predilections.

Social justice: to ensure there is reasonable equity within and between households and social groups. To create a welfare safety net for people on low income.

Standards: to maintain quality as well as quantity.

Economy: to enable the food economy to thrive, giving employment and growth.

Process of government: to be "transparent" in decision-making to ensure maximum public confidence and to enable the market to work efficiently.

Education: to pass on to future generations the skills and information to enable them to be active citizens. To meet future needs in training and education.

Culture: to promote food as part of local, regional and national life and to celebrate diversity and specialities.

Source: Lang T (1997). *Food for the 21st Century*. London: Centre for Food Policy Thames Valley University. Discussion Paper 3.

Training Materials 2.4

The nutrition transition and globalization

The nutrition transition refers to the process by which diets, tastes and health profiles transfer from region to region and especially from the rich to the poorer regions. [1] [2] [3] A key question is the rate of the transfer of ill health following this dietary shift. Particular concern is over diet-related degenerative diseases such as coronary heart disease and some cancers.[4] [5]

By the 1980s, epidemiologists with experience of developing countries were concerned about the spread of diseases hitherto associated mainly with developed countries. A new pattern was emerging in which the "old" problems of mal- or under-nutrition existed alongside problems more associated with over- or inappropriate nutrition. Researchers who were early to note this problem began to ask, for instance, "whether Western influence in Africa, Asia, Central and South America and the Far East is unnecessarily imposing our diseases on other populations who are presently relatively free of them."[6]

The general dietary trends associated with the nutrition transition have been characterized thus:[7]

- simple traditional dishes prepared from raw products in the household are replaced with refined, industrially processed food;
- food consumption patterns no longer follow the seasonal circle;
- there is a trend towards "exotic" food among certain groups of the population.

In environmental terms, these trends are also associated with a shift in energy use throughout the food supply chain from farm to distribution and the home.

The nutrition transition is also a cultural phenomenon, most obviously the ubiquitous "burgerization" and spread of US-style fast food chains. What is important here is less the existence of speedy food (all cultures have it) so much as the commercialization, branding and appeal through advertising. One global fast food chain's Chief Executive Officer memorably commented on his own brand's capacity to be sold by stating: "I've never seen a brand that is more responsive to advertising – you put your ad on the air on Monday and you can see sales climbing on Wednesday."[8]

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[1] Popkin B. M. (1994), 'The Nutrition Transition in Low-Income Countries: An Emerging Crisis', *Nutrition Reviews,* 52, 285–298.
[2] Drewnoski A. & Popkin, K. (1997), 'The Nutrition Transition: New Trends in the Global Diet', *Nutrition Reviews*, 55, 31–43.
[3] Popkin B (1998), 'The nutrition transition and its health implications in lower-income countries', *Public Health Nutrition*, 1, 5–21.
[4] Shetty, P. & Gopalan, C. eds. (1998). *Diet, Nutrition and Chronic Disease: an Asian perspective*. London: Smith-Gordon.
[5] WCRF (1997). *Food, Nutrition and the Prevention of Cancer*. Washington DC: World Cancer Research Fund /American Institute for Cancer Research.
[6] Robson, J (1981). 'Foreword' in Trowell, H, Burkitt, D, eds. *Western Diseases: their emergence and prevention*. London: Edward Arnold. ix-xi.
[7] Heilig, G K (1993). 'Food, lifestyles and energy' in van der Heij D G, Lowik M R H, Ockhuizen T, eds. *Food and Nutrition Policy in Europe*. Wageningen: Pudoc Scientific Publishers, 61–87.
[8] quoted in Willman J (1999). 'Black belt with a voracious appetite', *Financial Times*. January 29 p12.

There is nothing new about food tastes moving across the globe. What is new today is the pace, penetration, scale and control of this process. Even when tastes and foods from the developing world go North, as has happened with Indian, Chinese or Mexican foods, they can be easily commodified and lose their cultural and original resonance. This has been the fate of ready-made curries and sauces, frozen or "diet" Chinese meals, convenience tacos, for example.

The nutrition transition poses formidable challenges for health analysts and epidemiologists both how to collect data and how interpret them. The issue is to what extent can trends be associated with the dietary shifts? And can any ill health prevention strategy be put into place? Is the process unstoppable? While some argue that the transition might bring greater variety to people who have narrow diets, the policy challenge is whether health costs can and should be traded off against the gains of development.[9] [10]

The WHO World Health Report shows that certain food-related cancers are increasing worldwide.[11] Different types of cancers feature in the South than in the North, for instance. In the South there are more cancers of the oesophagus, liver and cervix. In the North, there is a predominance of cancers of the lung, colon, pancreas and breast.

The good news is that Coronary Heart Disease (CHD) is declining in the North after years of growth. The bad news is that CHD is now emerging in the South, particularly among the more affluent classes who are adopting a western lifestyle and dietary attributes. They are consuming more meat and dairy fats, salt and sugary foods and drinks, and less cereals and legumes, and taking less exercise.

Diabetes is also on the increase alarmingly. The WHO anticipates a rise from 143m cases in 1997 to 300m in 2025. Rising levels of diabetes are associated with diet and lifestyle changes in the shift from traditional diet and from an activity-based lifestyle to a more sedentary one. In India, for instance, the incidence of diabetes is expected to rise from 15m cases in 1990 to 35m by 2000.[12] Incidence is much higher in urban than rural populations.[13]

In the Middle East, the World Health Organization has reported that changing diets and lifestyles with urbanization are now resulting in changing patterns of mortality and morbidity.[14] In Saudi Arabia, for instance, meat consumption doubled and fat consumption tripled between the mid 1970s and early 1990s. Jordan has seen a sharp rise in deaths from cardiovascular disease. But these problems sit alongside protein-energy malnutrition, especially among children. A huge study of the nutrition transition within a developing country, China, found that as the population sample urbanized, its health profile began to

[9] Popkin B. M. (1994). 'The Nutrition Transition in Low-Income Countries: An Emerging Crisis', *Nutrition Reviews,* 52, 285–298.
[10] Drewnoski A, Popkin, B (1997). 'The Nutrition Transition: New Trends in the Global Diet', *Nutrition Reviews*, 55, 31-43.
[11] WHO (1999). *World Health Report 1999*. Geneva: World Health Organization.
[12] Ramachandran, A (1998). 'Epidemiology of non-insulin-dependent diabetes mellitus in India' in Shetty, P, Gopalan, C, eds, *Nutrition and Chronic Disease: an Asian perspective,* London: Smith-Gordon, 38–41.
[13] Yajnik, C S (1998). 'Diabetes in Indians: small at birth or big as adults or both?' in Shetty, P, Gopalan, C, eds, *Nutrition and Chronic Disease: an Asian perspective,* London: Smith-Gordon, 43.
[14] Verster, A (1996). 'Nutrition in transition: the case of the Eastern Mediterranean Region' in Pietinen, P, Nishida, C, Khaltaev, N, eds. *Nutrition and Quality of Life: Health Issues for the 21st century*. Geneva: World Health Organization.57–65.

follow a more Western pattern of diet-related disease.[15] Its diet altered, with the replacement of legumes such as soya bean by animal protein in the form of meat. As a result, degenerative diseases became more prevalent. One review of this problem concluded that exhortation to consume more soy when they were voting with their purses to eat more meat would be ineffective "in the context of an increasingly free and global market."[16] The battle to prevent Western diseases appears already to have been lost.

Key diet-related indicators for the Nutrition Transition include:

- Obesity/Body-Mass Index
- Diabetes
- Coronary heart disease
- Cancers

Questions arising:

The public policy issues arising from the nutrition transition thesis are:

- Can countries afford to pay for this emerging cost?
- Who is to pay?
- Who has responsibility for causing the problem?
- Who can tackle the problem?
- How?

[15] Chen J, Campbell T C, Li J, Peto R (1990). *Diet, Lifestyle and Mortality in China: a Study of the Characteristics of 65 counties*. Oxford: Oxford University Press.

[16] Geissler C (1999). 'China: the soybean-pork dilemma', *Proceedings of the Nutrition Society*, 58, 345–353.

Session 3: What existing food and nutrition policies are there?

Aims

1. To explain what food and nutrition policy is.
2. To describe existing policy commitments (e.g. ICN 1992) and networks.
3. To examine some examples of UN food and nutrition policy documents.

Time

2 hours.

Teaching Methods

Group work and plenary with short lecture (Training Material 3.11) and discussion.

Plan

Having established the need for comprehensive policies in Session 2, this session reminds participants of existing international and national governmental commitments such as the International Conference on Nutrition (ICN)1992 and World Food Summit (WFS)1996.

In groups, preferably from the same country or geographic region, participants are invited to consider some of the food and nutrition policy documents related to the UN system. Besides the ICN and WFS, they consider food safety and hygiene policy, the World Health Assembly WHA 53.15 (WHA 2000) (Food Safety "Pillar", training material 3.6.2); The CINDI dietary guide (12 steps) (Nutrition "Pillar", training material 3.8) and the WHO European Region Urban and Peri-Urban Food and Nutrition Action Plan (Food Security "Pillar", training material 3.11). These are provided in the Training Materials (3.1 to 3.11), along with other documents.

Outcomes

At the end of this session participants should:

1. Understand existing food and nutrition policies;
2. Be aware of key international policy commitments and networks;
3. Begin to see how partnerships, based on agreements already made by governments, can be developed between different networks;
4. Understand how the three "pillars" of food safety, nutrition and sustainable food supply can be linked within different policies and networks.

Training Materials

3.1 Lecture Notes: what is Food and Nutrition Policy?
3.2 UN commitments by Governments
3.3 Summary of HEALTH21
3.4 Local Agenda 21 and UN Commission for Sustainable Development
3.5 Healthy Cities Network
3.6 Food Safety Policies
3.7 Health Promoting Schools
3.8 The CINDI network

3.9 The Baby-friendly Hospital Initiative
3.10 National Environmental Health Action Plans (NEHAPs)
3.11 Goals of the WHO/EURO Urban Food and Nutrition Action Plan

Activities

3.1 What is food and nutrition policy?
3.2 The International Conference on Nutrition (ICN) 1992 and other international commitments.
3.3 Using some UN policy documents.

Activity 3.1
Lecture: What is food and nutrition policy?

Activity Instructions

The facilitator:
Either gives a short presentation (using overheads the facilitator has prepared earlier using Training Material 3.1.)
Or, asks participants to read Training Material 3.1. in their own time.

This Activity should last no more than 30 minutes.

Activity Background

This is provided in the Lecture Notes in Training Material 3.1.

Activity Round-up

At the end of this activity participants will have been introduced to the fact that there is a rich tradition of thinking about, and development of, food and nutrition policy.

Activity 3.2

The International Conference on Nutrition (ICN) 1992 and other international commitments

Activity Instructions

Participants are taken through the key existing international food-related commitments. If possible, they should be given the full documents.

Activity Background

Training Materials 3.2 summarizes the main commitments. These include The International Conference on Nutrition (ICN) 1992, the World Food Summit (WFS) and other Internationally Agreed Political Commitments.

If the full documents are not available, Training Material 3.2 provides a four page summary of the International Conference on Nutrition (ICN) and 1996 World Food Summit (WFS). Other policy commitments are listed.

Activity Round-up

The purpose of this activity is to convey the breadth and range of existing international commitments. Participants are reminded that they do not need to "reinvent the wheel." The thought is planted that attention is needed on implementation and monitoring the enforcement of these international commitments.

Activity 3.3
Using some UN policy documents

Activity Instructions

In this Activity, groups consider some policies.

Each group will be asked to:

- consider the policy in only ONE of the three "pillars": food safety, nutrition, or sustainable food supply.
- Consider what their own government has done to deliver the commitments.
- Identify tensions and difficulties in delivering the commitments.

The facilitator needs to think carefully which groups study which UN documents.

Groups could be allocated policies which are of special interest to their national situation. The following are recommended:

- Food safety and hygiene policy in the context of a strategy for food safety/control (training material 3.6.2) (Food Safety "Pillar")
- The CINDI 12 steps to healthy eating (training material 3.8) (Nutrition "Pillar")
- The WHO European Urban and Peri-Urban Food & Nutrition Action Plan (training material 3.11) (Food Security "Pillar")

Activity Background

Conflict/tensions might emerge over implementation:

- Competition between food safety specialists and those responsible for nutrition;
- Food safety specialists responsible to different governmental authorities resulting in duplication or fragmentation;
- Maintaining local farmers/food markets that do not reach food hygiene (HACCP) standard;
- Baby friendly hospitals – "rooming in" may contravene hygiene regulations;
- Eradicating iodine deficiency while recommending caution with salt intake;
- Local produce (vegetables) may be perceived to be contaminated with heavy metals or pesticides.

Activity Round-up

Each group should report back by summarizing briefly their specific topic (food safety, nutrition or sustainable food supply) and list what their government has done to achieve the recommendations.

During the reporting back session the facilitator should ask participants if they can begin to see links/connections between the three "pillars". It would be useful if they can foresee any tensions or conflicts between the three pillars. Later (in Sessions 7–9), participants will identify ways to overcome potential barriers to implementing a comprehensive policy.

At the end of this session, the facilitator should stress the linkages between the three pillars and that a comprehensive policy needs all three. Participants should begin to see how safe food and healthy nutrition are inextricably linked to food security and a sustainable food supply. The session highlights the need for food policies that are comprehensive and integrated. This requires team work and close collaboration between actors in the food supply chain identified in Sessions 1 and 2.

Training Materials 3.1
Lecture Notes – What is Food and Nutrition Policy?

Introduction

"Food and nutrition policy" is a general term to mean the use of public policy measures to deliver improved public health. Much as there are foreign policies or economic policies, it is now recognized that there are food and nutrition policies. Sometimes these are explicit – set by governments – and sometimes they are implicit – a combination of private policies by industry, agencies. In this pack, we refer to food and nutrition policies at the governmental level but in session 1 it was suggested that there are many "actors" who can between them make food and nutrition policy. Measures to improve diet-related health may be very varied. They range from health education to taxation and setting regulations. A food and nutrition policy refers not so much to those measures themselves as to the setting of desired public goals. It is the application of public policy to the area of food and nutrition in order to lead to more concerted inter-sectoral action.

The capabilities of the World Health Organization in food and nutrition policy

WHO has produced many documents arguing for improved national and international food and nutrition policy.

These documents come in three forms:
- Intergovernmental agreements
- Expert reports
- Programme documents

From WHO's point of view, both international agreements and expert reports are central to its work which promotes improvements in food and nutrition policy.

Intergovernmental Agreements

The International Conference on Nutrition 1992 (see Training Material 3.1) saw 159 countries agreed to eliminate hunger and to reduce all forms of malnutrition. It set four overall objectives, created guidelines, agreed 9 strategies and actions, and committed signatories to produce follow-up plans of action and to monitor performance.

The World Food Summit of 1996 brought together 186 countries and confirmed this general perspective and linked the strategy more firmly with the goals of poverty eradication and environmental protection/sustainable development. The Final Declaration of the WFS is a key document, alongside the ICN. (www.fao.org/wfs/final/rep-1-e.htm).

Expert Reports

An example of an expert report is the 1990 WHO report on Diet and Chronic Disease which made recommendations to alter national diets (WHO 1990). This followed on from an expert report produced for the European Region (WHO 1988). Both these reports highlighted the strong evidence for:

- the impact of nutrition on human health;
- changes in diet producing changing patterns of disease;
- preventive action.

Nancy Milio has summarized the approach thus:

> *"National food and nutrition policies are necessary to sustain the new nutrition: national diets low in fatty animal products, sugar, salt and alcohol; and high in fibre and plant foods. And the new nutrition [...] is fundamental to sustainable health and agriculture."* (Milio & Helsing 1998: 12).

An area like food and nutrition policy covers a wide range of policy issues, so the process of creating it is highly complex and takes years. The draft urban food and nutrition action plan (WHO, Copenhagen 2000) is an example of a policy document which is being created to integrate public and environmental health goals.

Expert and other Programme Documents

International bodies such as the WHO and other UN bodies also produce working papers and reports. These are extremely useful both in gathering information, via governments and other sources, and in "floating" ideas. These may or may not develop through the formal decision-making process, and ultimately gain Ministerial intergovernmental agreement status. Examples of programme documents include:

- Papers monitoring breastfeeding programmes;
- Reports summarizing national food and nutrition work following the ICN.

Other approaches to Food and Nutrition Policy: the OECD

Most definitions that focus on policy tend to stress nutrition rather than wider food policies. One of the only attempts to set out a workable definition of what is meant by food policy stemmed from a rather unlikely source, the Organization for Economic Co-operation and Development (OECD).

In a little quoted report from its Agricultural Policies Working Party in 1981, it defined food policy as those policies affecting food – its supply and impact – which reflect *'the dominant priorities and objectives of governments…*" (OECD 1981: 10).

Food policies, according to the OECD, are those which govern the food economy, defined as "*the set of activities and relationships that interact to determine what, how much, by what method and for whom food is produced*" (p. 10).

Food policy is "*a strategy that views the food economy and policies relating to it in an integrated way and in a broad economic and political context*."

The OECD approach stressed the historical and dynamic nature of food policy. Food policy is a "*dynamic in which there is continual interaction and re-action*" (p. 13).

Problems with the OECD 1981 approach

Although the OECD report was useful, it suffers some limitations. These include:

- A focus only on the role of government; food policy is whatever the government of the day does and thinks. It implies that government can always control policy and their outcomes.
- A "top down" approach to policy-making: it tends to down-play the role of other forces in the food system, e.g. NGOs, industry. The interplay between companies and consumers may be just as significant in forming policy (Tansey & Worsley 1995).
- An assumption that there is consensus rather than conflict over food and nutrition; in fact, this area is both sensitive and highly debated.
- An under-estimation of the complexity of the modern food system; in the decades since the 1981 report, immense changes have emerged: globalization, new technologies such

as genetic modification, new food products, new world institutions such as the World Trade Organization.

We must distinguish therefore between *explicit* and *implicit* food policies. A government may state a policy officially but implicitly accept that its shape will be different. We should note, too, that even though the OECD is an inter-governmental body itself, it actively gathers views and the involvement of bodies outside governmental circles.

A comprehensive approach to Food and Nutrition Policy?

The key idea here is that food and nutrition policy must be made and not just allowed to happen. The assumption behind this training workshop is that public health can be improved or worsened by different decisions and actions. There are public policy choices. Governments, companies, people and organizations make those choices, sometimes overtly, sometimes by default. In trying to develop food and nutrition policies or to improve them, our interest is in making good decisions which can affect: who eats; what is eaten; when and where it is eaten and how this influences health

The subject and the practice of food & nutrition policy means that we have to link policy inputs from diverse sources. Two things follow from this:

1. If we want to formulate realistic but useful food & nutrition policies, we need to understand better how current food systems work.
2. We need to draw upon many academic disciplines: food science, nutrition, veterinary and human medicine, social and political sciences, economics, history.

Some other definitions of food and nutrition policy

"*Food policy encompasses the collective efforts of governments to influence the decision-making environment of food producers, food consumers, and food marketing agents in order to further social objectives*." Timmer C P, Falcon WP, Pearson SR/ World Bank (1983). *Food Policy Analysis*. World Bank. Baltimore, Maryland: Johns Hopkins University Press, p. 9.

"… a balanced government strategy regarding the food economy, which takes account of the interrelationships within the food sector and between it and the rest of the national and international economy." OECD (1981). *Food Policy.* Paris: Organisation for Economic Co-operation and Development.

"*Governmental nutrition policy, given appropriate conditions for the feasibility of its development, is determined by the body politic. Inasmuch as nutrition is usually recognized to be , at least in part, a technical area, scientists (health specialists, nutritionists and economists) are generally called upon to advise legislators, cabinet ministers, and planners in the formulation and implementation of policy.*" Dwyer J, Mayer J (1979). 'Beyond economics and nutrition: the complex basis of food policy' in J Mayer and J Dwyer, eds. *Food and Nutrition Policy in a Changing World*. New York: Oxford University Press. p. 1.

" *Food policies [are] intended to be coherent bodies of measures. There are two main goals: first, to prevent illness and to further public health by informing people about the importance of a 'prudent diet'. (…) Second, a food policy purports to guarantee the safety of food products, which means issuing and enforcing rules and regulations for food producing, food processing and food distributing companies."* Mennell S, Murcott A, van Otterloo A H

(1992). *The Sociology of Food: eating, diet and culture*. London: Sage/International Sociological Association, p. 39.

"*Food policy is about the decision-making process which affects who eats what, when, where and on what conditions. (...) In the sphere of food policy, we are interested in the distribution of power over food, this vital means for human subsistence. We try to piece together the different areas of activity which affect the total picture of food production, distribution and consumption. The shape of food policy may be as interesting to us as its content*." Lang, T (1997). *Food Policy for the 21st century*. Discussion Paper 4. London: Centre for Food Policy, Thames Valley University. p. 2.

"…the basic aims of food policy [are] the provision of a safe, secure, sustainable, sufficient, nutritious diet for all, equitably.." *Tansey G, Worsley T (1995).* The Food System. *London: Earthscan*. p. 222.

"The challenge we face,…., is not simply a matter of meeging the global demand for food. That is relatively easy. […] The difficult task over the next twenty-five years is to ensure that [the 750 million people who are chronically under-nourished]…are well fed." *Conway G (1997).* The Doubly Green Revolution. *Harmondsworth:* Penguin p. 285.

References on Food and Nutrition Policy

Conway, G (1997). *The Doubly Green Revolution: food for all in the 21st century*. Harmondsworth: Penguin.

James WPT, Ralph A, Bellizzi M (1997). Nutrition Policies in Western Europe: National Policies in Belgium, the Netherlands, France and the United Kingdom. *Nutrition Reviews*, vol 55, no 11, pp s4–s20.

Lang T (1999c). 'Food and nutrition' in Weil O, McKee M, Brodin M, Oberlé D, eds (1999). *Priorities for public health action in the European Union*. Vandoeuvre-les-Nancy: Société Francaise de Santé Publique 138–156.

Milio N, Helsing E, eds. (1998). *European food and nutrition policies in action*. Copenhagen: World Health Organization. WHO Regional Publications, European Series no. 73.

OECD (1981). *Food Policy*. Paris: Organisation for Economic Co-operation & Development

Pinstrup-Andersen P, ed. (1993). *The Political Economy of Food & Nutrition Policies*, Baltimore: Johns Hopkins University Press.

World Health Organization (1990). *Diet, Nutrition and the Prevention of Chronic Diseases*. Technical series reports, no 797. Geneva: WHO.

World Health Organization / Food & Agriculture Organization (1992a) *World Declaration and Plan of Action for Nutrition.* FAO/WHO International Conference on Nutrition, Rome, December.

World Health Organization / Food & Agriculture Organization (1992b). *International Conference on Nutrition: Nutrition and development – a global assessment.* Rome: Food and Agriculture Organization / World Health Organization.

World Health Organization (1998) *Comparative Analysis of Nutrition Policies in WHO European Member States*. Copenhagen: WHO Regional Office for Europe.

World Health Organization (2000). *Draft Urban Food and Nutrition Action Plan: Elements for local community action to promote local production for local consumption*. Copenhagen: World Health Organization. April.

FAO/WHO (1996). *Declaration of the World Food Summit*. Rome: Food and Agriculture Organization / World Health Organization. November.

Training Material 3.2

UN Commitments by governments

Refer to the WHO EURO documents:

- Comparative Analysis of Nutrition Policies in the WHO European Region (1998 and 2001);
- Comparative Analysis of Elimination of Iodine Deficiency Disorders in the WHO European Region (2000); and
- Comparative Analysis of implementation of the Innocenti Declaration in the WHO European Region (1999).

International action on improving national nutrition policies and strategies

ICN: background and preparatory process

The International Conference on Nutrition (ICN) was convened jointly by WHO and FAO in 1992. The ICN was the first global intergovernmental conference on nutrition and as such provided a unique opportunity to focus the world's attention on the multifaceted and often changing nature of nutrition and diet-related problems, and to address them in a comprehensive manner.

The ICN was the culmination of more than 2 years of joint efforts by WHO and FAO to increase awareness of the extent and seriousness of nutrition and diet-related problems and to achieve consensus on the way forward in addressing them. In recognition of the vast differences in nutrition and diet-related problems around the world, the ICN had a strong regional and country focus. In fact, the process of preparing for the ICN started in countries themselves. Over 150 countries nominated a national focal point and organized national seminars to mobilize people from different sectors and to coordinate preparations for the ICN. Through these efforts, over 140 countries prepared reviews of their national nutrition situation, including the extent and causes of nutrition and diet-related problems, past experience in addressing them and even plans for future action.

In addition, a series of regional and sub-regional preparatory meetings was held in all regions of the world during the first quarter of 1992, and the national and regional strategies identified at the regional and sub-regional meetings provided the basis for developing the Global Plan of Action adopted by the ICN.

In August 1992, the first meeting of the Preparatory Committee took place in Geneva and was attended by more than 700 participants, including:

- 480 country representatives from 132 Member States;
- representatives of 13 organizations and bodies of the United Nations system; and
- 86 other intergovernmental and nongovernmental organizations.

In December 1992, the ICN was held in Rome and was attended by more than 1300 participants, including:

- over 1000 country representatives (approximately 140 were of ministerial level) from 159 Member States and the European Community;

- representatives of 15 organizations and bodies of the United Nations system; and
- over 150 other intergovernmental and nongovernmental organizations.

The World Declaration and Plan of Action for Nutrition adopted at the ICN identified 9 goals and 9 strategies as global priority nutrition action areas, building on the nutrition-related goals and commitments already established in major international summits and conferences, including the Alma-Ata Conference on Primary Health Care, the 4th United Nations Development Decade, the World Summit for Children, the Montreal Policy Conference on Micronutrient Malnutrition, the United Nations Conference on Environment and Development, to mention just a few.

The Plan of Action provided a technical framework for the preparation of national plans of action through 9 strategies which involve various sectors of government, international agencies, NGOs and the private sector. These 9 action-oriented strategies include:

- Incorporating nutritional objectives, considerations and components into development policies and programmes
- Improving household food security
- Protecting consumers through improved food quality and safety
- Preventing and managing infectious diseases
- Promoting breastfeeding
- Caring for the socioeconomically deprived and nutritionally vulnerable
- Preventing and controlling specific micronutrient deficiencies
- Promoting appropriate diets and healthy lifestyles
- Assessing, analysing and monitoring nutrition situations.

The goals and strategies adopted by the ICN was subsequently endorsed in their entirety by the World Health Assembly (resolution WHA46.7) and have been serving as a platform for WHO's nutrition strategies and collaborative support to countries.

The World Food Summit held in Rome in 1996 reiterated and reinforced the validity of these goals and strategies. It also provided an exceptional opportunity to reaffirm the commitment to achieving food and nutrition security for all, to build on efforts already made in implementing the ICN World Declaration and Plan of Action for Nutrition and to invest resources effectively at national, regional and global levels to accelerate the translation of national nutrition plans into meaningful action and visible results.

Progress and outcome

By April 2000, WHO had provided technical and financial support to 170 of its Member States specifically for strengthening their national nutrition plans. Through its vigorous regional nutrition programmes, WHO had also organized 28 regional follow-up meetings, most often in collaboration with FAO and UNICEF, to assist countries in identifying key factors for successfully improving nutrition, accelerating a reduction of malnutrition, and strengthening national nutrition programmes. Most regional offices have prepared up-to-date reports providing details of the magnitude of malnutrition (especially protein-energy malnutrition, iodine deficiency, vitamin A deficiency, and obesity) and progress achieved in promoting good nutrition and reducing malnutrition. A joint FAO/WHO report of global progress and action, presented to the ACC Sub-Committee on Nutrition in March 1997, was submitted through the United Nations Economic and Social Council (ECOSOC) to the United Nations General Assembly.

Due to this momentum, by April 2000, a total of 149 countries and 4 territories had finalized or drafted their national plans of action for nutrition, and the plans of another 17 countries and 3 territories were under preparation. This represents an impressive 87% of WHO's Member States, most of which continue the process of development, implementation and monitoring.

Regional review and evaluation meetings

During the course of 1999-2000, WHO is holding in collaboration with other concerned agencies such as FAO and UNICEF, a series of regional review meeting in order to evaluate country experiences and identify key elements for successful development of national nutrition plans and policies and key factors for successful translation of national plans and policies into action. The outcomes of these regional review meetings will be incorporated in the global review and analysis which is currently being undertaken (see below).

Dates

October 1999:	Western Pacific Region
November 1999:	European Regional
December 1999:	South-East Asia Region
September 2000:	Region of the Americas
October 2000:	African Region (Francophone countries)
October 2000:	African Region (Anglophone countries)
November 2000:	Eastern Mediterranean Region

Global review and analysis

Eight years have passed since the ICN. But today, malnutrition still underlies almost half the under-five mortality worldwide, in particular, in the world's poor and marginalized populations and a continuation of present trends would leave millions of people undernourished and suffering from all the major forms of malnutrition in the next millennium. WHO is, therefore, undertaking a global review and analysis of national nutrition policies and plans of action for re-directing and enhancing WHO's collaborative support to countries, and for renewing political commitment of the international community for achieving food and nutrition security for all. This global review and analysis examines:

- the progress towards developing and implementing national nutrition policies and plans;
- the essential components of effective and sustainable nutrition policies and plans;
- multisectoral and intersectoral approaches to nutrition promotion under UNDAF/CCA framework;
- monitoring and surveillance tools for food and nutrition insecurity and vulnerability; and
- the key elements for success in translating national policies and plans into operational action.

It will also address some of the emerging global and regional issues, such as:

- the impacts of global transition on nutrition, in particular, the increasing global public health problem of obesity and its associated problems;
- the global burden of diet-related diseases
- the impacts of HIV/AIDS on household food and nutrition security, particularly in Africa; and
- the nutrition implications of GMO.

It is envisaged that a draft review and analysis document will be ready by the end of the year (working outline of the global review and analysis document is attached).

Training modules for multisectoral national nutrition policies and plans

To provide tools for facilitating countries' efforts, WHO is preparing modules for developing effective and sustainable national nutrition policies and plans, takes into account the increasing "nutrition transition" which many countries are experiencing, and its impact on household food and nutrition security. The first field-testing of these training modules was conducted in Moscow in October 1997 and their further field-testing with the south-east European countries is being planned in Slovenia in June 2000, and with the Baltic countries in Latvia in August 2000. It is envisaged that the draft training modules will be adapted initially for the Asian regions where it will be field-tested in early 2001.

Other Policy Agreements over the Past Ten Years

World Health Assembly 2000: WHA 53.15–Food Safety 2000
This is a move towards developing sustainable, integrated food safety systems for the reduction of health risk along the entire food chain, from the primary producer to the consumer.

European Commission White Paper on Food Safety 2000
The European Commission proposes a series of measures to organize food safety in a more coordinated and integrated manner with a view to achieving the highest possible level of health protection. A number of policy initiatives are described, including the establishment of a European Food Authority and the development of EU dietary guidelines and an EU nutrition policy. The document also proposes establishing an EU-wide survey of food consumption patterns.

World Health Assembly 2000 WHA Resolutions 51.18 and WHA 53.17 Noncommunicable Diseases Prevention and Control

HEALTH21 1998
WHO member states endorsed HEALTH21. At least twelve of the 21 targets call on Member States to increase intersectoral activities (see the box inside the front cover). The development and implementation of food and nutrition action plans provide a concrete example of how HEALTH21 should be translated into practice.

UN/ECE "Århus Convention" 1998
The signatories to the Århus Convention agreed to improve public access to information, public participation in decision-making and access to justice on environmental matters. At the 1999 European Ministerial Conference on Environment and Health, ministers of health and environment jointly re-affirmed their commitment to: improving public access to information; securing the role of the public in decision-making; and providing access to social justice for health and environment issues. This includes food policies.

Amsterdam Treaty 1997
The Amsterdam Treaty of the European Union states that health considerations will be considered in all EU policies and that public health should be ensured. The Amsterdam Treaty provides Member States with an opportunity to call for health impact assessments on EU policies relating to food production, distribution and control.

Human Settlement, Istanbul 1996
UN (Second) Conference on Human Settlement. Habitat II, Habitat Agenda and Istanbul Declaration.

Food Summit, Rome 1996
The World Food Summit (WFS) 1996 provided an excellent opportunity to reaffirm the international community's commitment made at the ICN 1992 to reinforce the efforts being made to eliminate hunger and malnutrition, and to achieve food and nutrition security for all.

Social Development, Copenhagen 1995
World Summit for Social development. Copenhagen Declaration on Social development and Programme of Action.

Women's Conference, Beijing 1995
UN (Fourth) World Conference on Women. Dealt with the importance of food and nutrition security, information and education and promoting, protecting and supporting breastfeeding. Beijing Declaration and Platform for Action.

Population and Development, Cairo 1994
International Conference on Population and development (ICPD). Programme of Action.

Human Rights, Vienna 1993
World Conference on Human Rights. Vienna Declaration and Programme of Action.

International Conference on Nutrition 1992
In 1992, the International Conference on Nutrition (ICN) adopted the World Declaration and Plan of Action for Nutrition. Since then action has been supported by over 30 resolutions of the World Health Assembly. A 1996 a follow-up consultation was held in the European Region to review progress, and reports from the WHO European Regional office have evaluated the progress being made by member states on policy implementation.

Environment Conference, Rio de Janeiro 1992
UN Conference on Environment and Development (UNCED). Rio Declaration on Environment and Development, the UN Framework Convention on Climate Change and the UN Convention on Biological Diversity. Sustainable development was defined in 1992 as development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Many food and health policies can be incorporated into Agenda 21 activities in member states. WHO, as task manager for Chapter 6 of Agenda 21, has played a key role in addressing the health objectives of Agenda 21.

Innocenti Declaration on Protection, Promotion & Support of Breastfeeding 1991
The Innocenti Decaration sets a goal for achieving optimal health for infants and mothers in Member States (adapted):

- Appoint a national breastfeeding coordinator and appropriate authority, and established a multisectoral national breastfeeding committee composed of representative form relevant government departments, nongovernmental organizations, and health professional associations;
- Ensure that every facility providing maternity services becomes "Baby-Friendly" and fully practices all Ten Steps to Successful Breastfeeding set out in the joint WHO/UNICEF

statement "Protecting, promoting and supporting breastfeeding: the special role of maternity services";

- Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement; and
- Take action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety (see below)

The International Code of Marketing of Breast milk Substitutes and subsequent WHA resolutions 1981–1996 (1981–2001)

World Summit for Children (1990)
Dealt with the importance of food and nutrition security, information and education and promoting, protecting and supporting breastfeeding. World Declaration and Plan of Action.

Convention Rights of Child(1989)
Dealt with the importance of food and nutrition security, information and education and promoting, protecting and supporting breastfeeding.

Training Material 3.3
Summary of HEALTH21

An introduction to the health for all policy framework for the WHO European Region

Is it healthy? The question is simple but profound. By asking it, decision-makers can alter the course of human development. As the 21st century approaches, the people of Europe are searching for a more socially responsible and sustainable approach to development and growth. Very often this involves a trade-off: a resolution of the conflict between the pursuit of wealth and the protection and improvement of health.

As stated in the 1998 World Health Declaration, the enjoyment of health is one of the fundamental rights of every human being. Health is a precondition for wellbeing and the quality of life. It is a benchmark for measuring progress towards the reduction of poverty, the promotion of social cohesion and the elimination of discrimination.

Good health is fundamental to sustainable economic growth. Inter-sectoral investment for health not only unlocks new resources for health but also has wider benefits, contributing in the long term to overall economic and social development. Investment in outcome-oriented health care improves health and identifies resources that can be released to meet the growing demands on the health sector.

The HEALTH21 policy for WHO's European Region has the one constant goal to achieve full health potential for all. To do this, it sets out:

- to promote and protect people's health throughout their lives; and
- to reduce the incidence of the main diseases and injuries, and alleviate the suffering they cause.

Three basic values form the ethical foundation of HEALTH21:

- health as a fundamental human right;
- equity in health and solidarity in action between and within all countries and their inhabitants; and
- participation and accountability of individuals, groups, institutions and communities for continued health development.

Four main strategies for action have been chosen to ensure that scientific, economic, social and political sustainability drive the implementation of HEALTH21:

- multi-sector strategies to tackle the determinants of health, taking into account physical, economic, social, cultural and gender perspectives, and ensuring the use of health impact assessment;
- health outcome-driven programmes and investments for health development and clinical care;
- integrated family- and community-oriented primary health care, supported by a flexible and responsive hospital system; and
- a participatory health development process that involves relevant partners for health at home, school and work and at local community and country levels, and that promotes joint decision-making, implementation and accountability.

Twenty-one targets for health for all have been set, which specifically spell out the needs of the whole European Region and suggest the necessary actions to improve the situation. They will provide the "benchmarks" against which to measure progress in improving and protecting health, and in reducing health risks.

These 21 targets together constitute an inspirational framework for developing health policies in the countries of the European Region. HEALTH21 should be incorporated into the health development policy of every Member State of the Region and its principles should be embraced by all major European organizations and institutions.

To support HEALTH21, the WHO Regional Office for Europe intends to play the following five main roles:

1. act as a "health conscience", defending the principle of health as a basic human right, and identifying and drawing attention to persistent or emerging concerns related to people's health;
2. function as a major information centre on health and health development;
3. promote the health for all policy throughout the Region and ensure its periodic updating;
4. provide up-to-date evidence-based tools that countries can use to turn policies based on health for all into action; and
5. work as a catalyst for action by:
    - providing technical cooperation with Member States – this can be strengthened through the establishment of a strong WHO function in every country, to ensure the mutually beneficial exchange of experience between the country and the regional health organization;
    - exercising leadership in Region-wide efforts to eradicate, eliminate or control diseases that are major threats to public health, such as epidemics of communicable diseases and pandemics such as tobacco-related diseases;
    - promoting policies based on health for all with many partners through networks across the European Region; and
    - facilitating the coordination of emergency preparedness for and response to public health disasters in the Region.

Source/further details: Web site: http://www.who.dk.

Training Material 3.4

Local Agenda 21 and UN Commission for Sustainable Development

Local Agenda 21 is an international environment and development plan that was agreed and signed by the world's heads of state in 1992 at the Earth summit in Rio de Janeiro. This was a United Nations led initiative. As well as government involvement, there was also input from a wide range of nongovernmental organizations (NGOs).

The Earth Summit was inspired by the publication of the Brundtland report in 1987. This report called for a balance between the responsibilities of the North and the South and the need to integrate environment and development.

Local Agenda 21 has implications for regional, national and local work based around balancing sustainability and the environment. At a regional level its impact has been muted by the inactivity of national governments and the actions of TNCs. Environmental concerns have taken second place to the lowering of trade barriers and in many instances environmental and sustainable concerns have been seen as barriers to trade.

The final document from the Rio conference stipulated that "by 1996 most local authorities in each country should have undertaken a consultative process with their populations and achieved a consensus on Local Agenda 21 for the[ir] communities." This was not achieved but Local Agenda 21 is still a potentially powerful development for those wishing to promote local sustainability. The LA 21 movement has much in common with the healthy cities movement (Baum 1998). The healthy cities project in Johannesburg also uses the LA 21 label. It has when used broadly many similarities to the new public health movement and ecological public health.

Many local authorities in the United Kingdom have Local Agenda 21 committees. At a local level, LA21 has been taken up by local authorities as a means of improving the quality of life. It has broadened its scope from traditional environmental issues such as pollution and waste/recycling issues to looking at biodiversity, the built environment, transport and unemployment.

The range of initiatives is however variable with some Local Agenda 21 groups looking at issues such as local allotments and others taking a broader approach and tackling issues such as employment and the creation of local sustainable communities.

The International Council for Local Environmental Initiatives acts as a clearing house for LA21.[17] They operate three LA21 initiatives:

- **LA21 Model Communities Program** this is a research and development initiative that helps municipalities design, test and evaluate sustainable development programs.
- **LA21 Communities Network** Works with those who have set up and established participatory LA21 programmes.
- **National LA 21** provides technical support for national governments wishing to establish national programmes.

[17] ICLEI can be contacted at the 8th Floor, East Tower, City Hall, Toronto, Ontario, M5 2N2. Tel 416 392 1462, E-mail: icelei@iclei.org; http://www.iclei.org.

An Example: City of South Sydney, Australia

The strategy for a Sustainable City was developed as a planning strategy and became the basis framework for South Sydney Council's 1996–99 management plan. Community consultation identified the environment as the most important goal. Local planning teams were established, which included residents and representatives of local organizations. A planning team was established and a number of community-based consultations were held on the issue of affordable housing and State Government plans for a former goods yard site.

The resulting strategy identified five main areas as being important for programme implementation:

- Environment
- Land use and transport
- Character and identity
- Community wellbeing and
- City management.

For each of the above areas specific objectives and strategies were identified.

Further Reading

Baum F (1998). *The New Public Health: An Australian Perspective.* Melbourne: Oxford University Press.
Dodds F (1997). *The Way Forward: Beyond Agenda 21*. London: Earthscan Books.
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Whent H (2000). 'Think globally, act locally: What are the implications for health promotion and research?'. In Watson J and Platt S *Researching Health Promotion*. London: Routledge. 39–53.
World Commission on Environment and Development (1987). *Our Common Future* (The Brundtland Report). Oxford: Oxford University Press.

Training Material 3.5

Healthy Cities Network

The Healthy Cities Project is a long-term international development project, under the auspices of the World Health Organization. Its goals are:

- to put public health onto the agenda of decision-makers in cities;
- to build a strong lobby for public health at the local level;
- to create links and international networks to encourage mutual support and learning;
- to enhance the physical, mental, social and environmental wellbeing of people who live and work in cities.

A principle of Healthy Cities is that the urban location can play a key role in creating health for their citizens and to help turn cities into beacons for sustainable development. The Healthy Cities Project approach has four elements:

- cross-party political support for the WHO HEALTH 21, Agenda 21 and Healthy Cities principles;
- commitment to developing and implementing a comprehensive city health development strategy;
- establishing a capacity to manage change and facilitate institutional reform, where needed;
- investment in local partnerships of health and international cooperation and networking.

The Healthy Cities Network is a worldwide alliance of local authorities committed to making their urban locations more healthy. It was set up in the 1980s and has grown to number hundreds of cities around the world. There are international conferences where they come together to learn from each other and to renew commitments. In the WHO

European Region, there are many city members. They can be reviewed from the Web site. Taken at random, cities include: Horsens, Jerusalem, Gothenburg, Frankfurt-am-Main, Maribor, Turku. In Hungary alone, for example, there are 18 different member cities.

What makes the Health Cities Network special includes the following:

- How it works. Healthy Cities are linked "horizontally", directly from city to city, so that they can learn directly from each other without having to do "up" a decision tree to a superior body.
- It is local authority-led. Healthy Cities are a beacon for the "re-localization" of health governance. The Healthy Cities believe that they can help make their dwellers healthier. Health is not the responsibility of central government alone.
- Political involvement. Healthy Cities do not deny that their vision of health is political, only that support for making their urban space healthy should not be a political football. Healthy Cities have multi-party support.

The Healthy Cities project/network has sparked off many initiatives. One of the most important is the huge conference at which Healthy City teams and supporters gather. It has also sparked the Aalborg Charter, part of the European Sustainable Cities & Towns Campaign, launched in Denmark, in 1994. The Charter commits cities to develop in a more environmentally-friendly way. They have to produce, publish and implement an action plan. This is the biggest European initiative for local sustainable development and Local Agenda 21.

At the Athens Healthy Cities Conference1998, over 100 cities signed the Athens Declaration whcih pledged them to be guided by the principles of: Equity; Sustainability; Intersectoral cooperation; Solidarity.

The Healthy Cities Project has supported and promoted the WHO booklet, *Social Determinants of Health: the Solid Facts*, ISBN 92-890-1287-0 (available from the Web site). Further details: Web site: http://www.who.dk/healthy-cities/.

Training Material 3.6
Food Safety Policies

3.6.1 International Conference on Nutrition, 1992: A Challenge to the Food Safety Community

Protecting consumers through improved food quality and safety

A safe food and water supply of adequate quality is essential for proper nutrition. The food supply must have an appropriate nutrient content and it must be available in sufficient variety and quality. It must not endanger consumer health through chemical, biological and other contaminants and it must be presented honestly. Food safety and quality control ensures that the desirable characteristics of food are retained throughout the production, handling, processing, packaging, distribution and preparation stages. This promotes healthy diets, reduced food losses and encourages domestic and international food trade. Food quality encompasses the basic composition of foods and aspects concerning food safety. Consumers have the right to a good quality and safe food supply and governments and food industry actions are needed to ensure this. Effective food quality and safety control programmes are essential and may comprise a variety of measures, such as laws, regulations and standards, together with systems for effective inspection and compliance monitoring including laboratory analysis. Where appropriate, governments, in close collaboration with other interested parties, should:

(a) Adopt and strengthen comprehensive measures to cover the control of food quality and safety with a view to protecting the health of consumers and producers and ensuring sound production, good manufacturing and fair trade practices. Where measures exist, they should be regularly reviewed and updated as appropriate, for better producer and consumer protection.

(b) Establish measures to protect the consumer from unsafe, low quality, adulterated, misbranded or contaminated foods. Measures should include provisions for minimum acceptable levels of food quality and safety, for differences in the way in which food is produced, processed, packaged, labelled and stored, as well as for the conditions under which it is presented and purveyed. Food regulations should cover the fortification of foods with micronutrients and should fully take into account the recommended international standards of the Codex Alimentarius Commission. Food labels should be clear and easy to understand and attention should be given to harmonizing labelling requirements; better information on nutrient analysis and food composition is need for this task. Measures to assist individuals with food intolerances should be considered. Claims in food labelling or advertising should be carefully controlled and false for misleading claims should be prohibited. FAO and WHO should encourage greater involvement of developing countries in Codex activities and review avenues to facilitate such participation and they should find appropriate means of making contact with concerned food control institutions and provide them with information and technical knowledge in this field.

(c) Give high priority to establishing food safety and quality control infrastructures, including food inspection, sampling and laboratory facilities to enforce the law and regulations, to ensure that food products comply with applicable requirements for domestic consumption or export.

(d) Give consumer and producer organizations rights of consultation with advisory and decision-making bodies and facilitate open and transparent access to information and participation in the establishment of food safety, quality control and labelling standards. Also, establish or strengthen mechanisms to resolve consumer problems with the food supply. Cooperation should be fostered among the food sector, government and consumers.

(e) Establish effective working relationships with the food industry, including producers, processors and purveyors of food, in order to ensure that food industry quality control systems are adequate to secure compliance with requirements of the law and regulations. Primary responsibility for production, manufacturing and distribution of the food supply rests with the farming, agriculture processing and retailing sectors, thus the food industry should provide safe, wholesome, nutritious and palatable foods so that the health of consumers is protected.

(f) Support international and multilateral efforts to extend and enhance food standards and food-labelling programmes. Developing countries should be provided with international technical assistance to improve their food safety quality programmes for domestic markets and international trade.

(g) Develop the human resources required for designing, implementing and monitoring food and water quality control systems. Education and training in the safe handling of agrochemicals are essential for farmers and for food handlers, both commercial and domestic.

(h) Implement, through National legislation, regulation and other appropriate measures, existing international agreements on the marketing and distribution of agrochemicals, such as the International Code of Conduct of the Distribution and Use of Pesticides.

(i) Promote the development of sustainable and ecologically sound agricultural practices and integrated pest management and strengthen research and extension programmes that help facilitate their adoption. Techniques that help reduce the use of agricultural chemicals should be encouraged.

(j) Support consumer education to contribute to an educated and knowledgeable public, safe practices in the home, community participation and active consumer associations. FAO and WHO should provide member countries with material on food quality and safety for use in consumer education programmes.

(k) Promote research on food quality and safety, including weaning products and street foods, taking into account the socioeconomic conditions of production, handling and storage technologies.

(l) Develop surveillance and monitoring programmes for foodborne diseases and contaminants.

(m) Ensure that foods for emergency feeding programmes for refugees and displaced persons are good quality and safe for consumption. Mechanisms should be established to monitor specific problems such as pest infestation, contaminants and product age and to promote the exchange of relevant information.

3.6.2 FIFTY-THIRD WORLD HEALTH ASSEMBLY WHA53.15 May 2000

Food safety

The Fifty-third World Health Assembly,

Deeply concerned that foodborne illnesses associated with microbial pathogens, biotoxins and chemical contaminants in food represent a serious threat to the health of millions of people in the world;

Recognizing that foodborne diseases significantly affect people's health and well-being and have economic consequences for individuals, families, communities, businesses, and countries;

Acknowledging the importance of all services – including public health services – responsible for food safety, in ensuring the safety of food and in harmonizing the efforts of all stakeholders throughout the food chain;

Aware of the increased concern of consumers about the safety of food, particularly after recent foodborne-disease outbreaks of international and global scope and the emergence of new food products derived from biotechnology;

Recognizing the importance of the standards, guidelines and other recommendations of the Codex Alimentarius Commission for protecting the health of consumers and assuring fair trading practices;

Noting the need for surveillance systems for assessment of the burden of foodborne disease and the development of evidence-based national and international control strategies;

Mindful that food safety systems must take account of the trend towards integration of agriculture and the food industry and of ensuing changes in farming, production, and marketing practices and consumer habits in both developed and developing countries;

Mindful of the growing importance of microbiological agents in foodborne-disease outbreaks at international level and of the increasing resistance of some foodborne bacteria to common therapies, particularly because of the widespread use of antimicrobials in agriculture and in clinical practice;

Aware of the improvements in public health protection and in the development of sustainable food and agricultural sectors that could result from the enhancement of WHO's food safety activities;

Recognizing that developing countries rely for their food supply primarily on traditional agriculture and small- and medium-sized food industry, and that in most developing countries, the food safety systems remain weak,

1. URGES Member States:

(1) to integrate food safety as one of their essential public health and public nutrition functions and to provide adequate resources to establish and strengthen their food safety programmes in close collaboration with their applied nutrition and epidemiological surveillance programmes;

(2) to develop and implement systematic and sustainable preventive measures aimed at reducing significantly the occurrence of foodborne illnesses;

(3) to develop and maintain national, and where appropriate, regional means for surveillance of foodborne diseases and for monitoring and controlling relevant microorganisms and chemicals in food; to reinforce the principal responsibility of producers, manufacturers, and traders for food safety; and to increase the capacity of laboratories, especially in developing countries;

(4) to integrate measures in their food safety policies aimed at preventing the development of microbial agents that are resistant to antibiotics;

(5) to support the development of science in the assessment of risks related to food, including the analysis of risk factors relevant to foodborne disease;

(6) to integrate food safety matters into health and nutrition education and information programmes for consumers, particularly within primary and secondary school curricula, and to initiate culture-specific health and nutrition education programmes for food handlers, consumers, farmers, producers and agro-food industry personnel;

(7) to develop outreach programmes for the private sector that can improve food safety at the consumer level, with emphasis on hazard prevention and orientation for good manufacturing practices, especially in urban food markets, taking into account the specific needs and characteristics of micro- and small-food industries, and to explore opportunities for cooperation with the food industry and consumer associations in order to raise awareness regarding the use of good and ecologically safe farming and good hygienic and manufacturing practices;

(8) to coordinate the food safety activities of all relevant national sectors concerned with food safety matters, particularly those related to the risk assessment of foodborne hazards, including the influence of packaging, storage and handling;

(9) to participate actively in the work of the Codex Alimentarius Commission and its committees, including activities in the emerging area of food-safety risk analysis;

(10) to ensure appropriate, full and accurate disclosure in labelling of food products, including warnings and best-before dates where relevant;

(11) to legislate for control of the reuse of containers for food products and for the prohibition of false claims;

2. REQUESTS the Director-General:

(1) to give greater emphasis to food safety, in view of WHO's global leadership in public health, and in collaboration and coordination with other international organizations, notably the Food and Agriculture Organization of the United Nations (FAO), and within the Codex Alimentarius Commission, and to work towards integrating food safety as one of WHO's essential public health functions, with the goal of developing sustainable, integrated food safety systems for the reduction of health risk along the entire food chain, from the primary producer to the consumer;

(2) to support Member States in the identification of food-related diseases and the assessment of foodborne hazards, and storage, packaging and handling issues;

(2 bis) to provide developing countries with support for the training of their staff, taking into account the technological context of production in these countries;

(3) to focus on emerging problems related to the development of antimicrobial-resistant microorganisms stemming from the use of antimicrobials in food production and clinical practice;

(4) to put in place a global strategy for the surveillance of foodborne diseases and for the efficient gathering and exchange of information in and between countries and regions, taking into account the current revision of the International Health Regulations;

(5) to convene, as soon as practicable, an initial strategic planning meeting of food safety experts from Member States, international organizations, and nongovernmental organizations with an interest in food safety issues;

(6) to provide, in close collaboration with other international organizations active in this area, particularly FAO and the International Office of Epizootics (OIE), technical support to developing countries in assessing the burden on health and prioritizing disease-control strategies through the development of laboratory-based surveillance systems for major foodborne pathogens, including antimicrobial-resistant bacteria, and in monitoring contaminants in food;

(7) in collaboration with FAO and other bodies as appropriate, to strengthen the application of science in the assessment of acute and long-term health risks related to food, and specifically to support the establishment of an expert advisory body on microbiological risk assessment and to strengthen the expert advisory bodies that provide scientific guidance on food safety issues related to chemicals, and to maintain an updated databank of this scientific evidence to support Member States in making health-related decisions in these matters;

(8) to ensure that the procedures for designating experts and preparing scientific opinions are such as to guarantee the transparency, excellence and independence of the opinions delivered;

(9) to encourage research to support evidence-based strategies for the control of foodborne diseases, particularly research on risk factors related to emergence and increase of foodborne diseases and on simple methods for the management and control of health risks related to food;

(10) to examine the current working relationship between WHO and FAO, with a view to increasing the involvement and support of WHO in the work of the Codex Alimentarius Commission and its committees;

(11) to support Member States in providing the scientific basis for health-related decisions regarding genetically modified foods;

(12) to support the inclusion of health considerations in international trade in food and food donations;

(13) to make the largest possible use of information from developing countries in risk assessment for international standard-setting, and to strengthen technical training in developing countries by providing them with a comprehensive document in WHO working languages, to the extent possible;

(14) to proactively pursue action, on behalf of developing countries, so that the level of technological development in developing countries is taken into account in the adoption and application of international standards on food safety;

(15) to respond immediately to international and national food safety emergencies and to assist countries in crisis management;

(16) to call upon all stakeholders – especially the private sector – to take their responsibility for the quality and safety of food production, including environmental protection awareness throughout the food chain;

(17) to support capacity building in Member States, especially those from the developing world, and facilitate their full participation in the work of the Codex Alimentarius Commission and its different committees, including activities in food safety risk analysis processes.

Eighth plenary meeting, 20 May 2000
A53/VR/8

Sources/ further reading on food safety policies:

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WHO (1998). *Food safety and globalization of trade in food: a challenge to the public health sector.* Geneva: World Health Organization Good Safety Unit.
WHO (1996). *Guidelines for strengthening a National Food Safety Programme*. Geneva: WHO Food Safety Unit.

Training Materials 3.7

Health Promoting Schools

EU Commission, Council of Europe and WHO joined forces in 1991/ 1992 to create the European Network of Health Promoting Schools. Beginning as a pilot project in four of the countries of Central and Eastern Europe, the network now includes over 500 pilot schools with 400,000 students, in 38 countries. Thousands of additional schools are linked to the network through national or regional arrangements. The Network has expanded rapidly. The Network is working to create an international consensus on the concept of a health promoting school. It is seen by the health and education sectors as a consolidating initiative, gathering together existing knowledge and understanding about health promotion in the school setting. With partnership as both method and goal, the Network provides a flexible framework in which schools can determine their needs and work to meet them in their own ways. Participating pilot schools commit themselves to promoting health in schools by making them safe and health-enhancing social and physical environments.

Organization

The network aims to be as decentralized as possible. The three organizations supporting the network have formed an International Planning Committee (IPC) with a Technical Secretariat (based in WHO/Europe) as the coordinating body. The IPC provides focus and ensures links and opportunities for all the parties in the network. Each country with pilot schools has a National Coordinator who meet together once a year to discuss experiences, needs and challenges. The Technical Secretariat aims at supporting the National Coordinators as much as possible by keeping track of the development of the European Network of Health Promoting Schools in each country, giving technical guidance in countries, assisting in the organization of workshops, giving presentations at international and regional meetings, and arranging the annual business meetings for all National Coordinators. This meeting considers an agenda that addresses the future needs for members of The Network. The Secretariat also produces material for health education and health promotion, and tries to raise funds for the project.

The rapid changes taking place in many countries of the European Region present challenges and new opportunities for health promotion. Clearly, the education system provides an ideal conduit for health promotion. It is important that health and education professionals and members of the community recognize this role, so that they can begin to address such issues as: how the school setting can be conducive to the development of healthy lifestyles; how it contributes to creating and maintaining the health of its staff, pupils and local communities; and which school procedures and environments require change to make the social and physical environment more health enhancing.

Consequently, the health promoting school aims to achieve healthy lifestyles for the whole school population by developing supportive environments conducive to the promotion of health. It offers opportunities for and requires commitments to the provision of a safe and health-enhancing social and physical environment.

The health promoting school sets out to create the means for all who live and work within it to take control over and improve their physical and emotional health. It does this through changes in its management structures, its internal and external relationships, the teaching and learning styles it adopts and the methods it uses to establish synergy with its social environment.

An integrated approach

Central to its success is the drive to integrate health promotion into all aspects of the school's daily routine. Thus, health promotion becomes an essential component of all curriculum activity, and the curriculum is structured to enable pupils to revisit aspects of health in varying and innovative ways throughout their school careers. Further, healthy programmes and practices are integrated into the overall school routine. This generates a greater awareness of and an improvement in working conditions, the development of stronger relationships with the school community and better rapport between the school and the community.

Active collaboration between pupils, staff, parents and the community, to implement the health promoting school concept, is encouraged. Environmental improvements that affect the ethos of the school, school policy development and the creation of a supportive atmosphere for teaching and learning are also encouraged.

A holistic and integrated approach to health promotion such as this has a considerable impact on school life. It necessitates structural change and the introduction of new ideas and methods throughout the school. These permeate all levels of school life: from senior management through to the classroom and links with the external community. The health promoting school is an investment that European countries cannot afford to delay, avoid or ignore.

Experience in health promotion and education has shown that health-promoting schools are characterized by a series of action programmes with the following goals:

- clarifying the school's social aims and highlighting its potential for health promotion;
- promoting a sense of responsibility for the health of the individual, the family and the community;
- promoting pupils' self-esteem, enabling them to fulfil their physical, psychological and social potential;
- developing good relations throughout the school's internal and external community;
- realizing the potential of specialist and other community resources to advise on and support health education and action for health promotion;
- planning a coherent health education curriculum;
- presenting a realistic and attractive range of health choices in order to encourage a healthy lifestyle; and
- providing a safe and healthy environment (meals, buildings, playgrounds, leisure facilities, etc.).

Training Materials 3.8
The CINDI Network

Mission and objectives

The WHO countrywide integrated noncommunicable disease intervention (CINDI) programme, initiated in 1982, has the aim of improving community health and quality of life by reducing premature death, disease and disability.

The overall objective of the Programme is to enable the Member States to:

1. develop integrated disease prevention and health promotion measures diseases as part of their primary health care system for preventing noncommunicable diseases (NCD) by simultaneously reducing the common risk factors (smoking, unbalanced nutrition, alcohol abuse, low physical activity, psychosocial stress), and thereby reducing morbidity caused by the corresponding major NCD (including cardiovascular diseases, cancer, chronic respiratory diseases, accidents, diabetes and mental disorders);
2. establish effective collaborative mechanisms and methodologies for integrated, intersectoral NCD prevention and control.

Main programme features

CINDI provides participating countries with a framework for activities to preventing and controlling such risk factors as smoking, high blood pressure, high blood cholesterol, obesity, excessive alcohol consumption, as well as to addressing their social and environmental determinants. The concept of an integrated approach towards the prevention and control of major chronic diseases is central to CINDI. Target setting, intervention and the evaluation of intervention methods and outcomes are key parts of CINDI. The CINDI programme in participating countries is focused on the implementation of existing prevention knowledge– initially in demonstration areas and, subsequently, countrywide. Particularly valuable asset of CINDI is international collaboration of the network of participating countries. As a network, CINDI member countries reflect not only a mixture of cultures, experiences and ideas but also a wide range of political and social systems and approaches to health CINDI international collaboration provides a mechanism whereby member countries can share their experience in developing their national programmes.

International collaboration is very useful in programme planning, protocol development and the dissemination of programme results. The WHO CINDI Programme provides access to research literature, resource materials, improved communication with other programmes of the Regional Office for Europe, and workshops and events at which participants exchange information and experience on issues of concern.

Structure and organization

CINDI functions according to its Protocol and Guidelines. The Regional Office acts as the CINDI programme coordinating centre, providing the technical coordination of the core projects.

The key organizational components of CINDI are:

1. the Council of Programme Directors (the highest decision-making body of CINDI), comprising programme directors designated by the health ministry in each country;

2. the Programme Management Committee, comprising three programme directors (on a rotational basis, elected by the Council of Programme Directors), two representatives of WHO/Europe, one representative of WHO headquarters and one representative of the CINDI Data Management Centre;
3. CINDI working groups which cover priority action areas of the programme; and
4. the CINDI Data Management Centre which is responsible for the management of the core data of the CINDI programme.

Resources

CINDI's resources include: a policy framework agreed by the participants; WHO Collaborating Centres on Policy Development for the Prevention of Noncommunicable Diseases; on Cardiovascular Disease and on Research and Development in the Control of Cardiovascular Disease and other Noncommunicable Diseases; an annual publication: CINDI Highlights; a number of publications, documents and reports including the CINDI dietary guide (see 12 steps below); a database of process and outcome monitoring; and the capacity for mobilizing both primary care and public health services.

Twelve steps to healthy eating

The CINDI Dietary Guide highlights twelve key areas for action. The table below summarizes them as steps; each step is accompanied by a detailed explanation in the following pages. It is important that each step be considered, not in isolation, but within the context of all the others steps and the written explanations following each.

Twelve steps to healthy eating

1.	Eat a nutritious diet based on a variety of foods originating mainly from plants, rather than animals.
2.	Eat bread, grains, pasta, rice or potatoes several times per day.
3.	Eat a variety of vegetables and fruits, preferably fresh and local, several times per day (at least 400 g per day).
4.	Maintain body weight between the recommended limits (a BMI of 20–25) by taking moderate levels of physical activity, preferably daily.
5.	Control fat intake (not more than 30% of daily energy) and replace most saturated fats with unsaturated vegetable oils or soft margarines.
6.	Replace fatty meat and meat products with beans, legumes, lentils, fish, poultry or lean meat.
7.	Use milk and dairy products (kefir, sour milk, yoghurt and cheese) that are low in both fat and salt.
8.	Select foods that are low in sugar, and eat refined sugar sparingly, limiting the frequency of sugary drinks and sweets.
9.	Choose a low-salt diet. Total salt intake should not be more than one teaspoon (6 g) per day, including the salt in bread and processed, cured and preserved foods. (Salt iodization should be universal where iodine deficiency is endemic).
10.	If alcohol is consumed, limit intake to no more than 2 drinks (each containing 10 g of alcohol) per day.
11.	Prepare food in a safe and hygienic way. Steam, bake, boil or microwave to help reduce the amount of added fat.
12.	Promote exclusive breastfeeding for about 6 months, but for at least 4, and recommend the introduction of appropriate foods at correct intervals during the first year of life.

Training Materials 3.9

The Baby-Friendly Hospital Initiative

Current health care practices are often at odds with recommendations on the best ways to successfully establish breastfeeding. The "10 Steps to Successful Breastfeeding" (see below) are the foundation of the Baby-Friendly Hospital Initiative (BFHI), launched worldwide by UNICEF and WHO in 1992, following the Innocenti Declaration in 1991 (see Training Material 3.2 "other policy agreements). The 10 steps summarize the maternity practices necessary to establish a supportive environment for women wishing to breastfeed and thereby bring about improvements in the incidence and duration of breastfeeding. The BFHI also prohibits free and low-cost infant formula supply in hospitals, and demands the elimination of advertising and promotional activities for infant formula or feeding by bottle. To become a baby-friendly hospital every facility that contributes to maternity services and to the care of newborn infants must implement the 10 steps.

The 10 steps to successful breastfeeding

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food and drink other than breast milk, unless *medically* indicated.
7. Practise rooming-in–allow mothers and infants to remain together–24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Reinforcing this, the 45th World Health Assembly (1992) urged member states to encourage and support all public and private health facilities providing maternity services so that they become "baby-friendly". The training and continued education of hospital staff are central to the realization of the aims of the BFHI. It is expected that all hospital staff and community workers will have a positive attitude to breastfeeding and be able to offer consistent and accurate advice in a language and style which parents understand. There is strong evidence that conflicting advice from health professionals is related to early cessation of breastfeeding. To ensure consistency of information, local public health child nutrition policies should be developed with the help of parents. In addition, governments are urged to implement the International Code of Marketing of Breast Milk Substitutes (below) and subsequent WHA resolutions, and companies that manufacture breast milk substitutes are urged to adhere to it. Furthermore, health professions should have good knowledge of the provisions of the Code because they have a number of responsibilities under it (IBFAN, 1993).

The International Code was adopted by the World Health Assembly in 1981 as a "minimum requirement" to be enacted "in its entirety" in "all countries". The Code does not try to stop the availability or sale of breast-milk substitutes, but it does seek to stop activities which persuade people to use them. Most importantly, it also protects artificially fed children by ensuring safe labels and ensuring decisions are made on the basis of truly independent health advice. The key provisions are summarized below.

Summary of the International Code of Marketing of Breast-milk Substitutes WHA Resolutions

The Code and subsequent WHA resolutions are designed to limit the promotion of commercial baby milks and associated products that could undermine breastfeeding. The provisions include the following:

- No advertising of any breast-milk substitutes (any product marketed or represented to replace breast milk) or feeding bottles or teats.
- No free samples or free or low cost supplies to mothers.
- No promotion of products in or through health care facilities.
- No contact between marketing personnel and mothers (mother craft nurses or nutritionists paid by companies to advise or teach).
- No gifts or personal samples to health workers or their families.
- Product labels should be in an appropriate language and no words or pictures idealising artificial feeding, (pictures of infants or health claims) should be used.
- Only scientific and factual information to be given to health workers.
- Governments should ensure that objective and consistent information is provided on infant and young child feeding.
- All information on artificial infant feeding, including labels, should clearly explain the benefits of breastfeeding and warn of the costs and hazards associated with artificial feeding.
- Unsuitable products e.g. sweetened condensed milk should not be promoted for babies.
- All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.

Manufacturers and distributors should comply with the Code [and all the Resolutions] independently of any government action to implement it.

Since 1981, eight WHA Resolutions have been passed which further clarify and strengthen the Code. Important provisions made in the WHA Resolutions include:

- follow-on milks are not necessary and that complementary foods should not be promoted too early (WHA 39.28 1986);
- that obstacles to breastfeeding should be removed from health services, the workplace and the community;
- that complementary feeding practices should be fostered from about six months emphasizing continued breastfeeding and local foods;
- that there should be no free or subsidized supplies of breast milk substitutes in any part of the health care system (WHA 47.50 1994);
- governments should ensure that financial support for professionals working in infant and young child health does not create conflicts of interest;
- governments should ensure truly independent monitoring of the Code and Resolutions;
- the marketing of complementary foods should not undermine exclusive and sustained breastfeeding (WHA 49.15 1996);

These Resolutions have the same status as the Code itself and should be read with it.

Training Materials 3.10

National Environmental Health Action Plans (NEHAPs)

A NEHAP contains commitments to undertake environmental measures to protect public health.

Scope and purpose of a NEHAP

One key feature is a **definition of environmental health**. Countries have used a variety of definitions. The fact that other countries are preparing NEHAPs brings added value because:

- certain environmental health problems will require international action and cooperation for their solution and this can be more easily achieved when countries are acting at the same time within a common framework;
- WHO/EURO and other international organizations are organized to help with particular problems, including problems of resources, that are associated with developing a NEHAP;
- the experience of other countries can provide support, thus making the task easier.

A NEHAP is a tool to achieve **policy objectives** for a country. There may be advantage in explicitly setting out those objectives, especially if they require a long time scale. The NEHAP can then be seen and judged as a step towards the longer-term aims. An effective environmental health plan has a number of **defining features**:

- the **objectives** to be attained
- a **situation report** giving the current status of environmental health in the country and giving the starting point of the plan
- a judgement of the **significance** of any disparity between the objectives and the situation report
- **actions** for closing the gap between the objectives and the situation report
- a **time frame**
- a choice of **priority actions** if not all the gaps can be closed
- a judgement on the availability of **resources** in the time frame.

The **institutional framework** of a country at national, regional and local level (whether government, agency or private sector) may need to be considered with regard to its effectiveness:

- in providing **information** for understanding the environmental health situation
- for **control** of emissions, dumping and
- for **enforcement** of laws and standards
- for issuing **warnings** of both imminent and emerging problems
- for **reporting** on progress made under the NEHAP and other plans
- for **monitoring** environmental health.
-

The effectiveness of a NEHAP depends on whether:

- **responsibility is assigned** for carrying out any proposed action
- **powers** are adequate for discharging those responsibilities
- **resources** are made available for performing responsibilities.

One part of a NEHAP could be the amendment of the institutional framework where it has been found to be ineffective. For many countries there is not enough capacity to undertake all the desirable actions at one time: some proposals are given **priority** over others. Cost-benefit analysis plays a part, but **equity** may also be a consideration.

Most countries will need to consider how to raise the funds to undertake their proposals and there may well be an interaction between proposals and financing. This means that a **financial strategy** will be a key factor in implementing a NEHAP.

Examples of specific concerns in a country

- high incidence of **tick-borne encephalitis** in Latvia
- noise and **chemical safety** in Hungary and Sweden
- "hot-spots" of heavy metal contamination in Bulgaria.

Implementing the NEHAP strategy

- Is responsibility clearly assigned? Is it accompanied by adequate powers? How will the proposal be financed or otherwise resourced?
- Are actions set in a timescale with clear target dates? For the longer term projects are there specific reporting milestones?
- Is there a system for reporting the achievement of milestones and target dates?

Training Materials 3.11

Goals of the WHO Europe Urban and Peri-Urban Food and Nutrition Action Plan

The overall objective of the Urban Food and Nutrition Action Plan is to promote health and quality of life through an integrated approach to food and nutrition, environment, and health, especially in communities. The benefits of increasing local food production include environmental, social, direct and indirect economic benefits in addition to health benefits. The action plan is written for everyone from the local/municipal authorities through to the community itself, interested in food and sustainable development.

To increase the availability of locally grown vegetables and fruit, local/municipal authorities can:

- make land, technical and financial support available to increase local food production;
- recognize the added value of combining vacant spaces with growing food in the city;
- help to restore confidence in locally produced food;
- promote local food production to reduce poverty;
- strengthen technical support structures to provide information, credit and advice;
- review legislation hampering development.

To increase access to locally grown vegetables and fruit, especially by vulnerable groups:

- growers can forge a closer link with consumers;
- local shops should be preserved;
- assist elderly to access the food they need
- retailers can improve access to affordable produce sourced locally;
- improve logistics to increase access and remove inequities e.g. bus routes and home deliveries.

Promote consumption of locally grown vegetables and fruit:

- encourage community participation;
- involve schools and help children acquire skills and information;
- community initiatives by NGOs;

Implementing policies which advocate sustainable food production, equitable distribution, wide access and increased consumption of vegetables and fruit provide a concrete way of achieving the HEALTH21 goals. Growing, buying, and eating more vegetables and fruits can reduce the risk of noncommunicable diseases, such as cardiovascular diseases and certain types of cancer, and can simultaneously promote healthy environments and sustainable development.

WHO recommends consumption of *more than* 5 portions of vegetables and fruits per day not including potatoes. For this goal to be achieved communities themselves must determine their problems and the actions needed to solve them. Sustainable solutions are more likely to be achieved through wide community participation, broad involvement of all sectors and local government commitment. Municipalities have a key role to play in promoting public-civic-private partnerships to increase the production of, access to and consumption of locally grown vegetables and fruits.

Session 4: Developing a comprehensive and integrated national food and nutrition policy

Aims

1. To link the three pillars for a comprehensive national policy: food safety, nutrition and sustainable food supply.
2. To consider what structures exist locally, nationally, regionally and internationally to support policy development and implementation.

Time

2 hours: 1 hour for group work and 1 hour for feedback and discussion in main group.

Teaching methods

Work in groups followed by feedback and discussion in the whole group.

Plan

The activity involves working in the same groups as before. Groups will explore the links between nutrition, food safety and sustainable food supply. Participants will consider a specific health problem related to food. They will consider how this can be improved in different settings and by different sectors. They should be able to explain the mechanism how national and local authorities, sometimes with international agencies (such as the FAO, WHO, European Commission), can coordinate with each other to solve problems. The groups present feed-back in the plenary session. The facilitator should draw out the multi-sector and multi-dimensional nature of food and nutrition policy.

Outcomes

At the end of this session participants should:

- Have developed a grid showing the linkages between nutrition, food safety and sustainable food supply.
- understand which different actors, institutions and stakeholders are appropriate for implementing strategies.
- be aware that many food-related health issues can be tackled successfully at the national and international level.

Training Materials

4.1 The Environment, Sustainable Development and Food Supply Chain.
4.2 How to influence health policy and healthcare at the international level.

Activity 4
Mapping the different dimensions of specific food-related ill health

Activity Instructions

Groups are allocated ONE food problem from the EIGHT listed below.

Each group is asked to:

- Make recommendations to national government to resolve the problem.
- Identify whom or which agencies would take action.
- Report back on whether it was easy or not to draw out the links between nutrition, food safety and sustainable food supply while resolving the problem.

Groups are encouraged to use Table 4.1 to guide them. This can be modified in any way they choose.

Activity

One problem from the following may be chosen:

1. A food poverty problem emerges. This may be for a particular area of a country or a particular social group, e.g. low-income consumers or ethnic minorities, such as gypsies.
2. A food safety crisis e.g. contaminated meat is suspected of coming into the country. This may be as a result of the UK-created crisis over meat contaminated with Bovine Spongiform Encephalopathy (BSE) or be a suspected consignment of food causing an outbreak of food poisoning.
3. A food processing company wishes to export food but it has to comply with the EU/WTO food hygiene standards first. What should they do?
4. The health of new-borns, infants and young children is suffering because of the food situation.
5. The minister of education decides that school-age children must receive an optimum quantity of high quality, safe and nutritious food to improve educational performance.
6. The minister of health decides to tackle the problem of increasing prevalence of obesity and related noncommunicable diseases.
7. The health of older people is suffering because of the food situation.
8. A micronutrient deficiency. The group is asked to design a strategy to eradicate either iodine deficiency disorders OR iron deficiency anaemia.

Each group should report back in the plenary session using OHPs or flipcharts. They may be used later in Sessions 7 and 8.

If any group or participant has difficulties about thinking about a sustainable food supply, Training Material 4.1 provides a quick check-list the linkages between sustainable food supply, nutrition and food safety. Training Material 4.2 provides some linkages within Public Health.

Activity Background

Groups should remember that they might need to make recommendations beyond the national level. Action to resolve the health problem may require regional, local or international action.

If so, groups should think carefully about which level of intervention they need to recommend action on.

The purpose of this activity is to link food safety, nutrition and sustainable food supply. Groups need to identify who the different agencies and actors are at different governmental levels. Each group is given a different problem to analyse. They are reminded of the analysis given in Session 1 that food and nutrition are affected by actions and policy-making at FOUR levels – local, national, regional, global (see Session 1 Training Material 1.3).

Tackling the specific problem assigned to the group, participants are asked to identify what they would recommend to the authorities. Groups may also list organizations at local, national, or international levels that ought to be involved to tackle the problem most effectively.

Activity

The table below can be used to ensure that groups do not think only about one "pillar" of activity. They need to consider inter-relationships.

Table 4.1. Recommendations for action

Sector/Setting	1. Nutrition	2. Food Safety	3. Sustainable food supply	Agency/ Institution/Actors
Farm supply industries				
Agriculture				
Food processing				
Distribution				
Catering				
Retailing & distribution				
Marketing				
Media				
Research				
NGOs (BINGOs, GONGOs, PINGOs (Training Material 1.3)				
Consumers				

Activity Round-up

In the feed-back, the facilitator should encourage groups to outline how they thought about the linkages between three pillars: nutrition, safety and sustainable food supply. The facilitator should bring out whether groups found it easy or not to link the three policy pillars. An overview of the linkages between the three pillars is given below in Example Table 4.2.

Activity Example Table 4.2
Linkages between the three pillars of the WHO/EURO Food and Nutrition Action Plan

Sector	Nutrition	Food safety	Environment
Agriculture	Local production Livestock, etc Security Seasonal variation	*Use of pesticides* Fertilization Transport Breeding practices Animal health	Reduction of pollution Appropriate technology and mechanization Urban planning Sustainable local development
Food processing	Healthy processing Production of food Labelling Low fat, sugar Fortification Dietary style	Hygiene; Storage Transport GAP (good agricultural practice) HACCP Quality assurance Food standards	Waste disposal Water contamination
Retail and distribution	Quantitative & qualitative redistribution Nutrient preservation Availability; Freshness Accessibility Affordability	Hygiene Packaging Transport Storage Distribution	Waster disposal Transport Freons from cooling facilities Smooth border crossing
Catering	Healthy preparation Food variety Meal planning Proper technology Dietary habits	Hygiene Storage Transport Strengthening control & penalties	Waste disposal Anti smoking policy Organic waste Tourism regulation for waste disposal
Consumers	Health education Choice; Knowledge Attitude; Culture Awareness; Fiscal policy	Hygiene Legal protection of consumers	Waste management Education Awareness of pollution Indoor air pollution
Media	Information; Education Exchange of expertise Health promotion	Information Education	Information; Recycling Education about proper waste management
Other	Promotion of healthy eating at all levels; Obesity – risk factor influencing health insurance Social & cultural aspects Migrant needs; Tourism Exception situations...	Eating raw food of animal origin Condition of food preparation Inadequate food storage	

Training Materials 4.1

The Environment, Sustainable Development and Food Supply Chain

New public health thinking suggests the close linkage between environmental and human health. Examples which show this include:

- **water**: food requires clean water, undepleted aquifers, steady flow of water in rivers for crops and human/animal consumption;
- **soil**: good food comes from fertile soil with adequate organic matter; minimal erosion; carbon sequestration from atmosphere;
- **air**: plants and animals require clean air to breathe, with minimal emissions of methane, ammonia, nitrous oxide;
- **diversity**: wildlife, landscape and genetic diversity all make contributions to aesthetic landscape value and provide habitats for wildlife crops; diversity means the maintenance of key species;
- **contaminants**: food needs to be free of harmful residues, e.g. of pesticides and harmful micro-organisms.

This analysis places challenges locally and internationally. Food is created by complex environmental and human processes which cannot easily be restricted. Food is traded. It crosses borders. It is often made in an international division of labour.

The challenge

Sound food-related public policy needs to be based upon a good understanding of:

- the general impact of the food supply chain on the environment;
- the externalities and internalization of costs throughout the supply chain;
- lessons from health impact assessments of modern agriculture;
- how to tackle the food distribution problem of "food miles/kilometres", the distance food travels between primary producer and end consumer.

The impact of the Food Supply chain on the Environment: An overview.

The environmental impact of current food policy range widely. They include:

- farm practices
- transport
- shopping practices
- impact on biodiversity (plants, animals)
- energy use
- health costs.

Costs of all these "externalities" have not been collated, but they need to be. The impact of modern food supply chains is often hidden, occurring far away, out of sight or knowledge of the consumer.

Reading

Pretty J (1995). *Regenerating Agriculture*. London, Earthscan.
Pretty J (1998). *The Living Land.* London, Earthscan.
Knai & Robertson (2000). *The benefits of vegetable and fruit production and consumption to Public Health in the EU.*

Training Materials 4.2

How to influence policy on health and health care at the international level

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Based on a chapter in: Pencheon D, Melzer D, eds, *Oxford Handbook of Public Health.* Oxford: Oxford University Press, forthcoming.

1. Why bother about the international when public health and ill health is manifest locally?

One could argue that having to address the international dimensions of public health is a luxury – something one would like to do, if only there was time. Or that international affairs are best left to bodies such as the World Health Organization (WHO) or the United Nations Children's Fund (UNICEF). This chapter argues that these views may be common but are flawed. Far from being an optional extra, it is now essential in public health always to ask the international questions. Environmentalists have long subscribed to the view that citizens have to "think globally and act locally". Now, even this is inadequate. 21st century public health professionals not only have to think but act internationally even as we think and work locally. What are the reasons for this broader focus?

The first reason is that diseases have no boundaries. National borders, like all most boundaries, are social constructs. Communicable diseases do not need passports or identity cards to cross borders. Epidemics always have a tendency to travel, within and between countries. The mediaeval plagues can still send a shiver down European backs even as some of the worst killers of the 20th century were not world wars but influenzas which spread rapidly, notably just after the First World War.[18] [19] [20] The role of public health bodies has always included the monitoring of how diseases spread. This is why early warning supply chains need to be in place.

The second reason for thinking and acting internationally is that noncommunicable diseases also cross borders, but in different ways and through different mechanisms than communicable diseases. Whereas the latter spread by infection (usually), the former tend to spread in other ways. For example, diet-related diseases are spreading globally through lifestyle and social changes. Obesity and coronary heart disease (CHD) have until relatively recently been seen as a diseases of affluence, less of a problem in developing countries than in rich, industrialized ones. This is no longer true.[21] [22] CHD and some food-related cancers (e.g. bowel) [23] are on the increase in developing countries, where the more affluent social groups are tending towards a more "Western" lifestyle – eating different foods, taking less

[18] Karlen A 1995 *Plague's progress: A social history of man and disease*. Victor Gollancz. London.
[19] Wills C 1996 *Plagues: Their origin history and future*. London: Harper Collins.
[20] Ziegler P 1991 *The Black Death*. Gloucestershire: Sutton.
[21] Drewnoski A, Poplin K. The Nutrition Transition: New Trends in the Global Diet. *Nutrition Reviews* 1997; 55**:** 31-43.
[22] Shetty, P and G Gopalan, eds. (1998). *Diet, Nutrition and Chronic Disease: An Asian perspective*. London: Smith-Gordon.
[23] WCRF. *Food, Nutrition and the Prevention of Cancer*. Washington DC: World Cancer Research Fund /American Institute for Cancer Research, 1997, chapter 9.

exercise and not just aspiring to, but achieving, western patterns of consumption. In developing countries obesity now exists alongside more traditional problems of under-nutrition. As in developed countries, abundance exists alongside people going hungry.[24] [25]

Thirdly, people are travelling increasing distances (and more rapidly) out of choice. Air travel in particular facilitated an astonishing rise in quick but long-distance movement in the late 20th century. An estimated 600 million people are international tourists each year. A tenth of humanity is thus crossing borders in pursuit of pleasure but bringing back diseases. It has been estimated that these tourists run an estimated 20–50% risk of contracting a foodborne illness.[26] The very act of travel can also be a significant contribution to environmental damage, air transport being associated with pollution.

Fourthly, goods, too, are travelling increasingly. With the removal of barriers to trade at a global level, through the General Agreement on Tariffs and Trade (GATT), this trend is accelerating. There are different patterns for different commodities but in the case of food, for example, rich consumer societies are increasingly able to source elements of their diet globally. They can eat foods "out of season" and buy other people's land and food space. This can have a tremendous impact within poorer countries – leading to a situation where food is exported when there is need locally (something that happened in the Irish Famine in the 19th century, too [27] [28] [29]). Generally, a revolution in the food trade has meant that more food comes longer distances. This has been called "food miles" effect.[30] In the United Kingdom, for instance, the distance food travels between producer and consumer rose by 30% in 15 years at the end of the 20th century.[31] A mass food supply chain increases the chance of problems when there is a breakdown in health controls.

Fifthly, why public health professionals have to think and work internationally is because they cannot always assume that the political and institutional frameworks for addressing the "transnationalization" of health patterns are either resourced enough or modernized to keep abreast of these economic, social and cultural changes. Public health institutions tend to be locally and nationally focused and based, partly due to funding and tax-collection systems, while economic and social changes tend to be driven internationally. The main drivers of globalization tend to be economic and commercial. There has been considerable change in economic rules at the regional (continental) and world level, whereas public health interventions tend only to receive modernization when there is a crisis. Health is a "threat" while trade is perceived as an "opportunity".[32] Despite spending most of the 1980s and 1990s dismantling public health trade barriers, the BSE crisis taught the European Union

[24] Leather, S. *1996 The Making of Modern Malnutrition: The Caroline Walker Trust Lecture.* The Caroline Walker Trust. London.
[25] Acheson D 1998 *Independent Inquiry into Inequalities in Health Report*. London: The Stationery Office.
[26] Kaeferstein F K, Motarjemi Y, Bettcher D W. Foodborne Disease Control: A Transnational Challenge. *Emerging Infectious Diseases* 1997; **3**: 503–510.
[27] Hayden T (ed) 1997 Irish Hunger: Personal reflections on the legacy of the famine. Roberts Rinehart, Colorado.
[28] Tóibín, C.1999 The Irish Famine. Profile Books: London.
[29] Woodham-Smith, C 1962/1991 The Great Hunger: Ireland 1845-1849. Penguin Books, London.
[30] Paxton, A *The Food Miles Report*. London: Sustainable Agriculture, Food and Environment (SAFE) Alliance
[31] Raven H, Lang T (1995). *Off Our Trolleys*? London: Institute for Public Policy Research.
[32] Unwin N, Alberti G, Aspray T, Edwards R, Mbanya JC, Sobngwi E, Mugusi F, Rashid S, Setel P and Whiting D 1998 Economic globalisation and its effect on health. *British Medical Journal*, vol 316 pp 1401–1402.

the need for stronger public health measures. It has now set up a Rapid Alert System to that effect.[33] The crisis showed that public health lacked a voice compared to trade.

Vice versa, local/national decisions can have international repercussions. When the nuclear reactor in the former Soviet Union at Chernobyl broke down in the late 1980s, contamination spread across thousands of square miles, requiring a vast public health intervention. This ranged from setting up monitoring systems to ensuring that reindeer in Lapland and sheep in Britain grazing on contaminated land were not consumed by humans and were safely disposed of. In the 1960s, there was an outbreak of typhoid in Aberdeen, Scotland caused by contaminated Latin American corned beef. This outbreak could only be understood by tracking down failures in the production process the other side of the world. Such crises expose how the local and international can be connected.[34]

The internationalization of life and culture means that health professionals also have to think and work internationally. This does not mean dropping local or national work. Whatever the work, public health protection and promotion requires action on four levels simultaneously: the local, national, regional and global. If any one is missing, the health jigsaw is incomplete.

2. Can anything be done about the international dimension of public health?

The public health reflex to isolate sources of ill health and to control their source is difficult if a problem is international. The modern world is highly complex and isolating causation of changing health patterns takes time and skill. The impact of economic restructuring can take decades to betray a health effect. "Westernization" of diets and lifestyles, for instance, showed up in new patterns of diabetes in India[35] and cancers in the developing world.[36] Once an international problem is recognized, public health professions can argue for action. This does not mean, necessarily, that they will win policy or political support for their work, but it helps. The global campaign to address AIDS /HIV is an illustration. Even Governments which adopted a censorious moral stance – blaming "lax" social mores for the spread of sexually transmitted diseases – were ultimately persuaded of the need to act. Global health action can be naked self-interest.[37]

It is easy to focus on symptoms rather than causes, as can happen in the case of obesity or the treatment of communicable diseases such as HIV/AIDs. There is a need to refocus on what has been called the social determinants of health.[38] [39] For example the food system (combined with a reduction in exercise levels) and the food we eat contributes to obesity. Concentrating on altering individual behaviour ought to be accompanied, perhaps pre-empted

[33] CEC (2000). *White Paper on Food Safety*. Brussels 12 January 2000. COM(1999) 719 final. Brussels: Commission of the European Communities.
[34] Scottish Home and Health Department (1964). *The Aberdeen Typhoid Outbreak 1964: Report of the Departmental Committee of Enquiry, Chairman: Sir David Milne GCB.* Edinburgh: HMSO.
[35] Ramachandran, A (1998). 'Epidemiology of non-insulin-dependent diabetes mellitus in India' in Shetty, P, Gopalan, C, eds, *Nutrition and Chronic Disease: an Asian perspective,* London: Smith-Gordon, 38–41.
[36] WCRF (1997). *Food, Nutrition and the Prevention of Cancer*. Washington DC: World Cancer Research Fund /American Institute for Cancer Research
[37] Navarro V, 1999 Health and Equity in. the world in the era of "globalisation*". International Journal of Health Services*, 29, 2, 215–226.
[38] Wilkinson, R. 1996 *Unhealthy Societies:The Afflictions of Inequality*. Routledge: London.
[39] Marmot M, Wilkinson R, eds (1999). *Social Determinants of Health*. Oxford: Oxford University Press.

by a refocus "upstream".[40] What forces promote excessive consumption? What stops people taking exercise?

There is a rich public health tradition of global action. The eradication of smallpox, for instance, took years and required formidable coordination, funds and above all, political backing. Unless professionals have access to the full international picture of disease and of the determinants of (ill) health, it is likely that they will expend considerable amounts of time and money treating symptoms rather than preventing causes.

The classic model of public health intervention is to search for the single cause of a health problem. Thus Dr Jon Snow is celebrated for his action to contain a cholera outbreak in London in the mid 19th century. He removed of the pump handle at Broad Street pump in London which stopped the citizens drinking water from what he thought was the source of disease. This classical model of public health intervention does not fit international public health reality. Ironically, at the same time as Snow's actions, Dr William Hunter, Medical Officer of Health in Liverpool, another early industrial and trading city, had a harder time over cholera. Liverpool's water was from deep wells (not likely to be contaminated) and at least some of its outbreaks were almost definitely associated with immigration, flies and poor housing, harder to tackle than a pump handle.[41] If Snow's action is the classical model, Hunter's problems remind us not just that life can also be complex but that the international is manifest before our eyes. Hunter argued: tackle the social conditions of ill health and health will improve.

The use of regulation to protect public health has been politically unfashionable within the dominant neo-liberal model of economics. Regulation has been demoted in favour of a consumer-driven model, where individuals are encouraged to make their own decisions and to take responsibility for their own health. In this respect, 20th century globalization highlights a choice of approaches for public health, one primarily individual-focused, the other population-oriented.[42] [43] Food policy is a good example of where these public policy choices for health have become clear in recent years. Tensions over food standards and information given to consumers have led to questions about whether market mechanisms can be relied upon to protect public health. The social and moral questions stem directly from changes in the food economy. Health costs are "externalized" and not reflected in the cost paid for food by consumers at the checkout till. This is represented schematically in Table 4.3, where the economic neo-liberal model based on free trade and choice is contrasted with an ecological model of public health.

[40] McKinlay, J.B.(1993).'The promotion of health through planned sociopolitical change: challenges for research and policy', *Social Science and Medicine,* 36, 2, 109–117
[41] Frazer W M (1947). Duncan of Liverpool. London: Hamish Hamilton Medical Books. 79–89
[42] Petersen A, Lupton D (1996). Risk, health and health care: a qualitative approach. London: Sage
[43] Sram I and Ashton J (1998). 'Millennium Report to Sir Edwin Chadwick', British Medical Journal, 317, 592–586

Table 4.3. Two approaches to public health

Policy Agenda	Neo-liberal model	"New" Public Health or ecological model
Relationship to general economy (health/wealth nexus)	Trickle down theory; allow for inequalities; based on markets	Reduce inequality by state action provides health safety net
Economic direction for health policy	Individual risk insurance	Social insurance including primary care and public health services
Morality	Individual responsibility/self-protection	Societal responsibility based on a citizenship model.
Health accountancy/costs	Costs of ill health not included in price of goods	Costs internalized where possible
Approach to the State	Keep it minimal; avoid "nannyism"	Potential corrective lever on the imbalance between individual and social forces
Consultation with the end user	As consumer	As citizen having a stake in the public health.
Approach to problems	Target "at risk" groups; focus on the end consumer	Population-wide; review entire chain of ill health creation

In practice, as Hunter of Liverpool knew, it is hard to develop appropriate public health responses to global phenomena especially at a local or regional level. Changes may seem sweeping and overwhelming. For instance, the WHO predicts that 1997–2020, there will be a rapid growth of obesity and diabetes.[44] How are local and national public health approaches supposed to deal with such global phenomena? It means tackling powerful food interests, advertising and lifestyle appeals, governments and much more. Can public health proponents really take this on? Or must they just deal with the symptoms?

[44] WHO (1999) *World Health Report 1998*. Geneva, World Health Organization.

What global levers do we have?

There are a number of institutions that operate on a global level. Table 4.4 summarizes these. Some are official governmental; others are nongovernmental and commercial.

Table 4.4. Global institutions involved in health

Remit	Examples of Organization/bodies
Public health	World Health Organization (WHO), Food and Agriculture Organization
Children and health	UNICEF, UNESCO
Global economic bodies with health impact	World Bank, International Monetary Fund, UN Conference on Trade & Development (UNCTAD), World Trade Organization (WTO), World Intellectual Property Organization (WIPO), Organisation for Economic Co-operation and Development.
Intergovernmental Agreements with a health impact (see Session 3)	Bio-safety Convention, International Conference on Nutrition, Basel Convention on hazardous waste
Emergency aid	World Food Programme, International Committee of the Red Cross, Red Crescent Societies
Environmental health	Global Panel on Climate Change, UN Conference on Environment & Development (UNCED), International Maritime Organization; UN Commission on Sustainable Development.
Commercial interests	International Chamber of Commerce, Transnational Corporations, International Federation of Pharmaceutical Manufacturers Associations, etc.
Regional bodies with health role	European Union, Regional Offices of WHO and FAO
Trade Associations	International Hospitals Federation, etc.
Networks to promote public health ([UN] indicates UN support)	Healthy Cities Network (WHO), Local Agenda 21 network, Pesticides Action Network, Tobacco Free Initiative (WHO)
Professional associations	International Union of Health Education,
Nongovernmental organizations	International Baby Food Action Network (IBFAN), Médecins sans Frontières, Médecins du Monde, World Federation of Public Health Associations, EPHA, Greenpeace, Friends of the Earth, Oxfam,

The world bodies concerned with health have adopted a number of conventions and agreements. The Convention on the Rights of the Child was adopted on 20th November 1989 and based upon Article 49 of the UN Charter. It provides a basis for international action to ensure, for example, good food and education, precursors to health. The WHO Code on Breastfeeding, agreed by UNICEF and the WHO in 1990 has the goal that "all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breast-milk from birth to 4–6 months." It committed national governments to implementing a wide range of policies such as taking action on the marketing of breast-feeding supplements and to promote breast-feeding for instance in hospitals.[45] Although agreed, it has met difficulty in practice, in part due to failure of governments, hospitals and services to implement it, and in part due to systematic attacks by business. Companies making breast-milk substitutes have looked to developing countries as new markets, subject to fewer controls than developed economies.[46]

[45] WHO/UNICEF (1990). Breastfeeding in the 1990s: A Global Initiative (The Innocenti Declaration). Geneva: World Health Organization.

[46] Palmer G (1993). *The politics of breastfeeding*. London, Pandora Press.

The International Conference on Nutrition provides an example of a global commitment, this time by national governments to monitor the food security of "at risk" social groups.[47] Another is the WHO European Region's 51 Member States who by signing the Health for All 21 Programme have committed themselves to a regional policy approach to public health. Twenty-one targets are set for the 21st century.[48] Such actions build on the 1978 Alma-Ata Declaration on Primary Health Care.[49] This committed Governments to strengthen and re-orient health services towards primary care and "to respond to current and anticipated health conditions, socio-economic circumstances and needs of the people…"[50]

In other words, conventions and international agreements already exist which can justify public health action. The problem, however, is that they often seem remote and practitioners may not know about them. A health visitor trying to promote breastfeeding, in the face of a local hospital flouting the WHO/UNICEF Code on Marketing of Breast-milk substitutes, might get personal satisfaction from knowing that she is right to do so, but lack levers to get her management to put their own house in order.

Considerable education within the public health world may be needed to shake up local complacencies. Vested interests and power blocs are always strong. Alliances are needed, inside and outside the place of work. Health impact assessments offer a way forward for public health workers at a local level to build in a global public health perspective. Health workers can learn from the pioneering thinking and methodology developed by environmental scientists.

Environmental Impact Assessments (EIA) has been defined as "a technique and a process by which information about the environmental effects of a project is collected, both by the developer and from other sources" before any new development, such as town planning changes, are approved.[51] Having to prepare an EIA makes relevant bodies think ahead as to any proposal's health consequences.

Health Impact Assessments (HIA) would have to include an international dimension. So for example a HIA on a UK hospital canteen might include in its remit issues such as whether the food was grown locally or transported long-distance; whether the standards to which it was cooked met local, UK, EU or WHO guidelines; whether consumers were being informed about the impact of diet and health and whether international experience gives evidence of good practice. The point is not to just to explore food as an issue at the point of consumption but also to look at the impact of supply and the implications of trade on local economies.

What all this entails is a need to move beyond health education and health promotion to adopting a global population perspective and a view of health that acknowledges transnational influences on health. Too often an international perspective in health is no more than an appeal to campaign. NGO work shows how effect this can be. Campaigns on Genetically Modified foods or pesticides have been highly effective in debating and encouraging preventive action. Public health, as Snow and Duncan knew, requires material and political

[47] FAO/WHO (1992). International Conference on Nutrition. Rome: Food and Agriculture Organization.
[48] World Health Organization Regional Office for Europe (1998). 21 Targets for the 21st Century – a public health guide to the targets to the Health for All Policy for the European Region. Copenhagen: WHO.
[49] World Health Organization 1978 Alma-Ata: Primary Health Care. Health for All Series No 1. Geneva: WHO.
[50] World Health Organization (1998). World Health Declaration. Geneva: WHO paragraph lll.
[51] British Medical Association (1998). *Health and Environmental Impact Assessment*. London: British Medical Association.

not just attitudinal change. Policy development should be premised on the notion of consultation and alliances but there has to be action, not just promises.

3. Conclusion

If a global perspective teaches us that the cause of problems may be complex, it also shows us that public health cannot be achieved by individual action. Alliances are essential, across sectors as well as regions. The international dimension to public health teaches the following:

- Good public health combines the local, national, regional and global approaches;
- The international dimension makes action more complex but realistic;
- Health impact is never local or global but both;
- International health institutions exist but need strengthening;
- Partnerships and alliances are essential when tackling the forces of ill health.

4. Key texts

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Townsend P (1995). 'Poverty in Eastern Europe: The latest manifestation of global polarisation' In Rodgers, A.G. and Der Hoeven, V.(eds). *New Approaches to poverty Analysis and Policy III: The Poverty Agenda: Trends and Policy Options.* International Institute for Labour Studies. Geneva.
Unwin N, Alberti G, Aspray T, Edwards R, Mbanya JC, Sobngwi E, Mugusi F, Rashid S, Setel P and Whiting D (1998). 'Economic globalisation and its effect on health', *British Medical Journal*, 316, 1401–1402.
Weil O, McKee M Brodin M and Oberlé D (1999). *Priorities for Public Health Action in the European Union.* Vandoeuvre-les-Nancy: Société Francaise de Santé Publique.
WHO (1999). *Health for All in the 21st Century.* Copenhagen, World Health Organization.

Session 5: Examples of food and nutrition policies

Aims

1. to demonstrate government (national and local) policies in practice
2. to explore good practice
3. to encourage participants to inform themselves about the diversity of initiatives.

Time

2 hours: 1 hour for group work and one for feedback and general discussion.

Teaching Methods

Work on case studies within groups followed by feedback from each group in plenary.

Plan

The session explores examples of food and nutrition policies. Four are given in the Training Materials. Others from the facilitator can also be used. Using the case studies given in the training materials, participants are asked to itemize what they can learn from them. Each group is asked to provide a brief summary of the case study, summarizing successes and weaknesses.

Outcomes

At the end of the session participants should:

1. be aware of the considerable national and international experience in developing food and nutrition policy;
2. learn from the case studies;
3. identify what constitutes good policy and what they could transfer to their circumstances.

Training Materials

5.1 Norway's National Food Policy since 1975
5.2 Heartbeat Wales
5.3 Slovenian Plan for Healthier and Sustainable Life
5.4 The Nordic experience of integrating nutritional and environmental goals
5.5 Key elements for successful development of national food and nutrition plans and policies.

Activity 5
Checking policies in practice

Activity Instructions

Each group is allocated a different case study either from the Training Materials 5.1 to 5.4 or from others that the facilitator or participants recommend.

Activity

Groups are invited to discuss and provide:

- A brief summary of the case study.
- Based on the following check-list: was the policy integrated with other policies? Was the policy built on partnerships? How comprehensive was the policy? How progressive was the policy?
- The main factors that contributed to its success.
- Any weaknesses in the case study.
- What is not transferable due to cultural, economic or social reasons.
- The transferable lessons. (Ask: what can be taken and applied in practice? What lessons can be learned about the process?)

Activity Background

The Training Materials have been chosen to illustrate different types of food and nutrition policy. The Table below categorizes the differences.

Table 5.1. Different types of food and nutrition policy

Policy/project:	Illustration of:	Training material
Norway	Well established and comprehensive national food and nutrition policy	5.1
Heartbeat Wales	A policy focused upon health promotion	5.2
Slovenian policy	Small country's initiative to integrate policy	5.3
The Nordic experience	Regional experience of integrating policies	5.4

Other case studies may be presented. They should be:

- well documented;
- diverse;
- appropriate for this group.

Activity Round-up

Participants will report back on the lessons learnt (policy integration, partnership involvement, vision) to the plenary.

The feedback should be followed by a short discussion with the facilitator gathering responses as to what is transferable and what lessons have been learned.

Attention should be drawn to Training Material 5.5. This provides the key lessons drawn from the WHO review of the South East Asia and Western Pacific Region national nutritional and policies.

Participants should see whether their analysis concurs with the WHO reviews.

Training Materials 5.1

Norway's national food policy since 1975

Norway's food and nutrition policy was formalized in 1975 but the process began around a decade earlier. This preparatory process clarified the areas of agreement that found expression in the final law. By the mid 1970s, Norway had set four main goals for its comprehensive food policy:

1. encourage a health-promoting diet, reducing fat consumption, especially saturated fats, and replacing them with polyunsaturated fats, whole grains and vegetables;
2. promote domestic food production ad reduce food imports, increasing national self-sufficiency from 39% of total calories to 52% by 1990;
3. promote agricultural development in the country's less advantaged, outlying regions with due regard for preserving the environmental resource base;
4. contribute to world food security, promoting production and consumption in poor countries.

The idea was to integrate a number of policy objectives: food supply, public health, social cohesion, and consumers. By the early 1990s, much progress had been made, especially on dietary habits, regional development and the contribution to world food security aspects. Dietary changes were most evident in fat consumption, with average total fat consumption dropping from over 40% to under 34% of total calories; death from heart disease fell.

There is much to learn from Norway's experience of developing a policy within national borders. This has been a government-led food and nutrition policy. Its experience is useful for others trying to develop policy. Norway has learned much about the difficulties, strategies and policy instruments needed to implement a broad-ranging food policy. One assessment concluded that the Inter-ministerial Council, which was set up to **coordinate policy implementation** and which had the power to do so, was relatively passive. The advisory body, the National Nutrition Council, became the force pushing the policy along, using information as a key weapon.

While much has changed in Norway, the complex interactions between the different factors continue. Both official and consumer groups are continuing their efforts to meet the goals. The whole process, however, has led to former opponents of the policy, such as the food and agriculture industries, becoming much more willing to listen to arguments from nutritionists and health authorities.

Adapted from: Tansey G, Worsley T (1996). *The Food System.* London, Earthscan.

Further sources of information on Norway's food and nutrition policy

Helsing E (1987). *Norwegian Nutrition Policy in 1987: what works and why?* Report from a research seminar, Vettre, Norway 27–28 April. Copenhagen: WHO.
Milo N (1990). *Nutrition Policy for Food-Rich Countries, A Strategic Analysis,* Baltimore MD: John Hopkins University Press.
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Royal Norwegian Ministry of Agriculture (1975). *On Norwegian nutrition and food policy*, report no. 32 to the Storting. Oslo: Royal Norwegian Ministry of Agriculture.

Training Materials 5.2

Heartbeat Wales

The Heartbeat Wales programme was launched in March 1985 as a national demonstration project in the UK to promote good health and reduce the incidence of coronary heart disease, morbidity and mortality in Wales. The programme was a combination of initiatives from the central government combined with a series of locally led projects which used a comprehensive approach across all sectors.

Aims of the strategy

- To reduce the incidence of the known risk factors for coronary heart disease – smoking, raised blood pressure; raised serum cholesterol – across the population.
- The means of achieving the aim was to encourage change in the health related behaviours of individuals; for example, diet and exercise.
- The programme also sought to achieve environmental and organizational change which supported and encouraged individuals to achieve healthier lifestyles. For example working with food suppliers, shops and caterers.
- A multi-sector, integrated approach was used and included:
  - developing public policies – for consumers, at work, and in the public sector;
  - developing personal skills through the mass media;
  - strengthening community action and cooperation by involving people;
  - targeting disadvantaged groups;
  - creating supportive environments in the workplace, in primary healthcare;
  - monitoring progress
- Developments included the introduction of healthier eating options in shops, restaurants and workplace canteens.

First steps

One of the first tasks was to try and establish a climate of opinion which was supportive of policy development and action. This was achieved by:

- involving key political figures in a practical way;
- developing a mass media campaign;
- producing a document for wide consultation on future action;
- setting up discussions across all sectors to encourage and identify others who could contribute and/or encourage action.

Obstacles

One of the key things which had to be overcome in the case of the Heartbeat Wales programme was opposition to a population/community-based approach amongst some health professionals.

Plan to overcome obstacles

Achieving a change of opinion by:

- high media profile which brought about a groundswell of opinion and helped to soften some professional attitudes;
- the publication of several national and international reports;

- discussion with organizations outside health sector – particularly the food industry;
- securing the support of opinion-leaders through discussion and information.

A consultation document provided a detailed description of the background to, and rationale for, the programme, its conceptual framework, and the proposed five-year strategy. Feedback and ideas were requested. Widespread support from the health sector, government departments, education, commerce, industry, and nongovernmental organizations was achieved.

Communities in Action

Some specific actions within communities included:

- Work with retailers
- Work with food producers
- Work with caterers
- Work with the media

Some results

Between 1985–1993, there were considerable changes in the health related behaviour:

- 740 000 more adults choose healthier, low-fat options when drinking milk;
- 70 000 more adults took regular exercise;
- Fresh poultry (increase in sales compared to red meat)
- Fish – wet and pre-packed (doubled)
- Polyunsaturated margarine (10% greater than other margarines)
- Low-fat yoghurts and cheese (up 20–25%)
- Low fat milks (increase 7 times greater than full fat milks)
- Wholemeal bread (doubled)
- Past, rice, pulses (up 50%)
- Fresh fruit, salad, vegetables (up 15–20%)

The following reference is a report on the impact of the Heartbeat programme:

Tudor-Smith C, Nutbeam D, Moore L, Catford J (1998). 'Effects of the Heartbeat Wales programme over five years on behavioural risks for cardiovascular disease: quasi-experimental comparison of results from Wales and a matched reference area', *British Medical Journal*, 316, 818–822.

Training Materials 5.3
Slovenian Plan for Healthier and Sustainable Life

(Working draft Slovenia, 3.6.2000)

The overall **aim** is to promote health and quality of life through an integrated approach to food and nutrition, environment and health in our region.

Objectives:

1. to improve the quality of life
2. to improve the level of knowledge about importance and consequences of improper eating habits
3. to improve the manner of sustainable food production,
4. to improve the manner of environment protection

1. Food production:
   - Regional institute of agriculture
   - local Food industry
   - individuals (farmers…)
2. Food safety:
   - ISO standard
   - HACCP
3. Nutrition:
   - at home
   - at kindergarten
   - at school
   - at work place…
4. Health care system:
   - primary health care
   - secondary health care
   - insurance politics
5. Environment protection:
   - separate waste collection
   - effect of pesticides and other pollutants
   - pollution of water, ground, air…
6. Education:
   - the whole population
   - vulnerable groups (infants and breastfeeding, maternal health, adolescent, health for elderly…)
   - prevention of chronic noncommunicable diseases…

This represents a comprehensive and integrated approach of food safety, dietary guidelines, environment and health. Because of the intersectoral nature of environment and health issues, successful implementation of the project is dependent on collaboration and support of all actors at international, national and local levels.

In one region of Slovenia a group of diverse experts started to work on a plan to improve: the quality of life; the level of knowledge about eating habits; sustainable food production; and environment protection. Initiatives involve the collaboration of individuals, government and

nongovernmental organizations, industry, agencies and local authorities from relevant sectors. The aim is to identify opportunities and threats to intersectoral collaboration.

One goal of this five-year project is to establish a regional agency that would involve experts from different sectors (health professionals, food safety experts, nutritionist and dietetics, biotechnologist, technologist from food industry, agriculture, environment, inspection) and provide a platform for information exchange and dialogue. One of the tasks of the agency is to support community-based local food production and distribution with the aim of promoting economic growth in addition to improving physical, mental and environmental health.

A programme to improve and increase the food production was prepared by regional institute of agriculture. The stimulation of integrated production would lead not only to increased availability of locally grown food, but would also lead to increased consumption. This could significantly benefit the environment by producing food in a sustainable way. The local food industry provides the public with information about food production technologies, food quality, safety, through proper labelling. Education efforts will be implemented in schools and through local newspapers, and industry will be a partner in this activity. The promotion of dietary guidelines will be focused on groups, like infants, young children, adolescent (network of health promoting schools), adults (with impacts of work place environment), elderly; through the mass media, meetings and publications.

An integrated health care system will include monitoring and education of individuals and target groups. Health information systems are needed to collect, analyse, interpret and disseminate health data. A survey will focus on risk factors of healthy living. Primary health care system in Slovenia is well organized, but there is still need to improve some activities and to strength its facilities. The insurance companies should find a solution for stimulating disease prevention in medical care.

Impact of environmental pollution is considered within this project. The public should learn and stop the amount of waste that is deposited everywhere. The state of environment is monitored on the national level. The existing data for our region are available and will contribute to the evaluation of impacts of environment on health via food production (pollution of the ground, water, air).

The project on separate waste collection has been well accepted by the public. Clean environment has positive effects on safe food production and thus secure nutrition. This cycle represents an integrated approach of food, environment and health.

Training Material 5.4

The Nordic experience of integrating nutritional and environmental goals

A number of Nordic countries – Finland, Sweden and Norway – have tried to integrate a public health dimension to their food supply in an attempt to reduce the incidence of food-related ill health. The very first documents were produced in 1962. These dealt with fat intake.[52] The first set of Nordic dietary goals or guidelines were compiled by a group of Nordic nutrition professors and published in Swedish in 1969 but they only became official government policies years later.[53] The Nordic experiments are show that:

- governments can take a lead;
- policy battles can be won by health interests;
- public and environmental health can be fused with food and agricultural policy;
- improvements in health can go hand in hand with sound economies;
- challenges continue in the new era of globalization.

Norway – a pioneer in changing food supply

In the mid 1970s, Norway set four main goals for its comprehensive food policy:

- encourage a health-promoting diet, reducing fat consumption, especially saturated fats, and replacing them with polyunsaturated fats, whole grains and vegetables;
- promote domestic food production ad reduce food imports, increasing national self-sufficiency from 39% of total calories to 52% by 1990;
- promote agricultural development in the country's less advantaged, outlying regions with due regard for preserving the environmental resource base;
- contribute to world food security, promoting production & consumption in poor countries.

In Norway the farm lobby saw the value of adapting to the emerging diet-health paradigm and helped introduce an effective national food policy, linking policies on agricultural, food processing, consumers, health and rural affairs. [54] [55] [56] [57]

[52] Norum K, Johansson L, Botten G, Gunn-Elin A B, Oshaug A (1997). 'Nutrition and Food Policy in Norway', in A Bendich, R J Deckelbaum, eds. *Preventive Nutrition*, Totwa NJ: Humana Press Inc. 455–469.

[53] Truswell AS (1996). 'Emerging issues on establishing nutrient goals' in Pietinen P, Nishida C, Khaltaev N, eds *Nutrition and Quality of Life: Health Issues for the 21st Century*. Geneva: World Health Organization. 23–37.

[54] Helsing E (1987). *Norwegian Nutrition Policy in 1987: what works and why?* Report from a research seminar, Vettre, Norway 27–28 April. Copenhagen: WHO Regional Office for Europe.

[55] RNMA (1975). *On Norwegian nutrition and food policy*, report no. 32 to the Storting. Oslo: Royal Norwegian Ministry of Agriculture.

[56] Milio N (1990). *An analysis of the implementation of Norwegian Nutrition Policy 1981–1987*, First European Conference on Food and Nutrition Policy, Budapest, 1-5 October 1990, Copenhagen: WHO Regional Office for Europe. EUR/ICP/NUT 133/BD/1.

[57] Oshaug A (1992). *Towards Nutrition Security*, Country Paper for Norway, International Conference on Nutrition, Oslo: Nordic School of Nutrition, University of Oslo.

Heart disease in Finland

In the early 1970s, Finland had the highest recorded coronary mortality in the world.[58] And within Finland, the region of North Karelia had the worst record. The North Karelia project was set-up by the Finnish government. The project targeted smoking, blood pressure control and diet, and started preventive activities throughout the country. Over 20 years, the dietary intake of Finns has been monitored and has vegetable consumption has doubled. Fruit and berry consumption – the latter culturally important within the Finland also increased. The proportion of saturated fats in total fat consumption declined, while fish consumption rose.

The health agencies worked with the food industry to alter the food supply, thereby linking the push of supply with the pull of demand. The result is a culture which encourages Finns to eat for life, not a premature grave. A 55% decline in Finnish male mortality from coronary heart disease, for example, has been recorded in the period 1972–1992. Changes have been even greater for women.[59] The secret has been close integration between health and other agencies, for instance dietary guidelines were designed for schools, other mass catering institutions and other social groups including old people and the armed forces.

Food safety and the environment in Sweden

Sweden's entry into a linked food and health policy stemmed from a food crisis. It began to introduce a tough pro-active food hygiene policy, following a dreadful bout of salmonella which killed 100 people in the early 1950s. This led to the setting up of its National Food Administration and much more effort to link good, safe production with high health standards. Such integration was helped by the progressive stance of its farming organization, but it also stems from responding to pressure for change from consumers and other interests outside the food/agricultural economy.[60]

Agriculture and Environment Ministries are developing re-orientation programmes to reduce fossil fuel/energy use and to meet health targets. [61] This is based on the Factor Four approach of the Club of Rome,[62] trying to increase efficiency fourfold by increasing technological sophistication.

Sweden intends to halve resource use by 2021.[63] Sweden is also exploring how to achieve tough targets on reducing greenhouse gases from food consumption[64] – one of the public health recommendations of WHO, the World Meteorological Organization and the United

[58] Pietinen P (1996). 'Trends in Nutrition and its consequences in Europe: The Finnish Experience' in Pietinen P, Nishida C, Khaltaev N, eds *Nutrition and Quality of Life: Health Issues for the 21st century*. Geneva: World Health Organization.67–71.

[59] Pietinen P (1996). 'Trends in Nutrition and its consequences in Europe: The Finnish Experience' in Pietinen P, Nishida C, Khaltaev N, eds *Nutrition and Quality of Life: Health Issues for the 21st century*. Geneva: World Health Organization.67–71.

[60] Vail D (1994). 'Sweden's 1990 Food Policy Reform' in McMichael P, ed, *The Global Restructuring of Agro-Food Systems*. Ithaca: Cornell University Press 53–75.

[61] Commission on Environmental Health (1996). *Environment for Sustainable Health Development – an Action Plan for Sweden*. Stockholm: Ministry of Health and Social Affairs. Swedish Official Reports Series 1996: 124.

[62] von Weizacher E, Lovins AB, Lovins LH (1997). *Factor Four: doubling wealth, halving resource use.* London: Earthscan.

[63] Swedish Environmental Protection Agency (1999). *A Sustainable Food Supply Chain: a Swedish Case study*. Stockholm: SEPA. Report 4966.

[64] Carlsson-Kanyama A (1998). 'Climate Change and Dietary Choices: how can emissions of greenhouse gases from food consumption be reduced?', *Food Policy*, 23, 3, June.

Nations Environment Programme.[65] On current evidence, it is nowhere near meeting those targets. One comprehensive audit of the consequences of eating and travelling in Sweden has shown that far more energy is used than fits proposed energy quotas. This implies "substantial lifestyle changes".[66] [67] Whole new methodologies are required to improve energy auditing in food systems.

Challenges to Nordic policy

How is this more health-oriented food policy faring under globalization? Observers have argued that the progressive Nordic direction must inevitably be curtailed in the process of adapting to globalization and the GATT. [68]

In all the Nordic countries, the effort to integrate food/agricultural policies with health goals has taken considerable energy and debate.

Sweden and Norway permit no TV food advertisements for children under 12 years of age,[69] a policy much admired elsewhere for its protection of children from junk food advertising. This is now under attack in the name of creating a common EU-wide framework on advertising.

All Nordic countries are already globalized and internationalist in their economic outlook but there are differences. Sweden and Norway, for instance, took different positions on regionalization, with Sweden voting to join the EU and Norway voting to stay out. In Norway, concerns about the EU undermining its food and agriculture policies featured centrally in the political debate but by signing on to the 1994 GATT, its ban of food colourings, for instance, which has been in place since the 1970s as part of the national food policy desire for "real food", has now been altered by acceptance of Codex Alimentarius Commission's more permissive stance on food colourings.

Norway is arguing a strong case for being able to support national agriculture in the name of food security.[70] Sweden has also been analysing the health implications of the Common Agricultural Policy.[71] Clearly, the Nordic attempt to marry food and health is still facing challenges.

Lessons of policy integration

Nordic policy integration is as inspirational as it is rational and not easy. Giving a higher priority to health met with considerable resistance. Norway has a food and nutrition policy that is integrated with agricultural, fishery, price, consumer and trade policies as well as

[65] McMichael AJ, Haines A, Slooff R, Kovats RS, eds. (1996). *Climate Change and Human Health*. Geneva: World Health Organization, UN Environment Programme, World Meteorological Organization.
[66] Carlsson-Kanyama A (1999). *Consumption Patterns and Climate Change: consequences of eating and travelling in Sweden*. Doctoral thesis. Stockholm: University of Stockholm Dept of Systems Ecology.
[67] Carlsson-Kanyama A (1998). 'Climate change and dietary choices: how can emissions of greenhouse gases from food consumption be reduced?', *Food Policy*, 23, 3 / 4, 277–293.
[68] Vail D (1994). 'Sweden's 1990 Food Policy Reform' in McMichael P, ed, *The Global Restructuring of Agro-Food Systems*. Ithaca: Cornell University Press 66.
[69] EASA (1995). *Survey on self-regulation for advertising and children in Europe*. Brussels: European Advertising Standards Alliance. October.
[70] Royal Ministry of Agriculture (1999). *Food Security and the role of Domestic Agricultural Production.* Oslo: RMA. 4 June.
[71] Whitehead M, Nordgren P, eds. (1996). *Health Impact Assessment of the EU Common Agricultural Policy*. F-serien 8, 1996. Stockholm: National Institute of Public Health.

educational and research policy. However, the Norwegians themselves point out that the improvements have not been as marked as they wished and took longer than expected.

Norum (1997) suggests some of the reasons for this:[72]

> *"Two main reasons were that the dairy and meat industry were against the policy, and that the National Nutrition Council had little power and political influence. The dairy industry tried to counteract the policy by producing foreign experts who claimed milk, butter and other dairy products had no influence on risk factors for CHD, and that therefore the Norwegian nutrition policy was built on false premises…"*[73]

Despite such friction, both in Finland and Norway, government policy built around public health and food have made measurable changes in the composition and availability of the national food supply. They have achieved health-promoting shifts in food production subsidies, provided incentives for low-fat milk and lean meat production, improved the quality of vegetables, promoted access to fish, enhanced the content and accuracy of food labelling, enlarged and improved public information as well as professional and school-based nutrition education, and expanded nutrition programme and policy-related research.[74]

[Adapted from: Lang T, Heasman M (2001). *Food Wars*. London: Earthscan]

[72] Norum, K. (1997). 'Some aspects of Norwegian nutrition and food policy' in Shetty P, McPherson K, eds *Diet, Nutrition and Chronic Disease: Lessons from contrasting worlds.* Chichester: J Wiley and Sons, 195–206.
[73] Norum K. (1997). 'Some aspects of Norwegian nutrition and food policy' in Shetty P, McPherson K, eds *Diet, Nutrition and Chronic Disease: Lessons from contrasting worlds.* Chichester: J Wiley and Sons p. 198.
[74] Milio N. (1993). 'After the Big Bang: structure of food and nutrition policy-making processes in Europe'. in van der Heiji DG, Lowik M, Ockhuizen Th., eds, *Food and Nutrition Policy In Europe*, Wageningen: Pudoc Scientific Publishers.

Training Material 5.5

Key elements for successful development of national food and nutrition plans and policies

In 1999, the World Health Organization conducted a review in the South East Asia and Western Pacific Region. This reviewed the progress in a number of countries of their food and nutrition policies and plans since the 1992 International Conference on Nutrition. This review drew out a number of important conclusions.

Key elements for successful development of national food and nutrition policy and plans

1. Political commitment
   - need for an influential "parent" ministry to lead the process
   - have a high profile advocate

2. Focused approach
   - identify targeted priorities

3. Consultation with stakeholders

Key elements for successful translation of food and nutrition policies and plans into action

While many countries have policies, they have not always found ways of turned them into action. The list below gives the lessons from those countries that have successfully managed this transition.

1. Official Government adoption of the policy and plan

2. Establishment and good working of an intersectoral coordinating committee:
   - location in the government structure
   - specifically allocated budget
   - members from all concerned sectors and interests
   - effective structure
   - ability to prioritize
   - periodic reviews

3. Designation of responsible ministries

4. Prioritization of activities

5. Incorporation of Monitoring and Evaluation

6. Availability of national food, nutrition and health information.

Session 6: NGOs campaigning for food and nutrition policy

Aim

To introduce the public health role of nongovernmental organizations (NGOs).

Time

2 hours.

Teaching Methods

Work in groups, followed by feedback in plenary session.

Plan

In this session participants will explore the contribution NGOs can make to food and nutrition policy. The purpose of the session is to remind participants that policies will be strengthened by generating external support for food and nutrition action plans. NGOs can be essential. The key issues are: to learn from others; to work in partnerships/alliances; and to set clear objectives.

The Facilitator introduces the relevance of NGOs, using Training Material 6.1, pointing out the range of NGOs covered in Training Materials 6.2 to 6.8. This is done in 5–10 minutes. Then Activity 6 is set in motion. Working in groups, participants are invited to read a relevant case study or where participants do not have English as their first language, the facilitator should explain the relevant case study to the group. Participants should discuss: the goal of the NGO; how to achieve the goal; how the NGO functions; where they get their funds from and if they are effective. This should take about 30 minutes before participants are invited to feed-back in plenary.

Outcomes

At the end of this session participants should understand:

- what NGOs are and how they help shape and implement food and nutrition policy;
- what makes NGO campaigns successful;
- potential barriers to the success of an NGO.

Training Materials

6.1 The Role of NGOs & Ten Rules for a food and nutrition campaigner
6.2 Breast-feeding and baby foods: International Baby Food Action Network (IBFAN)
6.3 Food security campaigns: Sustain (UK food poverty network)
6.4 Food safety: Pesticides Action Network (PAN)
6.5 Labelling: European Heart Network (EHN)
6.6 Urban agriculture: a grass roots movement of many NGOs
6.7 Protection and promotion of health: European Public Health Alliance (EPHA)
6.8 Elimination of Iodine Deficiency Disorders (IDD): The International Council for control of Iodine Deficiency Disorders

Activity 6
Develop a NGO to address one of the following issues

Activity Instructions

This activity is in three sections. The first is done by the facilitator in 5–10 minutes. The next two are done in groups and it is up to the groups how long they spend on each or in what order:

1. The Facilitator introduces the relevance of NGOs, using Training Material 6.1, pointing out the range of NGOs covered in Training Materials 6.2 to 6.8. This is done in about 10 minutes.

2. In groups, participants are given one problem from Table 6.1 and asked to use the background information on a specific NGO (training materials 6.2 – 6.8) to complete Table 6.2.

3. Clarify what the NGO actually does. Use the questions in Activity Table 6.3 below to help this process.

Table 6.1. Selecting the Problem and Using the Training Material

Problem	Relevant Training Material
Increase the rate of breastfeeding	6.2 Breastfeeding and Baby Foods (IBFAN)
Tackle problems of lack of food due to poverty	6.3 Food Security Campaigns: Sustain (UK Food Poverty Network)
Cut down on pesticide residues in fruit and vegetables which is discouraging consumers from eating more	6.4 Food Safety: Pesticides Action Network
Improve information available to consumers to allow consumers to make informed choices	6.5 Labelling: European Heart Network
Increase local production of fruit & vegetables	6.6 Urban Agriculture: a grassroots movement of many NGOs
Strengthen the public health dimension in the Common Agricultural Policy (e.g. when joining or being influenced by the European Union)	6.7 Protection and promotion of health: European Public Health Alliance (EPHA)
Eliminate iodine deficiency disorders	6.8 Elimination of Iodine Deficiency Disorders (IDD): The International Council for control of Iodine Deficiency Disorders

Activity

Table 6.2 can be used to create a list of actions that NGOs can implement using the three "pillars" of food safety, nutrition and sustainable food supply.

Table 6.2. NGO Actions to implement a food and nutrition action plan

Action	Nutrition	Food Safety	Sustainable food supply

Clarify what the NGO actually does. Use the questions in Activity Table 6.3 below to help this process.

Table 6.3. What does the NGO do? How does it work?

Questions about the NGO	Your answer
What is the main goal of the NGO?	
How does the NGO work?	
How is it funded?	
How effective is it in achieving its goals?	
What skills does it have?	
What stops it succeeding?	
What can you learn from it?	
Etc. etc.	

In plenary, groups should report back.

Activity Background

NGOs are an important part of public policy formulation. Internationally, NGOs have rights of information and are increasingly important in public debate about food and health. Experience and practice varies at national, regional and local levels. Relationships between NGOs and governments, commerce and international bodies varies. Sometimes the relationship is close and on other occasions more difficult. Participants should envisage how they already work with NGOs or how they would like to.

To obtain free subscriptions to "Consumer Voice" from the European Commission, e-mail: SANCO-CONSUMER-VOICE@cec.eu.int Details on food NGOs is given both by EPHA (training material 6.7) and by the Food Magazine: Web site: www.foodcomm.org.uk or e-mail: foodcomm@compuserve.com

Activity Round-up

Participants should be encouraged to regard NGOs in a positive light. Their information and experience can be crucial in creating, promoting and implementing Food and Nutrition Action Plans.

Training Materials 6.1

The Role of NGO

Adapted from European Public Health Alliance's (EPHA) UPDATE, Spring, 2000

Democratic accountability

Although NGOs are not elected, they fulfil an important role in supporting participatory democracy in Europe in a number of ways:

- voicing the concerns of citizens involved in organized civil society to politicians and political institutions;
- informing citizens of developments within the international institutions so that they can be better informed and engaged in European policy processes;
- monitoring and evaluating EU policy developments from a citizens' rights perspective; and
- contributing to policy discussions, management of proposals and policy implementation and appraisal.

As the world becomes ever more global and integrated in terms of economic, social and monetary policy, NGOs form a crucial link with the general public. They can ensure that citizens at grassroots level can contribute to building a society where citizens' voices are heard and heeded. NGOs enable representatives of society to be directly involved in formulating, implementing and evaluating policy.

NGOs – vibrancy of a citizens' Europe

NGOs have participated for decades in international organizations such as the United Nations, the World Health Organization and the Council of Europe. Within the European Community (EC) the NGO voice is increasingly being heard and sought, and the Commission published a discussion paper on how to strengthen NGO partnerships within its services. As decision making continues to evolve further and further from national and local political environments, the EC has realized that civil dialogue is an important tool in redressing the democratic deficit, and essential in opening up the policy process to other stakeholders whose voices are often not heard.

What are NGOs

As NGOs influence increases, it is important for policy makers to have a common understanding what NGOs are and what it is that they do. In many European countries there is a strong tradition of NGOs working to improve social conditions. Motivated by a number of reasons such as religious or humanitarian beliefs, compassion or civic duty, they generally share common beliefs in social justice and solidarity.

NGOs differ tremendously in terms of history, size, specific aims, methods and resources. Some tackle specific issues (social exclusion, homelessness, poverty, environmental protection, public health), while others address the needs of a particular group of people (including women, older people, children, those who are unemployed, migrants, disabled people, lesbians and gay men and so on). NGOs operate at all levels of society: local, nation, European and international and perform different functions such as policy implementation, project delivery, advocacy or lobbying. NGOs are not-for-profit organizations, although their funding and membership base varies greatly form one organization to another. As NGOs are

so diverse and heterogeneous, and legal statutes governing NGOs may vary from country to country, it is not easy to find a common definition of the term "nongovernmental".

Common NGO characteristics

It is generally agreed that NGOs cannot be profit making, that they are formed voluntarily and usually involve an element of voluntary participation within the organization, but this loose definition means the term NGO can be confusing and sometimes misleading. For example, a group of similar commercial interests could feasibly create an NGO to promote their sectoral interests (see training material in session 1). In order to clarify this situation, many NGOs are working to better define NGOs and civil society. The most significant defining characteristics is that "NGOs are not self-serving in their aims and related values. Their aim is to act in the public arena at large, on groups of people or society as a whole". *(Adapted from EPHA UPDATE Spring 2000)*.

Ten Rules for a food and nutrition campaigner

1. Clarify your goals; keep them simple and do not take on more than you can manage.
2. Prepare your ground well. Spend time researching and monitoring the field. Get well briefed. Collect up-to-date data on the issues. Be aware of the latest policy development and legislation.
3. Set priorities. Be realistic about what can be done. Set goals for the short-term, the medium-term and the long-term.
4. Assess resources you have and need: people and equipment all need proper funding. Energy and a good vision help, but so does funding! And you need energy and vision to get funding. They are circular.
5. Assess your strengths and weaknesses. Be sure people working with you know what they are talking about and that you have good spokespeople.
6. Work to your own campaign's strengths. Exploit your opponents' weakness.
7. Build an alliance using existing networks. Only create a new one if absolutely necessary.
8. Ensure you have networks and alliances at appropriate levels – local, national, regional, global.
9. Think strategically. Be prepared to think "laterally" and in new ways.
10. Review progress constantly. Learn from your experience. This encourages everyone to share and participate. Celebrate any victories but be prepared for set-backs. It all takes time!

Training Materials 6.2

Breast-feeding and baby foods: International Baby Food Action Network (IBFAN)

IBFAN works to ensure that the *International Code* and the subsequent World Health Assembly Resolutions (see Baby Friendly Hospitals Initiative Training Materials 3.9) keep pace with marketing trends, that they are enacted as law or equivalent in all countries and that they are independently monitored and enforced.

IBFAN principles:

- the right of infants everywhere to the highest level of health;
- the right of families, in particular women and children, to have enough nutritious food;
- the right of women to breastfeed and to make informed choices about infant feeding;
- the right of all people to health services which meet their basic needs;
- the right of women to full support for breastfeeding and for sound infant feeding practices;
- the right of health workers and consumers to health care systems which are free of commercial pressures;
- the right of people to organize in international solidarity to secure changes which protect basic health.

Inappropriate marketing of baby foods means any marketing which is prohibited by *the International Code* and subsequent WHA resolutions. Under the *International Code*, marketing means product (baby food and other breast milk substitutes) promotion, distribution, selling, advertising, product public relations and information services.

Breastfeeding is the optimal way to feed an infant in the vast majority of circumstances and the World Health Organization (WHO) estimates that as many as one and a half million infants die each year because they are not breastfed. Breastfeeding saves lives. To that end, the International Baby Food Action Network (IBFAN) campaigns to promote breast-feeding and to highlight practices which undermine good breastfeeding practice. IBFAN was founded in 1979. For many decades the commercial promotion of artificial feeding has been shown to be a major contributory factor in the undermining of breastfeeding. For this reason a number of UN resolutions have been passed. The most significant UN Resolution, *The International Code of Marketing of Breast-milk Substitutes*, (the *International Code*) was adopted through the due democratic process of the World Health Assembly, the policy setting body of WHO in 1981.

The adoption of the *International Code* as a minimum public health requirement for all countries was clearly a breakthrough in consumer protection. All companies are required to implement it in its entirety and every two years Governments are required to report to the WHO on their progress in *International Code* implementation. Since 1981, eight additional WHA Resolutions have been passed which strengthen and clarify the *International Code's* provisions and a series of UN meetings and international conferences have put breastfeeding firmly on the agenda for policy formation.

Breastfeeding and infant health remains as much under threat now as it was in the late 1970s. The baby feeding industry maintains a powerful influence in the many fora where decisions are made which affect infant feeding, such as: the World Health Assemblies; the FAO/WHO

Codex Alimentarius Commission; the Economic and Social Council of the United Nations (ECOSOC); the UN Conference on Trade and Development (UNCTAD); the World Trade Organization (WTO) ; the International Labour Organization (ILO); the European Commission the European Parliament and the EU Scientific Committees; national governments; regional and local authorities; health authorities etc.

The WHO has come under constant pressure from the baby feeding industry to drop breastfeeding from its agenda. Governments have been lobbied to adopt weak voluntary agreements rather than strong legislation and to include the industry on all discussions and monitoring bodies. The establishment of the World Trade Organization (WTO) has given the FAO/WHO Codex Alimentarius Commission a new status and there are fears that governments may be forced to use Codex standards as a basis for legislation. At the same time pressure from the World Bank and Structural Adjustment Programmes to liberalize trade rules and encourage private investment has increased dependency on commercial sponsorship in all sectors. For the baby feeding industry this has created important marketing opportunities.

IBFAN's work includes capacity building and Code training courses for NGOs, consumers and policy makers in all parts of the world, campaigns such as the Nestlé Boycott, and work on maternity legislation, emergency relief programmes and HIV. IBFAN's approach, by emphasizing strong networking in all sectors of society, helps to ensure that in all the above fora, there is transparency, concerns of mothers and infants are heard and the economic and social impact of inappropriate feeding is addressed.

Web sites: www.babymilkaction.org and www.ibfan.org

Training Materials 6.3

Food security campaigns: Sustains food poverty network

The purpose of the Food Poverty Network is to improve access to healthy diets for people on low incomes within the United Kingdom.

Even in an affluent country like the United Kingdom, there is evidence of deprivation as a factor in inequalities in health (Marmot & Wilkinson 1999). The Food Poverty Network, part of Sustain a large alliance of United Kingdom NGOs working on food, argues that food poverty is the "lack of money, inadequate shopping facilities, conflicting information about food and health, and poor transport ...". These "mean that many people are denied healthy food choices." Poor diets lead to poor health. People on lower incomes are more likely to suffer or die from diet-related diseases such as heart attacks, cancers and strokes.

The Food Poverty Network

The Network has grown considerably over the years. It:

Provides a forum for project workers, researchers and campaign groups to create appropriate policies to tackle food poverty;

Publishes and campaigns for policy change. In 2000, Sustain produced a policy document to start a debate about whether surplus food distribution schemes (known in North America as Food Banks or Second Harvest schemes) are efficient and effective means for providing good diets for people on low income (Hawkes and Webster 2000). It argued that on balance, they are not.

Pools and distributes information about a variety of community food projects, including food cooperatives, community cafes, growers' groups, cook-and-taste sessions, producers' markets, voucher schemes and many more;

Provides advice to anyone planning a local food project;

Produces "Let Us Eat Cake!", a quarterly newsletter which keeps members in touch and up to date on the Network's activities; provides news of funding, campaigns, national policy developments, events and publications; and celebrates the achievements of community food groups everywhere;

Runs The Food and Low Income Database which was launched in 1996. It contains details of community food projects – from food co-ops and community cafes to cooking clubs and community allotments – all working to improve food awareness, access and availability to people on a low income. It produces a summary or full "project report" for each of the initiatives recorded on the database. Each full project report tells you how the project is managed, how it is funded and how to make contact. A key objective of the Food and Low Income Database is to encourage good practice. It promotes information exchange between local food projects to encourage shared learning. It is also an excellent mapping device for the wide range of food projects currently active across the country.

Coordinates The Community Mapping Project which was set up in 1998 as a partnership between Sustain, Oxfam and Development Focus, all NGOs. The project is conducting local democratic processes to ask and include people's own views of what they want their local

food economies to be. It borrows from approaches learned and developed in developing countries. People begin to develop solutions to the problems they face in securing a healthy diet for themselves and their families.

The rationale for community mapping is that a key feature of social exclusion is that many groups and individuals are prevented from participating fully in society. They have little knowledge of or control over the decision-making processes that affect their lives. Community mapping assumes that people are the experts in their own communities, and that it is vital that their perspectives be taken into account when developing policies for these communities. In the past, people have often been asked for their views, but not involved in the decision-making process, so that their expectations were raised but their needs left unmet. Advantages include the following:

- The people involved have a much greater understanding of the factors that contribute to their local food economy and thus a firmer basis for evaluating any changes.
- Local projects can lead to community action, for example the development of food co-operatives or community cafes.
- There are direct implications for local and national policy processes. When local people are aware of how the food economy works, they are in a better position to encourage or oppose developments that will improve or threaten their access to food.
- Valuable partnerships are formed between different sectors of the communities where the studies take place. Sustain believes that initiatives intended to improve access to food are more effective where such partnerships exist.

Sustain is more than aware that the problems of food poverty will not be solved by food projects alone. Extensive public policy changes are needed for that. The Food Poverty Network, pooling the knowledge and experience of so many people working in the field, can help bring those changes about. The Food Poverty Network has coordinated the voices of local projects and of people on low incomes themselves. It has helped persuade government to give a higher priority to the food dimensions of health inequalities.

Hawkes C, Webster J (2000). *Too Much & Too Little?* London: Sustain.
Lang T (1997). 'Dividing up the cake: food as social exclusion' in Alan Walker, Carole Walker, eds, (1997). *Britain Divided: the growth of social exclusion in the 1980s and 1990s*. London: Child Poverty Action Group. 213–228.
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Further information: Food Poverty Network, Sustain, 94 White Lion Street, London N1 9PF, UK tel: +44-(0)20.7837.1228; Fax +44-(0)20.7837.1141. Web site: www.sustainweb.org; E-mail: sustain@sustainweb.org.

Training Materials 6.4

Food safety: Pesticides Action Network

Pesticides Action Network (PAN) aim to reduce pesticide use and to improve the health and safety of farmers and farm-workers as well as environmental health and safety.

This NGO played an important role in bridging the gap between traditional nutritional concerns and the environmental of sustainable development. In 1990, the WHO report on diet and disease (WHO 1990) acknowledged that consumer concerns about contaminants such as pesticide residues deserved policy responses. In the 1990s, considerable effort was expended by NGOs and public health professionals in trying to see if such issues exposed genuine or illusory conflicts of interest.

What is PAN?

Pesticide Action Network (PAN) is a network of over 600 participating nongovernmental organizations (NGOs), institutions and individuals in over 60 countries. PAN works to replace the use of hazardous pesticides with ecologically sound alternatives. Projects and campaigns are coordinated by five autonomous Regional Centres:

- PAN North America
- PAN Europe
- PAN Asia and the Pacific
- PAN Africa
- PAN Latin America

PAN international campaigns

PAN Regional Centres share a vision for ecologically sustainable, culturally diverse production of food and fibre. It focuses on rural livelihoods of women and men, farmers and communities, and agricultural workers. While each Regional Centre pursues its own work programs, there are many areas of collaboration and shared focus. PAN Centres share work through a common program work. Examples are given below:

International events

PAN attends strategically chosen international events and processes, such as the revision of the FAO International Code of Conduct on the Distribution and Use of Pesticides and the Convention on Biodiversity. In doing so its participants bring evidence from research in the field to demonstrate adverse impacts of pesticides; advocate strong measures to combat pesticide problems and for investment in alternatives; provide briefings for governments both at and between international meetings.

PAN international conferences

PAN holds international conference, at which groups and people meet and discuss experiences. The first for the third Millennium was in Senegal, May 2000.

"No Pesticide Use" Day

In 1998, PAN declared that December 3rd each year is a Day of "No Pesticide Use". That date was the anniversary of the Bhopal pesticide factory toxic gas leak. It was felt that this day was an appropriate point to mark that and other pesticide tragedies.

Campaigns on pesticide use

Community monitoring and other studies on the impact of pesticide use on women's and men's health, the environment and economic aspects of women and men farmers' livelihoods in developing countries will form the basis of evidence to be presented to strategic international fora. These studies will investigate international initiatives and government policies that support or dilute pesticide-related health and environmental safety and related issues.

PAN research

PAN research provides information on corporate strategies which promote high input/pesticide dependent agriculture. PAN monitors the consolidation of interests between pesticides and seeds companies, as well as any activities which promote the use of seeds which are genetically engineered for pesticide use. Corporations present the case to governments that their products, and particularly genetically engineered seeds, are essential in order to "feed the world". PAN investigates the impact of corporate activities, interests and lobbying on food security at a local level on agricultural biodiversity, increased use of pesticides, and impact on farmer incomes.

Research and advocacy on food security without pesticides

While campaigning against the adverse impacts of pesticides, PAN groups demonstrate viable sustainable alternatives such as organic agriculture, farmer-participatory IPM and other ecological agriculture, emphasizing consultation and inclusion of women, in a fair-trade context, to support alternatives to pesticides.

References

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PAN Europe Web site is: www.pan-uk.org.
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Training Materials 6.5
Food Labelling: the European Heart Network

What is the European Heart Network?

The European Heart Network (EHN) is an alliance linking 28 national heart foundations and other national nongovernmental organizations committed to the prevention of CVD in 24 countries across Europe. It began at a meeting in Lisbon in 1986 and was initially called the International Heart Network – changing its name to the European Heart Network in 1992.

The EHN's aim is: "to achieve concerted action on CVD prevention within Europe and to promote the exchange of experience and cooperation on CVD prevention between its members." Its General Assembly meets every year to enable its members to share information and to forge common positions on issues such as smoking, physical activity, nutrition, the collection of data relevant to prevention policies, etc.

Heart Foundations

- fund research into the prevention and treatment of CVD
- help educate the public about CVD.

Over the years heart foundations have increasingly recognized that unhealthy diets – particularly diets that are high in saturated fat and sodium and low in complex carbohydrate, vitamins and minerals – contribute to high rates of CVD. It has been estimated that a third of premature deaths from CVD in Europe are due to unhealthy diets. This means that approximately 270 000 deaths a year in Europe, among people aged below 65 could be avoided if diets were improved. (A similar number of premature deaths from cancer could also be avoided if diets were improved.)

They have identified improvements to food labelling as one way of supporting their educational programmes, recognizing that if food labelling was more informative this would help people who wanted to eat more healthily.

Surveys have suggested that the nutrition claims on food packets – such as "reduced fat", "low salt", etc. are often misleading. Furthermore the nutrition labelling (giving the amounts of nutrients per 100 g or per serving) is not always provided and when it is present it is extremely difficult for consumers to understand. Increasingly food packets claim that their contents are "good for the heart" or that they "help reduce the risk of heart disease". Such health claims – when applied to certain foods such as fruit and vegetables are clearly true – but many other heath claims are based on less substantial evidence.

The national governments of the Member States of the European Union (EU) cannot now make changes to their food labelling law: this is effectively the responsibility of the EU. Heart foundations recognizing that if they were to change labelling law they needed to lobby EU institutions – the European Commission, the European Parliament, etc. – rather than their national governments, and that this was better done in conjunction with other heart foundations in Europe.

One of EHN's first activities was to lobby the European Commission for the introduction of a directive on nutrition labelling to require the labelling of all foods with their fat, saturated fat,

sugars, sodium and salt content in a standard way which consumers could readily understand. The EU did eventually introduce a directive on nutrition labelling in 1990 – the 1990 Nutrition Labelling Directive (European Communities 1990) – but the directive only made nutrition labelling compulsory in some instances (i.e. when a nutrition claim was made). It also allowed manufacturers to give nutrition labelling in a number of different formats making comparisons between foods difficult.

During the 1990s the EU made attempts to change its laws on health and nutrition claims: the European Commission began to draw up directives on health and nutrition claims but none of these drafts were agreed by the whole Commission – a necessary first step in getting a directive implemented. During this period the EHN continued to lobby the European Commission to introduce directives on nutrition claims and to improve the nutrition labelling directive but to no real effect. The EHN therefore turned its attention to the Codex Alimentarius Commission – the International Food Standards setting body – at the time revising its guidelines on health and nutrition claims. Codex Alimentarius Commission begun to assume increasing importance in shaping EU food law.

The EHN sent a representative to the Codex Alimentarius Committee on Food Labelling which meets in Ottawa ever 18 months and joining forces with the International Organization of Consumer Unions – now Consumers' International – and delegates from countries which have better food labelling law than the European Union (notably the US and Australia) – effectively lobbied for relatively tough guidelines on nutrition claims. New guidelines on health claims are still being discussed, as are changes to the Codex Alimentarius guidelines on nutrition labelling.

In parallel with such lobbying the EHN convened a Nutrition Expert Group to strengthen its reputation in European circles as an authoritative body on nutritional issues. At first this Expert Group consisted of nutritionists directly attached to heart foundations but more recently has involved nutritionists with an international reputation for research into diet and CVD. The Expert Group's first task was to produce a consensus document intended "to inform policy makers and other health organizations of the EHN's agenda for action on food and nutrition" (European Heart Network 1998). The European Heart Network will continue to seek to ensure that any new legislation on food labelling is a significant help to consumers seeking to adopt healthier diets.

References

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European Heart Network (1998) Food, nutrition and cardiovascular disease prevention in the European Union. Brussels: EHN (www.ehnheart.org).
British Heart Foundation (2000) European cardiovascular disease statistics. London: BHF (www.heartstats.org).
For further information about the European Heart Network see its website at www.ehnheart.org.

Training Materials 6.6

Urban agriculture – a grass roots movement of many NGOs

NGOs try to reduce food insecurity through sustainable community development projects Initiatives linked to food, the vulnerable and community development allows optimum use of resources and creates "added value" from finding similar solutions to different problems. Below a small selection of NGOs and useful contacts are listed.

1. EU Sustainable Cities and Towns Campaign

In 1993, as a means to self-help, the Commission, together with the Expert Group on the Urban Environment, a group established by the Council in 1991 following publication of the Commission's Green Paper on the urban environment, launched the Sustainable Cities Project. The main aims of the project are to:

- promote new ideas on sustainability in European urban settings;
- foster a wide exchange of experience;
- disseminate good practices on sustainability at the urban level;
- formulate recommendations for the EU institutions, national, regional and local authorities
- to assist with the European Community's 5th Environmental Action Programme.

Contact: The European Sustainable Cities and Towns Campaign, Campaign Office, Rue de Trèves/ Trierstraat 49–51, Box 3, B – 1040 Brussels.
Fax +32 2 / 230 88 50. Phone +32 2 / 230 53 51. Web site: www.sustainable-cities.org

2. UNCHS Best Practices database

The Best Practices Initiative, part of the United Nations Programme on Human Settlements, contains a selection of human settlements success stories. In partnership with the Together Foundation, UNCHS developed a database with a search engine that enables users to address the database quickly and efficiently. The database contains information about the case study, key contact persons and institutions directly involved in implementation.

Contact: The Best Practices and Local Leadership Programme, UNCHS (Habitat), P.O. Box 30030, Nairobi, Kenya
Phone: +254 2 624328. Fax: +254 2 624266/624267. E-mail: bestpractices@unchs.org

3. ETC (Ecology, Technology and Culture) Netherlands, Urban Agriculture Programme

In 1997, ETC Netherlands took the initiative to set up the European Support Group on Urban Agriculture (ESGUA) to facilitate information Exchange/networking and development of urban agriculture in Europe.

The ESGUA aims to:

- stimulate the "dialogue" on urban agriculture between city councils, citizens, farmers and other stakeholders on both local, regional, and European level;
- discuss present and future research and policy development with regard to sustainable urban agriculture and development;

- provide information and support to individual persons or organizations in the development of urban agriculture and integration of urban agriculture in urban policies and planning.

Contact: ETC, Kastanjelaan 5, 3833 AN Leusden, Netherlands
Phone: +31 33 4943086. Fax: + 31 33 4940791. E-mail: office@etcnl.nl

4. City Farmer, Canada

City Farmer, a non-profit society that started in 1978, promotes urban agriculture and collects valuable information on Internet, which is difficult to find elsewhere. The homepage is regularly updated and contains general information on urban agriculture, articles, conference announcements, resources and provides links to other relevant Internet sites.

Contact: Mike Levenston, City Farmer, Canada's Office of Urban Agriculture, #801–318 Homer Str., Vancouver, B.C. V6B 2V3, Canada
Phone: +604 685 5832: Fax: +604 68 E-mail: cityfarm@unixg.ubc.ca: Internet: http://www.cityfarmer.org

5. Soil Association, United Kingdom

The Soil Association has worked for more than 50 years in supporting sustainable agriculture. The Soil Association emphasizes a holistic approach to Developing sustainable food economies and works in close cooperation with other organizations working in related areas. Members receive the *Living Earth* magazine, with the Latest in local food Links, organic food news, sustainable agriculture and Forestry.

Contact: Soil Association, Bristol House, 40–56 Victoria Street, Bristol, BS1 6BY, UK
Tel: +44-117 929 0661. Fax: +44-117 925 2504
Contact for Local Food Links Tel: +44-117 929 2425. E-mail: lfl@soilassociation.org

6. The Food Commission, United Kingdom

The Food Commission is a national non-profit organization campaigning for the right to safe, wholesome food. The Food Commission publishes *The Food Magazine* which members receive quarterly. This covers national, European and international food and nutrition issues.

Contact: The Food Commission Ltd, 94 White Lion Street, London N1 9PF, United Kingdom
Tel: +44-20-7837-2250. Fax: +44-20-7837-1141. E-mail: foodcomm@compuserve.com

7. WHO Regional Office for Europe, Copenhagen

WHO European Region (2001). *Urban and Peri-Urban Food and Nutrition Action Plan* Copenhagen: World Health Organization. This is available on the Web site: www.who.dk/Nutrition/pdf/urban99.pdf and contains information on different grass roots activities and NGOs.

Training Materials 6.7

European Public Health Alliance (EPHA)

The European Public Health Alliance (EPHA) represents over 70 nongovernmental and other not-for-profit organizations working in support of health in Europe. EPHA aims to promote and protect the health of all people living in Europe and to strengthen dialogue between EU institutions, citizens and NGOs in support of healthy public policies by:

- monitoring the policy making process within the EU institutions and maximizing the flow of information concerning health promotion and public health policy developments amongst all interested players including: Commission officials, MEPs, member state and candidate country ministries, NGOs and citizens.
- promoting greater awareness amongst European citizens and nongovernmental organizations about policy developments and programme initiatives that effect the health of EU citizens so that they can contribute to the policy making process and take practical action to take part in appropriate programmes.
- supporting collaboration at a European level between nongovernmental organizations and other not for profit organizations active in the member state and candidate countries in health promotion and public health.

EPHA issues a bi-monthly magazine on health policy in the EU and Europe — the European Public Health Update, to which non-members can subscribe. The Update is available in English, French and German. In addition to the Update, EPHA members receive membership newsletters and have access to our EU help desk.

In the European Parliament, EPHA provides secretarial assistance to an informal working group of parliamentarians called the Health Forum Intergroup. This working group provides a forum for discussion between health NGOs and Members of Parliament interested in health issues. Officials from the European Commission and other EU institutions also take part in the Intergroup.

The EPHA Secretariat is located in Brussels near the European Parliament and other EU institutions. (Metro: Malbeek): 33 rue de Pascale, 1040 Brussels, Belgium Tel: +32 2 230 30 56. E-mail: epha@epha.org

EPHA FOOD CAMPAIGN:
Statement on food, health, environment, social justice, sustainable development and the Common Agriculture Policy

There is increasing recognition of the links between methods of farming production, food quality and health, and growing criticism that aspects of the current system of providing public finance to support the agricultural sector in the EU hinders rather than promotes health and does not respond to consumer demands.

European citizens have already paid a very high price for CAP – not only in terms of public expenditure, but also in environmental degradation, ill health, rural exodus and loss of social cohesion, and most recently, loss of consumer confidence.

The purpose of this statement is to outline our main demands for policy change, and to provide a focus for joint action by nongovernmental organizations and other public interest

groups in promotion of healthier food production, social justice and environmental sustainability in relation to future CAP reform and the enlargement process

To fulfil the new Amsterdam Treaty requirements

Article 152 requires the EU to ensure a high level of human health in the definition and implementation of Community policies and activities, and that Community action should be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health.

Article 153 calls on the EU to take into account consumer protection requirements in the definition and implementation of other Community policies and activities.

Article 6 requires the EU to integrate environmental protection measures in the definition and implementation of Community policies and activities, in particular with regards to promoting sustainable development.

Articles 13,136 and 137 call on the EU to combat poverty and discrimination and promote social inclusion.

The Protocol on Protection and Welfare of Animals calls on the Community to pay full regard to the welfare requirements of animals when formulating and implementing agricultural policy.

To improve farming policies and food practices to support health

Access to safe healthy food is a human right emphasized in the WHO's policy framework ICN and HEALTH21, and the CAP should be reformed to reflect this.

The CAP should increase financial support to healthy consumption and production, including an increased availability of fruits and vegetables. This must be accompanied by health promotion efforts to raise awareness of the risks associated with an unhealthy diet.

Animal husbandry practices affect not only the health of the animal, but human health as well. Routine use of antibiotics in feed as growth promoters not only compromises animal welfare but also contributes to the growing public health threat of antibiotic resistance in humans and animals. The EU should follow WHO and the EU Scientific Committees advice to implement a ban on such antibiotics. The EU should also uphold its ban on hormone treated beef and dairy products.

The public health implications of GM crops and foods, particularly the use of antibiotic resistant markers, are causing concern among a growing number of public health experts and scientists. The EU should invoke the precautionary principle and ban genetically modified foods until more evidence is available about potential health consequences.

The use of pesticides should be significantly reduced to protect the health of agricultural workers, consumers (exposed to pesticide residues in drinking water and food products) and farm animals.

To respond to consumer demands

In its opinion on the reform of the CAP, the Consumer Committee called for a farming policy that delivers "safe and nutritious food, produced as naturally as possible, at reasonable prices, respects environment and animal welfare and makes effective contribution to rural development".

Consumers are also increasingly concerned about production methods including those relating to genetic engineering, animal welfare and sustainability and are demanding better information about the production and quality of food products.

Consumers are also calling for the consistent and transparent application of the precautionary principle, in particular in relation to GMOs.

To improve the environmental sustainability of agriculture and the quality of agricultural products.

Intensive production is ecologically inefficient, consuming far more energy than it produces and polluting soil, air and water. CAP support has to be shifted away from intensive/industrialized farming towards environmentally sustainable farming practices that serve at the same time to enhance biodiversity and food security by increasing the range and variety of plants and animals.

Agri-environmental measures and low input systems such as organic farming offer additional environmental benefits in terms of reduced pollution, enriched soil fertility and protection of wildlife habitats, and such efforts should increasingly receive a greater portion of the CAP budget.

The EU should support local/regional marketing of agricultural and food products instead of favouring long transport and concentration of processing and retailing sector.

To reduce food poverty and increase rural employment both within and outside the EU

Health and wellbeing in rural areas depend on the viability of agriculture and CAP reform should reflect this. Within Europe, the EU should promote forms of agriculture that are more labour intensive, such as extensive or organic systems, which use more skilled labour, and horticulture.

The EU should recognize the vital role of agriculture in poverty alleviation and the health and welfare of the population in developing countries. It should seek to formulate agricultural and associated trade policies which do not distort trade or undermine national and regional agricultural development or food security. Trade and financial assistance should be established which support the development of environmentally friendly production methods in developing countries.

Early elimination of export subsidies and dumping practices would benefit agriculture in many developing countries where dumping of EU and USA produce destroy local food production.

To enrich the diversity of food culture and wildlife

Current production patterns are based on a narrow and shrinking variety of agricultural products processed, packaged and promoted to appear different from each other. Sustainable

production of more fruit, vegetables, legumes, starchy staples, a diverse variety of cereals and fish would increase choice and help to halt the erosion of food cultures throughout the EU.

To respond to international trade issues

WTO should be reformed to allow broader interpretation of members' demands to promote sustainable development and agriculture, and protect health, the environment and animal welfare. These reforms should include a consistent definition and application of the precautionary principle. The role of Codex Alimentarius and its decision-making process should be reformed to prioritize health and consumer interests over those of trade and industry, and provide more transparency. The EU should facilitate increased NGO and other public interest groups participation in these international fora to strengthen the representation of civil society and provide a more democratic decision-making process.

Training Materials 6.8

The International Council for Control of Iodine Deficiency Disorders (ICCIDD)

The International Council for Control of Iodine Deficiency Disorders (ICCIDD) is the only international organization specifically constituted to promote the elimination of IDD. ICCIDD's multidisciplinary global network of experts consists of some 400 specialists from more than 82 countries. They include scientists in the medical and nutrition fields, public health administrators, development managers, technologists, communicators, economists, salt technologists and other industry experts. All of them are committed to assisting governments and international agencies in developing national programs for the virtual elimination of IDD as a public health problem.

ICCIDD was formed in 1986 with support from UNICEF, WHO and the Australian government in order to bridge the gap between available knowledge and its application in solving the problem of IDD for the millions at risk. ICCIDD has played a major role in communicating the IDD threat to decision makers of national governments and international agencies and to a wide variety of health professionals and planners.

By participating in public policy development and advocacy, program development, implementation and training, ICCIDD consultants assist countries with significant IDD problems to develop national IDD control programs, in cooperation with: national governments; institutions and individuals; private industries and welfare agencies; major international agencies; key bilateral aid giving agencies.

ICCIDD is a non-profit NGO with official consultant status with WHO and the UN system and an official participant in the annual World Health Assembly.

ICCIDD Mandate has been established:

1. to promote awareness of the magnitude of IDD and the fact that it can be eliminated at an affordable cost;
2. to provide technical assistance in the assessment of prevalence in countries and the development of strategies for IDD elimination;
3. to provide technical assistance in monitoring the application of these strategies and evaluate their effectiveness;
4. to support training programs at national and regional levels for survey design, program management, monitoring and evaluation, social communication and technical assistance to quality assurance systems;
5. to encourage research on issues relating to the virtual elimination of IDD:

The suggested Action Plan for the WHO European Region includes:

1. Maintenance and even reinforcement of advocacy and training on IDD at local national, regional and global levels. Advocacy still needs to be targeted to all partners involved in the process, i.e. the people of the affected countries and their governments, the health sector including the physicians, the salt and food industry, the agriculturalists, the policy makers, communicators and educators.

2. Ongoing detailed evaluation and registration of the extend of IDD in Europe. This "state of the art" report could be based on the proceedings of a series of past meetings on IDD in Europe, for example in Ashkhabad (14), Brussels (11), Munich (10), and Kiev (in preparation); on a comparative analysis of the progress in elimination of IDD in Europe (15) and in the world (9) and on the ICCIDD database. The ideal situation would be the existence of a joint WHO-UNICEF-ICCIDD database accessible on the web.

3. Contribution to the implementation of USI wherever IDD is documented, if not yet achieved. This would imply at the European level, coordination between producers and importers of iodized salt at national levels; standardization of techniques and regulations on salt iodization in terms of the compounds used, levels of iodination, regulations on trade, importation and taxes; implementation of quality control programmes of iodized salt from the producer to the consumer. In between and in parallel until USI will be fully implemented.

4. Administration if necessary of iodized oil in areas "hard to reach" with severe iodine deficiency and persistence of cretinism, at least in child-bearing women.

5. Iodine supplementation by tablets of potassium iodide at physiological levels during gestation, lactation, infancy and early childhood in areas with mild or moderate iodine deficiency.

6. Organization of quality control and monitoring of the programmes of iodine supplementation from the producer to the consumer. This objective implies the following: Agreement on the indicators, epidemiological, clinical and biochemical; Availability of a network of iodine laboratories including national and regional reference laboratories; Implementation and support to national IDD Committees having easy and effective access to decisions at the levels of Ministries of Health, industry and commerce in order to sustain the programmes of iodine supplementation and fortification; Organization of partnership evaluations of country programmes by national and international expert teams; Develop operational research for example on simplified kits for the measurement of iodine in salt and urines; the use of neonatal TSH as a monitoring tool; evaluation of the consequences of moderate and mild iodine deficiency on neurointellectual development.

7. Evaluation of side effects of iodine which include essentially the occurrence of iodine induced hyperthyroidism, IIH; the possibility of triggering the development of thyroid autoimmunity by iodine and the change in the pattern of thyroid cancer (18). Iodine induced hypothyroidism and allergy to iodine have never been reported following salt iodization (19).

8. Monitoring of salt intake. The promotion of iodized salt should not result in an increase of salt intake. The necessary monitoring of iodized salt intake is a unique opportunity to evaluate and monitor the salt intake and to respect and support the WHO recommendation to maintain or decrease the salt intake at healthy levels.

Session 7: The WHO and national food and nutrition policies and action plans

Aims

1. Introduce the WHO European Region's Food and Nutrition Action Plan (FNAP).
2. Show how the FNAP can help the development of food and nutrition policies.

Time

2 hours.

Teaching Methods

Short lecture introducing the First Food and Nutrition Action Plan for the WHO European Region, followed by work in groups. Concludes with feedback from each group in plenary.

Plan

The FNAP should be distributed to all participants preferably before attending the workshop. In group discussions, participants discuss the Food and Nutrition Plan and seek to clarify anything they do not understand. If no complete copies are available, there is a summary in Training Materials 7.1. Based on the outline of the FNAP and drawing on existing national information (such as country assessments done for the World Food Summit 1996, the International Conference on Nutrition 1992 and the Malta consultation 1999) groups begin to outline their food and nutrition action plans.

Outcomes

At the end of this session participants should:

- Have a clear idea of the First Food and Nutrition Action Plan for the WHO European Region;
- Remind themselves what their existing national policies are on nutrition, food safety and sustainable food supply;
- Start to outline the contents of their food and nutrition action plan.

Training Materials

7.1 A Summary of the Food and Nutrition Action Plan for the European Region.
7.2 Proposed outline for National Policies and Action Plans.

Food and Nutrition Action Plan for the European Region (FNAP) – the full document – should be provided to each participant. It is available in English, French, German and Russian (2000).
www.who.dk/nutrition/action.htm

Activity 7.1

Lecture: The WHO European Region's Food and Nutrition Action Plan

Activity Instructions

The facilitator:
Either gives a short presentation (using overheads the facilitator has prepared earlier OR talking participants through Training Material 7.1).
Or asks groups to talk through the key features of the WHO document, using the summary in Training Material 7.1. Groups should be asked to itemize what they think is most important.

This Activity should last 15–30 minutes.

Activity Background

The WHO European Region has produced a comprehensive policy on food and nutrition. This provides an overview of what national food and nutrition action plans should address. The full document is on the web, and should be available for the session, even if it has been provided earlier. All the Member States (51) belonging to the European Region of WHO endorsed the resolution and action plan on 14 September 2000.

Activity Round-up

By the end of this activity participants will be clear that the WHO European Regional Office is committed to encouraging the development and implementation of national food and nutrition policies and action plans. Thus, what participants are doing during the workshop is based on agreed international policy.

Activity 7.2
Food and Nutrition Action Plan: Getting into the detail

Activity Instructions

The groups are each given the task of preparing an outline of their national policy and action plan following the lines of the WHO document and its recommendations.

Using Training Materials 7.2, begin to draw up a national Food and Nutrition Action Plan.

Activity

Use existing country materials such as country profiles produced for:

- International Conference on Nutrition 1992
- World Food Summit 1996
- Malta WHO European Region Consultation on the draft WHO Food and Nutrition Action Plan

Documents such as these should be supplemented by other national documents and information to ensure that all three pillars of the FNAP are addressed:

- Nutrition
- Food safety
- Sustainable food supply

Activity Background

The purpose of this session is to get into the detail of national FNAPs, building on the WHO European Region's commitment, discussed in Activity 7.1.

Activity Round-up

Groups should report on their deliberations and the facilitator should provide feed-back on omissions and points of interests. Differences between reports and national policies and priorities should be used constructively.

Training Materials 7.1

WHO Food and Nutrition Action Plan (FNAP)

FIRST FOOD AND NUTRITION ACTION PLAN. EUROPEAN REGION OF WHO 2000–2005

Summary

Access to a safe and healthy variety of food, as a fundamental human right, was stressed by the International Conference on Nutrition in 1992 and by the World Food Summit in 1996. A supply of nutritious and safe food is a prerequisite for health protection and promotion. In spite of commitments expressed and efforts made at national and international levels, there is still a need for policies which reduce the burden of food-related ill health and its cost to society and health services.

It is estimated that each year around 130 million Europeans are affected by episodes of foodborne diseases. Diarrhoea, a major cause of death and growth retardation in young children, is the most common symptom of foodborne illness. New pathogens are emerging, such as the agent of bovine spongiform encephalopathy. The use of antibiotics in animal husbandry and the possible transfer of antibiotic resistance to human pathogens are a major public health concern.

Low breastfeeding rates and poor weaning practices result in malnutrition and disorders such as growth retardation, poor cognitive development, and digestive and respiratory infections in young children. Iodine deficiency disorders affect around 16% of the European population and are a major cause of mental retardation. Iron deficiency anaemia affects millions of people and impairs cognitive development in children and, during pregnancy, increases the risk to women.

The prevalence of obesity is up to 20–30% in adults, with escalating rates in children, increasing the risk of cardiovascular diseases, certain cancers and diabetes. Obesity is estimated to cost some health services about 7% of their total health care budget. Around one third of cardiovascular disease, the first cause of death in the Region, is related to unbalanced nutrition, and 30–40% of cancers could be prevented through better diet.

In countries of the European Union, a preliminary analysis from the Swedish Institute of Public Health suggests that 4.5% of disability-adjusted life years (DALYs) are lost due to poor nutrition, with an additional 3.7% and 1.4% due to obesity and physical inactivity. The total percentage of DALYs lost related to poor nutrition and physical inactivity is therefore 9.6%, compared with 9% due to smoking.

This document stresses the need to develop food and nutrition policies which protect and promote health and reduce the burden of food-related disease, while contributing to socioeconomic development and a sustainable environment. It insists on the complementary roles played by different sectors in the formulation and implementation of such policies. It provides a framework within which Member States can begin to address the issue. The framework consists of three interrelated strategies:

- A food safety strategy, highlighting the need to prevent contamination, both chemical and biological, at all stages of the food chain. The potential impact of unsafe food on human health is of great concern, and new food safety systems which take a "farm to fork" perspective are being developed.
- A nutrition strategy geared to ensure optimal health, especially in low-income groups and during critical periods throughout life, such as infancy, childhood, pregnancy and lactation, and older age.
- A sustainable food supply (food security) strategy to ensure enough food of good quality, while helping to stimulate rural economies and to promote the social and environmental aspects of sustainable development.

An action plan is proposed for the period 2000–2005, with approaches and activities to support Member States who wish to develop, implement and evaluate their food and nutrition policies.

The need for coordination between sectors and organizations will increase as ethics and human rights, in addition to science and economics, play a greater role in decision-making. Countries can consider which mechanisms are needed to facilitate better coordination between sectors and ensure that health and environmental concerns are considered when food and nutrition policies are made.

It is proposed to set up a food and nutrition task force, to facilitate coordination between the European Union, the Council of Europe, United Nations agencies (especially UNICEF and FAO) and environmental and other international, intergovernmental and nongovernmental organizations. The Regional Office is ready to ensure the secretariat of the task force.

Training Material 7.2

Proposed outline for any National Policies and Action Plans

(Also see "Guidelines – Developing national plans of action for nutrition" from FAO, Rome 1993)

1. Summary

2. Goals

3. Existing political commitments

4. Social Inequalities and Burden of Food-Related Ill Health (e.g. from country reports submitted to the WHO consultation in Malta 1999).

- Foodborne diseases
- Nutrient deficiency and food insecurity
- Obesity and noncommunicable diseases

Each country using the country reports that were submitted to the WHO consultation in Malta 1999 can outline its background and earlier situation. In addition participants could outline potential risks and burden from food-related ill health that might be expected in the future.

5. A Comprehensive Policy

- Food Safety Strategy
- Nutrition Strategy
- A sustainable food supply strategy (sustainable agriculture and rural development)

Food and nutrition strategies. Each group is invited to list the actions necessary to bring about desirable changes in their current systems, based on the previous section on food-related ill health. Guide them to pay attention to what actions are required to harmonize intersectoral policies and to develop a more comprehensive and integrated approach to food and public health. Fig. 3 in the FNAP document may be a useful guide in this respect.

6. Proposed Action Plan

- Developing a comprehensive approach – bringing the three strategies together
- Monitoring Health information
- Improving knowledge
- Strengthening partnerships
- Establishing an advisory and coordination mechanism with budget

7. Additional considerations

Approaches at the international/national/local levels. Each group should identify what **action and support** from the WHO and other UN, International and European organizations would help to develop food and nutrition policies at national and local level. What could governments and citizens in European Region expect from a Food and Nutrition Task Force (or similar entity) for the WHO European Region?

Session 8: Putting national policies and Food and Nutrition Action Plans into operation

Aims

1. develop a strategy for the development of national food and nutrition action plans
2. identify actions, responsibility, partners, timing and resources
3. identify potential gaps and weaknesses.

Time

1–2 hours.

Teaching Method

Group-work followed by feedback in plenary.

Plan

This session clarifies the process by which the food and nutrition policy will be developed and reviewed. Groups undertake two exercises, one to identify goals and how they will be met, and the other to identify potential gaps in the Action Plan. Groups should build on and use the notes and reports developed in the Session 7.

Outcomes

At the end of this session participants should have:

- An idea of how the Food and Nutrition Action Plan is going to be developed;
- A list of potential partners;
- An awareness that everyone has to "own" this process.

Training Materials

8.1 A check-list: working with others for food and nutrition policy.

Activity 8
Targets, actions and strategies

Activity Instructions

The purpose of this activity is to get the participants to make plans, identify actions and work out who should take responsibility or be involved.

Activity

Using the frame-works in Tables 8.1 and 8.2, participants should outline what will be done in the coming period. They should distinguish between short-term, medium-term and long-term goals and actions.

Table 8.1. Clarifying actions: Who? Partners? Timing? Resources?

Policy goals, by "strategy"	Actions	Who is responsible	Partners	Timing	Resources
Nutrition					
Food Safety					
Sustainable Food Supply					

Table 8.2. Identifying the gaps

Policy Area, by "strategy"	What is lacking?	How might these obstacles be overcome?	Who will be responsible for addressing this?
Nutrition			
Food Safety			
Sustainable Food Supply			

When completing the tables participants should first identify their own contributions and actions they can make and then identify the gaps using the check-list in training material 8.1. Invite all groups to report back in the plenary. Ask if they identified other important key elements that should be added to the check-list.

Activity Background

Participants should identify the actions needed to develop a national food and nutrition policy document by answering the following questions:

- Is there governmental authorization for the process to start?
- What is going to be done to develop the policy document?
- Who is going to develop the policy document?
- How is it going to be developed?
- With whom (stake-holders)?
- By when?
- What is the consultation process to ensure general consensus and adoption of the policy document?
- How and when will the document be approved by the authorities?

In plenary, the facilitator should note the strengths and weaknesses groups identify. Further reading on check-lists for policy and plan implementation is in:
Haglund, BJA, Pettersson D, Finer P, Tillgren P (1996). *Creating supportive environments for health: Stories from the Third International Conference on Health Promotion, Sundsvall, Sweden*. Geneva: World Health Organization

Activity Example

Table 8.3 provides an example from a previous workshop: see next page.

Activity Round-up

After working through this Activity, participants should have identified not just the goals they think appropriate but also the strengths and weaknesses in their own national capacity to develop their policy and action plan.

By this stage, participants should be drawing on the resources presented throughout the Programme. In thinking about whom partners could be, they can use work on the food supply chain, for example in Session 1, training materials 1.1.

Example from a previous workshop (July 2000)

Country X chose the following priorities for developing a food and nutrition policy:

- Legal and Administrative basis (office and committee on FNAP)
- Targets:
  a. To reduce the health, social, financial and other burdens of food related disease
  b. To improve health, eating habits and healthy lifestyles
- Equal emphasis to nutrition, food safety and sustainable food supply

NB: This group did not explore budget and technical expertise

Table 8.3. Actions, timing and responsibility

Actions	Timing	Responsibility
Preparation of food-based dietary guidelines	Short term	Ministries of health, education, finance, MoEcon, CINDI national office
Preparation of food tables	Medium term	MAFF, MoH, MoSc, MoEd, MoFin
Promotion of physical activity	Short term	MoH, MoEd, Mlab, H.PPOF, Phys. Activity Prof, teachers, NGOs, media, local community
Nutritional labelling (information for consumers): geographical indication, bio products	Short term	MoH, MAFF
Raising awareness, knowledge and skills of consumers	Short term and permanent	All relevant ministries and professionals, media, NGO, CINDI-national office
Nutritional education at all levels of schooling	Permanent	MoH, MoEd, MAFF, MoSc
Nutritional education of professionals	Medium term and permanent	Universities, CINDI-national office
Health education community actions	Short term and permanent	Local communities, mayors and other local authorities, media, NGOs, CINDI
Ensuring adequate quantities of safe, healthy food through production and trade	Short term and permanent	MAFF, MoEnvi, MoEcon, MoFin.
Surveillance of health status	Permanent	MoH, CINDI
Surveillance of dietary habits	Permanent	MoH, MAFF, MoEd
Surveillance of food supply	Permanent	MAFF, MoEcon, Chamber of Commerce
Food safety legislation based on evidence-based findings	Short term	MoH, MAFF
Efficient food control	Permanent	MoH, MAFF, MoEcon
National monitoring of food contaminants	Short term and permanent	MoH, MAFF, MoEnvi
Surveillance of foodborne diseases	Permanent	MoH
Change and adaptation of agricultural policy	Medium term	MAFF, MoEcon, MoEnvi, MoFin, MoSc, farmers
Changes and adaptation of food processing industry	Medium term	MAFF, MoEcon, MoH, farmers, food industry, chamber of commerce
Protection of geographical names – protection of designation of origin and geographical indication, bio products,		

Training Material 8.1

Working with others for food and nutrition policy: a check-list

International experience of setting up either local or national food and nutrition policy initiatives enables us to learn from others. Whichever targets and approach for a Food and Nutrition Action Plan is taken, no one can promote or deliver a FNAP on their own. This will require a team effort. Some key questions and themes for consideration are set out below. These are not in any order of priority. Work through these and discuss them.

1. Collaboration between a wide range of organizations and individuals from both the public and private sectors

- What organizations must be involved?
- Which organizations should be involved?
- Which organizations could be involved?
- What is the best way of focusing and coordinating efforts?
- Who could act as coordinator?

2. Public support and interest in the policy/plan:

- Is there interest by the public in health issues related to food and nutrition already?
- Can public interest be nurtured and stimulated more?
- Are there any specific parts of the population (e.g. women or parents) that should be targeted as a priority?
- How could the public/communities be involved in action to eat a healthier food?
- What market research might be done to explore the current views of the population?
- Are there any key target populations or groups upon whom success depends?
- Are there any interest groups, formed by the target groups, who could be contacted?
- Can it be demonstrated that healthier eating is possible under economic conditions?

3. Role of food producers, manufacturers, retailers and mass catering outlets

- What is the policy of food supply sectors? Is there consensus about what it wants?
- What is the structure of the food sectors? Is it dominated by small or large companies?
- Can you contact/work with them (e.g. via food inspection in retail outlets)? Will it be an equal partnership?
- Are there any representative or trade bodies that could be part of the team?
- What organizations/groups must be involved as a priority?
- How can discussion be stimulated?
- How can manufacturers and retailers be involved to promote health interests?
- What benefits could there be for manufacturers and retailers to be involved?

4. Existing policy

- What level of support currently exists to ensure there is progress with food and nutrition policy?
- Are levels of support uniform or does support vary at different levels?
- Who is supportive of the need for food and nutrition policy?
- Who needs to be persuaded on the need for a food and nutrition policy?
- How best can support be build within the government/political circles?

5. Working with the media

- What existing contacts/links with the media is there?
- Which are the key media organizations (TV, radio, press)?
- Are there any with an existing interest in the subject of food/nutrition (for example, what programmes or articles have already focused on the subject of food?
- Can existing opportunities be expanded or new media outlets be found?

6. Is there an appropriate structure (e.g. food and nutrition council) to deliver the policy/plan

- Does a good organizational base exist?
- Is there an office?
- What people/support staff exist?
- Is there official backing from the government and the necessary institutional support?
- Where might there be there resistance or potential blocks?
- Are there other advisory teams that can support and share information and experience?

7. Setting Targets

- Have you got "performance indicators"?
- Are they measurable?
- How do you want success or failure to be measured?
- How long or short-term is your target?
- Who will measure the performance?
- Will it be audited? By whom? (see process evaluation manual developed by CINDI)

8. Success for all the above requires skills

- What skills does your team need?
- What skills has your team got?
- What skills would individuals in your team find useful to learn?
- What skills that are lacking can be found within another organization?

Session 9: Resources for Implementation

Aims

1. Consider general economic and specific budgetary concerns.
2. Consider other resource implications.
3. Provide a reality check for the Food and Nutrition Action Plan.

Time

1 –2 hours.

Teaching Method

Group work followed by group presentations in plenary.

Plan

This session assumes that groups are well underway with their food and nutrition action plans. The session is to "get real" about implementation. Participants are invited to think about their national economic situations, and what arguments they can use to propose that the Food and Nutrition Action Plans deserves a high priority. Groups are given only ONE of the three pillars to focus on. In the plenary, these different foci and arguments are brought back together, highlighting the challenge of producing a comprehensive policy and action plan.

Outcomes

At the end of this session participants should be able to:

- identify what needs to be done to implement national food and nutrition policy;
- calculate resource considerations: material, human and financial;
- identify arguments which could be used to promote the cost advantages as well as social benefits of food & nutrition policy.

Training Materials

9.1 Are food policies sustainable – who takes the risk and who gains the benefit?

Activity 9

Developing implementation strategies.

Activity 9
Developing implementation strategies

Activity Instructions

Based on the work carried out in sessions 7 and 8, groups outline the resources needed for implementation of one of the three pillars for food and nutrition policy: food safety, nutrition, and sustainable food supply. Thus group A focuses on nutrition, group B on food safety, group C on sustainable food supply, etc.

Activity

Each group should calculate a budget for the administration of a National Food and Nutrition Council or similar mechanism that will be responsible for developing the overall policy and monitoring the Food and Nutrition Action Plan's implementation.

Invite each group to feedback and allow time for comment and discussion.

In the plenary, the different arguments from nutrition, food safety and a sustainable food supply are brought together by the facilitator. Their integration is highlighted as a key element of the challenge ahead.

Activity Background

The following are questions the facilitator can pose to each group to encourage participants to think about resources:

- What are the costs of personnel, facilities, equipment, materials, transport, administration, training and other costs, which may include capital costs or major events within the implementation strategy?
- What justifications exist for the resources being requested? To what extent can a cost/benefit analysis be used (include social, economic and health benefits)?
- Where can sources for the necessary resources be found?
- What could improve the flow of resources? What political and public health arguments can be used to justify the FNAP?
- What can be done when funding is inadequate?
- How soon can you deliver a progress report to policy-makers
- How can progress be monitored?
- What economic trends within the food chain and food retailing are likely to affect successful implementation of a food and nutrition action plan?

Activity Round-up

In the plenary, the facilitator has to bring together the different strategies on nutrition, food safety and a sustainable food supply to remind participants that in real life, they need to focus on ALL THREE simultaneously.

The facilitator should use the following questions to ensure that the whole programme is being rounded up adequately and that participants are clear about how to move forward in the immediate future.

Questions include:

- Are the goals appropriate?
- Is responsibility clearly assigned?
- Are there any legal or institutional implications?
- Is there a team who might carry the Food and Nutrition Action Plan forward?
- How will the proposal be financed or given adequate resources?
- Are actions set in a time-scale with clear target dates?
- Is there a system for reporting the achievement of milestones and target dates?
- What effect might the Food and Nutrition Action Plan have on national, local and private sector economies?
- What changes might be needed in food production capacity?
- How will the effectiveness of the national food and nutrition policy as a whole be measured?
- Can health improvements be monitored?
- Is there provision for review of the national food and nutrition policy?
- Who is setting budgets and reviewing accounts?
- Are health and social goals being merged with financial goals and measures?

Training Materials 9.1

Are food and nutrition policies sustainable – who pays the cost and who gains the benefit?

Food policies in many countries have a production bias in contrast to a health bias. When production is the primary factor under consideration issues such as yield, efficiency of production, priority for resources or inputs, protection of products in the market place and a cost-benefit analysis with a producer bias emerge. However consumers raise concerns such as access to food, the quality and safety of food, impact of production on environmental quality and the risk-benefit question of who takes the risk and who gains the benefit. Lack of consumer confidence poses the greatest challenge to agriculture. This includes environmental concerns, competition for resources, and consumer perceptions regarding the safety and quality of production systems. In addition producers recognize that availability of farm labour and the demands of a global market are increasing challenges.

Re-orienting agriculture to have a more consumer health bias, than a production bias, could encourage a more regionally sustainable agricultural system and create a more diversified agricultural system throughout Europe. It would also require an understanding by consumers of how regional products can meet food-based dietary guidelines.

It is presumed food and health policies must be good but analyses are needed to convince sceptics that scarce resources should be allocated. Given the many competing issues. It is useful to begin by asking why policy interventions related to food and health might be desirable. For most economists the two possible justifications for governmental policy interventions are: (1) to increase efficiency/productivity and (2) to redistribute resources.

Resources are used efficiently, in the economic sense, if they are used to obtain the most products possible given the resources and if the product increases the welfare of society. An investment or expenditure related to food and health is efficient if the social benefit equals its social cost. If the social benefit is greater than the social cost, society is not investing enough and would benefit from increasing the level of investment until the social benefits and costs are equal. Improvements in food related disease and ill health may have important implications for health insurance policies.

The good news about prevention from scientific research is that it appears to improve health. The cost-benefit rule applies when the potential gain to all those affected by an intervention exceeds its costs, and so there is a potential gain in societal welfare. By this standard, preventive policies can be worthwhile even when they do not reduce lifetime medical expenditures or increase lifetime earnings. In terms of health care, the distinction between the internal costs for an individual patient versus the external costs to others is an important conceptual issue. Practical issues include ensuring completeness of the analysis. In principle the analysis should examine all the effects and resource costs of the intervention. This includes: changes in morbidity; mortality; the quality of life; allocations of patient time; care-giving of others; and traditional health sector costs.

Cost of illness studies attempt to quantify the impact of illness on the economy. Medical costs are termed the "direct costs" of treating illness. When illness reduces workers productivity the resulting losses are termed "indirect costs" of illness. The original cost of illness studies estimated both the medical expenditure and productivity losses due to specific conditions such

as heart disease and cancer. The available studies are summarized by the National Institutes of Health, US (1998) in Table 9.1 This presents estimates of the cost of illnesses associated with dietary risk factors and physical in-activity patterns: heart disease, diabetes, stroke, osteoporosis, gall bladder disease, breast cancer, colon cancer, and prostrate cancer. The estimated costs of non-insulin dependent diabetes mellitus (NIDDM), colon cancer and prostrate cancer do not include the costs of productivity losses due to morbidity and mortality. However, the estimated costs of the others do measure the lost earnings associated with lost workdays and premature mortality, but exclude reductions in the productivity of working patients and the lost earnings of unpaid caregivers. All of the studies use the "prevalence-based" approach to estimate the costs incurred by the number of persons suffering from each illness. In contrast the "incidence-based" approach estimates the costs attributable to new cases of the illness during a given year.

Table 9.1. Economic costs of diet and exercise related ill health

Disease	Direct costs Medical expenditure US $ billion	Indirect costs Productivity losses US $ billion	Total costs US $ billion
Heart disease	97.9	77.4	175.3
Stroke	28.3	15.0	43.3
Arthritis	20.9	62.9	83.8
Osteoporosis	n.a.	14.9	14.9
Breast cancer	8.3	7.8	16.1
Colon cancer	8.1	n.a.	8.1
Prostrate cancer	5.9	n.a.	5.9
Gall bladder disease	6.7	0.6	7.3
Diabetes (NIDDM)	45.0	55.0	100.0
Obesity	55.7	51.4	107.1

Sources: National Institutes of Health (1998) and Wolf and Colditz (1998). Costs are expressed in dollars 1998 using the consumer price index.

The estimates in Table 9 establish a context for the economics of diet-related ill health. Given that heart disease is the leading cause of death in Europe as well as the US it is not surprising that it generates the most costs. Based on the analyses by McGinnis and Foege 1993 and Colditz 1992 it is plausible that dietary risk factors and sedentary lifestyles are associated with 60% of diabetes, 35% of breast, colon and prostrate cancers, 30% of gall bladder disease, 25% of arthritis and 20% of heart disease and stroke.

This implies that the economic cost of diet and exercise related ill health in the US in 1998 was US $137 billion. For comparison, the economic cost of alcohol abuse and dependence was estimated at US $118 billion while the economic cost of smoking was estimated at US $90 billion (NIH 1998). For another comparison, medical expenditures (the "direct costs" due to diet and exercise related ill health) totalled US $67 billion representing about 7% of total US personal health care expenditures in 1998.

Weaknesses of this approach include the fact that it does not capture important aspects of burden of disease such as reduced functioning, pain and suffering, and other aspects of the quality of life.

Nevertheless, cost of illness studies appear to be influential in setting priorities in the US and other countries (Wiseman & Mooney, 1998). In the US, there is a strong empirical relationship between the estimated costs of different illnesses and the support they receive. Based on information from the National Institutes of Health (NIH) (1998), for every 10% increase in the cost of an illness there is about a 6% increase in NIH support; or measured in dollars, for every additional billion dollars spent on treating illnesses, there is an additional US $300–400 million of NIH support provided (Kenkel & Manning).

References

Kenkel DS & Manning 1999 W Economic evaluation of nutrition policy Or, there's no such thing as a free lunch! Food Policy 24, 145–162.

National institutes of Health 1998. Disease specific estimates of direct and indirect costs of illness and NIH support:1998 Update. Report submitted to the US House of Representatives Committee on Appropriations.

Wolf AM & Colditz GA 1998 Current estimates of the economic cost of obesity in the US. Obesity Research 6 (2), 97–106.

McGinnis JM & Foege WH 1993 Actual causes of death in the US JAMA 270 (18) 2207–2212.

Colditz GA 1992 Economic costs of obesity American Journal of Clinical Nutrition 55, 503S–507S.

Wiseman V & Mooney G 1998 Burden of illness estimates for priority setting: a debate revisited. Health Policy. 43, 243–251.

Session 10: Review of workshop

Aims

1. Complete an evaluation of the workshop.
2. Discover how workshop can be improved.
3. Discover if workshop can be implemented by participants.

Time

1 hour.

Plan

This session is an opportunity for participants to provide evaluation of the workshop and discover if they feel competent to carry out a similar workshop within their own region or country. This is done firstly by each of them completing an evaluation form, which is confidential, and handing it to the facilitator. Then, there should be a group discussion in which people take turns to provide their views of how the course worked or did not work for them. The facilitator should not dominate but listen and respond at the end, giving thanks to all who have helped create the course, and most of all to the participants, themselves.

Activity

10.1 Written evaluation.
10.2 Feedback in group.

Training Materials

10.1 Evaluation Form.

Outcomes

At the end of this session participants should:

- Feel satisfied!
- Feel ready to work on their national FNAP in any way appropriate.

Activity 10.1
Written evaluation

Instructions

Give out the forms in Training Material 10.1. Ask participants to fill it in and hand back.

Background

The purpose of this is to enable course organizers to evaluate the programme, which is why it is essential to have every participant complete a form.

Activity 10.2
Feedback in Group

Activity Instructions

Get the whole group to sit around in a circle, after allowing them time to fill in the evaluation form. Ask each individual to tell the rest of the group:

1. Were the aims of the course met?
2. Were the materials adequate?
3. Were the methods appropriate?
4. Do they have any suggestions for improvement?
5. Any other comments?

Activity Round-up

The facilitator(s) should thank:

- all participants
- local organizers
- other colleagues present
- invited speakers and guests (if used)
- accommodation staff and support
- administration support both present and not present
- funding bodies
- etc.
- etc.

Training Material 10.1 Evaluation Form

Training workshop
Participants form for evaluating different sessions

1. The time allotted to the session was:

[ ] Too short [ ] About right [ ] Too long

Comments: .....

.....

.....

2. Was the content of the workshop relevant to your work?

[ ] Extremely relevant [ ] Somewhat relevant [ ] Not very relevant [ ] Not at all relevant

Comments .....

.....

.....

3. Will your participation in the workshop help make a contribution to the development or strengthening of national food and nutrition policies and implementation?

[ ] Extremely relevant [ ] Somewhat relevant [ ] Not very relevant [ ] Not at all relevant

Comments: .....

.....

.....

4. The quality of the training was:

[ ] Very high [ ] Somewhat high [ ] Somewhat low [ ] Very low

Comments: .....

.....

.....

5. The quality of the facilitated discussion was

[ ] Very high [ ] Somewhat high [ ] Somewhat low [ ] Very low

Comments: .....

.....

.....

6. Do you have any other comments and suggestions for improving the workshop?

.....

.....

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.....

.....

THANK YOU

PLEASE HAND THIS BACK TO THE FACILITATOR